Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Briege Donaghy
Chief Executive
The Regulation and Quality Improvement Authority
James House,
2-4 Cromac Avenue,
BELFAST,
BT7 2JA

28 November 2023

BY EMAIL ONLY: [redacted]

Dear Madam,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring Witness Statement & the production of documents

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry is investigating the matters set out in its Terms of Reference. A key part of that process is gathering all of the relevant documentation from relevant departments, organisations and individuals.

In keeping with the approach we are taking with other departments, organisations and individuals, the Inquiry is now issuing a Statutory Notice (known as a 'Section 21 Notice') pursuant to its powers to compel the production of relevant documentation.

This Notice is issued to you as a representative of RQIA. It relates to documents within the custody or control of the RQIA. The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. Please provide any documentation which you consider is of relevance to our work and has not been provided to us to date.

If it would assist you, I am happy to meet with you, your officials and/or the RQIA's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

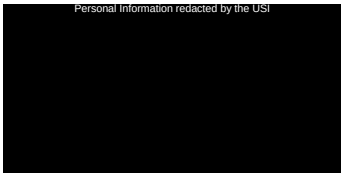
Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit your organisation must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty. The Inquiry will be pleased to receive your documents in tranches; you do not have to wait until you are in a position to fully comply with the Notice before you begin to send documents. Indeed it will greatly assist the progress of the Inquiry's work if you immediately begin the process of forwarding documents to the Inquiry.

If your organisation does not hold documentation in respect of some of the categories of document specified in the Section 21 Notice, please state this in your response. If it is possible to indicate by whom such information might be held, if it is not held by your organisation, the Inquiry would find that of assistance.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully



Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 27 of 2023]

Pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO:

Briege Donaghy
Chief Executive
The Regulation and Quality Improvement Authority
James House,
2-4 Cromac Avenue,
BELFAST,
BT7 2JA

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

DOCUMENTS TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(b) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry the documents set out in the Schedule to this Notice by **12.00 noon on 12th December 2023.**

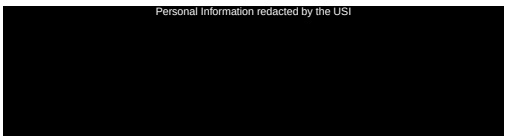
APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **12.00 noon on 5th December 2023.**

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 28th November 2023

Signed: 

Christine Smith QC
Chair of Urology Services Inquiry

SCHEDULE

[No 27 RQIA of 2023]

1. Please provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the RQIA Solicitor, or in the alternative, the Inquiry Solicitor.

2. Please also address the following questions. If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

RQIA – Role and responsibilities

3. The Inquiry understands that RQIA was established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 ("The Order"), which created the legal framework for RQIA to have overall responsibility for monitoring and regulating the quality of health and care services delivered in Northern Ireland. Please explain how RQIA monitors and regulates the delivery of hospital services in Northern Ireland.

4. The Order makes provision for the duties and responsibilities of the RQIA, which may be summarised as:
    i. Keeping the Department informed about the overall state and provision of health and social care services, and in particular, about their availability and their quality.

ii. Encouraging improvement in the quality of services by conducting reviews of health and social care organisations' clinical and social care governance arrangements against quality standards; and thematic and service reviews; and specific investigations as directed by the Department.
iii. Regulation of certain establishments and agencies.

5. Please explain how RQIA carries out its functions at i – iii above (a) generally, and, (b) specifically in relation to hospital services in Northern Ireland

6. RQIA website informs that "*RQIA undertakes a programme of inspections at acute hospitals, which examine the quality of care and leadership within specific wards or clinical areas…*"

    i. Please set out how RQIA examines the quality of care provided to patients within hospitals? Your answer should include the following information:
        a. Please explain the methodology, assessment methods and metrics used.
        b. How might RQIA become aware of a quality of care issue?
        c. What actions are taken if there is a concern about the quality of care?
        d. How, if at all, are these assessments reviewed or revisited?
        e. What are the escalation pathways for RQIA should they consider a concern about the quality of care is not being addressed?
        f. What sanctions or actions are available to RQIA in such instances?

    ii. Please explain how RQIA examines the quality of leadership provided to patients within hospitals? Your answer should include the following information:

a. Please explain the methodology, assessment methods and metrics used.
b. How might RQIA become aware of a quality of leadership issue?
c. What actions are taken if there is a concern about the quality of leadership?
d. How, if at all, are these assessments reviewed or revisited?
e. What are the escalation pathways for RQIA should they consider a concern about the quality of leadership is not being addressed?
f. What sanctions or actions are available to RQIA in such instances?

7. Please set out how RQIA assesses risk in care provided within hospitals?

    i. Please explain the methodology, assessment methods and metrics used.
    ii. How might RQIA become aware of an issue regarding risk?
    iii. What actions are taken if there is a concern about risk?
    iv. How, if at all, are these assessments reviewed or revisited?
    v. What are the escalation pathways for RQIA should they consider a concern about risk is not being addressed?
    vi. What sanctions or actions are available to RQIA in such instances?

8. Does RQIA liaise with Trust Boards in furtherance of its statutory remit? If yes, please explain fully. If not, why not, and would formal engagement with Boards assist the RQIA in fulfilling its role?

9. What is RQIA's view of the quality of engagement by (i) Boards, (ii) senior hospital staff (iii) medical staff (iv) general hospital staff, when reviews and monitoring are undertaken by them?

10. How, if at all, do resources impact on the ability of the RQIA to properly fulfill its statutory role regarding hospitals? Please explain your answer in full, providing examples as appropriate.

11. What, if any, other factors does RQIA consider impacts its ability to fulfill its statutory role regarding hospitals?

RQIA, hospitals, and the Southern Health and Social Care Trust ("SHSCT")

12. Peter May Permanent Secretary, Department of Health states in his section 21 Notice reply at **WIT-42414**:

> 151. Hospitals are not regulated in Northern Ireland. RQIA can however issue Improvement Notices where they find non-compliance with the 2006 Quality Standards. Where RQIA have serious concerns they may suggest that the Department introduce special measures to a hospital or Trust but the decision as to whether to accept RQIA's recommendation rests with the Department. Another function is RQIA Reviews, which seek to provide assurance to the public about the quality, safety and availability of health and social care services in Northern Ireland. The reviews aim to encourage continuous improvements in health and social care services and ensure the rights of service users are safeguarded. Of relevance to this Inquiry may be the review of Consultant Medical Appraisal Across HSC Trusts September 2008, which is provided to the Inquiry at Appendix 38.

Please address the following:

i. How, if at all, does hospitals not being regulated in Northern Ireland impact upon RQIAs overall responsibility for monitoring and regulating the quality of health and care services delivered in Northern Ireland?
ii. How, if at all, does hospitals not being regulated in Northern Ireland impact upon RQIAs ability to monitor and regulate governance within those settings and to properly enable them to fulfil their statutory role in having overall responsibility for monitoring and regulating the quality of health and care services delivered in Northern Ireland?

iii. Should hospitals in Northern Ireland be regulated?

iv. Please explain the 2006 Quality Standards, the responsibilities and duties RQIA has regarding same and how those responsibilities and duties are carried out.

v. Please provide examples of what RQIA may consider "serious concerns", details of when have such concerns have arisen, and what action was taken by both RQIA and the Department.

vi. The Inquiry notes that Mr May states that *"[w]here RQIA have serious concerns they may suggest that the Department introduce special measures…*" (emphasis added). Does RQIA consider their powers to be sufficiently robust to properly enable them to fulfil their statutory role in having overall responsibility for monitoring and regulating the quality of health and care services delivered in Northern Ireland.

vii. Please detail all occasions when RQIA have had serious concerns and suggested that the Department introduce special measures to a hospital or Trust? Please set out the Department's response to any such suggestions.

viii. Please explain RQIA Reviews, providing a list of all Reviews carried out by RQIA. Where applicable, please provide the detail and outcomes of all Reviews carried out within the SHSCT.

ix. Please provide details of the RQIA "Review of Consultant Medical Appraisal Across HSC Trusts September 2008", explaining the current position regarding recommendations made.

13. Mr May also states in his section 21 reply at para 152 at **WIT-42414**

> 152. In terms of governance reviews, RQIA has published its reviews of clinical and social care governance arrangements in health and social care boards, Trusts and agencies across Northern Ireland. The findings from its reviews demonstrate how the concepts and practicalities of clinical and social care governance and risk management are being taken forward in health social care organisations across Northern Ireland. A list of relevant governance reviews is provided to the Inquiry at Appendix 39 to this statement.

Please address the following:

i. Please provide details of RQIAs reviews of clinical and social care governance arrangements in health and social care boards, Trusts and agencies across Northern Ireland.
ii. Please provide an update of any recommendations made arising from those reviews.
iii. Please details any specific reviews relevant to the SHSCT regarding clinical and social care governance.

14. The Inquiry notes the "*Review of Clinical and Social Care Governance Arrangements in Health and Social Care Trusts in Northern Ireland 2008 – Southern Health and Social Care Trust*" found at: CONTENTS (rqia.org.uk) . Please provide a copy of this Review and address the following:

i. Please set out RQIAs understanding in relation to the recommendations made by RQIA following that review.
ii. In particular, please provide an update on the following recommendations:
    a. RECOMMENDATION 5: *The Trust should develop and implement a unified policy on consent within this current financial year and ensure that mandatory consent training is provided to all staff as appropriate. This should be of satisfactory depth to ensure that informed consent is being both obtained and recorded.*

    b. RECOMMENDATION 13: *The Trust need to reinforce the new complaints and feedback systems to both service users and to staff, ensuring that learning from complaints is effectively shared across Southern HSC Trust Final Report 57 Southern HSC Trust Final Report 58 the service. To this end the Trust should continue to change the culture of complaints handling to ensure that the views of both users and frontline staff are taken into account to improve services, implementing and*

evaluating the effectiveness of the Lessons Learned model as a priority.

iii. How, if at all, does RQIA follow up on and monitor the acceptance and implementation of Recommendations made to the Trust?

iv. Does RQIA consider it has sufficient powers to ensure that Recommendations made by them, in furtherance of their statutory duties and responsibilities, are taken seriously and properly implemented to address concerns regarding the quality of health and care services delivered in Northern Ireland.

15. Mr May further states in his section 21 reply at para 152 at **WIT-42414**

> 153. The preceding paragraphs are a means of providing the context for a forthcoming fundamental review of regulation, to be led by the Department. A draft consultation document on such a review had been completed in 2020 but was not published owing to the Covid pandemic. That draft is currently being updated to take account of lessons learned from the pandemic, as well as from the findings of the INI and indeed the preparation of this statement. It is the Minister's intention that this fundamental review will be taken forward during the current mandate of the Assembly. A copy of the draft, unpublished consultation document 'The Right Touch: A New Approach to Regulating Health and Social Care in Northern Ireland' is provided to the Inquiry at Appendix 40 to this statement. An analysis of issues 'The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 – Gaps and Issues' is provided to the Inquiry at Appendix 41.

Please address the following:

i. Please explain RQIAs understanding of the current status of the "*fundamental review of regulation*" being undertaken by the Department;

ii. Please provide, as available, a copy of any RQIA response to consultation.

16. Where not already covered by questions already asked, please set out all occasions when the RQIA monitored and regulated the quality of health and care services delivered by the SHSCT.

17. Where not already covered by questions already asked, please set out all occasions when the RQIA monitored and regulated the quality of health and care services delivered by all other Trusts in Northern Ireland.

18. The Inquiry understands that in 2014 RQIA was tasked to undertake inspections of acute hospitals. This is done under the provision for using inspection as part of a review (article 35 1(d)) of the 2003 Order. The Hospital Inspection Programme (HIP) is a rolling programme of inspections (Peter May section 21 at para 146, **WIT-42413/4**). Please provide all hospital inspection reports completed as part of the HIP and detail whether recommendations were accepted and acted upon. Please detail any reports which remain outstanding.

19. The Inquiry understands that RQIA's *Hospitals Programme Team* had planned to undertake a series of inspections to outpatient departments during 2021/22 as part of follow up of the RQIA review of Governance Arrangement in the Belfast Trust but that this work has not yet commenced (Peter May section 21 at para 149, **WIT-42415**).

i. Please provide the Inquiry with details and outcomes of the RQIA review of Governance Arrangement for the Belfast Trust, including the current position regarding any recommendations made;

ii. Please update the Inquiry as to progress to date on the proposed outpatient department inspections, detailing barriers to commencement and completion.

20. Mr Paul Kavanagh (SPPG) states in his section 21 Notice reply at para 422 at **WIT-104354**:

> 422. In respect of the RQIA, the SPPG will be advised of inspections, reports and recommendations that are relevant to its role by RQIA, as are all HSC organisations. SPPG remains open to direct engagement with RQIA, as required, but it has no role in directing the RQIA workload. SPPG can however make suggestions to inform RQIA of concerns which can result in RQIA undertaking inspection activity

Please address the following:

i. Please explain the way in which SPPG and RQIA interact in furtherance of RQIA fulfilling its statutory role?

ii. Does RQIA consider that their engagement with SPPG is effective in achieving this aim? If not, what could be improved upon?

iii. Has SPPG ever made "*suggestions to inform RQIA of concerns*" which (i) have or (ii) have not resulted in RQIA undertaking inspection activity.

RQIA and SAIs

21. In his section 21 Notice reply at paras 166 and 167 at **WIT-104290 – WIT 104291**, Paul Kavangh (SPPG) states:

> 166. In April 2018, RQIA was commissioned by the Department to examine the application and effectiveness of the SAI procedure. The time taken to complete RQIA's review was significantly impacted by the Covid-19 pandemic. However, its 'Review of Systems and Processes for Learning from SAIs' report was published in June 2022 (SG Appendix 308 - SPPG – C – 00457 DoH RQIA Review of the Systems and Process for Learning from SAIs in NI - WIT 73620 to WIT 73683).
>
> 167 A project to redesign the current SAI Procedure commenced in July 2023. It is being led by the Department's Healthcare Policy Group. It will address the recommendations from the Inquiry into Hyponatraemia-related Deaths and the Independent Neurology Inquiry, alongside the recommendations in the RQIA's 2022 report. The recommendations in these reports provide a strong evidence base to support the introduction of a new framework for the identification and embedding of learning from adverse healthcare incidents or events

22. Please detail in full the current role of RQIA in SAIs.

23. What is RQIAs understanding of the outworking of its 2022 Review? What, if any, changes have been made as a result of the Review and what remains outstanding?

24. What role, if any, does RQIA play in monitoring and overseeing the outworking of its 2022 Review? If not RQIA, who carries out the monitoring and oversight of the Review outcomes?

25. If RQIAs review has been superseded by the project commenced in July 2023 regarding the introduction of a new framework for the identification and embedding of learning from adverse healthcare incidents or events, what is RQIAs understanding of the timeframes for the July 2023 project and RQIAs anticipated role in it?

RQIA and the SHSCT Lookback Review

26. The Inquiry is in receipt of the RQIA report into the Lookback Review undertaken by the SHSCT. Please provide an update on the outworkings of that Report, detailing what, if anything, has been changed as a result. What remains outstanding and RQIAs understanding of why recommendations made, have not been implemented.

RQIA and the Inquiry Terms of Reference

27. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of RQIA's involvement in or knowledge of all matters falling within the scope of those Terms. This should include a detailed description of any issues raised with or by RQIA, meetings attended, and actions or decisions taken by RQIA and others to address any concerns or governance issues arising, including prior to, during and after the Early Alert

Communication from the Trust to the Department on 31 July 2020. Your answer should include all relevant information, including but not limited to the following issues:

i. Was RQIA aware that a formal process under the framework contained within Maintaining High Professional Standards in the Modern HPSS commenced in December 2016 (in relation to Mr Aidan O'Brien), in part, as a response to information uncovered during the investigation into the SAI for Patient 10 (RCA 52720)? If so, outline when and in what circumstances RQIA became so aware and outline the RQIAs understanding of how that process progressed. If RQIA was not made aware of the commencement of this MHPS process, should it have been made aware?

ii. When, if at all and in what circumstances did RQIA first receive information which identified or could have identified concerns regarding Mr. Aidan O'Brien's practice?

iii. Prior to 31 July 2020, was RQIA aware of any concerns in relation to Urology Services within the Trust, including service capacity or waiting list issues, or in relation to the practice of Mr. Aidan O'Brien in particular.

iv. Did RQIA reach any view concerning the appropriateness, quality and timeliness of the steps taken by the Trust to communicate and escalate the reporting of issues of concern within the Trust to the Department, the HSCB or any other relevant body? If so, fully outline the view which has been reached and set out the reasons for the view which has been reached. If the RQIA has not evaluated this issue, please explain why.

v. Did RQIA reach any view concerning the effectiveness of the corporate and clinical governance procedures and arrangements within the Trust in the context of the matters which gave rise to the

need to issue an Early Alert? If so fully outline the view which was reached and set out the reasons for the view which had been reached. If the RQIA did not evaluate this issue, please explain why.

vi. Detail what advice, if any, was given to the Trust by RQIA in response to the Early Alert and any matters related to the Inquiry Terms of Reference.

vii. Detail any meetings or discussions between officials from RQIA and the Trust, the Department, the PHA, the HSCB/SPPG and any other relevant organisation concerning the handling of the concerns raised or related issues. With regards to each meeting or discussion, specify:

    a. The date;
    b. The attendees;
    c. The matters discussed;
    d. Any decisions taken;
    e. Any advice provided by the Department or received by RQIA;
    f. Disclose or refer to any and all documentation relating to same.
    g. Detail any communications RQIA had with any of the following persons/bodies as part of the process leading to the establishment of the public inquiry:
        1. The Trust;
        2. The Department;
        3. The PHA;
        4. The HSCB;
        5. Mr. O'Brien's representatives; and
        6. Any other relevant person or organisation.

viii. What assurances did RQIA seek and receive (if any) with regard to the appropriateness of the use of the Lookback Review undertaken in

relation to the patients of Mr. O'Brien from 1 January 2019 to 30 June 2020?

28. Where not already addressed above, please set out in detail RQIAs ongoing role and steps taken, if any, in monitoring, seeking assurance and ensuring patient and general public safety arising out of the concerns about patient care and safety raised by the SHSCT.

29. Where not already addressed above, please detail:

    I. What, if any, reforms RQIA is aware of the Trust having made to clinical governance arrangements to address any issue which may have been identified?
    II. What, if any, processes have been implemented or steps taken by the Trust to monitor or provide assurance that the clinical governance arrangements within the Trust are to the RQIAs satisfaction and ensure patient safety?
    III. What, if any, assurances has RQIA sought and received from the Trust with regard to any reforms to clinical governance arrangements?
    IV. What, if any, monitoring has the RQIA implemented to ensure that the clinical governance arrangements within the Trust protect patient safety?

30. How, if at all, have any reforms or assurances been tested? In addressing this question also outline what, if any, assurances RQIA received or continues to receive, and outline whether the assurances received to date are considered by RQIA to be satisfactory.

31. Does RQIA consider there remains outstanding work to be done by the Trust before its governance structures are sufficiently robust to prevent a reoccurrence of the issues which arose within the Trust's Urology Services? Whether your answer is yes or no, please explain.

32. In light of the Minister's Oral Statement to the Assembly on Tuesday 24 November 2020, where he stated:

> The consultant also had a significant amount of private practice and that much of this was carried out in private domestic premises, therefore sitting outside of the regulatory framework which requires registration and external assurance of facilities in the Independent Sector in which clinicians may undertake private practice. This is also of significant concern to me as many of these patients may be unknown to the Southern Trust or the wider HSC system.
>
> …
>
> *The Minister went on to list actions to be taken, which included the following:*
>
> Thirdly, in relation to his private patients who are not known to the Southern Trust, I have requested that his solicitors outline how Mr. O'Brien intends to provide a similar independent process to ensure that those private patients are alerted to issues arising and that their immediate healthcare needs are being met. Whilst the Department has no explicit duty to take this particular matter forward, as part of our wider healthcare responsibilities, I want to do all I can to safeguard patients who may have received care or treatment in a private capacity from this consultant.

What, if any, assurances has RQIA sought and received regarding the care and governance of Mr. Aidan O'Brien's private patients from:

I. The Trust;
II. Mr. Aidan O'Brien;
III. Mr. O'Brien's legal representatives; or
IV. Any other relevant person, organisation or source.

33. If assurances have been sought and provided in respect of Mr. O'Brien's private patients, how has RQIA tested the effectiveness of these assurances? Is RQIA satisfied by the assurances provided? If not, what are the RQIA proposed next steps, if any, regarding Mr. O'Brien's private patients?

34. Has RQIA reached any view concerning the appropriateness, quality and timeliness of the steps taken by the Trust to address the issues of concern and ensure patient safety? If so, fully outline the view which has been reached and set out the reasons for the view which has been reached. If RQIA has not evaluated this issue, please explain why.

Learning

35. From the information available to RQIA to date, what does it consider went wrong within the Trust's urology services and with regard to Trust governance procedures and arrangements? Has RQIA reached any view on how such issues may be prevented from recurring? Has RQIA taken any steps with a view to preventing the recurrence of such issues?

36. Does RQIA consider that it did anything wrong or could have done anything differently which could have prevented or mitigated the governance failings of the Trust?

37. From RQIA's perspective, what lessons have been learned from the issues of concern which have emerged from urology services within the Trust? Has this learning informed or resulted in new practices or processes for RQIA? Whether your answer is yes or no, please explain.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

The Regulation and Quality Improvement Authority

Anne Donnelly
Urology Services Inquiry
1 Bradford Court
Belfast
BT8 6RB
By email only- [redacted]

15th January 2024

Dear Madam

RE: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust ("The Inquiry")

I refer to the Inquiry's Section 21 Notice of 28th November 2023 requiring RQIA to submit its witness statement and evidence in relation to the above Inquiry. I now enclose my signed statement dated 15th January 2024 along with zip folder containing the exhibited documentation referred to therein.

The Inquiry has asked that reasons be provided when a document is provided in redacted form in accordance with its Procedural Protocol. The names of staff below Chief Executive level and individuals not employed by RQIA have been removed. This has been done for confidentiality purposes on the basis that the Inquiry may wish to publish documents at a later date but also that all RQIA decision making was taken at Chief Executive level or above. I can of course provide the Inquiry with these documents in unredacted form should it wish to consider these in the first instance.

Should the Inquiry require me to make any amendment(s) to my statement or provide further information and/or clarification then I will of course attend to this as expeditiously as possible.

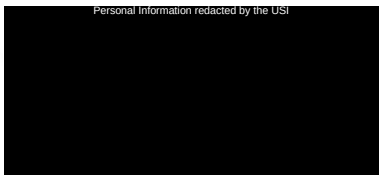
I would be grateful if the Inquiry could acknowledge receipt of the enclosed documentation.

RQIA, 1st Floor
James House
Gasworks
2 – 4 Cromac Avenue
Belfast
BT7 2JA

Tel [redacted]
Email info@rqia.org.uk
Web www.rqia.org.uk
Twitter @RQIANews

The Regulation and Quality Improvement Authority

Yours faithfully



Chief Executive

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 27 RQIA of 2023

Date of Notice: 28th November 2023

Note: An addendum to this witness statement was received by the Inquiry on 16 Feb 2024 and is located at WIT-106891 to WIT-107046. A further addendum was received on 19 Feb 2024 and is located at WIT-107047 to WIT-107048.
Annotated by the Urology Services Inquiry.

Witness Statement of: Briege Donaghy

I, Briege Donaghy, will say as follows: -

Introduction

1. This statement is made on behalf of the Regulation and Quality Improvement Authority ("RQIA") in response to a request for evidence by the Inquiry Panel for the purposes of the Urology Public Inquiry.

2. I provide this statement in my role as Chief Executive Officer of RQIA, a position that I have held since July 2021 when I was appointed by the Authority, which I explain further below, with the approval of the Department of Health ("the Department"). I lead RQIA's Executive Management Team and I am responsible to the Authority for the general exercise of its functions.

3. This is my first statement to the Inquiry.

4. By letter of 28 November 2023, the Inquiry required RQIA to provide a statement to assist the Inquiry.

5. RQIA therefore provides this statement to inform the Inquiry in relation to the topics set out in the correspondence of 28 November 2023. I have been supported in providing this statement by current employees of RQIA, including RQIA's Director of Hospital Services, Independent Healthcare, Audit and Reviews (the Directorate within which sits our Inspection and Review Teams that focus on healthcare services). Where I provide information in this statement it is a product of my own knowledge or the product of information provided to me by colleagues who I understand are informed of the matters which are detailed.

6. There may be a limit on the information which I can supply to the Inquiry but I have sought to assist as best I can. I have sought to set out any particular issue which I do not feel that I can comment on and why.

7. This statement provides information relating to the questions raised by the Inquiry in its correspondence to RQIA, Schedule [No 27 RQIA of 2023]. This includes information on the context of RQIA's legislative role, functions and adopted processes, and, in particular, those that relate to Health and Social Care Services (HSC) Hospitals in Northern Ireland, delivered by the HSC Trusts, and which are referred to as "statutory services".

Introduction to RQIA

8. The RQIA was established as a body corporate by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, as amended, ("the 2003 Order") and came into existence in April 2005.[1]

9. The RQIA is Northern Ireland's independent health and social care regulator, a non-departmental public body within the Department of Health in Northern Ireland.

10. The Membership of the RQIA is set out in the 2003 Order (Schedule 1, Article 5), and consists of a Chairman and other members appointed by the Department of Health ("the Department"), through a Public Appointments process. Collectively, the Chairman and members constitute the Authority. The Authority appoints a Chief Executive, with the approval of the Department. The Authority may appoint such other staff as it considers appropriate, including Directors and inspection staff. The structure of the RQIA prior to the Covid-19 pandemic is available at **Exhibit BD1** including Authority Chair and Members. The organisation has subsequently been re structured, with effect from January 2022.

11. The Authority is accountable through the Permanent Secretary of the Department of Health to the Minister. The Department may make directions under Article 6(2) of the 2003 Order as to the exercise of its functions by the RQIA; and the RQIA must comply with these.

[1] The RQIA was established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. Available: The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (legislation.gov.uk)

RQIA'S DUTIES FUNCTIONS AND POWERS

12. RQIA's general duties, set out in Article 4 of the 2003 Order are:

    a. keeping the Department informed about the provision of services, and in particular their availability and quality; and,

    b. encouraging improvement in the quality of services.

13. It carries out these duties primarily through:

    a. registering and inspecting (under Part III of the 2003 Order) a wide range of services including residential care homes and nursing care homes;

    b. Under Part IV of the 2003 Order,

        i. Conducting reviews of arrangements by statutory bodies for the purpose of monitoring and improving the quality of health and social care services for which they are responsible;

        ii. Carrying out investigations into the management, provision or quality of health of health and social care services for which statutory bodies have responsibility;

        iii. Conducting reviews of the management, provision or quality of or access to or availability of particular types of health and personal social care services for which statutory bodies or service providers have responsibility;

        iv. Inspecting statutory bodies and service providers, and persons who provide or are to provide services for which statutory bodies or service providers have responsibility.

14. In addition, following the transfer of functions from the Mental Health Commission to the RQIA in 2009, RQIA is responsible for keeping under review the care and treatment of Patients under Article 86 of the Mental Health (Northern Ireland) Order 1986 ('patient' being defined by the 1986 Order, except in Part VIII, as someone suffering or appearing to be suffering from a mental disorder), and other functions under that order and under the Mental Capacity Act (Northern Ireland) 2016.

15. RQIA undertakes these duties in accordance with Regulations and Standards made by the Department of Health; and, due to resource constraints, increasingly on a risk assessed basis. It makes reports on these activities to the Department, and publishes these on its website; alongside any enforcement actions which it may have taken.

16. RQIA also engages regularly with, and provides information to, the Department e.g. through the provision of a Liaison Report, issued on a quarterly basis, by the Office of the Chair and Chief Executive. The Liaison Report currently provides information on current and emerging issues within services and organisations, in addition to financial and performance monitoring information.

17. RQIA's powers, and therefore also its functions, are different depending upon whether a service is registered or not.

18. Not all health and social care services are required to register with RQIA under the 2003 Order. Services provided by, or arranged by, the Health and Social Care Trusts, including acute hospitals, are not required by Part III of the 2003 Order to be registered with RQIA, and are referred to hereafter as "statutory services". RQIA's functions in respect of such services are set out in Part IV of the 2003 Order (Article 35).

19. Whilst the 2003 Order established the role and functions of RQIA it also, through Article 34, introduced a statutory duty of quality on HSC Trusts, and the then HSC Boards. These Boards were subsumed into the Regional HSC Board under the Health and Social Care (Reform) Act 2009, and (following the abolition of the HSCB by the Health and Social Care Act (Northern Ireland) 2022) now form the Strategic Planning and Performance Group "SPPG" within the Department of Health.

20. It should be noted that while the original Health and Social Care Boards, and their successor, the Regional Health and Social Care Board, were subject both to the statutory duty of quality set out in Article 34 of the 2003 Order and to RQIA oversight under Article 35, the Department itself, and SPPG as an integral part of the Department, are not so subject. Additionally, RQIA has no power to serve an improvement notice (Article 39) on SPPG; or to require from SPPG the production of information necessary or expedient for the purposes of its functions (Article 41).

21. While all of the services provided by or through the Health and Social Care Trusts are subject to the statutory duty of quality under Part IV, Article 34 of the 2003 Order, most are not required to register with RQIA under Part III of the 2003 Order. Exceptions are those services specifically listed in Part III of the Order including children's homes, care homes and domiciliary care services provided by the Health and Social Care Trusts. So there are some HSC services which are "registered services".

22. RQIA has the power to take enforcement action against registered services and their providers, up to and including cancelling the registration of the service/provider. It is a criminal offence for these services to operate if they are not registered with RQIA. However, the majority of services provided by the Health and Social Care Trusts are not registered with RQIA. In respect of these unregistered services, RQIA's powers are limited to the authority to:

c. review; to investigate; and to inspect;
d. report findings including making formal Reports to the Department if RQIA comes to the view that the services being provided are of unacceptably poor quality or there are significant failings in the way in which the service is being run;
e. require improvements to be made.

23. However, RQIA does not have authority to set conditions on services being provided, or (by removing registration) to close such services.

24. Such decisions remain with the Department.

RQIA's ROLE, RELATIONSHIPS, FUNDING AND STRUCTURE

25. The role of RQIA is described within a Framework Document, dated September 2011, produced by the Department in accordance with Section 5 of the Health and Social Care Reform Act (NI) 2009. This is contained within **Exhibit BD2**. The Framework Document describes the roles and functions of HSC bodies and the systems that govern their relationships with each other and the Department. The Framework Document states that all HSC bodies remain ultimately accountable to the Department for the discharge of their functions as these are set out in their respective founding legislation. It also refers to Article 67 of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended, which provides a duty of co-operation between bodies to secure and advance health and social welfare in Northern Ireland. Therefore, all health and social care bodies must work together and with the Department to further this overall duty.

26. Specific to RQIA, the Framework Document sets out core statutory functions of RQIA as summarised at paragraph 12, above, and it also describes (para 2.46 of the Framework Document) RQIA's relationship with the Department and wider HSC system; noting that the relationship is driven by RQIA's independent role and wider responsibility to encourage improvement. It notes that HSC bodies look to RQIA for independent validation of internal arrangements for clinical and social care governance, provided through a programme of thematic reviews within the HSC.

27. RQIA is currently funded primarily from an allocation made annually by the Department. Just over £8m of an annual budget of circa £9.2m comes from public funds via the Departmental allocation. Under £1m comes from fees that RQIA raise from those services that must register with it. These include care homes, independent clinics and independent hospitals. The fee to register a care home, by way of example, with RQIA is £952, with an annual fee thereafter based on the number of registered beds/ places. These fees were set out in The Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (NI) 2005 ("the 2005 Regulations") and have not been adjusted since (see below). Except in relation to allowances for pay awards, RQIA's budget has remained static for some time. There has been no uplift of RQIA's budget allocation by the Department.

28. RQIA's role as regional regulator of health and social care services covers both services provided by statutory bodies and service providers (Part IV of the 2003 Order), and by the independent sector through registered services (Part III of the 2003 Order). Some registered services are also provided by the HSC Trusts, including childrens homes and domiciliary care agency services. However, the 2003 Order places functions on RQIA specifically in relation to registered (Part III) services. This is reinforced by Regulations specifying, for example, the frequency of inspections to be conducted by RQIA in respect of such services i.e. the 2005 Regulations set out above, with no equivalent provision existing in respect of statutory services. Accordingly, RQIA's capacity and resources have traditionally been focussed heavily towards registered (Part III) services, with the majority of the Departmental allocation from public funds being directed towards RQIA's activity in respect of these (overwhelmingly independent sector) services.

29. The current infrastructure of RQIA and its work force is set out in the evidence folder **(Ref Exhibit BD3)**. RQIA employs approximately 140 staff (headcount), including around 65 inspectors.

30. RQIA's activities in relation to statutory (Part IV) services are conducted through its Directorate of Hospital Services, Independent Healthcare, Audits and Reviews. Currently, the annual budget for this Directorate is approximately £1.45m; and 8.6 inspectors and 2 senior inspectors work within the Directorate, whose responsibilities include some registered (Part III) services, such as independent hospitals, clinics and dental practices as well as HSC services (Part IV). £285k of the Directorate's budget is aligned to professional staff and inspectors directed to Hospital services. This currently includes the HSC acute hospitals (including the principal acute hospitals:, such as Royal Victoria Hospital, Antrim Area Hospital, Ulster Hospital, Craigavon Hospital, and Altnagelvin Hospital) and independent hospitals with overnight beds (of which there are six). In addition, administration staff are available to the Directorate, along with a Director and Assistant Directors as senior managers.

31. As described above, RQIA's core statutory duties are set out in Article 4 of the 2003 Order, which provides, in summary, that RQIA will:

f. keep the Department informed about the provision of services, and in particular their availability and quality; and,

g. encourage improvement in the quality of services.

32. It carries out these duties primarily through:

h. registering and inspecting (under Part III of the 2003 Order) a wide range of services including residential care homes and nursing care homes; independent hospitals; dental practices.

i. Under Part IV of the 2003 Order,

i. Conducting reviews of arrangements by statutory bodies for the purpose of monitoring and improving the quality of health and social care services for which they are responsible;

ii. Carrying out investigations into the management, provision or quality of health of health and social care services for which statutory bodies have responsibility;

iii. Conducting reviews of the management, provision or quality of or access to or availability of particular types of health and personal social care services for which statutory bodies or service providers have responsibility;

iv. Inspecting statutory bodies and service providers, and persons who provide or are to provide services for which statutory bodies or service providers have responsibility.

33. In addition, following the transfer of functions from the Mental Health Commission to the RQIA in 2009, RQIA is responsible for keeping under review the care and treatment of Patients under Article 86 of the Mental Health (Northern Ireland) Order 1986 ('patient' being defined by the 1986 Order, except in Part VIII, as someone suffering or appearing to be suffering from a mental disorder), and other functions under that order and under the Mental Capacity Act (Northern Ireland) 2016.

34. RQIA's powers, and therefore also its functions, are different depending upon whether a service is registered or not.

35. Not all health and social care services are required to register with RQIA under the 2003 Order. Services provided by, or arranged by, the Health and Social Care Trusts, including acute hospitals, are not required by Part III of the 2003 Order to be registered with RQIA, and are referred to hereafter as "statutory services". RQIA's regulation of these services is provided for in Part IV of the 2003 Order.

36. Whilst the 2003 Order established the role and functions of RQIA, it also, through Article 34, introduced a statutory duty of quality on HSC Trusts, and the then-HSC Boards ("HSCB"). These Boards were subsumed into the Regional HSC Board under the Health and Social Care (Reform) Act 2009, and (following the abolition of the HSCB by the Health and Social Care Act (Northern Ireland) 2022) now form the Strategic Planning and Performance Group ("SPPG") within the Department. It should be noted that while the original HSCB, and their successor, the Regional Health and Social Care Board, were subject both to the statutory duty of quality set out in Article 34 of the 2003 Order and to RQIA oversight under Article 35 of the 2003 Order, the Department itself, and SPPG as an integral part of the Department, are not so subject. Additionally, RQIA has no power to serve an improvement notice (Article 39 of the 2003 Order) on SPPG; or to require from SPPG the production of information necessary or expedient for the purposes of its functions (Article 41 of the 2003 Order).

37. While all of the services provided by or through the Health and Social Care Trusts are subject to the statutory duty of quality under Part IV, Article 34 of the 2003 Order, most are not required to register with RQIA under Part III of the 2003 Order. Exceptions are those services types specifically listed in Part III of the Order including children's homes, care homes and domiciliary care services provided by the Health and Social Care Trusts. So, there are some HSC services which are "registered services".

38. RQIA has the power to take enforcement action against registered services and their providers, up to and including cancelling the registration of the service/provider. It is a criminal offence for these services to operate if they are not

registered with RQIA. However, the majority of services provided by the Health and Social Care Trusts are not registered with RQIA. In respect of these statutory services, RQIA's powers are limited to the authority to:

j. review; to investigate; and to inspect;

k. report findings including making formal reports to the Department if RQIA comes to the view that the services being provided are of unacceptably poor quality or there are significant failings in the way in which the service is being run;

l. require improvements to be made.

39. However, RQIA does not have authority to set conditions on services being provided, or (by removing registration) to close such services. Such decisions remain with the Department in accordance with its statutory duties laid out at Section 2 of the Health and Social Care Reform Act (NI) 2009.

Functions in relation to Statutory Services: Examining and Reporting on Quality of Care

40. RQIA's powers in relation to statutory services are restricted to the functions of conducting reviews and carrying out investigations of statutory bodies and service providers. RQIA can also carry out an inspection of a specific statutory service. As referred to earlier, these functions are set out at Article 35 of the 2003 Order.

41. An RQIA review examines quality of care and adherence to best practice for a service, condition or policy (e.g. maternity services; risk of choking for vulnerable adults; or use of the Serious Adverse Incident procedure across HSC organisations in Northern Ireland). The Review Protocol is contained within **Exhibit BD4.**

42. An inspection of a specific service assesses the service against the Department's Quality Standards for Health and Social Care, published March 2006 ("the Quality Standards"). The Quality Standards are contained within **Exhibit BD5**. RQIA uses the Quality Standards in planning for and undertaking an inspection and when seeking evidence of compliance with those minimum standards.

43. RQIA's inspection methodology will focus on the following four domains against which services will be assessed according to the relevant Quality Standards, and best practice, asking:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well led?

RQIA inspections seek evidence through the use of:

- **engaging with people**: holding interviews with staff across an organisation, at the front line, in middle management and in senior management roles; through engaging with patients, families and carers to seek information on their personal experience and making use of surveys and focus groups;
- **direct observation**: observing how staff interact with each other, with patients and how they operate at an individual and team level;
- **reviewing relevant document e.g. records, policies, registers**: including policies and procedures, rotas, logs and reports;
- **quantitative data, evidence, information:** considering benchmarks; trends and patterns of activities; reports from other sources.

44. RQIA's inspection methodology collates and triangulates information secured through physical inspection with a review of relevant information and intelligence held by RQIA (including concerns, whistleblowing and Early Alerts, for example), and also examines previous inspection reports.

45. Metrics will include quantitative indicators, for example recorded incident reporting, including oversight and management of incidents; actions taken and learning applied; training records; evidence of staffing rotas and compliance with the identified staff skill mix needed for a particular patient group or specialty. Qualitative evidence will also be sought through engaging with patients and staff, direct face to face discussions, and through the use of survey forms during the inspection.

46. Inspection questions and tools are most often developed bespoke to the specific issue; service or specialty being inspected. Inspections adopt the same framework but the tools used, questions asked and evidence sought will be tailored suitable to the environment being inspected. I enclose a copy of the 'Acute Hospital Outpatient Department Inspection Framework' within **Exhibit BD6** by way of example. This is the inspection methodology adopted in relation to the 'The Review of the Governance of Outpatient Services in the Belfast Health and Social Care Trust (with a particular focus on Neurology Services and other High Volume Specialties)', published February 2020, and is referred to further in this statement.

47. The Inquiry has asked specifically how RQIA may become aware of a quality of care issue within a service or organisation. RQIA becomes aware of such issues through assessment of intelligence received, from patients and families contacting RQIA or from staff; through reports and contacts with other organisations; and from analysis of Early Alerts; as well as by reviewing previous inspections and reviews. In advance of an inspection, such information and intelligence will be assessed and considered. Sometimes, information and intelligence received by RQIA will lead to an inspection, if RQIA judge this is justified and needed.

48. Where RQIA are concerned about the quality of care, based on assessed intelligence or through inspection, this matter may be raised with the HSC Trust in first instance. Depending on the nature of the matter, and the actions the Trust take, RQIA may consider further actions. This may include follow up inquiries with the Trust, the Department or other bodies e.g. professional bodies, trade unions, Commissioners, and other regulators. Action may include physical inspection.

49. Inspections result in an Inspection Report being issued to the Trust. Where failings are identified, the Trust will be required to submit to RQIA a Quality Improvement Plan (QIP), with actions and timescales. RQIA may also take further enforcement action including the serving of an Improvement Notice, or recommending Special Measures to the Department. In any of these circumstances, RQIA would require the Trust to submit evidence of actions being taken. RQIA may follow up with further inspections to review or revisit the findings and impact of actions taken, to assess if these have addressed or are addressing the failings. Decisions to take enforcement action may be after a Serious Concerns meeting or an 'Intention to

Serve an Improvement Notice' meeting. These are part of the RQIA Enforcement Procedures.

50. During an inspection or review, where RQIA staff identify an issue of concern about the quality of care that they consider requires immediate attention, an Escalation Pathway is in place for RQIA to raise the matter with the HSC Trust senior management Team and senior staff within RQIA. The matter may also be drawn to the attention of the Department

51. As has been stated earlier in this statement, RQIA do not have the authority to place any sanctions on the HSC Trust where there are failures to meet Quality Standards. The RQIA can take action, in that it can require the Trust to complete and submit a QIP; RQIA can issue a service Improvement Notice; and can report to the Department and recommend special measures. However, RQIA cannot place conditions on the Trust and it cannot direct that the Trust ceases to provide services. The RQIA Escalation Policy and Procedure is contained within **Exhibit BD7**.

Assessing quality of leadership and risk in care

52. The Inquiry has asked in particular how 'the quality of leadership' is assessed and how 'risk in care' is assessed. RQIA understand that these specific questions relate to the elements of RQIA inspections which ask "is the Service Well Led"; and "is Care Effective".

53. As has been described earlier, the RQIA inspection framework refers to the Quality Standards for HSC Services. Quality Standard 4 (Theme 1) in the Quality Standards is "**Corporate Leadership and Accountability of Organisations**", followed by "**Safe and Effective Care** " (Theme 2).

54. In order to assess the quality of a HSC Trust's Leadership, RQIA Inspectors will seek evidence to show that the Trust demonstrates the elements set out in the Quality Standards for this Theme 1. These consider if the Trust:

a) has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability;

b) has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance;

c) has processes in place to develop leadership at all levels including identifying potential leaders of the future;

d) actively involves service users and carers, staff and the wider public in the planning and delivery, evaluation and review of the corporate aims and objectives, and governance arrangements;

e) has processes in place to develop, prioritise, deliver and review the organisation's aims and objectives;

f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;

g) has systems in place to ensure compliance with relevant legislative requirements;

h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

i) undertakes systematic risk assessment and risk management of all areas of its work;

j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with Departmental policy and guidance; professional and other codes of practice and employment legislation.

k) undertakes robust pre-employment checks including qualifications of staff to ensure they are suitably qualified and are registered with the appropriate professional or occupational body; police and Protection of Children and Vulnerable Adults checks , as necessary; health assessment, as necessary; and the provision of references.

l) has in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning, facilitate professional and regulatory requirements, and informs the organisation's training, education and workforce development;

m) has a training plan and training programmes, appropriately funded, to meet identified training and development needs which enable the organisation to comply with its statutory obligations;

n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.

55. As noted above, the methodology, assessment methods and metrics will include a combination of observation, review of documentation, quantitative and qualitative information, including staff experience and the lived experienced of patients, families and others.

56. RQIA may become aware of leadership issues from a review of intelligence it receives, including concerns raised by staff, patients, professional bodies and others.

57. As with any concern identified, a number of actions are open to RQIA including requesting the production of a Quality Improvement Plan, or serving an Improvement Notice pursuant to Article 39 of the 2003 Order on a particular Trust, where there is a failure to demonstrate or achieve the leadership and accountability minimum standards, setting out what improvements RQIA considers necessary. This Improvement Notice is published on the RQIA website and made known to key stakeholders.

58. If, on carrying out such an inspection, the RQIA reaches the view the service is of unacceptably poor quality, or there are significant failings in the way the service has been run, the RQIA must, pursuant to Article 35 of the 2003 Order, make a report of its view to the Department. That report must include evidence as to how RQIA reached that view. The view must be based on evidence RQIA secured during its review or inspection, compared to the minimum standards required under the Quality Standards, and considering best practice. With that report, RQIA may recommend that the Department take special measures in relation to that body or service. RQIA does not determine the nature of such special measures, though it may make recommendations for Departmental consideration. Recommending special measures is the ultimate sanction available to RQIA in respect of statutory services. It is a very material step, and must be supported by robust and tangible evidence.

59. As referred to earlier, RQIA cannot set sanctions, conditions or restrictions on any the HSC Trust Service. Any such considerations fall to the Department, in accordance with its statutory duty to provide, or secure the provision of, Health and social care.

60. This same approach is adopted in assessing whether 'Care is Safe and Effective'. This falls under Quality Standard theme two; the HSC Quality Standards set out the required evidence to demonstrate organisational effectiveness in this regard. It is these standards RQIA assess within an inspection.

61. RQIA operational staff do not engage with Trust Boards in the discharge of RQIA functions under the 2003 Order. Direct engagement is primarily with, in the first instance, the Trust Chief Executive and the senior management team, or specific nominated Director/s or others, dependent on the nature of the inspection or review undertaken. For planned reviews, RQIA will write to the Chief Executive and seek contact details for a nominated lead officer. For unannounced Inspections, when RQIA staff arrive at a Trust service/ premises, a letter will (simultaneously) be issued to the Chief Executive by email. RQIA staff will present to the Trust staff within the service their identification (which refers to their Power of Entry under Article 41 of the 2003 order) and a letter that advises of the inspection, that will then commence. Overall, RQIA staff are received respectfully. Trust staff, both senior and operational, afford time and effort to enable RQIA to undertake their work. RQIA staff demonstrate mutual respect for the Trust staff they are engaging with and aim to be least disruptive to the operational delivery of the service during the inspection.

62. The current RQIA Chair and Chief Executive have now established a series of meetings with the Chair and Chief Executive of each of the HSC Trusts in Northern Ireland. This is intended to provide an opportunity to understand what is important to the organisations, and to discuss strategic issues that are impacting on service delivery and on regulatory work. The meetings also demonstrate that RQIA recognises the role and responsibilities of the Trust Board, which carries the statutory duty of quality under the 2003 Order. These meetings are intended to occur twice annually; they are cordial and appear well received.

Resources and fulfilment of role

63. The RQIA receives the majority of its funding from public funds allocated by the Department. In addition, RQIA receives a small income through fees paid by registered services. Currently, because of the requirements of the Fees and Frequencies Regulation 2005, made by the Department, RQIA devotes almost all of its workforce capacity of professionally qualified staff (inspectors/senior inspectors) towards registered services, in an effort to comply with the specified frequency of inspection of registered establishments, whilst also monitoring, inspecting and where necessary taking enforcement action in those registered establishments where intelligence indicates there is cause for concern or a heightened level of risk RQIA's ability to meet this demand is stretched. It has been established that an additional £2.4m annually is required to satisfy the prescribed frequency of inspections of registered services. Accordingly, very little resource is available to devote to fulfilment of RQIA's statutory duties in respect of Trust or statutory services. Currently, only 3.6 whole time equivalent inspectors are devoted to un-registered statutory services, s these do not have a frequency of inspections prescribed in regulations.

64. The 2005 Regulations also mean that RQIA cannot move to an intelligence based system of inspections of registered services and, therefore, rebalance its responsibilities with registered services or with statutory services. This is because the 2005 Regulations require a frequency based inspection model.

65. A shortage of resources to undertake inspections, reviews and investigations into HSC Trust, hospital and other statutory services, severely limits RQIA in properly fulfilling its statutory duty to keep the Department informed about the safety, quality and accessibility of services, as well as providing assurance to the public, through independent inspection and reports being placed in the public domain. Neither can it fulfil its statutory duty to encourage improvement in the quality of services provided by statutory bodies

66. RQIA consider that its limited review or inspection programme (due to extremely limited resources) cannot respond comprehensively to issues of concern and risk that arise in HSC services. As set out above, RQIA has severe limitations of

capacity associated with resourcing and with the existing frequency based (rather than intelligence driven) prescribed inspection regime for registered services.

67. For example, in the year 2022/2023, RQIA carried out and published just under 2000 inspection reports of registered services: including in care homes; private hospitals and dental practices in contrast, there were 13 published reviews or inspections of HSC Trust services. While HSC Trust reviews and inspections are of a significantly greater scale when compared to an individual care home or dental practice inspection, it nonetheless illustrates the current imbalance of resource allocation, which leans heavily towards registered services.

68. RQIA also consider that a 'full cost recovery' model should be implemented for the funding of regulatory work for registered services, so that compliance is achieved with the provisions of Department of Finance requirements on funding of regulatory activity. Public funding allocated to RQIA could then be used to enable RQIA to discharge its statutory duties and functions in respect of the HSC Trusts and statutory services, including hospital services.

69. RQIA's ability to properly fulfil its statutory role is also impacted by the nature of existing legislation, including the 2003 Order. This legislation is now over 20 years old and is not fit for purpose in the current service profile in Northern Ireland. There are gaps, including services that are not subject to regulation, such as independent services that may be run by personnel other than medical professionals; and on-line providers of services, by way of example. The 2005 Regulations require registered providers to be inspected on a set frequency with no reference to the need to respond to increased risks that may come to the RQIA through information from patients, families, staff or other sources. RQIA consider that the legislation should adopt an activity based approach, and embrace intelligence led and risk based regime, in order to provide greater protections for service users and improve the information available across the totality of health and social care services available to people in Northern Ireland.

70. The Inquiry has specifically referred to the Section 21 Notice reply of the Permanent Secretary, which states that 'Hospitals are not regulated in Northern Ireland'. RQIA would qualify this statement and in response to the specific questions set out would advise as follows.

71. HSC hospitals in Northern Ireland, are subject to an oversight and regulatory regime including by the RQIA, as described earlier. RQIA's statutory duties under the 2003 Order play a key part in this, through its reviews and inspections, and its ability to serve Improvement Notices and recommend special measures to the Department. This regulatory activity is undertaken by seeking evidence that statutory services are meeting the minimum standards expected in accordance with the Quality Standards set by the Department of Health, referred to above. RQIA therefore does have a regulatory role in respect of HSC hospitals. However, as described above, this role is constrained, both in its extent and by the limited resources which have been made available to enable RQIA to discharge it. RQIA does not have 'overall responsibility' for monitoring and regulating the quality of health and care services delivered in Northern Ireland. Whilst the statutory duty of quality for HSC services lies with the Trust Boards, and is subject to RQIA oversight, the overall performance of the Trust Boards themselves and of their operational performance is subject to the direct monitoring and control of the Department. Therefore, RQIA does not have 'overall responsibility' for regulating and monitoring the quality of health and social care.

72. RQIA's ability to monitor and report upon governance within HSC organisations is limited by its resourced capacity and constrained by legislative powers. Whilst it does have the role of independent regional regulator, but its delivery of its duties is severely limited by the resources allocated to HSC services, and its powers, which are limited to review, investigate and inspect HSC services, providing reports on its findings to the Department.

73. Whether HSC hospitals in Northern Ireland should be subject to the same regulation as registered services, which would bring the regulatory regime more closely into line with the approach adopted in England, for example, is a political decision, requiring reform to the legislation. Trusts are currently established to

discharge statutory functions, delegated to them by the Department. It would require a material shift to create a system that requires all HSC Trusts, and other health and social care services, such as General Practice contracted by the Department to register and be subject to regulation by RQIA.

74. The 2006 HSC Quality Standards were developed and set by the Department. They provide the assessment framework which RQIA uses when inspecting HSC Trust services. They are made up of five elements, five quality Standards. All HSC 'statutory' services are required to comply with these minimum quality standards. These standards include Quality Standard (Theme 1) "Corporate Leadership and Accountability of Organisations"; and "Safe and Effective Care "(Theme 2). During RQIA inspections of HSC services, evidence is sought to demonstrate whether these minimum standards are being met by the HSC statutory service This forms the basis of the RQIA inspection report and any quality improvement actions required from the Trust. The Department can adjust or modify the Standards; and RQIA may provide advice (Article 5 of the 2003 Order) to the Department on changes which the RQIA consider should be made to them.

75. 'Serious Concerns' is a term used by RQIA as part of its enforcement procedures. After inspection, pending analysis of evidence identified by RQIA inspectors, an internal meeting will be held called an Enforcement Decision Making (EDM) to consider evidence available. Based on the outcome of that meeting, and the judged level of risk to service users, RQIA will invite the Responsible Individual to meet. The purpose is to present the specific issues and findings on the matter or matters; provide the Responsible Individual an opportunity to advise of actions already taken or planned; and set out remedial actions required and timescale. It will also advise the Responsible Individual what further enforcement actions that may be taken if compliance is not achieved. I can confirm from the RQIA's iConnect System (Enforcement Module), that from 2019 to date, there are 78 serious concerns meetings are recorded with HSC Trusts (Ref **Exhibit BD8**). 57 in total were for registered services (i.e. this includes children's homes; domiciliary care agency; daycare providers; and nursing or residential homes) The majority of these (48 of the 78) refer to children's homes. 9 related to Mental Health/Learning Disability Inpatient Units (which are subject to the Mental Health Order 1986); and 12 related to HSC Hospitals, not subject to registration with RQIA. Examples of issues that lead to the meetings included: identified restrictive practice; issues relating to staff

training or supervision; staffing levels or skills; and the suitability of the environment. In 38 of the 78 cases, no further enforcement action was recorded as taken after the meetings. In such cases, the Trust would have been required to submit its Quality Improvement Plan (QIP) and timescale. In other cases, follow up inspections may be planned or, on receipt of the Trust's planned actions, if these were not considered sufficient, it may be determined to proceed to consider an Improvement Notice. It should be noted that 'Serious Concerns' is one type of enforcement action and there are also other types of meetings including an 'Intention to Serve an Improvement Notice' meeting. Both these types of meetings apply to HSC (unregistered) statutory services.

76. The powers of RQIA, and the statutory duty of quality placed upon HSC Trust Boards, are set out in legislation, as referred to earlier. A change in policy would be required if HSC services were to be required to register with RQIA and be subject to regulatory actions appropriate to registered services. This is not a matter for RQIA but a policy decision.

77. RQIA has recommended Special Measures to the Department on two occasions: these relate to Muckamore Abbey Hospital in 2019; and to the NI Ambulance Service (NIAS) in 2018.

78. With regards to NIAS, RQIA had conducted an unannounced inspection at a number of NIAS stations in 2018 and identified serious concerns about infection prevention and control issues, and associated governance arrangements. Follow up inspections showed insufficient improvement. An Improvement Notice was served with further inspections showing similar findings. By February 2018, RQIA recommended the imposition of special measures to the Department, recommending a senior experienced infection prevention and control practitioner be appointed for a period. The Department accepted this and advised NIAS to proceed to take this action.

79. With regards Muckamore Abbey Hospital, following unannounced inspections in February and in April 2019, RQIA wrote to the Department advising of RQIA's serious concerns in relation to care, treatment and services provided at that time for patients, and recommended that the Department implement special measures for the Belfast Health and Social Care Trust. The Department placed the service

under enhanced monitoring arrangements and establishing an oversight group to monitor progress against a number of actions that were to be taken. While the Department did not reply to RQIA to say that it considered or accepted its recommendations, RQIA consider the actions taken by the Department amount to the imposition of special measures.

80. RQIA's review protocol is provided in the evidence file. A list of reviews carried out is included within **Exhibit BD9**. This is the most up-to-date record of all reviews carried out by RQIA, to the best of my knowledge. This lists 107 Reviews since 2005 to date. 67 of these are reported as having involved the Southern Health and Social Care Trust. Such reviews result in recommendations made by the Review Team. These are reported in each individual Review Report. RQIA has not, historically, systematically followed up on the implementation of Review Recommendations. There is no routine mechanism in place for RQIA to be informed about achievement or implementation of review recommendations, nor for RQIA to be necessarily involved in any revisiting of the issues identified within the review. This responsibility lies with the Trust Board and with Department.

81. There is currently a lack of a process for reporting to the RQIA of the implementation of the recommendations made in its RQIA reviews. In the past, RQIA did receive updates from the Department on progress against implementation of some reviews, but this has not been the case in recent years. Recently, the Department has undertaken to strengthen the arrangements in place with HSC Trusts to oversee implementation of RQIA review recommendations. Correspondence from the Department to RQIA, dated 16 November 2023 (Ref **Exhibit BD10)** noted that the Department had agreed to close the RQIA reviews listed in an attached Annex to that correspondence, listing 18 reviews, the earliest dated 2013. The Department advised that this had followed an exercise involving consideration of the reviews by relevant Departmental Policy Directors. The listed reviews were now deemed closed by the Department and will no longer be followed up, as they have either no remaining open recommendations or the relevant policy lead had advised that further reporting is no longer required. RQIA understands that the Department now manages an oversight group to follow up and record implementation of recommendations made within reviews that remain open.

82. The list provided to RQIA of 'closed' reviews does not include the "Review of Consultant Medical Appraisal Across HSC Trusts, September 2008". That review recommended that:

"RQIA recommends that all Trusts should as a matter of urgency comply in full where possible with the four high level indicators outlined in "Assuring the Quality of Medical Appraisal" and with the sub criteria outlined within this report. Trusts should also note the recommendations contained in "Assuring the Quality of Training for Medical Appraisers". RQIA are not aware of the current status of the recommendations made within that Review.

83. In response to questions about governance reviews, RQIA provides in its evidence folder (please see **Exhibit BD9**) a list of all RQIA reviews. To the best of my knowledge, since 2005 107 Reviews are listed, 65 of which include aspects of clinical and social care governance arrangements in HSC Trusts. The outcome of such reviews result in recommendations made by the Review Team. These are reported in each individual Review Report. RQIA has not previously followed up systematically on the progress of implementation of its Review recommendations. As referred to earlier, there is no routine mechanism for RQIA to be informed about achievement on implementation of the review recommendations, nor for RQIA to be necessarily involved in revisiting of the issues identified within the review. This responsibility has been considered to lie with Trust Board itself and with the Department. Of the 65 reviews carried out that included clinical and social care governance, records indicate that 48 of these have included the Southern Health and Social Care Trust.

84. A copy of the 'Review of Clinical and Social Care Governance Arrangements in Health and Social Care Trusts in Northern Ireland 2008 – Southern Health and Social Care Trust', which is published on the RQIA website, is included within **Exhibit BD11**. RQIA are not currently in a position to provide the Inquiry with an update on the Recommendations made in that review of 2008. The "Review of Consultant Medical Appraisal Across HSC Trusts, September 2008" is not included in the list of "closed" reviews recently provided to RQIA by the Department.

85. The Authority is concerned that the complex work of undertaking reviews, drawing on specialist expertise and performing a robust and effective review,

before making recommendations that, if implemented, will make a material difference to the quality of care and treatment provided, does not lead to any clearly and publicly recorded outcome. Neither does there appear to be any measure of the impact of that work on direct patient care and outcomes. However, it should be noted that the statutory duty of quality lies with Trusts, which report directly to the Department. RQIA's statutory duty is to provide information to the Department on the quality of services; and to support the Trusts in implementing their Duty of Quality through independent, expert analysis of evidence and practice, and by making recommendations that Trusts can implement. It is for the Department to seek assurance, through accountability, from the Trusts on the actions implemented. Nevertheless, the Authority continue to consider how it might make better use of its powers under Articles 35 and 41 of the 2003 Order to provide a fuller picture of the nature, extent, and results of its actions in the statutory sector.

86. The Authority notes the reference in the Inquiry Notice to the reply from the Department's Permanent Secretary referring to the 'fundamental review of regulation' and that there is a draft document with the Department referred to as 'The Right Touch: A New Approach to Regulating Health and Social Care in Northern Ireland'. Whilst RQIA is aware of the public consultation on proposals to change the Fees and Frequencies Regulations 2005 led by the Department in 2016, and the publication of submissions from stakeholders, and a post consultation report in 2017 which are published on the Department's website, I am not aware that RQIA made a submission to this public consultation process.

87. The Authority is currently not aware of, nor (to my knowledge) has it had any sight of the proposals set out in the draft document referred to 'The Right Touch: A New Approach to Regulating Health and Social Care in Northern Ireland', or been involved in the development of the proposals.

88. The attached list of enforcement actions (Ref **Exhibit BD12**) drawn from RQIA's iConnect system, from 2019 to date, shows 31 enforcement actions taken by RQIA in that period relating to the Southern Health and Social Care Trust. 12 of these referred to children's homes; day care 6 actions; domiciliary care 6 actions; hospital services 4 actions and 3 actions relating to a Trust nursing home. From

2019, the enforcement action list reports 358 enforcement actions taken by RQIA relating to HSC Trusts other than the Southern Health and Social Care Trust.

89. The Inquiry has specifically asked RQIA to address the Hospital Inspection Programme (HIP) in 2014. This started out as a rolling programme of inspections across HSC hospitals relating to 'hygiene inspections'. An allocation of 3.5 staff was made to RQIA to undertake this. From 2014 to 2019/20, 106 HIP Inspections were carried out contained within **Exhibit BD13**. Each inspection report that was produced was issued to the relevant Trust, accepted and published on RQIA website. None are outstanding insofar as recommendations are concerned. From 2020 to 2023, the pandemic has had an impact on the HIP programme. Following the standing down (in June 2020) of the Departmental Direction of March 2020 to pause physical inspections in registered and in statutory services, from September 2020 a series of inspections commenced with a focus on infection prevention control in the HSC Trust acute hospitals, and 2 private hospitals. These inspections did not take place until September 2020 as many of RQIA's hospital inspectors remained engaged in the work of the response to the Pandemic. Since then a further 31 hospital inspections have taken place

90. The Inquiry has noted the planned RQIA inspections following 'The Review of the Governance of Outpatient Services in the Belfast Health and Social Care Trust (with a particular focus on Neurology Services and other High Volume Specialties)', published February 2020 (Ref **Exhibit BD14**). The Inquiry notes that RQIA are to undertake a series of such inspections to the other HSC Trust outpatient services.

91. The oversight of the implementation of the recommendations within this review, both as they apply to Belfast Trust and to the other HSC Trusts (whilst they have not as yet had their own individual Inspection), lies with the Department, through the now SPPG. SPPG have shared with RQIA a copy of the status on each of the recommendations, dated February 2023 (Ref **Exhibits BD15** and **BD16**). Of the 26 recommendations made, the SPPG Assessment Overview indicates that the Trusts are achieving a range of positions, Belfast Trust confirming 19 of the 26 recommendations completed and Southern Trust reporting 1 recommendation completed and 20 on target to be completed.

92. The original review was undertaken in the Belfast Trust. The Department commissioned RQIA to undertake a series of such reviews of the Governance of Outpatient

Services in the other Trusts. This programme of work has commenced, with the pre- inspection preparation and physical inspection phases having been completed in the Western Trust (Altnagelvin Hospital, Omagh Primary Care Complex, and the South West Acute Hospital) in late 2023. The report is now being compiled and will be subject to a factual accuracy check prior to formal submission to the Trust, and to the Department, and will be published on the RQIA website. The remaining Trust reviews have also been planned, though paused. The next to be subject to review, the South Eastern HSC Trust, originally scheduled to commence in late 2023 has been rescheduled to Spring 2024, as the South Eastern Trust is leading the implementation regionally of the new Encompass system for Northern Ireland, which went 'live' on 9 November 2023. The remaining Trusts will be reviewed over the period thereafter. As referred to above, it is the Department which monitors the implementation of the recommendations and a progress report on the review in the Belfast Trust, dated February 2023, has been provided.

93. In respect of Mr Kavanagh's Section 21 Notice reply and the questions arising, I can say that RQIA and SPPG engage on an ongoing basis, as far as might be necessary depending on the issue RQIA is examining at any point in time. SPPG is integral to the Department and, as such, is also in receipt of RQIA's Quarterly Liaison Report provided to the RQIA Sponsor Branch in the Department (previously, in the CMO's command; now in Secondary Care Directorate). RQIA senior staff will also engage in specific instances, where required. Recent examples include RQIA's provision of reports relating to Muckamore Abbey Hospital; issues concerning childrens homes, and pressures in acute hospitals, including in Emergency Departments. RQIA and the Department are working towards the development of a Partnership Agreement setting out the working arrangements between the Department and the RQIA. RQIA considers that its engagement with SPPG is generally adequate.

94. RQIA cannot identify or confirm a time/issue when SPPG may have passed information to it; and this did not lead to some inspection by RQIA. Information provided in relation to issues at Muckamore Abbey previously provided by SPPG to RQIA resulted in a follow up investigation by RQIA (reporting of incidents).

RQIA and SAIs

RQIA does not have a direct role in the investigations of serious adverse incidents (SAIs). RQIA does not receive copies of completed SAIs for HSC or statutory services. It is only in

respect of registered services, and mental health and learning disability services where copies of completed SAI's must be provided to RQIA.

95. The Inquiry refers to the Review undertaken by RQIA into the effectiveness of the regional HSC Serious Adverse Incident (SAI) Procedure, which was published in June 2022. This was undertaken by RQIA under a request from the Department in April 2018. This had its origins in the recommendations of the Independent Inquiry into Hyponatraemia related Deaths; and formed part of the Department's Implementation Programme following that Report.

96. The outcome of the June 2022 Review is that RQIA consider that an effective learning system is essential for HSC services, which must provide for the timely application of learning so that the potential for harm is reduced. The Review found that the existing SAI Procedure is not fit for purpose and must be re-designed on a co-produced basis, with some urgency. To date, RQIA are not aware of any changes that have been made to the existing SAI Procedure to address the failings found in the Review. To our knowledge, all of the recommendations remain to be addressed.

97. I am aware that the Department has now established a Re-design Process to take forward the review of the SAI procedure. This was established in July 2023, under Departmental leadership. While RQIA does not have a role to play in leading this Re-design Process, RQIA has been invited to sit on an oversight group, along with the Patient Client Council and the Office of the Mental Health Champion. RQIA is undertaking this role in the endeavour to offer advice and reflect on good practice that the Re-design Team would be encouraged to consider. RQIA will also seek to provide an independent assurance process on new policies and procedures as they are developed to ascertain effectiveness, should that be helpful.

98. The RQIA review has not been superseded by the establishment of the project commenced in July 2023, rather RQIA's understanding is that the Redesign Process seeks to take forward the work recommended by the RQIA Review.

99. RQIA is not aware of the timeframe for completion of the Redesign Process. However, RQIA is aware the Department have indicated an urgency to complete the process, and has set out to recruit person/s of lived experience to be part of the

process. The Re-design Group is established and plans are beginning to be developed to undertake the process.

RQIA and the SHSCT Lookback Review

100. On 20th February 2022, the Southern Trust Chief Executive wrote to ask RQIA to conduct a review of the process adopted by the Trust to undertake a lookback exercise regarding Urology Services. The lookback exercise reviewed patients who had been under the care of Mr O'Brien. Having undertaken nine SAI cases to date, it had been determined that the Trust would not adopt that case by case approach going forward. Instead the Trust had developed a 'Structured Clinical Record Review' ("SCRR"), which is a process based on the 'Structured Judgement Review' methodology developed by the Royal College of Physicians. The SCCR process had been developed to enable the Trust to identify areas of learning, and areas where patient safety needed to be improved. The Trust asked RQIA to review the choice of the SJR methodology that had been used as the basis for the SCRR process; and also to review the SCRR process in relation to its effectiveness in identifying learning (Ref **Exhibit BD17**) RQIA engaged with the Department about this request, and accepted the request (Ref **Exhibit BD18**).

101. RQIA's Review Team set out the methodology for undertaking the review of the SCRR process; established an expert review panel; and reported the findings of the review to the Trust on 13 September 2022. The Report was later modified to ensure it appropriately reflect the role and scope of the Urology Services Public Inquiry; otherwise the content and recommendations remained unchanged. (Ref **Exhibits BD19** and **BD20).** The review made 18 recommendations for improvement. The report and its recommendations were accepted by the Southern Trust (Ref **Exhibit BD21**).

102. Although RQIA does not supervise the implementation of the recommendations made, the Trust made a submission to RQIA (ref **Exhibit BD22**) with an action plan and an update on implementation of the recommendations. The Report indicates, the Trust identified 25 actions to effect the Recommendations. The Report supplied to RQIA in March 2023 advised that 20 of the identified 25 actions had been completed.

103. However, while RWIA was in the process of undertaking the review of the SCRR process on the request of the Southern Trust, the Department wrote to RQIA

on 11 August 2022 asking RQIA to undertake a review of the Southern HSC Trust urology services, and of the robustness of the Lookback review (Ref **Exhibits BD23** and **BD24**). This review looks more broadly at the quality of the urology services delivered in the Southern HSC Trust, not limited to the lookback exercise. It also aims to ensure that all patients who should have been recalled, have been.

104. RQIA has commenced this review, establishing an expert review team and has submitted its interim report on the review of the SHSCT Trust Urology Services and Lookback Review to the Department on 26 July 2023 (Ref **Exhibit BD25**). This interim review focusses on the first aspect of RQIA's terms of reference, examining progress made against the recommendations in the earlier Lookback Review, with further field work underway to examine the remaining terms of reference. The interim review made five draft recommendations relating to strengthening the lookback process.

105. The interim report indicated that, while there were recommendations made to improve processes, the first cohort of patients recalled were appropriately reviewed. This assurance enabled the Department to publish the SHSCT Urology Lookback Review Cohort 1 Outcomes Report. The Department also announced a second cohort of patients to be reviewed, on 9 August 2023. This first interim report was referred to as Phase 1 of the Review. Phase 2 continues and is due to report shortly to the Department. It will incorporate the work from Phase one and will complete the full terms of reference of the review.

RQIA and the Inquiry's Terms of Reference

106. The Inquiry seeks to understand any knowledge or involvement of RQIA relating to the scope of the Terms of Reference, particularly referring to the period before, during and after the Early Alert notice by the Trust to the Department on 31 July 2020. In order to set context to this evidence, RQIA feel the Inquiry should be aware that HSC Trusts are not required to notify RQIA of any untoward incident or event occurring in unregistered statutory ("Part IV" services). This differs from the position in registered services which are required to notify RQIA of such circumstances. The Early Alert system referred to is an administrative measure adopted to enable HSC services to notify the Department of issues that are likely

to attract regional media interest, or to notify the Department about a breach of statutory duty; or to raise issues requiring urgent regional action (among other possible criteria). The Department then circulates the Early Alert to wider HSC organisations, given the regional interest or aspect of the event. As an HSC organisation, RQIA also receive these Early Alerts.

107. RQIA consider the receipt of an Early Alert, relating to an HSC Trust (Part IV) service, as intelligence. It is recorded on the internal IT system, iConnect, and the intelligence within it may then be taken into account in a future planning for a service review or an inspection.

108. RQIA received an Early Alert dated 30th December 2016 on 4th January 2017 (Ref **Exhibit BD26**). It referred to the Southern Trust excluding a Doctor for 4-week period, under the Terms of Maintaining High Professional Standards (MHPS), using the period to scope out the scale of potential issues. This was the only information provided to RQIA. This Early Alert does not identify the doctor nor their specialty. At that stage, it is unlikely that this intelligence provided sufficient information for RQIA to consider further action i.e. it did not indicate any patient involvement or harm; or if the SAI procedure had been invoked. It only indicated that MHPS had been invoked.

109. On 6 December 2019, RQIA was contacted by the General Medical Council, (GMC), referring to a Maintaining High Professional Standards Formal Investigation, relating to the Southern Health and Social Care Trust, that the GMC said had commenced in September 2018 (Ref **Exhibit BD27**). GMC also referred to findings of systemic concerns. GMC indicated that the Trust had been recommended to carry out an independent review of their administration processes, but it seemed this had not yet commenced. Sharing of information between the GMC and RQIA is part of an information sharing agreement under a MoU between the two organisations. The information supplied by GMC did not name either the speciality nor their doctor. However, this information did bring to RQIA's attention potential systemic issues regarding the reporting of issues.

110. An RQIA Deputy Director spoke with Dr Maria O'Kane (Chief Executive SHSCT) on 8 November 2019 by telephone to discuss several matters. This

conversation is referred to in follow up correspondence that the Deputy Director sent to Dr O'Kane on 9 January 2020 (Ref **Exhibit BD28**). However, during the 8 November call, the matter of the MHPS investigation of September 2018, and recommendations to review the administration processes, were not referred to (Ref Exhibit BD 28) This letter explains that RQIA had not been aware of the matter until b alerted by the GMC on 6 December 2019. In the 9 January 2020 correspondence, RQIA sought information from the Trust about the detail of the case referred to by GMC; and about the status of the GMC recommended independent review of administration processes.

111. RQIA received a response from the Trust Chief Executive on 14 February 2020 (Ref **Exhibit BD29**). RQIA was advised that the MHPS investigation had begun in February 2017 and was completed in September 2018. The response referred to the MHPS investigation recommendations. The correspondence advised that the individual subject to the MHPS process had subsequently raised concerns which were then being investigated. The Trust referred to a lookback exercise being undertaken and a number of SAIs being investigated. The Trust was considering all these aspects together, regarding timeliness for completion.

112. RQIA responded to this letter on 20 April 2020 (Ref **Exhibit BD30**), advising that while RQIA remained uninformed about the detail of the concerns (including the identity of the doctor or the speciality), RQIA trusted that the Trust would advise RQIA should any issues impacting on care delivery and effectiveness of governance arrangements be identified, that may then fall to be considered by RQIA as the system regulator of health and social care services.

113. RQIA did not receive information identifying Mr O'Brien until the Early Alert of the 31st July 2020. Prior to this RQIA were not aware of any concerns relating to Urology waiting lists or service capacity, or this particular Doctor, more than would be widely known of the extremely long waiting lists for many specialties across HSC services in Northern Ireland.

114. RQIA did not reach any view on the appropriateness nor timeliness of the steps taken by the SHSCT to raise the concern on these matters. RQIA could not consider this matter as RQIA are not routinely notified by Trusts of incidents or issues that arise, as this is not required by the primary legislation; and RQIA has

not used its powers under Article 41 of the 2003 Order to require Trusts to provide such information routinely.

115. In terms of the governance arrangements within the Trust, which gave rise to the need to raise the Early Alert, RQIA did not give consideration to, or reach an immediate view on this matter. It has not been regarded as part of the RQIA's core work to provide reactive assessment and response to such incidents, given the statutory duty of the Trust, and their reporting arrangements and relationship to the Department. RQIA was, however, later engaged by the Trust to examine its approach to the Lookback Review, and later by the Department to examine the arrangements in the Trust for the management and delivery of Urology services, as referred to earlier. The outcome of this process is discussed above.

116. RQIA did not provide advice to the Trust upon receipt of the Early Alert of 31st July 2020. It is not RQIA's role to provide ad hoc advice to a Trust on its internal corporate and clinical governance, outside of carrying out inspections and reviews, leading to reports and recommendations. RQIA's role was conducted through its review of the Trust's Lookback exercise; it did not attend meetings or discussions outside of this.

117. RQIA's remaining work with regard this matter is the completion of the Review requested by the Department, which is due to report shortly.

118. The review being undertaken by RQIA, as commissioned by the Department, is not yet complete. Beyond what is said above, RQIA cannot at this stage provide answers to questions on the current governance arrangements in place within the Trust; what changes have been made; and impact of these changes. These questions may be answered with the completion of the review. RQIA does not provide routine monitoring of clinical governance in Trusts. RQIA is alerted to issues of concern at times from members of the public, staff and others, as referred to earlier in this statement.

119. As the Inquiry Notice to RQIA refers, and is referred to in the Minister's Oral Statement to the Assembly on 24 November 2020, it seems Mr O'Brien had a significant private practice. To date, RQIA's approach to regulation of the independent health sector provides an exemption from registration of Independent

Medical Clinics where the doctors providing the service have an established connection with HSC bodies. This may be either through a contract of employment with one of the Trusts for example; or by way of a contract with the HSCB/SPPG, as a member of the General Practitioners' Performers List.

120. Therefore, private practice, as undertaken by Mr O'Brien, has not been subject to registration, regulation or inspection by RQIA. RQIA have not had oversight, therefore, of Mr O'Brien's private practice, and have had no engagement with him in this regard, or with any legal representatives or any other organisation or source about to assurances in relation to that practice.

121. The Trust sought advice from RQIA as to how the Trust might seek information on the case records of private patients of Mr O'Brien, via his legal representatives. This was based on the fact that RQIA had undertaken a review of a number of the records of the deceased patients of Dr Watt, the subject of the Neurology Public Inquiry. RQIA shared the approach it had adopted in approaching Dr Watt's legal representatives, should that be helpful to the Southern Trust in approaching the legal representatives of Mr O'Brien, about the case records of Mr O Brien's private patients.

122. RQIA provide the role of Responsible Officer (RO) for those doctors who provide an RO role for doctors working exclusively in private practice. RQIA understand that RO's for doctors working in HSC services have oversight both of that doctor's statutory services (NHS) work, and any work that doctor may undertake in private practice, through the appraisal process. This is referred to as "whole practice appraisal". Doctors working in the statutory services are required to ensure their RO is aware of their private practice and any issues or events that may arise from it.

123. While RQIA's historic practice has not required doctors working in HSC services to register with it where they also provide Independent Medical Clinics, recent legal advices to RQIA have required it to reconsider this position. The current Legal Advice is clear that the key consideration in deciding whether or not registration of an establishment is required, is whether the services to be provided there are "for the purposes of the 1972 Order" (i.e. ultimately, are provided by the

Department in pursuance of its duty to provide health services for the public in Northern Ireland). Any services which are not provided for "the purposes of the 1972 Order" are therefore require to be registered. Considerations around any employment/contractual relationship there may be elsewhere, between a clinician concerned and an HSC body are therefore considered irrelevant under the revised legislative interpretation. RQIA has advised the Department of this revised legal advice and propose to develop a programme based on a full cost recovery approach to enable RQIA to be adequately resourced to undertake the registration and regulation of Independent Medical Clinics. (Ref **Exhibit BD31**). Without this approach, or funding provided by the Department to RQIA as an alternative, RQIA will not be in a position to register and regulate independent medical clinics (Doctors).

124. RQIA do register a small number of independent clinics that are wholly private (not connected to HSC services). As stated above, the full range of regulatory powers that are afforded RQIA in relation to registered services are not available to regulate HSC Hospital services. This is how the existing legislation is designed. It affords responsibility for the safety and quality of services to the Trust Board, through a statutory duty of quality. Legislation also does not establish a programme of independent assessment of how those Trust Boards fulfil that statutory duty. The allocation of resources by the Department to RQIA, which is fixed and has not been uplifted, and the fact that the fees that can be recovered from registered services, which were set in 2005 and have not been uplifted or moved to a full cost recovery model, appears to affirm that Trusts and their Trust Boards are the primary source of assurance on the safely and quality of their services to the Department.

125. As set out above, whether hospitals should be regulated in a manner consistent with registered services is a matter for the legislature. However, any step in that direction would require reform of the legislation, and of operational structure and capacity for RQIA. RQIA is in regular communication with other regulators in these Islands through a forum; there are memorandums of understanding in place with a range of other regulators and oversight bodies; and regular meetings between senior staff, in organisations such as England's CQC, where all services are registered. RQIA is not aware of any comparative study of the differing systems.

126. It is the outcome of the Review Programme (the reports and their recommendations) that may see approximately five or more reviews carried out within an annual period. This contributes to RQIA's fulfilment of its role of keeping the Department informed about the provision of health and social care services, and in particular, about their availability and their quality.

127. Over the last number of years RQIA has carried out a number of reviews of HSC services or arrangements. This includes a number relating to acute hospital services, which included or were specifically related to acute hospital services provided by the Southern Health and Social Care Trust.

128. As referred to above, there is no routine mechanism for RQIA to be informed about achievement or implementation of its review recommendations, nor for RQIA to be necessarily involved in any revisiting of the issues identified within the Review. This responsibility lies with the Trust Board and the Department.

Learning

129. This matter appears to have originated in the practice of an individual Doctor, and where oversight arrangements that should have detected poor or inappropriate medical practice failed to do so. RQIA is not aware if this Doctor was the subject of a whole practice medical appraisal with an RO, or if evidence was presented through appraisal or if any evidence provided an accurate insight into the Doctor's clinical practice, from examining outcomes, incidents, patient experience and peer feedback. The nature of the evidence submitted /considered may be an important factor in considering if the Doctor's appraisal and revalidation process was robust, if information showing cause for concern was forthcoming from involvement in medical appraisal and its findings, for this doctor and others, the clinical governance arrangements in the Trust should be sighted on any such concerns. This may also present an area to reflect on for learning and action.

130. The Authority acknowledges that, while it does not have a regular programme of inspection of clinical and social care governance arrangements in Trusts (because the focus of hospital inspections is often operational- infection prevention control, for example), it is now considering if in future RQIA's focus should be at a

more strategic level. For example, on considering a Trust's fulfilment of its statutory duty of quality, using RQIA's functions under Article 35(1)(a). This provision states:

> *"the function of conducting reviews of, and making reports on, arrangements by statutory bodies for the purpose of monitoring and improving the quality of the health and social care for which they have responsibility".*

131. However, in the absence of additional resources, this activity would have to replace the current, operationally focussed Hospital Inspection Programme.

132. The Authority acknowledge that, if it were resourced appropriately, it could provide much more extensive examination of HSC Trust governance and strategic management arrangements. In the current instance, scrutiny and reporting on Trust governance arrangements might have identified issues.

133. In addition, a requirement for private medical (including surgical) practices to register with RQIA might have identified issues within the practice of this Doctor; such registration would have facilitated consideration of the need for any subsequent mitigation measures. Again, adequate resourcing is required to enable RQIA to carry out this role.

134. The Authority considers there is a pressing need for a more joined-up approach between regulators in Northern Ireland. RQIA are planning to commence an 'Emerging Concerns' protocol with service regulators, including GMC, from spring 2024. This is about working together to better optimise the use of intelligence, leading to improved identification of key issues, and enabling each organisation to take appropriate steps to explore and act on these through their different roles.

135. There is also need to encourage and support a culture of openness, focussed on patient safety. Staff must feel safe to 'speak up' when they are concerned about issues, without fear. Patients' and families' experiences must be heard; and regarded as a valuable and trusted source of, often early, insight into quality and safety issues. RQIA will play its part in this by facilitating discussion across HSC organisations about the shared responsibility to develop a culture that promotes and encourages 'speak up', being open, and encouraging action, learning and improvement. RQIA hosted an event involving patients and their families, senior leaders and clinicians from across the HSC in November 2023 to explore how the responsibility to do can be shared, and action taken forward. Further events on this theme are planned in coming months.

136. In particular, RQIA will develop a 'safety culture' assessment tool to identify, encourage and support 'openness' and 'learning'. This will enable robust report back of findings in this area to HSC organisations to assist them in taking action to improve.

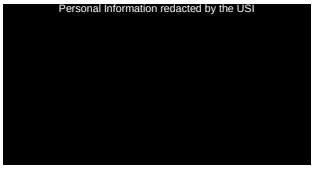
Conclusion

Under the current legislation and with constrained resources it is important that RQIA focus on key priorities. Here, reform of the legislation to enable a more efficient and effective intelligence driven and risk based approach, with a better balance of attention between the independent and the statutory sectors, and increased flexibility to address new ways of service delivery and new sectors of health and social care, is essential to improve the protection and safety of the public.

Statement of Truth

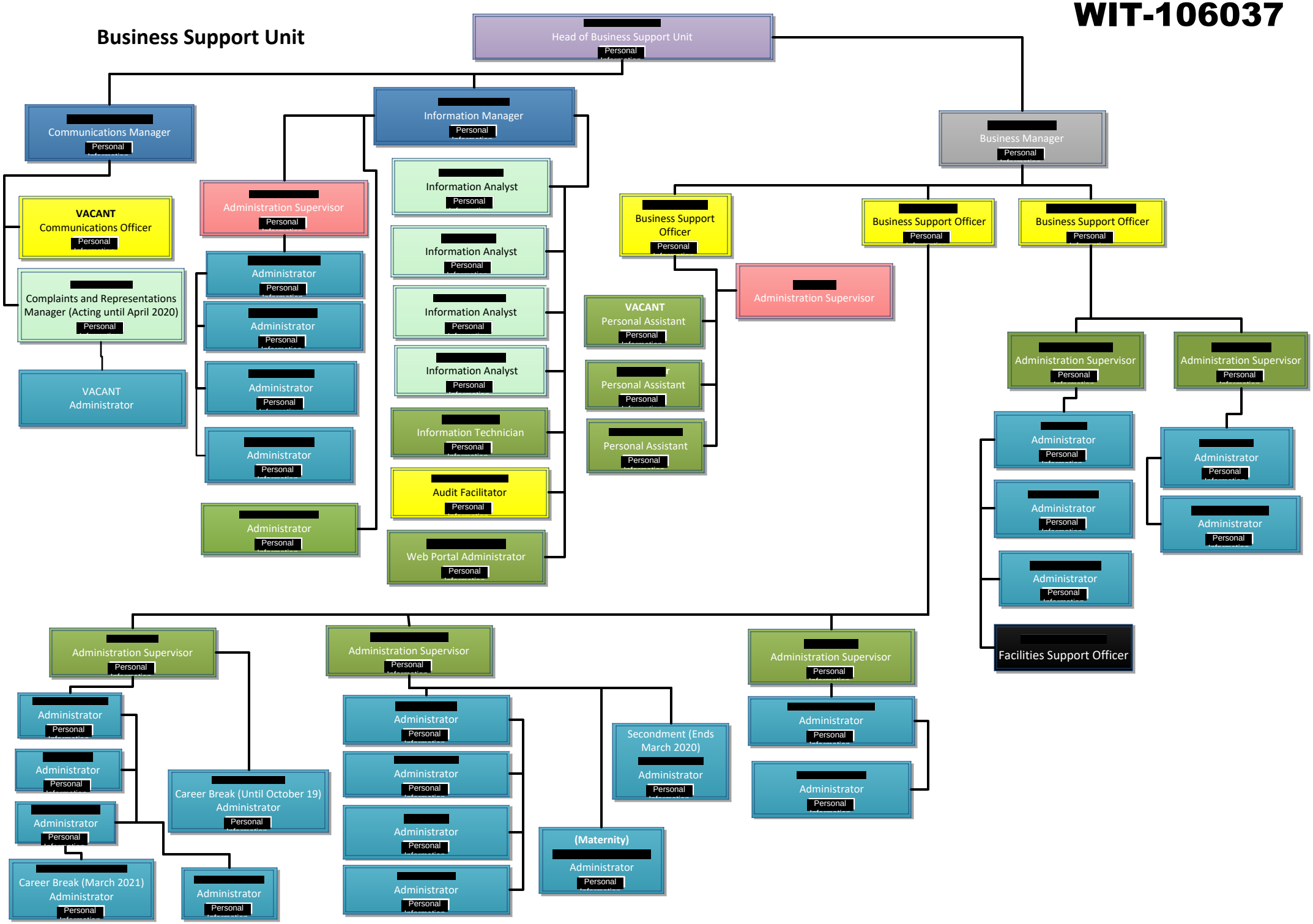
I believe that the facts stated in this witness statement are true.

Signed:



Date: 15th January 2024

Business Support Unit



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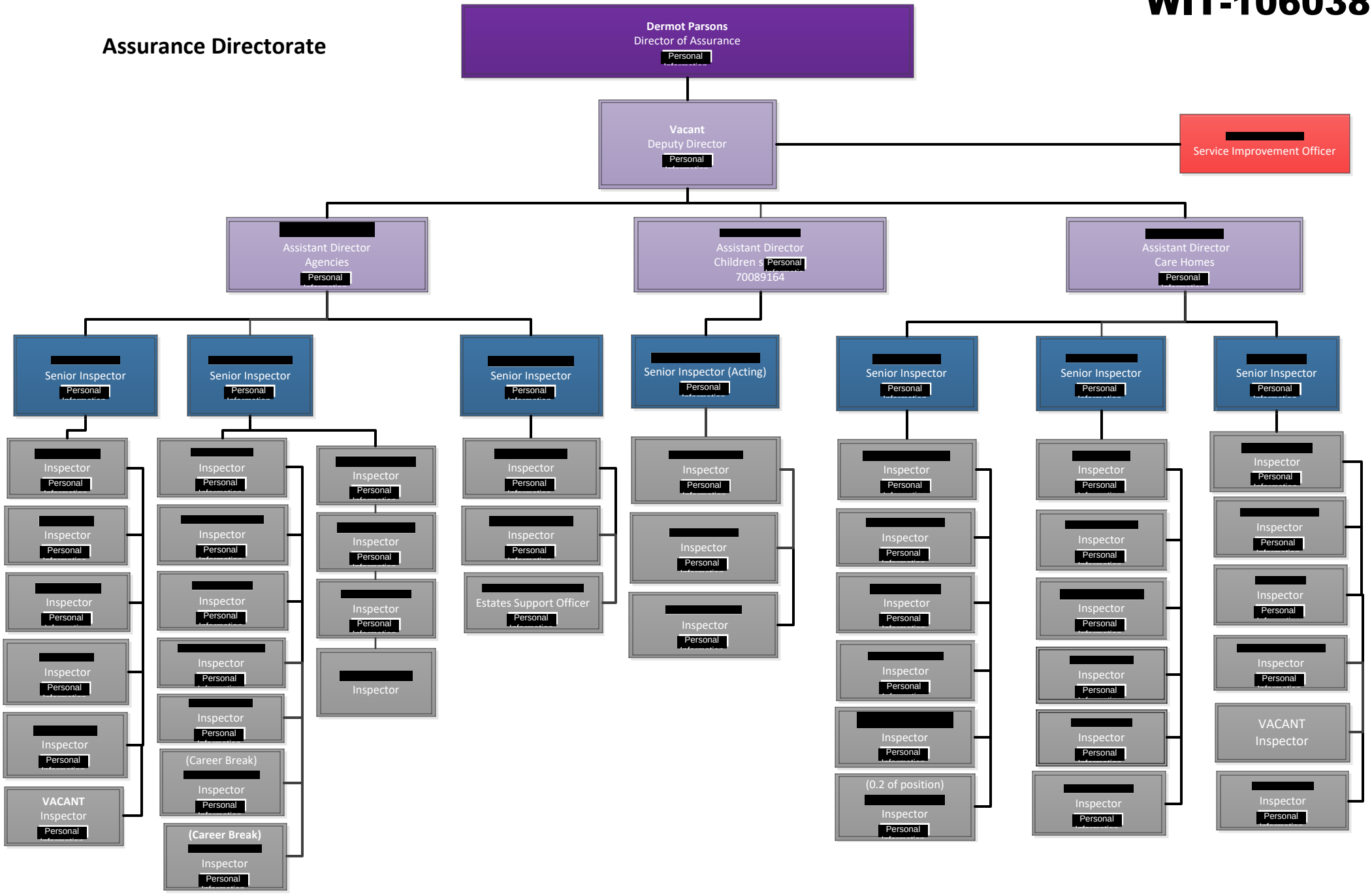
Assurance Directorate



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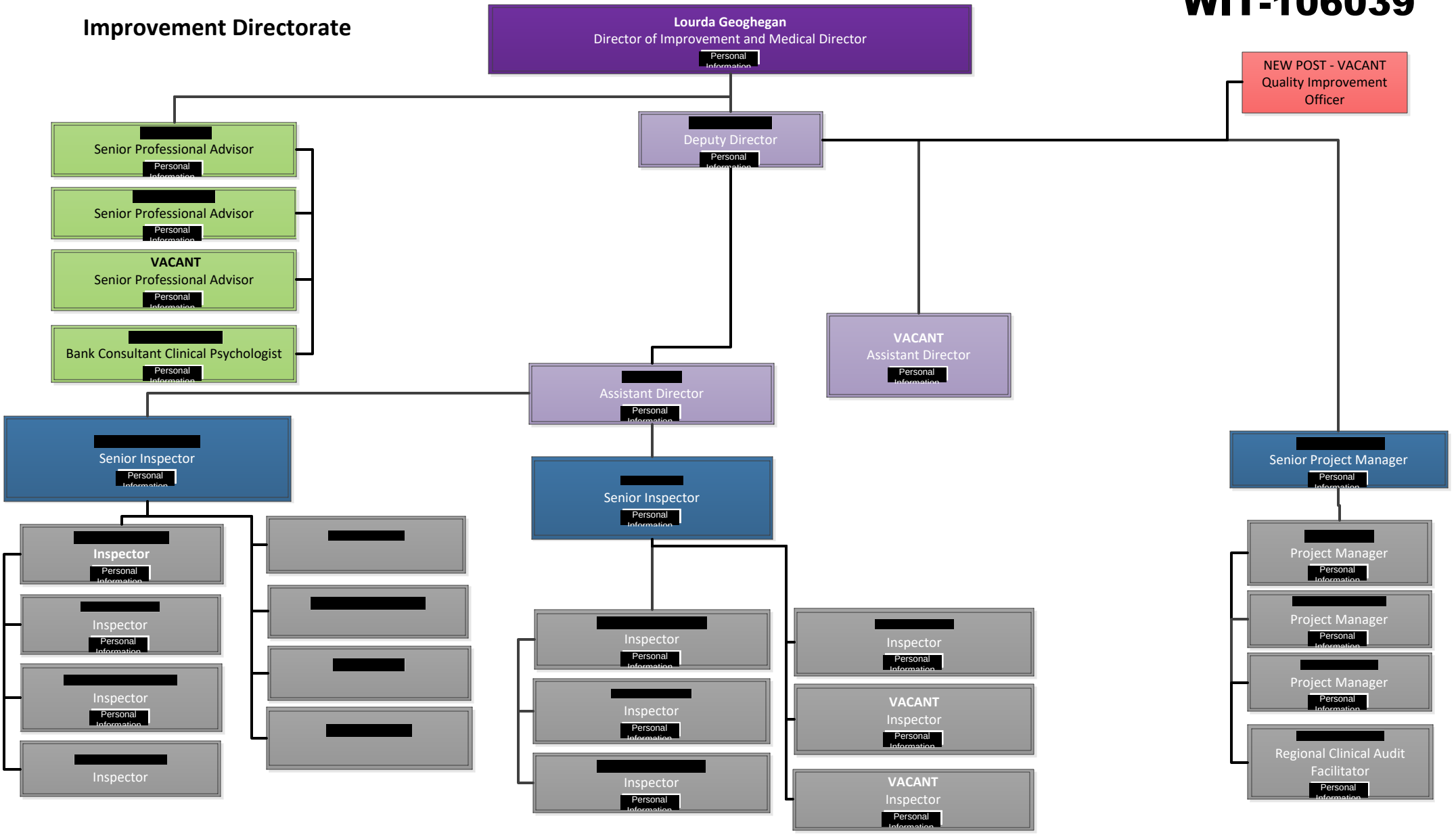
Improvement Directorate



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Version September 2011

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

FRAMEWORK DOCUMENT

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1. Introduction

2. Structures, Roles and Statutory Responsibilities

3. Setting the Agenda

4. Commissioning

5. Personal and Public Involvement

6. Holding the System to Account

7. Conclusion

1. INTRODUCTION

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

Background

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

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

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

effective delivery of health and social care in Northern Ireland.

Framework Document

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

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

ii the matters for which the body is responsible;

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

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

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

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

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

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

iv HSC Trusts;

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

vi Patient and Client Council; and

vii Regulation and Quality Improvement Authority

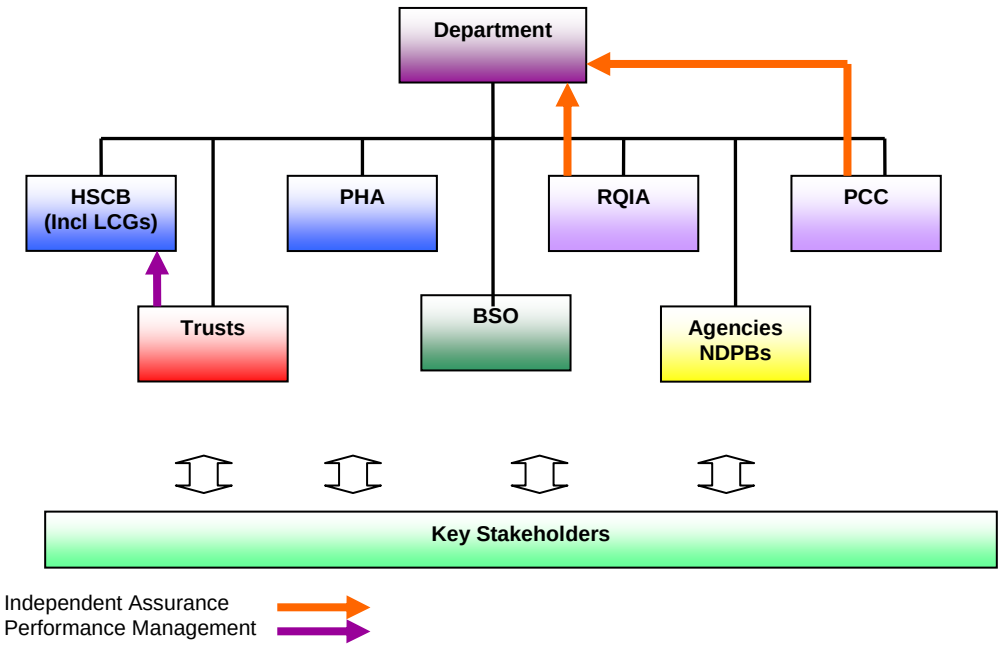
1.7. The focus of the Framework Document is the health and social care system in Northern Ireland and, although not covered by the Reform Act, the Northern Ireland Practice and Education Council and the Northern Ireland Social Care Council are included in the document for completeness. The Northern Ireland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

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

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

2. STRUCTURES, ROLES AND STATUTORY RESPONSIBILITIES

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



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

Department of Health, Social Services & Public Safety

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

i health care designed to secure improvement:

- in the physical and mental health of people in Northern Ireland, and
- in the prevention, diagnosis and treatment of illness; and

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

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

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

Health & Social Care Board

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

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

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

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

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

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

Public Health Agency

2.10. The PHA, which is established as the Regional Agency for Public Health & Social Well-being under Section 12(1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009 incorporates and builds on the work previously carried out by the Health Promotion Agency, the former Health and Social Services Boards and the Research and Development Office of the former Central Services Agency. Its primary functions can be summarised under three broad headings.

2.11. **Improvement in health and social well-being** – with the aim of influencing wider service commissioning, securing the provision of specific programmes and supporting research and development initiatives designed to secure the improvement of the health and social well-being of, and reduce health inequalities between, people in Northern Ireland;

2.12. **Health protection** – with the aim of protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being, including dangers arising on environmental or public health grounds or arising out of emergencies;

2.13. **Service development** – working with the HSCB with the aim of providing professional input to the commissioning of health and social care services that meet established safety and quality standards and support innovation. Working with the HSCB, the PHA has an important role to play in providing professional leadership to the HSC.

2.14. In exercise of these functions, the PHA also has a general responsibility for promoting improved partnership between the HSC sector and local government, other public sector organisations and the voluntary and community sectors to bring about improvements in public health and social well-being and for anticipating the new opportunities offered by

community planning.

Health and Social Care Trusts

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

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

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

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

Business Services Organisation

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

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

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

Patient and Client Council

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

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

Regulation and Quality Improvement Authority (RQIA)

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

include:

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

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

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

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

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

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

Special Agencies

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

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

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

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

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

Non Departmental Public Bodies (NDPBs)

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

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

Summary of working relationships

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

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

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

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

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

The Health and Social Care Board and the Public Health Agency

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

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

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

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

Health and Social Care Board and HSC Trusts

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

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

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

Health and Social Care Board and Family Practitioner Services

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

Business Services Organisation and the Wider HSC

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

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

Patient and Client Council and Wider HSC

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

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

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

Regulation and Quality Improvement Authority, the Department and Wider HSC

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

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

Special Agencies and the Department

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

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

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

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

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

3. SETTING THE AGENDA

Establishing the Priorities

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

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

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

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

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

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

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

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

policies in measurable objectives and targets.

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

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

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

Allocating the resources

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Funding the Patient and Client Council

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

Funding the Business Services Organisation

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

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

Funding Health and Social Care Trusts

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

Funding the Regulation and Quality Improvement Authority

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

Funding the Northern Ireland Guardian ad Litem Agency

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

Funding the Northern Ireland Medical and Dental Training Agency

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

approved by the Department.

Funding the Northern Ireland Blood Transfusion Service

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

Funding the Northern Ireland Practice and Education Council

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

Funding the Northern Ireland Social Care Council

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

The Capital Allocation and Reporting Process

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

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

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

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

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

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

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

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

4. COMMISSIONING

Introduction

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

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

The Commissioning Cycle

4.3. Commissioning includes the following activities:

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

populations and communities of interest;

ii Prioritising needs within available resources;

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

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

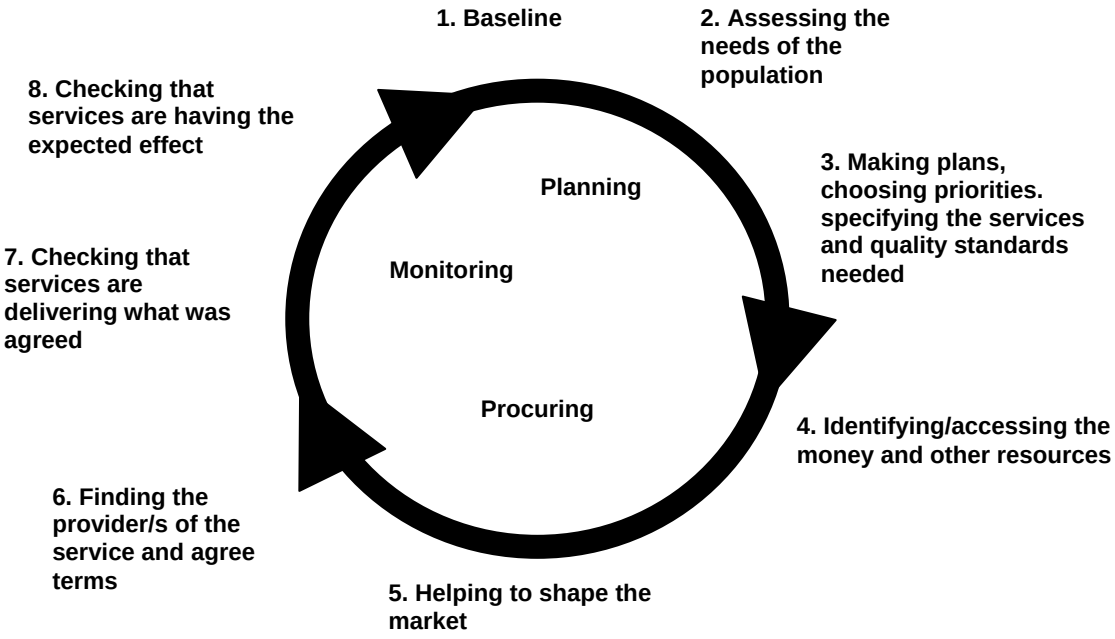
v Securing, through Service and Budget Agreements, the delivery of value for money services that meet standards and service frameworks for safe, effective, high quality care;

vi Safeguarding the vulnerable; and

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

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

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



The Commissioning Plan Direction

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

The Commissioning Plan

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

Local Commissioning

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

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

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

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

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

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

Link between Commissioning and Performance Management

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

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

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

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

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

Procurement by HSC Trusts

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

5 PERSONAL AND PUBLIC INVOLVEMENT

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

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

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

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

Roles in Personal and Public Involvement (PPI)

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

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

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

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

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

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

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

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

6 HOLDING THE SYSTEM TO ACCOUNT

Introduction

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

Performance and Assurance Dimensions

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

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

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

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

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

Key Principles

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

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

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

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

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

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

arise, and thereby minimising the need for formal intervention.

Corporate Control Dimension

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

6.5. All HSC bodies shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Safety and Quality Dimension

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

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

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

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

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

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

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

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

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

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

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

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

development etc;

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

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

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

x Implementation of statutory functions under agreed Schemes of Delegation;

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

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

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

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

ii Compliance with statutory midwifery supervision requirements;

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

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

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

i Implementation of Service Frameworks;

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

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

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

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

6.18. The Department is responsible for monitoring:

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

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

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

Finance Dimension

6.20. Appropriate financial accountability mechanisms are necessary to:

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

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

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

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

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

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

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

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

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

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

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

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

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

Operational Performance and Service Improvement

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

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

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

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

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

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

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

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

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

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

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

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

iv provide training and support;

v review Trust action plans;

vi provide support to individual providers to address specific issues

and manage provider-provider interfaces;

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

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

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

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

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

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

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

Independent Challenge

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

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

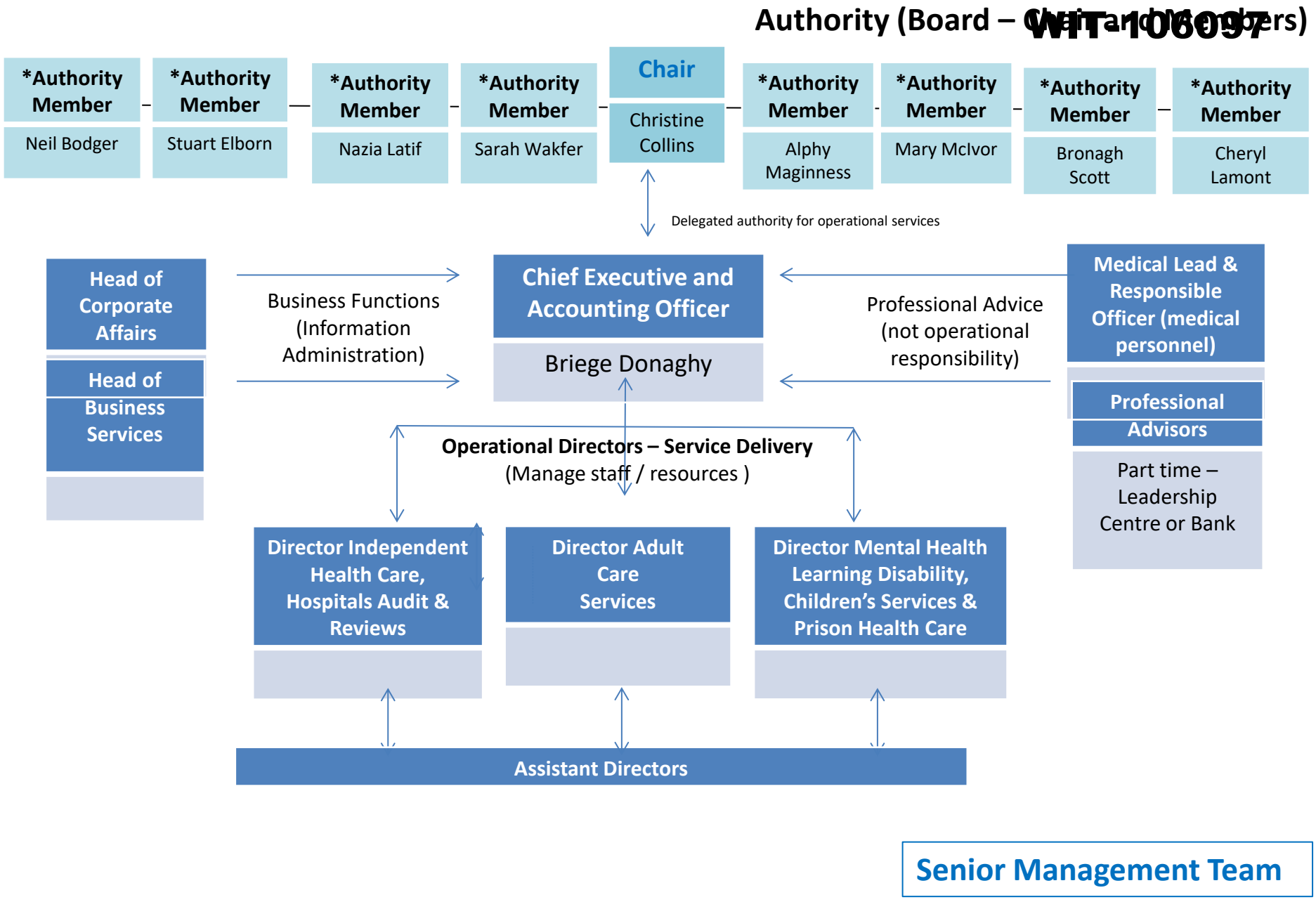
6.42. Both of these organisations provide important independent assurance to the wider public about the quality, efficacy and accessibility of health and social care services and the extent to which they are focused on user needs.

7 Conclusio n

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

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

Office of Permanent Secretary
DHSSPS
Personal Information redacted by the USI



RQIA Organisational Structure: February 2023

Received from Briege Donaghy 15/01/2024. Annotated by the Urology Services Inquiry.

Protocol for RQIA Programmed Reviews

Planned Three Year Review Programme

Additional Commissioned and Additional RQIA Initiated Reviews

Approved: November 2013
Date for Review: November 2015

Protocol for RQIA Programmed Reviews

**Planned Three Year Review Programme,
Additional Commissioned and Additional RQIA Initiated Reviews**

1. In the exercise of its functions under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, RQIA produces a three-year review programme covering the same three-year period as the Corporate Strategy.

Selection of Topics

2. The topics for review include those commissioned by the Minister and those prioritised by RQIA after a process of consultation with representatives of the Department and the statutory, voluntary and independent sectors. The prioritised list of review topics is selected after careful consideration of all the proposals made during the consultation process in reference to a set of prioritisation criteria and to ensure that the overall programme is appropriately balanced.

3. All RQIA initiated and commissioned reviews are conditional on the resources being available to carry them out.

4. **Additional Commissioned reviews only**: At any time during the three-year review period the Minister may request RQIA to carry out a review, subject to the procedures described in paragraph 7 below and this will then be included within the RQIA review programme. These requests may be for a single piece of work, a piece of follow-up work or for a rolling programme.

5. **Additional RQIA initiated reviews only**: RQIA may also add to the review programme at any time, in accordance with the procedures described in paragraph 8.

6. The progress of the review programme and potential changes to the programme will be discussed with the Department twice yearly at the accountability meetings chaired by the Permanent Secretary.

7. **Additional Commissioned reviews only**: When the Minister wishes to commission a review from RQIA, the CMO will write to the Chief Executive of RQIA, requesting that RQIA undertake the review. The Chief Executive of RQIA will confirm in writing to CMO that the commission has been accepted or, alternatively, may seek further information before confirmation is issued. Representatives of RQIA and the Department will then meet to consider the scope and timeframe of the work to be undertaken. CMO will identify who the policy lead will be within the Department. Further information will be provided subsequently as set out in paragraph 10 below.

8. **Additional RQIA initiated reviews only**: If the RQIA intends to initiate a review of any matter arising from the exercise of its functions, in addition to those already identified in the three-year review programme, the Chief Executive, in accordance with the Management Statement and Financial Memorandum for the Regulation and Quality Improvement Authority, will advise CMO, of the proposal. RQIA will take account of any comments provided by Departmental policy leads and chief professionals. These should be provided by way of a letter from CMO to the Chief Executive of the RQIA. Further information on the review will be provided subsequently as set out in paragraph 12 below.

Scoping a Review

9. **Reviews in the RQIA Three Year Review Programme:** Upon commencement of a review in the planned RQIA Three Year Review Programme, the Chief Executive will write to CMO requesting nomination of Departmental policy/professional lead(s). In a written reply, CMO will identify the policy/professional lead(s). RQIA will seek similar senior contacts to liaise with in other relevant HSC bodies as appropriate (e.g. the HSC Board or Public Health Agency). After consulting the policy/professional lead(s) in the Department (and other contacts as relevant), the lead official in RQIA will determine:

    a. the Terms of Reference
    b. the standards to be applied (where relevant)
    c. the organisations subject to the review
    d. the format of the report
    e. the timescales that will apply.

    Initial consideration should also be given to the manner of publication (to be confirmed when the final report is sent to Minister – see paragraphs 26 to 30).

    A Project Brief will be shared with Department policy/professional lead(s) (copied to Sponsor Branch) before the review begins.

10. **Additional Commissioned reviews only:** Further to the letter from CMO, the policy/professional lead and a lead official nominated by RQIA will meet, with other Departmental officials and representatives of other HSC bodies as appropriate, to determine:

    a. the Terms of Reference
    b. the standards to be applied (where relevant)
    c. the organisations subject to the review
    d. the format of the report
    e. the timescales that will apply

    Initial consideration should also be given to the manner of publication (to be confirmed when the final report is sent to Minister – see paragraphs 26 to 30).

Once agreed, these will be the subject of a further letter from CMO to the Chief Executive of the RQIA, copied to the Chief Executives of other HSC bodies as appropriate.

11. The Chief Executive of RQIA will reply to CMO, indicating acceptance of the commission in the terms stated.

12. **Additional RQIA initiated reviews only**: If RQIA, in the exercise of its functions, intends to initiate a review, the Chief Executive should advise CMO in writing. In a written reply CMO will identify the policy/professional lead for that review within the Department. RQIA will seek similar senior contacts to liaise with in other relevant HSC bodies as appropriate (e.g. the HSC Board or Public Health Agency). After consulting the policy lead in the Department (and other contacts as relevant) the lead official in RQIA will determine:

    a. the Terms of Reference
    b. the standards to be applied (where relevant)
    c. the organisations subject to the review
    d. the format of the report
    e. the timescales that will apply.

    Initial consideration should also be given to the manner of publication (to be confirmed when the final report is sent to Minister – see paragraphs 26 to 30).

    CMO will be notified in writing by the Chief Executive of RQIA before the review begins about the details of the review as outlined above. The Chief Executive of RQIA will also advise in writing the bodies to be included in the review and the relevant stakeholders of the intention to carry out the review.

13. RQIA will add any agreed new work to the review programme.

14. For additional commissioned, additional RQIA initiated reviews and those planned reviews in the RQIA Three Year Review Programme, RQIA will complete a Project Brief and will forward this to the Departmental Policy Lead (copied to Sponsor Branch).

Conducting a Review

15. Where a review involves working directly with an HSC organisation, the organisation will be invited by RQIA to appoint an affiliate to liaise with the review team.

16. If any matter comes to light during the conduct of the review that makes it necessary to activate the RQIA escalation policy for reviews, CMO and all relevant statutory agencies will be informed immediately in writing without waiting for the completion or submission of a draft report.

17. Should the Department's policy lead or the RQIA's lead official change within the duration of a review, the other party should be advised in writing of any change of personnel.

18. The progress of reviews should be reported regularly by RQIA to the Department at the bi-monthly meeting between the Director of SQSD and the Chief Executive of RQIA.

19. Additional meetings between the lead official at RQIA and the policy lead for the Department may also be arranged, as required, throughout the review.

20. As part of the review process, bodies subject to review will receive draft reports for factual accuracy checking. All proposed corrections will be considered by the review team.

21. A draft report will be shared in confidence with identified members of the RQIA Board.

The Final Report

22. Further to the actions in paragraphs 20 and 21 above, the final draft report will be sent by the Chief Executive of RQIA to CMO at least four weeks prior to its intended publication date.

23. RQIA, if required and on request, will provide an oral briefing on its report to Departmental officials and/or Minister during this four-week period.

24. CMO will advise the Chief Executive of RQIA of any factual errors in the final draft report or any major issues that would require additional time to resolve. This should be done to allow publication timescales to be met.

25. Following acceptance of the draft report by RQIA, the Chairman of RQIA will submit a final report to the Minister, copied to CMO.

Publication

26. **Reviews in the RQIA Three Year Review Programme:** Normal practice will be for the report to be published by RQIA within one month of submission of the final report to the Department. CMO will write to the Chief Executive of RQIA on receipt of the Report, confirming the publication date and, in exceptional circumstances, requesting that publication be deferred to take account of specific considerations.

27. **Additional Commissioned reviews only:** For a commissioned review, where the Minister has requested an urgent report to be provided by RQIA within a specified timescale, the times set out above may not apply. However, the general principles of the protocol should apply to all reviews. Normal practice will be for RQIA to publish reports on receipt of correspondence from CMO within one month of

submission of the final report to the Department or on any other timescale that may be advised to the Chief Executive of RQIA in writing by CMO.

28. **Additional RQIA initiated reviews only**: Normal practice will be for the report to be published by RQIA within one month of submission of the final report to the Department. CMO will write to the Chief Executive of RQIA on receipt of the Report, confirming the publication date and, in exceptional circumstances, requesting that publication be deferred to take account of specific considerations.

29. The manner of publication may vary. In some cases it could simply involve putting the report on the RQIA website. In others there may be a press release or there could be an official launch. The method of publication should be addressed in the Chairman's letter to Minister (paragraph 25) and finalised in CMO's letter (paragraphs 26 and 28).

30. RQIA press releases relating to the publication of reports will be shared with the Department for information in advance of release. Reports may be made available to the media on an embargoed basis, but in adopting a flexible approach it is important that close contact be maintained between the RQIA and Departmental press offices.

Implementation

31. Where the recommendations contained in a report are accepted, the Department's policy lead will provide a submission to the Minister recommending approval and indicating the timescale for the development of an action plan. The Department's policy lead, in collaboration with other HSC bodies as appropriate, will ensure that an action plan is developed. When it is agreed, the action plan will be copied to both the Chief Executive of RQIA and the Director of SQSD.

32. The appropriate Deputy Secretary or CMO (whichever has the lead policy responsibility) will write to Chief Executives of all relevant HSC bodies enclosing a copy of the action plan to include timescales for implementation and reporting arrangements.

33. The Minister may commission RQIA, or RQIA may initiate, a further review to assess the implementation of the recommendations at an appropriate time.

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

The Quality Standards for Health and Social Care

SUPPORTING GOOD GOVERNANCE AND BEST PRACTICE IN THE HPSS

March 2006

FOREWORD BY THE MINISTER

The people of Northern Ireland are entitled to the highest standards of health and social care. Having standards in place to ensure that people have the right care wherever they live in Northern Ireland is a fundamental principle of reform and modernisation of the health and social care system.

I am committed to putting patients, clients and carers first. The *Quality Standards for Health and Social Care* set out the standards that people can expect from Health and Personal Social Services (HPSS). In developing these standards, my aim is to raise the quality of services and to improve the health and social wellbeing of the people of Northern Ireland. At the heart of these standards are key service user and carer values including dignity, respect, independence, rights, choice and safety.

The standards have five key quality themes:

- Corporate leadership and accountability of organisations;
- Safe and effective care;
- Accessible, flexible and responsive services;
- Promoting, protecting and improving health and social well-being; and
- Effective communication and information.

The publication of the quality standards is an important milestone in the process of putting patients first. They will be used by the new Regulation and Quality Improvement Authority to assess the quality of care provided by the HPSS. The new Authority will be looking to see how the HPSS provide quality services and will be reporting their findings both to the Department and to the public.

Given the rapidly changing environment in which the HPSS now operates including changes arising from the Review of Public Administration, it is important that these standards do not become outdated or serve to stifle innovation. Therefore, the standards will be reviewed by the end of 2008.

SHAUN WOODWARD MP
Minister for Health, Social Services and Public Safety

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Section 1: Introduction to the Development of Standards

1.1 Introduction

Almost 95% of the population of Northern Ireland makes contact with health and social services on an annual basis. This contact may be through primary care services, community care services or through hospitals. In all of these contacts, people are entitled to the highest standards of health and social care.

This document sets out clearly for the public, service users and carers, and those responsible for the commissioning, planning, delivery, and review of services, the quality standards that the Department considers people should expect from Health and Personal Social Services (HPSS). It represents a significant step in the process of placing the needs of the service user and carer, and the wider public, at the centre of planning, delivery and review of health and social care services.

1.2 Background to the development of standards

Quality improvement is at the forefront of the development of health and social care services in Northern Ireland. These improvements are centred around five main areas, which are an integral part of modernisation and reform:

- setting of standards – to improve services and practice;
- improving governance in the HPSS - in other words, the way in which the HPSS manages its business;
- improving the regulation of the workforce, and promoting staff development through life-long learning and continuous professional development;
- changing the way HPSS organisations are held to account for the services they provide; and
- establishing a new, independent body to assess the quality of health and social care.

The consultation document “Best Practice – Best Care”, published in April 2001, sets out the detail of this framework to improve the quality of care. This included links to national standard setting bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE).

1.3 Improving governance in health and social care

The outcome of the Review of Public Administration, announced in November 2005, signalled major changes to the structure and functions of HPSS organisations. Regardless of these changes there remains a statutory duty of quality on HSS Boards and Trusts. This means that each organisation has a legal responsibility for satisfying itself that the quality of care it commissions and/or provides meets a required standard. This requirement is just as important as the responsibility to demonstrate financial regularity and propriety. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care. This process is known as *Governance*.

1.4 The setting of standards

In addition to drawing on national and professional standards, a range of local standards is being developed to enhance governance arrangements in the HPSS. These include controls assurance standards, so that by 2006-07, there will be a comprehensive set of specific assurance standards, which the HPSS can use to assess compliance against the required attainment levels. In addition, a number of care standards have been developed to facilitate the inspection and regulation of specific health and social care services provided by the HPSS and the independent sector. These care standards are specified in legislation and will be inspected, regulated and monitored by a new organisation called the Health and Personal Social Services Regulation and Improvement Authority (the Regulation and Quality Improvement Authority - RQIA).

The development of the *Quality Standards for Health and Social Care*, as outlined in this document, is intended to complement standards already issued or currently in development. Consequently, evidence of compliance with existing or new standards, such as professional standards, charter standards, controls assurance and/or care standards will form part of the evidence of practitioner or organisational commitment to these new quality standards.

1.5 What is a standard?

A standard is a level of quality against which performance can be measured. It can be described as ‘essential’- the absolute minimum to ensure safe and effective practice, or ‘developmental’, - designed to encourage and support a move to better practice. The *Quality Standards for Health and Social Care*, which are contained in this document, are classed as essential.

Given the rapidly changing environment in which the HPSS operates, it is important that standards do not become outdated or serve to stifle innovation.

To prevent this, standards need to be regularly reviewed and updated. It will be the Department's responsibility, drawing on the best evidence available, including advice, reports and/or information from the RQIA, to keep the quality standards under consideration, with a formal review being completed by the end of 2008.

1.6 Why are standards important?

Raising and maintaining the quality of services provided by the HPSS is a major objective for all involved in the planning, provision, delivery and review of health and social care services. Currently, there remains unacceptable variation in the quality of services provided, including timeliness of delivery and ease of access.

In order to improve the quality of these services, change is needed, underpinned and informed by a more cohesive approach to standards development.

Standards:

- give HPSS and other organisations a measure against which they can assess themselves and demonstrate improvement, thereby raising the quality of their services and reducing unacceptable variations in the quality of services and service provision;
- enable service users and carers to understand what quality of service they are entitled to and provide the opportunity for them to help define and shape the quality of services provided by the HPSS and others;
- provide a focus for members of the public and their elected representatives, to consider whether their money is being spent on efficient and effective services, and delivered to recognised standards;
- help to ensure implementation of the duty the HPSS has in respect of human rights and equality of opportunity for the people of Northern Ireland; and
- promote compliance, and underpin the regulation and monitoring of services to determine their quality and safety and to gauge their continuous improvement.

By promoting integration, these *Quality Standards for Health and Social Care* will contribute to the implementation of clinical and social care governance in the HPSS and will be used by HPSS and other organisations, service users and carers, the wider public and the RQIA to assess the quality of care provision.

1.7 The five quality themes

There are five quality themes on which the standards have been developed to improve the health and social well-being of the population of Northern Ireland. These themes have been identified through consultation with service users, carers and HPSS staff and through a review of standards developed elsewhere at local, national and international level.

The five quality themes are:

1. Corporate Leadership and Accountability of Organisations;
2. Safe and Effective Care;
3. Accessible, Flexible and Responsive Services;
4. Promoting, Protecting and Improving Health and Social Well-being; and
5. Effective Communication and Information.

1.8 Assessing quality

The RQIA was established by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and began work on 1 April 2005. It has two main functions:

- inspection and regulation of specified health and social care services provided by the HPSS and the independent sector; and

- inspection and review of the services provided by the HPSS in Northern Ireland.

The RQIA has a general duty to encourage improvements in the quality of services commissioned and provided by HPSS and other organisations. It will promote a culture of continuous improvement and best practice through inspection and review of clinical and social care governance arrangements.

The RQIA has taken over responsibility for the registration, inspection and regulation of providers of care, for example, residential care, nursing homes and day care facilities. On a phased basis, the RQIA will assume further responsibilities over the coming years, including reporting on the quality of care provided by the HPSS. Where serious and/or persistent clinical and social care governance problems come to light, it will have a key role to play, in collaboration with other regulatory and inspectoral bodies, in the investigation of such incidents. It will report on its findings to the Department and to the public.

1.9 How will the standards be used to measure quality?

The RQIA, in conjunction with the HPSS, service users and carers, will agree how the standards will be interpreted to assess service quality. It is envisaged that specific tools will be designed to allow the RQIA to measure that quality and to assist the HPSS in assessing themselves. Once developed, not only will these tools assess HPSS structures and processes but they will also contribute to the assessment of clinical and social care outcomes.

Whilst it is for the RQIA to provide guidance on what assessment methods it will use, it is recognised that collecting the evidence to demonstrate that relevant standards have been successfully achieved may be a time consuming process for the HPSS. Therefore, information that is currently compiled on existing standards will also be able to be used to contribute to the demonstration of achievement for these standards.

The RQIA will commence reviewing clinical and social care governance within the HPSS in 2006/07, using the five themes contained within this document. RQIA will report on the quality of care provided by the HPSS following its review. This approach will promote quality improvement across organisations.

Section 2: Values and Principles Underpinning the Standards

2.1 Introduction

There are three key premises, which underpin these quality standards and are central to all aspects of planning, provision, delivery, review and improvement of the HPSS. They are that:

- people in receipt of services should be actively involved in all decisions affecting their lives and should fully contribute to any planning for, delivery and evaluation of, services;

- clinical and social care governance in the HPSS must take account of the organisational structures, functions and the manner of delivery of services currently in place. Clinical and social care governance must also apply to all services provided in community, primary, secondary and tertiary care environments;

- service users and carers should be fully valued by HPSS staff who, in turn, should be valued by service users, carers and others.

2.2 The values underpinning the Standards

The quality of a service provided is dependent on managers and HPSS staff basing their practice on the following values and principles; these complement those already outlined in the care standards for independent agencies, establishments and certain other services provided by HPSS organisations.

They are:

DIGNITY AND RESPECT	The uniqueness and intrinsic value of the individual is acknowledged and each person is treated with dignity and respect. This is applicable to service users, carers, staff and others who come in contact with services.
INDEPENDENCE	A balance between the promotion of independence and risk taking is needed. Service users have as much control as possible over their lives. Service users are informed about risk whilst being protected against unreasonable risks.
PROMOTION OF RIGHTS	In the context of services delivered to them, the individual and human rights of service users are promoted and safeguarded. Where necessary, appropriate advocacy arrangements are put in place.
EQUALITY AND DIVERSITY	Equality of opportunity and positive outcomes for service users and staff are promoted; their background and culture are valued and respected.
CHOICE AND CAPACITY	Service users are offered, wherever possible, according to assessed need and available resources, the opportunity to select independently from a range of options based on clear and accurate information, which is presented in a manner that is understood by the service user and carer.
PRIVACY	Service users have the right to be free from unnecessary intrusion into their affairs and there is a balance between the consideration of the individual's safety, the safety of others and HPSS organisational responsibilities.
EMPOWERMENT	Service users are enabled and supported to achieve their potential in health and social well-being. Staff are supported and developed to realise their ability and potential.
CONFIDENTIALITY	Information about service users and staff is managed appropriately and everyone involved in the service respects confidential matters.
SAFETY	Every effort is made to keep service users, staff and others as safe as is possible. In all aspects of treatment and care, service users are free from exploitation, neglect or abuse.

2.3 The principles underpinning the Standards

The following principles are fundamental to the development of a quality service.

PUBLIC AND SERVICE USER INVOLVEMENT	The views and experiences of service users, carers, staff and local communities are taken into account in the planning, delivery, evaluation and review of services. Service users and carers, wherever possible, are involved in, and informed about, decisions made when they seek access to or receive services during their treatment or care.
SAFETY AND EFFECTIVENESS	Systems are in place to ensure that the safety of service users, carers, staff and the wider public, as appropriate, underpin all aspects of health and social care delivery. For example, the imperative to protect children and vulnerable adults may take precedence over the specific wishes of the service user and their carers. In addition, the protection of staff may need to be balanced with the specific wishes of service users, carers, families and friends. Quality systems are in place to enable staff to play a full and active role in providing effective and efficient health and social care services for all who use these services. Staff are fully supported, regularly supervised and appropriately trained and educated, to provide safe and effective health and social care services.
ROBUST ORGANISATIONAL STRUCTURES AND PROCESSES	Robust organisational structures and processes are in place, which are regularly reviewed to promote safe and effective delivery of care. Timely information is shared and used appropriately to optimise health and social care.
QUALITY of SERVICE PROVISION	Policies, procedures and activities are in place to encourage and enable continuous quality improvement. Service developments and provision are based on sound information and knowledge of best practice, as appropriate.

Section 3: Format of the Standards

3.1 The five quality themes

The five quality themes are applicable to the whole of the HPSS, including those services, which are commissioned or provided by HPSS organisations and family practitioner services. They are underpinned by the duty of quality on HSS Boards and Trusts. Where care is commissioned outside Northern Ireland, commissioners must ensure that the quality of care is commensurate with these and other associated standards.

The five quality themes, encompassing the standards, are set out in sections four to eight of this document. These are:-

- Corporate Leadership and Accountability of Organisations (Section 4);
- Safe and Effective Care (Section 5);
- Accessible, Flexible and Responsive Services; (Section 6);
- Promoting, Protecting and Improving Health and Social Well-being (Section 7); and
- Effective Communication and Information (Section 8).

3.2 Format of the standards

Each theme has a **title**, which defines the area upon which the standard is focused. Then, a **standard statement** will explain the level of performance to be achieved. The reason why the standard is seen to be important will be covered by the **rationale**. The standard statement will then be expanded into a series of **criteria**, which will provide further detail of areas for consideration by the HPSS and by RQIA.

Section 4: Corporate Leadership and Accountability of Organisations (Theme 1)

4.1 Standard Statement

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

4.2 Rationale

The HPSS must provide effective leadership and a clear direction to make the most of its resources (people, skills, time and money), and to deliver high quality services to the public in as safe an environment as is possible. The aim is to ensure a competent, confident workforce and an organisation that is open to learning and is responsive to the needs of service users and carers. This will facilitate staff in the organisation to take individual, team and professional responsibility in order to promote safe, sustainable and high quality services. The organisation needs to maintain and further enhance public confidence.

4.3 Criteria

The organisation:

a) has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability;

b) has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance;

c) has processes in place to develop leadership at all levels including identifying potential leaders of the future;

d) actively involves service users and carers, staff and the wider public in the planning and delivery, evaluation and review of the corporate aims and objectives, and governance arrangements;

e) has processes in place to develop, prioritise, deliver and review the organisation's aims and objectives;

f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;

g) has systems in place to ensure compliance with relevant legislative requirements;

h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

i) undertakes systematic risk assessment and risk management of all areas of its work;

j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- Departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation.

k) undertakes robust pre-employment checks including:

- qualifications of staff to ensure they are suitably qualified and are registered with the appropriate professional or occupational body;
- police and Protection of Children and Vulnerable Adults checks , as necessary;
- health assessment, as necessary; and
- references.

l) has in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning, facilitate professional and regulatory requirements, and informs the organisation's training, education and workforce development;

m) has a training plan and training programmes, appropriately funded, to meet identified training and development needs which enable the organisation to comply with its statutory obligations; and

n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.

Section 5: Safe and Effective Care (Theme 2)

5.1 Standard Statement

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

5.2 Rationale

A quality service is one which is safe, effective and sustainable. Diminished standards on safety reflect a poor quality of service. The provision of health and social care is complex and will never be one hundred percent error-free. However, more can always be done to avoid injury and harm to service users, from the treatment and care that is intended to help them. This is an integral part of continuous quality improvement. Services must be delivered in a way that appropriately manages risk for service users, carers, staff, the public and visitors. Where an adverse incident has occurred or has been prevented from happening (a near miss), then systems need to be in place to assist individuals and organisations to learn from mistakes in order to prevent a reoccurrence.

It is acknowledged, however, that in some situations, living with a risk can be outweighed by the benefit of having a lifestyle that the individual really wants and values. In such circumstances, risk taking can be considered to be a positive action. Health and social care staff need to work in partnership with service users and carers to explore choices and agree on how risk can be managed and minimised for the benefit of individual service users, carers, families and communities.

The promotion of safe care must be complemented by the provision of effective care. Care should be based on the best available evidence of interventions that work and should be delivered by appropriately competent and qualified staff in partnership with the service user. Systems and processes within organisations should facilitate participation in, and implementation of, evidence-based practice.

This theme of “Safe and Effective Care” has been subdivided into three areas:

- ensuring safe practice and the appropriate management of risk;
- preventing, detecting, communicating and learning from adverse incidents and near misses; and
- promoting effective care.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

a) has effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes and appropriate interagency approaches;

b) acknowledges and promotes the central place that patients, service users and carers have in the prevention and detection of adverse incidents and near misses;

c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

d) promotes effective interagency working in relation to raising awareness of the risk factors associated with abuse, including domestic violence and in the promotion of effective interagency responses;

e) has a safety policy in place which takes account of the needs of service users, carers and staff, the public and the environment; and

f) has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure:

- efficacy and comparability of outcomes in health and social care;
- compliance with professional and other codes of practice;
- effective and efficient procedures for obtaining informed consent for examination, treatment and/or care;
- accurate, timely and consistent recording of care given or services provided and associated outcomes;
- protection of health, welfare and safety of staff;
- awareness raising and staff knowledge of reporting arrangements for adverse incidents and near misses, and whistleblowing arrangements when poor performance and/or unsafe practice in examination, treatment or care comes to light;
- there is choice where food and/or fluid is provided, which reflects cultural and spiritual preferences and that procedures are in place to promote the safe handling of food and a healthy diet;

- safe practice in the selection, procurement, prescription, supply, dispensing, storage and administration of medicines across the spectrum of care and support provided, which complies with current medicines legislation;

- promotion of safe practice in the use of medicines and products, particularly in areas of high risk, for example:

    - intrathecal chemotherapy;
    - blood and blood products;
    - intravenous fluid management;
    - methotrexate;
    - potassium chloride; and
    - anticoagulant therapy.

- risk assessment and risk management in relation to the acquisition and maintenance of medical devices and equipment, and aids and appliances across the spectrum of care and support provided;

- promotion of general hygiene standards, and prevention, control and reduction in the incidence of healthcare acquired infection and other communicable diseases;

- appropriate decontamination of reusable medical devices;

- safe and effective handling, transport and disposal of waste, recognising the need to promote the safety of service users and carers, staff and the wider public, and to protect the environment;

- interventional procedures and/or any new methods undertaken by staff are supported by evidence of safety and efficacy;

- address recommendations contained in RQIA reports (when available), service and case management reviews; and

- participation in and implementation of recommendations contained in local or national enquiries, where appropriate, e.g. National Confidential Enquiries.

5.3.2 Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses

The organisation:

a) has systems and processes in place to prevent, identify, assess and manage and review adverse incidents and near misses across the spectrum of care and support provided;

b) promotes an open and fair culture, rather than one of blame and shame, to encourage the timely reporting and learning from adverse incidents and near misses;

c) has reporting systems in place to collate, analyse and learn from all adverse incidents, and near misses, share knowledge and prevent reoccurrence of adverse incident or near miss; and

d) has systems in place that promote ongoing communication with service users and carers when treatment or care goes wrong, and puts in place an individual care plan to minimise injury or harm.

5.3.3 Promoting Effective Care

The organisation:

a) provides relevant, accessible, information to support and enhance service user and carer involvement in self-management of their health and social care needs;

b) promotes a person-centred approach and actively involves service users and carers in the development, implementation, audit and review of care plans and care pathways;

c) promotes a culture of learning to enable staff to enhance and maintain their knowledge and skills;

d) ensures that clinical and social care interventions are carried out under appropriate supervision and leadership, and by appropriately qualified and trained staff, who have access to appropriate support systems;

e) uses recognised clinical and social care standards and outcomes as a means of measuring health and social care quality;

f) promotes the implementation of evidence based practice through use of recognised standards and guidelines including guidance from the Department, NICE, SCIE and the National Patient Safety Agency (NPSA);

g) has in place systems to promote active participation of staff in evidence based practice, research, evaluation and audit;

h) has systems in place to prioritise, conduct and act upon the findings of clinical and social care audit and to disseminate learning across the organisation and the HPSS, as appropriate;

i) provides regular reports to the organisation's executive and non-executive board directors on clinical and social care governance arrangements and continuous improvement in the organisation; and

j) promotes the involvement of service users and carers in clinical and social care audit activity.

Section 6: Accessible, Flexible and Responsive Services (Theme 3)

6.1 Standard Statement

Services are sustainable, and are flexibly designed to best meet the needs of the local population. These services are delivered in a responsive way, which is sensitive to individual's assessed needs and preferences, and takes account of the availability of resources.

Each organisation strives to continuously improve on the services it provides and/or commissions.

6.2 Rationale

To meet the needs of local communities and to narrow inequalities in health and social well-being, services should take account of the current and anticipated needs of the local community. Service users, carers, front line staff and the wider public should be meaningfully engaged in all stages of the service planning and decision-making cycle. Assessment of need should be undertaken in partnership with the statutory, voluntary, private and community sectors. This should be informed by the collation and analysis of information about the current health and social well-being status of the local population, unmet need, legislative requirements, and evidence of best practice and review of current service provision. Service planning should also take account of local and regional priorities and the availability of resources.

In order to promote systematic approaches to the development of responsive, flexible and accessible services for the local population and for individuals, this theme has been sub-divided into two main areas:

- service planning processes; and
- service delivery for individuals, carers and relatives.

6.3 Criteria

6.3.1 Service Planning Processes

The organisation:

a) has service planning processes which promote an equitable pattern of service provision or commissioning based on assessed need, having regard to the particular needs of different localities and people, the availability of resources, and local and regional priorities and objectives;

b) integrates views of service users, carers and local communities, and front line staff into all stages of service planning, development, evaluation and review of health and social care services;

c) promotes service design and provision which incorporates and is informed by:

- information about the health and social well-being status of the local population and an assessment of likely future needs;
- evidence of best practice and care, based on research findings, scientific knowledge, and evaluation of experience;
- principles of inclusion, equality and the promotion of good relations;
- risk assessment and an analysis of current service provision and outcomes in relation to meeting assessed needs;
- current and/or pending legislative and regulatory requirements;
- resource availability; and
- opportunities for partnership working across the community, voluntary, private and statutory sectors.

d) has service planning and decision-making processes across all service user groups, which take account of local and/or regional priorities;

e) has standards for the commissioning of services which are readily understood and are available to the public; and

f) ensures that service users have access to its services within locally and/or regionally agreed timescales.

6.3.2 Service Delivery for Individuals, Carers and Relatives

The organisation:

a) ensures that all service users, carers and relatives are treated with dignity and respect and that their privacy is protected and promoted, including, where appropriate, the use of advocates and facilitators;

b) has systems in place to ensure that service users, carers and relatives have the appropriate information to enable them to make informed decisions and choices about their treatment and care, or service provision;

c) ensures that information, where appropriate, is provided in a number of formats, which may include, large print, audio format on tape or compact disc, computer readable format, Braille, etc. and is:

- written in easy to understand, non-technical language;
- laid out simply and clearly;
- reproduced in a clear typeface;
- available on the internet; and
- in the preferred language of the reader, as necessary;

d) incorporates the rights, views and choice of the individual service user into the assessment, planning, delivery and review of his or her treatment and care, and recognises the service user's right to take risks while ensuring that steps are taken to assist them to identify and manage potential risks to themselves and to others;

e) ensures that individual service user information is used for the purpose for which it was collected, and that such information is treated confidentially;

f) promotes multi-disciplinary team work and integrated assessment processes, which minimise the need for service users and carers to repeat basic information to a range of staff; and

g) provides the opportunity for service users and carers to provide comment on service delivery.

Section 7: Promoting, Protecting and Improving Health and Social Well-being (Theme 4)

7.1 Standard Statement

The HPSS works in partnership with service users and carers, the wider public and with local and regional organisations to promote, protect and improve health and social well-being, and to tackle inequalities within and between geographic areas, socio-economic and minority groups, taking account of equality and human rights legislation.

7.2 Rationale

Individuals, families and carers have a major part to play in their own and their dependents' health and social well-being. Although many factors influence the health and social well-being of individuals, many of these factors are societal issues and are outside the control of individuals. Examples include poverty, social exclusion, poor education, unemployment, crime, and poor housing. Resolving these issues requires a broad-based approach and concerted action by a wide range of people and agencies including the statutory, voluntary, community and business sectors. The HPSS, working in partnership with these other agencies and community groups, should actively seek to influence and support better decision-making, and establish systems to promote and improve the health and social well-being of the public and to reduce inequalities. The goal is to improve the health and social well-being of the population of Northern Ireland, by increasing the length of their lives, improving the quality of life through increasing the number of years spent free from disease, illness, or disability, and by providing better opportunities for children and support for families.

7.3 Criteria

The organisation:

a) has structures and processes in place to promote and implement effective partnership arrangements, to contribute to improvements in health and social well-being, and promote social inclusion and a reduction in inequalities;

b) actively involves the services users and carers, the wider public, HPSS staff and the community and voluntary sectors, in the planning and development of local solutions to improve health and social well-being and to reduce inequalities;

c) is committed to human rights, as identified in human rights legislation and United Nations Conventions, and to other Government policies aimed at tackling poverty, social need and the promotion of social inclusion;

d) actively pursues equality screening and, where appropriate, equality impact assessment in compliance with section 75 of the Northern Ireland Act 1998;

e) promotes ownership by service users, carers and communities to enable service users and the public to take responsibility for their own health, care and social well-being, and to participate as concerned citizens in promoting the health and social well-being of others;

f) collects, collates, develops and uses health and social care information to assess current and future needs of local populations, taking account of health and social well-being inequalities;

g) has effective and efficient emergency planning processes and co-ordinated response action plans in place, as appropriate, to deal with major incidents or emergency situations and their aftermath. The planning processes and action plans are compliant with Departmental guidance;

h) has processes to engage with other organisations to reduce local environmental health hazards, as appropriate;

i) has evidence-based chronic disease management programmes and health promotion programmes and, as appropriate, community development programmes, which take account of local and regional priorities and objectives;

j) has systems to promote a healthier, safer, and “family friendly” workforce by providing advice, training, support and, as appropriate, services to support staff;

k) has quality assured screening and immunisation programmes in place, as appropriate, and promotes active uptake among service users, carers and the public;

l) uses annual public health and social care reports in the development of priorities and planning the provision and delivery of services; and

m) provides opportunities for the use of volunteers, as appropriate.

Section 8: Effective Communication and Information (Theme 5)

8.1 Standard Statement

The HPSS communicates and manages information effectively, to meet the needs of the public, service users and carers, the organisation and its staff, partner organisations and other agencies.

8.2 Rationale

Good communication and effective use of information are the basis for decision-making by individuals, the public and organisations. They ensure that all relevant facts are collated and used to inform treatment and care, and the assessment, planning, service delivery and resource allocation processes. For information to be useful, it needs to be in an understandable format, accessible to those who need it and readily available. The communication and information management processes within an organisation must take account of the needs of service users and carers, staff and the public and the media, and any legislative or regulatory requirements. Protecting personal information and confidentiality are important to ensure that information is appropriately communicated to those who need to know and effectively used to inform any decisions made. The HPSS should be sensitive to the range of information needs required to support individuals, communities and the organisation itself.

8.3 Criteria

The organisation has:

a) active participation of service users and carers and the wider public. This includes feedback mechanisms appropriate to the needs of individual service users and the public;

b) an effective information strategy and communication strategy, appropriate to the needs of the public, service users and carers, staff and the size, functions and complexity of the organisation;

c) an effective and integrated information technology and information systems which support and enhance the quality and safety of care and provision of services;

d) system(s) and process(es) in place to ensure that urgent communications, safety alerts and notices, standards and good practice guidance are made available in a timely manner to relevant staff and partner organisations; these are monitored to ensure effectiveness;

e) clear communication principles for staff and service users, which include:

- openness and honesty;
- use of appropriate language and diversity in methods of communication;
- sensitivity and understanding;
- effective listening; and
- provision of feedback.

f) clear information principles for staff and service users, which include:

- person-centred information;
- integration of systems;
- delivery of management information from operational systems;
- security and confidentiality of information; and
- sharing of information across the HPSS, as appropriate;

g) the organisation has effective training for staff on how to communicate with service users and carers and, where needed, the public and the media;

h) effective records management policies and procedures covering access and the completion, use, storage, retrieval and safe disposal of records, which it monitors to assure compliance and takes account of Freedom of Information legislation;

i) procedures for protection of service user and carer information which include the timely sharing of information with other professionals, teams and partner organisations as appropriate, to ensure safe and effective provision of care, treatment and services, e.g. in relation to the protection of children or vulnerable adults, and the safe and efficient discharge of individuals from hospital care;

j) effective and efficient procedures for obtaining valid consent for examination, treatment and/or care;

k) an effective complaints and representation procedure and feedback arrangements, which is made available to service users, carers and staff and which is used to inform and improve care, treatment and service delivery; and

l) a range of published up-to-date information about services, conditions, treatment, care and support options available, and how to access them both in and out of service hours, which are subject to regular audit and review.

APPENDIX 1

GLOSSARY OF TERMS

Adverse incident	Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.
Carer	Carers are people who, without payment, provide help and support to a family member or friend who may not be able to manage at home without this help because of frailty, illness or disability.
Care plan	The outcome of an assessment. A description of what an individual needs and how these needs will be met.
Care Standards	Care Standards are service specific standards currently being developed. They will cover a range of services provided by public, voluntary and private organisations such as nursing homes, residential homes, independent clinics etc.
Clinical and Social Care Governance	A framework within which HPSS is accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.
Community care	Health and social services aimed at supporting individuals to remain safely in their own homes for as long as possible.
Community development	Consultation with, and involvement of local communities and groups in improving health and social well-being of the community.
Controls Assurance Standards	These standards focus on key areas of potential risk and help HPSS organisations demonstrate that they are doing their reasonable best to manage themselves and protect stakeholders from risk. They support effective governance.
Equality impact assessment	Consideration of a policy having regard to its impact on and the need to promote equality of opportunity between: persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation, men and women generally, persons with a disability and persons without and between persons with dependants and persons without.
Evidence based practice	Provision of services which are based on best practice as proven by research findings, scientific knowledge and evaluation of experience.
Family Practitioner Services (FPS)	The principal primary care services i.e. family doctors, opticians, dentists and pharmacists.
HPSS (Health and Personal Social Services)	An organisation which either commissions or provides health and social services, e.g. HSS Boards, Strategic Health and Social Care Authority, a Trust providing hospital and community services, a local commissioning body, and Family Practitioner Services.

NPSA	The National Patient Safety Agency promotes safe practice in clinical care and supports the development of solutions and the cascade of learning to reduce areas of high risk.
Person-centred assessment	An assessment, which places the individual at the centre of the process and which responds flexibly and sensitively to his/her needs.
Primary care	The many forms of health and social care and/or treatment accessed through a first point of contact provided outside hospitals e.g. family doctors, pharmacists, nurses, allied health professionals (physiotherapists, psychologists, dieticians etc) social workers, care assistants, dentists, opticians and so on.
Secondary care	Specialist services usually provided in an acute hospital setting following referral from a primary or community healthcare professional.
Statutory duty	A legal responsibility.
Statutory sector	Government-funded organisations e.g. HSS Boards, Strategic Health and Social Services Authority, Trusts, Special Agencies and Local Commissioning Groups.
Tertiary care	Highly specialised services usually provided in an acute hospital setting by medical and other staff with expertise in a particular medical specialty.

APPENDIX 2

REFERENCES, CIRCULARS AND PUBLICATIONS

Legislation

1. Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

Circulars

2. Circular HSS (OS) 1/73 – (DHSSPS) Notification of untoward events in psychiatric and special hospitals.

3. Circular HSS (PDD) 1/1994 – (DHSSPS) Management of Food Services and Food Hygiene in the HPSS.

4. Circular HSS (THRD) 1/97 – (DHSSPS) Notification of untoward events in psychiatric and specialist hospitals for people with learning disability.

5. Circular HSS (THR) 1/1999 – (DHSSPS) Management of Food Services and Food Hygiene in the HPSS.

6. Circular HSS (PPM) 3/2002 - Corporate Governance: Statement on Internal Control (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp.

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March 2006

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The Regulation and Quality Improvement Authority

Acute Hospital Outpatient Department Inspection Core Indicators

Date	
Trust	
Hospital	
OPD location/ Specialties	
Inspector/s	

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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Inspection Details and Participants

Name of Inspectors:	
Name of Clinician/s:	
Name of Pharmacist/s:	
Name of Peer Reviewer/s:	
Name of Lay Assessor/s:	
Name of Additional Participants/Observer	

The Inspection Framework

The RQIA Acute Hospital Inspection Programme is designed to support HSC trusts to understand how they deliver care, identify what works well and where further improvements are needed. The inspection framework has been designed to support the Acute Hospital Inspection Programme and to assess 4 key stakeholder outcomes.

Is Care Safe? Is Care Effective? Is Care Compassionate? Is The Area Well Led?

The inspection framework includes:

- The use of data, evidence and information to inform the inspection process.
- Core Indicators.
- Feedback from patients, relatives/carers.
- Feedback from staff.
- Direct observation.
- Observation sessions (QUIS).
- The review of relevant documentation.

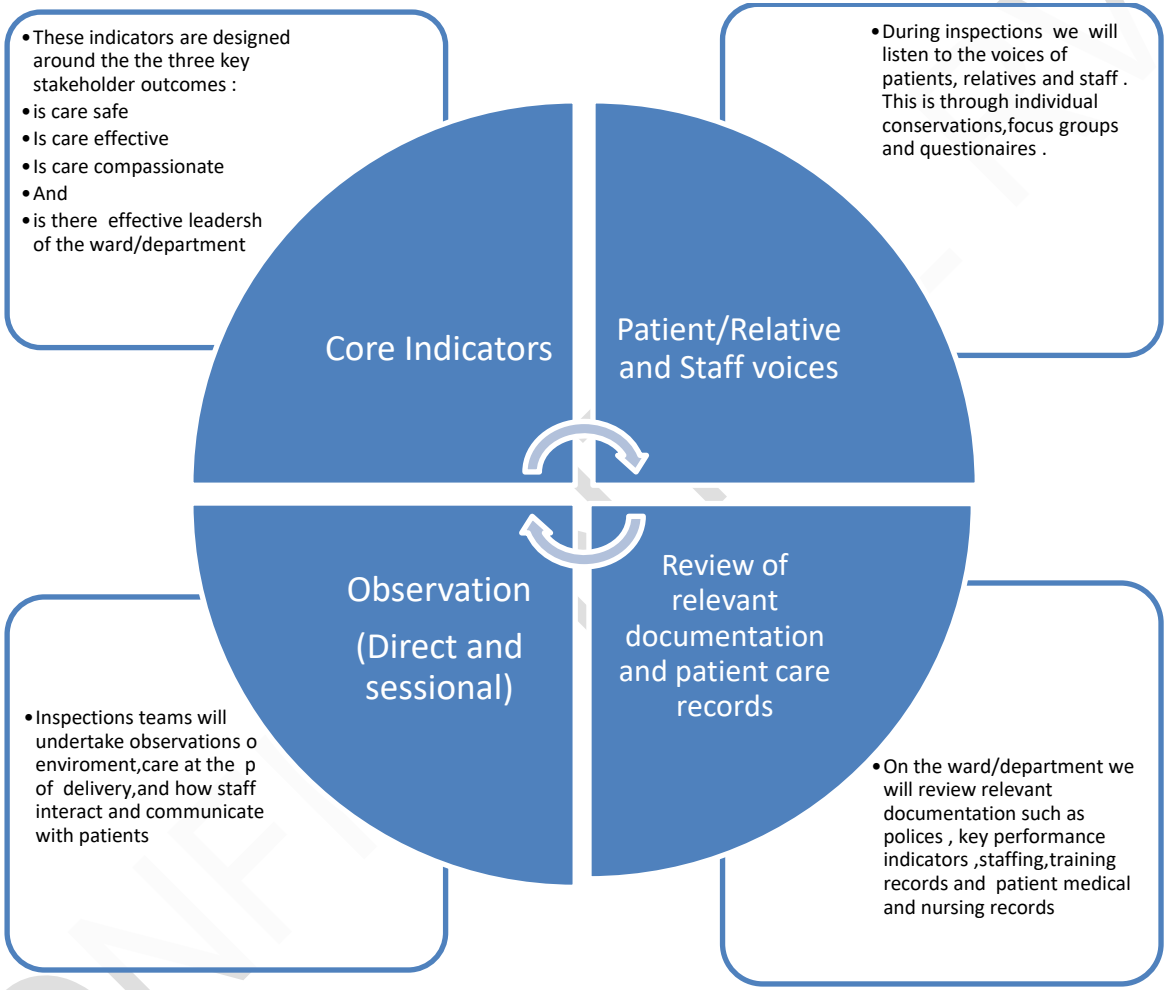
Supported by:

- The use of peer reviewers (staff who are engaged in the day to day delivery of health and social care).
- The use of lay assessors (who are service users and members of the public and who bring their own experience, fresh insight and a public focus to our inspections).

The Inspection Framework draws from a range of sources including Department of Health (DoH) standards and guidelines, NICE Guidelines and other best practice standards and guidelines which are relevant to the delivery of safe, high quality care and treatment in an Outpatient Department setting. In addition the inspection teams will rely on other sources of published information such as HSC trust Quality Reports. The framework for the inspection is explained more fully in the inspection guidance.

To enable the inspection team to reach an overall outcome assessment as to the performance of the wards or departments subject to inspection the inspection will be based on the framework shown below:

Inspection Framework



Core Indicators

The core indicators are designed around 9 areas for inspection, each area of inspection is underpinned by relevant criteria. Each indicator will correlate to one aspect the four domains of Safe, Effective, Compassionate care and Leadership and Management of the Clinical Area.

Is Care Safe?	Is Care Effective?	Is Care Compassionate?
Environmental Safety and Infection Prevention and Control Patient Safety Medicines Management	Record Keeping Patient Access/Information and Documentation Patient Individual Needs	Person Centred Care Communication This section includes the outcomes of Patient and Relative Questionnaires and Observation Sessions'

Is the Area Well Led?
Leadership and Management of the Hospital

The assessment process is detailed in the **Acute Hospital Inspection Guidance** available online at www.rqia.org.uk.

The inspection framework is designed to enable the inspection team to reach a rounded conclusion as to the performance of the departments subject to inspection.

General Information

This page should be used to record any general information about the area being inspected e.g. clinic layout, number of consultation rooms, names of key staff etc.

Name and Grade of nurse currently in charge of the ward	
Service Manager	
Number of consultation rooms	
Clinic Times: start/finish time, evening clinics	
Number of procedure/treatment areas e.g. plaster room, phlebotomy room	
Facilities available for patients	
Additional information from nurse in charge on: types of treatment, specialist staff, tests, procedures undertaken in the clinic	
Ask for copies of Nursing safety brief sheets	

Additional Information

Staffing Information

Staffing Requirements (WTE) Funded staffing levels Actual staffing levels Deficit in staffing levels ***Complete Documentation Booklet**	
Medical specialties/numbers	
Allied Health Professionals e.g. **Occupational Therapist,** **SALT,** **Dietician,** **Physiotherapists,** **Social Worker,** **Pharmacist,** **Mental Health,** **Podiatry** **Specialist Nurses**	
Others e.g. **Domestic staff** **Specialist nurse/nurse practitioner**	
Administrative	

Additional Information

WELL LED

September 2018
Received from Briege Donaghy 15/01/2024. Annotated by the Urology Services Inquiry.

AREA FOR INSPECTION: Leadership and Management of the Clinical Area **OUTCOME: Effective leadership is displayed, the department is managed and organised in a way that patients and staff feel safe, secure and supported. (EFFECTIVE)**	
KEY LINES OF ENQUIRY	**COMMENTS**
Governance	
1. The sister*/nurse in charge is easily identifiable, visible and available to support dept. activities. *Term ward sister denotes: Charge Nurse, Ward Sister and Ward Manager	
2. The sister has the necessary support to carry out their role (dedicated ward administration/ward support, deputy staff carry out designated duties, and support from line management).	
3. Staff have access to a range of policies and guidance documents at ward level. How are new policies disseminated to staff and embedded into practice?	
4. The department displays up to date results of safety/performance/patient experience audits for both patients and staff e.g. cardiac arrests, hand hygiene, environmental cleanliness.	
5. Mechanisms are in place to inform patients when they are affected by something that goes wrong, informed of actions taken and given an apology.	

6. There is evidence of key performance indicators measured at department level, compliance levels achieved and action plans in place to address deficits in performance.	
7. How many of the following were identified in the last year: SAIs/ Complaints/compliments/ RCAs/ IR1?	
8. How are lessons learned and themes from concerns and complaint identified, and is action taken as a result to improve the quality of care? How are lessons shared with others?	
9. There is evidence of trend analysis in relation to complaints, compliments, incidents, accidents, and SAIs at corporate level which is shared down professional lines.	
10. Is there evidence that the directorate risk register is examined, updated and mitigated in relation to issues identified? E.g. waiting lists, ask for copy	
11. Are there mortality and morbidity meetings conducted in the organisation and shared down professional lines?	
12. There is evidence of effective communication and dissemination of information to all staff for example: Safety briefing/handovers/staff meeting – standard agenda/ patient safety/medical devices alerts/ vulnerable patients.	

13. What systems are in place to supervise visiting professionals? What line management structure is in place?	
14. How are patients/relatives views and experiences gathered and acted on to shape and improve the services and culture?	
15. The sister has considered the health and safety of her staff and patients and there is a health and safety risk assessment with identified actions completed for this area. (There is an effective plan in place that has identified risks and actions in place to address same)	

Staffing - Nursing	COMMENTS
1. How are staffing levels and skill mix planned and reviewed so that patients receive safe care and treatment at all times?	
2. How do actual staffing levels compare to the planned levels? Does the skill mix meet the needs of the department?	
3. Where there are identified deficits in nursing staffing, appropriate escalation systems are in place.	
4. Are arrangements in place for using bank, agency and locum staff to keep the service safe at all times?	
5. Are there concerns in the turnover of staffing over the last yea?	
6. There is evidence of forward planning when vacancies arise.	

Staffing - Medical	COMMENTS
1. How are staffing levels and skill mix planned and reviewed so that patients receive safe care and treatment at all times?	
2. How do actual staffing levels compare to the planned levels? Does the skill mix meet the needs of the department?	
3. Are arrangements in place for using locum staff to maintain and keep the service safe at all times?	
4. There is evidence of forward planning when vacancies arise.	
5. There is adequate medical staffing to hold clinics and there are appropriate escalation procedures when deficits are identified. Junior medical staff are supported with decision making	
6. Escalation of clinical concerns to colleagues within or between teams is in keeping with local policy. (Discussion between the relevant medical staff, either in person or by telephone conversation).	

Staff Training & Supervision	COMMENTS
1. Outline arrangements for statutory and/or mandatory training for staff in the department.	
2. How is poor or variable staff performance identified and managed? How are staff supported to improve?	
3. Is there a link person system in operation within the department, evidence dissemination of information to staff for learning?	
4. There is evidence of effective induction, mentorship mandatory training, role specific training, with supportive documentation.	
5. There is evidence of ongoing supervision and appraisal evidenced by records.	

Access and Flow	COMMENTS
1. How does the department prioritise care and treatment for patients with the most urgent needs?	
2. Are there clear pathways and processes for the assessment of people (within the department) or who are clinically unwell and require hospital admission? What care pathways are in place to optimise patient care if applicable e.g. stroke, chest pain.	
3. Is there evidence of effective engagement with patient flow?	
4. What action is taken to minimise the time patients have to wait for treatment or care?	
5. Is care and treatment only cancelled or delayed when absolutely necessary?	

Staff Engagement (Questionnaires)	COMMENTS
1. Do staff feel respected and valued?	
2. Is there a strong emphasis on promoting the safety and wellbeing of staff?	
3. Do staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality care?	
4. How does the department management encourage candour, openness and honesty?	
5. Do staff have appropriate training to meet their learning needs?	
6. Are staff encouraged and given opportunities to develop?	
7. How are improvements to quality and innovation recognised and rewarded?	

Complaints/ Concerns/ Safety Incidents	COMMENTS
1. Do staff understand their responsibilities to record safety incidents, concerns and near misses, and to report them internally and externally?	
2. Are staff aware of how to report incidences and near misses to promote a safety culture	
3. Do staff feel comfortable raising concerns with others within the department when they see something that may negatively affect patient care.	
4. Staff feel supported when safety/ security issues arise.	
5. Do staff have access to mental health liaison (covering the age range of the ward/ clinic) and/or other specialist mental health support if they are concerned about risks associated with a patient's mental health?	

Please use this box to identify any additional organisation and management initiatives/issues.

Have any areas for development been identified in the next 12 months? (e.g. lean, productive ward/department, dignity and care, butterfly scheme)
Have staff received any additional training to enhance their skill? How are compliments recorded?

Comment on Best Practice/Failures/ Escalation

Overall impression on achievement of outcome
Area of Good Practice
1.
2.
Area for Improvement
1.
2.
Additional Issue (if identified)

safe

AREA FOR INSPECTION: Environmental Safety and Infection Prevention and Control
OUTCOME: The environment is safe for patients, staff and visitors. Patients are cared for and treated in an environment where the risk of cross infection is minimised. (SAFE)

AREA FOR INSPECTION: Environmental Safety and Infection Prevention and Control **OUTCOME: The environment is safe for patients, staff and visitors. Patients are cared for and treated in an environment where the risk of cross infection is minimised. (SAFE)**	
KEY LINES OF ENQUIRY	**COMMENTS**
Environmental Safety	
1. The environment is clean, clutter free, in a good state of repair and free of trip and fall hazards. Equipment not in use is stored appropriately.	
2. The needs of patients with dementia or mobility issues have been considered e.g. large clocks, signage, hand rails.	
3. The department space is adequate to meet the current footfall of patients, and the available space is used effectively.	
4. Crowding/congestion/lack of space in the department does not comprise patient safety, infection prevention and control and the use of patient equipment (a timely response to emergency situation such as resuscitation, fire can be achieved).	
5. There is no unauthorised access to treatment areas.	
6. Emergency exits are clearly identified, kept closed and not blocked.	

Infection Prevention and Control	COMMENTS
1. Hand washing sinks are clean, accessible, located near to the point of examination/care and are in accordance with local and national policy	
2. Alcohol rub is available at the entrance to the department and directly accessible at the point of care/ treatment.	
3. A range of Personal Protective Equipment (PPE) is available and worn appropriately	
4. Were a patient undergoing examination has been identified as requiring isolation e.g. communicable disease TB/Flu, infectious diarrhoea, infection control measures are appropriately implemented/known to staff	
5. A patient equipment cleaning schedule is available. Equipment is clean, free from damage and in good repair	
6. The resuscitation trolley is: easily accessible, clean and sealed*, equipment is maintained and replaced, checks are carried out on a daily basis (checking schedules should identify and record that daily checking procedures have been completed). The contact details for the resuscitation crash team are clearly displayed.	

7. Hand hygiene is performed at each of the WHO 5 moments of care using the 7 step technique	
8. Invasive devices* are managed in line with best practice guidance. *specialist clinics	
9. Staff are compliant with ANTT practices and can demonstrate when ANTT procedures are applied *If ANTT practices are poor recommend ANTT competency training for staff	
10. Staff within the department are compliant with the HSC trust dress code policy	
11. Mechanisms are in place to manage waste and clinical specimens safety* *classification,segregration,storage,labelling,handling,disposal, transportation	

Hand Hygiene

Observations	Designation (Nurse/ MO/AHP)	Moment For Hand Hygiene (1,2,3,4,5,)	Opportunity Taken (Y/N)	7 Step Technique (Y/N)*	Bare below the Elbow	Comment
1						
2						
3						
4						
5						

*** Soap and water or alcohol (Soap and water then alcohol gel in augmented care areas)**

Use of PPE

No	Designation	Situation	PPE used Appropriately Y/N	Comment
1				
2				
3				

Please use this box to identify any additional environmental safety and infection control initiatives/issues.

Comment on Best Practice/ Failures/ Escalation

Overall impression on achievement of outcome
Area of Good Practice
1.
2.
Area for Improvement
1.
2.
Additional Issue (if identified)

AREA FOR INSPECTION: Patient Safety **OUTCOME: The delivery of care and treatment avoids, prevents and ameliorates outcomes or injuries stemming from healthcare. (SAFE)**	
KEY LINES OF ENQUIRY	**COMMENTS**
1. Patients who require supervision are risk assessed and located where their safety can be maintained. (Consideration is given to patient placement, safety, staffing and vulnerability).	
2. The department has the sufficient equipment to support patient care/treatment.	
3. If applicable, patients National Early Warning Score (NEWS) are accurate and trigger set.	
4. If applicable, there is an appropriate clinical response to NEWS triggers. Actions include referral to more senior or specialised staff when certain scores are reached.	
5. Staff are aware of and respond to the change and deterioration in patients well-being, medical emergencies and behaviour challenges. *Staff can outline action to take in these situation	

SAFEGUARDING	COMMENTS
1. Are staff aware of local safeguarding arrangements and their responsibilities for both adult and children safeguarding and escalation protocols. (A nominated safeguarding champion(s) is in place).	
2. Have staff been trained in safeguarding?	
3. Is information regarding safeguarding from abuse displayed where patients/relatives will see it?	
4. How do staff gain consent from patients to deliver care/treatment/examination. Have staff an understanding of consent and how this is gained – take into account children, dementia, patients with cognitive impairment etc? Is gaining of consent audited?	

Please use this box to identify any additional patient safety initiatives/issues.

Comment on Best Practice/ Failures/ Escalation

Overall impression on achievement of outcome
Area of Good Practice
1.
2.
Area for Improvement
1.
2.
Additional Issue (if identified)

AREA FOR INSPECTION: Medicines Management **OUTCOME: Avoidable patient harm in relation to medicines management will be eliminated. (SAFE)**	
KEY LINES OF ENQUIRY	**COMMENTS**
MEDICINE STORAGE	
1. Are medicines used and stored in the outpatient clinic? If so – which type of medicines?	
2. Are all medicines are stored safely and securely? - Cold storage – temperature monitoring/stocks - Medical gases – signage in place?	
3. What systems in place to check stock levels, dates, medicines to be supplied to the clinic?	
4. Are there medicines which require cold storage?	
5. What systems are in place to uplift specialist medicines at end of clinic where applicable?	

6. Are controlled drugs used including those not subject to safe custody legislation?	
7. Are there robust systems in place to ensure safe management of controlled drugs?	
8. Are drug preparation areas available, well lit, uncluttered and positioned appropriately to prevent unnecessary interruptions?	

MEDICINES ADMINISTRATION	
1. Who is responsible for prescribing and administering medicines in the clinic? Are private prescriptions written?	
2. Are there safe arrangements for management of IV meds prep and administration?	
3. Are there systems in place to manage anaphylaxis e.g. post IV admin?	
4. Does observed medication administration meet good practice guidance e.g. NMC standards? Will it be the consultant at e.g. pain clinic?	
5. System regarding patients on time critical medicines?	
6. Are oral syringes available for oral administration? paeds?	

7. Are patients/representatives (parents/relatives) involved in decisions about their medicines e.g. decision making regarding new or as required medicines and receive the information they need to take their medicines?	

MEDICINE RECORDS	
1. Is there a list of the patient's current medicines available in the clinic?	
2. What are the arrangements to obtain patient information for unexpected or additional patients being added to clinic lists?	
3. Do patients' records include their allergy/medicine sensitivity status?	
4. Is the patient's weight measured at the clinic e.g. paed?	
5. Is there a record of administration of any medicines administered at the clinic?	
6. How ensure that changes in medicines information is shared with the patient, the GP and clinic records and updating ECR?	
7. ECR – who is responsible for updating ECR? - within what time frame must changes be made? - what system in place to ensure that medicine changes have been added?	

8. What systems are in place to ensure follow up / review of patients with new medicine regimes or changes to medicines?	
9. What systems are there to ensure medicines information is captured if attending more than one medical clinic or when transferring from different Trusts or clinics?	
10. What assurances are provided regarding completion of scheduled therapeutic drug monitoring?	

GOVERNANCE	
1. Are there clearly defined policies and procedures for medicines management within the clinic? Are these readily accessible?	
2. What systems are in place to monitor prescribing to ensure in line with current guidance/local formulary? Is there a system to review a sample of TANs or prescribing?	
3. How are medicine related incidents which occur at clinic level recorded, reported and analysed?	
4. What auditing systems are in place to audit medicines management usage within the clinic?	
5. What pharmacist /pharmacist technician support is provided to the clinic? Is there access to pharmaceutical advice during clinic hours?	
6. What medicines management training is provided e.g. specialist nurses?	
7. What system is in place to monitor usage, ensure secure storage and issue of TAN pads?	

8. Is there a system to oversee the accuracy of typed notes?	
9. Is Antimicrobial Policy implemented within the clinic when antimicrobials prescribed?	

Please use this box to identify any additional medicines management initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

Overall impression on achievement of outcome
Area of Good Practice
1.
2.
Area for Improvement
1.
2.
Additional Issue (if identified)

EFFECTIVE

AREA FOR INSPECTION: Record Keeping **OUTCOME: Records are completed in line with best practice standards. (EFFECTIVE)**	
KEY LINES OF ENQUIRY	**COMMENTS**
Nursing	
1. All documentation is completed in line with the NMC Code* written legibly, with clear signatures, dated, timed and signed, contemporaneous. *Professional standards of practice and behaviour for nurses and midwives	
2. Where risks are identified e.g. pressure care, falls assessments have been completed and referral made to relevant specialist intervention e.g. tissue viability nurse.	

Specialist Staff/Allied Health Professionals (AHP)	**COMMENTS**
1. Entries are comprehensive, demonstrate on-going assessment and evaluation of treatment and outline the patient management.	
2. Entries include: date, time, entry author, legible signature. Deletion and alterations are signed and dated.	

Medical	COMMENTS
1. Patients have a documented assessment and plan of treatment.	
2. There is documented evidence that the patient and/or family has been involved in decision making and agreeing the treatment plan	
3. All documentation is completed in line with best practice guidance written legibly, with clear signatures, GMC number, dated, timed and signed, contemporaneous. *Deletions or alterations are countersigned. Medical Defence Union – Good Record Keeping	
4. There is evidence of investigation results being actioned	
5. Staff can outline how consent is obtained prior to examination/delivering treatment.	
6. Consent forms are completed fully and appropriately in line with DoH guidance	

7. Pre-admission assessment documentation has been fully completed e.g. VTE risk assessment	
8. A process is in place for making/documenting MDT referrals. Patient access to specialist advice/MDT clinic is timely. (Outline process/any issues)	

Please use this box to identify any additional care record initiatives/issues.

Comment on Best Practice/ Failures/ Escalation

Overall impression on achievement of outcome
Area of Good Practice
1.
2.
Area for Improvement
1.
2.
Additional Issue (if identified)

AREA FOR INSPECTION: Patient Access/Information and Documentation **OUTCOME: Information and Documentation is accessible to ensure effective care and treatment (EFFECTIVE)**	
KEY LINES OF ENQUIRY	**COMMENTS**
1. Information needed to deliver effective care and treatment is available to relevant staff in a timely and accessible way. (This includes patient care and risk assessments, case notes and test results.)	
2. All staff delivering care and treatment have access to electronic care records (ECR) for diagnostic results, patient information	
3. How is the GP made aware of the outcome of clinics (care/treatment plan/medication prescribed). How long does the process take and is the effectiveness of this process audited?	
4. Is there a system for ensuring medical records availability for clinics? Is this audited? Can risk be mitigated - i.e. are records available electronically?	
5. What happens if notes are not available – are clinic appointments cancelled or patients seen without notes?	
6. Key diagnostics are available for patients in a timely manner to guide and support care/treatment.	

7. How are patients provided with information about the relevant procedure, test and diagnosis?	
8. How do patients receive results (and in what format) after the relevant procedure?	
9. Health care records are stored securely and in a way that ensures confidentiality.	
10. The number of patients on the clinic list at the beginning of the day corresponds to the number of patients seen at the clinic at the end of the day? Are there any unexpected arrivals/additional patients added to the clinic? Where have they come from?	
11. What system is in place to obtain notes for unexpected arrivals/additional patients added to the clinic? Are investigations, test results available? How are they accessed?	
12. Do patients get fast tracked into the clinic? Where they are fast tracked from? What system is in place to capture these patients on the system, provide records?	
13. Is there a priority grading system in place for patients to be seen at the clinic? Who reviews referral letters?	

14. How are patients booked for an outpatient's appointment? • New patient? • Review patient? • Patient post op?	
15. What mechanisms are in place to ensure that patients are not missed, ie: that they are booked within an appropriate time?	
16. Do clinics routinely commence and finish on time?	
17. What is the scheduled time clinics commence and finish?	
18. Is the patient's arrival time and seen time captured? How? Is this audited?	
19. How often are clinics cancelled by the hospital? Why are clinics cancelled? How are the appointments accommodated or re-arranged?	
20. What is the make-up of the clinic, ie: how many new patients and how many review patients?	
21. What is the average allocated patient time slots e.g. 15 mins?	

Is this sufficient?	
22. Are patients routinely kept updated re clinic waiting times? (verbally and displayed)	
23. What is the scheduled time clinics commence and finish?	

Please use this box to identify any additional care record initiatives/issues on the ward.

Comment on Best Practice/ Failures/ Escalation

Overall impression on achievement of outcome
Area of Good Practice
1.
2.
Area for Improvement
1.
2.
Additional Issue (if identified)

AREA FOR INSPECTION: Patient Individual Needs - Assessment, Treatment and Advice **OUTCOME: Patients are provided with care and treatment to meet their individual needs (EFFECTIVE)**	
KEY LINES OF ENQUIRY	**COMMENTS**
1. How are patients nutrition and hydration needs assessed and met? What food and beverage arrangements are in place for patients who are in the department for any length of time (this includes specialised dietary requirements)?	
2. Beverages/snacks are available and easily accessible in the department	
3. How is a patient's pain assessed and managed, particularly for those who may have difficulty communicating	
4. Is there adequate pain relieving measures available for patients receiving treatment i.e. simple comfort measures: pillows	
5. Where pain management advice is required appropriate professionals are available and responsive	

6. Staff have access to a range of specialist advice and AHP services e.g. tissue viability, cardiology, incontinence management, diabetes, physiotherapy, SALT etc. Specialist services are easily accessible and responsive.	
7. There is evidence of effective MDT working. Do staff work together to assess and plan ongoing care and treatment in a timely way when patients are due to move between teams or services, including referral, discharge and transition?	
8. Has patient care been compromised due to delays in AHP assessments and intervention?	
9. Specialist equipment is available for patient e.g. stoma bags, incontinence aids, splints, crutches as required	

Please use this box to identify any additional nutrition and hydration initiatives/issues.

Comment on Best Practice/ Failures/ Escalation

Overall impression on achievement of outcome
Area of Good Practice
1.
2.
Area for Improvement
1.
2.
Additional Issue (if identified)

COMPASSIONATE

September 2018

FOR INSPECTION: Person Centred Care OUTCOME: Every patient is treated as an individual, with compassion all of the time. (COMPASSIONATE)	
KEY LINES OF ENQUIRY	**COMMENTS**
1. Is the environment appropriate and patient centred (comfortable/sufficient seating, toilets and magazines, drinks machine, separate play area for children in an adult clinic)?	
2. A call bell system is in place, in working order and available in all patient areas e.g. consultation rooms/sanitary facilities.	
3. Patient call bells are appropriately positioned, within easy reach (not unplugged).	
4. Staff respond promptly to call bells and patient requests for assistance e.g. general assistance, mobility, toileting (how long).	
5. Patient privacy is maintained by the use of curtains, screens, and appropriate clothing. Curtains are fully closed (appropriate length/good state of repair).	
6. Patient dignity is maintained at all times (including moving between areas).	
7. There are adequate supplies of laundry to meet the needs of the ward/department.	

8. Staff advise/alert the patient before entering any private areas i.e. curtains, bathrooms, consultation rooms.	
9. Appropriate sanitary facilities are available and accessible (which take account of individual preferences).	
10. Are patients offered the support of a chaperone when receiving care/treatment from a member of the opposite sex? Do staff ensure that chaperones are, where possible, the same gender as the patient?	
11. How does the department take account of individual needs of the following groups of patients: complex needs, mobility, learning disabilities, dementia, bariatric patients	
12. Patient personal details are displayed in a way that promotes patient dignity. Patient information is not easily viewed e.g. computer.	
13. Information and support systems are available for patients/relatives who require support e.g. advocacy services, those receiving difficult news (Macmillan/ Palliative)	
14. Is support with transportation available to patients with mobility issues	

Please use this box to identify any additional person centred initiatives/issues.

Comment on Best Practice/ Failures/ Escalation

Overall impression on achievement of outcome
Area of Good Practice
1.
2.
Area for Improvement
1.
2.
Additional Issue (if identified)

AREA FOR INSPECTION: Communication **OUTCOME: Patient relatives and carers experience effective communication, sensitive to their individual needs and preferences, which promote high quality care for the patient. This includes communication to staff which identified an individual's communication needs. (COMPASSIONATE)**	
KEY LINES OF ENQUIRY	**COMMENTS**
1. There is signage to direct patients/relatives. *check signage in place to prevent access to areas where x-rays etc are being carried out	
2. Staff treat patients and visitors courteously. Staff introduce themselves before carrying out care and include patients in general conversations. "Hello my name is" initiative is in place (expected more frequently for patients with dementia).	
3. Hospital staff are easily identified from their name badges.	
4. Staff are made aware of patients with cognitive impairment to provide support and assistance during their time within the department	

KEY LINES OF ENQUIRY	COMMENTS
1. Before care is carried out, staff provide an easily understood explanation of the care for patients. (Staff stay with the patient as necessary whilst receiving treatment/examination).	
2. Staff speak discretely e.g. patient's medical condition is not discussed within hearing of others.	
3. Communication aids are available e.g. picture cards/booklets/loop system.	
4. Patients and relatives have access to appropriate information and leaflets within the area, both general and specific to that clinic	
5. Information is available in various formats (Braille, sign language, different languages etc.) including access to interpreting services as and when required.	
6. Is there any use of telemedicine / skype/ telephone appointments as alternative to face to face appointments	
7. Information regarding the Trust's complaints procedure is available/displayed.	

Please use this box to identify any additional communication initiatives/issues.

Comment on Best Practice/ Failures/ Escalation

Overall impression on achievement of outcome
Area of Good Practice
1.
2.
Area for Improvement
1.
2.
Additional Issue (if identified)

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
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5 Lanyon Place
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BT1 3BT

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Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement i n Health and Social Care

September 2018

RQIA Escalation Policy and Procedure

Policy type:	**Operational**
Directorate area:	**All**
Policy author/champion:	**Hall Graham**
Equality screened:	**10/04/13**
Date approved by Board	**14/11/13**
Date of issue to RQIA staff	**20/11/13**
Date of review	**14/11/16**

1 Introduction

RQIA provides independent assurance about the quality, safety and availability of health and social care services in Northern Ireland, while encouraging continuous improvements in these services and safeguarding the rights of service users.

This policy relates to the reporting and escalation by RQIA of concerns, direct allegations and/or disclosures, which have resulted, or are likely to result, in risk to patient safety and/or risk of service failure arising during inspections and / or reviews carried out by RQIA. It applies to both the statutory and independent sectors.

The policy outlines the process for assessment and categorisation of risk, and the procedure to be followed by staff/external reviewers who wish to alert senior management of concerns, direct allegations and / or disclosures. It also sets out the procedure to be followed when a matter requires attention by the organisation being inspected or reviewed, and where appropriate for notification to other organisations.

This policy should be read in conjunction with the RQIA Enforcement Policy and Procedure which outlines enforcement activity that may result from escalation of issues.

2 Scope of the policy

This policy applies to all staff employed by RQIA, and to those working on behalf of RQIA, including -

- mental health/learning disability team inspectors
- infection, prevention and hygiene team inspectors
- regulation directorate inspectors
- all external reviewers including peer, lay and expert reviewers
- RQIA Board members

For the purposes of this policy:

- a concern is any event or circumstance that has or could lead to harm, loss or damage to people, property, environment or reputation.
- a direct allegation is any claim or assertion made by an individual about another individual's action or behaviour, raised during the course of an inspection or review.
- a direct disclosure is any claim or assertion made by an individual about his or her own action or behaviour, raised during the course of an inspection/review.

3 Policy Statement

RQIA promotes an open and positive approach to the reporting and management of concerns, direct allegations and disclosures to:

- protect patients and clients from harm
- maintain standards
- manage risks appropriately
- minimise and/or prevent the recurrence of said event/s
- facilitate learning

RQIA Escalation Policy and Procedure is applicable in all key areas of work and delivery as follows.

3.1 RQIA Reviews

The RQIA review programme takes into consideration relevant standards and guidelines, the views of the public health care experts and current research.

During reviews, RQIA examines the organisation and/or the service/s provided, highlights areas of good practice and makes recommendations to the service/organisation under review.

Findings are reported and any lessons learned are shared across the wider health and social care sector.

3.2 Infection Prevention and Hygiene Inspections

Infection, prevention and hygiene inspections are part of an overall programme designed to reduce healthcare associated infections in Northern Ireland, and provide public assurance about services.

A rolling programme of announced and unannounced inspections in acute and non-acute hospitals in Northern Ireland has been developed to assess compliance with the Regional Healthcare Hygiene and Cleanliness Standards.

3.3 Regulation and Inspection

The Regulation Directorate is responsible for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers. These services are provided in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003 and its supporting regulations.

Regulated services include residential care homes, nursing homes, children's homes, independent health care providers, nursing agencies, adult placement agencies, domiciliary care agencies, residential family centres, day care settings and boarding schools.

3.4 Mental Health and Learning Disability

RQIA has a specific responsibility to assess mental health and learning disability services under the Mental Health (Northern Ireland) Order 1986, as amended by the Health and Social Care (Reform) Act (Northern Ireland) 2009.

RQIA has also been designated as a national preventive mechanism by the UK government under the Optional Protocol to the Convention Against Torture and other Cruel Inhuman or Degrading Treatment or Punishment (OPCAT) which aims to ensure the protection of the rights of those in places of detention.

4 Responsibilities

In line with the Scheme of Delegation for RQIA Policies, the RQIA Board has responsibility for the approval of the Escalation Policy. The RQIA Board will monitor escalation activity through the Chief Executive's Report to the Board and on the basis of an annual summary report of formal escalations.

The Chief Executive has responsibility for ensuring that the Escalation Policy is applied within the legislative framework and in a consistent manner. The Chief Executive will inform the RQIA Board of any formal escalation at the earliest available opportunity.

Directors will ensure that matters which require escalation are brought to the attention of the Chief Executive in a timely manner.

The Executive Team has operational responsibility for ensuring that the Escalation Policy and Procedure is applied appropriately at all times and escalation issues are managed appropriately in accordance with this policy. Directors are also responsible for:

- ensuring that where appropriate, issues are brought to the RQIA Serious Concerns and Complaints Group (SCCG)
- identifying trends and proactively minimising risk of further harm by informing external organisations as appropriate
- dissemination of learning to relevant staff, through the heads of programme/senior inspectors by relevant briefings / training as appropriate.

Heads of programme/senior inspectors have responsibility for ensuring that all relevant RQIA staff and external reviewers are aware of and adhere to this policy. They must ensure that staff and reviewers escalate concerns correctly and pass on concerns when appropriate to the relevant director. Heads of programme will also have responsibility for maintaining a list of all escalated concerns, direct allegations and/or disclosures. They are responsible for the dissemination of learning on behalf of RQIA. Inspectors/project managers have responsibility for adhering to the policy and ensuring that they raise any concerns, direct allegations and /or disclosures and escalate appropriately. They have responsibility for ensuring that all external reviewers also adhere to this policy.

5 Training

It is the responsibility of the heads of programme/senior inspectors to ensure that all RQIA staff members are aware of their duties and responsibilities in respect of the RQIA Escalation Policy and Procedure.

It is also the responsibility of the heads of programme/senior inspectors to ensure that all external reviewers are aware of their duties and responsibilities in respect of the RQIA Escalation Policy and Procedure.

6 Equality

This policy was equality screened on 10 April 2013 and was considered to have neutral implication for equality of opportunity. The policy does not require to be subjected to a full equality impact assessment.

7 Monitoring

The policy will be reviewed by the heads of programme/senior inspectors on behalf of RQIA.

8 Review

This policy will be reviewed in November 2016.

9 Procedure - Stages of Escalation

Appendix 1 contains specific advice for inspectors/project managers/reviewers on dealing with the initial disclosure/allegation.

The chart in Appendix 2 indicates the pathway to follow when dealing with concerns, direct allegations and/or disclosures.

If during the course of an inspection or review an inspector, project manager or external reviewer becomes aware of any issue which presents a risk to a service user, and has the potential to cause harm, they should inform the RQIA review team/inspection team lead immediately.

These issues are then graded in terms of severity and for agreement of actions to reduce/minimise further harm. This is to ensure that the most appropriate personnel are involved in managing the individual categories of concerns, direct allegations and/or disclosures. Issues may be categorised as minor, moderate or major.

Minor

If following risk assessment there is a minor risk to service users, the appropriate service provider is informed and a record is kept by the review/inspection team. The risk is dealt with at a local level at the time, and in the case of inspection is followed up through recommendations and requirements set out in a quality improvement plan.

Moderate

If following risk assessment there is a moderate risk to services users, the appropriate RQIA director is informed through the line management pathway. They will then contact the relevant service provider/ trust staff. An action plan and time frame for action is agreed and any necessary follow up considered.

Major

If following risk assessment there is a major risk to service users which has the potential to cause significant harm, and for which immediate remedial action is needed, as a first step, the relevant RQIA director is informed.

The director will inform RQIA's Chief Executive who will, in turn, bring the matter to the attention of the chief executive, registered person or responsible individual of the organisation concerned. This will be in the form of a letter of escalation, which will provide the necessary information and stipulate what action should be taken and within what timeframe, in order to remedy the situation.

All such letters of escalation will be copied to the chief executives of appropriate external organisations, for example, the Health and Social Care Board, Safeguarding Board Northern Ireland, and to the relevant officer at the Department of Health, Social Services and Public Safety. The RQIA Chairman and Board will be advised of all such matters at the earliest opportunity.

Inspectors and reviewers will need to use professional judgement, based on evidence and current best practice guidance, to categorise concerns and to determine the degree to which a risk presents an immediate or continuing threat to patient / client safety. All project managers, inspectors and external reviewers will discuss the nature and extent of the perceived risk with their team leader and/or line manager as part of the escalation policy flow chart.

The initial assessment of an incident may need to be carried out quickly, even when all relevant facts may not be immediately available. The decision whether to escalate a matter to director or chief executive level will be taken on the basis of the degree of risk and the likelihood of significant harm being experienced by patients and clients.

APPENDIX 1

Specific Advice on Dealing with Initial Disclosures/Allegations

- Always listen straight away to someone who wants to tell you about incidents, suspicions of abuse or other issues of concern.

- If possible, write brief notes of what they are telling you while they are speaking. These notes may help later if you have to remember exactly what was said.

- If you do not have the means to write a note at the time, complete a contemporaneous record of what was said as soon as possible afterwards.

- Keep the original notes.

- Do not give a guarantee that you will keep what is said confidential or secret. If you are told about concerns you have a responsibility to inform the right people in order to get something done about it.

- Explain that if you are going to be told something very important that has implications for patient safety, you will need to tell the people who can deal with it. However, you will only tell people who absolutely have to know. Also point out that you cannot offer help if you are not told.

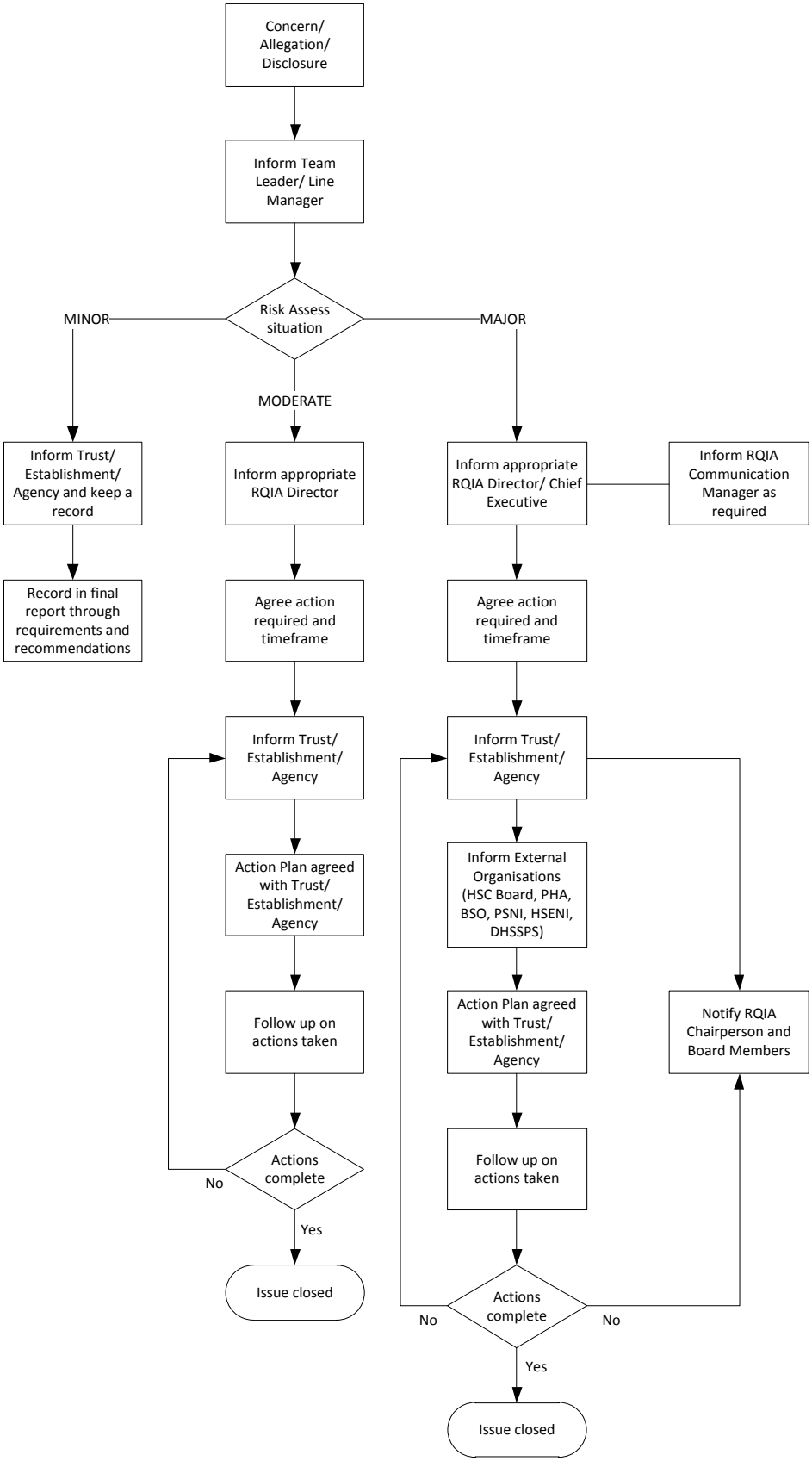
- Do not ask leading questions that may suggest your own ideas of what might have happened. Simply ask “What do you want to tell me?” or “Is there something else you want to say?”

- If required, seek advice immediately from the senior inspector/line manager or head of programme who will ensure that the correct procedures are followed.

- Discuss with the person in charge or, if the concern is about the person in charge, with a responsible individual, or if the concern is about the responsible individual it should be brought immediately to the attention of the head of programme and the Director of Regulation and Nursing, to determine whether any steps need to be taken to protect the person who has brought the matter to your attention.

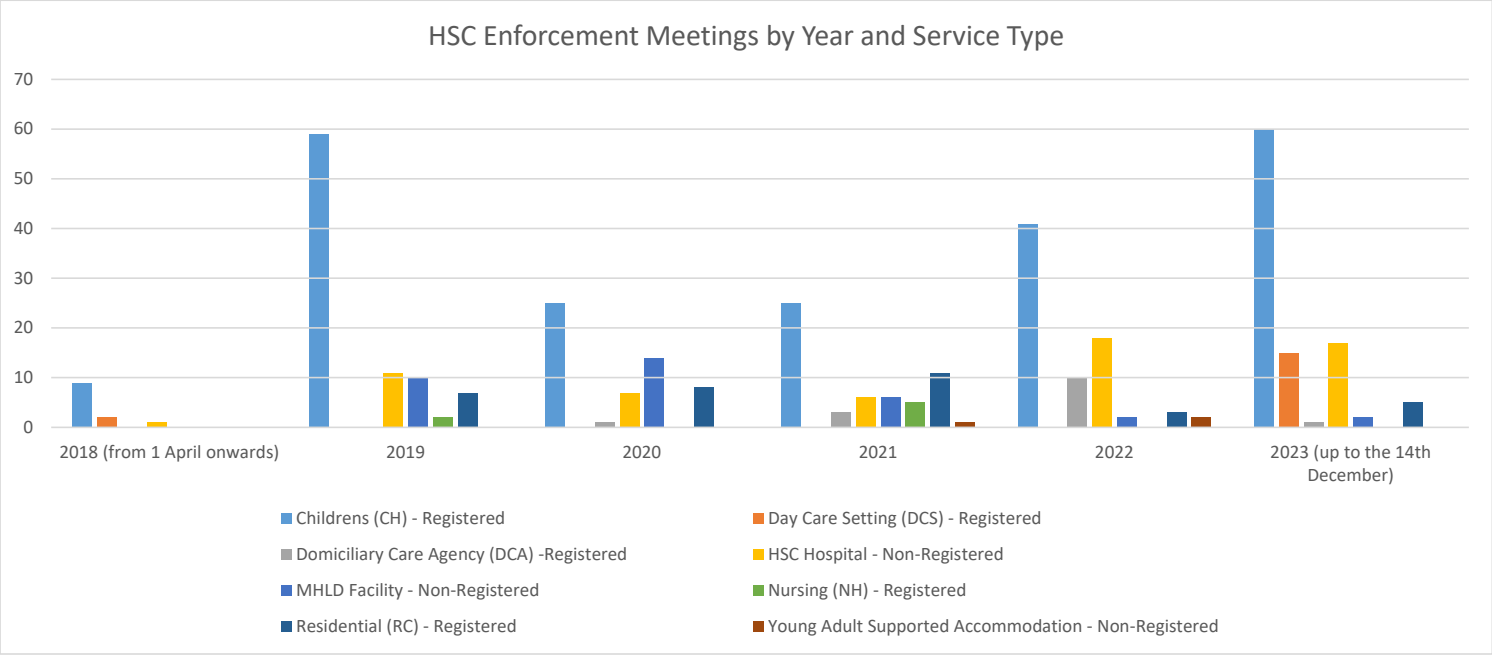
APPENDIX 2

Escalation Flow Chart



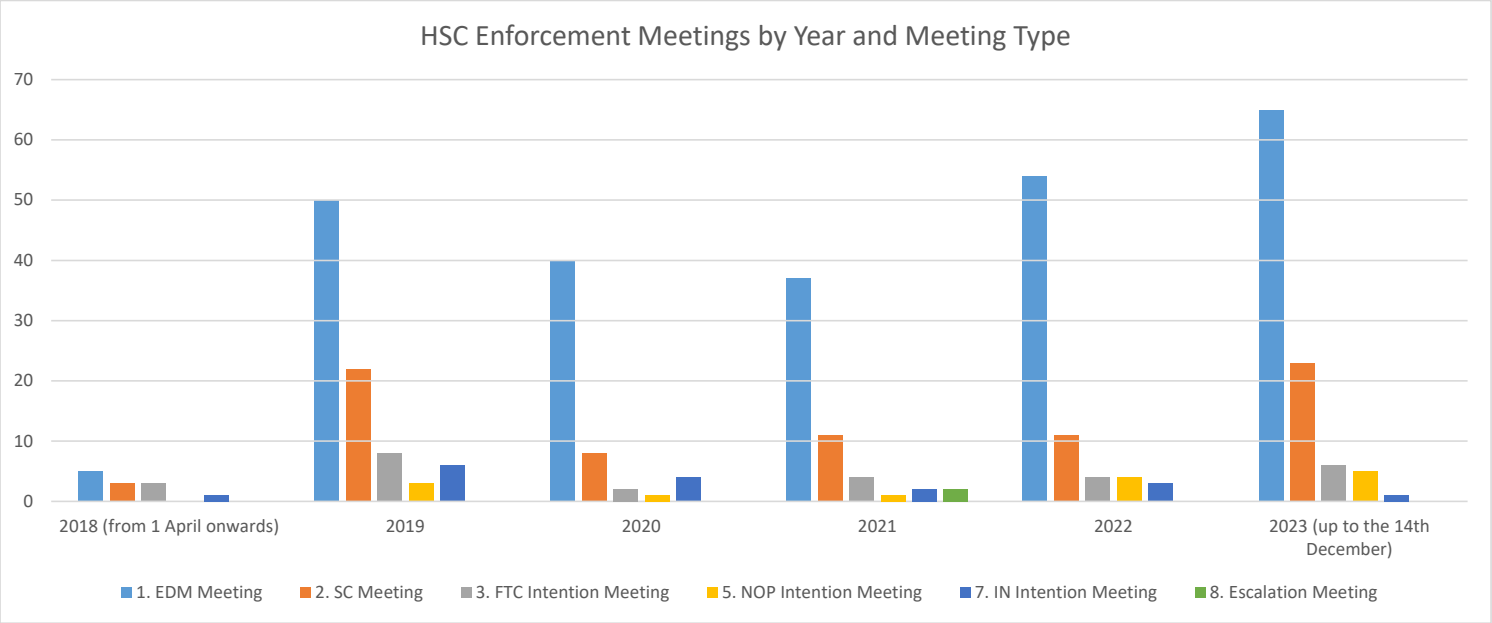
All HSC Trust Enforcement Meetings 01.04.2018 - 14.12.2023

Year	Childrens (CH) - Registered	Day Care Setting (DCS) - Registered	Domiciliary Care Agency (DCA) - Registered	HSC Hospital - Non-Registered	MHLD Facility - Non-Registered	Nursing (NH) - Registered	Residential (RC) - Registered	Young Adult Supported Accommodation - Non-Registered	Grand Total
2018 (from 1 April onwards)	9	2		1					12
2019	59			11	10	2	7		89
2020	25		1	7	14		8		55
2021	25		3	6	6	5	11	1	57
2022	41		10	18	2		3	2	76
2023 (up to the 14th December)	60	15	1	17	2		5		100
Grand Total	**219**	**17**	**15**	**60**	**34**	**7**	**34**	**3**	**389**

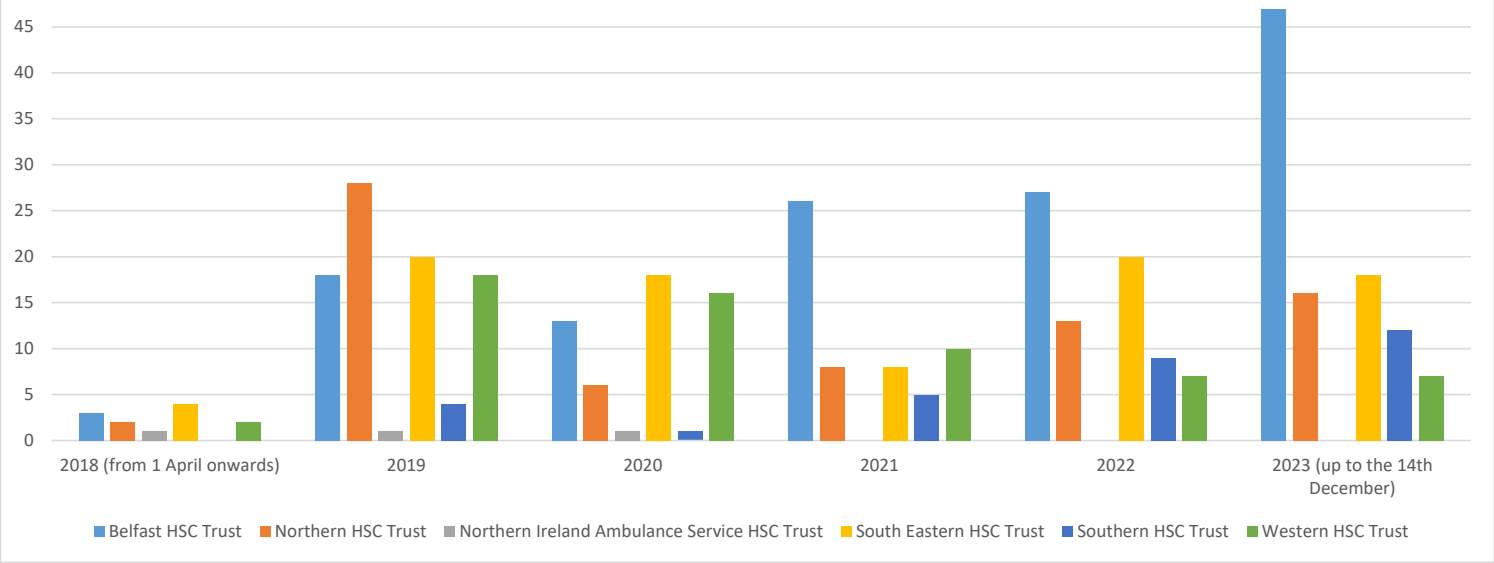


Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	8. Escalation M	Grand Total
2018 (from 1 April onwards)	5	3	3		1		12
2019	50	22	8	3	6		89

2020	40	8	2	1	4		55
2021	37	11	4	1	2	2	57
2022	54	11	4	4	3		76
2023 (up to the 14th December)	65	23	6	5	1		100
Grand Total	**251**	**78**	**27**	**14**	**17**	**2**	**389**



Year	Belfast HSC Trust	Northern HSC Trust	Northern Ireland Ambulance Service HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Grand Total
2018 (from 1 April onwards)	3	2	1	4		2	12
2019	18	28	1	20	4	18	89
2020	13	6	1	18	1	16	55
2021	26	8		8	5	10	57
2022	27	13		20	9	7	76
2023 (up to the 14th December)	47	16		18	12	7	100
Grand Total	**134**	**73**	**3**	**88**	**31**	**60**	**389**



Lead Inspector	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	8. Escalation M	Grand Total
Personal Information redacted by the USI	4			1	5		10
	3	2					5
	5	1					6
	6		4	2			12
	2	1	1				4
	1	1					2
	1	1					2
	12	5					17
	7	1					8
	1	1					2
	4	2	2				8
	2				1		3
	1	1					2
	1						1
	5	1	1	1			8
	2	1					3
	6	4			1		11
	3				1	2	6
	40	13	3	4	2		62
	10	3	1		2		16
	2						2

Personal Information redacted by the USI								
		2						2
		1						1
		4						4
		1						1
		1						1
		1						1
		2	1	1				4
		2	1					3
		5	2					7
		8	2					10
		1	1					2
		32	10		4	2		48
		6						6
		2						2
		22	8	7	1	1		39
		2						2
		3	2	2				7
		4	1					5
		22	6	3	1	1		33
		3	2			1		6
		4		1				5
		3	1	1				5
		2	3					5
Grand Total		**251**	**78**	**27**	**14**	**17**	**2**	**389**

Meeting Outcome	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	8. Escalation M	Grand Total
01-No Further Enforcement Action	43	38	9	2	6		98
02-Monitoring Inspection Planned	10	8			2		20
03-Schedule SC Meeting	58						58
04-Issue IN Notice/s					7		7
05-Schedule FTC Intention Meeting	17						17
06-Schedule NOP Intention Meeting	7						7
07-Schedule EDM Meeting		2					2
08. Schedule IN Meeting	12						12
09-FTC Issued			9				9
10-NOP Issued				8			8
12-Extend FTC Notices/s	4						4
13-Extend IN Notice/s	3						3
14-NOP Notice/s Lifted	3						3
15-NOD Notice/s Confirmed	3						3
16-Make Application for UO	1						1

17-DMP Meeting Required	1						1
22. Other, Refer to Meeting Notes	70	23	6	2	1		102
23. Escalation: Action Plan Required						2	2
(blank)	19	7	3	2	1		
Grand Total	**251**	**78**	**27**	**14**	**17**	**2**	**389**

Belfast HSC Trust

Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	Grand Total
2018 (from 1 April onwards)	1	1	1			3
2019	10	2	1	1	4	18
2020	10	2	1			13
2021	16	5	4		1	26
2022	20	3	1	2	1	27
2023 (up to the 14th December)	31	12	1	3		47
Grand Total	**88**	**25**	**9**	**6**	**6**	**134**

Northern HSC Trust

Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	Grand Total
2018 (from 1 April onwards)	1	1				2
2019	15	8	3	1	1	28
2020	5	1				6
2021	6	1			1	8
2022	9	2		2		13
2023 (up to the 14th December)	10	3	1	1	1	16
Grand Total	**46**	**16**	**4**	**4**	**3**	**73**

Northern Ireland Ambulance Service HSC Trust

Year	1. EDM Meeting	2. SC Meeting	7. IN Intention Meeti	Grand Total
2018 (from 1 April onwards)			1	1
2019		1		1
2020	1			1
2021				0
2022				0
2023 (up to the 14th December)				0
Grand Total	**1**	**1**	**1**	**3**

South Eastern HSC Trust

Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	Grand Total
2018 (from 1 April onwards)	2	1	1			4
2019	13	3	3	1		20
2020	11	3			4	18
2021	5	2		1		8
2022	15	3	2			20
2023 (up to the 14th December)	11	5	2			18
Grand Total	**57**	**17**	**8**	**2**	**4**	**88**

Southern HSC Trust

Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	Grand Total
2018 (from 1 April onwards)				
2019	3	1		4
2020	1			1
2021	3	2		5
2022	5	3	1	9
2023 (up to the 14th December)	10		2	12
Grand Total	**22**	**6**	**3**	**31**

Western HSC Trust

Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	8. Escalation M	Grand Total
2018 (from 1 April onwards)	1		1				2
2019	9	7	1		1		18
2020	12	2	1	1			16
2021	7	1				2	10
2022	5				2		7
2023 (up to the 14th December)	3	3		1			7
Grand Total	**37**	**13**	**3**	**2**	**3**	**2**	**60**

Meeting Number	Type (Enforcement/ Escalat on) (Enforcement/ Escalat on)	Status Reason	Enforcement/Escalation	Service (Enforcement/Escalation) (Enforcement/Escalation)	Service Type (Service) (RQIA Service)	Registration Status	Prov der (HSC Trust)	Meeting End Date	Meeting Type	Issue Type	Meeting Outcome	13. Final Sign Off Deadline	Created On	01. Notes Due by Note Taker	03. Notes Completed By Note Taker	Hyperlink to Parent Enforcement Record
EM000243	Enforcement	Inactive	Personal Information redacted by the USI			Registered	Western HSC Trust	14/06/2019	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	06/07/2019	07/06/2019 11:12	19/06/2019	21/06/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000239	Enforcement	Inactive				Registered	Western HSC Trust	05/06/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	27/06/2019	06/06/2019 10:25	10/06/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001202	Enforcement	Active				Registered	Western HSC Trust	12/10/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	02/11/2022	16/01/2023 11:25	17/10/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000280	Enforcement	Inactive				Registered	Western HSC Trust	23/07/2019	3. FTC Intention Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	01/08/2019	05/07/2019 17:07	15/07/2019	24/07/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000279	Enforcement	Inactive				Registered	Western HSC Trust	23/07/2019	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	01/08/2019	05/07/2019 17:05	15/07/2019	24/07/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000273	Enforcement	Inactive				Registered	Western HSC Trust	03/07/2019	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	25/07/2019	03/07/2019 18:27	08/07/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000469	Enforcement	Active				(Registered	Northern HSC Trust	13/03/2020	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	01/04/2020	07/03/2020 09:53	15/03/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000907	Enforcement	Active				Registered	Western HSC Trust	26/11/2021	1. EDM Meeting	5. Other	22. Other, Refer to Meeting Notes	18/12/2021	25/11/2021 09:35	01/12/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000823	Enforcement	Active				Registered	Western HSC Trust	13/08/2021	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	04/09/2021	12/08/2021 16:02	18/08/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001146	Enforcement	Inactive				(Registered	Northern HSC Trust	10/10/2022	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	31/10/2022	07/10/2022 16:19	15/10/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000226	Enforcement	Inactive				Registered	Northern HSC Trust	21/05/2019	7. IN Intention Meeting	1. Care Issues	02-Monitoring Inspection Planned	12/06/2019	13/05/2019 15:38	26/05/2019	03/06/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000215	Enforcement	Inactive				Registered	Northern HSC Trust	09/05/2019	1. EDM Meeting	1. Care Issues	08. Schedule IN Meeting	31/05/2019	09/05/2019 20:26	14/05/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000145	Enforcement	Inactive				Registered	Northern HSC Trust	11/02/2019	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	05/03/2019	07/02/2019 16:22	16/02/2019	14/02/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000144	Enforcement	Inactive				Registered	Northern HSC Trust	11/02/2019	3. FTC Intention Meeting	1. Care Issues	09-FTC Issued	05/03/2019	07/02/2019 16:03	16/02/2019	13/02/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000143	Enforcement	Inactive				Registered	Northern HSC Trust	06/02/2019	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	28/02/2019	06/02/2019 15:22	11/02/2019	12/02/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001419	Enforcement	Active				Registered	South Eastern HSC Trust	11/09/2023	1. EDM Meeting	1. Care Issues		03/10/2023	08/09/2023 15:06	16/09/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000965	Enforcement	Inactive				Registered	South Eastern HSC Trust	25/02/2022	1. EDM Meeting	1. Care Issues	16-Make Application for UO	19/03/2022	28/02/2022 15:00	02/03/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000961	Enforcement	Inactive				Registered	South Eastern HSC Trust	23/02/2022	3. FTC Intention Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	17/03/2022	21/02/2022 11:24	28/02/2022	09/03/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000951	Enforcement	Inactive				Registered	South Eastern HSC Trust	03/02/2022	3. FTC Intention Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	25/02/2022	02/02/2022 13:32	08/02/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000947	Enforcement	Inactive				Registered	South Eastern HSC Trust	28/01/2022	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	19/02/2022	27/01/2022 21:03	02/02/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000791	Enforcement	Active				Registered	South Eastern HSC Trust	25/06/2021	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	16/07/2021	21/06/2021 13:27	29/06/2021	29/06/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000788	Enforcement	Active				Registered	South Eastern HSC Trust	18/06/2021	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	10/07/2021	18/06/2021 12:26	23/06/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000189	Enforcement	Active				Registered	South Eastern HSC Trust	12/04/2019	3. FTC Intention Meeting	1. Care Issues	09-FTC Issued	03/05/2019	02/04/2019 11:30	16/04/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000188	Enforcement	Active				Registered	South Eastern HSC Trust	01/04/2019	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	23/04/2019	01/04/2019 15:01	06/04/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000160	Enforcement	Active				Registered	South Eastern HSC Trust	13/03/2019	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	04/04/2019	08/03/2019 10:32	18/03/2019	15/03/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000159	Enforcement	Active				Registered	South Eastern HSC Trust	07/03/2019	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	29/03/2019	07/03/2019 10:26	12/03/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000149	Enforcement	Active				Registered	South Eastern HSC Trust	22/02/2019	3. FTC Intention Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	16/03/2019	19/02/2019 12:51	27/02/2019	26/02/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000148	Enforcement	Active				Registered	South Eastern HSC Trust	18/02/2019	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	12/03/2019	18/02/2019 17:11	23/02/2019	12/04/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000121	Enforcement	Active				Registered	South Eastern HSC Trust	23/11/2018	3. FTC Intention Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	15/12/2018	21/11/2018 15:00	28/11/2018	27/11/2018	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000119	Enforcement	Active				Registered	South Eastern HSC Trust	20/11/2018	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	12/12/2018	21/11/2018 14:46	25/11/2018		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000106	Enforcement	Active				Registered	South Eastern HSC Trust	11/10/2018	2. SC Meeting	5. Other	01-No Further Enforcement Action	01/11/2018	08/10/2018 15:39	16/10/2018	15/10/2018	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000105	Enforcement	Active				Registered	South Eastern HSC Trust	08/10/2018	1. EDM Meeting	5. Other	03-Schedule SC Meeting	29/10/2018	08/10/2018 15:29	13/10/2018		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001444	Enforcement	Inactive				Registered	Southern HSC Trust	02/10/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	24/10/2023	02/10/2023 13:08	07/10/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001319	Enforcement	Inactive				Registered	Southern HSC Trust	12/06/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	04/07/2023	13/06/2023 11:06	17/06/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000940	Enforcement	Active				Registered	Southern HSC Trust	27/01/2022	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	18/02/2022	18/01/2022 15:32	01/02/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000939	Enforcement	Active				Registered	Southern HSC Trust	17/01/2022	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	08/02/2022	17/01/2022 12:11	22/01/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000227	Enforcement	Inactive				Registered	Southern HSC Trust	14/05/2019	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	05/06/2019	14/05/2019 11:35	19/05/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000184	Enforcement	Inactive				Registered	Southern HSC Trust	28/03/2019	2. SC Meeting	1. Care Issues	02-Monitoring Inspection Planned	19/04/2019	25/03/2019 14:55	02/04/2019	02/04/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000177	Enforcement	Active				Registered	Southern HSC Trust	22/03/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	13/04/2019	21/03/2019 13:10	27/03/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000548	Escalation	Inactive				Non-Registerec	Southern HSC Trust	30/07/2020	1. EDM Meeting	5. Other	01-No Further Enforcement Action	21/08/2020	04/08/2020 09:30	04/08/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000178	Escalation	Active				Non-Registerec	Western HSC Trust	25/03/2019	2. SC Meeting	1. Care Issues	02-Monitoring Inspection Planned	16/04/2019	21/03/2019 14:13	30/03/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000176	Escalation	Active				Non-Registerec	Western HSC Trust	15/03/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	06/04/2019	21/03/2019 09:14	20/03/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001379	Enforcement	Active				Registered	Southern HSC Trust	04/08/2023	1. EDM Meeting	1. Care Issues		26/08/2023	04/08/2023 15:01	09/08/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001309	Enforcement	Active				Registered	South Eastern HSC Trust	13/06/2023	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	05/07/2023	02/06/2023 18:25	18/06/2023	16/06/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001305	Enforcement	Active				Registered	South Eastern HSC Trust	31/05/2023	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	22/06/2023	02/06/2023 10:37	05/06/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001107	Enforcement	Active				Registered	South Eastern HSC Trust	02/09/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	24/09/2022	05/09/2022 19:17	07/09/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001007	Enforcement	Inactive				Registered	South Eastern HSC Trust	20/05/2022	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	11/06/2022	22/05/2022 20:52	25/05/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000833	Enforcement	Inactive				Registered	South Eastern HSC Trust	26/08/2021	1. EDM Meeting	5. Other	22. Other, Refer to Meeting Notes	17/09/2021	25/08/2021 12:46	31/08/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000781	Enforcement	Inactive				Registered	South Eastern HSC Trust	09/06/2021	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	01/07/2021	10/06/2021 13:23	14/06/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000710	Enforcement	Active				Registered	South Eastern HSC Trust	15/03/2021	1. EDM Meeting	1. Care Issues	15-NOD Notice/s Confirmed	06/04/2021	15/03/2021 15:34	20/03/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000691	Enforcement	Active				Registered	South Eastern HSC Trust	10/02/2021	5. NOP Intention Meeeting	1. Care Issues	10-NOP Issued	04/03/2021	10/02/2021 17:09	15/02/2021	16/02/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000690	Enforcement	Active				Registered	South Eastern HSC Trust	10/02/2021	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	04/03/2021	10/02/2021 17:07	15/02/2021	17/02/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000686	Enforcement	Active				Registered	South Eastern HSC Trust	02/02/2021	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	24/02/2021	02/02/2021 09:03	07/02/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000600	Enforcement	Active				Registered	South Eastern HSC Trust	30/09/2020	1. EDM Meeting	1. Care Issues	13-Extend IN Notice/s	21/10/2020	29/09/2020 14:59	04/10/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000512	Enforcement	Active				Registered	South Eastern HSC Trust	19/06/2020	7. IN Intention Meeting	1. Care Issues	04-Issue IN Notice/s	09/07/2020	04/06/2020 16:41	22/06/2020	22/06/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000511	Enforcement	Active				Registered	South Eastern HSC Trust	03/06/2020	1. EDM Meeting	1. Care Issues	08. Schedule IN Meeting	25/06/2020	02/06/2020 17:01	08/06/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000490	Enforcement	Active				Registered	South Eastern HSC Trust	06/05/2020	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	28/05/2020	06/05/2020 14:31	11/05/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000379	Enforcement	Inactive				Registered	South Eastern HSC Trust	24/10/2019	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	14/11/2019	24/10/2019 10:49	28/10/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000185	Enforcement	Active				Registered	South Eastern HSC Trust	01/04/2019	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	23/04/2019	25/03/2019 15:21	06/04/2019	09/04/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000175	Enforcement	Inactive				Registered	South Eastern HSC Trust	20/03/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	11/04/2019	21/03/2019 03:48	25/03/2019	25/03/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000867	Escalation	Active				Non-Registerec	Southern HSC Trust	01/10/2021	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	23/10/2021	05/10/2021 14:45	06/10/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001509	Enforcement	Active				Registered	Southern HSC Trust	27/11/2023	3. FTC Intention Meeting	1. Care Issues		19/12/2023	11/12/2023 13:24	02/12/2023	11/12/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001481	Enforcement	Inactive				Registered	Southern HSC Trust	10/11/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	02/12/2023	09/11/2023 13:41	15/11/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001137	Enforcement	Active				Registered	Southern HSC Trust	05/10/2022	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	27/10/2022	29/09/2022 10:57	10/10/2022	11/10/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001130	Enforcement	Active				Registered	Southern HSC Trust	22/09/2022	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	14/10/2022	23/09/2022 10:36	27/09/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001109	Enforcement	Active				Registered	Southern HSC Trust	09/09/2022	2. SC Meeting	5. Other	22. Other, Refer to Meeting Notes	01/10/2022	06/09/2022 15:47	14/09/2022	14/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001105	Enforcement	Active				Registered	Southern HSC Trust	02/09/2022	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	24/09/2022	05/09/2022 09:42	07/09/2022	05/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001362	Enforcement	Inactive				Registered	South Eastern HSC Trust	03/08/2023	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	25/08/2023	19/07/2023 16:11	08/08/2023	10/08/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001353	Enforcement	Inactive				Registered	South Eastern HSC Trust	18/07/2023	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	09/08/2023	13/07/2023 09:25	23/07/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000588	Enforcement	Active				Registered	South Eastern HSC Trust	16/09/2020	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	08/10/2020	16/09/2020 12:08	21/09/2020	30/09/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000483	Enforcement	Active				Registered	South Eastern HSC Trust	17/04/2020	1. EDM Meeting	1. Care Issues	14-NOP Notice/s Lifted	09/05/2020	20/04/2020 11:17	22/04/2020	20/04/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000448	Enforcement	Active				Registered	South Eastern HSC Trust	30/01/2020	1. EDM Meeting	1. Care Issues	12-Extend FTC Notices/s	21/02/2020	30/01/2020 22:05	04/02/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000434	Enforcement	Active				Registered	South Eastern HSC Trust	03/01/2020	1. EDM Meeting	1. Care Issues	15-NOD Notice/s Confirmed	25/01/2020	03/01/2020 16:09	08/01/2020	03/01/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000399	Enforcement	Active				Registered	South Eastern HSC Trust	22/11/2019	5. NOP Intention Meeeting	1. Care Issues	10-NOP Issued	14/12/2019	13/11/2019 16:12	27/11/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000398	Enforcement	Active				Registered	South Eastern HSC Trust	22/11/2019	3. FTC Intention Meeting	1. Care Issues	09-FTC Issued	14/12/2019	13/11/2019 16:11	27/11/2019	26/11/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000397	Enforcement	Active				Registered	South Eastern HSC Trust	12/11/2019	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	04/12/2019	12/11/2019 14:01	17/11/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000383	Enforcement	Active				Registered	South Eastern HSC Trust	17/04/2019	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	09/05/2019	30/10/2019 11:20	22/04/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000153	Enforcement	Active				Registered	South Eastern HSC Trust	25/02/2019	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	19/03/2019	26/02/2019 08:37	02/03/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001318	Enforcement	Active				Registered	Northern HSC Trust	03/05/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	25/05/2023	12/06/2023 17:56	08/05/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001092	Enforcement	Inactive				Registered	Northern HSC Trust	25/08/2022	5. NOP Intention Meeeting	1. Care Issues	10-NOP Issued	16/09/2022	22/08/2022 10:11	30/08/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001085	Enforcement	Inactive				Registered	Northern HSC Trust	15/08/2022	1. EDM Meeting	1. Care Issues	06-Schedule NOP Intention Meeting	06/09/2022	18/08/2022 08:55	20/08/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001021	Enforcement	Active				Registered	Northern HSC Trust	07/06/2022	1. EDM Meeting	1. Care Issues		29/06/2022	07/06/2022 10:51	12/06/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000960	Enforcement	Active				Registered	Northern HSC Trust	01/03/2022	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	23/03/2022	18/02/2022 13:44	06/03/2022	02/03/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e

			Personal Information redacted by the USI										
EM000959	Enforcement	Active		egistered	Northern HSC Trust	18/02/2022	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	12/03/2022	18/02/2022 13:38	23/02/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000841	Enforcement	Active		egistered	Northern HSC Trust	20/09/2021	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	15/10/2021	16/09/2021 14:52	28/09/2021	21/09/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000840	Enforcement	Active		egistered	Northern HSC Trust	15/09/2021	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	07/10/2021	15/09/2021 20:28	20/09/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000536	Enforcement	Inactive		egistered	Northern HSC Trust	08/07/2020	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	30/07/2020	10/07/2020 10:09	13/07/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000502	Enforcement	Inactive		egistered	Northern HSC Trust	20/05/2020	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	11/06/2020	19/05/2020 15:26	25/05/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000330	Enforcement	Active		egistered	Northern HSC Trust	20/08/2019	1. EDM Meeting	1. Care Issues	14-NOP Notice/s Lifted	11/09/2019	20/08/2019 11:43	25/08/2019	20/08/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000277	Enforcement	Active		egistered	Northern HSC Trust	18/07/2019	5. NOP Intention Meeeting	1. Care Issues	01-No Further Enforcement Action	30/07/2019	05/07/2019 14:55	13/07/2019	18/07/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000274	Enforcement	Active		egistered	Northern HSC Trust	03/07/2019	1. EDM Meeting	1. Care Issues	06-Schedule NOP Intention Meeting	25/07/2019	03/07/2019 23:14	08/07/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000183	Enforcement	Active		egistered	Northern HSC Trust	28/03/2019	3. FTC Intention Meeting	1. Care Issues	09-FTC Issued	19/04/2019	25/03/2019 12:05	02/04/2019	29/03/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000182	Enforcement	Active		egistered	Northern HSC Trust	28/03/2019	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	19/04/2019	22/03/2019 17:15	02/04/2019	29/03/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000179	Enforcement	Active		egistered	Northern HSC Trust	20/03/2019	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	11/04/2019	21/03/2019 15:16	25/03/2019	29/03/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001416	Enforcement	Active		egistered	South Eastern HSC Trust	30/08/2023	3. FTC Intention Meeting	1. Care Issues	01-No Further Enforcement Action	21/09/2023	06/09/2023 14:22	04/09/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001415	Enforcement	Active		egistered	South Eastern HSC Trust	30/08/2023	2. SC Meeting	1. Care Issues		21/09/2023	06/09/2023 14:21	04/09/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001401	Enforcement	Inactive		egistered	South Eastern HSC Trust	29/08/2023	2. SC Meeting	1. Care Issues		20/09/2023	23/08/2023 15:33	03/09/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001400	Enforcement	Inactive		egistered	South Eastern HSC Trust	29/08/2023	3. FTC Intention Meeting	1. Care Issues		20/09/2023	23/08/2023 15:31	03/09/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001399	Enforcement	Inactive		egistered	South Eastern HSC Trust	22/08/2023	1. EDM Meeting	1. Care Issues		13/09/2023	21/08/2023 13:51	27/08/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001136	Enforcement	Inactive		egistered	South Eastern HSC Trust	29/09/2022	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	21/10/2022	28/09/2022 15:48	04/10/2022	03/10/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001131	Enforcement	Inactive		egistered	South Eastern HSC Trust	28/09/2022	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	20/10/2022	27/09/2022 09:50	03/10/2022	28/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001038	Enforcement	Inactive		egistered	South Eastern HSC Trust	29/06/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	21/07/2022	24/06/2022 10:17	04/07/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000345	Enforcement	Active		egistered	South Eastern HSC Trust	02/10/2019	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	05/10/2019	12/09/2019 14:30	18/09/2019	04/10/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000335	Enforcement	Active		egistered	South Eastern HSC Trust	29/08/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	20/09/2019	29/08/2019 10:37	03/09/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001193	Enforcement	Inactive		egistered	Western HSC Trust	06/03/2023	5. NOP Intention Meeeting	1. Care Issues	22. Other, Refer to Meeting Notes	26/01/2023	23/12/2022 07:11	09/01/2023	06/03/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001313	Enforcement	Active		egistered	Southern HSC Trust	07/06/2023	1. EDM Meeting	3. Finance Issues	01-No Further Enforcement Action	29/06/2023	07/06/2023 09:40	12/06/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001133	Enforcement	Active		egistered	Southern HSC Trust	10/10/2022	1. EDM Meeting	3. Finance Issues	22. Other, Refer to Meeting Notes	25/10/2022	27/09/2022 15:22	08/10/2022	13/10/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001124	Enforcement	Inactive		egistered	Southern HSC Trust	23/09/2022	3. FTC Intention Meeting	1. Care Issues	01-No Further Enforcement Action	15/10/2022	16/09/2022 12:52	28/09/2022	27/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001116	Enforcement	Inactive		egistered	Southern HSC Trust	13/09/2022	1. EDM Meeting	5. Other	05-Schedule FTC Intention Meeting	05/10/2022	09/09/2022 16:13	18/09/2022	13/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000721	Enforcement	Inactive		egistered	Southern HSC Trust	22/04/2021	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	14/05/2021	16/04/2021 14:39	27/04/2021	27/04/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000719	Enforcement	Inactive		egistered	Southern HSC Trust	12/04/2021	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	07/05/2021	08/04/2021 15:09	20/04/2021	12/04/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001380	Enforcement	Inactive		egistered	South Eastern HSC Trust	08/08/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	30/08/2023	08/08/2023 11:02	13/08/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000541	Enforcement	Active		Non-Registerec	Northern HSC Trust	28/07/2020	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	19/08/2020	27/07/2020 12:21	02/08/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000498	Enforcement	Active		Non-Registerec	Northern HSC Trust	12/05/2020	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	03/06/2020	15/05/2020 13:09	17/05/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000493	Enforcement	Active		Non-Registerec	Northern HSC Trust	19/05/2020	2. SC Meeting	1. Care Issues	07-Schedule EDM Meeting	06/06/2020	07/05/2020 17:20	20/05/2020	22/05/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000347	Enforcement	Inactive		Non-Registerec	Northern HSC Trust	27/09/2019	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	19/10/2019	13/09/2019 10:46	02/10/2019	11/09/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000317	Enforcement	Active		Non-Registerec	Northern HSC Trust	27/08/2019	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	18/09/2019	12/08/2019 16:30	01/09/2019	11/09/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000305	Enforcement	Active		Non-Registerec	Northern HSC Trust	31/07/2019	1. EDM Meeting	5. Other	03-Schedule SC Meeting	22/08/2019	31/07/2019 16:31	05/08/2019	31/07/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000938	Enforcement	Active		Non-Registerec	Northern HSC Trust	14/01/2022	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	05/02/2022	14/01/2022 09:33	19/01/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000480	Enforcement	Inactive		Non-Registerec	Northern Ireland Ambulan	24/03/2020	1. EDM Meeting	1. Care Issues	02-Monitoring Inspection Planned	15/04/2020	06/04/2020 17:18	29/03/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000318	Enforcement	Inactive		Non-Registerec	Northern Ireland Ambulan	11/09/2019	2. SC Meeting	5. Other	02-Monitoring Inspection Planned	27/09/2019	13/08/2019 10:53	10/09/2019	18/10/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000139	Enforcement	Inactive		Non-Registerec	Northern Ireland Ambulan	17/12/2018	7. IN Intention Meeting	1. Care Issues	04-Issue IN Notice/s	08/01/2019	20/12/2018 12:02	22/12/2018		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001370	Enforcement	Inactive		Non-Registerec	South Eastern HSC Trust	26/07/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	17/08/2023	27/07/2023 14:55	31/07/2023	27/07/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001210	Enforcement	Active		Non-Registerec	South Eastern HSC Trust	19/12/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	10/01/2023	25/01/2023 14:50	24/12/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001209	Enforcement	Inactive		Non-Registerec	South Eastern HSC Trust	25/01/2023	1. EDM Meeting	5. Other	22. Other, Refer to Meeting Notes	15/02/2023	24/01/2023 15:09	29/01/2023	30/01/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001294	Enforcement	Active		Non-Registerec	Southern HSC Trust	17/05/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	08/06/2023	19/05/2023 08:54	22/05/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001350	Enforcement	Active		Non-Registerec	Western HSC Trust	10/07/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	01/08/2023	10/07/2023 12:36	15/07/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001212	Enforcement	Active		Non-Registerec	Western HSC Trust	20/01/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	11/02/2023	27/01/2023 12:43	25/01/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001392	Enforcement	Active		egistered	Western HSC Trust	15/08/2023	1. EDM Meeting	1. Care Issues		06/09/2023	15/08/2023 10:20	20/08/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001332	Enforcement	Active		egistered	Western HSC Trust	07/07/2023	2. SC Meeting	1. Care Issues		29/07/2023	21/06/2023 14:10	12/07/2023	19/07/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000187	Enforcement	Inactive		egistered	Western HSC Trust	20/03/2019	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	11/04/2019	27/03/2019 14:35	25/03/2019	20/03/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001336	Enforcement	Inactive		egistered	Northern HSC Trust	03/07/2023	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	25/07/2023	27/06/2023 09:58	08/07/2023	05/07/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001334	Enforcement	Inactive		egistered	Northern HSC Trust	22/06/2023	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	14/07/2023	22/06/2023 16:18	27/06/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001058	Enforcement	Inactive		egistered	Northern HSC Trust	15/07/2022	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	06/08/2022	15/07/2022 13:47	20/07/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001162	Enforcement	Active		Non-Registerec	Western HSC Trust	26/10/2022	1. EDM Meeting	1. Care Issues		16/11/2022	24/10/2022 10:14	30/10/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001140	Enforcement	Active		Non-Registerec	Western HSC Trust	30/09/2022	1. EDM Meeting	1. Care Issues	02-Monitoring Inspection Planned	22/10/2022	03/10/2022 13:53	05/10/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000963	Enforcement	Active		Non-Registerec	Western HSC Trust	01/03/2022	7. IN Intention Meeting	1. Care Issues	04-Issue IN Notice/s	23/03/2022	23/02/2022 10:08	06/03/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000844	Enforcement	Active		Non-Registerec	Western HSC Trust	22/09/2021	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	14/10/2021	22/09/2021 12:31	27/09/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000842	Enforcement	Active		Non-Registerec	Western HSC Trust	21/09/2021	8. Escalation Meeting	1. Care Issues	23. Escalation: Action Plan Required	13/10/2021	17/09/2021 12:01	26/09/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000832	Enforcement	Active		Non-Registerec	Western HSC Trust	20/08/2021	8. Escalation Meeting	1. Care Issues	23. Escalation: Action Plan Required	11/09/2021	23/08/2021 14:53	25/08/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000831	Enforcement	Active		Non-Registerec	Western HSC Trust	20/08/2021	1. EDM Meeting	1. Care Issues	08. Schedule IN Meeting	11/09/2021	23/08/2021 14:49	25/08/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000343	Enforcement	Active		egistered	South Eastern HSC Trust	09/09/2019	1. EDM Meeting	2. Pharmacy Issu	02-Monitoring Inspection Planned	01/10/2019	07/09/2019 10:29	14/09/2019	09/09/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001097	Enforcement	Active		egistered	South Eastern HSC Trust	24/08/2022	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	15/09/2022	23/08/2022 17:45	29/08/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001496	Enforcement	Inactive		egistered	Southern HSC Trust	20/11/2023	3. FTC Intention Meeting	1. Care Issues	01-No Further Enforcement Action	12/12/2023	20/11/2023 16:15	25/11/2023	24/11/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001477	Enforcement	Inactive		egistered	Southern HSC Trust	30/10/2023	1. EDM Meeting	1. Care Issues		21/11/2023	06/11/2023 13:54	04/11/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001183	Enforcement	Inactive		egistered	South Eastern HSC Trust	25/11/2022	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	17/12/2022	26/11/2022 13:47	30/11/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000198	Enforcement	Active		egistered	Northern HSC Trust	18/04/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	10/05/2019	19/04/2019 12:50	23/04/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000197	Enforcement	Active		egistered	Northern HSC Trust	24/04/2019	2. SC Meeting	5. Other	01-No Further Enforcement Action	16/05/2019	19/04/2019 12:30	29/04/2019	25/04/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001228	Enforcement	Inactive		egistered	Northern HSC Trust	23/02/2023	3. FTC Intention Meeting	1. Care Issues	01-No Further Enforcement Action	17/03/2023	23/02/2023 16:38	28/02/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001223	Enforcement	Inactive		egistered	Northern HSC Trust	15/02/2023	1. EDM Meeting	5. Other		09/03/2023	13/02/2023 18:48	20/02/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001507	Enforcement	Active		egistered	South Eastern HSC Trust	05/12/2023	1. EDM Meeting	1. Care Issues		27/12/2023	04/12/2023 15:53	10/12/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000985	Enforcement	Active		egistered	South Eastern HSC Trust	12/04/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	04/05/2022	12/04/2022 10:55	17/04/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000525	Enforcement	Active		egistered	South Eastern HSC Trust	03/07/2020	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	25/07/2020	26/06/2020 09:17	08/07/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000522	Enforcement	Active		egistered	South Eastern HSC Trust	25/06/2020	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	17/07/2020	24/06/2020 17:31	30/06/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000354	Enforcement	Active		egistered	South Eastern HSC Trust	25/09/2019	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	17/10/2019	25/09/2019 09:39	30/09/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001197	Enforcement	Inactive		Non-Registerec	Western HSC Trust	03/01/2023	2. SC Meeting	1. Care Issues	02-Monitoring Inspection Planned	25/01/2023	03/01/2023 16:03	08/01/2023	03/01/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001057	Enforcement	Inactive		Non-Registerec	Western HSC Trust	28/10/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	09/08/2022	13/07/2022 20:40	23/07/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000797	Enforcement	Active		Non-Registerec	Western HSC Trust	29/06/2021	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	21/07/2021	24/06/2021 08:24	04/07/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000712	Enforcement	Active		Non-Registerec	Western HSC Trust	24/03/2021	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	15/04/2021	22/03/2021 14:31	29/03/2021	24/03/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000581	Enforcement	Active		Non-Registerec	Western HSC Trust	11/09/2020	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	03/10/2020	11/09/2020 11:57	16/09/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000556	Enforcement	Active		Non-Registerec	Western HSC Trust	18/08/2020	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	09/09/2020	13/08/2020 14:05	23/08/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000535	Enforcement	Active		Non-Registerec	Western HSC Trust	08/07/2020	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	30/07/2020	10/07/2020 08:45	13/07/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000487	Enforcement	Active		Non-Registerec	Western HSC Trust	28/04/2020	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	19/05/2020	24/04/2020 17:42	02/05/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000486	Enforcement	Active		Non-Registerec	Western HSC Trust	07/04/2020	1. EDM Meeting	5. Other	22. Other, Refer to Meeting Notes	19/05/2020	23/04/2020 11:21	02/05/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000484	Enforcement	Active		Non-Registerec	Western HSC Trust	10/03/2020	1. EDM Meeting	4. Estates Issues	08. Schedule IN Meeting	01/04/2020	22/04/2020 14:45	15/03/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000479	Enforcement	Active		Non-Registerec	Western HSC Trust	07/04/2020	1. EDM Meeting	5. Other	22. Other, Refer to Meeting Notes	25/04/2020	01/04/2020 14:01	08/04/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000471	Enforcement	Active		Non-Registerec	Western HSC Trust	10/03/2020	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	01/04/2020	10/03/2020 12:54	15/03/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000441	Enforcement	Active		Non-Registerec	Western HSC Trust	27/01/2020	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	11/02/2020	20/01/2020 09:52	25/01/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000439	Enforcement	Active		Non-Registerec	Western HSC Trust	20/12/2019	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	11/01/2020	16/01/2020 13:55	25/12/2019	07/01/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000423	Enforcement	Active		Non-Registerec	Western HSC Trust	06/06/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	28/06/2019	05/12/2019 15:49	11/06/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000422	Enforcement	Active		Non-Registerec	Western HSC Trust	19/11/2019	1. EDM Meeting	1. Care Issues	08. Schedule IN Meeting	11/12/2019	05/12/2019 15:10	24/11/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e

			Personal Information redacted by the USI										
EM000421	Enforcement	Active		Non-Registered	Western HSC Trust	18/07/2019	7. IN Intention Meeting	1. Care Issues	04-Issue IN Notice/s	09/08/2019	05/12/2019 15:03	23/07/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000405	Enforcement	Active		Non-Registered	Western HSC Trust	19/11/2019	1. EDM Meeting	1. Care Issues	13-Extend IN Notice/s	11/12/2019	19/11/2019 11:44	24/11/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000340	Enforcement	Active		Non-Registered	Western HSC Trust	02/09/2019	2. SC Meeting	1. Care Issues	07-Schedule EDM Meeting	24/09/2019	02/09/2019 17:36	07/09/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000287	Enforcement	Active		Non-Registered	Western HSC Trust	17/07/2019	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	08/08/2019	16/07/2019 14:33	22/07/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000286	Enforcement	Active		Non-Registered	Western HSC Trust	10/07/2019	2. SC Meeting	1. Care Issues	02-Monitoring Inspection Planned	01/08/2019	16/07/2019 14:30	15/07/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000899	Enforcement	Active		Non-Registered	Northern HSC Trust	11/11/2021	7. IN Intention Meeting	1. Care Issues	01-No Further Enforcement Action	03/12/2021	17/11/2021 12:05	16/11/2021	17/11/2021 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001499	Enforcement	Active		Registered	Northern HSC Trust	23/11/2023	7. IN Intention Meeting	1. Care Issues		15/12/2023	27/11/2023 13:15	28/11/2023	06/12/2023 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001464	Enforcement	Active		Registered	Northern HSC Trust	25/10/2023	1. EDM Meeting	1. Care Issues	08. Schedule IN Meeting	15/11/2023	25/10/2023 13:20	29/10/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000514	Enforcement	Active		Registered	South Eastern HSC Trust	10/06/2020	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	02/07/2020	04/06/2020 19:00	15/06/2020	16/06/2020 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000513	Enforcement	Active		Registered	South Eastern HSC Trust	04/06/2020	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	26/06/2020	04/06/2020 17:14	09/06/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001312	Enforcement	Inactive		Registered	Southern HSC Trust	04/04/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	26/04/2023	06/06/2023 12:15	09/04/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000656	Enforcement	Inactive		Registered	Western HSC Trust	07/12/2020	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	29/12/2020	01/12/2020 09:29	12/12/2020	09/12/2020 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000654	Enforcement	Inactive		Registered	Western HSC Trust	25/11/2020	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	17/12/2020	25/11/2020 08:17	30/11/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001506	Escalation	Active		Non-Registered	Western HSC Trust	12/12/2023	2. SC Meeting	1. Care Issues		03/01/2024	04/12/2023 13:18	17/12/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000631	Enforcement	Inactive		Registered	Western HSC Trust	26/10/2020	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	17/11/2020	25/10/2020 20:03	31/10/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000593	Enforcement	Inactive		Registered	Western HSC Trust	22/09/2020	1. EDM Meeting	1. Care Issues	12-Extend FTC Notices/s	14/10/2020	21/09/2020 21:24	27/09/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000562	Enforcement	Inactive		Registered	Western HSC Trust	18/08/2020	5. NOP Intention Meeeting	1. Care Issues	10-NOP Issued	09/09/2020	19/08/2020 17:43	23/08/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000561	Enforcement	Inactive		Registered	Western HSC Trust	18/08/2020	3. FTC Intention Meeting	1. Care Issues	09-FTC Issued	09/09/2020	19/08/2020 17:43	23/08/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000555	Enforcement	Inactive		Registered	Western HSC Trust	12/08/2020	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	03/09/2020	12/08/2020 21:25	17/08/2020	13/08/2020 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001288	Enforcement	Inactive		Registered	Northern HSC Trust	12/05/2023	1. EDM Meeting	1. Care Issues	15-NOD Notice/s Confirmed	03/06/2023	12/05/2023 08:55	17/05/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001287	Enforcement	Inactive		Registered	Northern HSC Trust	17/02/2023	1. EDM Meeting	1. Care Issues	06-Schedule NOP Intention Meeting	11/03/2023	12/05/2023 08:49	22/02/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001231	Enforcement	Inactive		Registered	Northern HSC Trust	12/04/2023	5. NOP Intention Meeeting	5. Other		04/05/2023	08/03/2023 15:07	17/04/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001338	Enforcement	Inactive		Registered	Northern HSC Trust	04/04/2023	1. EDM Meeting	1. Care Issues	02-Monitoring Inspection Planned	26/04/2023	27/06/2023 17:01	09/04/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000933	Enforcement	Active		Registered	Northern HSC Trust	22/12/2021	1. EDM Meeting	1. Care Issues		13/01/2022	21/12/2021 21:21	27/12/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000770	Enforcement	Active		Registered	Northern HSC Trust	01/06/2021	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	23/06/2021	01/06/2021 09:52	06/06/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000696	Enforcement	Active		Registered	Northern HSC Trust	19/02/2021	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	13/03/2021	21/02/2021 20:58	24/02/2021	21/02/2021 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000263	Enforcement	Active		Registered	Northern HSC Trust	14/06/2019	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	06/07/2019	21/06/2019 11:17	19/06/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001501	Enforcement	Active		Non-Registered	South Eastern HSC Trust	11/10/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	01/11/2022	28/11/2023 21:56	16/10/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001150	Enforcement	Inactive		Non-Registered	South Eastern HSC Trust	11/10/2022	1. EDM Meeting	5. Other	01-No Further Enforcement Action	01/11/2022	11/10/2022 19:15	16/10/2022	11/10/2022 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001376	Enforcement	Active		Non-Registered	Southern HSC Trust	02/08/2023	1. EDM Meeting	1. Care Issues	02-Monitoring Inspection Planned	24/08/2023	02/08/2023 14:53	07/08/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001248	Enforcement	Active		Non-Registered	Southern HSC Trust	20/03/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	11/04/2023	23/03/2023 09:43	25/03/2023	20/03/2023 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001022	Enforcement	Active		Registered	Northern HSC Trust	07/06/2022	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	29/06/2022	07/06/2022 17:51	12/06/2022	04/10/2022 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000680	Enforcement	Active		Registered	Northern HSC Trust	20/01/2021	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	11/02/2021	20/01/2021 10:50	25/01/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000424	Enforcement	Inactive		Registered	Northern HSC Trust	04/12/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	26/12/2019	05/12/2019 18:26	09/12/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000420	Enforcement	Inactive		Registered	Northern HSC Trust	06/12/2019	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	28/12/2019	05/12/2019 14:29	11/12/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000401	Enforcement	Inactive		Registered	Northern HSC Trust	25/10/2019	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	15/11/2019	14/11/2019 11:56	29/10/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000371	Enforcement	Inactive		Registered	Northern HSC Trust	15/10/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	05/11/2019	15/10/2019 14:45	20/10/2019	28/10/2019 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000370	Enforcement	Active		Registered	Northern HSC Trust	15/10/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	05/11/2019	15/10/2019 14:28	20/10/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000147	Enforcement	Inactive		Registered	Northern HSC Trust	11/02/2019	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	05/03/2019	12/02/2019 14:00	16/02/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000030	Enforcement	Active		Registered	Northern HSC Trust	29/05/2018	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	20/06/2018	24/05/2018 14:16	03/06/2018	04/06/2018 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000028	Enforcement	Active		Registered	Northern HSC Trust	23/05/2018	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	14/06/2018	24/05/2018 10:05	28/05/2018	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001073	Enforcement	Active		Registered	Western HSC Trust	12/08/2022	7. IN Intention Meeting	5. Other	01-No Further Enforcement Action	03/09/2022	09/08/2022 08:55	17/08/2022	17/08/2022 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001071	Enforcement	Active		Registered	Western HSC Trust	05/08/2022	1. EDM Meeting	4. Estates Issues	08. Schedule IN Meeting	27/08/2022	05/08/2022 14:09	10/08/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000741	Enforcement	Active		Registered	Western HSC Trust	18/05/2021	2. SC Meeting	5. Other	01-No Further Enforcement Action	09/06/2021	14/05/2021 09:57	23/05/2021	21/05/2021 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000739	Enforcement	Active		Registered	Western HSC Trust	12/05/2021	1. EDM Meeting	5. Other	03-Schedule SC Meeting	03/06/2021	13/05/2021 10:56	17/05/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000268	Enforcement	Active		Registered	Western HSC Trust	24/07/2019	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	15/08/2019	25/06/2019 10:45	29/07/2019	30/07/2019 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000267	Enforcement	Active		Registered	Western HSC Trust	24/06/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	16/07/2019	25/06/2019 10:17	29/06/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001216	Enforcement	Active		Registered	South Eastern HSC Trust	03/02/2023	1. EDM Meeting	1. Care Issues		25/02/2023	03/02/2023 10:43	08/02/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000628	Enforcement	Active		Registered	South Eastern HSC Trust	22/10/2020	7. IN Intention Meeting	1. Care Issues	01-No Further Enforcement Action	12/11/2020	22/10/2020 17:12	26/10/2020	24/10/2020 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000615	Enforcement	Active		Registered	South Eastern HSC Trust	22/10/2020	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	12/11/2020	13/10/2020 16:41	26/10/2020	24/10/2020 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000614	Enforcement	Active		Registered	South Eastern HSC Trust	22/10/2020	7. IN Intention Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	12/11/2020	13/10/2020 16:41	26/10/2020	24/10/2020 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000607	Enforcement	Active		Registered	South Eastern HSC Trust	09/10/2020	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	30/10/2020	09/10/2020 12:20	14/10/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000574	Enforcement	Active		Registered	South Eastern HSC Trust	07/09/2020	7. IN Intention Meeting	1. Care Issues	01-No Further Enforcement Action	25/09/2020	01/09/2020 16:12	08/09/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000572	Enforcement	Active		Registered	South Eastern HSC Trust	27/08/2020	1. EDM Meeting	1. Care Issues	08. Schedule IN Meeting	18/09/2020	28/08/2020 11:38	01/09/2020	06/09/2020 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000339	Enforcement	Inactive		Registered	South Eastern HSC Trust	28/08/2019	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	19/09/2019	02/09/2019 17:02	02/09/2019	02/09/2019 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000055	Enforcement	Inactive		Registered	Western HSC Trust	26/06/2018	3. FTC Intention Meeting	1. Care Issues	09-FTC Issued	18/07/2018	25/06/2018 13:07	01/07/2018	29/06/2018 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000047	Enforcement	Inactive		Registered	Western HSC Trust	19/06/2018	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	10/07/2018	15/06/2018 16:20	23/06/2018	26/06/2018 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001154	Enforcement	Active		Registered	Northern HSC Trust	27/09/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	19/10/2022	13/10/2022 13:29	02/10/2022	13/10/2022 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001128	Enforcement	Active		Registered	Northern HSC Trust	22/09/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	14/10/2022	22/09/2022 14:46	27/09/2022	13/10/2022 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001316	Enforcement	Inactive		Non-Registered	South Eastern HSC Trust	01/06/2023	2. SC Meeting	5. Other	22. Other, Refer to Meeting Notes	23/06/2023	11/06/2023 06:52	06/06/2023	06/06/2023 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001178	Enforcement	Inactive		Non-Registered	South Eastern HSC Trust	25/11/2022	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	17/12/2022	18/11/2022 14:27	30/11/2022	01/12/2022 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001093	Enforcement	Inactive		Non-Registered	South Eastern HSC Trust	07/09/2022	1. EDM Meeting	5. Other	03-Schedule SC Meeting	13/09/2022	22/08/2022 13:45	27/08/2022	08/09/2022 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001330	Enforcement	Active		Registered	Northern HSC Trust	15/06/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	07/07/2023	20/06/2023 14:36	20/06/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001263	Enforcement	Active		Registered	Northern HSC Trust	19/04/2023	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	11/05/2023	05/04/2023 10:55	24/04/2023	25/04/2023 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001261	Enforcement	Active		Registered	Northern HSC Trust	03/04/2023	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	25/04/2023	02/04/2023 22:06	08/04/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001219	Enforcement	Active		Registered	Northern HSC Trust	10/02/2023	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	04/03/2023	07/02/2023 19:53	15/02/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001218	Enforcement	Active		Registered	Northern HSC Trust	07/02/2023	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	01/03/2023	07/02/2023 12:59	12/02/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001166	Enforcement	Inactive		Non-Registered	South Eastern HSC Trust	27/10/2022	1. EDM Meeting	5. Other	22. Other, Refer to Meeting Notes	17/11/2022	27/10/2022 14:34	31/10/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001032	Enforcement	Active		Registered	Northern HSC Trust	16/06/2022	5. NOP Intention Meeeting	1. Care Issues	01-No Further Enforcement Action	08/07/2022	13/06/2022 12:18	21/06/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001020	Enforcement	Active		Registered	Northern HSC Trust	07/06/2022	1. EDM Meeting	1. Care Issues		29/06/2022	06/06/2022 18:18	12/06/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000821	Enforcement	Active		Registered	Northern HSC Trust	06/08/2021	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	28/08/2021	05/08/2021 11:45	11/08/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000214	Enforcement	Active		Registered	Northern HSC Trust	09/05/2019	1. EDM Meeting	1. Care Issues	12-Extend FTC Notices/s	31/05/2019	09/05/2019 12:15	14/05/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000200	Enforcement	Active		Registered	Northern HSC Trust	29/04/2019	3. FTC Intention Meeting	1. Care Issues	09-FTC Issued	21/05/2019	19/04/2019 14:52	04/05/2019	30/04/2019 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000199	Enforcement	Active		Registered	Northern HSC Trust	18/04/2019	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	10/05/2019	19/04/2019 14:43	23/04/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000146	Enforcement	Inactive		Registered	Northern HSC Trust	14/02/2019	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	12/03/2019	08/02/2019 14:36	23/02/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000141	Enforcement	Active		Registered	Northern HSC Trust	06/02/2019	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	27/02/2019	01/02/2019 10:21	10/02/2019	08/02/2019 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001502	Enforcement	Inactive		Registered	South Eastern HSC Trust	18/10/2019	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	08/11/2019	28/11/2023 22:17	23/10/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001409	Enforcement	Inactive		Registered	South Eastern HSC Trust	01/09/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	23/09/2023	31/08/2023 09:32	06/09/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001302	Enforcement	Inactive		Registered	South Eastern HSC Trust	01/06/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	23/06/2023	31/05/2023 15:33	06/06/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001142	Enforcement	Active		Registered	South Eastern HSC Trust	11/10/2022	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	01/11/2022	05/10/2022 13:38	16/10/2022	12/10/2022 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001129	Enforcement	Active		Registered	South Eastern HSC Trust	27/09/2022	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	19/10/2022	23/09/2022 10:18	02/10/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000765	Enforcement	Active		Registered	Southern HSC Trust	28/05/2021	2. SC Meeting	5. Other	01-No Further Enforcement Action	19/06/2021	26/05/2021 12:39	02/06/2021	02/06/2021 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000763	Enforcement	Active		Registered	Southern HSC Trust	26/05/2021	1. EDM Meeting	5. Other	03-Schedule SC Meeting	17/06/2021	25/05/2021 17:35	31/05/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000225	Enforcement	Inactive		Registered	Southern HSC Trust	10/05/2019	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	01/06/2019	10/05/2019 20:59	15/05/2019	10/05/2019 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001339	Enforcement	Active		Registered	Belfast HSC Trust	14/06/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	06/07/2023	27/06/2023 18:52	19/06/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000762	Enforcement	Inactive		Registered	Belfast HSC Trust	24/05/2021	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	15/06/2021	24/05/2021 19:07	29/05/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001405	Enforcement	Inactive		Registered	Belfast HSC Trust	29/08/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	20/09/2023	25/08/2023 14:53	03/09/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001307	Enforcement	Active		Registered	Belfast HSC Trust	08/06/2023	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	30/06/2023	02/06/2023 13:35	13/06/2023	15/06/2023 https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e

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EM001304	Enforcement	Active	Registered	Belfast HSC Trust	01/06/2023	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	23/06/2023	31/05/2023 16:59	06/06/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000820	Enforcement	Active	Registered	Belfast HSC Trust	29/07/2021	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	20/08/2021	04/08/2021 10:00	03/08/2021	04/08/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000814	Enforcement	Inactive	Registered	Belfast HSC Trust	16/07/2021	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	07/08/2021	16/07/2021 16:39	21/07/2021	16/07/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001354	Enforcement	Active	Registered	Belfast HSC Trust	03/07/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	25/07/2023	13/07/2023 11:32	08/07/2023	13/07/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001337	Enforcement	Inactive	Registered	Belfast HSC Trust	27/03/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	18/04/2023	27/06/2023 16:57	01/04/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001257	Enforcement	Inactive	Registered	Belfast HSC Trust	07/04/2023	2. SC Meeting	5. Other	01-No Further Enforcement Action	29/04/2023	31/03/2023 08:31	12/04/2023	17/04/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001252	Enforcement	Inactive	Registered	Belfast HSC Trust	27/03/2023	1. EDM Meeting	5. Other	03-Schedule SC Meeting	18/04/2023	27/03/2023 17:00	01/04/2023	27/03/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000809	Escalation	Active	Non-Registered	Belfast HSC Trust	09/07/2021	1. EDM Meeting	1. Care Issues	02-Monitoring Inspection Planned	31/07/2021	06/07/2021 16:38	14/07/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000723	Escalation	Inactive	Non-Registered	Belfast HSC Trust	20/04/2021	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	11/05/2021	17/04/2021 07:21	24/04/2021	21/04/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000711	Escalation	Active	Non-Registered	Belfast HSC Trust	19/03/2021	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	10/04/2021	18/03/2021 14:08	24/03/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001132	Enforcement	Inactive	Registered	Belfast HSC Trust	27/09/2022	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	19/10/2022	27/09/2022 13:34	02/10/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000852	Enforcement	Active	Registered	Belfast HSC Trust	30/09/2021	3. FTC Intention Meeting	5. Other	01-No Further Enforcement Action	22/10/2021	27/09/2021 14:25	05/10/2021	01/10/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000851	Enforcement	Active	Registered	Belfast HSC Trust	27/09/2021	1. EDM Meeting	5. Other	05-Schedule FTC Intention Meeting	19/10/2021	27/09/2021 14:22	02/10/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000778	Enforcement	Inactive	Registered	Belfast HSC Trust	10/06/2021	2. SC Meeting	5. Other	02-Monitoring Inspection Planned	02/07/2021	04/06/2021 13:47	15/06/2021	15/06/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000773	Enforcement	Inactive	Registered	Belfast HSC Trust	02/06/2021	1. EDM Meeting	4. Estates Issues	03-Schedule SC Meeting	24/06/2021	03/06/2021 10:17	07/06/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000567	Enforcement	Inactive	Registered	Belfast HSC Trust	21/08/2020	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	12/09/2020	25/08/2020 15:06	26/08/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000699	Enforcement	Active	Registered	Belfast HSC Trust	01/03/2021	3. FTC Intention Meeting	1. Care Issues	01-No Further Enforcement Action	23/03/2021	25/02/2021 16:24	06/03/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000694	Enforcement	Active	Registered	Belfast HSC Trust	23/02/2021	3. FTC Intention Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	17/03/2021	18/02/2021 09:49	28/02/2021	03/03/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000692	Enforcement	Active	Registered	Belfast HSC Trust	16/02/2021	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	10/03/2021	11/02/2021 20:13	21/02/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001446	Enforcement	Inactive	Registered	Belfast HSC Trust	03/10/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	25/10/2023	03/10/2023 11:41	08/10/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000446	Enforcement	Active	Registered	Belfast HSC Trust	31/01/2020	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	22/02/2020	27/01/2020 16:15	05/02/2020	03/02/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000444	Enforcement	Active	Registered	Belfast HSC Trust	22/01/2020	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	13/02/2020	22/01/2020 20:47	27/01/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001180	Enforcement	Active	Registered	Belfast HSC Trust	18/11/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	10/12/2022	21/11/2022 16:53	23/11/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000649	Enforcement	Active	Registered	Belfast HSC Trust	18/11/2020	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	10/12/2020	19/11/2020 18:07	23/11/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001497	Enforcement	Active	Registered	Belfast HSC Trust	29/11/2023	3. FTC Intention Meeting	5. Other		21/12/2023	21/11/2023 00:38	04/12/2023	04/12/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001489	Enforcement	Active	Registered	Belfast HSC Trust	15/11/2023	1. EDM Meeting	1. Care Issues		07/12/2023	14/11/2023 16:32	20/11/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001462	Enforcement	Active	Registered	Belfast HSC Trust	26/10/2023	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	16/11/2023	23/10/2023 10:43	30/10/2023	01/11/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001459	Enforcement	Active	Registered	Belfast HSC Trust	19/10/2023	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	09/11/2023	19/10/2023 09:46	24/10/2023	19/10/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001258	Enforcement	Active	Registered	Belfast HSC Trust	17/04/2023	2. SC Meeting	5. Other		09/05/2023	31/03/2023 11:06	22/04/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001253	Enforcement	Active	Registered	Belfast HSC Trust	27/03/2023	1. EDM Meeting	5. Other	03-Schedule SC Meeting	18/04/2023	28/03/2023 09:21	01/04/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001421	Enforcement	Active	Registered	Belfast HSC Trust	19/09/2023	2. SC Meeting	1. Care Issues		11/10/2023	11/09/2023 12:52	24/09/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001414	Enforcement	Active	Registered	Belfast HSC Trust	11/09/2023	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	03/10/2023	06/09/2023 12:32	16/09/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001207	Enforcement	Active	Registered	Belfast HSC Trust	20/01/2023	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	11/02/2023	20/01/2023 17:00	25/01/2023	24/01/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001199	Enforcement	Active	Registered	Belfast HSC Trust	11/01/2023	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	02/02/2023	11/01/2023 13:06	16/01/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000034	Enforcement	Active	Registered	Belfast HSC Trust	07/06/2018	3. FTC Intention Meeting	1. Care Issues	01-No Further Enforcement Action	29/06/2018	01/06/2018 12:22	12/06/2018	08/06/2018	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000006	Enforcement	Active	Registered	Belfast HSC Trust	16/04/2018	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	27/04/2018	10/04/2018 14:43	10/04/2018	05/04/2018	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000005	Enforcement	Active	Registered	Belfast HSC Trust	13/04/2018	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	05/05/2018	09/04/2018 09:32	18/04/2018	17/04/2018	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001149	Enforcement	Active	Registered	Belfast HSC Trust	13/10/2022	1. EDM Meeting	5. Other		03/11/2022	11/10/2022 15:30	18/10/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000233	Enforcement	Active	Registered	Belfast HSC Trust	30/04/2019	1. EDM Meeting	5. Other	22. Other, Refer to Meeting Notes	22/05/2019	24/05/2019 12:24	05/05/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000938	Enforcement	Active	Non-Registered	Belfast HSC Trust	14/01/2022	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	05/02/2022	14/01/2022 09:33	19/01/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001035	Enforcement	Inactive	Registered	Belfast HSC Trust	22/06/2022	3. FTC Intention Meeting	5. Other	01-No Further Enforcement Action	14/07/2022	14/06/2022 23:53	27/06/2022	28/06/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001034	Enforcement	Inactive	Registered	Belfast HSC Trust	14/06/2022	1. EDM Meeting	5. Other	05-Schedule FTC Intention Meeting	06/07/2022	14/06/2022 23:39	19/06/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001018	Enforcement	Inactive	Registered	Belfast HSC Trust	01/06/2022	1. EDM Meeting	5. Other	22. Other, Refer to Meeting Notes	23/06/2022	02/06/2022 13:30	06/06/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001125	Escalation	Active	Non-Registered	Belfast HSC Trust	14/09/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	06/10/2022	19/09/2022 18:32	19/09/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001407	Enforcement	Active	Registered	Belfast HSC Trust	29/08/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	20/09/2023	29/08/2023 15:36	03/09/2023	29/08/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001389	Enforcement	Active	Registered	Belfast HSC Trust	11/08/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	02/09/2023	11/08/2023 11:45	16/08/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001292	Enforcement	Active	Registered	Belfast HSC Trust	26/05/2023	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	17/06/2023	18/05/2023 21:51	31/05/2023	31/05/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001240	Enforcement	Active	Registered	Belfast HSC Trust	15/03/2023	5. NOP Intention Meeeting	1. Care Issues	22. Other, Refer to Meeting Notes	06/04/2023	16/03/2023 10:57	20/03/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001239	Enforcement	Active	Registered	Belfast HSC Trust	15/03/2023	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	06/04/2023	16/03/2023 10:08	20/03/2023	21/03/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001229	Enforcement	Active	Registered	Belfast HSC Trust	06/03/2023	1. EDM Meeting	1. Care Issues	06-Schedule NOP Intention Meeting	28/03/2023	06/03/2023 10:18	11/03/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001155	Enforcement	Active	Registered	Belfast HSC Trust	23/09/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	15/10/2022	13/10/2022 14:46	28/09/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001098	Enforcement	Active	Registered	Belfast HSC Trust	30/08/2022	5. NOP Intention Meeeting	1. Care Issues	10-NOP Issued	21/09/2022	24/08/2022 09:25	04/09/2022	01/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001095	Enforcement	Active	Registered	Belfast HSC Trust	23/08/2022	1. EDM Meeting	1. Care Issues	06-Schedule NOP Intention Meeting	14/09/2022	23/08/2022 13:23	28/08/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001317	Enforcement	Active	Registered	Belfast HSC Trust	12/06/2023	1. EDM Meeting	1. Care Issues		04/07/2023	12/06/2023 13:34	17/06/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000913	Enforcement	Active	Registered	Belfast HSC Trust	01/12/2021	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	23/12/2021	01/12/2021 12:37	06/12/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000881	Enforcement	Active	Registered	Belfast HSC Trust	14/10/2021	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	04/11/2021	21/10/2021 14:30	19/10/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000878	Enforcement	Active	Registered	Belfast HSC Trust	18/10/2021	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	08/11/2021	18/10/2021 10:57	23/10/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000872	Enforcement	Active	Registered	Belfast HSC Trust	14/10/2021	2. SC Meeting	1. Care Issues	02-Monitoring Inspection Planned	04/11/2021	12/10/2021 14:25	19/10/2021	18/10/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000870	Enforcement	Active	Registered	Belfast HSC Trust	11/10/2021	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	01/11/2021	11/10/2021 21:09	16/10/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001460	Enforcement	Active	Registered	Belfast HSC Trust	26/10/2023	2. SC Meeting	5. Other	01-No Further Enforcement Action	16/11/2023	19/10/2023 13:24	30/10/2023	02/11/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001455	Enforcement	Active	Registered	Belfast HSC Trust	18/10/2023	1. EDM Meeting	5. Other		08/11/2023	18/10/2023 08:33	23/10/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001412	Enforcement	Active	Non-Registered	Belfast HSC Trust	31/08/2023	2. SC Meeting	1. Care Issues	02-Monitoring Inspection Planned	22/09/2023	01/09/2023 11:55	05/09/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001393	Enforcement	Active	Non-Registered	Belfast HSC Trust	11/08/2023	1. EDM Meeting	5. Other	03-Schedule SC Meeting	02/09/2023	15/08/2023 14:35	16/08/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001226	Enforcement	Active	Non-Registered	Belfast HSC Trust	20/02/2023	1. EDM Meeting	1. Care Issues		14/03/2023	20/02/2023 10:53	25/02/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001126	Enforcement	Active	Non-Registered	Belfast HSC Trust	23/09/2022	2. SC Meeting	1. Care Issues		15/10/2022	21/09/2022 11:05	28/09/2022	27/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001102	Enforcement	Active	Non-Registered	Belfast HSC Trust	01/09/2022	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	23/09/2022	01/09/2022 12:52	06/09/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001088	Enforcement	Active	Non-Registered	Belfast HSC Trust	04/08/2022	7. IN Intention Meeting	5. Other	01-No Further Enforcement Action	26/08/2022	18/08/2022 14:09	09/08/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001066	Enforcement	Active	Non-Registered	Belfast HSC Trust	27/07/2022	1. EDM Meeting	1. Care Issues		18/08/2022	26/07/2022 16:40	01/08/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000482	Enforcement	Active	Non-Registered	Belfast HSC Trust	03/04/2020	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	25/04/2020	07/04/2020 14:55	08/04/2020		https://iconnect.hscni.net/RQIA/main.aspx?et https://ico
EM000481	Enforcement	Active	Non-Registered	Belfast HSC Trust	20/03/2020	1. EDM Meeting	1. Care Issues	08. Schedule IN Meeting	11/04/2020	07/04/2020 14:45	25/03/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000429	Enforcement	Active	Non-Registered	Belfast HSC Trust	13/12/2019	1. EDM Meeting	1. Care Issues	13-Extend IN Notice/s	04/01/2020	13/12/2019 11:11	18/12/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000322	Enforcement	Active	Non-Registered	Belfast HSC Trust	14/08/2019	7. IN Intention Meeting	1. Care Issues	04-Issue IN Notice/s	05/09/2019	15/08/2019 14:09	19/08/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000306	Enforcement	Active	Non-Registered	Belfast HSC Trust	01/08/2019	7. IN Intention Meeting	1. Care Issues	04-Issue IN Notice/s	23/08/2019	01/08/2019 15:06	06/08/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000304	Enforcement	Active	Non-Registered	Belfast HSC Trust	30/07/2019	7. IN Intention Meeting	1. Care Issues	04-Issue IN Notice/s	21/08/2019	31/07/2019 14:00	04/08/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000284	Enforcement	Active	Non-Registered	Belfast HSC Trust	05/07/2019	1. EDM Meeting	1. Care Issues	08. Schedule IN Meeting	27/07/2019	09/07/2019 10:34	10/07/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000158	Enforcement	Active	Non-Registered	Belfast HSC Trust	04/03/2019	1. EDM Meeting	1. Care Issues	08. Schedule IN Meeting	26/03/2019	06/03/2019 09:44	09/03/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000157	Enforcement	Active	Non-Registered	Belfast HSC Trust	07/03/2019	7. IN Intention Meeting	5. Other	02-Monitoring Inspection Planned	29/03/2019	05/03/2019 12:22	12/03/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000883	Enforcement	Inactive	Registered	Belfast HSC Trust	01/11/2021	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	23/11/2021	27/10/2021 13:44	06/11/2021	05/11/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001167	Enforcement	Active	Registered	Belfast HSC Trust	31/10/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	22/11/2022	31/10/2022 09:00	05/11/2022	31/10/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001461	Enforcement	Active	Registered	Belfast HSC Trust	03/10/2023	5. NOP Intention Meeeting	1. Care Issues	10-NOP Issued	25/10/2023	23/10/2023 09:08	08/10/2023	04/10/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001442	Enforcement	Active	Registered	Belfast HSC Trust	02/10/2023	1. EDM Meeting	1. Care Issues	14-NOP Notice/s Lifted	24/10/2023	02/10/2023 09:45	07/10/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001410	Enforcement	Active	Registered	Belfast HSC Trust	13/09/2023	5. NOP Intention Meeeting	1. Care Issues		05/10/2023	31/08/2023 17:21	18/09/2023	19/09/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001406	Enforcement	Active	Registered	Belfast HSC Trust	25/08/2023	1. EDM Meeting	1. Care Issues	06-Schedule NOP Intention Meeting	16/09/2023	29/08/2023 09:25	30/08/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001325	Enforcement	Active	Registered	Belfast HSC Trust	27/06/2023	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	19/07/2023	16/06/2023 14:29	02/07/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001321	Enforcement	Active	Registered	Belfast HSC Trust	14/06/2023	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	06/07/2023	15/06/2023 11:15	19/06/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001301	Enforcement	Active	Registered	Belfast HSC Trust	10/05/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	01/06/2023	30/05/2023 08:30	15/05/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001251	Enforcement	Active	Registered	Belfast HSC Trust	27/03/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	18/04/2023	27/03/2023 15:05	01/04/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001148	Enforcement	Active	Registered	Belfast HSC Trust	10/10/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	31/10/2022	10/10/2022 08:16	15/10/2022	13/10/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e

			Personal Information redacted by the USI										
EM000353	Enforcement	Active		Registered	Belfast HSC Trust	15/09/2019	1. EDM Meeting	5. Other	22. Other, Refer to Meeting Notes	07/10/2019	24/09/2019 11:41	20/09/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000351	Enforcement	Active		Registered	Belfast HSC Trust	28/10/2019	5. NOP Intention Meeeting	1. Care Issues	10-NOP Issued	17/10/2019	18/09/2019 14:44	30/09/2019	28/10/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001225	Enforcement	Inactive		Non-Registerec	Belfast HSC Trust	06/02/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	28/02/2023	17/02/2023 12:44	11/02/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001083	Enforcement	Active		Non-Registerec	Belfast HSC Trust	15/08/2022	1. EDM Meeting	1. Care Issues	02-Monitoring Inspection Planned	06/09/2022	15/08/2022 17:24	20/08/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001503	Enforcement	Active		Non-Registerec	Belfast HSC Trust	14/12/2023	1. EDM Meeting	1. Care Issues		05/01/2024	01/12/2023 09:10	19/12/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001015	Enforcement	Active		Non-Registerec	Belfast HSC Trust	08/04/2022	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	30/04/2022	30/05/2022 14:51	13/04/2022	20/04/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000962	Enforcement	Active		Non-Registerec	Belfast HSC Trust	24/02/2022	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	18/03/2022	22/02/2022 15:04	01/03/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001453	Enforcement	Active		Non-Registerec	Belfast HSC Trust	10/10/2023	1. EDM Meeting	5. Other	02-Monitoring Inspection Planned	31/10/2023	12/10/2023 15:17	15/10/2023	12/10/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001423	Enforcement	Active		Non-Registerec	Belfast HSC Trust	13/09/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	05/10/2023	13/09/2023 09:48	18/09/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001237	Enforcement	Active		Non-Registerec	Belfast HSC Trust	13/03/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	04/04/2023	15/03/2023 16:00	18/03/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001236	Enforcement	Active		Non-Registerec	Belfast HSC Trust	09/03/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	31/03/2023	15/03/2023 13:09	14/03/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001213	Enforcement	Active		Non-Registerec	Belfast HSC Trust	29/12/2022	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	20/01/2023	27/01/2023 14:45	03/01/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001138	Enforcement	Inactive		Non-Registerec	Belfast HSC Trust	29/09/2022	1. EDM Meeting	1. Care Issues	02-Monitoring Inspection Planned	21/10/2022	30/09/2022 13:24	04/10/2022	30/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000769	Enforcement	Active		Non-Registerec	Belfast HSC Trust	20/05/2021	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	11/06/2021	28/05/2021 09:53	25/05/2021	25/05/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000727	Enforcement	Active		Non-Registerec	Belfast HSC Trust	20/04/2021	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	12/05/2021	21/04/2021 14:44	25/04/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001340	Enforcement	Inactive		Registered	Belfast HSC Trust	05/07/2023	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	27/07/2023	27/06/2023 20:41	10/07/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001335	Enforcement	Inactive		Registered	Belfast HSC Trust	26/06/2023	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	18/07/2023	26/06/2023 11:00	01/07/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000464	Enforcement	Active		Registered	Belfast HSC Trust	09/03/2020	3. FTC Intention Meeting	1. Care Issues	01-No Further Enforcement Action	31/03/2020	05/03/2020 14:16	14/03/2020	16/03/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000463	Enforcement	Active		Registered	Belfast HSC Trust	04/03/2020	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	26/03/2020	05/03/2020 12:23	09/03/2020	09/03/2020	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000282	Enforcement	Active		Registered	Belfast HSC Trust	03/07/2019	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	25/07/2019	08/07/2019 16:42	08/07/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000658	Escalation	Active		Non-Registerec	Belfast HSC Trust	02/12/2020	1. EDM Meeting	1. Care Issues	02-Monitoring Inspection Planned	24/12/2020	04/12/2020 15:49	07/12/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000543	Escalation	Active		Non-Registerec	Belfast HSC Trust	30/07/2020	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	21/08/2020	29/07/2020 16:07	04/08/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000497	Escalation	Active		Non-Registerec	Belfast HSC Trust	21/05/2020	2. SC Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	12/06/2020	15/05/2020 10:24	26/05/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000494	Escalation	Active		Non-Registerec	Belfast HSC Trust	07/05/2020	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	29/05/2020	11/05/2020 15:55	12/05/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000458	Escalation	Active		Non-Registerec	Belfast HSC Trust	12/02/2020	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	05/03/2020	12/02/2020 14:41	17/02/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001000	Enforcement	Inactive		Registered	Belfast HSC Trust	09/05/2022	1. EDM Meeting	1. Care Issues	17-DMP Meeting Required	31/05/2022	10/05/2022 22:49	14/05/2022	10/05/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000991	Enforcement	Inactive		Registered	Belfast HSC Trust	26/04/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	18/05/2022	26/04/2022 10:35	01/05/2022	30/04/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000982	Enforcement	Inactive		Registered	Belfast HSC Trust	06/04/2022	5. NOP Intention Meeeting	1. Care Issues	10-NOP Issued	28/04/2022	05/04/2022 14:43	11/04/2022	07/04/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000981	Enforcement	Inactive		Registered	Belfast HSC Trust	01/04/2022	1. EDM Meeting	1. Care Issues	06-Schedule NOP Intention Meeting	23/04/2022	04/04/2022 19:08	06/04/2022	01/04/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000972	Enforcement	Inactive		Registered	Belfast HSC Trust	11/03/2022	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	02/04/2022	15/03/2022 10:55	16/03/2022	15/03/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000862	Enforcement	Active		Registered	Belfast HSC Trust	06/10/2021	7. IN Intention Meeting	1. Care Issues	01-No Further Enforcement Action	28/10/2021	04/10/2021 11:26	11/10/2021	08/10/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000858	Enforcement	Active		Registered	Belfast HSC Trust	29/09/2021	1. EDM Meeting	1. Care Issues	08. Schedule IN Meeting	21/10/2021	29/09/2021 14:31	04/10/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000835	Enforcement	Active		Registered	Belfast HSC Trust	31/08/2021	1. EDM Meeting	1. Care Issues	12-Extend FTC Notices/s	22/09/2021	31/08/2021 13:37	05/09/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000792	Enforcement	Active		Registered	Belfast HSC Trust	24/06/2021	3. FTC Intention Meeting	1. Care Issues	09-FTC Issued	16/07/2021	21/06/2021 16:57	29/06/2021	08/07/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000785	Enforcement	Active		Registered	Belfast HSC Trust	18/06/2021	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	06/07/2021	14/06/2021 09:31	19/06/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000411	Enforcement	Inactive		Registered	Belfast HSC Trust	22/11/2019	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	14/12/2019	21/11/2019 14:41	27/11/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000390	Enforcement	Active		Registered	Belfast HSC Trust	04/11/2019	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	26/11/2019	03/11/2019 20:24	09/11/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000316	Enforcement	Inactive		Registered	Belfast HSC Trust	08/08/2019	1. EDM Meeting	1. Care Issues	05-Schedule FTC Intention Meeting	30/08/2019	12/08/2019 14:02	13/08/2019	22/08/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000315	Enforcement	Inactive		Registered	Belfast HSC Trust	16/08/2019	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	07/09/2019	12/08/2019 10:12	21/08/2019	22/08/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000314	Enforcement	Inactive		Registered	Belfast HSC Trust	16/08/2019	3. FTC Intention Meeting	1. Care Issues	09-FTC Issued	07/09/2019	12/08/2019 10:04	21/08/2019	22/08/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000152	Enforcement	Active		Registered	Belfast HSC Trust	27/02/2019	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	21/03/2019	21/02/2019 16:18	04/03/2019	05/03/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000151	Enforcement	Active		Registered	Belfast HSC Trust	20/02/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	14/03/2019	21/02/2019 10:13	25/02/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e

Num	Name of Review	Review Initiated (date)	Involves Clinical and Social Care Governance?	Involves Southern HSC Trust specifically	Report Finalised Date	Link on RQAI Website (where available)
1	Review of the Lessons Arising from the Death of Mrs Janine Murtagh	Feb-05	y	n	Oct-05	www.rqia.org.uk/rqia/files/4c/4caa7dda-4a3
2	RQIA Governance Review of the Northern Ireland Breast Screening Programme	Mar-06	y	n	Mar-06	www.rqia.org.uk/rqia/files/40/40a699e4-f2b
3	Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	Sep-07	n	n	Sep-07	488f2c5b-689d-4e65-9cf8-0569f60ca209.pdf (rqia.org.uk)
4	Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	Feb-08	Yes	Yes	Feb-08	rqia report - Southern Trust has individual report
5	Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	Oct-07	Yes	Yes	Mar-08	www.rqia.org.uk/rqia/files/be/be47f4f8
6	Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	Apr-08	n	Yes	Apr-08	
7	Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	Jun-08	Yes	n	Jun-08	CLOSTRIDIUM DIFFICILE - (rqia.org.uk)
8	Review of The "Safeguards in Place for Children And Vulnerable Adults in Mental Health and Learning Disability Hospitals" in HSC Trust	Jun-08	Yes	Yes	Jun-08	Sections NOT included are denoted in red (rqia.org.uk)
9	Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	Aug-08	Yes	Yes	Aug-08	Clostridium Difficile - RQIA Independent Review
10	Review of General Practitioner Appraisal Arrangements in Northern Ireland	Sep-08	Yes	n	Sep-08	e5f0657e-86c7-4306-b2c4-8c900e2f398f.pdf (rqia.org.uk)
11	Review of Consultant Medical Appraisal Across Health and Social Care Trusts	Sep-08	Yes	Yes	Sep-08	
12	Review of Actions Taken on Recommendations From a Critical Incident Review within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	Oct-08	Yes	n	Oct-08	Reviewer Writing Workbook (rqia.org.uk)
13	Review of Intravenous Sedation in General Dental Practice	May-09	n	Yes	May-09	
14	Blood Safety Review	Feb-10	Yes	Yes	Feb-10	

15	Review of Intrapartum Care	May-10	Yes	Yes	May-10	31819a02-35fd-4c82-be42-545603e04026
16	Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	Jul-10	n	n	Jul-10	Microsoft Word - FINAL Hyponatraemia Re
17	Review of General Practitioner Out-of-Hours Services	Sep-10	Yes	Yes	Sep-10	
18	RQIA Independent Review of the McDermott Brothers' Case	Nov-10	Yes	Yes	Nov-10	
19	Review of Health and Social Care Trust Readiness for Medical Revalidation	Dec-10	Yes	Yes	Dec-10	Microsoft Word - RQIA Revalidation OVERALL NI final report 141210.doc
20	Follow-Up Review of Intravenous Sedation in General Dental Practice	Dec-10	Yes	n	Dec-10	Microsoft Word - final report161210 (rqia.org.uk)
21	Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	Feb-11	Yes	n	Feb-11	Microsoft Word - RQIA Review of NIAS Feb 11
22	RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	Feb-11	Yes	Yes	Feb-11	Microsoft Word - CAMHS_Report_Final_21022011 v1.0 (rqia.org.uk)
23	A Report on the Inspection of the Care Pathways of a Select Group of Young People who Met the Criteria for Secure Accommodation in Northern Ireland	Mar-11	Yes	Yes	Mar-11	Microsoft Word - RQIA Pathways Report March 11 Published Version 16 Jun 11.doc
24	An Independent Review of Reporting Arrangements for Radiological Investigations – Phase One	Mar-11	Yes	Yes	Mar-11	Microsoft Word - Northern Ireland Overview report 24.03.11.doc (rqia.org.uk)
25	Review of Child Protection Arrangements in Northern Ireland	Jul-11	Yes	Yes	Jul-11	Microsoft Word - CP Overview Report 27 07 11 Final copy approved by Board MF 3 Aug 11 (rqia.org.uk)
26	Review of Sensory Support Services	Sep-11	Yes	Yes	Sep-11	
27	Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	Oct-11	-	-	Oct-11	
28	Revalidation in Primary Care Services	Dec-11	Yes	n	Dec-11	
29	Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	Feb-12	Yes	Yes	Feb-12	4df1353e-4642-403a-bd80-ef567e0d57ee.pdf (rqia.org.uk)

30	RQIA Independent Review of Pseudomonas - Interim Report	Mar-12	Yes	Yes	Mar-12	
31	RQIA Independent Review of Pseudomonas - Final Report	May-12	Yes	Yes	May-12	ee76f222-a576-459f-900c-411ab857fc3f.pdf (rqia.org.uk)
32	An Independent Review of Reporting Arrangements for Radiological Investigations – Phase Two	May-12	Yes	Yes	May-12	801e4d47-f7d3-48d2-b845-684184b8801f.pdf (rqia.org.uk)
33	Mixed Gender Accommodation in Hospitals Overview Report	Aug-12	n	Yes	Aug-12	c24f26bd-51c5-4cd7-85e4-1a1d3e4f1b87.pdf (rqia.org.uk)
34	Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home	Oct-12	Yes	n	Oct-12	53abe429-7bee-44c5-88de-af76f16e4b0c.pdf (rqia.org.uk)
35	Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	Oct-12	n	Yes	Oct-12	b6abf607-b26c-4c35-bff3-29061d01f271.pdf (rqia.org.uk)
36	Review of the Northern Ireland Single Assessment Tool - Stage Two	Nov-12	Yes	Yes	Nov-12	d0b8f20e-1fb4-4838-b1b2-f4bda63f3f03.pdf (rqia.org.uk)
37	Review of the Implementation of the Cardiovascular Disease Service Framework	Nov-12	n	n	Nov-12	www.rqia.org.uk/rqia/files/61
38	RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	Dec-12	Yes	Yes	Dec-12	04aed398-20e6-430c-8b32-46f8bf52708a.pdf (rqia.org.uk)
39	Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	Feb-13	Yes	Yes	Feb-13	e097e03d-f631-4875-84b5-95365db723e2.pdf (rqia.org.uk)
40	Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	Mar-13	n	n	Mar-13	Section 1: Introduction (rqia.org.uk)
41	Independent Review of the Management of Controlled Drug Use in Trust Hospitals	Jun-13	Yes	Yes	Jun-13	d7cbdeb1-653d-44b1-8018-5620a40952d3.pdf (rqia.org.uk)
42	Review of Acute Hospitals at Night and Weekends	Jul-13	n	Yes	Jul-13	https://www.rqia.org.uk/RQIA/files/25/25f3c412-c40b-424f-b6d0-d85154f199b4.pdf
43	National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	Jul-13	Yes	Yes	Jul-13	Section 1: Introduction (rqia.org.uk)
44	A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	Aug-13	n	Yes	Aug-13	a3b73f17-35b3-4873-8797-e96ff1c44992.pdf (rqia.org.uk)

45	A Baseline Assessment and Review of Community Services for Children with a Disability	Aug-13	n	Yes	Aug-13	5c6d81e9-834c-4ece-8aa4-3be76d857328.pdf (rqia.org.uk)
46	Review of Specialist Sexual Health Services in Northern Ireland	Oct-13	Yes	Yes	Oct-13	1114fc0c-1244-46ba-b32a-6b85d72e7b9e.pdf (rqia.org.uk)
47	Review of Statutory Fostering Services	Dec-13	n	Yes	Dec-13	3554bcdf-8cdb-4e2b-a839-c61c901d798a.pdf (rqia.org.uk)
48	Respiratory Service Framework	Mar-14	n	n	Mar-14	36654318-b183-4bce-a34f-131ec780fd6c.pdf (rqia.org.uk)
49	Review of the Implementation of NICE Clinical Guideline 42: Dementia	Jun-14	Yes	Yes	Jun-14	https://rqia.org.uk/RQIA/files/ca/ca65f091-1ae0-47e5-9f85-d3a63d30c8bc.pdf
50	Overview of Service Users' Finances in Residential Settings	Jun-14	Yes	Yes	Jun-14	https://rqia.org.uk/RQIA/files/6e/6e146dae-acac-4e37-ab39-03022944cbed.pdf
51	Review of Effective Management of Practice in Theatre Settings across Northern Ireland	Jun-14	Yes	Yes	Jun-14	https://rqia.org.uk/RQIA/files/c5/c5f8a061-f950-4071-acdb-ff3326131d44.pdf
52	Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	Jul-14	Yes	n	Jul-14	https://rqia.org.uk/RQIA/files/df/dfc9f6e6-cc1a-449d-995f-a0682ca6e0e0.pdf
53	Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	Jul-14	n	n	Jul-14	https://rqia.org.uk/RQIA/files/1f/1fc36cdd-154f-47a6-bd5d-366dcea2f3bf.pdf
54	Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	Aug-14	n	n	Aug-14	https://rqia.org.uk/RQIA/files/e1/e192169d-ecf6-40c1-8b25-5ef321cf61e2.pdf
55	Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	Nov-14	n	n	Nov-14	
56	Discharge Arrangements from Acute Hospital	Nov-14	Yes	Yes	Nov-14	https://rqia.org.uk/RQIA/files/f6/f62f6f24-2b4c-4608-ade5-9747c5d48d3e.pdf
57	Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	Dec-14	Yes	n	Dec-14	https://rqia.org.uk/RQIA/files/e2/e2968fd6-51f0-41a7-acfa-d34a66a7c86b.pdf
58	Review of Stroke Services in Northern Ireland	Dec-14	n	Yes	Dec-14	https://rqia.org.uk/RQIA/files/b8/b8f067de-3bf7-40c6-9297-b21a41a31811.pdf
59	Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	Dec-14	n	Yes	Dec-14	https://rqia.org.uk/RQIA/files/69/6992f0a9-b602-4832-ace7-e505d6dc1125.pdf

60	Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	Dec-14	n	Yes	Dec-14	https://rqia.org.uk/RQIA/files/60/60a81b58-5327-4c2e-b998-7f956385e678.pdf
61	RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	Dec-14	Yes	Yes	Dec-14	https://rqia.org.uk/RQIA/files/31/31b31f02-2984-4a30-bb94-33d107afed91.pdf https://rqia.org.uk/RQIA/files/04/043b77
62	An Independent Review of the Northern Ireland Ambulance Service	Mar-15	Yes	n	Mar-16	https://rqia.org.uk/RQIA/files/d3/d3c0d1c7-6461-4f53-8cbb-54ba077d4eb2.pdf
63	Review of Advocacy Services for Children and Adults in Northern Ireland	Mar-15	n	n	Jan-16	https://rqia.org.uk/RQIA/files/d7/d79ff542-b906-4118-b56d-ac405f10d9f2.pdf
64	Review of the Care of Older People in Acute Hospitals	Mar-15	Yes	Yes	Mar-15	https://www.rqia.org.uk/RQIA/files/63/63d712b2-f063-4bd1-b779-6e250d9865ca.pdf
65	Review of the HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	Apr-15	Yes	Yes	Dec-15	https://rqia.org.uk/RQIA/files/6e/6e0742d8-3fde-40f2-9bf4-13043171d727.pdf
66	Review of the Diabetic Retinopathy Screening Programme	May-15	Yes	n	May-15	https://rqia.org.uk/RQIA/files/2f/2fb1c0d1-e7f0-48e3-aeaa-d8a9efa2d36c.pdf
67	Review of Quality Improvement Systems and Processes	Jun-15	n	Yes	Jun-16	https://rqia.org.uk/RQIA/files/cc/cc11ffbd-7f69-4605-b637-ab763e049b1e.pdf
68	Review of Risk Assessment and Management in Addiction Services	Jun-15	n	Yes	Jun-15	https://rqia.org.uk/RQIA/files/47/47608b6b-42a0-4a75-a36a-35ef23790f34.pdf
69	RQIA Review of Governance Arrangements Relating to General Practitioner (GP) Services in Northern Ireland	Jul-15	Yes	n	Jul-16	https://rqia.org.uk/RQIA/files/eb/eb7b84c5-62a5-4dd8-9a08-0593a09c08dd.pdf
70	RQIA Review of HSC Trusts' Readiness to comply with an Allied Health Professions Professional Assurance Framework	Jul-15	Yes	Yes	Jun-16	https://rqia.org.uk/RQIA/files/2f/2f3c8a7d-e85a-4dd5-a3d4-cbc7d51a4d2c.pdf
71	Review of Medicines Optimisation in Primary Care	Jul-15	Yes	n	Jul-15	https://rqia.org.uk/RQIA/files/81/81925011-3d53-4d9e-b817-a8ffdc84a503.pdf
72	RQIA Report of Review of Maternity Strategy 2012-2018	Sep-15	n	Yes	Mar-17	https://rqia.org.uk/RQIA/files/3d/3d4d9d13-8079-403f-80d6-ee79008718da.pdf
73	Review of Brain Injury Services in Northern Ireland	Sep-15	Yes	Yes	Sep-15	https://rqia.org.uk/RQIA/files/3e/3ec2d69e-689e-4eac-802d-98ed6c14ee8b.pdf
74	A Project Examining Learning Arising From SAIs Involving Suicide, Homicide and Serious Self-Harm	Oct-15	Yes	n	Apr-17	https://rqia.org.uk/RQIA/files/b3/b31ca055-271d-4284-be39-2ce325ff1486.pdf

75	RQIA Review of the Operation of Health and Social Care Whistleblowing Arrangements	Oct-15	Yes	Yes	Sep-16	https://rqia.org.uk/RQIA/files/71/714c4651-e428-4f85-8142-4f88e81ba0ac.pdf
76	RQIA Review of Adult Learning Disability Community Services Phase II	Nov-15	Yes	Yes	Oct-16	https://rqia.org.uk/RQIA/files/4a/4a883fbc-92a7-4fda-97b0-ac2e664e5d8d.pdf
77	Review of Eating Disorder Services in Northern Ireland	Dec-15	n	Yes	Dec-15	https://rqia.org.uk/RQIA/files/ed/ed0a5f50-e0d1-4c97-9aee-0223124012b6.pdf
78	Review of the Implementation of the Developing Eyecare Partnerships Strategy	Jan-16	Yes	Yes	Sep-19	https://rqia.org.uk/RQIA/files/74/74023a70-47f4-494c-9710-cea2639b2d59.pdf
79	Review of the Regional Plastic Surgery Service in Northern Ireland	Jan-16	Yes	Yes	Jun-17	https://rqia.org.uk/RQIA/files/ae/aef58d5c-3cb1-474e-8225-b333ecfa4cef.pdf
80	RQIA Review of the Implementation of the Palliative and End of Life Care Strategy (March 2010)	Jan-16	n	Yes	Jan-16	https://rqia.org.uk/RQIA/files/1c/1c349f45-1c38-49bb-aeeb-e6a363f4c5ad.pdf
81	Review of Community Respiratory in Northern Ireland	Feb-16	n	Yes	Feb-16	https://rqia.org.uk/RQIA/files/31/31412e10-be7c-435c-a1bd-691d9541cc4e.pdf
82	Review of the Governance Arrangements for Child Protection in the HSC in Northern Ireland: Phase I	May-16	Yes	Yes		https://rqia.org.uk/RQIA/files/11/114d0d50-eb71-47b5-bc55-ad1518643d44.pdf
83	RQIA Review of the Regional Emergency Social Work Service	May-16	Yes	Yes	Jan-17	https://www.rqia.org.uk/RQIA/files/9c/9c3ad3e9-afc6-466a-a150-01827140d3ff.pdf
84	Review of the Implementation of the Dental Hospital Inquiry Action Plan (July 2013) – Phase 2	Oct-16	n	n	Jul-17	https://rqia.org.uk/RQIA/files/33/331ae69d-84ac-4ad1-ac13-4120b01a8a3c.pdf
85	Review of General Paediatric Surgery in Northern Ireland	Nov-16	n	Yes	Dec-19	https://rqia.org.uk/RQIA/files/41/416f3113-627c-47f9-9007-6d8f38ff8662.pdf
86	Review of Emergency Mental Health Service Provision across Northern Ireland	Dec-16	Yes	Yes	Sep-19	https://www.rqia.org.uk/RQIA/files/0a/0a8432b1-d9c0-4620-9ad4-7c2dafc9fc3d.pdf
87	Review of the Use of Restraint and Seclusion in Health and Social Care Trusts	Jan-17	-	-		? Is this the review of 'Awareness and Use of Restrictuve Practices in MH/LD Hospitals Dec 2014
88	RQIA Review of Perinatal Mental Health Services in Northern Ireland	Jan-17	Yes	Yes	Jan-17	https://rqia.org.uk/RQIA/files/28/28f4ee85-a5e9-4004-b922-525bc41ae56d.pdf
89	RQIA Review of Governance Arrangements in HSC Organisations that Support Professional Regulation	Jan-17	Yes	n	Jan-17	https://rqia.org.uk/RQIA/files/a8/a8547025-1073-4ef4-bb02-401bd088d99b.pdf

90	RQIA Acute Hospital Inspection Programme – Phase 1 Summary Report	May-17	n	n	May-17	https://rqia.org.uk/RQIA/files/93/93f81fde-221e-4cf2-99aa-409b494be60a.pdf
91	COMPREHENSIVE REVIEW OF SERVICE FRAMEWORK PROGRAME	Jun-17	-	-		more information needed
92	INTRAVENOUS FLUID THERAPY FOR CHILDREN AND YOUNG PEOPLE IN HOSPITAL	Nov-17	-	-		more information needed
93	Review of Implementation of NICE Clinical Guideline 174 Intravenous (IV) Fluid Therapy in Adults in Hospitals in Northern Ireland	Nov-17	Yes	Yes	Sep-20	https://rqia.org.uk/RQIA/files/21/210b5b2f-48ec-4bc8-8547-6494782d1516.pdf
94	Review of Children and Young People with disability: Community Services Phase II	May-18	-	-		
95	Review of the Governance Arrangements for Child Protection in the HSC in Northern Ireland: Phase I	May-18	-	-	May-18	
96	Review of Governance Arrangements in Independent Hospitals and Hospices	Aug-18	Yes	Yes	Jun-21	https://www.rqia.org.uk/RQIA/files/8d/8d31f796-c541-45e0-9457-865f524ef86b.pdf
97	RQIA Search for Independent Neurology Inquiry (INI) Summary Paper (December 2019)	Jan-19	-	-	Dec-19	
98	Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons	Feb-20	Yes	n	Oct-21	https://rqia.org.uk/RQIA/files/95/955cfa4a-5199-4be7-9f1a-801e1369ce84.pdf
99	Report on the Expert Review of Records of Deceased Patients (Neurology)	Feb-20	n	n	Feb-20	https://www.rqia.org.uk/RQIA/files/2f/2f9d52d7-9ea5-43c4-9b25-9b1998f8ec09.pdf
100	RQIA Review of the Urology Structured Case Record Review Southern Health and Social Care Trust	Apr-21	Yes	Yes	Sep-22	Not published
101	Review of GP Out-of-Hours Services in Northern Ireland	Apr-21	Yes	Yes	Apr-21	https://www.rqia.org.uk/RQIA/files/59/59be72a1-8c82-480d-9567-1400eb140803.pdf
102	RQIA Review of the implementation of recommendations to Prevent choking incidents across Northern Ireland	Jul-21	Yes	Yes	May-22	https://www.rqia.org.uk/RQIA/files/47/47f1583f-2860-4399-b493-de903dd6a11e.pdf
103	Review of the governance arrangements in place to support safety within Maternity Services in Northern Ireland	Jul-22	Yes	Yes	May-23	https://www.rqia.org.uk/RQIA/files/88
104	Review Of SHSCT Urology Services And Lookback Review, Which Relates To Potential Concerns For Patient Safety	Aug-22	NA	Yes		Not published

105	Exploratory Fact Finding Exercise in Relation to Preterm Induction of Labour in Cases of Severe Fetal Impairment or Fatal Fetal Anomaly	Mar-23	NA	NA		Not published
106	Review of Recommendations of Gov Review Independent Hospitals and Hospices	Sep-23	Yes	No	Jun-21	https://www.rqia.org.uk/RQIA/files/8d
107	Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland	Apr-18	No	No	Jun-22	https://www.rqia.org.uk/RQIA/files/24/24765aab-014c-42bb-ba0b-9aa85e739704.pdf

From Director of Quality, Regulation and Improvement
Kieran McAteer

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BY EMAIL

Ms Breige Donaghy
Chief Executive
Regulation and Quality Improvement Authority

Personal Information redacted by the USI

Our Ref: HE1/23/415873

Date: 16th November 2023

Dear Breige,

RQIA Reviews

I am writing to advise you that the Department has agreed to close the RQIA Reviews listed at Annex A. This follows an exercise involving consideration of the reviews by relevant Departmental policy Directors. These Review are now deemed closed and will no longer be followed up as they have either no remaining open recommendations or the relevant policy lead has advised that further reporting is no longer required.

I am copying this letter for information purposes to the Chief Executives of the HSC Trusts, PHA and NIAS, and to colleagues in the Department's Strategic Planning & Performance Group.

Yours sincerely,

Personal Information redacted by the USI

Kieran McAteer.

cc.
CEx of All HSC Trusts
CEx of PHA
CEx of NIAS

Annex A

- Implementation of the Palliative and End of Life Care Strategy (Published January 2016)
- Governance Arrangements Relating to General Practitioner (GP) Services in NI (Published July 2016)
- Operation of Health & Social Care Whistleblowing Arrangements (Published September 2015)
- The Implementation of the Developing Eye Care Partnerships Strategy (Published September 2019)
- Medicines Optimization in Primary Care (Published July 2015)
- Independent Review of the Management of Controlled Drug Use in Trust Hospitals (Published June 2013)
- Implementation of NICE Clinical Guideline 42: Dementia (Published June 2014)
- Eating Disorder Services in Northern Ireland (Published December 2015)
- Emergency Mental Health Provision Across NI (Published September 2019)
- Perinatal Mental Health Services in NI (Published January 2017)
- Risk Assessment & Management in Addiction Services (Published June 2015)
- HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services (Published December 2015)
- Governance Arrangements for Child Protection in the HSC in Northern Ireland: Phase I (Published May 2018)
- RQIA Independent Review of Statutory Fostering Services (Published December 2013)
- Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings (Published December 2014)
- Adult Learning Disability Community Services, Phase II (Published October 2016)
- Brain Injury Services in Northern Ireland (Published September 2015)
- Advocacy Services for Children and adults in Northern Ireland (Published January 2016)

The Regulation and Quality Improvement Authority

Review of Clinical and Social Care Governance arrangements in Health and Social Care Trusts in Northern Ireland

Overview Report 2008

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Executive Summary

Introduction

The Health and Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 places a statutory duty of quality on HSC Boards and Trusts.

The Quality Standards for Health and Social Care, published in March 2006 underpin the duty of quality and provide a measure against which quality of services provided in health and social care can be assessed.

The five quality themes are:
- Corporate leadership and accountability of organisations
- Safe and effective care
- Accessible, flexible and responsive services
- Promoting, protecting and improving health and social well-being
- Effective communication and information.

This overview report provides a summary of clinical and social care governance reviews carried out by the RQIA of the six HSC Trusts, between March and April 2008.

Methodology

The reviews assessed the achievement of HSC Trusts against three themes of the quality standards
- theme 3 - Accessible, flexible and responsive services
- theme 4 - Promoting, protecting and improving health and social well-being
- theme 5 - Effective communication and information.

There are 38 criteria associated with these three themes and the RQIA decided to undertake detailed reviews focusing on seven criteria, which would best provide an assurance of the standard of service user and patient engagement.

A self-assessment proforma was sent to the six HSC Trusts which incorporated all 38 criteria as well as some in depth questions, to fully examine the Trust's position. The Trusts were also able to self assess their own performance using a five point scale where "1" represented "unlikely to be achieved" and "5" represented "fully achieved"

On receipt of the completed self assessment, an analysis was carried out by the RQIA and an analysis report forwarded to review team members.

The RQIA then carried out site visits to Trusts. These visits assessed each Trust's achievements against the quality standards, particularly emphasising the criteria to be explored in more detail.

Finally the RQIA produced a report for each Trust based on the Trust's self declaration, written submissions to the RQIA as well as input from members of the review teams.

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Conclusions and Recommendations

Theme 3 - Accessible, Flexible And Responsive Services

Service planning processes

All six Trusts use a Trust Delivery Plan to illustrate how they intend to deliver services. There was some evidence that consultation does take place with service users, the voluntary, community sectors and statutory organisations but some Trusts needed to increase representation from staff and service users.

The RQIA recommends that HSC Trusts ensure increased involvement from staff, service users, the voluntary and community sectors and other relevant stakeholders in the Trust Delivery Plan.

Dignity and respect

All HSC Trusts rated themselves as having substantially achieved in relation to this criteria, though particular issues were highlighted in relation to dignity and respect within certain Trusts.

The RQIA recommends that HSC Trusts ensure the use of single sex accommodation and also prevent the use of shared hospital accommodation between children and adults.

The RQIA recommends that HSC Trusts need to make provision for dedicated rooms to be used for patients and relatives to discuss and receive confidential information.

Use of advocates and facilitators

The RQIA found that across HSC Trusts, advocacy support was much more developed within mental health services compared to other Trust directorates.

The RQIA recommends that HSC Trusts provide dedicated advocacy services in all directorates.

Provision of information

There is evidence of information being made available to service users in all HSC Trusts, however staff in the Belfast Trust are unaware of the appropriate use of the interpreting service, and in the Southern Trust there is little evidence of Minority groups accessing services.

The RQIA recommends that HSC Trusts provide interpreting services across all areas, ensuring also that staff and service users are provided with information on how to access services.

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Consent processes

Five HSC Trusts confirmed that they adhered to regional guidelines on consent; however policies on consent have not been updated since trusts were merged and this means that different policies are being used in the same trust.

The RQIA recommends that HSC Trusts put in place a single consent policy in line with regional guidance, which includes staff training and regular review.

The RQIA agrees that the majority of Trust self-assessed scores accurately reflect their level of achievement. However the RQIA questions the self assessed score of the South Eastern Trust regarding the three criteria assessed in depth suggesting a lower level of achievement.

Theme 4 - Promoting, Protecting and Improving Health and Social Well-being

Partnership arrangements

All six HSC Trusts have formal arrangements in place for partnership working which contribute to reducing health inequalities, promoting social inclusion and health and social well-being. It was however clear that greater co-ordination and increased awareness in relation to partnership working was needed.

The RQIA recommends that HSC Trusts develop more structured partnership arrangements within organisations to reduce health inequalities and promote health and well-being. Staff should be aware of relevant strategies and ongoing work in this area.

Personal and public involvement

Trusts were examined in relation to their performance in adopting Personal and Public Involvement (PPI) Guidance issued by DHSSPSNI in 2007.

The RQIA found that there is a need to ensure that PPI is better integrated into different directorates with increased service user input into service delivery.

The RQIA recommends that HSC Trusts should ensure full implementation of DHSSPS PPI Guidance.

With the exception of the Northern Trust, The RQIA found a lower level of achievement than that self-assessed by the Trusts regarding these criteria.

This area showed greatest variation between Trust self-assessed level of achievement and that found by the RQIA.

Active participation of service users and carers including feedback mechanisms appropriate to the needs of individual service users and the public.

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Theme 5 - Effective Communication and Information

All Trusts demonstrated involvement in partnerships with the voluntary or community sectors though the RQIA found a lack of a strategic approach in how feedback was used by Trusts.

The RQIA recommends that HSC Trusts make greater use of partners such as GP forums, the community and voluntary sectors and service users, in obtaining feedback about services.

Effective training for staff on how to communicate with service users and carers, and where needed, the public and media.

The RQIA found that all Trusts were involved in the delivery of training to staff on how to communicate with service users but that while some plans were readily available, others had not been updated.

The RQIA recommends that HSC Trusts develop:

- systems to ensure equal and regular access to staff training, appraisal and supervision
- methods to evaluate the effectiveness of communications training for staff
- a strategy on media training where applicable.

This area showed greatest consistency between Trust self assessed levels of achievement and that found by the RQIA.

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Introduction

This overview report provides a summary of the key findings of the clinical and social care governance reviews, undertaken by the RQIA in the six Health and Social Care Trusts, between March and April 2008. Individual reports specific to each HSC Trust are available from the RQIA and provide a more detailed account of each review.

The reviews were undertaken following a period of major transition for HSC Trusts. In April 2007 as part of the Review of Public Administration the number of Trusts was reduced from 19 to 6. This process involved the amalgamation of pre-existing legacy Trusts, and the RQIA has reflected this within individual HSC Trust reports.

The Quality Standards for Health and Social Care

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 places a statutory duty of quality (Article 34) on HSC Boards and Trusts. Each organisation had to ensure that there were rigorous structures, processes roles and responsibilities in place to deliver, monitor and promote safety and quality improvements in the provision of care.

Published in March 2006, The Quality Standards for Health and Social Care underpin the duty of quality which was placed on HSC Boards and Trusts. The five quality themes on which the standards have been developed were identified through consultation with service users, carers and HSC staff and through a review of standards developed elsewhere at local, national and international level.

The five quality themes are:
- Corporate leadership and accountability of organisations
- Safe and effective care
- Accessible, flexible and responsive services
- Promoting, protecting and improving health and social well-being
- Effective communication and information

The five quality themes are applicable to all parts of health and social care whether community, primary, secondary or tertiary care.

The Role and Responsibilities of the Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body, established with powers granted under *the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*. It is sponsored by the Department of Health, Social Services and Public Safety (DHSSPS), with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

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The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 placed a statutory duty of quality on Health and Social Care (HSC) organisations, and requires the RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

In order to fulfil its statutory responsibilities the RQIA developed a planned three year programme of clinical and social care governance reviews of all HPSS organisations, measuring achievement against the five quality themes.

Clinical and Social Care Governance

Clinical and social care governance is described as a framework within which HSC organisations can demonstrate their accountability for continuous improvement in the quality of services and for safeguarding high standards of care and treatment. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care.

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Setting the Scene

General overview of services

In Northern Ireland, health and social care services are integrated within a single structure.

Under the review of Public Administration, the previously existing 19 Trusts have been replaced by five new health and social care Trusts (combining acute and community health with social services) and a new Regional Health and Social Services Board, which has yet to be established. Each of the new Health and Social Care Trusts, with the exception of the Northern Ireland Ambulance Service, was established following an amalgamation of previously existing Legacy Trusts, as shown on the map below.

The Northern Ireland Ambulance Service HSC Trust is included within these services and brings to 6 the number of Health and Social Care (HSC) Trusts which provide health and social services. The six HSC Trusts became fully operational on 1st April 2007 and are overseen by the Department of Health, Social Services and Public Safety. The proposed new Regional Board, when established, will cover the entire province and will replace the commissioning function of the four existing Boards

Health and Social Services Boards

Health and Social Care Services in Northern Ireland are provided as an integrated service. At present th
Health and Social Services Boards plan and commission services for the residents of their areas.

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Health and Social Care Trust Structures [HSC Trusts]

The five new HSC Trusts consist of the Belfast Trust, Northern Trust, South Eastern Trust, Southern Trust and Western Trust. The Northern Ireland Ambulance Service (NIAS) operates as a regional service throughout Northern Ireland to manage ambulance, patient transport and communication services provided from ambulance control centres.

Figure 1: Map showing the new Health and Social Care Trusts

Context of reviews

These reviews have assessed the achievement of HSC Trusts against three themes of the HPSS Quality Standards [2006]:

- theme 3 - Accessible, Flexible and Responsive Services
- theme 4 - Promoting, Protecting and Improving Health and Social Well-being
- theme 5 - Effective Communication and Information.

Within these three themes, a detailed review was undertaken focusing on the following seven criteria, as the RQIA thought these would provide an assurance of the standard of service user and patient engagement within HSC Trusts.

Under Theme 3 "Accessible, Flexible and Responsive Services" criteria:

- 6.3.1 (a) The organisation has service planning processes which promote an equitable pattern of service provision or commissioning based on assessed need, having regard to the particular needs of different localities and people, the availability of resources, and local and regional priorities and objectives.
- 6.3.2 (a) The organisation ensures that all service users, carers and relatives are treated with dignity and respect and that their privacy is protected and promoted, including, where appropriate, the use of advocates and facilitators.
- 6.3.2 (b) The organisation has systems in place to ensure that service users, carers and relatives have the appropriate information to enable them to make informed decisions and choices about their treatment and care, or service provision.

Under Theme 4 " Promoting, Protecting and Improving Health and Social Well-being" criteria:

- 7.3 (a) The organisation has structures and processes in place to promote and implement effective partnership arrangements, to contribute to improvements in health and social well-being, and promote social inclusion and a reduction in inequalities.
- 7.3 (b) The organisation actively involves the services users and carers, the wider public, HPSS staff and the community and voluntary sectors, in the planning and development of local solutions to improve health and social well-being and to reduce inequalities.

Under Theme 5 "Effective Communication and Information" criteria:

- 8.3 (a) The organisation has active participation of service users and carers and the wider public. This includes feedback mechanisms appropriate to the needs of individual service users and the public

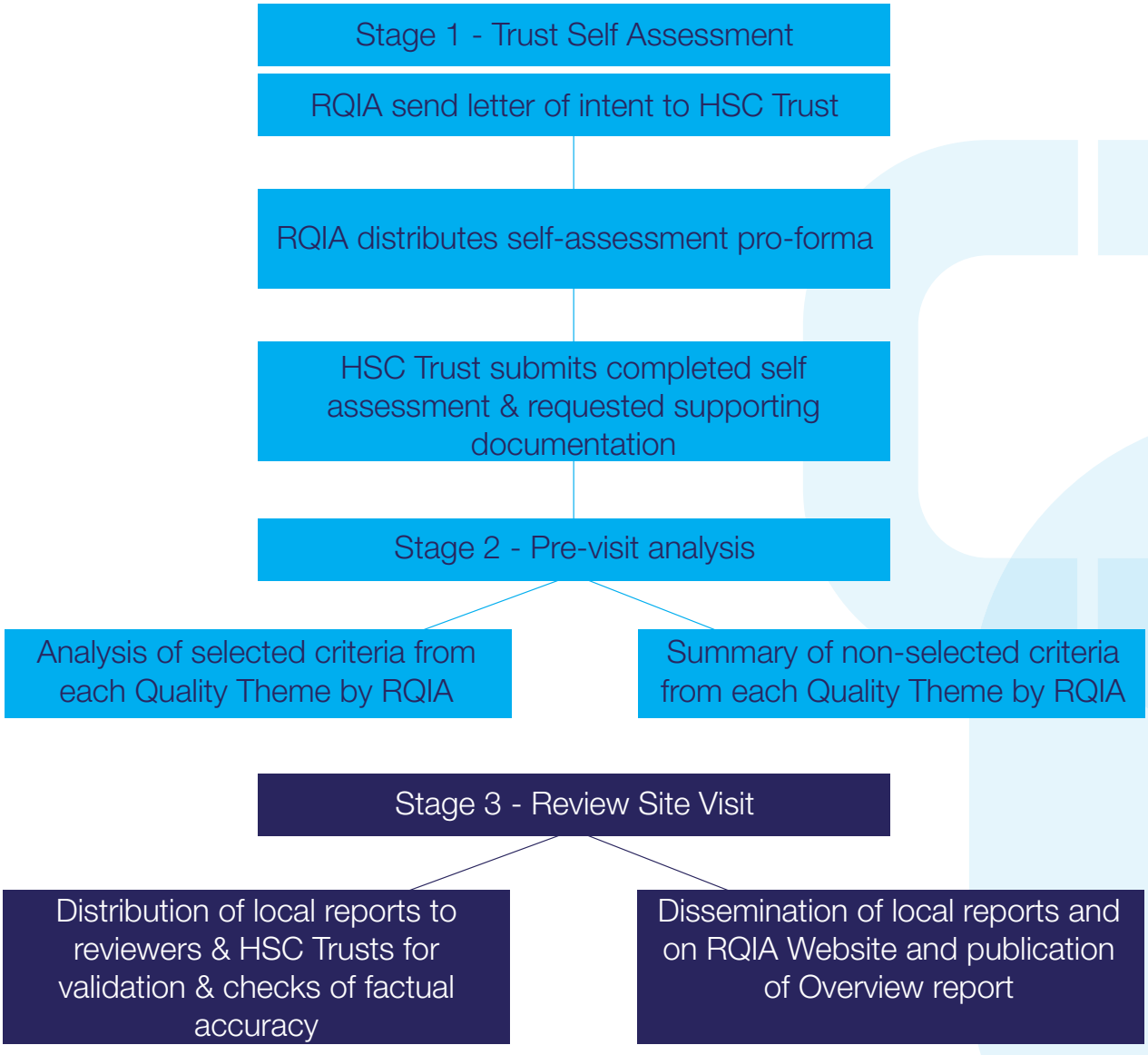
- 8.3 (g) The organisation has effective training for staff on how to communicate with service users and carers and, where needed, the public and the media.

In total there are 38 criteria associated with these three quality themes. Organisations were asked to provide information regarding all 38 criteria, and this formed part of the overall report by the RQIA. However, unless through analysis, or as part of the review process, there was an issue that needed to be addressed, these other criteria were not subject to the same level of scrutiny as the seven noted above.

The Review Process

The review process has three key stages:
(1) Local HSC Trust self-assessment (including completion of self declaration)
(2) Pre-visit analysis
(3) Review team visit

Figure 2: Review Process map



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Self-assessment

Self-assessment is based on the statutory Duty of Quality, and the requirement for HSC organisations to self assess their progress against the quality standards for health and social care. Self-assessment as a technique is used widely in health and social care regulation, accreditation and licensing across the UK and internationally.

A self assessment proforma, including all 38 of the criteria from the three quality themes to be assessed, was sent to the six HSC Trusts. As well as obtaining information from Trusts, the self assessment also provided Trusts with an opportunity to assess their progress against each criterion. This was done using a five point level of achievement where "1" represented "unlikely to be achieved" and "5" represented "fully achieved". The Trusts also submitted documentation requested by the RQIA which supported their achievements. The completed self-assessment proforma and evidence documents were submitted to the RQIA for analysis.

Article 34 of the *The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*, places a statutory duty of quality on HSC organisations to, "...put and keep in place arrangements for the purpose of monitoring and improving the health and personal social services that it provides to individuals; and the environment in which it provides them.". In meeting this legislative responsibility, the Trust's Chair and Chief Executive signed a declaration confirming the accuracy of the self-assessment returned to the RQIA.

Pre-visit analysis of self-assessment

When completed self-assessment forms were received, the self-assessment information and associated evidence was analysed. A pre-visit analysis report was produced which was sent to review teams, together with the self-assessment and any other documentary evidence.

The review visit

The RQIA assessed the extent of each organisation's achievements against the standards by undertaking site visits, allowing for a more in-depth analysis of the seven selected criteria. At the start of each site visit, the RQIA met key personnel responsible for the service being reviewed.

The RQIA then spoke with local stakeholders, including staff, patients, clients and carers about the services provided. Teams also obtained information by observation of physical surroundings and by examining documentation such as policies and procedures.

After these meetings, the RQIA assessed the performance of an organisation against the standards, based on the information gathered during the self-assessment exercise, pre-visit analysis and site visits.

Each RQIA visit ended with teams providing initial feedback on their findings to each organisation. This included specific examples of good practice drawn to the attention of review teams, together with an indication of any particular challenges.

The review teams

Review teams are multidisciplinary, and include both Health and Social Care professionals (peer) and members of the public (lay reviewers) who have undertaken training provided by the RQIA. Review teams are managed and supported by RQIA project managers and project administrators.

Lay reviewers

Lay reviewers come from a range of backgrounds from across Northern Ireland. Each plays a vital role in review teams, bringing new insights and providing a lay person's perspective on all aspects of the provision of health and social care services.

Peer reviewers

Peer reviewers have worked at a senior level in both clinical and non-clinical roles in the HPSS. They have a particular interest in the area of governance and a commitment to improving health and social care.

There is an identified leader for each review team who works closely with the RQIA project manager during the review, to guide the team in its work and ensure that team members are in agreement with the assessment reached.

The report

The findings in this report are based on the Trust's self-declaration and written submissions to the RQIA, as well as observations made by, and views expressed to, members of review teams during validation visits to each Trust.

Following each review visit, the RQIA drafted a local report detailing the findings of the review team and recommendations for improvement.

This draft report was sent to the review team for comment, and then to the organisation to check for factual accuracy.

The overview report will be made available to the general public in hardcopy, on the RQIA website and other formats on request.

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Quality Theme 3:
Accessible, flexible and responsive services

The DHSSPS Quality Standard, Theme 3 states: "Services are sustainable, and are flexibly designed to best meet the needs of the local population. These services are delivered in a responsive way, which is sensitive to individual's assessed needs and preferences, and takes account of the availability of resources. Each organisation strives to continuously improve on the services it provides and/or commissions."

There are a total of 13 criteria within this Standard and each Trust was asked to make a self assessment against these criteria under a Level of Achievement measure as illustrated in the table below.

Code	Level of Achievement	Definition
1	Unlikely to be Achieved	The criterion is unlikely to ever be achieved. (A reason must be stated clearly in the Trust response)
2	Not Achieved	The criterion is likely to be achieved in full but after March 2008. For example, the Trust has only started to develop a policy and implementation will not take place until after March 2008.
3	Partially Achieved	Work has been progressing satisfactorily and the Trust is likely to have achieved the criterion by March 2008. For example, the Trust has developed a policy and will have completed implementation throughout the Trust by March 2008.
4	Substantially Achieved	A significant proportion of action has been completed to ensure the Trust performance is in line with the criterion. For example, a policy has been developed and implemented but a plan to ensure practice is fully embedded has not yet been put in place.
5	Fully Achieved	Action has been completed that ensures the Trust performance is fully in line with the criterion. For example, a policy has been developed, implemented, monitored and an ongoing programme is in place to review its effectiveness.

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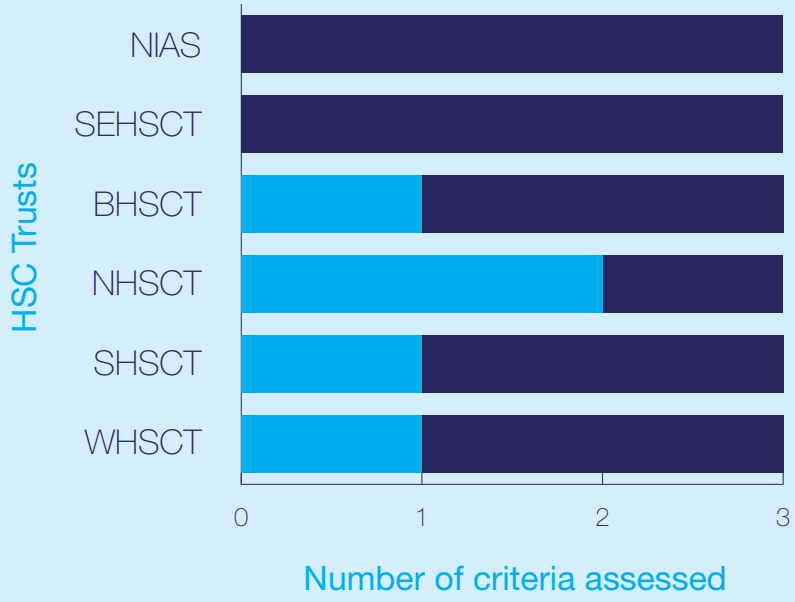
Examined by Review Team
Quality Theme 3: Accessible, Flexible and Responsive Services

Level of Achievement against Quality Theme

- 1- Unlikely to be achieved
- 2 - Not achieved
- 3- Partially achieved
- 4- Substantially achieved
- 5- Fully achieved

Figure 3: Service Planning and Delivery Criteria



The graph above shows HSC Trusts self-rating of 3 criteria relating to service planning and delivery. Trust self-ratings for performance on individual criteria are available within respective local Trust reports. The HSC Trusts rated their performance as having substantially or partially achieved the criteria.

The following criterion from Theme 3 regarding service planning processes, was examined by each review team during the review visits.

6.3.1a The organisation has service planning processes which promote an equitable pattern of service provision or commissioning based on assessed need, having regard to the particular needs of different localities and people, the availability of resources, and local and regional priorities and objectives.

Trust Delivery Plan

All six HSC Trusts use a Trust Delivery Plan [TDP] to illustrate how they will deliver services throughout the year. There was evidence that consultation does take place with service users, the voluntary, community sectors and statutory organisations to provide a service needs assessment. However, within some HSC Trusts [Northern, Western, Belfast, NIAS], there is a need to provide for increased representation from staff and service users.

Recommendation 1:

The RQIA recommends that HSC Trusts ensure increased involvement from staff, service users, the voluntary and community sectors and other relevant stakeholders in the Trust Delivery Plan.

Areas of good practice specifically commented on by the RQIA.

Within the NIAS, there is an increased weekend service to renal patients in Altnagelvin Hospital which is a direct result of patient and provider engagement. In this instance the NIAS responded to unmet need, without requiring high levels of additional resource.

In the Southern Trust, the RQIA welcomed the involvement of frontline practitioners in planning as this provided a different perspective on the challenges to be addressed. The RQIA also noted that there were benefits in moving away from consultation exercises towards longer term engagement processes.

The following criterion from Theme 3 regarding service delivery for individuals, carers and relatives was examined by each review team during the review visits.

6.3.2a The Trust ensures that all service users, carers and relatives are treated with dignity and respect and that their privacy is protected and promoted, including, where appropriate, the use of advocates and facilitators.

Dignity and respect

Dignity and respect are important principles in service delivery and all HSC Trusts rated themselves as having substantially achieved in relation to this criterion. They referred to various sources which incorporate these principles, such as corporate plans, the patient charter, staff induction documentation and policies and codes of professional conduct.

Both Western and Southern HSC Trusts made reference to the "Essence of Care" standards for privacy and dignity. Senior management stated that they had received assurances from staff that these principles were being applied and demonstrated this through the use of verbal feedback, findings within patient satisfaction surveys and the use of complaints procedures.

In the South Eastern and Northern HSC Trusts, the lack of single sex facilities was highlighted by patients as a concern, although staff gave assurances that mixed sex units are used only when necessary and that screening is used.

The RQIA, in the Western Trust raised a potential child protection issue where children were being placed in the regional adult endoscopy unit. When questioned, senior staff from the Trust gave an assurance that this was kept under review and is being managed within an ongoing risk assessment.

Recommendation 2:

The RQIA recommends that HSC Trusts ensure the use of single sex accommodation and also prevent the use of shared hospital accommodation between children and adults.

All HSC Trusts, where applicable, are aware of the need to provide a separate room for breaking bad news to relatives. Throughout the Trusts, staff expressed the need for such a dedicated facility within their respective units and this need was particularly evident within the South Eastern Trust.

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Recommendation 3:

The RQIA recommends that HSC Trusts should provide dedicated rooms to be used for patients and relatives to discuss and receive confidential information.

Areas of good practice specifically commented on by the RQIA.

The breast screening unit in the Southern Trust and the endoscopy unit in the Western Trust provide modesty clothing and an innovative funding approach provides a relatives room within the A&E Department in Altnagelvin Hospital.

Use of advocates and facilitators

Five HSC Trusts use advocacy services and commission these from outside the Trust. The Northern Ireland ambulance Trust does not make use of any advocates or facilitators. Across the other five HSC Trusts advocacy support is more developed within mental health services with much less use across other Trust directorates.

The RQIA found a poorly co-ordinated approach in the South Eastern Trust, a poor use of advocates within the Belfast Trust and no clearly defined role within the Western Trust. However, there is an awareness among staff of the need to expand this facility equally throughout all Trust areas.

Recommendation 4:

The RQIA recommends that HSC Trusts provide dedicated advocacy services in all Trust directorates.

Areas of good practice specifically commented on by the RQIA.

Antrim Hospital, in the Northern HSC Trust provides a “meet and greet” service for patients. Volunteers also escort patients within the hospital and offer a befriending service for those patients who have no relatives or no visitors.

The following criterion from Theme 3 regarding the Provision of Information, was examined by each review team during the review visits.

6.3.2b The Trust has systems in place to ensure that service users, carers and relatives have the appropriate information to enable them to make informed decisions and choices about their treatment and care, or service provision

Provision of information

Evidence of information available to service users was found in all HSC Trusts. This was evident mainly in the form of patient information leaflets. The Belfast Trust hosts the Regional Interpreting Service and both the Belfast Trust and the NIAS use "Language Line" which provides a translator for non-English speakers. The NIAS also has text phones available for use by members of the deaf community and uses a multi-lingual emergency phrase book.

Recommendation 5:

The RQIA recommends that HSC Trusts provide interpreting services across all areas. Trusts should ensure that staff and service users are provided with information on how to access these services.

Areas of good practice specifically commented on by the RQIA.

In the Southern HSC Trust, in both the Diabetic Service and Mandeville Cancer Unit, service users are able to address any concerns to named contact nurses, and both services offer a 24 hour advice line. The RQIA felt that these were valuable initiatives that could be used in other services across the Trust.

In the Southern HSC Trust, patients admitted to hospital have their medicines put into a "green bag" which makes sharing information about their medicines history easier. The review team felt this scheme had excellent potential to be used regionally.

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Consent processes

Five HSC Trusts excluding the NIAS adhere to Regional Guidelines on Consent; however consent policies have not been updated since Trusts were merged meaning that different policies are being used within the same Trust. The Northern Ireland Ambulance Service (NIAS) has participated in the Regional Consent Group and has highlighted the need for regional guidelines in an emergency situation, although they do comply with the Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines for informed consent.

All six HSC Trusts provide general mandatory training on consent for staff, which tends to happen during induction. However, there is no central system to record the number of staff trained within directorates, no accurate figures for those who have received training and there is evidence within Trusts that some staff have not been trained.

In the Southern and Northern HSC Trusts staff have received no consent training since the merger of Trusts. However, in some specialised areas within the South Eastern Trust there are examples where staff have received in depth training in consent.

Recommendation 6:

The RQIA recommends that HSC Trusts put in place a single consent pol[illegible]ional guidance which includes staff training and regular review.

Areas of good practice specifically commented on by the RQIA.

Both in the NIAS and the endoscopy unit in Altnagelvin Hospital in the Western HSC Trust, there is a policy allowing patients the option of withdrawing their consent for a procedure.

In the Oncology Unit at the Ulster Hospital, nursing staff have a mentoring programme for a minimum of one year. This ensures that staff have sufficient knowledge to provide a patient with adequate information about their treatment and care.

In the Ulster Hospital in the South Eastern Trust, an Outpatient Department has developed a 'green sheet' that is used to record information given to and discussed with patients. Recording discussions in this way has ensured greater continuity and consistency of use of patient information making informed consent easier.

RQIA commentary on the Trusts' self-assessed levels of achievement

The RQIA agrees that the majority of Trust self-assessed scores accurately reflect their level of achievement. Areas of disagreement are highlighted in individual Trust reports.

The RQIA questions the self-assessed score of the South Eastern Trust regarding the three criteria assessed in depth suggesting a lower level of achievement.

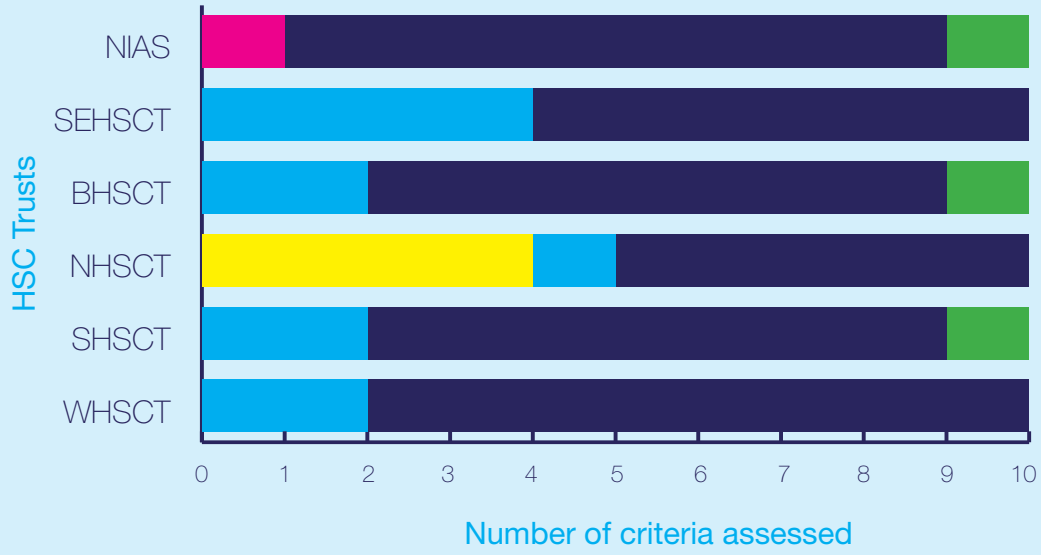
The following criteria were examined through analysis of each Trust's self-assessment return.

Quality Theme 3: Accessible, Flexible and Responsive Services

Level of Achievement against Quality Theme

- 1- Unlikely to be achieved
- 2 - Not achieved
- 3- Partially achieved
- 4- Substantially achieved
- 5- Fully achieved

Figure 4: Service Planning and Delivery Criteria



This graph shows each of the six HSC Trusts and their self-rating against ten criteria, describing service planning and delivery.

Most of the criteria were rated by the Trusts as having been partially or substantially achieved. However, the Northern Trust rated their position in relation to four criteria as having been 'not achieved'.
The NIAS rated one criteria as unlikely to be achieved. Three Trusts rated one criteria as having been fully achieved.

Information on Trust ratings for specific criteria is available within individual Trust reports.

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The following criteria under Quality Theme 3, were examined through analysis of each Trust's self-assessment return.

6.3.1b The organisation integrates views of service users, carers and local communities, and front line staff into all stages of service planning, development, evaluation and review of health and social care services.

Service planning

Each Health and Social Care Trust decides individually on the approach it will take in relation to the extent and method of service user involvement in service planning. Health and Social Care Trusts are required to consult with patients and public bodies before making changes to their services, however, it is difficult to evaluate the benefits of this involvement in terms of influence on service planning. HSC Trusts are working towards developing a Personal and Public Involvement Strategy (PPI) which may enable a more strategic approach to be taken to user involvement.

Examples of staff and user consultation in service planning and delivery were found in the Chemotherapy/ Cancer Unit in Laurel House, Antrim Hospital in the Northern Trust and in the Review of Mental Health Services at Tyrone County Hospital within the Western Trust.

In the Southern Trust there is user involvement within health promotion and community development teams, who contribute to the delivery of the "Investing for Health" Strategy at a local level. The Northern Ireland Ambulance Service (NIAS) works with community representatives through a number of Ambulance Liaison Groups which provide access to key decision makers within the NIAS.

Areas of good practice specifically commented on by the RQIA.

In the Southern Trust, the RQIA welcomed the involvement of frontline practitioners in planning as this provided a different perspective on the challenges to be addressed . The RQIA noted the benefits of moving away from purely consultation exercises towards longer term engagement processes.

In the South Eastern Trust, the RQIA noted that Local Councils and committees help to identify local health and social care needs, aiding service planning processes.

6.3.1c The organisation promotes service design and provision which incorporates and is informed by:

1. Information about the health and social well-being status of the local population and an assessment of likely future needs
2. Evidence of best practice and care, based on research findings, scientific knowledge, and evaluation of experience;
3. Principles of inclusion, equality and the promotion of good relations
4. Risk assessment and an analysis of current service provision and outcomes in relation to meeting assessed needs;
5. Current and/or pending legislative and regulatory requirements
6. Resource availability; and
7. Opportunities for partnership working across the community voluntary, private and statutory sectors

6.3.1d The organisation has service planning and decision-making processes across all service user groups, which take account of local and/or regional priorities

Service design and provision

Trusts implement service planning and decision making through Trust Delivery Plans and Planning Cycles, using a range of sources of information to help with service design and provision. These include, for example, access to information datasets [Northern Ireland Neighbourhood Information Services], Investing For Health (IFH) documentation and partnerships with the community development and voluntary sectors.

All HSC Trusts report that Directorates in their approach to service design and provision include risk assessment, equality and best practice procedures. All have assessed their performance as having substantially or fully achieved in relation to this criterion.

6.3.1e The organisation has standards for the commissioning of services which are readily understood and are available to the public.

Commissioning of services

HSC Trusts operate using regionally agreed contracts which contain organisational, financial and clinical and social care governance standards. However, analysis of the information provided indicates there are different monitoring arrangements in place across Trusts. The Trusts are in the process of developing and improving these arrangements.

A range of standards are used by five of the HSC Trusts for the commissioning of services, which include the Quality Standards from the DHSSPS and the Safety First framework. There are also Service and Budget agreements that incorporate various standards which the Trusts require provider organisations to comply with. These are all publicly available documents.

The NIAS does not commission services and considered the availability of commissioning standards to the public as not being relevant to their organisation.

Two HSC Trusts do not make standards in relation to Service Level Agreements available to the public. The Western HSC Trust has indicted that Service Level Agreements are "commercial in confidence documents". The Southern Trust has made available to the public, the Trust contract which contains standards relating to dignity and privacy, independence and choice and has involved service users in the development of standards, for example in relation to Looked After Children (LAC).

6.3.1f The organisation ensures that service users have access to its services within locally and/or regionally agreed timescales

All HSC Trusts reported having substantially or fully achieved this criteria in relation to users having access to services, within agreed timescales. Access to services within all Trusts is determined through the DHSSPSNI Priorities for Action (PfA) that provides local and regional standards for services. These targets form part of the Trust Development and Corporate Plans.

All HSC Trusts use access targets, and performance is assessed through Trust Board meetings that are open to the public. Performance is also reported against targets on a weekly basis and managed and reviewed on a daily basis by operational managers.

6.3.2c The Trust ensures that information, where appropriate, is provided in a number of formats, which may include, large print, audio format on tape or compact disc, computer readable format, Braille, etc. and is:

- written in easy to understand, non-technical language;
- laid out simply and clearly;
- reproduced in a clear typeface;
- available on the internet; and
- in the preferred language of the reader, as necessary.

6.3.2d The Trust incorporates the rights, views and choice of the individual service user into the assessment, planning, delivery and review of his or her treatment and care, and recognises the service user's right to take risks while ensuring that steps are taken to assist them to identify and manage potential risks to themselves and to others.

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Availability of information and service user choice

All Trusts have arrangements in place to help users access information on available services. This is done primarily by providing leaflets and through the provision of interpreter services.

In some Trusts there seemed to be more effective use of these services. For example within the Southern Trust referral forms indicate if a patient is a non English speaker, enabling an interpreter with the appropriate language to be booked ahead of the patient's appointment.

All Trusts offer a range of approaches to enable service users to receive information and make choices. These range from display screens and advocacy services to information leaflets for illnesses such as diabetes.

HSC Trusts incorporate the rights, views and choices of the individual by having a person centred approach and involving service users in their care planning and treatment. Information provided by Trusts stated that this is supported through a range of policies and practices.

6.3.2e The Trust ensures that individual service user information is used for the purpose for which it was collected, and that such information is treated confidentially

Confidentiality of information

All Trusts have policies, procedures, professional codes of practice and regional guidance to ensure confidentiality of service user information. Information leaflets are also given to patients showing how the Trust uses personal information. All Trusts are aware of the Data Protection Act and regional guidance, to ensure that information is only used for the purposes for which it is collected.

Recommendation 7:

The RQIA recommends that HSC Trusts develop:

- **a policy, supported by staff training to ensure that all patient information transmitted between health care professionals remains confidential**
- **regular monitoring and auditing of the process.**

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6.3.2f The Trust promotes multi-disciplinary team work and integrated assessment processes, which minimise the need for service users and carers to repeat basic information to a range of staff

6.3.2g The Trust provides the opportunity for service users and carers to provide comment on service delivery

Minimising need to repeat information and opportunity for commentary on service

All Trusts are involved to varying degrees in multidisciplinary working across different directorates. As an example Trusts were asked to provide evidence of multidisciplinary working specifically in relation to diabetes services. All Trusts were able to provide evidence of multidisciplinary working in this area.

All Trusts provide opportunities for service users to comment on service delivery using a range of methods, such as satisfaction surveys, service user focus groups, comment cards and leaflets and through provision of a complaints procedure.

Areas of good practice specifically commented on by the RQIA.

Within the South Eastern Trust, there is a "green sheet" to record information already given to and discussed with patients. This is used to avoid the need for repetition.

Within the NIAS, patient specific information is recorded by NIAS staff on a Patient Report Form that is then given to the receiving hospital, to reduce the need for the patient to restate personal information.

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Quality Theme 4: Promoting, protecting and improving health and social well-being

The DHSSPS Quality Standards Theme 4 states that "The HPSS works in partnership with service users and carers, the wider public and with local and regional organisations to promote, protect and improve health and social wellbeing, and to tackle inequalities within and between geographic areas, socio-economic and minority groups, taking account of equality and human rights legislation."

There are a total of 13 criteria within this Standard and Trusts were asked to make a self assessment against these criteria under a Level of Achievement measure as illustrated in the table below.

Code	Level of Achievement	Definition
1	Unlikely to be Achieved	The criterion is unlikely to ever be achieved. (A reason must be stated clearly in the Trust response)
2	Not Achieved	The criterion is likely to be achieved in full but after March 2008. For example, the Trust has only started to develop a policy and implementation will not take place until after March 2008.
3	Partially Achieved	Work has been progressing satisfactorily and the Trust is likely to have achieved the criterion by March 2008. For example, the Trust has developed a policy and will have completed implementation throughout the Trust by March 2008.
4	Substantially Achieved	A significant proportion of action has been completed to ensure the Trust performance is in line with the criterion. For example, a policy has been developed and implemented but a plan to ensure practice is fully embedded has not yet been put in place.
5	Fully Achieved	Action has been completed that ensures the Trust performance is fully in line with the criterion. For example, a policy has been developed, implemented, monitored and an ongoing programme is in place to review its effectiveness.

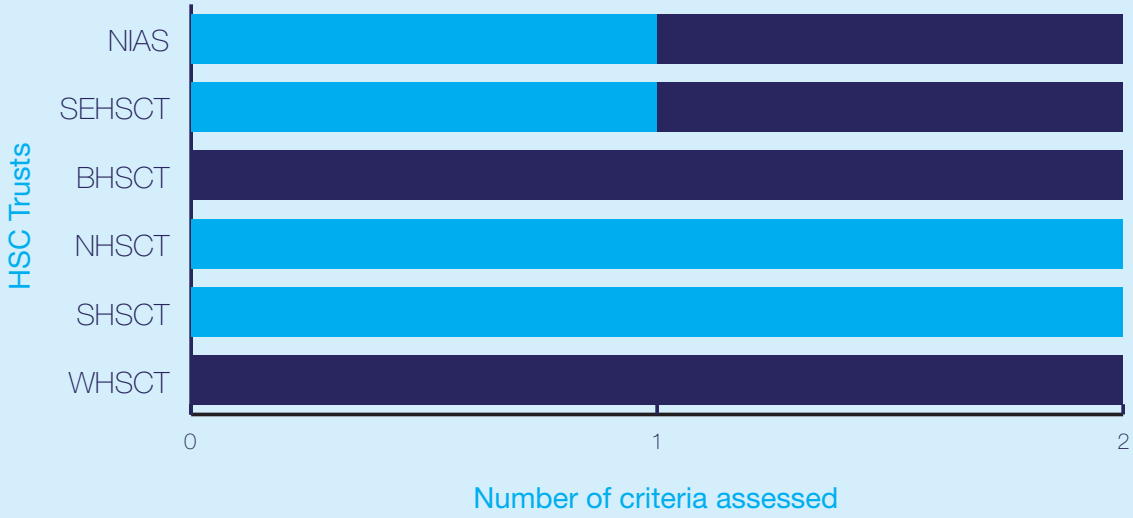
The Regulation and Quality Improvement Authority

Quality Theme 4: Promoting, Protecting and Improving Health and Social Well-being

Level of Achievement against Quality Theme

- 1- Unlikely to be achieved
- 2 - Not achieved
- 3- Partially achieved
- 4- Substantially achieved
- 5- Fully achieved

Figure 5: Trust Partnerships and Personal and Public Involvement Criteria



The graph shows each Trust self-rating for 2 criteria regarding partnerships and public involvement. The Trust self-ratings show a level of substantial or partial achievement.

The Belfast and Western Trust self-rated their performance as having substantially achieved in having structures and processes in place to promote and implement effective partnerships. They also reported substantial achievement in engagement and involvement of service users, carers and the wider public in the planning and development of services.

The Southern and Northern Trust rated both these criteria as having been partially achieved. The NIAS and South Eastern Trust showed a mixture of partial and substantial achievement for these criteria.

Trust self-rating for individual criteria is available within local Trust reports.

The Regulation and Quality Improvement Authority

The following criterion from Theme 4 regarding partnership arrangements, was examined by each review team during the review visits.

7.3a The organisation has structures and processes in place to promote and implement effective partnership arrangements, to contribute to improvements in health and social well-being, and promote social inclusion and a reduction in inequalities.

All six HSC Trusts have formal arrangements in place for partnership working, which contribute to reducing health inequalities, and promoting social inclusion and health and social well being. These arrangements include collaboration with a range of stakeholders, user groups, voluntary and community groups as well as independent providers.

Although there was clear evidence that Trusts have both formal and less formal partnership arrangements designed to reduce inequalities and promote health and wellbeing, it was also clear that greater co-ordination and increased awareness in relation to partnership working was needed.

In the Northern HSC Trust for example, the review team felt that more robust links and improved partnership arrangements needed to be established between the Trust and the Board. The RQIA also indicated the need for improved working relations between senior management and frontline staff in the NIAS. The RQIA, in the Southern Trust found evidence of an over-reliance on the community and voluntary sectors. A service provider in this area was being used as a first point of contact in child and adolescent crisis response, a function for which the organisation felt they were neither fully equipped nor funded to provide.

Recommendation 8:

The RQIA recommends that HSC Trusts develop more structured partnership arrangements within organisations to reduce health inequalities and promote health and wellbeing. Staff should be aware of relevant strategies and ongoing work in this area.

Areas of good practice specifically commented on by the RQIA.

In the Western HSC Trust there is evidence of integration of health improvement across the T n champions and sub groups in each Directorate. Feedback systems are in place to record issues and complaints raised by users and others and this information is used to identify trends and help with both essential learning and staff training initiatives.

In the Northern HSC Trust the review team thought that the development of a Disability Consultation Panel was a good example of social inclusion. This group had produced a development plan and had presented an action plan to the Trust Board to help with access to services for people with a disability. This had been endorsed and linked into various directorates within the Trust.

In the Northern HSC Trust, the Equality Manager described a meeting between the Chinese Welfare Association and the Assistant Director of Mental Health. This had led to Approved Social Workers being trained in the use of interpreting services to aid completion of mental health assessments.

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The following criterion from Theme 4 regarding Personal and Public Involvement (PPI), was examined by each review team during the review visits.

7.3b The organisation actively involves service users and carers, the wider public, HPSS staff and the community and voluntary sectors, in the planning and development of local solutions to improve health and social well-being and to reduce inequalities on service delivery

The RQIA found that all Trusts involve service users, staff and the wider public in planning and development of solutions to improve health and social well-being. This occurs more often when specific planning issues need to be addressed.

The Southern Trust has agreed a strategy involving all directorates, stakeholders and partner organisations to identify any issues and priorities as well as ways to address these.

In the Belfast Trust, staff involvement focused on encouraging them to raise issues with more senior staff. The RQIA did however highlight that relevant documents, such as corporate plans, are not routinely circulated to staff.

The Western and Northern Trusts use forums and panels where members of the public and service users are consulted. Within the NIAS there is engagement with local representatives and the public to prioritise locations with regard to ambulance provision. However, the RQIA thought there was scope for more proactive involvement by the NIAS in community engagement schemes.

Personal and Public Involvement (PPI)

Personal and Public Involvement (PPI) Guidance, supports the values underpinning the Quality Standards where effective personal and public involvement is central to the delivery of safe, high quality services and as such, is a key element of clinical and social care governance.

The RQIA has been tasked to determine how well, in the first year, HSC Trusts have adopted the principles set out in the guidance, and to what extent a systematic process of self-evaluation to strengthen PPI has been developed.

The 3 key premises, according to the Guidance, which underpin PPI, are that:

- people in receipt of services should be actively involved in decisions affecting their lives and should fully contribute to any planning, decisions, and feedback about their own care and treatment
- the wider public has a legitimate entitlement to have opportunities to influence health and social care services, policies and priorities
- PPI should be part of everyday practice within HSC organisations and should lead to improvements in an individual's personal experience of the service and the overall quality and safety of service provision.

HSC Trusts were examined in relation to their performance in adopting Personal and Public Involvement Guidance (PPI) issued by the DHSSPS in 2007. Specifically, Trusts were asked who was responsible for implementation of the guidance, what had been done in relation to taking forward the guidance, and to demonstrate progress towards achieving this goal.

All HSC Trusts were asked to identify a nominated lead responsible for implementing the Guidance and to provide evidence of a PPI strategy. Four Trusts have nominated directors to lead the work but neither the Belfast HSC Trust nor NIAS have a nominated lead. The RQIA noted that the Belfast Trust is forming a group to develop the strategy with input from service users and/or their representatives. The NIAS Trust does not appear to have made any progress in this area.

Five HSC Trusts are at the early stages of development of updated policies regarding PPI strategies. The NIAS demonstrated no evidence of going beyond the basic statutory requirements in relation to developing a Personal and Public Involvement strategy.

The Southern Trust has developed an action plan and infrastructure while the Western Trust had a draft PPI strategy. However, the RQIA found no engagement or consultation with staff, service users or the wider community in the drawing up of this strategy. The South Eastern HSC Trust is in the process of establishing a PPI committee with significant service user membership. The Northern Trust provided no report or action plan and staff are currently working with a Trust User/Carer Strategy with no awareness of PPI initiatives.

Within the Trusts the RQIA found that there is a need to ensure that PPI is better integrated into different directorates with increased service user input into service delivery.

Recommendation 9:

The RQIA recommends that HSC Trusts should ensure full implementation of DHSSPS PPI Guidance.

RQIA commentary on the Trusts' self-assessed levels of achievement

With the exception of the Northern Trust, the RQIA found a lower level of achievement than that self-assessed by the Trusts. This is highlighted in individual Trust reports.

This area showed greatest variation between Trust self- assessed level of achievement and that found by the RQIA.

The following criteria under Quality Theme 4, were examined through analysis of each Trust's self-assessment return.

Quality Theme 4: Promoting, Protecting and Improving Health and Social Well-Being

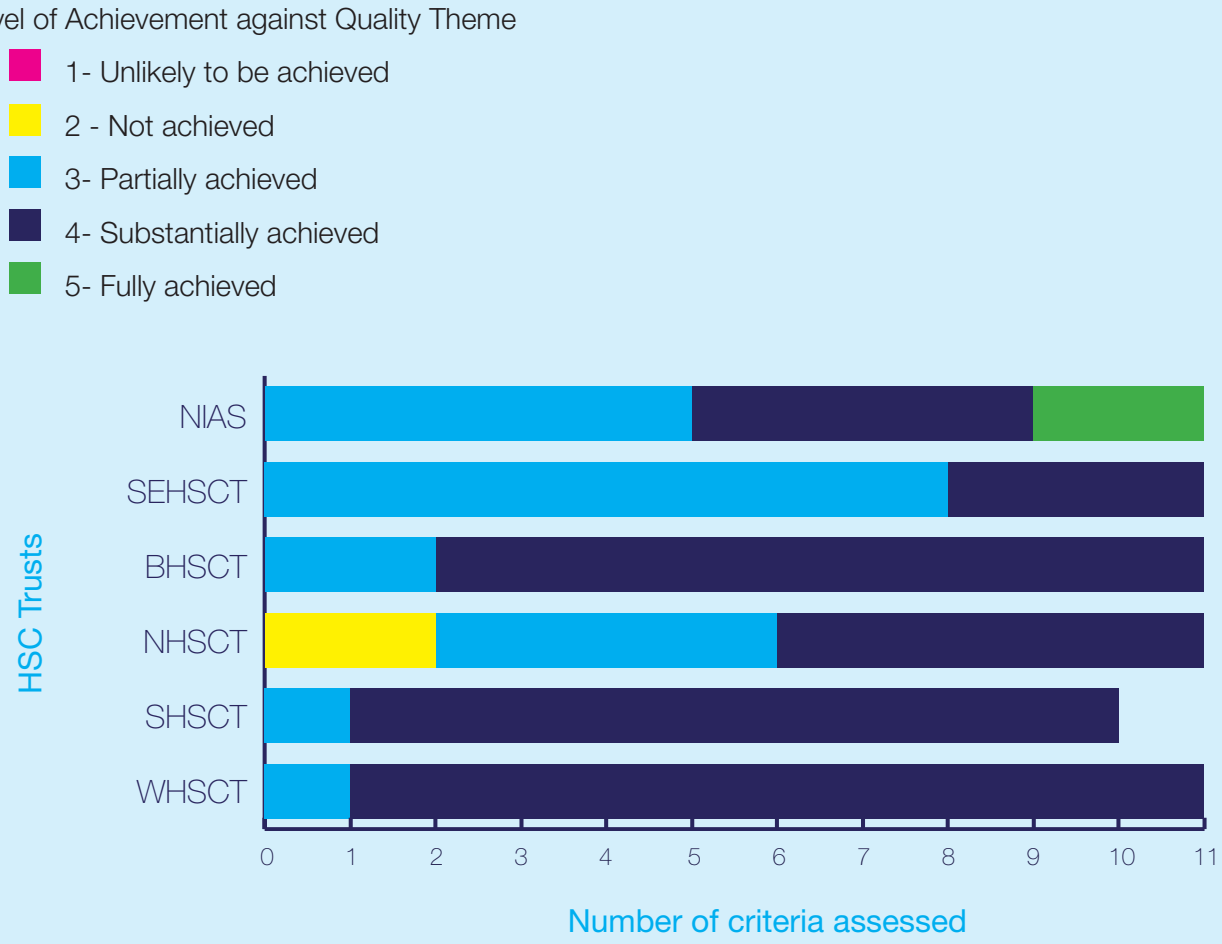


Figure 6: Trust Policies, Procedures, Systems and Programmes And Health and Social Care Needs Assessment Criteria

This graph shows each of the six HSC Trusts and their self-rating against eleven criteria, describing promoting, protecting and improving health and social well - being.

Most of the criteria were rated by the Trusts as having been partially or substantially achieved. However, the Northern Trust rated their position in relation to two criteria as having been 'not achieved'.

The NIAS rated two criteria as being 'fully achieved'.

Information on Trust ratings for specific criteria is available within individual Trust reports.

7.3c The organisation is committed to human rights, as identified in human rights legislation and United Nations Conventions, and to other Government policies aimed at tackling poverty, social need and the promotion of social inclusion.

7.3d The organisation actively pursues equality screening and, where appropriate, equality impact assessment in compliance with section 75 of the *Northern Ireland Act 1998.*

Human Rights.

Section 75 of the *Northern Ireland Act 1998* requires that each HSC Trust should have due regard to the need to promote equality of opportunity. There is also a statutory requirement to ensure that HSC Trust decisions and actions are compatible with the European Convention on Human Rights and that Trusts act in accordance with these rights.

All HSC Trusts indicated that they comply with human rights, equality screening and section 75 requirements. Trusts reported that staff are aware of the need to carry out an equality impact assessment in the development of any new service and the need for relevant staff training within these areas. There was also some reference within Trust policies and procedures of policy makers engaging with service users before making any changes to services.

Recommendation 10:

The RQIA recommends that HSC Trusts should have systems in place to ensure compliance with relevant human rights and equality legislation.

7.3g The organisation has effective and efficient emergency planning processes and co-ordinated response action plans in place, as appropriate, to deal with major incidents or emergency situations and their aftermath. The planning processes and action plans are compliant with Departmental guidance.

Emergency planning and dealing with a pandemic.

Five Trusts are at varying stages in developing mechanisms to deal with major emergencies. These were present before the merger and are currently being updated.

All Trusts were asked about plans to deal with a pandemic outbreak. A pandemic refers to the world-wide spread of a disease. Pandemics of influenza usually happen when a new influenza virus emerges which is different from other influenza viruses, and which has the ability to spread rapidly from person-to-person causing serious illness in a high number of cases. It is not possible to predict when a pandemic of human influenza will occur. The World Health Organisation (WHO) has advised countries around the world that a global pandemic of human influenza could emerge in the near future. Countries are urged to prepare plans to deal with such an eventuality [DHSSPS].

All Trusts recognise the need to have these plans in place and are moving away from a reliance on pre merger documentation. The NIAS has established detailed plans that conform to DHSSPSNI guidelines in emergency situations and has an ambulance specific response system in place for the management of pandemics.

Recommendation 11:

The RQIA recommends HSC Trusts work to produce policies and procedures for emergency planning, in particular dealing with a flu pandemic.

7.3h The organisation has processes to engage with other organisations to reduce local environmental health hazards, as appropriate

All HSC Trusts have systems and processes to reduce environmental health hazards, are familiar with Controls Assurance Standards, and engage with Environmental Health Organisations and Local Councils.

7.3j The organisation has systems to promote a healthier, safer, and “family friendly” workforce by providing advice, training, support and, as appropriate, services to support staff

7.3m The organisation provides opportunities for the use of volunteers, as appropriate

Family friendly workforce and use of volunteers.

All Trusts reported having a range of approaches to promote a safer, family friendly workforce which included flexible working arrangements such as those within the Western Trust. The Southern Trust focuses on health and wellbeing and work life balance policies, while the Northern Trust, through its Human Resources department ensures it is an employer of choice in terms of work life balance. The South Eastern Trust emphasised its "family friendly" policies.

The Belfast Trust showed little evidence of a "family friendly" ethos for their workforce and did not provide, as requested, an example of a family friendly policy. The NIAS has in place "thirteen work/life balance policies" and that up-take among staff is good. However, it would appear that staff induction seems to be the only time that management receive training on these policies, which need to be regularly updated and reviewed.

The use of volunteers within HSC Trusts is regarded by Trusts as an important asset and a valuable source of support for staff, service users and patients. All six Trusts have systems and policies to enable volunteers to apply for this work and to support them in it.

Areas of good practice specifically commented on by the RQIA.

The Belfast Trust currently employs 5 volunteer managers who have a remit for recruiting, training, placing and supporting volunteers within the organisation. The Trust also has a Service Level Agreement with the Voluntary Services Bureau in Belfast for the delivery of volunteering services.

The NIAS has a Memorandum of Understanding (MOU) with voluntary ambulance services and a number of community First Responder Schemes across the province.

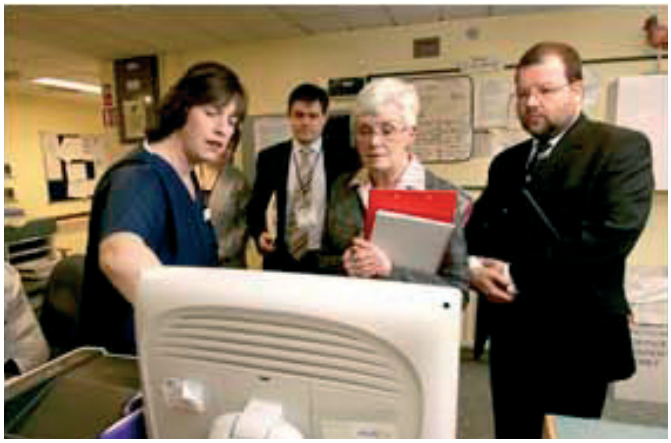
7.3e The organisation promotes ownership by service users, carers and communities to enable service users and the public to take responsibility for their own healthcare and social well-being, and to participate as concerned citizens in promoting the health and social well-being of others.

7.3i The organisation has evidence-based chronic disease management programmes and health promotion programmes and, as appropriate, community development programmes, which take account of local and regional priorities and objectives.

7.3k The organisation has quality assured screening and immunisation programmes in place, as appropriate, and promotes active uptake among service users, carers and the public.

All Trusts are involved in promoting individual responsibility for health, and in chronic disease management. This occurs mainly through existing health improvement, community development and health promotion programmes and in support of "Investing for Health" strategies.

The NIAS promotes responsibility for individual health by supporting and providing advice to those who use the emergency call system. The service is investigating alternative pathways to permit referral of patients to specialist disease management teams, rather than exclusively to A&E Departments.



Five HSC Trusts provide screening and immunisation programmes for service users. These are promoted through a variety of methods such as Health Visiting, GP practices, maternity services and the work of the Health Boards.

The NIAS ensures that all of its staff are appropriately vaccinated and that this arrangement is reviewed as necessary.

7.3f The organisation collects, collates, develops and uses health and social care information to assess current and future needs of local populations, taking account of health and social well-being inequalities.

7.3l The organisation uses annual public health and social care reports in the development of priorities and planning the provision and delivery of services.

Trusts use a range of approaches to assess both the needs and demands of their populations and to provide support for service planning. These include use of information available within the Northern Ireland Statistics and Research Agency (NISRA), Northern Ireland Neighbourhood Information Service (NINIS), Noble Indicators and use of census data for projecting population growth. The NIAS relies on incident data to help with resource deployment decisions at strategic and operational levels.

Trusts use numerous resources to develop priorities in planning for and delivery of services. Examples are reports relating to Public Health and Social Care, commissioner reports within the context of regional and local priorities, user involvement arrangements, the Bamford Review of Mental Health and Trust Delivery Plans and Health and Well Being Plans.

The Regulation and Quality Improvement Authority

Quality Theme 5: Effective communication and information

The DHSSPS Quality Standards Theme 5 states that, "The HPSS communicates and manages information effectively, to meet the needs of the public, service users and carers, the organisation and its staff, partner organisations and other agencies."

There are a total of 12 criteria within this Standard and the Trusts were asked to make a self assessment against these criteria under a Level of Achievement measure as illustrated in the table below.

Code	Level of Achievement	Definition
1	Unlikely to be Achieved	The criterion is unlikely to ever be achieved. (A reason must be stated clearly in the Trust response)
2	Not Achieved	The criterion is likely to be achieved in full but after March 2008. For example, the Trust has only started to develop a policy and implementation will not take place until after March 2008.
3	Partially Achieved	Work has been progressing satisfactorily and the Trust is likely to have achieved the criterion by March 2008. For example, the Trust has developed a policy and will have completed implementation throughout the Trust by March 2008.
4	Substantially Achieved	A significant proportion of action has been completed to ensure the Trust performance is in line with the criterion. For example, a policy has been developed and implemented but a plan to ensure practice is fully embedded has not yet been put in place.
5	Fully Achieved	Action has been completed that ensures the Trust performance is fully in line with the criterion. For example, a policy has been developed, implemented, monitored and an ongoing programme is in place to review its effectiveness.

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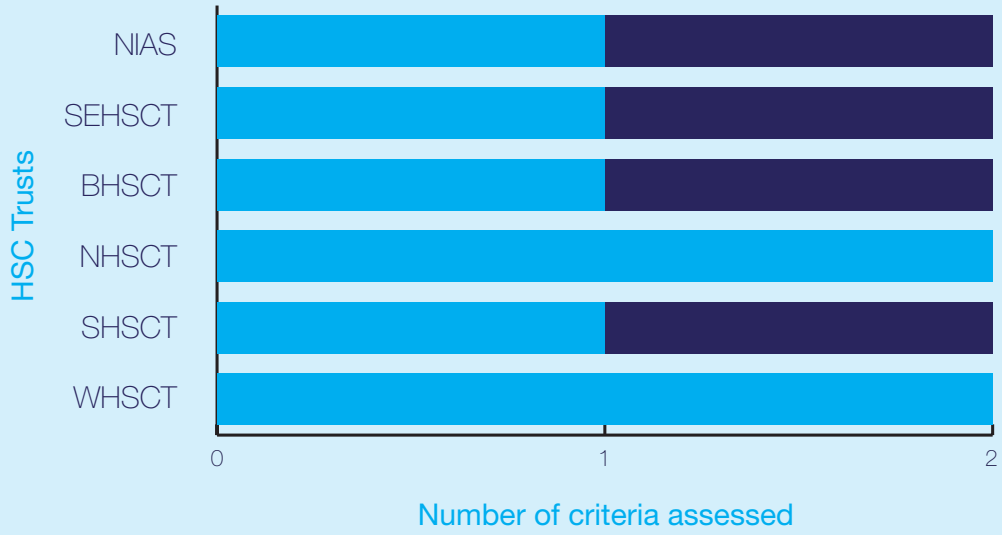
Criteria examined by review team

Quality Theme 5: Effective Communication and Information

Level of Achievement against Quality Theme

- 1- Unlikely to be achieved
- 2 - Not achieved
- 3- Partially achieved
- 4- Substantially achieved
- 5- Fully achieved

Figure 7: Participation of Service Users, Carers and the Public and Effective Training in Communication Criteria



The graph shows Trust self-ratings for two criteria describing involvement of service users and the public as well as delivery of communication training for staff.

The majority indicated a level of partial achievement with four Trust scoring their performance as having 'substantially achieved'.

Information on performance for individual criteria is available within local Trust reports

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The following criterion from Theme 5 regarding the participation of service users, carers and the public, was examined by each review team during the review visits

8.3a The organisation has active participation of service users and carers and the wider public. This includes feedback mechanisms appropriate to the needs of individual service users and the public.

Support for and the engagement of service users, carers and the wider public is important within health and social care organisations, and all HSC Trusts demonstrated involvement in partnerships with the voluntary or community sectors. Trust strategic documents were also used to support this process.

Guidelines have been issued by the DHSSPS to help Trusts develop a strategy in relation to Personal and Public Involvement. The RQIA considered that the NIAS was not proactive in public participation but relied on the goodwill and availability of staff on the ground. There was greater scope for NIAS staff, with their local knowledge to engage with service users but this needed to be supported by Trust senior management.

A range of approaches was used by each of the Trusts that included feedback from partnership groups, workshops, seminars, complaints systems, user forums and meetings. However, there is a lack of a strategic approach in how feedback is achieved and used by Trusts.

Recommendation 12:

The RQIA recommends that HSC Trusts make greater use of partners such as GP forums, the community and voluntary sector and service users in obtaining feedback about services.

Areas of good practice specifically commented on by the RQIA.

In the South Eastern Trust the Podiatry Department in Bangor Community Hospital had created a focus group of stakeholders that had helped to develop a new assessment process. The project had resulted in better foot care, including the provision of more suitable foot wear, for residents of 43 homes.

In the Northern HSC Trust diabetic outpatient clinic, through holding monthly meetings with user representatives additional clinics were secured for patients.

In the Kilkeel area the NIAS actively participated in a committee consisting of health care professionals, SHSSB and representatives from the local community, formed to investigate ways of working together to provide better services in the area. The outcome was the provision of doctor out of hours sessions in Kilkeel health centre. There was also significant investment in a new ambulance station in Kilkeel.

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8.3g The organisation has effective training for staff on how to communicate with service users and carers, and where needed, the public and the media

The RQIA found that all Trusts are involved in the delivery of training to staff on how to communicate with service users, but these arrangements are at varying stages of development. Some training plans are readily available, such as those in the NIAS and South Eastern Trust, while others are still being developed.

Trusts address the use of communication skills through staff induction, annual training needs analysis, supervision and appraisal processes. The RQIA was positive about the services they reviewed and the information they received from service users regarding the effectiveness of communication. The RQIA was particularly impressed with the dignity and respect with which NIAS front line staff treated service users.

The RQIA identified some training issues which included unequal access in certain areas within the South Eastern Trust and also gaps within the NIAS, where staff who were interested in receiving training in dealing with stressful situations (such as the sudden death of psychiatric patients) were unable to access suitable training.

Media training is available within HSC Trusts and this is targeted at senior staff or those who are likely to require it.

Recommendation 13:

The RQIA recommends that HSC Trusts develop:
- **methods to evaluate the effectiveness of communications training for staff**
- **a strategy on media training where applicable.**

Areas of good practice specifically commented on by the RQIA.

The Regional Ambulance Training Centre has developed links with a number of national bodies representing patients with special communication needs, for example The Royal National Institute for the Deaf. Through these links trainers have delivered training to NIAS staff enabling them to communicate better with this particular group of service users.

RQIA commentary on the Trusts' self-assessed levels of achievement

This area showed greatest consistency between Trust self- assessed level of achievement and that found by the RQIA.

The Regulation and Quality Improvement Authority

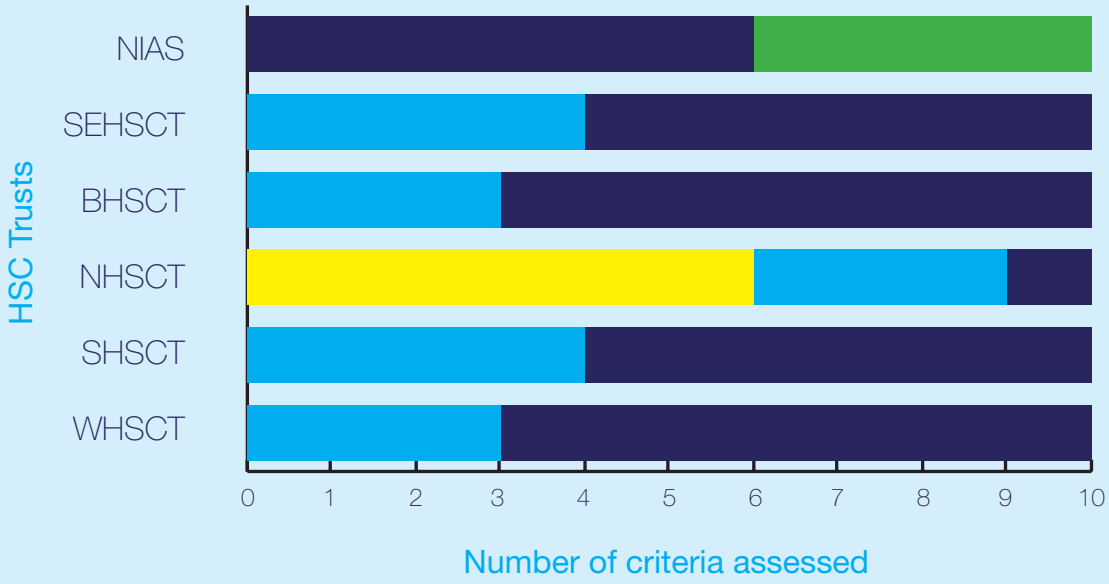
Criteria examined through HSC Trust self-assessment

Quality Theme 5: Effective Communication and Information

Level of Achievement against Quality Theme

- 1- Unlikely to be achieved
- 2 - Not achieved
- 3- Partially achieved
- 4- Substantially achieved
- 5- Fully achieved

Figure 8: Trust Strategies, Systems, Principles, Policies and Procedures Criteria



The Graph above shows HSC Trust self-rating for 10 criteria in having in place effective systems, strategies and policies.

The majority self-rated as having substantially achieved in relation to this.

The Northern Ireland Ambulance Service [NIAS] has self-rated 4 criteria as having been fully achieved, having in place effective and integrated information technology systems for urgent communications, procedures for valid consent and complaints systems.

The Northern HSC Trust rated 6 criteria as having not been achieved. These relate to communication and information strategies and principles, procedures for protection of service user and carer information, consent and complaints procedures and published up to date information about services.

8.3b The organisation has an effective information strategy and communication strategy, appropriate to the needs of the public, service users and carers, staff and the size, functions and complexity of the organisation.

8.3c The organisation has effective and integrated information technology and information systems which support and enhance the quality and safety of care and provision of services.

8.3d The organisation has systems and processes in place to ensure that urgent communications, safety alerts and notices, standards and good practice guidance are made available in a timely manner to relevant staff and partner organisations; these are monitored to ensure effectiveness.

Effective communication and information strategies are important to the smooth running of all organisations. There is an explicit commitment by Trusts to develop relevant strategies and all are at varying stages in this process in terms of draft documents and action plans.

All Trusts are developing, or already have in place a Safety Alert Broadcast System (SABS) and they also comply with guidance issued by the Northern Ireland Adverse Incident Centre. The Northern Trust uses a manual system for communication but is planning to introduce an electronic system in this current financial year.

Recommendation 14:

The RQIA recommends that HSC Trusts develop systems and strategies to promote effective communication and information sharing.

8.3e The organisation has clear communication principles for staff and service users, which include:

- openness and honesty;
- use of appropriate language and diversity in methods of communication;
- sensitivity and understanding;
- effective listening; and
- provision of feedback.

8.3f The organisation has clear information principles for staff and service users, which include:

- person-centred information;
- integration of systems;
- delivery of management information from operational systems;
- security and confidentiality of information; and
- sharing of information across the HPSS, as appropriate.

The principles of communication and information are incorporated within all relevant Trust strategies and form part of their core work in communicating with staff and service users. These principles are included in, for example, Trust corporate vision statements, codes of conduct and policy and procedure documents. The RQIA found appropriate use of communication and information principles through discussions and submitted documentation.

8.3h The organisation has effective records management policies and procedures covering access and the completion, use, storage, retrieval and safe disposal of records, which it monitors to assure compliance and takes account of Freedom of Information legislation.

All Trusts, affected by the Review of Public Administration (RPA), with the exception of the NIAS, have not updated all policies since Trusts were merged.

A records management strategy is in place in the Southern Trust and within the Belfast Trust an information governance group has been formed to direct this process. In the NIAS there are policies for the management of specific documents.

Trusts acknowledge there is still work to be done in developing new policies regarding records management.

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Recommendation 15:

The RQIA recommends that HSC Trusts:
- **develop new records management policies**
- **update all polices not reviewed following the merger of Trusts**
- **develop a system to ensure staff are aware of the content of all relevant policies.**

8.3i The organisation has procedures for protection of service user and carer information which include the timely sharing of information with other professionals, teams and partner organisations as appropriate, to ensure safe and effective provision of care, treatment and services, e.g. in relation to the protection of children or vulnerable adults, and the safe and efficient discharge of individuals from hospital care.

All Trusts have policies and procedures in place to manage the protection of service user and carer information and to promote "best practice" however these are often still in draft .

A number of methods are used to ensure that good protection measures are being used such as adherence to CREST guidelines and the use of POCVA checking systems as well as other systems to ensure patient confidentiality.

8.3j The organisation has effective and efficient procedures for obtaining valid consent for examination, treatment and/or care.

Effective consent processes are important to protect patients and all Trusts reported that they operate within these processes. Within the Trusts there are regional consent forms and information leaflets and work is being carried out to review consent issues, to update existing policies and procedures and provide training in relation to these. The NIAS use the National Clinical Guidelines on Consent issued by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).

8.3k The organisation has an effective complaints and representation procedure and feedback arrangements, which is made available to service users, carers and staff and which is used to inform and improve care, treatment and service delivery.

Complaints are important in helping to` reduce poor or ineffective practices. Five HSC Trusts operate using policies which have not been updated since the merger of Trusts. The NIAS already has a well established complaints mechanism and operates under a "lessons learned" system, which is also being applied in the Southern Trust. This enables amendments to be made to existing systems.

In addition to the complaints system, other approaches for service user feedback include satisfaction surveys, service user and patient forums, complaints review groups or service user feedback committees. The Northern Trust was highlighted by the RQIA as having an over reliance on their complaints system to the detriment of other options.

The Regulation and Quality Improvement Authority

Recommendation 16:

The RQIA recommends that HSC Trusts:

- **ensure they have an up to date complaints policy in place**
- **have a system to enable staff to learn from complaints**
- **ensure that all staff are able to deal with complaints**
- **ensure that service users are provided with feedback from their complaint**

8.3l The organisation has a range of published up-to-date information about services, conditions, treatment, care and support options available, and how to access them both in and out of service hours, which are subject to regular audit and review.

All Trusts provide up to date published information and use a variety of methods to communicate with staff and service users. These range from a Trust website and patient information leaflets to the use of annual reports. In addition, there are service user forums and representatives who contribute to working groups that assist with the production of a range of published information.

The Western Trust is in the process of reviewing the range of information it publishes and this will be subject to regular review and audit.

The Regulation and Quality Improvement Authority

Appendix 1 - Summary of key recommendations

Theme 3 - Accessible, Flexible, Responsive Services

Recommendation 1:
The RQIA recommends that HSC Trusts ensure increased involvement from staff, service users, the voluntary and community sectors and other relevant stakeholders in the Trust Delivery Plan.

Recommendation 2:
The RQIA recommends that HSC Trusts ensure the use of single sex accommodation and also prevent the use of shared hospital accommodation between children and adults.

Recommendation 3:
The RQIA recommends that HSC Trusts provide dedicated rooms to be used for patients and relatives to discuss and receive confidential information.

Recommendation 4:
The RQIA recommends that HSC Trusts provide dedicated advocacy services in all Trust directorates.

Recommendation 5:
The RQIA recommends that HSC Trusts provide interpreting services across all areas. Trusts should ensure that staff and service users are provided with information on how to access these services.

Recommendation 6:
The RQIA recommends that HSC Trusts put in place a single consent policy, in line with regional guidance which includes staff training and regular review.

Recommendation 7:
The RQIA recommends that HSC Trusts develop:

- a policy, supported by staff training to ensure that all patient information transmitted between health care professionals remains confidential
- regular monitoring and auditing of the process.

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Theme 4 - Promoting, Protecting and Improving Health and Social Wellbeing

Recommendation 8:
The RQIA recommends that HSC Trusts develop more structured partnership arrangements within organisations to reduce health inequalities and promote health and wellbeing. Staff should be aware of relevant strategies and ongoing work in this area.

Recommendation 9:
The RQIA recommends that HSC Trusts should ensure full implementation of DHSSPS PPI Guidance.

Recommendation 10:
The RQIA recommends that HSC Trusts should have systems in place to ensure compliance with relevant Human Rights and Equality Legislation.

Recommendation 11:
The RQIA recommends that HSC Trusts work to produce policies and procedures for emergency planning, in particular dealing with a flu pandemic.

Theme 5 - Effective Communication and Information

Recommendation 12:
The RQIA recommends that HSC Trusts make greater use of partners such as GP forums, the community and voluntary sector and service users, in obtaining feedback about services.

Recommendation 13:
The RQIA recommends that HSC Trusts develop:
- methods to evaluate the effectiveness of communications training for staff
- a strategy on media training where applicable.

Recommendation 14:
The RQIA recommends that HSC Trusts develop systems and strategies to promote effective communication and information sharing.

Recommendation 15:
The RQIA recommends that HSC Trusts:
- develop new records management policies
- update all policies not reviewed following the mergers of Trusts
- develop a system to ensure staff are aware of the content of all relevant policies.

Recommendation 16:
The RQIA recommends that HSC Trusts:
- ensure they have an up to date complaints policy in place
- have a system to enable staff to learn from complaints
- ensure that all staff are able to deal with complaints
- ensure that there are robust processes in place on an area wide basis so that service users are provided with feedback in relation to their complaint.

The Regulation and Quality Improvement Authority

Appendix 2 - Summary of areas of good practice identified during the review

Theme 3 - Accessible, Flexible, Responsive Services

Areas of good practice specifically commented on by the RQIA.

Within the NIAS, there is an increased weekend service to renal patients in Altnagelvin hospital which is a direct result of patient and provider engagement. In this instance the NIAS responded to unmet need, without requiring high levels of additional resource.

In the Southern Trust, the RQIA welcomed the involvement of frontline practitioners in planning as this provided a different perspective on the challenges to be addressed. the RQIA also noted that there were benefits in moving away from consultation exercises towards longer term engagement processes.

The breast screening unit in the Southern Trust and the endoscopy unit in the Western Trust provide modesty clothing and an innovative funding approach provides a relatives room within the A&E Department in Altnagelvin Hospital.

Antrim Hospital, in the Northern HSC Trust provides a “meet and greet” service for patients. Volunteers also escort patients within the hospital and offer a befriending service for those patients who have no relatives or no visitors.

In the Southern HSC Trust, in both the Diabetic Service and Mandeville Cancer Unit, service users are able to address any concerns to named contact nurses, and both services offer a 24 hour advice line. The RQIA felt that these were valuable initiatives that could be used in other services across the Trust.

In the Southern HSC Trust, patients admitted to hospital have their medicines put into a "green bag" which makes sharing information about their medicines history easier. The review team felt this scheme had excellent potential to be used regionally.

Both in the NIAS and the endoscopy unit in Altnagelvin Hospital in the Western HSC Trust, there is a policy allowing patients the option of withdrawing their consent for a procedure.

In the Oncology Unit at the Ulster Hospital, nursing staff have a mentoring programme for a minimum of one year. This ensures that staff have sufficient knowledge to provide a patient with adequate information about their treatment and care.

In the Ulster Hospital in the South Eastern Trust, an Outpatient Department has developed a 'green sheet' that is used to record information given to and discussed with patients. Recording discussions in this way has ensured greater continuity and consistency of use of patient information making informed consent easier.

In the Southern Trust, the RQIA welcomed the involvement of frontline practitioners in planning as this provided a different perspective on the challenges to be addressed . The RQIA noted the benefits of moving away from purely consultation exercises towards longer term engagement processes.

In the South Eastern Trust, the RQIA noted that Local Councils and committees help to identify local health and social care needs, aiding service planning processes.

Within the South Eastern Trust, there is a "green sheet" to record information already given to and discussed with patients. This is used to avoid the need for repetition.

Within the NIAS, patient specific information is recorded by NIAS staff on a Patient Report Form that is then given to the receiving hospital, to reduce the need for the patient to restate personal information.

Theme 4 - Promoting, Protecting and Improving Health and Social Wellbeing

In the Western HSC Trust there is evidence of integration of health improvement across the Trust with champions and sub groups in each Directorate. Feedback systems are in place to record issues and complaints raised by users and others and this information is used to identify trends and help with both essential learning and staff training initiatives.

In the Northern HSC Trust the review team thought that the development of a Disability Consultation Panel was a good example of social inclusion. This group had produced a development plan and had presented an action plan to the Trust Board to help with access to services for people with a disability. This had been endorsed and linked into various directorates within the Trust.

In the Northern HSC Trust, the Equality Manager described a meeting between the Chinese Welfare Association and the Assistant Director of Mental Health. This had led to Approved Social Workers being trained in the use of interpreting services to aid completion of mental health assessments.

The Belfast Trust currently employs 5 volunteer managers who have a remit for recruiting, training, placing and supporting volunteers within the organisation. The Trust also has a Service Level Agreement with the Voluntary Services Bureau in Belfast for the delivery of volunteering services.

The NIAS has a Memorandum of Understanding (MOU) with voluntary ambulance services and a number of community First Responder Schemes across the province

The Regulation and Quality Improvement Authority

Theme 5 - Effective Communication and Information

In the South Eastern Trust the Podiatry Department in Bangor Community Hospital had created a focus group of stakeholders that had helped to develop a new assessment process. The project had resulted in better foot care, including the provision of more suitable footwear, for residents of 43 homes.

In the Northern HSC Trust diabetic outpatient clinic, through holding monthly meetings with user representatives additional clinics were secured for patients.

In the Kilkeel area the NIAS actively participated in a committee consisting of health care professionals, SHSSB and representatives from the local community, formed to investigate ways of working together to provide better services in the area. The outcome was the provision of doctor out of hours sessions in Kilkeel health centre. There was also significant investment in a new ambulance station in Kilkeel.

The Regional Ambulance Training Centre has developed links with a number of national bodies representing patients with special communication needs, for example The Royal National Institute for the Deaf. Through these links trainers have delivered training to NIAS staff enabling them to communicate better with this particular group of service users.

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Appendix 3 - Glossary of terms and abbreviations

Term	Definition
Accountability	The state of being answerable for one's decisions and actions. Accountability cannot be delegated.
Advocate	One who enables the views of an individual to be represented.
Appraisal	Examination of people or the services they provide in order to judge their professional qualities, successes or needs.
Audit	The process of measuring the quality of services against explicit standards.
Clinical record	The record of all aspects of the patient's treatment, otherwise known as the patients notes.
Clinical and Social Care Governance (CSCG)	A framework within which HSC is accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.
Consultant	Medical or dental practitioner who works independently without supervision.
DHSSPS	Department of Health Social Services and Public Safety.
Essence of Care	Patient-focused benchmarking for health care practitioners designed to support the measures to improve quality.
HSC Trust	Health and Social Care Trust. An organisation which provides health and social care e.g. a Trust providing hospital and community services.
Informed consent	The legal principle by which a patient is informed about the nature, purpose and likely effects of any treatment proposed before being asked to consent to accepting it.

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MDEA	Medical Device/Equipment Alert. These are distributed to HSS Boards, Trusts, and Agencies for direct action and for onward transmission were appropriate in accordance with local procedures.
NIAS	Northern Ireland Ambulance Service. A regional service managing ambulance, patient transport and communication services provided from ambulance control centres.
Organisational structure	A graphical representation of the structure of the organisation including areas of responsibility, relationships and formal lines of communication and accountability.
Patient records	The record of all aspects of the patient's treatment, otherwise known as the patients notes.
Review of Public Administration (RPA)	Northern Ireland is currently undergoing a major reform programme which aims to rationalise the number of local authorities and public bodies within the region. This reform programme is known as the Review of Public Administration

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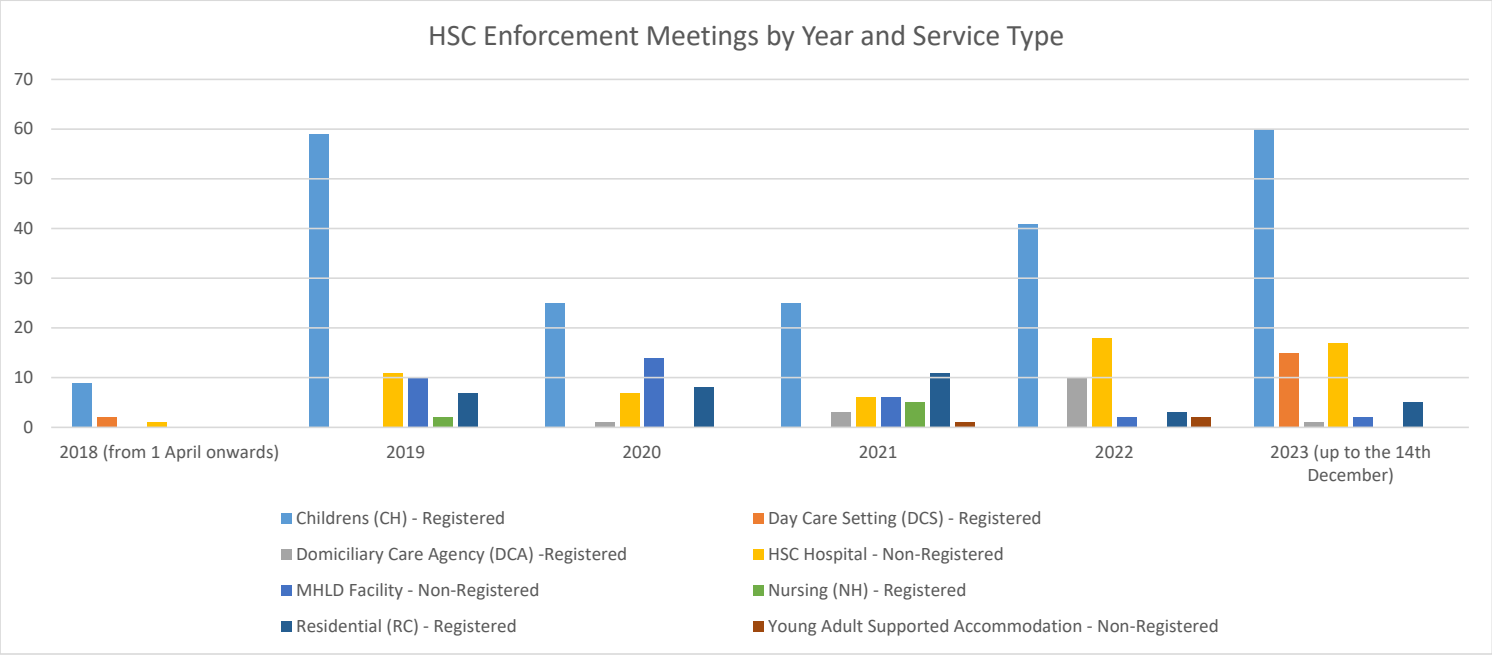
All HSC Trust Enforcement Meetings 01.04.2018 - 14.12.2023

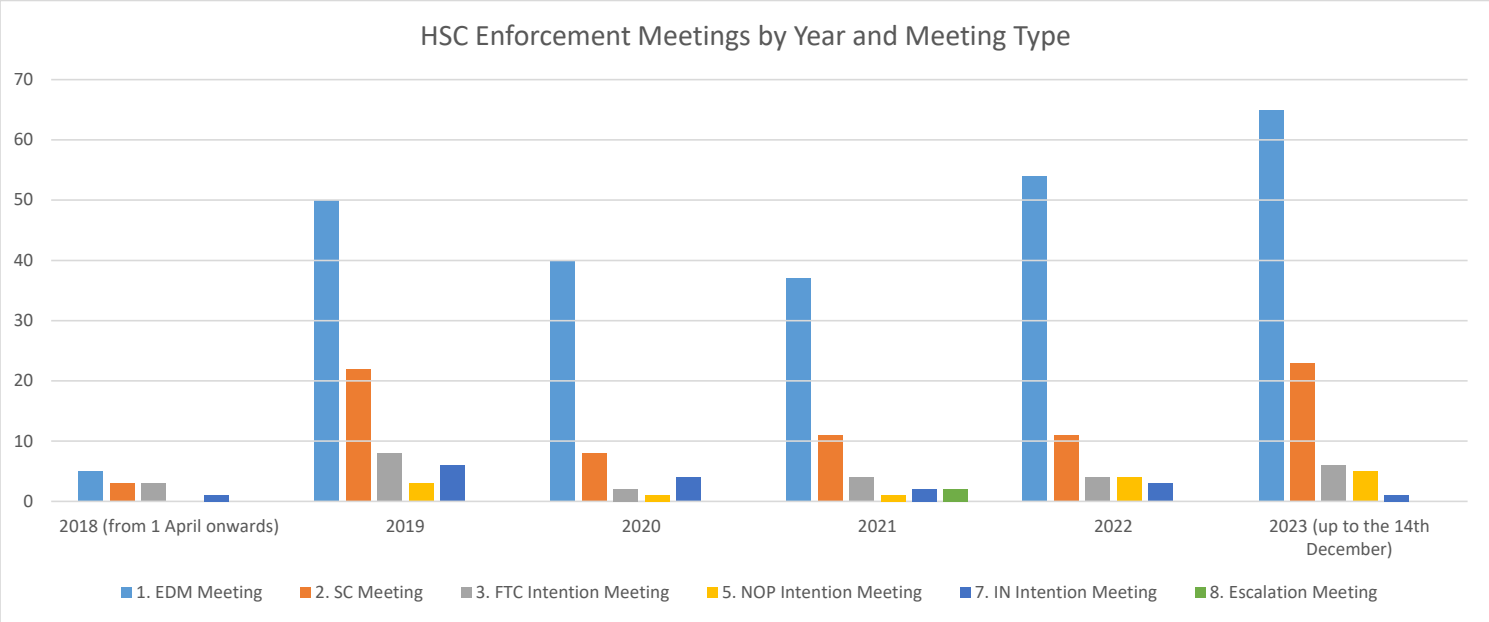
Year	Childrens (CH) - Registered	Day Care Setting (DCS) - Registered	Domiciliary Care Agency (DCA) - Registered	HSC Hospital - Non-Registered	MHLD Facility - Non-Registered	Nursing (NH) - Registered	Residential (RC) - Registered	Young Adult Supported Accommodation - Non-Registered	Grand Total
2018 (from 1 April onwards)	9	2		1					12
2019	59			11	10	2	7		89
2020	25		1	7	14		8		55
2021	25		3	6	6	5	11	1	57
2022	41		10	18	2		3	2	76
2023 (up to the 14th December)	60	15	1	17	2		5		100
Grand Total	**219**	**17**	**15**	**60**	**34**	**7**	**34**	**3**	**389**



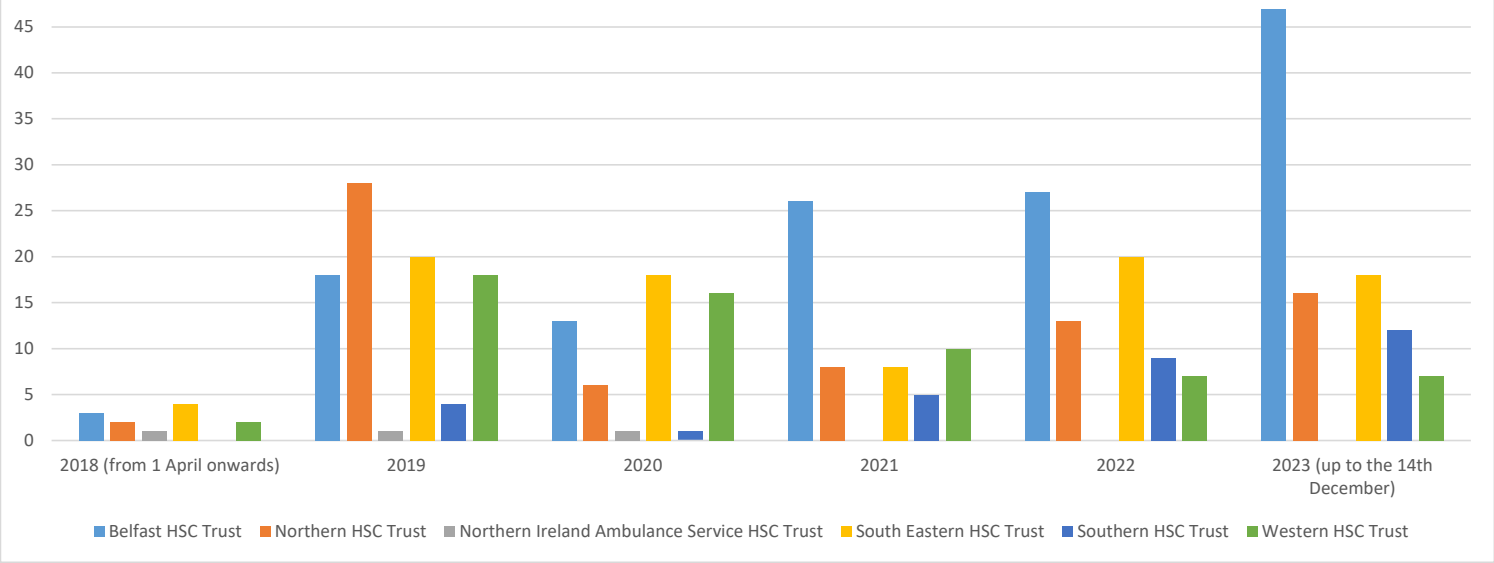
Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	8. Escalation M	Grand Total
2018 (from 1 April onwards)	5	3	3		1		12
2019	50	22	8	3	6		89

Received from Briege Donaghy 15/01/2024. Annotated by the Urology Services Inquiry.

2020	40	8	2	1	4		55
2021	37	11	4	1	2	2	57
2022	54	11	4	4	3		76
2023 (up to the 14th December)	65	23	6	5	1		100
Grand Total	**251**	**78**	**27**	**14**	**17**	**2**	**389**



Year	Belfast HSC Trust	Northern HSC Trust	Northern Ireland Ambulance Service HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Grand Total
2018 (from 1 April onwards)	3	2	1	4		2	12
2019	18	28	1	20	4	18	89
2020	13	6	1	18	1	16	55
2021	26	8		8	5	10	57
2022	27	13		20	9	7	76
2023 (up to the 14th December)	47	16		18	12	7	100
Grand Total	**134**	**73**	**3**	**88**	**31**	**60**	**389**



Lead Inspector	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	8. Escalation M	Grand Total
Personal Information redacted by the USI	4			1	5		10
	3	2					5
	5	1					6
	6		4	2			12
	2	1	1				4
	1	1					2
	1	1					2
	12	5					17
	7	1					8
	1	1					2
	4	2	2				8
	2				1		3
	1	1					2
	1						1
	5	1	1	1			8
	2	1					3
	6	4			1		11
	3				1	2	6
	40	13	3	4	2		62
	10	3	1		2		16
	2						2

Personal Information redacted by the USI								
		2						2
		1						1
		4						4
		1						1
		1						1
		1						1
		2	1	1				4
		2	1					3
		5	2					7
		8	2					10
		1	1					2
		32	10		4	2		48
		6						6
		2						2
		22	8	7	1	1		39
		2						2
		3	2	2				7
		4	1					5
		22	6	3	1	1		33
		3	2			1		6
		4		1				5
		3	1	1				5
		2	3					5
Grand Total		**251**	**78**	**27**	**14**	**17**	**2**	**389**

Meeting Outcome	**1. EDM Meeting**	**2. SC Meeting**	**3. FTC Intention Mee**	**5. NOP Intention M**	**7. IN Intention I**	**8. Escalation M**	**Grand Total**
01-No Further Enforcement Action	43	38	9	2	6		98
02-Monitoring Inspection Planned	10	8			2		20
03-Schedule SC Meeting	58						58
04-Issue IN Notice/s					7		7
05-Schedule FTC Intention Meeting	17						17
06-Schedule NOP Intention Meeting	7						7
07-Schedule EDM Meeting		2					2
08. Schedule IN Meeting	12						12
09-FTC Issued			9				9
10-NOP Issued				8			8
12-Extend FTC Notices/s	4						4
13-Extend IN Notice/s	3						3
14-NOP Notice/s Lifted	3						3
15-NOD Notice/s Confirmed	3						3
16-Make Application for UO	1						1

17-DMP Meeting Required	1						1
22. Other, Refer to Meeting Notes	70	23	6	2	1		102
23. Escalation: Action Plan Required						2	2
(blank)	19	7	3	2	1		
Grand Total	**251**	**78**	**27**	**14**	**17**	**2**	**389**

Belfast HSC Trust

Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	Grand Total
2018 (from 1 April onwards)	1	1	1			3
2019	10	2	1	1	4	18
2020	10	2	1			13
2021	16	5	4		1	26
2022	20	3	1	2	1	27
2023 (up to the 14th December)	31	12	1	3		47
Grand Total	**88**	**25**	**9**	**6**	**6**	**134**

Northern HSC Trust

Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	Grand Total
2018 (from 1 April onwards)	1	1				2
2019	15	8	3	1	1	28
2020	5	1				6
2021	6	1			1	8
2022	9	2		2		13
2023 (up to the 14th December)	10	3	1	1	1	16
Grand Total	**46**	**16**	**4**	**4**	**3**	**73**

Northern Ireland Ambulance Service HSC Trust

Year	1. EDM Meeting	2. SC Meeting	7. IN Intention Meeti	Grand Total
2018 (from 1 April onwards)			1	1
2019		1		1
2020	1			1
2021				0
2022				0
2023 (up to the 14th December)				0
Grand Total	**1**	**1**	**1**	**3**

South Eastern HSC Trust

Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	Grand Total
2018 (from 1 April onwards)	2	1	1			4
2019	13	3	3	1		20
2020	11	3			4	18
2021	5	2		1		8
2022	15	3	2			20
2023 (up to the 14th December)	11	5	2			18
Grand Total	**57**	**17**	**8**	**2**	**4**	**88**

Southern HSC Trust

Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	Grand Total
2018 (from 1 April onwards)				
2019	3	1		4
2020	1			1
2021	3	2		5
2022	5	3	1	9
2023 (up to the 14th December)	10		2	12
Grand Total	**22**	**6**	**3**	**31**

Western HSC Trust

Year	1. EDM Meeting	2. SC Meeting	3. FTC Intention Mee	5. NOP Intention M	7. IN Intention I	8. Escalation M	Grand Total
2018 (from 1 April onwards)	1		1				2
2019	9	7	1		1		18
2020	12	2	1	1			16
2021	7	1				2	10
2022	5				2		7
2023 (up to the 14th December)	3	3		1			7
Grand Total	**37**	**13**	**3**	**2**	**3**	**2**	**60**

Meeting Number	Type (Enforcement/ Escalat on) (Enforcement/ Escalat on)	Status Reason	Enforcement/Escalation	Service (Enforcement/Escalation) (Enforcement/Escalation)	Service Type (Service) (RQIA Service)	Registration Status	Prov der (HSC Trust)	Meeting End Date	Meeting Type	Issue Type	Meeting Outcome	13. Final Sign Off Deadline	Created On	01. Notes Due by Note Taker	03. Notes Completed By Note Taker	Hyperlink to Parent Enforcement Record
EM001444	Enforcement	Inactive	Personal Information redacted by the USI			Registered	Southern HSC Trust	02/10/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	24/10/2023	02/10/2023 13:08	07/10/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001319	Enforcement	Inactive				Registered	Southern HSC Trust	12/06/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	04/07/2023	13/06/2023 11:06	17/06/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000940	Enforcement	Active				Registered	Southern HSC Trust	27/01/2022	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	18/02/2022	18/01/2022 15:32	01/02/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000939	Enforcement	Active				Registered	Southern HSC Trust	17/01/2022	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	08/02/2022	17/01/2022 12:11	22/01/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000227	Enforcement	Inactive				Registered	Southern HSC Trust	14/05/2019	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	05/06/2019	14/05/2019 11:35	19/05/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000184	Enforcement	Inactive				Registered	Southern HSC Trust	28/03/2019	2. SC Meeting	1. Care Issues	02-Monitoring Inspection Planned	19/04/2019	25/03/2019 14:55	02/04/2019	02/04/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000177	Enforcement	Active				Registered	Southern HSC Trust	22/03/2019	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	13/04/2019	21/03/2019 13:10	27/03/2019		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000548	Escalation	Inactive				Non-Registered	Southern HSC Trust	30/07/2020	1. EDM Meeting	5. Other	01-No Further Enforcement Action	21/08/2020	04/08/2020 09:30	04/08/2020		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001379	Enforcement	Active				Registered	Southern HSC Trust	04/08/2023	1. EDM Meeting	1. Care Issues		26/08/2023	04/08/2023 15:01	09/08/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000867	Escalation	Active				Non-Registered	Southern HSC Trust	01/10/2021	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	23/10/2021	05/10/2021 14:45	06/10/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001509	Enforcement	Active				Registered	Southern HSC Trust	27/11/2023	3. FTC Intention Meeting	1. Care Issues		19/12/2023	11/12/2023 13:24	02/12/2023	11/12/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001481	Enforcement	Inactive				Registered	Southern HSC Trust	10/11/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	02/12/2023	09/11/2023 13:41	15/11/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001137	Enforcement	Active				Registered	Southern HSC Trust	05/10/2022	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	27/10/2022	29/09/2022 10:57	10/10/2022	11/10/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001130	Enforcement	Active				Registered	Southern HSC Trust	22/09/2022	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	14/10/2022	23/09/2022 10:36	27/09/2022		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001109	Enforcement	Active				Registered	Southern HSC Trust	09/09/2022	2. SC Meeting	5. Other	22. Other, Refer to Meeting Notes	01/10/2022	06/09/2022 15:47	14/09/2022	14/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001105	Enforcement	Active				Registered	Southern HSC Trust	02/09/2022	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	24/09/2022	05/09/2022 09:42	07/09/2022	05/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001313	Enforcement	Active				Registered	Southern HSC Trust	07/06/2023	1. EDM Meeting	3. Finance Issues	01-No Further Enforcement Action	29/06/2023	07/06/2023 09:40	12/06/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001133	Enforcement	Active				Registered	Southern HSC Trust	10/10/2022	1. EDM Meeting	3. Finance Issues	22. Other, Refer to Meeting Notes	25/10/2022	27/09/2022 15:22	08/10/2022	13/10/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001124	Enforcement	Inactive				Registered	Southern HSC Trust	23/09/2022	3. FTC Intention Meeting	1. Care Issues	01-No Further Enforcement Action	15/10/2022	16/09/2022 12:52	28/09/2022	27/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001116	Enforcement	Inactive				Registered	Southern HSC Trust	13/09/2022	1. EDM Meeting	5. Other	05-Schedule FTC Intention Meeting	05/10/2022	09/09/2022 16:13	18/09/2022	13/09/2022	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000721	Enforcement	Inactive				Registered	Southern HSC Trust	22/04/2021	2. SC Meeting	1. Care Issues	01-No Further Enforcement Action	14/05/2021	16/04/2021 14:39	27/04/2021	27/04/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000719	Enforcement	Inactive				Registered	Southern HSC Trust	12/04/2021	1. EDM Meeting	1. Care Issues	03-Schedule SC Meeting	07/05/2021	08/04/2021 15:09	20/04/2021	12/04/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001294	Enforcement	Active				Non-Registered	Southern HSC Trust	17/05/2023	1. EDM Meeting	1. Care Issues	22. Other, Refer to Meeting Notes	08/06/2023	19/05/2023 08:54	22/05/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001496	Enforcement	Inactive				Registered	Southern HSC Trust	20/11/2023	3. FTC Intention Meeting	1. Care Issues	01-No Further Enforcement Action	12/12/2023	20/11/2023 16:15	25/11/2023	24/11/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001477	Enforcement	Inactive				Registered	Southern HSC Trust	30/10/2023	1. EDM Meeting	1. Care Issues		21/11/2023	06/11/2023 13:54	04/11/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001312	Enforcement	Inactive				Registered	Southern HSC Trust	04/04/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	26/04/2023	06/06/2023 12:15	09/04/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001376	Enforcement	Active				Non-Registered	Southern HSC Trust	02/08/2023	1. EDM Meeting	1. Care Issues	02-Monitoring Inspection Planned	24/08/2023	02/08/2023 14:53	07/08/2023		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM001248	Enforcement	Active				Non-Registered	Southern HSC Trust	20/03/2023	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	11/04/2023	23/03/2023 09:43	25/03/2023	20/03/2023	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000765	Enforcement	Active				Registered	Southern HSC Trust	28/05/2021	2. SC Meeting	5. Other	01-No Further Enforcement Action	19/06/2021	26/05/2021 12:39	02/06/2021	02/06/2021	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000763	Enforcement	Active				Registered	Southern HSC Trust	26/05/2021	1. EDM Meeting	5. Other	03-Schedule SC Meeting	17/06/2021	25/05/2021 17:35	31/05/2021		https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e
EM000225	Enforcement	Inactive				Registered	Southern HSC Trust	10/05/2019	1. EDM Meeting	1. Care Issues	01-No Further Enforcement Action	01/06/2019	10/05/2019 20:59	15/05/2019	10/05/2019	https://iconnect.hscni.net/RQIA/main.aspx?etc=10038&e

Hospital Inspection Programme

Background

Final Draft

September 2020

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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Note: Refer to RQIA Version Control Policy and Guidelines for Electronic Documents

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Development of RQIA and the Hospital Inspection Programme

Purpose of this paper

1. This paper outlines the evolution of the Hospital Inspection Programme, with the purpose of informing discussion with colleagues in Department of Health (DoH) regarding modernisation and strategic direction of the programme going forward. It is hoped RQIA will reach agreement with the DoH on areas of priority for assurance, acknowledging existing resources and constraints.

Background

2. The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003[1] (herein the Order) created the legal framework for raising the quality of health and social care services in Northern Ireland, and extended regulation and quality improvement to a wide range of services.

Clinical and Social Care Governance

3. Based on one of the key proposals in the policy framework which preceded the Order (Best Practice, Best Care, 2002), Article 34 of the Order[2] created a statutory obligation on (what were) HPSS Boards and HPSS Trusts to "put and keep in place arrangements for the purpose of monitoring and improving the quality of health and personal services which it provided to individuals; and the environment in which it provides them"[3] i.e. a system of clinical and social care governance.

4. Clinical and social care governance is described as a framework within which Health and Social Care (HSC) organisations can demonstrate their accountability for continuous improvement in the quality of services and for safeguarding high standards of care and treatment. Organisations must ensure that there are visible and rigorous structures, processes, roles and

responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care.

5. The 2006 Quality Standards for Health and Social Care[4] underpin the duty of quality on the HSC Board and HSC Trusts. They complement standards and other guidelines already in use by organisations and give a measure against which organisations can assess themselves and demonstrate improvement.

6. The 2006 Quality Standards are made up of five quality themes:

- Corporate leadership and accountability of organisations;
- Safe and effective care;
- Accessible, flexible and responsive services;
- Promoting, protecting and improving health and social well-being; and
- Effective communication and information.

Duties of RQIA

7. RQIA has two general duties under the Order:

- To keep the DoH informed about the provision, availability and quality of health and social care services; and
- To promote improvement in the quality of health and social care services.

Article 35[5] lists the functions RQIA may undertake in respect of keeping the DoH informed as to the quality and availability of services provided by the HSC. This is the mechanism that provides independent scrutiny of the Board's and Trusts' systems of clinical and social care governance.

8. Article 35 states[6]: the Regulation and Improvement Authority shall have the following functions-
    - Conducting reviews of, and making reports on, arrangements by statutory bodies for the purpose of monitoring and improving the quality of the health and personal social services for which they have responsibility;
    - Carrying out investigations into, and making reports on, the management, provision of quality of the health and personal social services, for which statutory bodies or services providers have responsibility;
    - Conducting reviews of and making reports on the management, provision or quality of, or access to or availability of, particular types of health and personal social services for which statutory bodies or service providers have responsibility;
    - Carrying out inspections of statutory bodies and service providers, and persons who provide or are to provide services for which such bodies or providers have responsibility and making reports on the inspections; and
    - Such function as may be prescribed relating to the management, provision or quality of, or access to or availability of, services for which prescribed statutory bodies or prescribed service providers have responsibility.

It is according to these functions the RQIA conducts its duties.

Inspection of HSC Hospitals

9. HSC Trusts are not - of themselves - regulated in Northern Ireland. Some Trusts provide regulated services such as children's homes and are registered and inspected as providers of these specific services; but unlike in England, there is no requirement for Trusts as general providers of acute and community care to register with and be inspected by RQIA. However, RQIA has been instructed by Ministers to undertake a number of inspection programmes or aspects of HSC hospital provision.

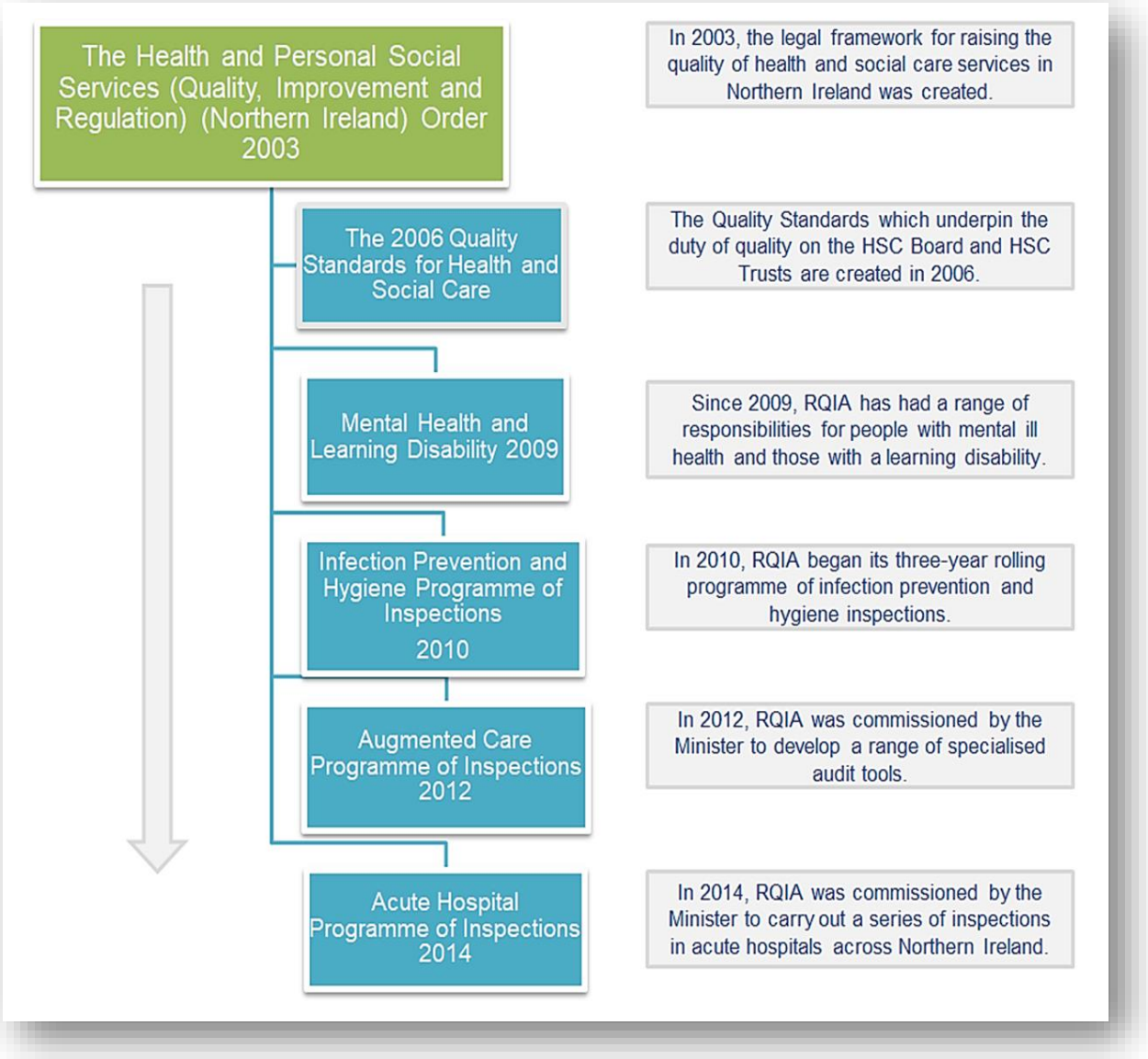
Hospital Programme Team

10. HSC hospitals are conducted by the Hospital Programme Team (HPT). The HPT was originally formed in 2008 to undertake an annual programme of inspection of environmental cleanliness, healthcare hygiene and its impact on the prevention and spread of healthcare-associated infection (HCAI). Since its inception, the HPT has consisted of 1.00 WTE lead Inspector- Band 8A, 3.00 WTE Inspectors- Band 7 and 0.5 WTE Administrative support-Band 3.

11. The HPT commitments have continued to evolve since 2008 however; the makeup of the HPT has remained consistent. Current HPT commitments include: responding to intelligence and concerns, acute hospital inspections, infection prevention and hygiene inspections of HSC hospitals and Northern Ireland Ambulance Service (NIAS), Inspections of independent hospitals, inspections of mental health and learning disability facilities (MHLD) and inspections of augmented care settings and prisons and police custody suites. These inspections can take place under Article 35, set out in paragraph 8 of this document.

12. This document presents the development of the HPT responsibilities arising in response to local and national learning and Ministerial direction. Figure 1 displays key HPT developments in chronological order.

Figure 1: Timeline of the development of the HPT



Infection Prevention and Hygiene Programme of Inspections

13. In 2008, following a major outbreak of Clostridium Difficile RQIA was commissioned by the Minister to commence a programme of unannounced infection prevention and hygiene inspections of acute hospitals in Northern Ireland. RQIA assess compliance using the Regional Healthcare standards[7], the inspection programme was subsequently expanded to include other areas including mental health and learning disability facilities. The initial cost for this programme in 2008/09 financial year was £205,054 in total, which included the provision: 1.00 WTE Lead inspector- Band 8A; 3.00 WTE Inspectors- Band 7; 0.5 WTE Administrative support – Band 3; and an allowance for goods and services.

Hygiene Inspections Business Case - 30.9.

14. On the 15th of January 2009, RQIA began a three-year rolling programme of infection prevention and hygiene inspections. Hospitals are categorised depending upon the number of beds and specialist areas they provide. The number of inspections and areas to be inspected is proportionate to the type of services provided and the size of the hospital. Hospitals with over four hundred and fifty beds were subject to three inspections, over three years to include four areas on each inspection. Hospitals with over one hundred and forty beds received two inspections, over three years, across two to three areas on each inspection. Hospitals with less than one hundred and forty beds underwent two inspections, over three years across one to two areas of inspection. Mental Health, Learning Disability and Community Hospitals were included in a targeted inspection process.

15. Currently, Infection Prevention and Hygiene inspections are subject to a risk and intelligence-based approach to inspection activity. Intelligence informing this model includes: complaints, whistle-blowing, incident notifications and outbreak data collected by the Public Health Agency (PHA). Details of the

frequency of Infection Prevention and Hygiene Inspections are contained in Appendix 2 and 2.1.

Mental Health and Learning Disability

16. Since 2009, following amendments to The Mental Health (Northern Ireland) Order 1986[8] by the Health and Social Care (Reform) Act (Northern Ireland) 2009[9], RQIA has had a range of responsibilities for people with mental ill-health and those with a learning disability. These are:
    - Preventing ill-treatment;
    - Remedying any deficiency in care or treatment;
    - Terminating improper detention in hospital or reception into guardianship; and
    - Preventing or redressing loss or damage to a patient's property.

    Part of RQIA's programme in discharging these responsibilities is the inspection of MHLD in-patient hospitals and wards across Northern Ireland. A more detailed overview of RQIA's responsibilities concerning MHLD will be provided in a separate dedicated document.

Augmented Care Programme of Inspections (Neonatal Units/ Critical Care Units/ other Augmented Care Units)

17. On the 30th of January 2012 and in parallel with its pseudomonas review[10], RQIA was commissioned by the Minister to develop a range of specialised audit tools to inspect augmented care settings following the outbreaks of pseudomonas aeruginosa in neonatal units. These tools were designed to assure the standards of infection prevention and control within neonatal units, critical care units and other augmented care settings (burns, renal, haematology, oncology units).

Ltr_HMtoRQIA_Neo_Review.pdf

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18. In the development of these tools, a range of local knowledge and expertise was drawn from the managers and staff of augmented care facilities across NI including: Neonatal Network for Northern Ireland (NNNI), Critical Care Network Northern Ireland (CCaNNI), Northern Ireland Cancer Network (NICaN) and clinical leads for other augmented care areas, renal, burns, and haematology.

19. The inspection programme aimed to build progressive improvement over a three-year inspection cycle. Capacity limitations impacted the formation of a structured formal inspection programme; however, neonatal unit inspections commenced in 2013 and were completed in 2018. Critical care unit inspections commenced in 2014 and were completed in 2019.

20. Following the completion of neo-natal and critical care inspections, in a letter from the department dated 22nd of November 2018, Chief Medical Officer asked the RQIA to work with the Critical Care Network Northern Ireland (CCaNNI) and Neonatal network (NNNI) to develop a process for self-assessment to be used by Trusts.

Letter from Dr Michael McBride - RQI

21. The Hospital Programmes Team (HPT) started to receive these self-assessments and had plans to commence a programme of validation. RQIA continue to undertake spot-check inspection visits to neonatal and adult critical care units to maintain a watching brief on systems and processes of care.

22. In line with the Neonatal and Critical Care inspection programmes, all other augmented care units are subject to a three-year rolling programme of inspection. In 2016/2017 RQIA commenced the planned programme of inspection of other augmented care areas and inspected one augmented care area in each Trust across Northern Ireland (these included: oncology, renal or

haematology). Details of the frequency of Augmented Care Programme of inspections are contained in Appendix 3.

Acute Hospital Programme of Inspections

23. In 2014, and following the publication of the Francis public enquiry[11], the Minister asked RQIA to carry out a series of inspections in acute hospitals across Northern Ireland. In a statement to the Northern Ireland Assembly on 1 July 2014, the Minister stated that "*inspections will focus on a number of quality indicators about triage, admission, assessment, care, monitoring and discharge of patients. They will focus on a selection of quality indicators that will not be pre-notified to the Trusts for each inspection, and no advance warning will be provided to Trusts as to which sites or services within a hospital will be visited as part of an unannounced inspection. It is intended that the RQIA inspection reports will be published on a hospital-by-hospital basis as they are completed*".

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Phase I

24. Phase I of the acute hospital inspection programme ran from October 2015/ July 2016. Inspections were carried out using a multidisciplinary model that included peer reviewers (staff who engage in the day to day delivery of health and social care) and lay assessors. Phase I of the programme concentrated on large, acute hospitals and included three areas for inspection: emergency care, medical care (including older people care) and surgical care.

Phase II

25. Phase II of the acute hospital inspection programme ran from December 2016/ December 2017 and concentrated on smaller acute hospitals and included three areas for inspection, emergency care, medical care or surgical care.

Northern Ireland Ambulance Service (NIAS) Infection Prevention and Hygiene Programme of Inspections

26. In July 2017, RQIA commenced a rolling programme of unannounced infection prevention and control, hygiene and cleanliness inspections to NIAS. These inspections were conducted using a bespoke Healthcare Hygiene and Cleanliness - Infection Prevention & Control audit tool developed in collaboration with NIAS during 2016/2017. Details of the frequency of NIAS infection prevention and hygiene inspections are contained in Appendix 2.2

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_for_NIAS_270114.p

Phase III

27. Phase III of the Hospital Inspection Programme takes account of the RQIA commissioned governance review of neurology services[12]. In 2018 and following the Belfast HSC Trust recall of a number of patients treated by a consultant neurologist. RQIA was commissioned by the Department to conduct a review of the governance of outpatient services at the Belfast HSC Trust. This included an inspection of each hospital of the Trust which provided outpatient services.

28. This initially involved the BHSC Trust, however, on the foot of this review, RQIA was asked to expand this inspection programme to include outpatient services in each of the other HSC Trusts in 2020/21. A programme of inspections to these areas was in place and due to commence in 2019. Unfortunately, due to the developing situation of Coronavirus in NI, RQIA was advised by the CMO Dr Michael McBride on 20th March 2020 to cease its non-statutory inspection activity. This resulted in the programme being temporarily suspended. Details of the frequency of Acute Hospital Inspections are contained in Appendix 4.

Concerns and Whistle Blowing

29. The HPT respond to concerns reported in relation to HSC hospitals. There have been a total of 210 concerns logged the logging of concerns onto Iconnect[1] began in the third quarter of 2016/17. Acknowledging refinements made to the methodology used to categories concerns implemented toward the end of 2018, the number of concerns received by RQIA appears to be increasing year on year, with 103 or 49% of the total number of concerns logged in 2019/20 financial year alone. HSC Hospital Concerns by financial year are presented in Fig 2. Appendix 5.

Frequency of Inspection

30. Unlike regulated services such as nursing homes and domiciliary care agencies, there is no statutory minimum frequency of inspection for any of our inspections of HSC hospital services.

Enforcement

31. Enforcement action is guided by the 2006 Quality Standards for Health and Social Care and The Mental Health (Northern Ireland) Order 1986. This limits the enforcement action that RQIA can take against an HSC Trust in respect of hospital services. RQIA may issue an Improvement Notice under Article 39 of the Order[13]. Where RQIA finds an HSC hospital is failing to comply with a statement of minimum standards outlined in the 2006 Quality Standards, an Improvement Notice may be served.

32. Where RQIA is of the view that the service is of unacceptably poor quality or there are significant failings in the way the service is being delivered, RQIA may recommend in its report that the DoH take special measures in relation to the service provider. It is the DoH that decides if a special measure is to be imposed and the nature of that measure – although RQIA can make recommendations to the DoH in this regard.

[1] Iconnect is the RQIA electronic information system.

Current and Future HPT Commitments

33. During the current pandemic, the HPT has adapted to undertaken a series of Infection Prevention and Control Inspections, with a focus on the response to COVID-19. The HPT will continue to provide assurances regarding how HSC acute hospital services are responding to and managing COVID-19.

34. The HPT is making use of a risk and intelligence-based approach to infection prevention and hygiene inspection activity to HSC hospitals and the NIAS. As previously mentioned, intelligence informing this inspection model includes: complaints, whistleblowing, incidents and outbreak data composed by the Public Health Agency (PHA).

35. As presented in Figure 2, the number of concerns recorded by the RQIA has increased considerably over the past three years. The growing number of concerns recorded by the RQIA could be considered as demonstrating the public's increasing expectation of the RQIA's role in providing assurance. Responding to concerns represents a significant commitment for the HPT and one which is likely to further intensify as the number of concerns received continues to increase.

36. In 2019/20 following direction from Dr Michael McBride the HPT worked with CCANI and NNNI to implement an assurance process based on self-assessment (SA) across the augmented care settings. As a result of the COVID-19 pandemic, a number of settings have been delayed in submitting their self-assessment returns. The HPT has recently engaged with both networks to refresh and reinvigorate the SA process and will undertake a round of targeted inspection to augmented care areas to pilot this approach to assurance.

37. Following the completion of Phase I & Phase II of the Hospital Inspection Programme, the HPT do not have a mechanism or resource to follow-up on the Areas for Improvement made during inspections in these phases. Responsibility for this lies with the Trust in respect of their governance

arrangements. This approach however is not consistent with our other regulated services whereby standard policy is to follow-up on areas for improvement made during previous inspections. The introduction of a similar mechanism to allow follow-up within HSC healthcare would ensure a consistent approach across services.

38. Without further direction the HPT plan to continue their commitment to deliver a programme of outpatient department inspections, in line with the previously agreed Phase III Hospital Inspection Programme.

Conclusion

39. This paper demonstrates that for the period 2011-2020 the HPT has accumulated additional directions, each of which contains an expectation of ongoing assurances. Despite the accumulation to the HTP's role and responsibilities in assuring healthcare across this period, the team's composition and resources have remained static.

40. To meet the needs of the healthcare services and public who depend upon their assurance, absolute clarity in future HPT inspection priorities between RQIA and DoH will be paramount. As we continue to move through the remainder of this financial year and planning beyond 2021, RQIA would welcome the opportunity to agree upon future priorities and expectations in respect of future directions.

Future

41. We would welcome the opportunity to influence the Review of our Primary Legislation the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to carve a specific role for RQIA in the regulation and inspection of HSC services.

Appendix 1: RQIA HSC Hospitals Inspections by Programme from 2008 up until 2020

Table 1: All Programmes of Inspection

Year	IPH	NN	CC	AC	HIP	Total Areas
2008-09	37 areas	n/a	n/a	n/a	n/a	37
2009-10	22	n/a	n/a	n/a	n/a	22
2010-11	44	n/a	n/a	n/a	n/a	44
2011-12	40	n/a	n/a	n/a	n/a	40
2012-13	25	n/a	n/a	n/a	n/a	25
2013-14	23	7	0	0	n/a	30
2014-15	25	1	12	0	n/a	38
2015-16	9	6	7	0	3	25
2016-17	17	0	0	5	6	28
2017-18	18	7	0	0	4	29
2018-19	20	n/a	6	2	6	34
2019-20	17	n/a	n/a	1	1	19

Table 1.b All HSC Hospital Inspections from 2020- to 10.01.2024 (data from Iconnect)

Year	HSC Hospital Inspections
2020-21	12
2021-22	7
2022-23	9
2023-24*	3
Grand Total	**31**

*As of 10.01.2024

Table 1.c All HSC Hospital Inspections from 2020-to 10.01.2024 by HSC Trust (data from Iconnect)

Year	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Grand Total
2020/21	4	2	2	2	2	12
2021/22	1	1	3	1	1	7
2022/23	4	2	1	1	1	9
2023/24					3	3
Grand Total	**9**	**5**	**6**	**4**	**7**	**31**

Appendix 2: Infection Prevention and Hygiene Programme Inspections 2008 until 2014

Table 2: Infection Prevention and Hygiene Programme Inspections 2008 until 2014

Year	Number of inspections	Total Areas
2008-09	37 areas inspected	**37**
2009-10	22 areas inspected	**22**
2010-11	24 in acute/community hospitals	24
	12 in Mental Health and Learning Disability, including re-visits	12
	7 Independent Hospitals, including re-visits	7
		44
2011-12	24 acute/community hospitals and 6 re-visits	30
	1 prison (Roe House)	1
	3 Mental Health and Learning Disability Hospitals and 1 re visit	4
	4 Independent Hospitals, including 1 re-visit	5
		40
2012-13	17 Acute/Community Hospitals and 4 re-visits	21
	1 in MHLD and 3 re-visits	4
		25
2013-14	18 acute/community hospitals and 4 re-visits	22
	1 in Independent Hospitals Theatre	1
		23

Appendix 2.1: Infection Prevention and Hygiene Programme Inspections 2014 until 2020

Table 3: Infection Prevention and Hygiene Programme Inspections 2014 until 2020

Year	Number of inspections	Total Areas
2014-15	9 in acute/community hospitals and 4 re-visits	15
	6 Trusts +NIAS Governance	6
	4 Independent Hospitals Theatre	4
		25
2015-16	7 in acute/community hospitals and 2 re-visits	9
		9
2016-17	16 in acute/community hospitals and 1 re-visits	17
		17
2017-18	3 in acute/community hospitals and 1 re-visits	4
	2 NIAS and 2 re-visits 9 Enforcement 1 Fact finding Visit	14
		18
2018-19	9 in acute/community hospitals and 4 re-visits	13
	7 NIAS Enforcement	7
		20
2019-20	9 in acute/community hospitals and 1 re-visits	10
	7 NIAS Enforcement	7
		17
TOTAL		**106**

Appendix 3: Augmented Care Settings Programme

Table 4: Critical Care

Year	Year of Programme	Number of inspections	Total
2014-15	Year One	12 Inspection	12
2015-16	Year Two	7 Inspections	7
2018-19	Year Three	6 Inspections	6

Table 5: Neonatal Care

Year	Year of Programme	Number of inspections	Total
2013-14	Year One	7 inspections	7
2014-15	Year Two	1 Inspection	1
2015-16	Year Two	6 Inspection s	6
2017-18	Year Three	7 Inspections	7

Table 6: Augmented Care

Year	Number of inspections	Total
2016-17	5 inspections	5
2018-19	2 Inspections	2
2019-20	1 inspection	1

Table 7: Multi-Disciplinary Team (MDT)

Year	Phase	Number of inspections	Total
2015-16	I	3 Inspections	3
2016-17	I and II	2 Inspections 1 Fact Finding Visit 3 Inspections	6
2017-18	II	3 Inspections 1 re- visit Inspection	4
2018-19	II and III	1 re-visit inspection 5 inspections – OPD Phase	6
2019-20	II	1 re-visit MDT	1

Appendix 4: HSC Hospital Inspections

Table 8: Large Hospitals Inspected from 2015 to 2019

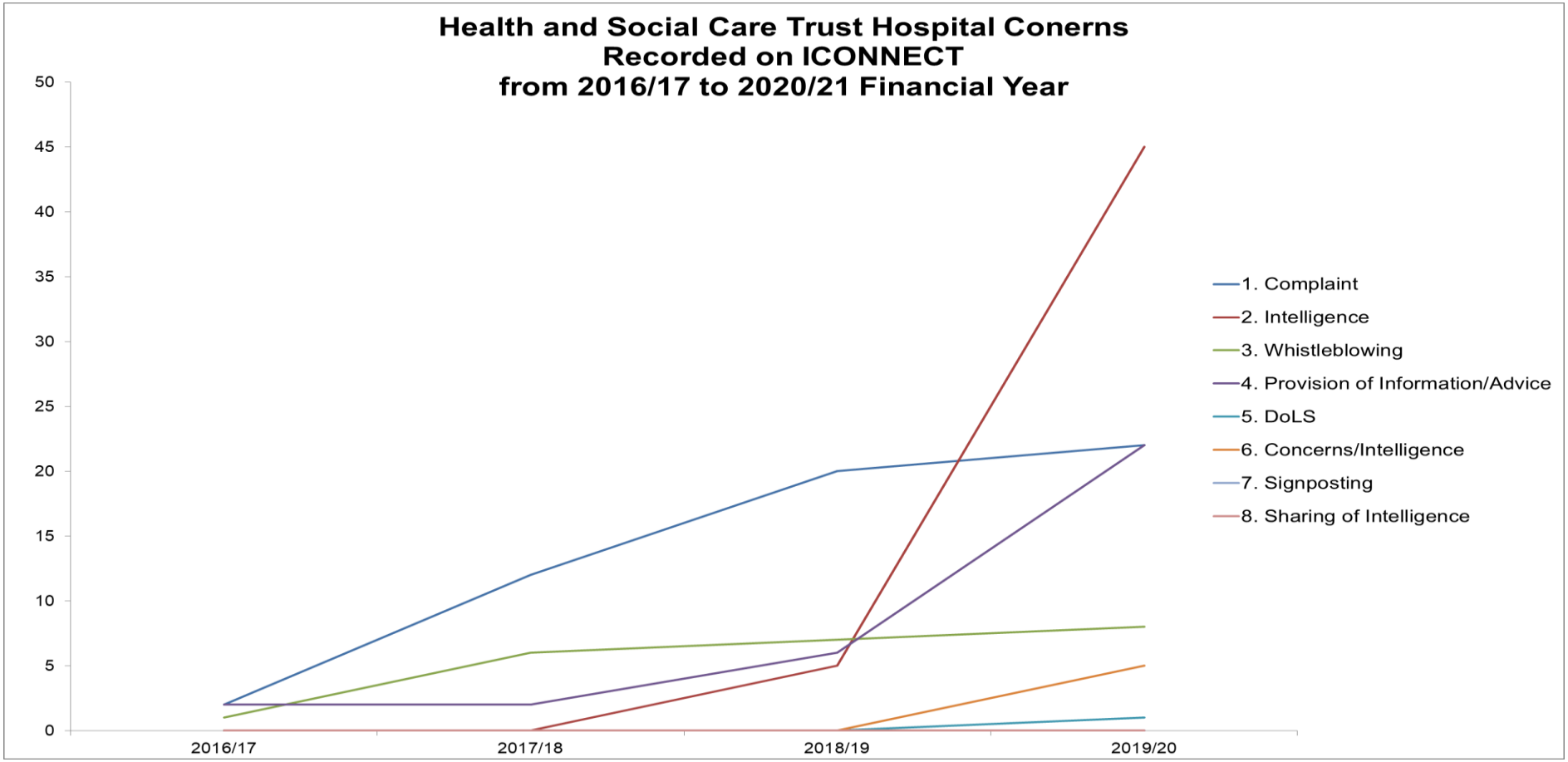
Hospital	Date of Inspection
Altnagelvin Hospitals	April, 2015
Antrim Area Hospital	May, 2015
Ulster Hospital	June, 2015
Craigavon Hospital	June, 2015
Mater Hospital	July, 2015

Table 9: Small Hospitals Inspected from 2015 to 2023

Hospital	Date of Inspection
Daisy Hill Hospital	December, 2016
Mater Hospital	January, 2017
Lagan Valley	March, 2017
Royal Belfast Hospital for Sick Children	May, 2017
South West Acute Hospital	October, 2017
Causeway Hospital	November, 2017
Royal Belfast Hospital for Sick Children (re-inspection)	December, 2017, December, 2019
Causeway Hospital (re-inspection)	June, 2018
Musgrave Park Hospital	

Appendix 5: Health and Social Care Hospitals Concerns by Concern Category

Figure 2: Health and Social Care Hospitals Concerns by Concern Category



Appendix 6: HSC Hospital Concerns by HSC Trust by Financial Year

Table 10: HSC Hospital Concerns by HSC Trust, Financial Year / Quarter

	HSC Hospital Concerns by HSC Trust, Financial Year / Quarter							
Concern Category	2016/17	2017/18	2018/19	2019/20	2020/21 (First quarter only)	2021-22	2022-23	Grand Total
Complaint	2	12	20	22	0			56
Intelligence	0	0	5	45	0			50
Whistleblowing	1	6	7	8	2			24
Provision of Information/Advice	2	2	6	22	0			32
Deprivation of Liberty (DoLS)	0	0	0	1	0			1
Concerns/Intelligence	0	0	0	5	34			39
Signposting	0	0	0	0	6			6
Sharing of Intelligence	0	0	0	0	2			2
Grand Total	5	20	38	103	44			210

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The Regulation and Quality Improvement Authority

Review of Governance of Outpatients Services in the Belfast HSC Trust with a Focus on Neurology and Other High Volume Specialties

February 2020

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Acknowledgements

RQIA wishes to thank all those who facilitated this review through participating in discussions, surveys and interviews, inspections, attending focus groups and providing relevant information.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's service reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced healthcare practitioners or experts by experience. Our reports are submitted to the Department of Health (DoH) and are available on our website at www.rqia.org.uk.

Our Stakeholder Outcomes

RQIA conducts service reviews and inspections against four key outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

Citation for this document

Regulation and Quality Improvement Authority: *Review of Governance of Outpatients Services in the Belfast HSC Trust with a Focus on Neurology and Other High Volume Specialties. 2020.*

Glossary of Terms

AHP	Allied Health Professional
ANTT	Aseptic Non Touch Technique
ABN	Association of British Neurologists
BRAAT	Belfast Risk Audit and Assessment Tool
Belfast Trust	Belfast Health and Social Care Trust
BOIS	Belfast Orthopaedic Information System
BSO	Business Services Organisation
CAPA	Corrective and Preventative Action Plan
CCG	Clinical Communications Gateway
CMO	Chief Medical Officer
CPD	Continuing Professional Development
CQC	Care Quality Commission
CTIMPs	Clinical Trials of Investigational Medicinal Products
DEC	Dedicated Equipment Controllers
DoH	Department of Health
ED	Emergency Department
ENT	Ear, Nose, Throat
ERRG	External Reports Review Group
ERT	Expert Review Team
FGH	Forster Green Hospital
GI	Gastrointestinal
GMC	General Medical Council
GP	General Practitioner
GUM	Genito-urinary Medicine
HCAI	Healthcare Associated Infection
HCN	Health and Care Number
HRPTS	Human Resources, Payroll, Travel and Subsistence System
HSC Board	Health and Social Care Board
IHI	Institute for Healthcare Improvement
Independent Sector	The term independent sector refers to those patients initially seen privately as opposed to within the HSC Services
IPC	Infection Prevention Control
MHRA	Medicines and Healthcare Products Regulatory Agency
M&M	Morbidity and Mortality
MOU	Memoranda of Understanding
MS	Multiple Sclerosis
NIECR	Northern Ireland Electronic Care Record
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery

NIPSO	Northern Ireland Public Services Ombudsman
NISRA	Northern Ireland Statistics and Research Agency
NMC	Nursing Midwifery Council
Northern Trust	Northern Health and Social Care Trust
OT	Occupational Therapy
PAS	Patient Administration System
PHA	Public Health Agency
PPE	Personal Protection Equipment
PPI	Personal Public Involvement
PRSB	Professional Record Standards Body
PTN	Private Transfer to NHS (Code on PAS System)
RCP	Royal College of Physicians, London
RFID	Radio Frequency Identification
RO	Responsible Officer
SAIs	Serious Adverse Incidents
SLA	Service Level Agreement
SBNI	Safeguarding Board for Northern Ireland
South Eastern Trust	South Eastern Health and Social Care Trust
Southern Trust	Southern Health and Social Care Trust
SOPs	Standard Operating Procedures
SQE	Safety, Quality and Experience
Trusts	Health and Social Care Trusts
UK	United Kingdom
Western Trust	Western Health and Social Care Trust

Executive Summary

This review follows the 1 May 2018 recall by the Belfast Health and Social Care Trust (Belfast Trust) of 2,500 patients who were under the active care of a consultant neurologist.

This review examines the governance arrangements with respect to outpatients services within the Belfast Trust. Good organisational and clinical governance are critical to delivering quality services and enabling early action to be taken in the event that issues or concerns arise. This review is particularly concerned with neurology and other high volume specialties delivered by the Belfast Trust. It also captures the views and experiences of service users (patients, families, carers) and General Practitioners (GPs) interacting with the service.

The review commenced in May 2018, with the formation of an Expert Review Team comprising members with experience in clinical and corporate governance at Chief Executive, Medical Director and Executive Government level; and members with expertise in hospital inspection and general practice.

Terms of Reference

The terms of reference for this review are:

1. To describe and assess the governance systems and processes in place in outpatients services in Belfast Trust, with a particular focus on neurology and other high volume specialties, which assure quality of care with regard to leadership, safety, effectiveness and compassion.

2. To assess the effectiveness of the arrangements for monitoring the quality of care and patient outcomes in outpatients services in the Belfast Trust, with a particular focus on neurology and other high volume specialties.

3. To assess the effectiveness of the arrangements for identifying and managing risk in outpatients services in Belfast Trust, with a particular focus on neurology and other high volume specialties.

4. To obtain the views and experiences of service users (patients, families, carers) and GPs of the outpatients services for neurology and other high volume specialties in Belfast Trust.

5. To report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvement.

Key Findings

Throughout this report we have identified several areas of good practice and have made 26 recommendations that, if implemented, we believe would strengthen the governance arrangements within and across the Belfast Trust's outpatients services.

Access and Organisation

The Expert Review Team identified the need for streamlining the many mechanisms for referring patients to the Belfast Trust's outpatient services. It also viewed that more robust validation of waiting lists and triaging of referrals was required; along with more appropriate oversight and monitoring of patients transferring to the Belfast Trust from the independent sector. We acknowledge the work underway within the Belfast Trust to improve productivity and efficiency of outpatients services and recommend that this work is expedited. There is also an opportunity to improve the written communication with patients following their attendance at outpatients services.

Safeguarding

Overall, the levels of training, knowledge and awareness of staff across outpatients services in relation to safeguarding were a significant concern for the Expert Review Team. We could not be confident that safeguarding matters would be recognised or actioned appropriately in the context of outpatients services delivered across the Belfast Trust. This matter was escalated by RQIA's Medical Director to the Belfast Trust's Chief Executive and relevant Executive Directors. The Belfast Trust has since met with senior RQIA staff to discuss the implementation of a targeted action plan to address these findings. In line with our established escalation policy, RQIA continues to monitor the Belfast Trust's delivery of improvements in this area.

Medicines Management

While there is robust oversight of prescribing of specialist medicines in outpatients services, we found there is only limited oversight of all other prescribing in outpatients services. Significant weaknesses were identified in the monitoring and oversight of medicines prescribed or recommended to be prescribed. The system currently operating is based on Treatment Advice Notes issued in hard copy to GPs. This limits the Belfast Trust's oversight of the prescribing practices of individuals and/or services delivering outpatient care and treatment. In turn the Belfast Trust has a limited ability to identify unusual prescribing practices and/or trends relating to medicines used in the context of outpatients services.

Governance Arrangements

Given the size of the Belfast Trust, the complexity of its services and the number of directorates providing outpatients; the Expert Review Team noted the challenge for senior managers and the Executive Team to maintain comprehensive oversight across all outpatients services.

The Expert Review Team acknowledged the Belfast Trust's clear commitment to implementing its collective leadership strategy and refreshing its organisational accountability arrangements in a meaningful way. While arrangements were clear, or in the process of being clarified through Directorate and Divisional structures, we found they were not necessarily as clear for staff providing care and/or treatment in outpatients services/departments.

The Expert Review Team recognised the significant importance of Sisters / Charge Nurses to providing stable, effective leadership at local level in outpatients services/departments across the Belfast Trust. Through our many engagements we did not find evidence that Sisters / Charge Nurses in outpatients settings were sufficiently connected into the Belfast Trust's collective leadership structures; or that they had harnessed their collective expertise and experience to influence and deliver improvement at a system level within the Belfast Trust.

Clinical Peer Review

The Expert Review Team identified the potential for isolation of medical and/or specialist nursing staff in outpatients services as a particular risk for the Belfast Trust. This risk is greatest where there is lone working outside a multidisciplinary team context: perhaps because of the nature of the specialty (i.e. highly complex); by the choice of the health professional; or because of a lack of governing systems across the service in question.

Patient Engagement

The Expert Review Team was encouraged by opportunities in some services/locations for patients to provide real time feedback; but was unable to find evidence of uniform or strategic mechanisms in place to ensure views are fully harnessed in a cohesive and strategic way across all of outpatients services in the Belfast Trust.

Information and Intelligence

There are a number of areas where the Expert Review Team believed that the use of data, information and intelligence would strengthen the governance and assurance of these services. This could include improved oversight of the activity of consultants and specialist nurses in outpatients services; support for the monitoring of patient outcomes; and national/regional benchmarking.

Conclusion

We recognise that this report contains a large number of recommendations and that in some areas the Belfast Trust has indicated work has already commenced. We hold the view that the recommendations have relevance for other organisations across the HSC and beyond who deliver a similar profile of services. In order to maximise the potential improvements, and collectively share in the responsibility for delivering these improvements, consideration should be given to co-ordination of this work at a regional level and the involvement of all five HSC Trusts in taking forward individual

recommendations in specific areas. This could support system wide improvement and reform as envisioned in the 2016 Northern Ireland policy 'Health and Wellbeing 2026: Delivering Together'.

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Section 1: Background and Context

1.1 Introduction

On 1 May 2018 the Belfast Health and Social Care Trust (Belfast Trust) announced a recall of 2,500 patients who were under the active care of a consultant neurologist[1]. As part of the system response to this patient recall RQIA was commissioned by the Department of Health (DoH) to undertake this review, specifically *'A Review of Governance of Outpatients Services in the Belfast Trust with a Focus on Neurology and other High Volume Specialties'*[2].

This review is one of three work streams delegated to RQIA by DoH, in the context of the system-wide response to the recall of neurology patients DoH has directed RQIA to undertake '*A Review of Governance Arrangements in Independent (Private) Hospitals in Northern Ireland*', work on this second governance review is currently in progress. RQIA has also been tasked, by DoH, to commission an expert review of the records of all patients of Dr A [consultant neurologist] who have died over the previous ten years, detailed preparatory work to support this review is also in progress.

On 10 May 2018, DoH announced the establishment of an Independent Neurology Inquiry (INI) to be chaired by Mr Brett Lockhart, Queen's Counsel (QC)[3]. The terms of reference for INI were advised as follows:

a. To examine the circumstances which led to the recall of patients in May 2018 (for the period from November 2016 until May 2018), and evaluate the corporate governance (with particular reference to clinical governance) procedures and arrangements within the Belfast Trust;
b. To review the Belfast Trust's handling of relevant complaints or concerns, identified or received prior to November 2016, and participation in processes to maintain standards of professional practice, including appraisals;
c. To identify any learning points and make recommendations to the Department in relation to points (a) and (b) above.

On 31 July 2018, DoH announced a Regional Review of Neurology Services covering all neurology specialties in Northern Ireland[4]. This review aims to identify optimal models for delivering neurology services and would derive relevant learning from the ongoing recall of neurology patients from the Belfast Trust.

Good governance is critical to delivering a safe, high quality service to patients. Evidence of good governance is seen in the effective functioning of the systems and processes that enhance the delivery and quality of services. Such systems will monitor quality, identify and manage risk, and ensure that all individuals and groups contributing to the organisation have a clear understanding of their roles and responsibilities. Also, key to good governance is ensuring that the needs of those using the services (that is the needs of patients and clients) are central to the decision-making processes within the organisation.

1.2 What we were asked to do

The following terms of reference for this review were agreed with members of the Expert Review Team and with the DoH:

1. To describe and assess the governance systems and processes in place in outpatients services in Belfast Trust, with a particular focus on neurology and other high volume specialties, which assure quality of care with regard to leadership, safety, effectiveness and compassion.

2. To assess the effectiveness of the arrangements for monitoring the quality of care and patient outcomes in outpatients services in the Belfast Trust, with a particular focus on neurology and other high volume specialties.

3. To assess the effectiveness of the arrangements for identifying and managing risk in outpatients services in Belfast Trust, with a particular focus on neurology and other high volume specialties.

4. To obtain the views and experiences of service users (patients, families, carers) and GPs of the outpatients services for neurology and other high volume specialties in Belfast Trust.

5. To report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvement.

High Volume Specialties

The request by DoH to undertake this review included a 'focus on neurology and other high volume specialties'. We (members of the core review team) met with commissioners from the HSC Board and the Public Health Agency (PHA) who advised that there was no established definition of high volume specialties currently in use across health and social care in Northern Ireland. We reviewed outpatient activity data available for 2016/2017, which included the number of new, review and total attendances across Northern Ireland (Table 1).

Table 1: Outpatient Activity for Consultant-Led Services by Specialty (equal to or greater than neurology services) in Northern Ireland 2016/2017[a]

Specialty	Attendances			Number of review attendances for every new attendance	New attendances as a percentage of total attendances
	New	Review	Total		
Trauma & Orthopedic Surgery	59,037	120,821	179,958	2	33%
General Surgery	66,547	70,028	136,575	1	49%
Ophthalmology	23,989	79,005	102,994	3	23%
Obstetrics (antenatal)	19,695	75,683	95,378	4	21%
Paediatrics	22,092	70,851	92,943	3	24%
Gynaecology	44,074	46,645	90,719	1	49%
Ears, Nose and Throat	41,330	48,429	89,759	1	46%
Dermatology	31,988	46,961	78,949	1	41%
Cardiology	24,025	33,475	57,500	1	42%
General Medicine	14,976	40,284	55,260	3	27%
Rheumatology	9,138	43,437	52,575	5	17%
Haematology (Clinical)	4,574	43,620	48,194	10	9%
Thoracic Medicine	9,299	28,713	38,012	3	24%
Gastroenterology	10,437	22,926	33,363	2	31%
Neurology	10,272	22,365	32,637	2	31%

The Expert Review Team reviewed this data and agreed to take a pragmatic approach (in the absence of an established definition) to determining which specialties would be included in this review. The Expert Review Team defined 'high volume specialties' as those with similar or higher volumes of activity than neurology, as outlined above.

[a] Information provided by Information and Analysis Directorate, Department of Health

1.3 What we did do and who we heard from

Fieldwork for this review commenced in May 2018 with discussion of draft terms of reference for the work with DoH and formation of an independent Expert Review Team. Membership of the Expert Review Team is as described in Appendix 1, the Team comprised members with significant experience in clinical and corporate governance at Chief Executive, Medical Director and Executive Government level. The Expert Review Team also included members with expertise in General Practice and regulation of hospital services. A smaller operational team was established to support the work of the Expert Review Team, membership of RQIA's Core Team is also outlined in Appendix 1.

Members of the Expert Review Team and RQIA's Core Team designed the following methodology for this governance review:

- We undertook a review of relevant literature to identify key themes and the areas likely to require focus during this review;
- We reviewed the Care Quality Commission's (CQC's) Inspection Framework for NHS Acute Hospitals for Core Service of Outpatients[5], and used this to develop a framework to support our work in this review;
- We designed a structured questionnaire, informed by CQC's Inspection Framework (as above), to capture information relating to outpatient services as delivered by Belfast Trust;
- We analysed information relating to key aspects of outpatients services delivered by the Trust (as described in the Trust's questionnaire submission), this included information relating to design and delivery of outpatient services, maintaining a well-led service, and ensuring safe and effective care is delivered;
- From this analyses we developed key lines of enquiry (KLOE) to underpin and support meetings between the Expert Review Team's and Trust staff;
- We held one week of meetings between members of the Expert Review Team and a range of staff from across Belfast Trust (the 'Review Week' held in September 2018); the Review Team met with in excess of 100 staff including the Chief Executive, the Chairman and Members of the Board, the Executive Team, Directors, Co-Directors, Clinical Directors, Service Managers, Specialist Neurology Nurses, Consultant Neurologists, Governance Managers and Information Managers, divisional nurses and Chairs of Division;
- During the 'Review Week' the Expert Review Team also met with staff in the HSC Board and Public Health Agency (PHA) who have responsibility for commissioning, public health expertise to service development and integrated care (pharmacy services);

- We completed unannounced multi-disciplinary inspections of the Trust's five main hospital sites that deliver outpatient services - the Royal Victoria Hospital, Belfast City Hospital, Musgrave Park Hospital, the Royal Belfast Hospital for Sick Children and the Mater Infirmorum Hospital (during October 2018); inspections were ongoing for 11 days across the five hospital sites during which approximately 60 specialist services delivered care and/or treatment in the outpatients areas inspected;
- We designed a survey to capture the experiences of and feedback from patients, relatives and carers; our survey was widely disseminated and promoted (through RQIA's communication channels and social media) and through the Patient and Client Council; dedicated members of our inspection teams promoted the survey and facilitated patients, relatives and/or carers to complete surveys as inspections were in progress;
- We designed a survey to capture the experiences of and feedback from General Practitioners working in Northern Ireland and interfacing with the Trust in the context of services provided to/for their patients;
- We held two focus groups with neurology patients and their relatives and/or carers, we were supported to plan and facilitate these focus groups by the Multiple Sclerosis Society (MS) in Northern Ireland, the Northern Ireland Neurological Charities Alliance, the Northern Ireland Rare Diseases Partnership, Northern Ireland Chest Heart and Stroke and the Stroke Association, Northern Ireland;
- We met with the General Medical Council and with Tier Two Responsible Officers in Northern Ireland to discuss matters relating to medical appraisal and revalidation.

As previously outlined, this review concentrated on the system-level aspects of oversight and governance of outpatients services delivered by Belfast Trust through its five main hospital sites (as described above). We excluded outpatients services categorised as Integrated Care and Assessment Treatment Services (ICATS)[b]. We excluded outreach clinics provided by Belfast Trust staff or personnel into other HSC Trusts, we expect that oversight and governance of these services will be addressed in future phases of this thematic review. We excluded outpatients services delivered as part of the Belfast Trust Dental Service as the School of Dentistry and its services have been subject to detailed review previously [5 6 7 8]. We also excluded services where people/patients may present directly to a hospital inpatient ward to receive clinical input in respect of a specific condition.

[b] **ICATS** is the term used for a range of outpatient's services which are provided by integrated multidisciplinary teams of health service professionals, including GPs with a special interest, specialist nurses and allied health professionals. They are provided in a variety of primary, community and secondary care settings and include assessment, treatment, diagnostic and advisory services.

The findings of this review are presented in sections, which are closely aligned to the domains of RQIA's inspection and review framework (see Figure 1).

Figure 1: RQIA's Inspection and Review Framework

Access and Organisation: we outline our findings relating to the systems and processes in place to access and deliver outpatients services.

Well Led: we outline our findings relating to the arrangements in place to manage, govern and lead the delivery of outpatients services.

Ensuring Safe and Effective Care: we outline our findings in relation to how the Trust ensures that treatment provides good outcomes and patients achieve a good quality of life and are protected from avoidable harm.

Compassionate Care: we outline our findings relating to the delivery of person centred care, patient experience and the involvement of patients in planning and delivery of their services.

Where our findings have led to recommendations these are clearly identified within the report. We have also included a number of examples of good practice identified through the course of this review.

1.4 Outpatients Services

Across the United Kingdom (UK), outpatients care accounts for the largest proportion of contacts between the general public and hospital-delivered services[9]. A number of specialties operate predominantly on an outpatient basis, for example: neurology, rheumatology and ophthalmology services. The definition of an outpatient service is as follows[10]:

> *"…A consultant-led service provided by Health and Social Care Trusts to allow patients to see a consultant, their staff and associated health professionals for assessment in relation to a specific condition. Patients are not admitted into hospital for this assessment*."

1.5 Delivering Outpatients Care

In its report *'Outpatients: the future – adding value through sustainability'*[11] the Royal College of Physicians has reflected that well-functioning outpatients services should:

- Minimise waiting times;
- Minimise disruption to the lives of patients and carers;
- Involve patients in the selection of a suitable appointment time;
- Ensure required information is available to the clinician/clinical team prior to the appointment;
- Provide information to the patient before their appointment;
- Empower patients to be involved in decisions about their care;
- Ensure seamless communication between hospital and community services; and
- Offer high quality clinical training and promote the well-being of both staff and patients.

There are three key stages in the outpatient pathway (Figure 2).

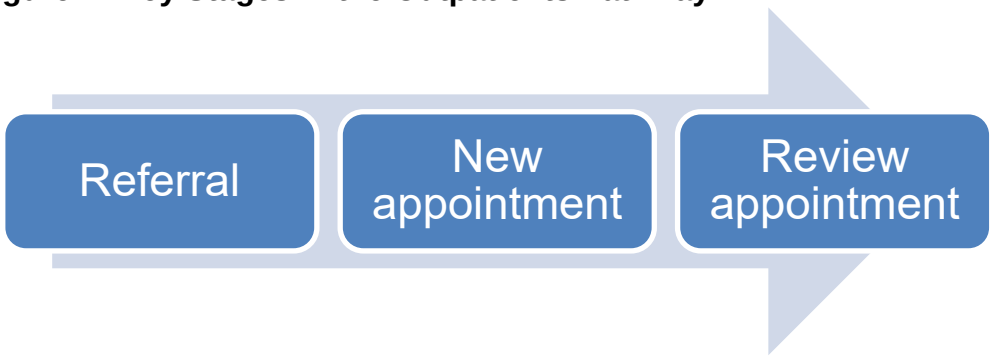
Referral: Outpatients services are typically accessed through referral from a patient's General Practitioner (GP) or from a hospital consultant, referrals may also be received from Emergency Departments (EDs) and other areas of the health care system (for example referrals for a review appointment following an inpatient hospital stay).

New appointment: Following referral, a patient will normally receive an appointment for an initial consultation at an outpatients clinic. At this consultation, the patient will be assessed (this involves a review of clinical history, examination and investigations), the patient may receive a diagnosis and treatment plan during their appointment, or they may receive an update relating to a previous diagnosis, they may also be referred for further investigations.

Review appointment: Having attended their first outpatients appointment a patient may require further follow-up appointments, this may be to discuss results of investigations, to plan further investigations or to support ongoing management of the patient's condition. Essentially, review appointments are all appointments which are not a first appointment.

Good planning of outpatients services is critically important to ensuring adequate capacity to meet demand for services. A patient may have care provided by a number of outpatients services at the one time. It follows that co-ordination of a patient's journey through outpatients services is a significant factor in the experience of high quality care, patient satisfaction and in achieving overall positive outcomes.

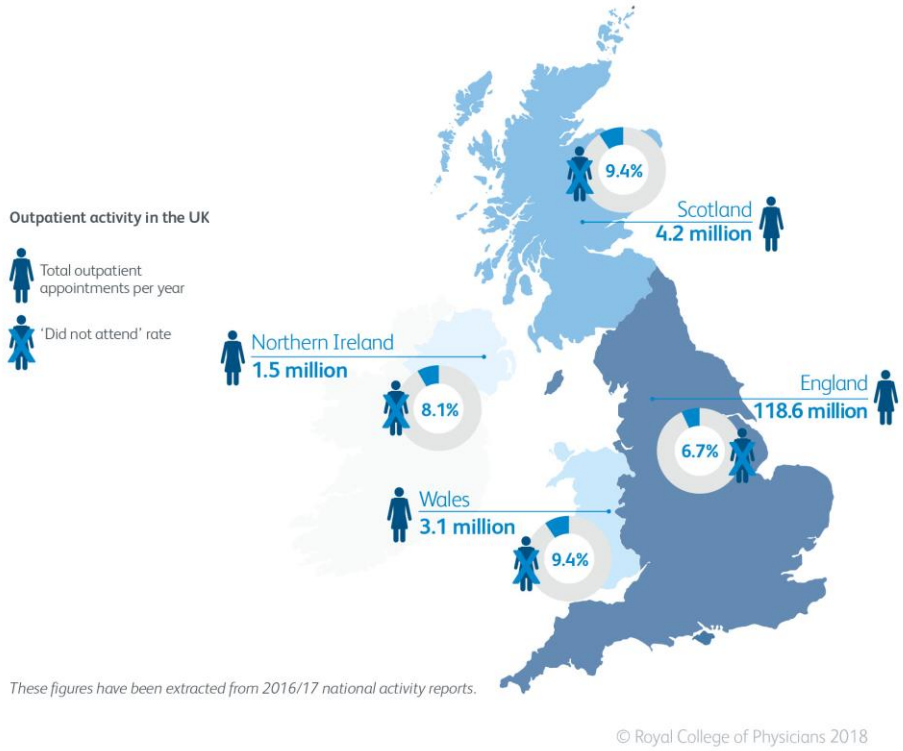
Figure 2: Key Stages in the Outpatients Pathway



National Outpatient Activity

Demand for outpatients appointments/services continues to rise and outpatients appointments across the UK now account for almost 85% of all hospital-based activity (excluding activity in EDs). In England alone outpatients appointments have almost doubled in the past decade, now reaching over 118 million per year[12]. Figure 3 presents outpatient activity across the UK in 2016/2017.

Figure 3: Outpatient Activity in the United Kingdom - Total Outpatient Appointments and Do-Not-Attend Rate during 2016/2017



Source: Reproduced with permission from Royal College of Physicians (2018). *Outpatients: the future – adding value through sustainability.* London Royal College of Physicians[13]

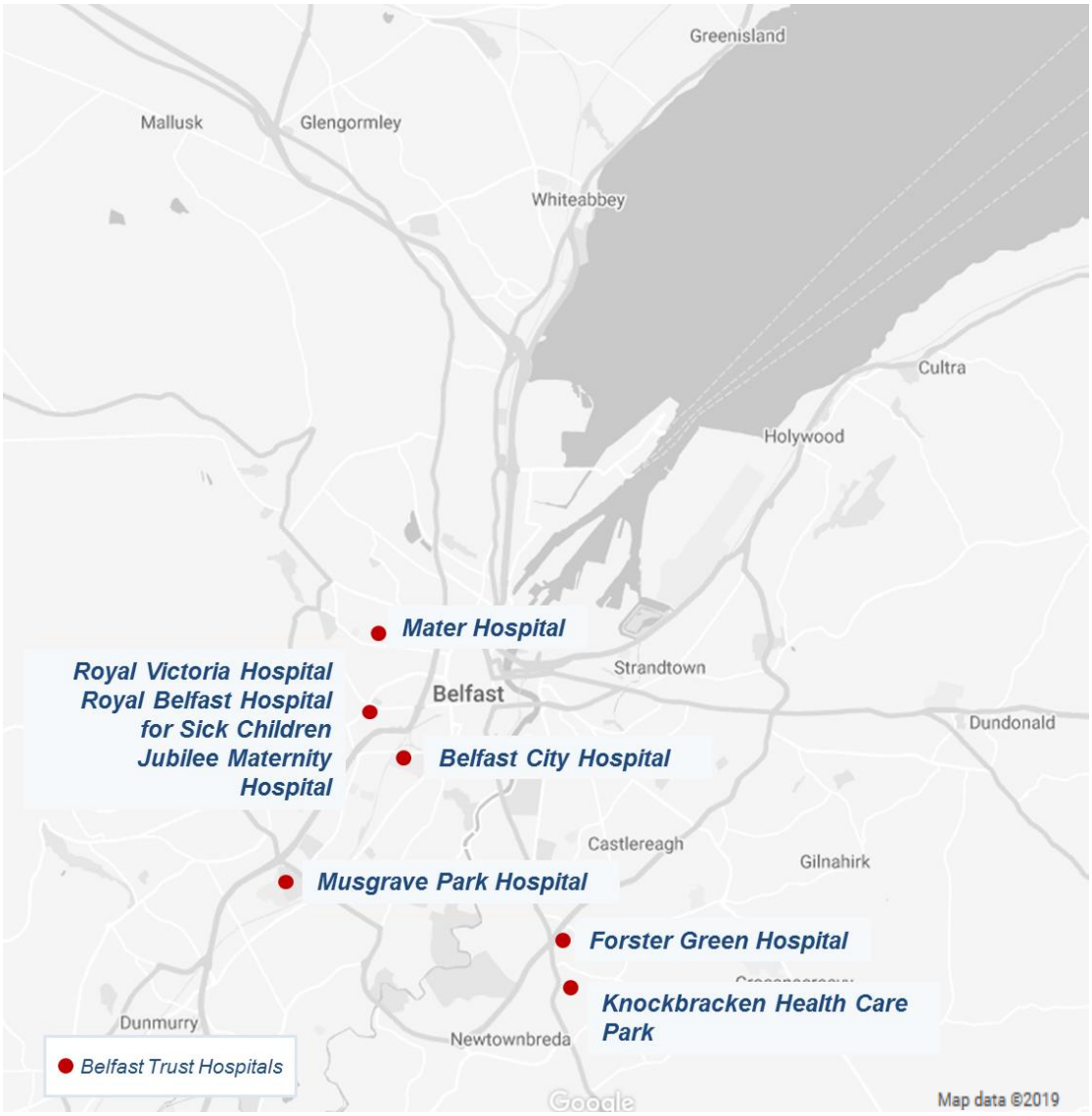
1.6 Outpatients Services in the Belfast Trust

The Belfast Trust is the largest integrated Trust in the United Kingdom[14]. The Trust delivers integrated health and social care to approximately 340,000 people in the greater Belfast area. It is one of five HSC Trusts created on 1 April 2007 in Northern Ireland and includes major teaching and training hospitals in the province. The Trust provides care to over 600,000 outpatients each year, while also delivering tertiary and secondary care to 150,000 hospital inpatients. It has an annual budget of £1.4 billion and a workforce of over 21,000 employees.

The Trust provides a range of specialist services including rheumatology, dermatology, nephrology and palliative care. These services are delivered and supported by specialist teams of multidisciplinary healthcare professionals. The Trust has several specialist regional units providing care in areas such as acquired brain injury, specialist fertility, neurorehabilitation, trauma, burns and plastic surgery and forensic psychiatry as well as clinics for gender identity and psychosexual services.

The Trust delivers services through eight hospitals which are located in Belfast and the surrounding area, these are Royal Victoria Hospital (which includes Royal Belfast Hospital for Sick Children and Royal Jubilee Maternity Service); Belfast City Hospital, the Mater Infirmorum Hospital, Musgrave Park Hospital, Knockbracken Health Care Park and Forster Green Hospital[c] (Figure 4).

Figure 4: Hospitals within the Belfast HSC Trust



Source: Google maps data 2019

[c] **Forster Green Hospital ceased to provide clinical services several years ago.**

Each hospital in the Trust offers a range of services, outpatients services delivered in the Royal Belfast Hospital for Sick Children were included in this review. Table 2 outlines the services delivered in the hospitals included in this review.

Table 2: Location of Outpatients High Volume Specialities within Belfast Trust

Trauma & Orthopaedic Surgery		✓		✓
General Surgery	✓	✓	✓	
Ophthalmology		✓	✓	
Obstetrics (Ante Natal)		✓	✓	
Paediatrics		✓		
Gynaecology	✓	✓	✓	
Ear, Nose and Throat	✓	✓	✓	
Dermatology	✓	✓		
Cardiology	✓	✓	✓	
General Medicine	✓	✓	✓	
Rheumatology	✓	✓		✓
Haematology (Clinical)	✓			
Thoracic Medicine	✓	✓	✓	
Gastroenterology	✓	✓	✓	
Neurology	✓	✓		

Source: Information submitted with the Trust's structured questionnaire.

1.7 Belfast Trust Outpatients Clinics

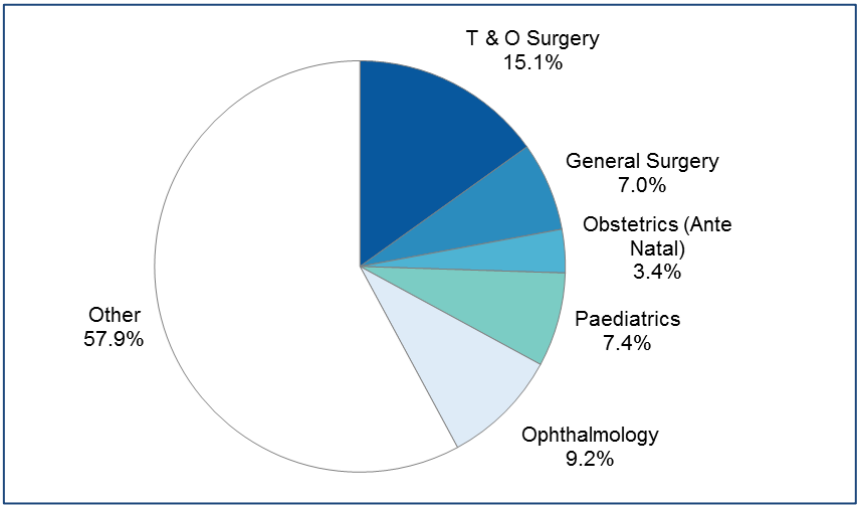
Belfast Trust delivers outpatients services in all of its hospitals and provides an average of 12,000 outpatient appointments per week. Outpatient clinics in each hospital may provide services for more than one service directorate within the Trust. For example, Belfast City Hospital delivers outpatients services on behalf of Surgery and Specialist Services (breast surgery), Unscheduled and Acute Care (cardiology, respiratory, neurology), Specialist Hospitals and Women's Health (gynaecology) and Adult Social and Primary Care (elderly care) Directorates.

During the review week (in September 2018) the Expert Review Team spent one full day in each of the five hospital locations (Royal Victoria Hospital, Royal Belfast Hospital for Sick Children, Mater Infirmorum Hospital, Musgrave Park Hospital and Belfast City Hospital). The Expert Review Team walked around each of the environments, met with staff and attended a range of meetings with staff groups.

As part of this review, unannounced inspections were undertaken (in October 2018) to the five main hospital sites where outpatients services are delivered for a wide range of specialties (Belfast City Hospital, Mater Infirmorum Hospital, Musgrave Park Hospital, Royal Belfast Hospital for Sick Children and Royal Victoria Hospital). Unannounced inspections were conducted over eleven days, during which time approximately sixty specialist clinics were delivered by a variety of Trust teams and services.

During 2017/2018 there were 614,544 outpatient attendances in Belfast Trust, of which just under half (42%) were within the five specialties of trauma and orthopaedic surgery, general surgery, obstetrics (antenatal services), paediatrics and ophthalmology (see Figure 5).

Figure 5: Consultant Led Outpatient Attendances in Belfast Trust by Specialty (2017/2018)



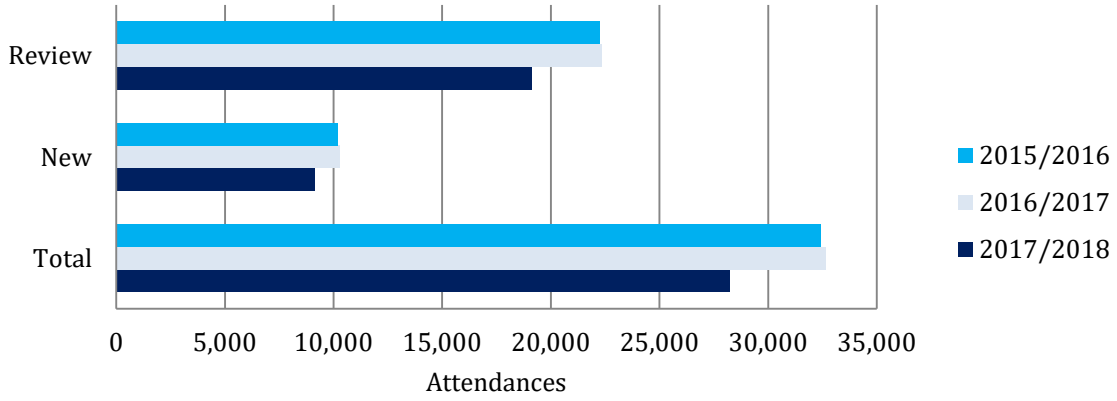
Source: Hospital Statistics Outpatient Activity Statistics 2017/2018, Information and Analysis Directorate, Department of Health (NI)[d]

[d] Other includes over 40 specialties including; neurosurgery, cardiology and neurology.

1.8 Neurology Outpatients Activity

During 2017/2018 total attendances at neurology outpatients clinics in Northern Ireland decreased to 28,259, having previously been in excess of 32,000 attendances each year in 2015/2016 and 2016/2017 (see Figure 6). Less than 10,000 attendances in 2017/2018 were for new appointments.

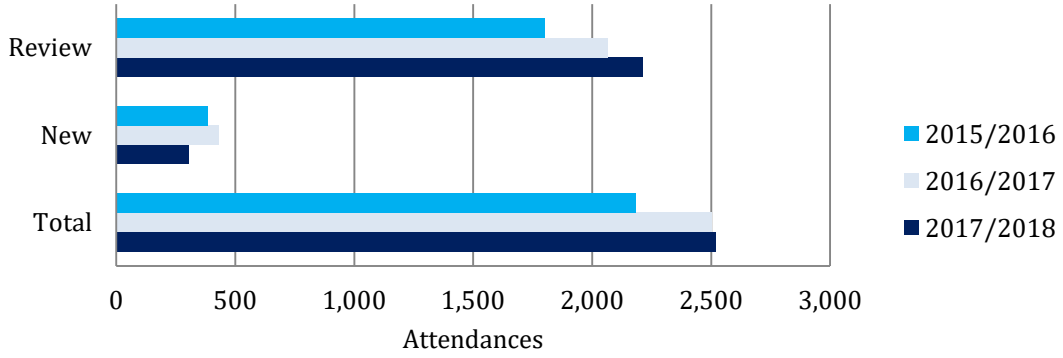
Figure 6: Outpatients Attendances for Neurology across Northern Ireland 2015/2016 to 2017/2018



Source: Hospital Statistics Outpatient Activity Statistics 2017/2018, Information and Analysis Directorate, Department of Health (NI)

Outpatients attendances at paediatric neurology services have increased by 13% over a three-year period, from 2,185 attendances in 2015/2016 to 2,518 in 2017/2018 (see Figure 7). Less than 500 attendances each year are for new appointments.

Figure 7: Outpatient Attendances for Paediatric Neurology across Northern Ireland 2015/2016 to 2017/2018



Source: Hospital Statistics Outpatient Activity Statistics 2017/2018, Information and Analysis Directorate, Department of Health (NI)

Neurology services face a significant challenge with large numbers of patients waiting for a first and/or review consultant-led outpatient appointment. At March 2019, 19,438 patients were waiting for a first consultant-led neurology outpatient appointment in Northern Ireland, with 11,249 patients (58%) waiting more than 52 weeks.

Belfast Trust currently delivers neurology outpatients services in three hospitals - Belfast City Hospital, the Royal Belfast Hospital for Sick Children and the Royal Victoria Hospital. During 2017/2018, half of all neurology outpatients attendances in Northern Ireland (51%) took place in either Belfast City Hospital and the Royal Victoria Hospital. In the same year almost all paediatric neurology outpatients attendances (95%) took place in the Royal Belfast Hospital for Sick Children[15].

A mixture of general and specialist neurology clinics are delivered by the Trust's neurology outpatients services. General neurology clinics include pre-assessment and rapid access neurology. Specialist outpatient clinics are delivered for multiple sclerosis (MS), epilepsy, epilepsy / obstetrics, movement disorders, neuromuscular disorders, motor neurone disease, headaches and cognitive function.

Section 2: Access and Organisation of Outpatients Services

2.1 Introduction

Fundamental to high quality outpatient services is the ability of patients to access these services quickly to enable needs to be assessed in a timely way. To understand the effectiveness of arrangements for access to Belfast Trust outpatients services we examined the mechanisms for referral from a GP, an ED, another service in the Belfast Trust, a service in another HSC Trust and/or a private consultation. We reviewed the various pathways into outpatients services in the Trust and the systems for triaging of referrals and the management of waiting lists. We also looked at the allocation of appointments, follow up after an appointment and discharge from the services.

Figure 8: Key contents covered in this section

2.2 Integrated Elective Access Protocol

The Integrated Elective Access Protocol (hereafter described as 'The Protocol') was issued by the Department of Health, Social Services and Public Safety (now the DoH) in April 2008. The Protocol provides a standardised approach in respect of arrangements for access to elective services across Northern Ireland[16]. HSC Trusts in Northern Ireland are required to plan and deliver services in line with this Protocol. The Protocol provides guidance on the management of referrals, booking and cancellations of appointments, organisation of clinics and management of waiting lists with a view to ensuring timely, equitable and appropriate treatment for all patients.

The Expert Review Team sought to understand the Trust's application of The Protocol and any related local guidance, as well as overall arrangements for monitoring and oversight of each patient's journey through outpatients services in the Trust. We noted that Belfast Trust staff are guided by an additional internal document titled 'Integrated Elective Access Protocol – Guidance for Staff'[17].

2.3 Referral

We examined the main referral routes into outpatients services across the Belfast Trust.

The majority of referrals to the Trust's outpatients services originate from GPs, for example, referrals from GPs to the neurology outpatients service accounted for 54.5% of all referrals to this service during 2017/2018[e]. There are exceptions, such as fracture clinics and adult cardiology clinics, where the majority of referrals originate predominantly in ED.

Referrals to outpatients services may also originate within hospital services and may be made from one hospital consultant to another or from one specialist service to another. The Trust reports that 33.4% of all referrals to neurology outpatient services originate from consultants within or outside the Trust. This proportion is higher than in most other specialties.

Neurology outpatients services have a number of sub-speciality clinics. These include clinics for patients with multiple sclerosis, epilepsy, epilepsy/ obstetrics, movement disorder, neuromuscular disorders, motor neurone disease and headaches. These services receive referrals from consultants and / or other services within the Trust. However all GP referrals must first be made to the core neurology service and not directly to a sub-specialty.

A range of mechanisms are used to refer and to register referrals to the Trust's outpatients services:

Referrals from GPs - Clinical Communications Gateway (CCG):

The CCG is the system for electronic exchange of clinical information from GPs. GPs can generate referrals to most hospital specialties on this system and these are sent to the Trust. These referrals are received by the Trust's Appointments Offices and are printed manually and sent to the respective consultant for triage. The Trust reported that not all GPs currently use the CCG system, with approximately 10%-15% of GPs continuing to forward written referrals to the Trust's Appointments Offices by post.

Referrals from Clinicians on Northern Ireland Electronic Care Record (NIECR) E-referral:

NIECR is an electronic system which enables health and social care staff to access records of investigation requests, appointments, encounter and discharge letters and information relating to patients' medical history. NIECR's E-referral facility enables secondary care clinicians to send and receive referrals through NIECR. GPs cannot currently send referrals through NIECR.

Referrals from Emergency Departments:

Referrals from ED to outpatients services are made in hard copy paper format. Upon receipt, these referrals are scanned into emails which are sent to the Trust's Appointments Offices. These are then printed and distributed to individual consultants for their triage.

[e] Information provided as an appendix to the Trust's completed structured questionnaire

Referrals from Other Trusts:

Belfast Trust reported that the majority of referrals from hospital consultants in other Trusts are posted to the Trust's Appointments Offices where they are registered on the Trust's PAS system and then forwarded to individual consultants for triage. The Trust indicated that a small number of referrals are sent directly to individual consultant's offices, and if this occurs the referral must also be forwarded to the Trust's Appointments Offices for registration and processing.

Referrals from the Independent Sector:

Staff reported that when an independent sector[f] patient wished to transfer into the Trust (to receive care as an HSC patient), they would advise their consultant that they wished to re-designate. The consultant would inform one of the Trust's Appointments Offices and also the Trust's Private Patients Office. This movement / re-designation would be recorded on PAS as 'Private to NHS' and identified by the use of the code PTN (Private Transfer to NHS). Staff told us that this code was introduced by the Trust in April 2018 to replace a number of previously used codes and to improve the oversight and monitoring of patients re-designating from the Independent Sector.

Referrals through Other Systems- Belfast Orthopaedic Information System (BOIS) and Paris

The referral routes described above apply to the majority of clinical specialties within the Trust, however two services receive referrals through other routes / information systems. The Trust's orthopaedic service uses a bespoke information system, known as BOIS and referrals through its orthopaedic outpatient services are registered through this system. Referrals received for community and mental health services are registered on the Trust's community information system, which is known as Paris.

We noted the myriad of referral routes into Belfast Trust's outpatients services. This multiplicity of referral routes and systems poses a significant challenge for administrators, managers and clinicians who may be reliant on two or three key individuals with expert knowledge of locally operating complex systems. Aspects of the Trust's referral systems are likely to include duplication and inefficiency, with local workarounds implemented to address the challenges encountered. This is likely to increase the complexity of locally operating systems and to add to challenges in assuring best practice at a system level across services and Divisions.

[f] When we use the term independent sector we are referring to those patients initially seen privately as opposed to within the HSC Services

We reviewed reports generated by various information systems and noted that, although current information systems generate reports of the numbers of referrals to outpatients services by profession of the referrer (i.e. GP, consultant, nurse, allied health professional (AHP), the Trust systems were unable to accurately identify those referrals to outpatients services arising from consultants or clinicians working in the Independent Sector. The Trust therefore does not have the information that it requires for oversight and assurance of patients re-designating from Independent Sector to HSC services.

Recommendation 1	**Priority 1**
Belfast Trust should review and streamline its systems and process for receiving and managing referrals to its outpatients services. Accurate data and intelligence arising from streamlined referral systems should be used to inform oversight and assurance of the Trust's referral processes.	

2.4 Triage

Triage is the process of assigning a level of priority to a referral to ensure that the patient is reviewed in order of their clinical condition / urgency. Referrals to outpatients services across Belfast Trust are triaged by hospital consultants or their authorised deputy. In some orthopaedic services delivered in Musgrave Park Hospital senior nurses undertake triage, guided by agreed protocols.

Outpatients referrals received by the Belfast Trust are categorised either as red flag [g], urgent [h] or routine on the basis of information provided on the referral form. A referral may be categorised as a red flag either at the time of referral by a GP or during the triage stage by the hospital consultant. When a referral is identified as a 'red flag' the patient in question requires urgent investigation for suspected cancer.

Following triage, referrals categorised as urgent should be booked within the maximum waiting time (as agreed by the relevant services) from the date of receipt of referral. Similarly referrals categorised as routine, should be booked within the maximum waiting time agreed by the relevant service. The prioritisation of referrals, including those relating to patients transferring from the Independent Sector is completed by individual hospital consultants or their authorised deputy.

We noted the Trust's single clinician approach to the triage of referrals to its outpatients services, referrals are not routinely reviewed or assessed by more than one clinician.

[g] Patients referred with suspected breast cancer are referred as 'Red Flag'. This term has been adopted by Belfast Trust to identify suspect cancer patients.
[h] The definition of clinical urgency is defined by specialty / procedure / service. Patients are treated on the basis of their clinical urgency, with urgent patients seen and treated first.

We also noted the absence of a robust system to validate and assure decisions relating to the outcome of triage of referrals received. Although the Trust's Appointments Offices advised they could audit cases where the triage grading had been changed and they could review individual clinician triage patterns, we found that this approach was not often requested or undertaken in the context of confirming or assuring best practice.

Recommendation 2	**Priority 2**
Belfast Trust should develop and implement a wider team approach to assure best practice in the triaging of referrals received for its outpatient services; a team approach is particularly important for referrals received to high risk specialties such as antenatal obstetric care.	

2.5 Waiting lists

The Expert Review Team noted that waiting lists present a particular and significant challenge for outpatients services in Belfast Trust, and that there is a similar position across other HSC Trusts in Northern Ireland. Current Ministerial waiting time targets advise that by March 2019[18], 50% of patients should be waiting no longer than 9 weeks for an outpatients appointment and that no patient should wait longer than 52 weeks. The Expert Review Team noted that at time of this review Belfast Trust was not achieving either of these targets. In its corporate performance report for July 2018 the Trust reported that 74% of patients on its outpatients waiting list at the end of May 2018, were waiting more than 9 weeks and that 31,882 patients were waiting longer than 52 weeks[19] for a first consultant led outpatient appointment.

We noted that challenges relating to excessive waiting times are included on the risk registers for all Directorates responsible for outpatient's services in the Trust. We met the Chief Executive of the Trust who emphasised his commitment to reducing waiting lists and implementing the 'Elective Care Plan: Transformation and Reform of Elective Care Services'[20]. We heard the Trust has established an Outpatient Modernisation Group, which has been tasked with modernisation of outpatients services across the Trust and with creating new ways of working in an attempt to manage services more efficiently and to increase capacity.

We heard of a number of initiatives to address the current waiting lists for outpatient services across the Trust, these include the establishment of mega clinics within orthopaedic services in Musgrave Park Hospital, the use of physiotherapists to undertake clinic assessments in orthopaedic services, and referral of patients with carpal tunnel syndrome to services within the Republic of Ireland. Although somewhat early in their development, we considered that initiatives such as these are promising, we heard positive feedback from multi-disciplinary staff involved in developing and delivering these services.

We noted the opportunity to increase skill mix and to provide career development for a range of staff through further development of new service initiatives. The Expert Review Team highlighted the critical importance of ensuring that all such service developments have a rigorous evaluation strategy agreed from the outset and of early proactive decisions, based on evidence, regarding value added and/or benefit gained from such service developments.

We noted that work has been progressed by the Trust's Outpatient Modernisation Group since its establishment. The Expert Review Team considered that the Trust could further support this group to expand and increase the pace of its work programme with a view to optimising capacity, further reducing waiting lists and delivering significant system-wide improvements across outpatient services.

Validation of Waiting Lists

The Protocol[i] advises that all patients referred to the Trust should be placed on a waiting list for an outpatients appointment, hospital admission, diagnostic procedures or in-patient treatment, as appropriate to their clinical need and priority. It advises that a continuous process of validation of waiting lists should be in place, that validation of waiting lists should be undertaken on a weekly basis (as a minimum) and that waiting lists should be continually reviewed as waiting times reduce.

The Trust advised it introduced a process of validation of waiting lists in 2017. As part of this process, patients waiting for particular outpatients services were contacted by telephone to confirm their continuing need to be on the relevant waiting list, either for a first outpatients appointment or for a review appointment. The Trust reported this validation methodology is in place for a specific number of outpatients services, and to date has resulted in a 25% reduction in the numbers of patients waiting for the relevant service. We were informed that the current process of validation is conducted in writing to patients.

The Trust advised that monitoring of waiting lists (numbers waiting, time waiting and waiting time for each clinic) is managed by the relevant service directorate in the Trust, and is supported by information and intelligence supplied by the Directorate of Performance, Planning and Informatics. Several reports are regularly produced and these are used to inform and support management of waiting lists, including:

- Capacity / Demand Monthly Report is shared with Directorates or Divisions with a view to facilitating extra clinics where needed;
- Primary Target Listings Report is used to calculate demand, to confirm triage completed and that the patient is on correct list; and
- Back Log Review: Long Waits is shared with the relevant Appointments manager, Service Managers and Hospital consultants.

[i] The Integrated Elective Access Protocol issued by the DoH provides a standardised approach in respect of arrangements for access to elective services across Northern Ireland

Although current processes for validation of specific Trust waiting lists (by telephone and/or postal communication) is clearly a valuable exercise, the Expert Review Team determined that additional focus should be placed on the clinical component of any validation process or processes undertaken by the Trust. Validation should preferably include a robust method of securing information on each patient's clinical condition, thereby enabling a risk stratification of those patients in most urgent need of review.

Robust validation of current waiting lists will assist the Trust in securing a clear understanding of the risks and clinical needs experienced by patients awaiting review, will provide an accurate picture of the numbers waiting and the associated timescales, and will greatly assist the Trust in planning and delivering its outpatients services.

Recommendation 3	**Priority 1**
Belfast Trust should strengthen its systems for validation of lists of patients currently awaiting review and / or assessment through outpatients services; validation should include risk stratification, by clinical need and priority, of patients currently on waiting lists.	

Transfer of patients from the Independent Sector

During our meetings with senior management and staff in the Trust we heard that referrals from the Independent Sector are handled in accordance with The Protocol[j].

The Protocol advises that when patients are seen by a consultant in the Independent Sector and indicate that they wish to re-designate to an HSC service, a referral is initiated by the patient's consultant to the relevant HSC service. Following receipt, this referral is triaged by the Trust and a relevant priority is assigned, the patient joins the waiting list for the relevant outpatient for the relevant HSC service at an appropriate point (which is based on clinical need and urgency determined through the triage process).

Representatives from the HSC Board and PHA advised the Expert Review Team that they were aware of patients moving between the Independent Sector and Trusts. They considered that it was the responsibility of individual Trusts to provide assurance that there is no disadvantage to HSC patients already on waiting lists as a consequence of patients moving from the Independent Sector into the HSC.

[j] The Integrated Elective Access Protocol issued by the DoH provides a standardised approach in respect of arrangements for access to elective services across Northern Ireland

The Expert Review Team observed that at the time of this review the Trust does not have a sufficiently robust system in place to assure best practice in this context. The Trust does not have effective operating systems to ensure patients transferring from Independent Sector services are appropriately identified and / or captured at the time of redesignation, there is no system for validation of decisions made in respect of triage of clinical need and / or urgency following referral to the Trust and the Trust does not have a robust system to audit transfers from the Independent Sector.

During unannounced inspections, undertaken as part of this review, we examined the Trust's systems and processes to identify, capture and record information, with a particular focus on patients redesignating from the Independent Sector to the HSC.

We reviewed data from the Trust's PAS system relating to a four-day period during October 2018. Of the 500 outpatient attendances captured in the PAS system, less than 1% were registered under the code PTN (Private Transfer to NHS, a new code introduced by the trust in April2018), indicating they had re-designated from the Independent Sector to HSC services.

We compared this finding to responses received to our patient survey (576 respondents) which indicated 5% of respondents had attended outpatients services in HSC following referral from care received in the Independent Sector. The Expert Review Team acknowledges these two groups are not directly comparable, however we note the difference between the survey findings (5%) and the inspection findings (1%) regarding patients moving from the Independent Sector. The Expert Review Team and our Inspection Team considered it is possible that use of the PTN code on the Trust's PAS system was not capturing all patients re-designating from the Independent Sector and that there was an under-ascertainment in this regard.

Recommendation 4	**Priority 2**
Belfast Trust should review its systems for identifying and recording information on patients transferring from the Independent Sector to Trust services; the Trust should ensure there is robust governance and oversight of all processes relating to transfer.	

2.6 Before the Appointment

During engagement with the Expert Review Team the Trust confirmed it follows The Protocol which advises the following booking arrangements for new patients and review patients:

New Appointments

All new routine and urgent patients referred to the Trust are partially booked. This means a written invitation is issued to the patient, inviting them to telephone the Trust's Appointments Office to make an appointment, within two to six weeks of receipt of their invitation. Two invitation letters to attend an outpatients clinic are issued to each patient. If there is no response to either letter the patient is discharged and the patient's GP or referring healthcare professional is advised in writing of their discharge. Trust staff told us, that if the patient then subsequently contacts the Appointments Office within a reasonable timescale (usually up to four weeks of being discharged) staff will try to make another appointment for the patient.

Review Appointment

Patients who require a review appointment are added to the review appointment waiting list and the majority are partially booked (i.e. a letter is issued requesting the patient to contact the Appointments Office to schedule their appointment, as described above).

We heard that a small number of specialist outpatient clinics book their own review appointments before the patient leaves the clinic in which they have been seen /assessed (for example: dermatology, hepatology and chest clinics). Other patients who have been seen in outpatients and require a review appointment are added to the review appointment waiting list for the relevant service and the majority are partially booked.

Cancellations, Do Not Attends (DNA) and Cannot Attend (CNA)

There are a number of ways in which an appointment booked for a patient to attend an outpatients clinic may be cancelled. Appointments may be cancelled by the hospital, patients may not attend for their appointment without giving prior notice (do not attend or DNA) or patients may cancel their appointment and give prior notice to the Trust (cannot attend or CNA). These scenarios contribute to significant lost productivity for outpatients services across the Trust.

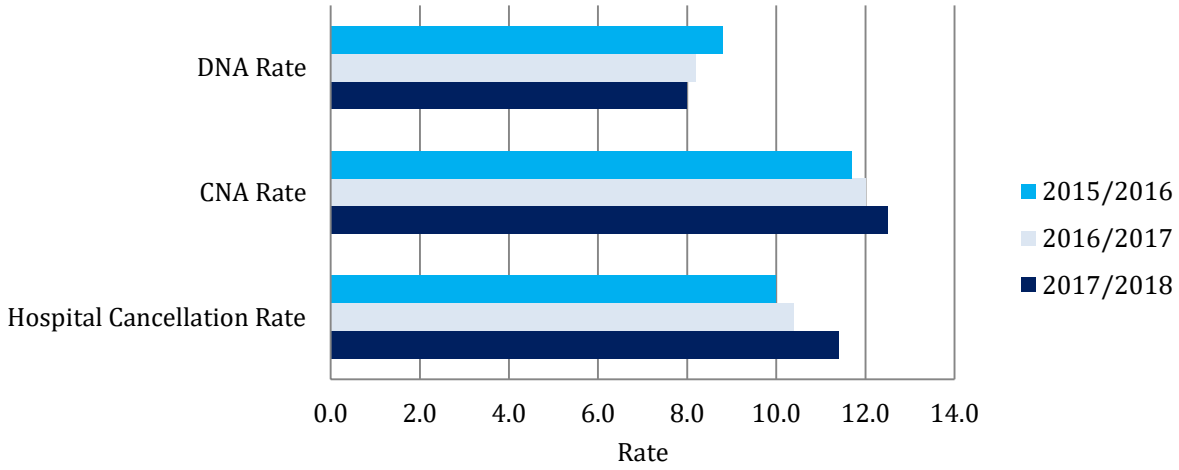
During 2017/2018, the Trust cancelled a total of 79,143 outpatients appointments per 100 referrals, equating to a hospital CNA rate[k] of 11.4. This cancellation rate is higher than the Northern Ireland average of 10.4.

[k] The Department of Health calculate CNA rate using this equation:

$$\frac{\text{Number of cancelled appointments}}{\text{Total attendances + number of cancelled appointments}}$$

Figure 9 illustrates that the Trust's cancellation rate has increased over a recent three-year period.

Figure 9: Outpatients Non-Attendance Rates at Consultant Led Services in Belfast Trust 2015/2016 to 2017/2018



Source: Hospital Statistics: Outpatients Activity Statistics 2017/2018, Information and Analysis Directorate, Department of Health (NI)

Discussions with staff during our 'Review Week' indicated a number of reasons why a clinic may be cancelled by the Trust, for example: planned leave, unplanned leave and / or study leave on the part of the hospital consultant. Staff indicated that the most common reason the Trust cancels a clinic is staff leave requested outside of the agreed six-week notice period.

We noted that only 15.7% of respondents to our patient, carer and relative survey, indicated that when their appointment was cancelled, the reason(s) for cancellation were explained to them and their appointment was promptly re-arranged. During our focus groups with neurology patients and their relatives we heard of instances where clinics had been cancelled two and three times.

We asked staff how data on cancellations and non-attendance at outpatients appointments (DNAs and CNAs) were used to help inform planning and delivery of services as well as services improvements. We were advised that cancellation reports were run on a monthly basis and used by the local Appointments Office Teams to ensure PAS reflected the reason for cancellation correctly. During our engagements with Service Managers responsible for outpatients services across the Trust it was not evident that this information was routinely requested or received or consistently used by Service Managers to inform service planning and improvement.

The Expert Review Team acknowledged the work progressed by the Trust to reduce the number of outpatient appointments lost as a result of cancellations and/or non-attended appointments.

However they considered that the level of appointments cancelled or not attended results in significant lost productivity for the Trust, cancellation may also cause considerable inconvenience for patients and their relatives/carers. The Trust must ensure that timely information is generated and made available on the number of cancelled and non-attended appointments and must communicate this information in a useful format to the relevant Service Managers who have operational responsibility for planning and delivering outpatient services. In Section 3 (Well Led) and Section 4 (Safe and Effective Care) of this report we consider further how the Trust is addressing productivity lost by cancellations and non-attendances and how effectively information is being used in this regard.

Recommendation 5	**Priority 1**
a) Belfast Trust should ensure that all outpatients services receive and actively use up-to-date information relating to productivity lost through clinics which are cancelled and / or not attended (DNAs and CNAs); b) The Trust should expedite its work to improve productivity and reduce the impact of cancellations and non-attendances at outpatient clinics.	

2.7 At the Appointment

During inspections undertaken as part of this review we visited outpatients clinics at the Royal Victoria Hospital, the Royal Belfast Hospital for Sick Children, the Mater Infirmorum Hospital, Musgrave Park Hospital and Belfast City Hospital. We observed patients being seen by a variety of multidisciplinary professionals during their outpatient clinic attendance. We observed patients receiving information about their condition and any tests or treatments which they were receiving or were recommended, this information was usually provided verbally by specialist hospital teams and/or outpatients staff.

Patients attending who are not booked

We identified a number of people attending outpatients services/clinic who had not been formally booked into the clinic on the day of their attendance. We learned this situation generally arose when a patient contacted a nurse or consultant with a concern relating to their known health condition; the nurse or consultant would subsequently have arranged for the patient to be accommodated at the end of the next planned outpatients clinic for the service in question. Our inspectors confirmed that a robust process was in place to capture and manage such short-notice attendances and that the patient's clinical notes were generally made available to support their attendance at the relevant clinic.

The Expert Review Team noted the dedication of many staff to ensuring patients who had reported a concern regarding their clinical condition were accommodated in as timely a way as possible.

Staff in some outpatients services initially reported that patients could potentially be added to or attend the end of an outpatient clinics and not be formally recorded in the Trust's information systems as having attended the relevant clinic. Inspectors monitored this throughout our unannounced inspections over eleven days in October 2018. Only a small number of patients were identified who were added at short notice to the end of clinics, all were noted to have valid reasons for attending, none of these were private/fee-paying patients and all were confirmed to be appropriately captured by the information system in operation for the relevant clinic.

Staff working in the orthopaedics outpatients service in Musgrave Park Hospital reported that patients presenting on the wrong date for their appointment and in the wrong location was a regular occurrence. Our inspectors observed this during our unannounced inspections in the hospital. Following discussion we noted that this was primarily related to content and format of appointment letters for orthopaedic clinics which are generated from the Trust's BOIS information system. All appointment letters, irrespective of the location of the orthopaedic clinic they relate to, have a large printed heading referring to Musgrave Park Hospital at the top of the letter. This results in some patients misreading the correspondence and presenting to Musgrave Park Hospital for their appointment rather than the specific location which is detailed within the body of the letter issued (which may not be Musgrave Park Hospital).

The Trust should address the potential for miscommunication in these letters and in agreeing a revised format will need to be cognisant of the main population groups likely to receive appointment letters for this service (will include elderly patients who have suspected or confirmed fractures). Our Inspection Team noted the helpful support and assistance provided by administration staff working in orthopaedic outpatients to patients presenting on the incorrect day or to the incorrect location for their appointment.

Recommendation 6	**Priority 1**
Belfast Trust should urgently review the content and format of appointment letters issued to patients attending orthopaedic outpatients services.	

2.8 After the Appointment: Follow-Up and Discharge

In July 2017, the Professional Record Standards Body (PRSB) published new standards in relation to outpatients letters[21]. These standards aim to improve communication between hospitals, other professionals and patients following outpatients appointments.

This was followed by the Academy of Medical Royal Colleges publication "Please, write to me" in September 2018, which offers guidance on issuing outpatients clinic letters directly to patients, rather than writing to their GP and sending a copy of the GP letter to the patient in question[22].

We noted a range of practices across the Trust in relation to communication with GPs following outpatients appointments. We noted an absence of clear operational standards for the Trust relating to the content, format and timelines for communication with GPs in this regard. Trust staff reported that each patient's GP receives a letter detailing when, where and by whom the patient was seen, the diagnosis or differential diagnoses made and treatment planned or advised for the patient. A majority of clinic letters were described as typed by the relevant consultant's secretary, added to the Trust's Patient Centre (PC)[I] system and then uploaded to the NIECR. We noted that some services issued clinic letters in a timely manner, while for other services there was a considerable delay in issuing letters to the patients' GP following the outpatient clinic. At the time of the Review we were not informed of any service that had agreed an approach to write directly to patients following their review at outpatients or to copy patients into the letter issued to their GP.

We heard that letters relating to patients in Musgrave Park Hospital were not immediately available on NIECR as they were created first on the local information system (BOIS), but that letters created on the Regional Information System for Oncology Haematology (RISOH) had been available to view on NIECR since 2018.

Through our online survey of GPs in Northern Ireland we noted that less than half of respondents (42%) reported they receive formal summary letters detailing their patients' outpatients review from Belfast Trust in a timely way. However, when we asked GPs if the information they received in the letters was detailed enough for them to provide ongoing care, 11% of those who responded to this question (17 out of 150 responses) stated that the letters lacked sufficient detail for them to provide ongoing treatment.

Figure 10: Feedback from our GP survey

We asked: *Do you receive formal summary letters detailing the outpatients review from the Belfast Trust in a timely way?*

***"Generally, yes, they are good quality".* GP**

***"The letters seem to be written for the doctor in outpatients or their consultant. I am frequently unsure what the outcome is".* GP**

***"Sometimes it is and sometimes it is not…depends on the specialty and doctor".* GP**

[I] Patient Centre is an electronic management system used in outpatients

During our engagement, Senior Trust staff acknowledged that systems and processes relating to discharge correspondence for patients receiving care in inpatient services were more robust than those for patients reviewed in outpatients services. We were advised that the Trust plans to undertake an audit of correspondence issued by outpatients services in order to describe current practices and to deliver improvements in the service.

The Expert Review Team noted that improvements have been made across inpatient services in the Trust, in relation to standardisation of content and timeliness of letters issued to GPs at the time of discharge. The Expert Review Team also noted that as part of the neurology recall patients were copied into communications relating to their outpatient review issued to the GP. We considered that the Trust will be in a position to identify important learning arising from these initiatives and to apply this learning across its outpatients services.

Recommendation 7	**Priority 1**
a) Belfast Trust should review its current practice in relation to communication with General Practitioners and other referrers, following patients' attendance at outpatients services. b) The Trust should agree, implement and monitor a standard set of key performance indicators across its outpatients services to underpin improvement in its written communication following outpatients review. c) The Trust should evaluate the impact and effectiveness of directly including patients in clinical correspondence following outpatients review, to determine if implementing this approach would be of benefit across all its outpatients services.	

Section 3: Well Led

Effective leadership is essential to ensure a high quality and well-led service. We considered the leadership and governance structures, systems and processes within the Belfast Trust and in particular across outpatients services. We reviewed the extent to which these support the Trust to identify and manage risk and to fulfil its accountability and transparency commitments. We also reviewed the systems and processes the Trust uses to measure, monitor and evaluate performance of outpatients services and to provide assurance to the Trust Board and Executive Management Team.

3.1 Vision

Belfast Trust has identified that its first priority is to be one of the safest, most effective and compassionate healthcare organisations. This priority is underpinned by the Trust's aim to be in the top 20% of high performing Trusts with regard to safety and quality by 2020. We met with many executives, senior managers, managers and frontline staff across the Trust during this review. We were impressed by their dedication to delivering the Trust's ambition and by their commitment to continuously improve the safety, quality and experience of people who access and receive services from the Trust.

The Trust is currently in the second year of its Corporate Plan 2018/2021[23]. Through this plan it has acknowledged the central importance of its workforce and has signalled its intention to work collaboratively to address future health and care needs and to build shared solutions to ensure the effective delivery of a transformed service. The Trust has highlighted four aspects of service improvement as the building blocks for achieving its' vision. These are; skilled clinical leadership, cultural change, data linked to organisational goals and standardisation of processes where possible. Through our visits to the Trust, our meetings with staff and our inspections of services we saw a range of projects and prototypes progressing work on these aspects of service improvement.

3.2 Accountability and Governance Structure

The Trust's Assurance Framework 2017/2018 identifies the role of Trust Board as a collective responsibility to add value to the organisation by directing and supervising Trust affairs. The Board provides active leadership to the Trust, it sets the Trust's strategic aims and ensures the necessary financial and human resources are in place for the Trust to meet its objectives. Figure 11 describes the roles of senior leaders across the organisation.

Figure 11: Trust Leadership Roles and Responsibilities

Within the Trust's devolved Directorate and Divisional structure and its collective leadership model, Directors have overall responsibility for their Directorate. Directors ensure staff within their Directorate understand and comply with systems for good governance. Each Directorate has its own operating and assurance structure and is supported by a Quality and Governance Manager.

Directorates are organised into Divisions, each with a Divisional Leadership Team that reports to and is collectively accountable to the relevant Director. Divisions are organised into Care Delivery Units, each with leadership teams that report to and are accountable to their Divisional Leadership Team. Leadership teams at Care Delivery Unit level are responsible for making decisions related to their particular area(s) and for working collaboratively with other teams within and across Directorates.

The Expert Review Team recognised and appreciated the Trust's clear commitment to implementing its collective leadership strategy and its refreshed organisational accountability arrangements in a meaningful way. While arrangements were clear, or in the process of being clarified, through Directorate and Divisional structures we found they were not necessarily as clear for staff providing care and /or treatment in outpatients services/ departments.

The Expert Review Team recognised the significant importance of Sister / Charge Nurses to providing stable, effective leadership at local level in outpatients services/departments across the Trust.

Through our many engagements we did not find evidence that Sisters / Charge Nurses in outpatients settings were sufficiently connected into the Trust's collective leadership structures or that they had harnessed their collective expertise and experience to influence and deliver improvement at a system level in the Trust (beyond their individual immediate service demands and priorities).

Recommendation 8	**Priority 1**
Belfast Trust should identify and strengthen mechanisms to engage Sisters / Charge Nurses across outpatients services in its work programmes addressing collective leadership and organisational accountability.	

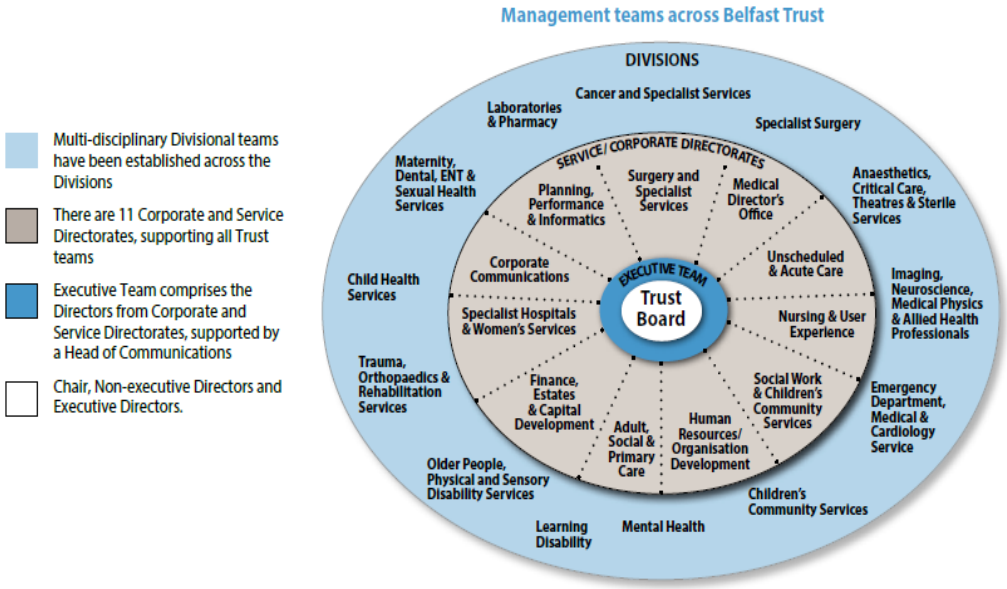
3.3 Delivering Services

The Trust's corporate objectives are informed by the needs of its population, its organisation specific requirements, standards and targets set out in the DoH's annual Commissioning Plan, and priorities advised by commissioners (the HSC Board and the PHA). These objectives are articulated through the Trust's Corporate Management Plan 2018-21[24] and its Annual Report [25] and implemented through the Trust's Directorate, Division and care delivery unit / service plans, and through team and individual staff plans. The Trust has identified that it will deliver improvement in elective care during each year of its most recent Corporate Management Plan 2018-2021[26], through building elective care capacity and improving outpatients, in-patient and day case waiting times.

The Trust delivers, manages and oversees its services through a Directorate structure, comprised of five service Directorates[m] and six corporate Directorates[n], as illustrated in Figure 12.

[m] Service Directorates: Unscheduled and Acute Care; Surgery and Specialist Services; Specialist Hospitals and Women's Health; Children's Community Service; Adult Social and Primary Care.
[n] Corporate Directorates: Planning, performance and Informatics; Medical Directors; Nursing and User Experience; Human Resources/ Organisation development; Finances Estates and Capital Development; Corporate Communications; Planning Performance and Informatics.

Figure 12: Belfast HSC Trust Management Structure



Source: Belfast Trust Corporate Management Plan 2018-21

Outpatients services in the Trust are delivered mainly through four Directorates - Surgery and Specialist Services, Unscheduled and Acute Care, Specialist Hospitals and Women's Health, Adult Social and Primary Care Services. The Performance, Planning and Informatics Directorate is an important partner to these service Directorates in the context of planning, scheduling, and operationally managing all outpatient services across the Trust.

Outpatients services are delivered in a range of locations in five main hospital sites across Belfast Trust. Each of the four service Directorates above is responsible for their own particular outpatients services. It follows that one outpatients clinic or department is likely to provide services for more than one service Directorate. For example Belfast City Hospital delivers outpatients services on behalf of Surgery and Specialist Services (breast surgery, neurology), Unscheduled and Acute Care (cardiology, respiratory), Specialist Hospitals and Women's Health (gynaecology) and Adult Social and Primary Care (elderly care).

During meetings with staff the Expert Review Team received feedback indicating general support for the Trust's service Directorate and Divisional operating structure. Clinicians told us that this model facilitates the care of patients at particular stages of their care pathway and also of patients who are moving between stages of care pathways. Managers told us this model facilitates integrated planning and delivery of Trust services.

Given the size and scale of Belfast Trust, the complexity of services the Trust delivers and the current service Directorate/ Divisions model it operates, the Expert Review Team noted that it was a challenge for senior managers in the Trust to have an accurate picture and maintain comprehensive oversight across all outpatients services they may be responsible for.

Recommendation 9	Priority 1
a) Belfast Trust should complete a mapping exercise to understand in detail the operational, management and governance arrangements across all outpatients services it delivers. b) The Trust should assure itself that operational arrangements for all outpatients services are appropriately aligned across service Directorates and Divisions, so that care delivered in outpatients is consistency well governed.	

3.4 Culture

The Trust described its ongoing work to develop a culture that reflects continuous improvement, person-centred care, and learning and development for all staff. Its corporate and strategic plans and associated documentation reflect this commitment. Many staff the Expert Review Team met during review meetings and our Inspection Team observed during unannounced inspections demonstrated the Trust values in action; respect and dignity, accountability, openness and trust, learning and development, and being leading edge.

The Expert Review Team met with the Trust Chair and two Non-Executive Director Members of the Trust Board. We appreciated their strong commitment to the Trust's values and to creating an open, transparent organisation in which everyone is empowered to speak up and challenge as necessary.

The Chair and Chief Executive described their regular visits to many frontline services across the Trust. They reflected on the openness of frontline staff they encounter during these visits and the willingness of staff to share what is good and what is challenging in the context of their work in delivering services. Members of the Executive Team described their regular leadership workarounds, highlighting the multiple purposes of these workarounds - to assess good practice; to identify challenges/issues; to celebrate success; to offer support and recognition to staff; and to engage with patients. The Expert Review Team recognised the Chief Executive's and the Executive Team's commitment to engaging with staff and patients across the Trust and to ensuring actions were progressed and improvements were made, as a result of learning identified during their visits with staff and patients, and following their walkarounds.

The Kings Fund has highlighted that 'leadership is the most influential factor shaping organisational culture, so ensuring the necessary leadership strategies, behaviours and qualities are developed is fundamental'[27]. The Trust has made a strong commitment to implementing a collective leadership model, a model which sees leadership as shared and distributed across the whole organisation and beyond.

In its Leadership and Management Framework 2016/ 2019[28] the Trust commits to creating a community of leaders which it defines as 'leaders at all levels of the organisation working towards achieving high performance and improvement'.

Through meetings and engagements with staff the Expert Review Team heard about the Trust's collective leadership model, adopted in 2016, and was encouraged by the positive reflections of many staff, including medical, nursing and other clinical groups, on implementation of this leadership model. We were advised of investments in teams at Directorate, Divisional and care delivery unit/service level, to enable a culture that engages and supports team members to find solutions and to improve together. We noted that each Collective Leadership Team is expected to include in its objectives a commitment to improving its effectiveness in working with other teams and organisations.

The Expert Review Team met with various Clinical Directors during our 'Review Week' who reported that the culture was changing across the Trust and that staff working in multidisciplinary teams were asking searching questions and providing challenge. We heard examples of service with good arrangements to support multidisciplinary working, for example the Trust's pain services.

Senior managers shared their experience of an improved culture, which they described as having greater openness, more questioning and more solution oriented approaches to challenges encountered. However, the Expert Review Team received variable feedback from frontline staff across outpatients services regarding visits from, and opportunities to engage with, senior Trust managers. Some outpatients staff could not recall when they had last seen or met with their Director or relevant senior leader. While the Expert Review Team recognised that implementing its collective leadership strategy and model is work in progress for the Trust, we noted that the Trust has signalled its intention to give further thought as to how this model will operate in its community facing services. The Expert Review Team welcomed this acknowledgement on the part of senior Trust managers, given that the emphasis of organisational development work undertaken to date has been predominantly on inpatient services and areas.

Recommendation 10	**Priority 2**
a) Belfast Trust should specify how its collective leadership strategy and model will specifically strengthen the delivery of safe, effective and compassionate care across outpatient services; b) The Trust should identify key measures to demonstrate the impact of its collective leadership strategy and model on outpatient services.	

3.5 Service Performance

The Trust employs a variety of systems and processes to evidence its performance and to provide assurance that it is meeting its objectives, these are underpinned by its Performance and Accountability Framework[29]. During meetings with the Expert Review team staff described performance reporting arrangements which included meetings of Trust Board, the Chief Executive, the Executive Team, Directors, Divisional Managers, Governance Managers and a range of other staff.

The Trust prepares a regular Trust Board Performance Report[30] which is presented to the Executive Team and the Board. This corporate report is presented in two main sections. The first describes the organisation's performance in relation to key indicators of safety, quality and experience (SQE) including mortality, healthcare associated infections, elements of the safety thermometer, medicines and patient experience. The second section sets out Trust progress against key standards and targets contained in the DoH annual Commissioning Plan Directions.

The performance of outpatient services is included in performance reporting arrangements for the Director and Divisional Teams of the relevant services. Given that outpatient services are delivered through at least four service Directorates and at least five hospitals across the Trust, the Expert Review team was not confident that current reporting arrangements enable comprehensive oversight of performance across all outpatient services delivered by the Trust.

We received a copy of the Trust Board Performance Report, we noted clarity in its presentation and we welcomed the use of data to inform oversight and assessment of performance and progress toward improvement. However, the majority of data reported in this Performance Report relates to inpatient rather than outpatient services. The report includes information relating to waiting times but is limited in respect of other indicators of quality or effectiveness for outpatient services. Given the proportion of the Trust's activity delivered through outpatients and the increasingly complex nature of care and treatment provided by outpatients services, the Trust needs to determine how it will measure and report appropriate indicators specifically relating to performance of outpatients services.

During visits and inspections undertaken as part of this review the Expert Review Team sought evidence that data was informing local service delivery and improvement within and across outpatients services. Frontline staff with whom we engaged demonstrated limited knowledge or understanding of how their service performance was measured or reported. Most outpatients sites displayed performance information relating to hand hygiene only, some displayed information relating to environmental cleanliness, and a few displayed data relating to other aspects of performance (for example medicines use, patient experience). The Expert Review Team noted that, in general, staff displayed low curiosity in relation to how performance of their service was measured and evidenced, with the exception of data relating to

clinic activity and/or patient throughput. All staff delivering outpatients services will need to be supported to understand the importance of measurement to evidence the quality of care they provide.

Recommendation 11	Priority 1
Belfast Trust should develop and implement a set of key indicators to assure its performance in relation to the care and / or treatment delivered through outpatients services. The Trust should not limit these indicators to activity data only. An agreed set of key indicators should be shared with the Trust Board and the Executive Team on a regular basis.	

3.6 Quality Improvement

The Trust has identified that one of the key aspects of its Quality Improvement (QI) Strategy is to have an open, transparent and supportive organisation that is continually learning and sharing[31]. A range of QI training programmes[o] are available to Trust staff, corresponding with skills and knowledge from Level 1 to Level 3 of the Regional Quality 2020 Attributes Framework[32]. The Trust Board, Chief Executive and Executive Team have actively participated in QI training. The Expert Review Team noted the clear commitment the Trust has made, including at Board level to improving the services it delivers and to equipping its staff with appropriate skills and knowledge to deliver these improvements. These QI programmes assist the Trust in creating and shaping its culture and in equipping staff to operate effectively within and across its complex health and care environments.

The Expert Review Team met with staff from the Trust's Human Resources and Organisation Development Directorate who highlighted the Trust's three previous successful accreditations with Investors in People (IiP). We heard about the Trust's plans to achieve re-accreditation with IiP Generation 6, staff highlighted that in this context a culture survey will be undertaken by the Trust during 2019.

Area of Good Practice

Building on learning from international best practice, nineteen staff from across the Trust have commenced work on a themed area of staff wellbeing described as 'Joy in Work'. Staff have completed online training with the Institute of Healthcare Improvement (IHI) and have now developed a project charter and a programme structure to progress work in this area across the Trust.

[o] QI Awareness Training
Level 1: a) Safety Quality Belfast- Level 2 of Regional Q2020 Framework, b) Specialty Trainees Engaged in Leadership Programme.
Level 2: STRIDE- Level 2 Scottish Improvement Leader
Level 3: Scottish Coaching and Leading for Improvement programme- Level 1.5.

The Expert Review Team received a detailed list of QI projects and audits undertaken by Trust staff in relation to outpatients services from 2015 onwards[33]. Examples undertaken included: improving outpatients wait times in orthopaedics; increasing the use of standardised patient letters in the Royal Victoria Hospital fracture clinic; and improving attendance at renal screening in patients with diabetes on maintenance haemodialysis. These QI projects were spread across a range of outpatients services and specialities including: cardiology; community paediatrics; dermatology; gastroenterology; general medicine; gynaecology; haematology; neurology; obstetrics and gynaecology; ophthalmology; orthopaedics; otorhinolaryngology; paediatric haematology; paediatrics; respiratory; and rheumatology.

It is clear that significant audit and QI work has progressed by Trust staff across a range of outpatients services and locations. While the Expert Review Team noted the volume and range of audit and QI work progressed and that the Trust has active plans to undertake further work in this regard, it was apparent that that much of this work has been undertaken on a single service or single location basis. While this approach will identify learning and deliver improvements for particular services and specific locations/sites, the Expert Review Team considered there are challenges in continuing with this approach in the absence of an overarching strategic framework. Effective co-ordination of disparate audit and QI projects is likely to require resource (with potential for duplication of effort), learning and improvements identified are likely to continue to focus on individual services or sites and there is a risk that the potential to identify and implement important system level improvements is not realised. The Trust will need to move beyond an approach that identifies learning arising from audits or improvement projects in a single service or location, to one which has the potential to deliver system wide improvement.

Recommendation 12	**Priority 2**
Belfast Trust should adopt a strategic approach to audit and quality improvement work involving outpatients services, to align with the Trust's organisation-wide approach to quality improvement and to focus on both specific service or site improvement and system level improvement.	

3.7 Managing Risk

The Risk Management Strategy

Risk management is the identification, evaluation and prioritisation of risk to control the probability and the impact of an incident[34]. The Trust shared its Risk Management Strategy 2017 - 2020[35] (hereafter The Risk Strategy) with the Expert Review Team. The Risk Strategy outlines the Trust's philosophy and strategic context, and sets out the responsibilities of staff to ensure successful management of risk.

The Risk Strategy articulates the Trust's commitment to providing and safeguarding the highest standards of care for patients and service users, and to:

"Do its reasonable best to protect: patient, service users, staff, stakeholders, other members of the public, its assets and reputation from risk which rises from its undertakings" [page 3 [36]].

Within The Risk Strategy the Trust identifies how staff at all levels (senior management, frontline, locum and agency staff) have a responsibility to identify risk. It recognises that even with a robust assurance framework in place, it is impossible to eliminate all risk, and that systems and controls in place across the Trust should not be so rigid they would impede innovation and the imaginative use of available resources.

The Trust has identified five risk objectives which are aligned to its organisation objectives:[37]

- A Culture of Safety and Excellence – ensuring an open and learning culture with robust systems to provide safe, effective care;
- Continuous Improvement - be a leading edge Trust through improvement;
- Partnerships - working collaboratively with all stakeholders and partners to deliver our purpose;
- Our People - showing leadership and excellence through organisation and workforce development;
- Resources - making the best use of resources by improving performance and productivity.

The Trust Assurance Framework and Principle Risk Document

The Trust has outlined that its Assurance Framework (hereafter The Framework) is a means by which the Board is assured of the effective identification and management of risk. The Framework enables the Board to review the principle risks to achieving the organisational objectives and identifies key controls through which these risks will be managed and mitigated.

Identifying Risk

Risks are documented, collated and tracked through the use of risk registers at various levels within the Trust. Risk registers aim to provide assurance about the effective identification and management of risk. During this review we received and reviewed these registers at a number of levels; the Principal Risk Document and Corporate Risk Register, Directorate Risk Registers and Departmental Risk Registers. We also spoke to frontline staff about their role in risk identification and management.

Principal Risk Document and Corporate Risk Register

The principle risk document outlines the main risks and related controls that the Trust had identified at the time of fieldwork for this review, these had been escalated through the organisation from the corporate risk register. We reviewed the principle risk document dated July 2018 and we noted two risks relating to outpatients services within Trust. The first was "the risk that patients who are not reviewed as clinically indicated could lead to clinical consequences and harm to patients". The Expert Review Team noted that the Trust appreciated the risk that patients currently on its waiting lists could experience harm as a consequence of delays in receiving care and treatment. The second risk outlined was "the risk to the safety and quality of care provided due to the case load of a single consultant neurologist". The Expert Review Team noted the Trust's description of this risk in the context of services delivered by one Consultant Neurologist. Other than the risks above identified within the principle risk document no other risks were identified in the Trust's corporate risk register specifically relating to outpatients services.

Directorate Risk Registers

Directorate risk registers collate the risks and controls for services across an entire Directorate. Risk registers for three Directorates were reviewed, namely; Surgery and Specialist Services, Specialist Hospitals and Women's Health and Unscheduled and Acute Care. We noted these were lengthy documents containing a large number of risks some of which had been on the register for long periods of time. Specifically relating to outpatients services, a range of risks were identified which related to waiting lists, non-adherence to regional guidance for decontamination of equipment, and physical accommodation.

Departmental Risk Registers

During unannounced inspections undertaken as part of this review our Inspection Teams reviewed specific departmental risk registers for services delivered in outpatients services in the Royal Belfast Hospital for Sick Children, Belfast City Hospital and the Mater Infirmorum Hospital. The Expert Review Team noted a large number of risks documented in these risk registers. A particular risk, in relation to the decontamination procedures for transoesophageal probes, was documented on all three risk registers. While we noted some common risks documented in risk registers reviewed, we did not find evidence of monitoring risks across a number of outpatients services (within one or more Directorates in the Trust) or that risks pertaining to outpatients services were being considered collectively across Directorates within the Trust.

Operational Level

The Trust advises that it employs a number of training programmes and approaches to actively promote and support a proactive approach to identification of risk and completion of risk assessments.

We noted the various risk templates ranging from health and safety to stress at work, which were available for staff on the Trust's intranet (the Hub). When our Inspection Teams spoke with frontline staff working in outpatient services across the Trust during unannounced inspections completed during this review, few had knowledge of or could describe the risks captured in the relevant risk registers or the main operational risks pertaining to their services.

Auditing Risk

The Trust has designed and uses a specific tool to enable services to undertake a regular self-assessment of the main risks impacting on their delivery of care and treatment to patients. This audit tool is known as the Belfast Risk Audit and Assessment Tool (abbreviated to BRAAT). Services across the Trust use this tool to assess and describe their compliance against key policies, procedures, guidance and legislation across five main areas. These are risk management; health and safety; medical gases and devices; organisational issues/matters; and health and social care of patients and clients.

Internal validation of BRAAT audit returns is undertaken by the Trust's Health and Safety Team. Following forty validation visits at August 2018, the Trust indicated that 96% of the fifty-six areas that completed BRAAT had achieved substantive compliance with the relevant standards outline in the audit tool.

The Expert Review Team considered that the BRAAT assessment tool in its current format and as currently completed, although a useful tool for periodic assessment of particular risks, is not a means of ensuring timely regular assurance of the Trust's robust management and mitigation of risks arising in relation to outpatient's services.

Communication of Risk

Senior managers described the Trust's weekly 'live' governance meeting. This is a one-hour teleconference meeting, held each Friday morning, with representation from governance managers and other senior staff across the Trust. Discussion at this meeting is proforma-guided and includes the following – incidents occurring that week, new serious adverse incidents (SAIs), new interface incidents, new early alerts, scheduled coroners cases and clinical negligence cases, complaints received, new/emerging corporate risks and RIDDOR[p] reportable incidents .

The Trust uses this teleconference as a mechanism to identify and report incidents and/or issues arising in clinical areas, the meeting also acts as a means of keeping people updated and building a shared understanding of new and emerging risks.

[p] RIDDOR stands for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. Under RIDDOR, employers, self-employed people and anyone who's in control of a business' premises are legally required to report specified workplace incidents, which include acts of non-consensual violence to people who are at work.

We reviewed the terms of reference for this weekly meeting as part of our work during this review and we noted that as well as covering a range of governance issues, participants are informed of any new corporate risks identified since the previous meeting. The structured proforma supporting this meeting ensures that an agreed set of areas, through which risks may emerge, is visited and discussed by senior governance managers in the Trust on a weekly basis. Papers summarising the teleconference discussion are shared with the Chief Executive and the Executive Team, enabling clear upward communication of new or emerging risks in a clear and structured way. It was notable however, that the Expert Review Team could not identify how outputs from this meeting are shared and disseminated from executive level in the Trust to frontline staff delivering care and treatment across outpatient services.

Having looked across the various systems to identify and manage risk, as currently operating in the Trust, the Expert Review Team noted some challenges. While a number of risks relating to service activity and throughput were clearly identified in risk registers, other risks relating to the clinical aspects of services delivered in outpatient settings were not necessarily identified (for example – risks relating to adult safeguarding, as described in Section 4 of this report). While individual service Directorates had systems in place to identify and manage/mitigate risks relevant to their particular services, evidence of a systematic mechanism to scrutinise risks for services delivered through more than one service Directorate was lacking. The Expert Review Team and our Inspection Teams also noted a challenge in relation to the availability of clear concise information on risks (emerging or continuing) and meaningful dissemination of that information to build a shared understanding across operational and management staff.

Recommendation 13	**Priority 1**
Belfast Trust should strengthen its approach to the identification and management of risk within and across the outpatients services it delivers by necessity this will include: a) A mechanism to ensure sharper focus for the known risks across the full range of Trust services delivered in outpatients settings; b) Progressing work to understand and mitigate new or previously unidentified risks, such as those described in this review; c) Ensuring that all staff delivering outpatients services are proactive in their approach to identifying risks as they emerge and to implementing systems to manage these risks; and d) Ensuring that the Executive Team and Trust Board are regularly updated and receive robust assurance regarding risks as they relate to outpatients services.	

3.8 Supporting Appraisal

The Trust reported that all staff participate in an annual appraisal. This meeting involves discussion between each staff member and their line manager or professional lead. A personal development plan is discussed and a set of personal objectives aligned to service requirements and the Trust's overall objectives, is agreed. Generally the agreed personal objectives and personal development plan are to be delivered during the twelve months following the appraisal.

Staff from Belfast Trust's Human Resources who met with the Expert Review Team indicated that the Trust has an appraisal target (across staff across all levels and Directorates) of 80% completion, at the time of this review the Trust-wide appraisal completion was reported as just over 75%. The Trust's Annual Quality Report for 2017/2018 indicates the Trust had a 98.8% rate of completion of appraisal for medical staff in 2016, against the 95% target for completion set by the DoH.

During our unannounced inspections, Specialist Nurses with whom our Inspection Teams engaged indicated that in general their annual appraisals were conducted by the relevant Service Managers for the service, who may not necessarily have a clinical background. We did not generally find evidence of wider professional input to annual appraisal for Specialist Nurses and did not hear of any examples of medical staff contributing to or providing professional input to appraisal of their team's or service's Specialist Nurses. The Expert Review Team noted this as a missed opportunity to support the Trust's Specialist Nursing workforce and to strengthen governance relating to specialist services delivered.

Practice appraisal and revalidation are processes through which consultant medical staff evidence their continuing professional development and maintain their licence to practice with the General Medical Council. These processes are facilitated through a system of established Medical Appraisers and Responsible Officers (ROs), who validate that the required standards relating to good medical practice have been achieved.

We did not find well-established data and intelligence systems to evidence good medical practice or to identify potentially poor practice (at an early stage) in the context of undertaking annual whole-practice appraisal with medical staff across the Trust. While some information was made available by the Trust to support annual appraisal (for example – information relating to number of complaints received or serious advise incidents reported), data relating to individual consultant activity, patient outcomes, procedures undertaken or treatment decisions made were not routinely available or supplied by the Trust. The Expert Review Team was advised that systems were in place to manage poor performance in respect of individual doctors, through medical and managerial lines of accountability and in line with the framework for Handling of Concerns about Doctors and Dentists in the HPSS 'Maintaining High Professional Standards'.

During the Expert Review Team's meeting with the Trust's Medical Director (who is RO for doctors connected to Belfast Trust) and Deputy Medical Directors, we heard about the Trust's work to develop the sources and quality of Trust information routinely available to evidence each doctor's medical practice at annual appraisal. Although the work was at an early stage at this time of this review, the Expert Review Team welcomed its commencement and highlighted that further development in this regard is essential to ensure Medical Appraisers and ROs are sufficiently sighted on each doctor's practice to inform discussion and decision-making during whole-practice appraisal.

The Expert Review Team concluded that the two initiatives – developing and implementing the regional electronic medical appraisal system and strengthening the Trust data and intelligence system to inform medical appraisal – are central to ensuring that both medical appraisal and revalidation are robust processes moving forward. The Team commended theTrust's recognition that system development in this context is required and welcomed the work initiated and commenced by the Trust prior to this review.

Recommendation 14	**Priority 1**
Belfast Trust should expedite work to develop its internal information systems so that data on clinical activity and patient outcomes (by service, by team and by consultant) are routinely reported and shared; this information should be available to support annual whole-practice appraisal and revalidation, as well as service planning and development.	

3.9 Incident management

In its Adverse Incident Reporting and Management Policy, Belfast Trust describes an Adverse Incident as "an event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation."[38] The Trust reported that adverse incidents are managed in accordance with their documents: Adverse Incident Reporting Management Policy[39], Reporting and Managing Incidents; Procedure for Grading an Incident; and Procedure for Investigating an Incident. The Trust also implements the HSC Board Procedure for the Reporting and Follow-up of Serious Adverse Incidents[40].

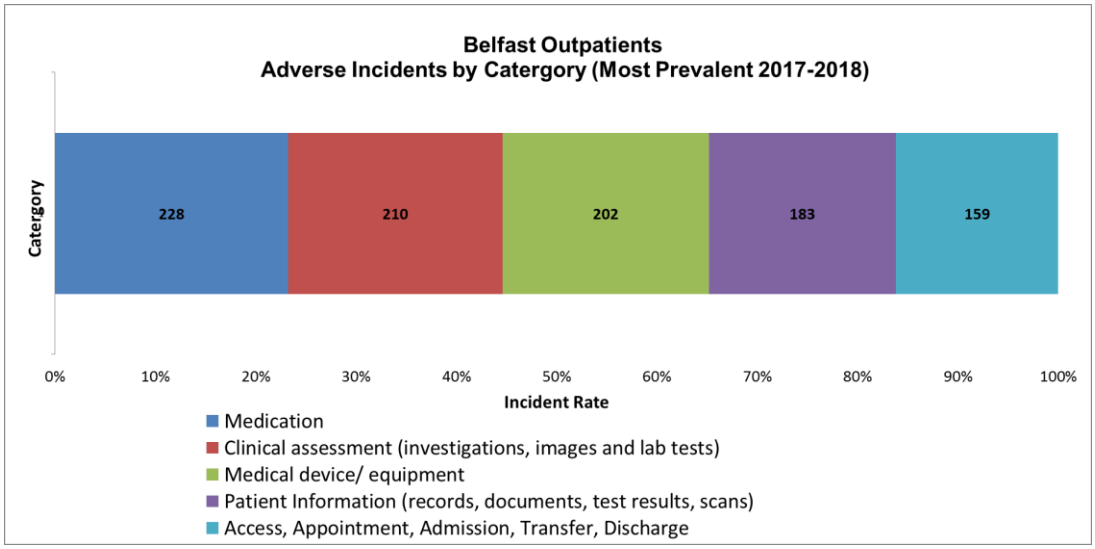
Belfast Trust uses the Datix electronic incident reporting system. All staff have access to the system through the Trust's intranet, any staff member can and is encouraged to report an incident through this system. Each incident entered on to the Datix system must have an identified approver linked to it; this is often the line manager of the staff member who reported the incident. The 'approver' reviews the details of the incident, ensures that the information entered by the person reporting the incident is clear and that the correct 'incident type' has been selected on the system. The 'approver' then approves and categorises the incident and will instigate an investigation into the incident when/as required.

We heard that the Trust uses a severity / consequence scoring matrix to grade incidents, to determine the level of investigation required and to establish if the incident meets the threshold to be categorised as a Severe Adverse Incident (SAI). We received a copy of this matrix to inform this review. We also received the Trust's Policy for Investigating an Incident (excluding SAI's) which describes processes for robust and systematic investigation of incidents arising across the Trust.

This policy articulates four levels of investigation depending on the incident in question (ranges from insignificant to catastrophic), the seniority of the staff member accountable for investigating each grade of incident, the required investigation methodology and the processes for sharing actions and learning arising from the Trust's investigation of the events in question. The policy advises that the Trust's relevant Co-Director or Director is accountable for the investigation of incidents with a major or high risk and catastrophic or extreme risk grading.

The Expert Review Team reviewed information regarding adverse incidents (AI) relating to outpatients services - 1,559 adverse incidents were recorded during 2017/2018, this accounted for 4.9% of all the Trust's adverse incidents reported that year. A summary of these incidents are illustrated in figure 13.

Figure 13: Belfast Outpatients Adverse Incidents 2017/2018



The Expert Review Team was advised that each service Directorate in the Trust has a Quality and Governance Lead, who is responsible for providing scrutiny and impartiality in assessing data and reviewing all incidents reported through their respective Directorate. It is the responsibility of these Managers, on behalf of their respective Director, to implement systems and processes to ensure that all adverse incidents, including Serious Adverse Incidents (SAI) within their Directorate are monitored and managed appropriately.

Serious Adverse Incidents

The DoH define a serious adverse incident (SAI) as: *"any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation"* which arises during the course of the business of an HSC organisation/ Special Agency or commissioned service[41]. An SAI must be reported to the HSC Board if the incident meets at least one of the SAI criteria as defined by the HSC Board within "Procedure for the Reporting and Follow-up of Serious Adverse Incidents, Nov 2016[42].

Investigations of an SAI are undertaken at three levels: Level 1 investigation- Significant Event Audit (SEA), the majority of SAI events will enter the investigation process at this level, and a SEA will immediately be undertaken to: assess why and what has happened; agree follow up actions and identify learning. If the SEA determines the SAI requires a more complex investigation, it will be progressed to either a Level 2 or Level 3 investigation. An SAI may also be categorised as a Level 2 incident from the outset (it is not essential to have undertaken a SEA at Level 1 prior to categorising an SAI as level 2). A Level 2 investigation is a Root Cause Analysis (RCA), which involves a systematic agreed methodology for identifying the root causes or an events which led to the incident occurring.

A Level 3 SAI investigation involves the independent investigation of an incident and is likely to involve a particularly complex event or incident, for example an event which involves multiple organisations or is high profile for a particular reason.

We reviewed SAIs identified and recorded by the Belfast Trust during 2017-2018 in Table 3. A total of eighty-six SAIs were recorded across the Trust during 2017/2018, of which two were identified and recorded in the context of outpatients services. Both were categorised at Level 1 (and hence had a significant event audit (SEA completed).

Table 3: Serious Adverse Incidents Belfast Trust 2017/ 2018

Investigation Level	Total Number (Trust wide)	Total Number (Outpatients)
Level 1	69	2
Level 2*	13	0
Level 3 **	4	0
Total	86	2

***5 SAI Investigations were escalated from Level 1 to Level 2**
****3 SAI Investigations were escalated from Level 1 to Level 3**
Source: Questionnaire returned from Belfast HSC Trust to inform this review (August 2018)

The Expert Review Team was advised that Belfast Trust has well-established systems for receiving, reporting and sharing information relating to adverse and serious adverse incidents. Safety alerts received by the Trust are circulated to the Quality and Governance Manager for each Directorate. These are reviewed by each Governance Manager for information, dissemination and action as appropriate within their Directorate. Senior Trust staff advised that significant work is undertaken by Governance Managers in relation to investigating and reporting adverse incidents.

Governance Managers reported that they triangulate data relating to adverse incidents, complaints, litigation and coroners cases on a regular basis, the Trust's weekly 'live governance' meeting was identified as important to facilitating this triangulation of data and information. The Trust's Medical Director reviews incidents on a regular basis, including the grading assigned to incidents reported, a monthly report is prepared by the Corporate Governance Team.

The Expert Review Team had an opportunity to discuss these systems and processes with both governance and clinical staff in the Trust. The Review Team appreciated the considerable work undertaken by a range of staff and was impressed by the commitment displayed by all staff to sharing information in a timely and productive manner and to actively identifying and mitigating emerging risks. However, the Review Team considered that there is scope to strengthen partnership working between clinical and governance staff in this regard.

The Review Team heard of instances where there was a perception that governance rather than clinical staff determined the seriousness/category of adverse incidents identified within services in service Directorates. It was notable that participation in the Trust's weekly 'live governance' meeting was predominantly governance rather than clinical staff. The Expert Review Team would highlight the importance of senior Trust staff supporting and assuring active participation of a range of staff in all governance activities.

The Trust described a number of processes through which learning arising from adverse incidents and SAIs is shared, including lunch-time learning events which all professional staff can attend. During unannounced inspections our Inspectors saw evidence of learning arising from incidents discussed at the morning safety briefings within outpatients services and departments. Nursing staff confirmed that learning from incidents is discussed at team meetings, shared by email and included in the Trust's governance newsletter. Consultant staff whom our Inspectors met confirmed that information relating to incidents and SAIs is circulated in the form of a summary report addressing incidents, accidents and related themes, and that they would expect particular incidents relating to their individual practice would be discussed at appraisal.

The Expert Review Team acknowledged the systems in place to capture, collate and respond to adverse incidents, SAIs, complaints and other related events. They noted examples of learning shared through operational service delivery arrangements in various parts of outpatients services across the Trust. They also noted the proportionately low number of SAIs reported in the context of outpatients services delivered by the Trust over one financial year (two SAIs reported over a twelve-month period), and wondered if this was an accurate picture of the services in question. The Review Team did not see evidence of data and/or intelligence relating to incidents displayed in outpatients services or used in a proactive way to pre-empt risks and to inform measures to enhance patient safety and service quality. They determined that prevailing approach across outpatients services to identifying and responding to adverse incidents, SAIs, complaints and other such events typically reactive rather than proactive.

Recommendation 15	**Priority 1**
Belfast Trust should strengthen its use of information and intelligence relating to incidents and complaints occurring in the context of outpatients services it delivers; the Trust should analyse this data and intelligence in a way that promotes a proactive approach to identifying risk and improving the quality and safety of outpatients services.	

Section 4: Ensuring Safe and Effective Care

Safety and effectiveness are cornerstones of high quality health care. To assess how the Trust's governance systems support safe and effective care we considered how these systems protect patients from abuse and avoidable harm, ensure care and treatment achieves good outcomes, promote good quality of life, and ensure that care delivered is based on the best available evidence.

4.1 Safeguarding

The practice of safeguarding is based on fundamental human rights and on respecting the rights of individuals, treating all persons with dignity and respecting their right to choose. Safeguarding should empower patients, including those at risk of harm, to manage their own health and well-being. It extends to intervening to protect people where harm has occurred or is likely to occur.

There are a number of regional and local policies, procedures and guidance in place within Belfast Trust, all have the specific intention of ensuring robust safeguarding practices. All HSC Trusts, including Belfast Trust, operate within the following guidance:

- Adult Safeguarding: Prevention and Protection in Partnership Policy (document issued by DoH, DHSSPS, July 2015)[43];
- Adult Safeguarding Operational Procedures (issued by HSCB, September 2016) Adults at Risk of Harm and Adults in Need of Protection[44];
- Co-operating to Safeguard Children and Young People in Northern Ireland (issued by DoH, August 2017)[45];
- Protocol for Joint Investigation of Adult Safeguarding Cases (issued by Northern Ireland Adult Safeguarding Partnership, August 2016)[46]; and
- Regional Core Child Protection Policy and Procedures (issued by the Safeguarding Board for Northern Ireland (SBNI) December 2017)[47];

Belfast Trust shared the following additional guidance documents with the Expert Review team and advised that all Trust staff were required to operate in accordance with these: Belfast Trust Adult Protection Policy and Procedures (issued by Belfast Trust, April 2013); and Intimate Care - Examination - Chaperoning Policy (issued by Belfast Trust, November 2012).

The Trust described safeguards within its recruitment process as set out in its organisational recruitment policy and procedures. Pre-employment checks are undertaken prior to an individual taking up a post in the Trust. The nature of pre-employment checks undertaken depends on the type of post to which the person is recruited and the expected level of interaction with patients and service users when the person is in the relevant post.

An alert list containing details of persons whose performance or conduct may place patients and/or staff at serious risk is also checked by the Business Services Organisation (BSO), Recruitment and Selection Shared Services Centre, prior to confirming successful appointments through the recruitment and selection process. Should a prospective candidate be on the alert list, recruitment may be suspended following discussion with the designated manager in the Trust depending on the nature of the concern identified and the particulars of the role in question.

The Trust has an adult protection policy and procedure in place[48], which outlines the roles and responsibilities of staff in relation to the safeguarding of adults. This policy outlines five levels of staff training in safeguarding, which depend on levels of patient contact across the wide range of roles staff may occupy within the Trust and also on the likely responsibilities staff may have in the context of ensuring adults receiving services in the Trust are appropriately safeguarded.

In the context of caring for children, in our questionnaire, the Trust describes how all outpatients services staff are required to complete Child Safeguarding Training and refresher courses in accordance with DoH requirements. The Trust's Child Safeguard Training is informed by the Safeguarding Board for Northern Ireland's (SBNI) Child Safeguarding Learning and Development Strategy and Framework 2015/2018[49].

The Trust initially reported that the majority of relevant staff working in the Royal Belfast Hospital for Sick Children had completed appropriate safeguarding training. During unannounced inspections of the Royal Belfast Hospital for Sick Children, undertaken as part of this review our Inspection Team found many examples of staff who had not been trained to Level 2 and staff who could not identify when they had last completed their training in safeguarding of children. The Expert Review Team was not assured that staff delivering outpatients services had updated their safeguarding training appropriately, many discussed safeguarding in relation to child protection only, rather than considering safeguarding in its wider, more holistic context.

In the context of ensuring safe care for adults attending outpatients services, the Trust's Adult Protection Policy and Procedures supplied to the Expert Team and to inform this review were dated 2013, and had an advised review date of 2015 (documentation provided middle 2018). Our Inspection Team could find no evidence to confirm that a review of this policy and procedures has been completed by the Trust.

During engagement with Trust managers and frontline staff across outpatients services, our Expert Review Team found it difficult to evidence a culture of safeguarding. Staff we spoke to indicated that they had undertaken safeguarding training, but despite this we found inconsistencies in their knowledge of local safeguarding arrangements.

Staff we encountered were aware of the presence of a safeguarding champion for children within the Trust, but were unable to advise us if a safeguarding champion for adults had been identified. The Expert Review Team were concerned that staff with whom they engaged were unclear of their potential roles and responsibilities in safeguarding and/or the triggers to identify and escalate safeguarding concerns.

Across adult and children's outpatients services in the Trust we found that staff were often unclear about the common signs or signals of a potential safeguarding concern, and were also unclear about the common triggers that could or would require escalation. Consequently, the Expert Review Team was not assured that safeguarding concerns would be appropriately identified, reported or escalated within outpatients services across the Trust.

We noted limited information in the form of posters or information leaflets available in the Trust's outpatients departments, to assist staff or service users. Senior managers told us that, in general, they felt frontline staff (including nurses) were confident in raising concerns relating to safeguarding. However, the Expert Review Team did not find evidence to support this assumption, noting staff reported inconsistently how they would report a safeguarding concern. Some staff reported that they would raise safeguarding concerns to their Team Leader or to the next person in the management structure while other staff indicated they may raise a concern with their Divisional Nurse.

We reviewed the Trust's risk registers in the context of identification and mitigation of risks relating to safeguarding of adults and children. The Unscheduled and Acute Care Directorate's risk register noted a risk in relation to systems for identifying vulnerable individuals in acute inpatient wards; this risk was not identified in the context of outpatients services.

The risk register we received from the Trust in relation to Unscheduled and Acute Care indicated that a lack of provision for adult safeguarding training in Allied Health Professions was identified and logged as a potential risk of harm to service users in June 2018. Further details in the register indicated that this risk had been escalated to Senior Management, with requests for funding to support training.

The risk register for the Specialist Hospital's Women's Health Directorate identified a risk relating to the Trust's inability to identify vulnerable children who are on the Child Protection Register and who present to an ED or to community services. A risk was noted on the Trust's Principal Risks and Controls Register in relation to children treated in areas of the Trust where clinical teams do not have the necessary training, including safeguarding. We noted that this risk had been retained on the risk register for a considerable time - it was created in May 2010 and was noted by the Expert Review Team in July 2018.

Overall, the levels of training, knowledge and awareness of staff across outpatients services in relation to safeguarding were a significant concern for the Expert Review Team; we could not be confident that safeguarding matters would be recognised or actioned appropriately in the context of outpatients services delivered across the Trust. This matter was escalated by RQIA's Medical Director to the Trust's Chief Executive and relevant Executive Directors. The Trust has since met with senior RQIA staff to discuss implementation of a targeted action plan to address these findings. RQIA continues to monitor the Trust's delivery of improvements in this area in line with our established escalation policy.

Recommendation 16	**Priority 1**
a) Belfast Trust should develop and implement a targeted action plan to improve knowledge and awareness of staff in relation to the safeguarding of adults and children receiving care and treatment in its outpatient services; b) The Trust must ensure it receives robust assurances in respect of compliance with best practice as advised by regional and local policies in this regard; and c) The Trust should review its risk register to ensure it is accurately capturing current risks relating to the knowledge and awareness of staff safeguarding roles and responsibilities.	

4.2 Staffing

Within all areas of healthcare, staff are a critical element of delivering safe and effective care. Outpatient clinics across Belfast Trust are staffed by administrators, healthcare support workers, medical practitioners, nurses, porters, receptionists and a range of other specialist professionals including occupational therapists, physiotherapists, podiatrists, radiologists, social workers and speech and language therapists.

Ensuring sufficient numbers of staff are available across all healthcare settings is a significant challenge for those who are charged with managing and planning services. At the time of the review the DoH is actively undertaking a series of workforce reviews as part of continuing implementation of its Health and Well-being 2026 Delivering Together (2016) policy, to better understand our future workforce requirements.

During engagements with the Trust's Executive Team and Senior Managers, the Expert Review Team was advised that there is a continuous assessment of staffing levels and that staff vacancies and absence rates are monitored on a monthly basis by care delivery/ service units, Divisions and Directorates across the Trust. Vacancies will be filled by locum, bank and/or agency staff where required and appropriate.

The Trust advised that a service gap continues despite the use of temporary staff and that outpatients clinics are adjusted to match staff availability, with some clinics reduced or cancelled if necessary. The Trust also reported continuing work with commissioners in the HSC Board and the PHA to progress service developments and investments aimed at enhancing staffing levels where particular needs are identified for particular services.

Effective Use of Medical Staff

New service models to deliver more efficient outpatients services are currently being tested and developed by the Trust (for example virtual clinics, outreach clinics and mega clinics) in specialties such as orthopaedics. The Trust indicated these service models aim to enhance the use of multidisciplinary teams in delivering services and to increase capacity across outpatients services which have traditionally been medically led and delivered.

We met with the Trust's Clinical Directors who provided examples of service developments which include telephone clinics; joint specialty clinics (neurology and endocrine); expanded and new clinics in the community; one stop shop clinics (ophthalmology cataract clinic) and multi-professional leadership of new service models (Allied Health Professional led in the spine service).

The Expert Review Team was impressed by commitment demonstrated by both clinical and managerial staff to seek and identify alternative or new models to deliver outpatients services. We considered that there were significant opportunities for the Trust to capitalise on new ways of working and to fully exploit the skills of a range of professionals (for example Allied Health Professionals and Pharmacists). The Expert Review Team is of the opinion that the impact of these service developments to date has been relatively modest and would encourage the Trust to expand and accelerate its current outpatients reform and modernisation program.

Some clinicians described a sense of frustration regarding their efforts to develop new models for service and/ or workforce. They indicated planning is sometimes undertaken in a fragmented way across the Trust, lacking a holistic view of the multidisciplinary nature of the service in question. In general, clinical staff reflected that where clinical networks exist, for example in cancer or stroke services, there is a more holistic and streamlined approach to both service development and workforce planning, which in turn provides a much greater opportunity for success in service modernisation.

During our discussions with neurology consultants we heard about the impact of additional clinics operating as part of the neurology patient recall. It was clear that clinicians working in neurology had responded to the increased demands of undertaking the recall however, the Expert Review Team concluded that such a level of increased service input would not likely be sustainable beyond the acute phases of the patient recall in progress as fieldwork for this review was undertaken.

The Review Team acknowledged the DoH commissioned "Review of Neurology Services in Northern Ireland", announced in July 2018, and anticipated this work would provide an appropriate forum to address neurology workforce planning in the context of a specialist regional service.

Overall, the Expert Review Team identified a lack of robustness in planning relating to capacity of the medical workforce across outpatients services in the Trust. This can be linked to the absence of an overarching strategic view of outpatients services across the Trust. We were unable to evidence effective oversight or systems to monitor and assure consultant caseloads, in particular oversight of outpatient caseloads and activity.

The Expert Review Team concluded there was an urgent need to collate and interrogate appropriate data relating to service activity and demand in order for the Trust to appropriately plan its medical workforce capacity. This is particularly important for services in which a significant proportion of activity and patient contact are likely to occur in outpatient settings.

Recommendation 17	**Priority 1**
Belfast Trust should ensure information relating to outpatient activity (by service, by team, by consultant) is collected, analysed and routinely shared; this data should be used to enable robust capacity planning and to inform future service development and modernisation of outpatient services across the Trust.	

Nursing Staffing

There are currently no defined tools to determine optimal nursing staff levels for outpatients services as there are for some inpatient services. Trust Managers reported that Sisters / Charge Nurses in outpatients services play an important role in monitoring staffing levels within and across clinics on a daily and weekly basis. Trust staff confirmed that Sisters / Charge Nurses in outpatients services meet weekly to assess staffing levels, to identify any shortfalls and to progress required actions to maintain service continuity. Sisters / Charge Nurses described their escalation measures to senior management when staffing challenges for their service(s) cannot be resolved locally.

Specialist Nurses

Specialist Nurses are nurses who have advanced skills in a particular area of practice. They frequently take a lead role in the delivery of aspects of a patient's care and treatment, and are often involved in the education and support of patients in managing long-term conditions. Some Specialist Nurses who have undertaken additional training are also able to prescribe medicines.

The Expert Review Team noted a large number of Specialist Nursing roles within and across outpatients services visited and inspected as part of this review. There also was a wide variation in roles undertaken by, and a range of services led by, Specialist Nurses. These included, by way of example - baby hip clinics in Musgrave Park Hospital; asthma clinics in Royal Belfast Hospital for Sick Children; hepatobiliary clinics and macular injection clinics in Mater Infirmorum Hospital; venous thromboembolism, tissue viability and bowel cancer clinics in Belfast City Hospital; and cardiology and respiratory clinics in the Royal Victoria Hospital.

Members of the Expert Review Team and our Inspectors engaged with a number of Specialist Nurses during our meetings and inspections, finding that many worked across multiple sites and appeared to have large and variable caseloads. In general, the Review Team did not find robust oversight of the Specialist Nurses who delivered outpatients services across the Trust. Supervision was usually provided by a line manager who was not part of an outpatients service. The Review Team was advised that supervision of Specialist Nurses does not routinely involve peer review of case notes or a review of patient outcomes. Appraisal and agreement of personal development plans are generally undertaken in a uni-professional rather than multi-professional manner (service aligned medical staff are generally not involved in appraisal). We noted one example of good practice in the Belfast City Hospital, whereby the tissue viability Specialist Nurses' notes are reviewed every month by the professional lead in the outpatients clinic, thus providing an element of clinical oversight, review of patient outcomes and supported learning for Specialist Nurses delivering the service.

The Specialist Nurses whom the Review Team met described limited involvement in multidisciplinary team meetings and in case presentations, indicating that workload and time constraints prevented them from participating. Our Expert Review Team acknowledged this feedback in the context of general nursing staff; however the Review Team was concerned about the lack of participation of Specialist Nurses in these important learning opportunities within their services.

The Specialist Nurses in Neurology services reported significant workloads at the time of the Review. These Specialist Nurses described how their managers and colleagues had ensured they had additional support since the introduction of the patient recall.

The Expert Review Team concluded that there is considerable variation in Specialist Nursing roles and responsibilities across outpatients services and sites in Belfast Trust. Many Specialist Nurse roles have evolved over time, and are not clearly defined. This has resulted in weakness within the systems of support, supervision, appraisal, professional development and revalidation for this group. The quality of care delivered by this group of staff is not routinely reviewed. The Review Team recommended that the care and treatment delivered by Specialist Nurses in outpatients services requires much closer oversight and monitoring.

Recommendation 18	Priority 1
a) Belfast Trust should ensure it develops and implements a robust system for oversight and monitoring of the quality of care delivered by Specialist Nurses and the related patient outcomes achieved across its outpatients settings; b) Specialist nurses should be appropriately supported to undertake their roles through effective supervision, professional development and support for annual appraisal and revalidation.	

4.3 Peer Review

An essential part of assuring and improving the care delivered through any service is the ability to undertake a regular review of clinical practice(s) within that service.

During meetings with Trust staff, the Expert Review Team heard several examples of peer review and support for clinical decision-making which the Trust secures from external partners / hospitals outside Northern Ireland. These include - joint clinics for hepatology, supplemented by an ongoing partnership with King's College Hospital, London, for the management of transplant patients and; peer review of particularly complex cases in children's services with in-reach initiatives with quaternary specialist services in the UK, for example: metabolic, endocrine and urological. The Review team was also advised that there are up to fourteen links with specialist services in the UK and that there is also an endocrinologist linked to Great Ormond Street Hospital in London. Allied Health Professionals who met the Review Team also confirmed that a proportion of their cases are subject to peer review on an ongoing basis.

The Trusts Annual Quality Report of 2017/2018 describes recently implemented systems and processes to support how the Trust learns to proactively identify risk of harm and continually seeks best practice as an organisation. The annual report describes the appointment of a Clinical Lead for Morbidity and Mortality whose role is to review associated systems and processes and to share learning outcomes[50].

During our review meetings and inspections, while many Trust staff described examples of clinical peer review in relation to particular services, the Expert Review Team was unable to evidence a systematic approach to deliver peer review of clinical practice across outpatients services.

Our Expert Review team viewed the potential for isolation of medical and/or specialist nursing staff in outpatients services as a particular risk for the Trust.

This risk is greatest where there is lone working outside a multidisciplinary team context, because of the nature of the specialty (can be highly complex), by the choice of the health professional or because of lack of governing systems across the service in question. This risk has been identified previously in the context of a patient recall in the Dental Hospital[51] in Belfast Trust.

Recommendation 19	Priority 1
Belfast Trust should develop, implement and assure a systematic approach to clinical peer review across its outpatients services.	

4.4 Working with General Practitioners (GPs)

The Trust reported that the introduction of the Northern Ireland Electronic Care Record (NIECR), has greatly improved its communications with GPs. Most referrals to the Trust's outpatients services originate from GPs. Formal clinical summary letters and hard copy Treatment Advice Notes (TANs) are predominantly used by the Trust to communicate back out with/to GPs; these will include the provision of information and outcomes in relation to individual patients.

Senior Trust staff told us that GPs contact the Trust through a variety of mechanisms including; emails, telephone calls and use of the Clinical Communications Gateway (CCG). The CCG is the national product across the HSC for the electronic exchange of clinical information. GPs can use CCG to send referrals to the Trust and also to monitor the progress of referrals.

The Medical Director and the Trust's Clinical Director of Primary Care advised the Expert Review Team that the Belfast Trust is accessible and responsive to GPs. The majority of Trust staff with whom the Review Team spoke reported that they felt GPs were comfortable raising concerns with, or to, the Trust should the need arise.

In our online survey to GPs (to which 175 GPs responded), we analysed the findings of two groups of GP's; those whose practices are based within the Belfast Trust geographical area (n= 68 respondents) and those whose practices are based in the catchment area of one of the other HSC Trusts in NI (n=99 respondents).

We asked GPs in both groups if they considered communication with Belfast Trust to be effective, a majority of these respondents (91% in each group: n=62: n=90) indicated that, from their perspective, communication in relation to Belfast Trust outpatients services was not effective. Table 6 describes survey responses from both groups of GPs.

Table 6: Question: How effectively does Belfast Trust communicate information about its outpatients services to you?

How effectively does the Belfast Trust communicate with you in relation to Outpatients services?	53%	38%	9%	0%	0%	Within Belfast Trust (n=68)
	57%	34%	6%	3%	0%	Other Trusts (n=99)

We then asked GPs if the Trust shared information in relation to their current range of outpatients services. Of those GPs whose practices are based within the Belfast Trust area- 76% of GPs (52 of 68 respondents) indicated that Trust services did not keep them updated regarding the current range of outpatients services. We then asked GPs who practices are based with the Belfast Trust catchment area if the Trust advised them of changes to services, for example- new / changed service models, changes to operating times etc., 92% (63 of 68 respondents) advised that they were not made aware of changes to services (Table 7).

Table 7: Question: Does the Belfast Trust keep you informed of changes to outpatient services for example: change to opening times, new ways of working.

	2%	92%	6%	Within Belfast Trust (n=68)

The majority of GPs indicated that communication in relation to outpatients services in the Belfast Trust could be improved through:

- Comprehensive information about the current outpatient services available; specialties and sub-specialties, teams delivering care and current waiting times;
- Improved legibility and timeliness of TANs and formal clinic summary letters; and
- Provision of details for an agreed point of contact in the Trust to receive queries originating from TANs or clinic summary letters.

We asked both groups of GPs (those working in the Belfast Trust area and those working in another HSC Trust area) if they knew how to raise a concern or complaint about outpatients services.

Two thirds of respondents, 66% (40 out of 61 respondents) did not know how they could raise a concern in relation to outpatients services, and almost three quarters 72% (44 out of 61 respondents) did not know how to raise a concern or complaint regarding a member of the outpatient healthcare team, see Table 8 below.

Table 8: Questions: Raising a concern about the Belfast Trust/ Belfast Trust staff member

Would you know how to raise a concern or a complaint about Outpatients in the Belfast Trust?	34%	66%	Both Groups (n= 61)
Would you know how to raise a concern or a complaint about the performance of a healthcare professional in Belfast Trust Outpatients?	28%	72%	

During this review the Expert Review Team identified divergence of perceptions on the part of the Trust and GPs regarding quality of communication with GPs in relation to outpatient services.

Recommendation 20	**Priority 2**
Belfast Trust and the Health and Social Care Board should establish clear mechanisms by which the Trust and General Practitioners can engage and communicate in relation to outpatient services delivered by the Trust. The Trust should also assure itself that General Practitioners who may have a concern relating to services delivered have been provided with clear information regarding how to raise their concern.	

4.5 Medicines Management

Only urgent medicines (which must be started without delay) and specialist medicines designated for Hospital Pharmacy supply are prescribed in outpatients services and subsequently dispensed by the Hospital Pharmacy Department. All other medication requirements for patients attending outpatients clinics are facilitated by the patient's GP following receipt of recommendation/advice in the form of a paper based outpatients TAN from the relevant outpatient clinic to the GP.

During inspections and review meetings, Trust staff confirmed that the majority of prescribing arising from outpatients services is undertaken by the patient's GP following receipt of recommendations from the outpatients doctor.

The TAN is used to communicate to the patient's GP, the details of diagnosis, treatment given at the outpatients clinic (if applicable) and the medication to be prescribed or adjusted (as applicable). The TAN is completed at the outpatient clinic and a copy is given to the patient to bring to their GP so that a prescription (if required) can be generated for the patient. If a prescription is generated then it is subsequently dispensed in a Community Pharmacy.

The Trust system operates in accordance with its Outpatient Treatment Advice Note Policy (October 2017). The TAN system is paper-based and the Trust currently has no effective method for oversight or assurance. We found no private prescriptions being issued through outpatients services during inspections undertaken as part of this review.

A regional "traffic light" system to manage the prescribing and supply of specialist medicines is in operation throughout Northern Ireland, this system is therefore the operational system within the Belfast Trust. Specialist medicines are classified either as Red List or Amber list. For Red List drugs the prescribing responsibilities reside with the consultant in charge or specialist clinician. Red list drugs often have particularly complex monitoring requirements necessitating specialist knowledge for the interpretation of results. Supply of Red List drugs is facilitated by the Hospital Pharmacy Department. For Amber List drugs it is recommended that the responsibility for prescribing be transferred with the agreement to the patient's GP and/or following establishment of "shared care" arrangements.

The Interface Pharmacist Network for Specialist Medicines oversees and monitors the Red/ Amber List and has developed patient-held monitoring booklets (for example: Methotrexate shared care monitoring booklet, Lithium Therapy Information Pack and regional shared care guidelines for specific medicines or therapeutic classes). A standardised specialist medicines prescription is utilised by all Belfast Trust and all HSC Trusts in Northern Ireland. This prescription includes a copy for the patient's GP. Arrangements for Red/Amber Lists are guided by the DoH Circular HSS (MD) 16/2003 entitled 'The Regional Group on Specialist Drugs – Implementation of Red/Amber Lists – 1 May 2003'[52]. In relation to the implementation of systems and processes relating to the red/amber lists, local oversight and assurance is achieved through the Interface Pharmacist in the Trust and the Trust's established Drugs and Therapeutics Committee.

For medicines stocked, prescribed or administered in outpatients, Trust staff reported that all medicines are managed as per the Trust's Medicine's Code. Each outpatients area has an agreed pre-printed "top-up" list of stock medicines to meet routine needs. Other items, required infrequently, can be ordered from the Hospital Pharmacy Department when needed using a Supplementary Order Book. If a medication needs to be administered to a patient during a clinic it will be prescribed on a specific Outpatient Kardex and the administration will also be recorded on this Kardex.

Any medicines identified on site visits were found to be stored appropriately, for example: oxygen cylinders stored correctly and clear signage in place. Inspectors also observed some pharmacists available in clinics to give advice, as needed. In the Mater Infirmorum Hospital, our Inspection Teams identified Patient Group Directions (PGDs) for the supply / administration of ophthalmology drugs which were out of date. Inspectors escalated this to Trust managers and this was immediately addressed with an extended date put in place for these drugs (to October 2019). However, upon return of the PGDs our Inspection Team evidenced that a number of additional PGDs in other categories were also past their expiry date. Inspectors brought this additional finding to the Trust's attention for immediate rectification. The Review team noted that that the Trust's internal governance arrangements did not identify this matter as an area of practice requiring attention.

Trust staff advised that incidents relating to medicines are reported through the electronic Datix system. These reports are reviewed at Medical Risk and Safety Groups, which examine trends and also share learning.

We enquired if the Trust would be able to identify any unusual prescribing patterns in relation to drugs, either prescribed within outpatients services or advised to be prescribed by the patient's GP for a patient seen in outpatients. We were advised this would be very challenging for two reasons; prescribing is generally completed by the GP following receipt of the hard copy TAN; and the Trust's top-up system for managing stock medicines is unable to provide data at a level whereby individual consultants and their prescribing practices can be identified.

During our meeting with HSC Board, the Head of Pharmacy indicated they would expect to be advised about unusual prescribing trends in Primary Care local HSC Board Pharmacy and Medicines Management teams and individual GPs who are required to inform him if they have a concern. He concurred that the current system which employs paper based TANs issued from outpatients services to GPs poses a significant challenge for oversight and assurance of prescribing and use of medicines across outpatients services.

The Expert Review Team concluded that, while there is robust oversight of prescribing of specialist medicines in outpatients services, there is only limited oversight of all other prescribing in outpatients services. There is a significant weakness in monitoring and oversight of medicines prescribed or recommended to be prescribed in the context of the currently operating system (is based on TANs issued in hardcopy to GPs). This presents a significant risk to the Trust as it has very limited ability to oversee prescribing practice of individuals and/or services delivering outpatient care and treatment. In turn the Trust has a limited ability to identify any unusual prescribing practices and /or trends relating to medicines used in the context of outpatients services.

The absence of an electronic prescribing system within the Trust and across the region to include outpatient services is a key limiting factor in this regard.

Recommendation 21	Priority 2
Belfast Trust should develop a system or systems to enable appropriate oversight and assurance of prescribing and prescribing advice across the Trust's outpatient services. This should include the development and implementation of an interim electronic system to replace the current paper based Treatment Advice Notes.	

4.6 Records Management

Maintaining accurate and up-to-date medical records is a key patient safety measure, a communication aid and a core professional responsibility for clinical practitioners. All HSC organisations operate under DoH best practice guidance Good Management, Good Records, which provides a framework for consistent and effective records management.

Staff used a mixture of electronic and paper-based records when delivering care in outpatient services in Belfast Trust. The Expert Review Team was advised that recording of clinical data is managed by clinical staff using the Trust's Record Keeping Policy[53] (December 2017). All documentation created during a patient's treatment is filed in their paper-based hospital medical record. 'Digitally born' records, for example, laboratory reports, radiological images / reports can be re-produced, if/as required. Much of the digitally recorded data can also now be viewed via the NIECR.

The Review Team noted that there are several electronic systems in use across outpatient clinics. Staff reported that these systems are not fully integrated with each other and some are outdated such as the PAS and BOIS systems. The Trust reported that a new digital single electronic care record is currently being developed through the Encompass Programme and will be used across the HSC in Northern Ireland. The Review Team welcomed this development, however also recognised that full operation of this care record is some time away.

The Trust reported that security of records was maintained by strict protocols governing permissions for access to electronic systems and ensuring that all staff had appropriate mandatory training in data protection (update required every three years).

The Trust submitted a number of other internal policies which staff were required to adhere to in the context of best practice in management of records including:

- Records Management Policy (dated, May 2018);
- Transportation of Records Policy (dated, May 2018);
- Retention Disposal Schedule (dated, May 2018);
- Policy for Processing Requests for Access to Patient/Client and Personal Records (dated, May 2018);
- Policy on the Access to Data for Organisations External to the Trust (dated, May 2018); and
- Policy on the Data Protection and Protection of Personal Information (dated, May 2018).

The Expert Review Team also heard about the use of Radio Frequency Identification (RFID) for tracking and management of patient records in the Royal Victoria Hospital. Electronic chips are attached to patient notes which enable staff to locate these notes during transport or within the hospital with a "go find me scanner".

The Expert Review Team noted that neurology services operating on the Belfast City Hospital and Royal Victoria Hospital sites had separate neurology clinical notes, these are in a blue file which is not enclosed within the main hospital record. Following a patient's review at outpatients services, a letter dictated by the medical practitioner is saved onto a PC system and the NIECR, and a copy of this dictated letter is filed with the patient's hard copy notes to ensure that information is available about the patient's outpatients attendance to other healthcare professionals.

This practice may result in the neurology service not having up-to-date and accurate information in respect of the holistic care of patients. Similarly, other specialist services attended by the patient may not have comprehensive details of all activities relating to the patient's neurology outpatients attendance or review. The Trust's staff who are responsible for information governance described the practice of creating a separate record for a specialty as historic custom and practice. During meetings with the Medical Director and Deputy Medical Directors the risks associated with this practice were acknowledged.

The Expert Review Team concluded that there are significant risks associated with the practice of retaining separate patient notes for specialty outpatients services (including neurology, dermatology and rheumatology).

Recommendation 22	**Priority 1**
Belfast Trust should cease the practice of retaining separate paper-based notes for particular outpatients specialities; the Trust should develop a system whereby patient notes for all specialities as retained as part of an integrated hospital-wide record.	

4.7 Outcomes

The Belfast Trust reported that, in outpatients services, the patient's assessed need and resulting care and treatment was based on relevant legislation, standards and evidence-based guidance (for example: NICE Quality Standards).

To examine how the Trust assures patients have good outcomes, we reviewed the systems and processes underlying how the Trust collects and monitors evidence of the effeteness of patient treatment, evaluates care against national and local benchmarks, and how the Trust uses audits to ensure effective care.

Regional and National Benchmarks

The Trust recently participated in the Patient Experience Collaborative, a national exercise which involves an independent team collating patient feedback across ten domains (for example: information communication, staff attitudes and other elements of the patient experience) and comparing the outcomes against those measured at thirteen[q] other organisations across the UK. Insights from this exercise indicate the Trust continues to improve upon its baseline score recorded in November 2017 (classified as below national average) to above average in July 2018.

We found examples of the Trust participating in a number of benchmarking initiatives, such as:

- The Annual Parkinson's disease UK Audit;
- The UK and Northern Ireland Epilepsy and Pregnancy Register (hosted by the Belfast Trust);
- The National Audit of Seizure Management in Hospitals; and
- MS Base (an information database on Multiple Sclerosis) and the UK MS Register.

[q] The Trust's Annual Quality Report does not refer to these organisations by name

In their response to our questionnaire, the Trust mentioned their participation in the national British Society for Rheumatology (BSR) gout audit, however, they acknowledge the more general review of Rheumatology care and treatment outcomes were “severely hampered” due to the lack of a local database and not being linked to a national database or audits.

We are encouraged by the Trust’s efforts to develop dashboards to enable reporting outpatients services activity at a speciality level, however the Expert Review Team felt that the inclusion of additional performance data for example: patient satisfaction rates, would prove invaluable.

Patient experience

We asked 576 patients and relatives how satisfied they were that care was effective. Of the 526 (91%) who answered this question; 85% (447) reported that they were either satisfied or very satisfied.
Positive comments related to:

- Excellent treatment with real and consistent improvement in the patient’s condition;
- Knowledgeable staff who explained things well, listened to concerns, were reassuring, caring and made the patient feel at ease; and
- Clear information provided and explanation of process, with discussion facilitated and encouraged.

[r] https://www.nhsbenchmarking.nhs.uk/projects/2017/4/10/outpatient-services

Negative comments related to:

- A feeling of care falling short, repeated procedures and not having the problem investigated;
- Staff not listening to concerns, patients unhappy with treatment plans, staff not having enough time, not having read patient notes and a feeling of being disorganised and notes not being updated;
- Patient not fully informed, problems with getting results or results not being explained in easy to understand terms;
- Timeliness of treatment; appointments rushed; timeframes not provided for further investigation/treatment; and
- A lack of signposting and lack of car parking for disabled patients.

Audit

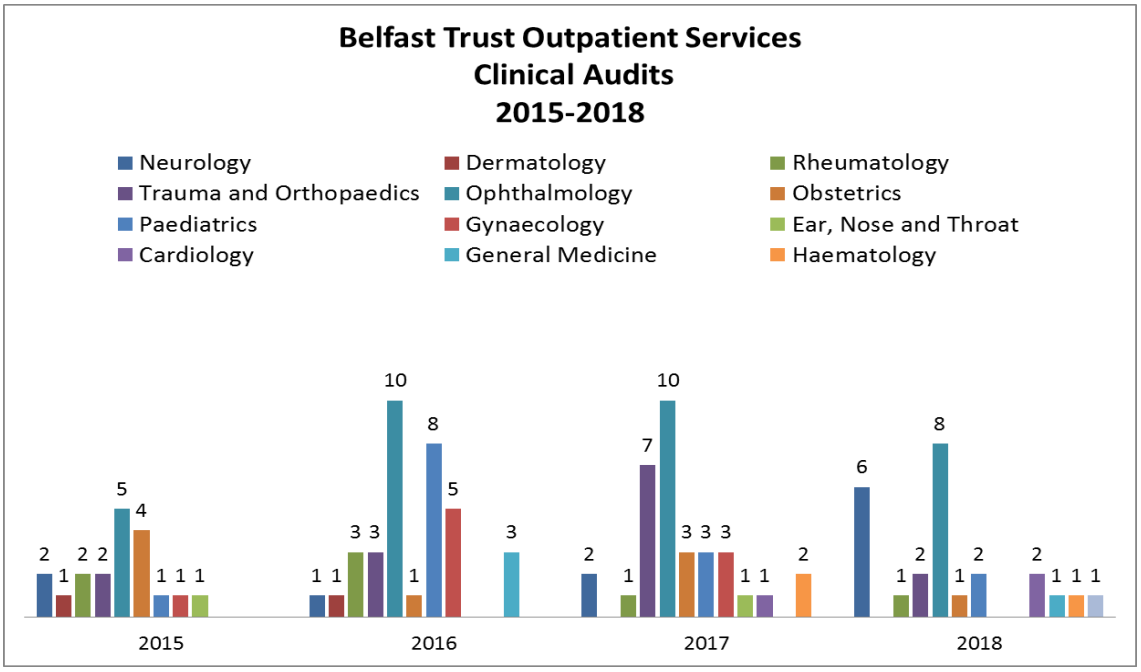
Clinical audits were undertaken within the Trust to assess performance against agreed standards. These would be undertaken in line with the Trust's Quality Improvement and Audit Policy, which aimed to provide a standardised approach.

In our meetings with senior staff, we were told that outpatients staff undertake clinical audits and used the findings for improvement of their services. Medical staff had protected time each month to complete such activities.

We were advised that staff in dermatology engaged in audits for the British Association of Dermatology, such as the National Audit of Psoriasis Management or the National Audit of Atopic Eczema. We heard that clinical audits were presented during Morbidity and Mortality meetings or monthly audit, governance or business meetings, for example, at the weekly meeting for neurosciences. In dermatology, we were told about local and regional audit and clinical governance meetings during the year.

The Trust submitted a list of over 100 audits which had been undertaken throughout high volume specialties in outpatients from January 2015 to July 2018. The clinical area these audits were untaken in 2015-2018 are presented in Figure 14. We note an increase in audit activity from 2015 to 2018 in particular Neurology.

Figure 14: Belfast Trust Outpatient Services Clinical Audits 2015-2018



Neurology Audits

We note the frequency of audit undertaken in Neurology services increased from the single example recorded in 2016 (neurosurgical management Normal Pressure Hydrocephalus) to six as recorded in 2018[s]. Audits undertaken in 2018 examined various aspects of Multiple Sclerosis, stroke, physiotherapy adherence and spasticity treatment provided by the Trust. Titles of the audits undertaken in Neurology services are presented by year in Table 9.

[s] August 2018- receipt of Trust data to inform this review

Table 9: Titles of Audits undertaken in Belfast Trust outpatient services

		Audit Title
Year	2015	Neurology Clinics Patient Satisfaction Audit of Prescribing Practice of Alemtuzumab in patients with Multiple Sclerosis
	2016	Audit of neurosurgical management of Normal Pressure Hydrocephalus (NPH)
	2017	Audit of red flag referrals to Belfast Trust neurology service Patient waiting from referral to being seen at Transient Ischemic Attack (TIA) Clinic
	2018	Audit of clinical status of patients with secondary progressive Multiple Sclerosis Audit of bone health monitoring in epilepsy patients Spasticity Clinic Audit Audit of adherence to the Northern Ireland care pathway for the use of fingolimod in patients with Multiple Sclerosis Physiotherapy and nurse-led neurological muscular clinic Decompressive Hemicraniectomy after Stroke

When we asked staff how they monitored the effectiveness and quality of the care and treatment that was being delivered, the majority of staff referred only to basic operational audits such as infection control and hand hygiene.

We welcomed the plans for development of specialty level dashboards and would encourage the Trust to expedite the development of these as a priority, ensuring outpatient indicators are included. These dashboards could include information such as number of incidents, attendances and cancellations, non-attendances, infection control, outcomes as captured through benchmarking activities, numbers waiting and patient satisfaction. This is vitally important in monitoring the quality of care delivered throughout the outpatient's service in the Trust.

Recommendation 23	**Priority 1**
a) Belfast Trust should agree a range of key performance indicators across all its outpatient services; b) It should assure and govern these systems for service improvement; c) It should communicate these to services through specialty level dashboards; and d) For highly specialist areas these may include particular indicators relating to interventions, treatments and investigations requested/delivered within outpatients clinics.	

4.8 Dealing with Complaints

Complaints offer an invaluable means of feedback to inform services and improve health and care. We sought to understand the Trust complaints system and how complaints were used to drive service development.

The Trust has a complaints department through which a patient or relatives can raise a complaint. The Trusts provides clear information on how to make a complaint and indicates that the department will acknowledge these within two working days of receipt, and that it aims to provide a response within twenty working days. This excludes exceptional cases for example, when a complaint involves multiple services, in which case the Trust will explain this to the complainant.

From its Annual Quality Report (2017-2018) we note the Trust receives a substantial number of complaints annually. The Annual Quality Report details that it received 1,680 formal complaints in 2017/2018. We noted that the top five most frequently made complaints were in relation to waiting lists, delays, and cancellations of outpatients appointments.

During discussions with staff, we were told that complaints in outpatients were low in number and centred on waiting times for first outpatient appointments. They also included complaints received regarding car parking facilities. This was a particularly noted on the RVH site.

Though the Trust receives a large number of complaints, responses to our survey indicated that some respondents did not feel they would be able to make a complaint. We asked patients if you / your relative felt you had to make a complaint about the care received in outpatients, would you / your relative feel able to do so. Approximately a quarter of those who answered this question (540) indicated that they did not feel able to make a complaint (Table 10).

Table 10: Question: if you wished to make a complaint about outpatient services would you feel able to do so.

If you / your relative felt you had to make a complaint about the care received in this outpatients clinic, would	52%	25%	23%

During our meetings with the Trust, we were told that they were receiving significant numbers of complaints in connection with the ongoing neurology patient recall exercise, which was placing complaint management systems and staff under pressure both within the central complaints department and in the neurology service. The substantial increase in the volume of complaints being received was impacting on the timeliness of response and required additional resources and the re-direction of resources from other areas in order to provide the necessary capacity to liaise with complainants, investigate concerns and issue formal responses.

Given the nature of the complaints connected with the recall, the Trust should ensure sufficient capacity exists to provide timely responses to complaints.

Through our questionnaire the Trust identified two mechanisms used to disseminate learning from complaints. The first concerns the Trust's complaints department which participates in the weekly Trust-wide governance teleconferences (previously mentioned in section 3.7 Managing Risk). These provide an opportunity to highlight trends in complaint topics, response times, risk grading, and identification of complaints in relation to an individual employee or department and multiple complaints for individual complainants.

The second involves the Trust's Service User Experience Feedback Group. We received this group's Terms of Reference to inform this review and noted that duties outlined include identifying trends and areas of concern in relation to the service user experience, monitoring high risk complaints including those under consideration of the Northern Ireland Public Service Ombudsman (NIPSO). The Terms of Reference also describe how this group ensure that lessons learned from service user experiences are shared with a Divisional Representative within the Trust and, where appropriate, across the HSC.

We recognise the Trust commitment to learn from complaints and that it manages a large volume of complaints annually. The increasing workload generated by the neurology patient recall is a challenge and the Trust should ensure the complaints are addressed in a timely way.

4.9 Infection Prevention and Control

Infection prevention and control practices were examined as part of this review as this is an important element of providing safe and effective care. We reviewed the Trust's Annual Quality Report (2017-2018)[54]. The Trust's Quality Report outlines the Trust's commitment to reducing instances of Health Care Associated Infections (HCAI) which it will achieve through: engagement with risk assessment, hand hygiene, aseptic technique, antimicrobial stewardship and cleaning.

The Trust has a number of policies in place to assist and guide staff, which include a Hand Hygiene Policy, Aseptic Non Touch Technique (ANTT); and Antimicrobial Stewardship.

Supporting these efforts is the Health Care Associated Infection Improvement Team (HCAIIT) who have developed and shared a guide and associated tool to facilitate ward/ department "walkarounds". We received a copy of the HCAI guide and accompanying "walk-around" tool to inform this review. We consider the walk-around tool to be useful.

The Trust indicated in its response to our questionnaire that environmental audits are carried out on a monthly or quarterly basis depending on the level of risk attached to the area in which services are delivered.

The Trust described how these audits are conducted in accordance with the Trust Cleanliness Policy which includes the assessment of estate and cleaning issues. Performance reports are circulated to all areas and managers on a monthly basis.

Trust-wide infection prevention and control performance is discussed at monthly HCAI meetings chaired by the Director of Nursing and Patient Experience who has responsibility for infection prevention and control.

During inspections we noted that the majority of staff adhered to the dress code policy and we noted that Personal Protective Equipment was available in most of the outpatient facilities. We observed staff following the Seven Steps of Hand Hygiene regime throughout all areas inspected and we evidenced that staff across the outpatient sites had good knowledge of infection control.

We were confident that staff knew the appropriate measures required when a patient attended with a known or suspected infection risk and they advised the patient would be scheduled to attend at the end of the outpatient clinic in order to facilitate infection control measures before and after the appointment.

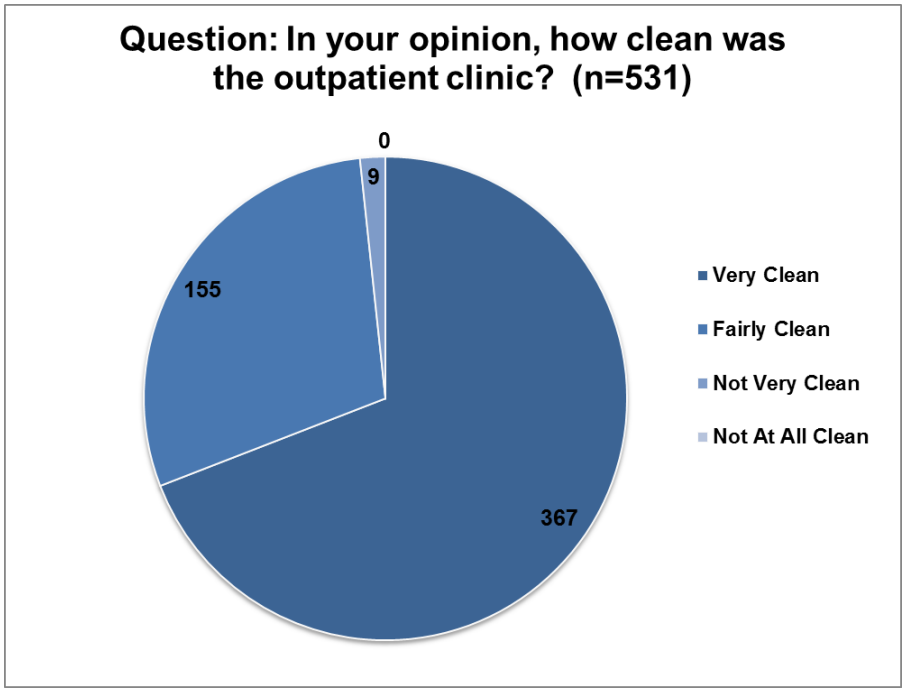
We were pleased to conclude that, in the main, arrangements for infection control across these varied outpatient sites were robust.

4.9.1 Environment

The environments in which services are provided will impact upon the safety, quality and experience of the care. We reviewed the environments in which the Trust delivers care and the policies, procedures and arrangements in place to ensure patient care is delivered in an environment conducive to their safe care.

In our patient and relatives survey we asked this group: "In your opinion, how clean was the outpatient clinic?" Of the 531 people who responded, 69% (n=367 people) considered the outpatient clinic to be very clean at their latest visit. Patient and relative responses are presented in Figure 15.

Figure 15. Survey responses to the question: In your opinion, how clean was the outpatient clinic?



We inspected the outpatient clinics using tools adapted from our hospital inspection programme. We included over 60 outpatient clinics across the following five sites: the Belfast City Hospital, Mater Infirmorum Hospital, Musgrave Park Hospital, the Royal Belfast Hospital for Sick Children and the Royal Victoria Hospital.

The outpatient departments were found to be generally clean, particularly in the Royal Belfast Hospital for Sick Children and in the Mater Infirmorum Hospital. There was some variation in the cleanliness of resuscitation trolleys across all five hospitals. Patient hoists and mobility equipment were often stored in corridors as a result of limited storage space. In particular, we noted a lack of appropriate environments for the care of patients attending the Royal Belfast Hospital for Sick Children for the treatment of bacterial infections.

We found examples of general wear and tear in the fabric of some buildings. Some areas within the Belfast City Hospital had small waiting areas and others (Wings E, F and G) were very spacious. We noted that the signage within the Belfast City Hospital was not particularly intuitive for patients to follow and the absence of private rooms and spaces for patient/ families who may receive bad news.

Car parking was frequently reported by both patients and staff as an issue across all sites, with the exception of Musgrave Park Hospital. Information gathered from our patient focus groups indicated that this issue resulted in significant additional stress for patients and their relatives. We acknowledged that space was limited for additional parking and that improving parking would present a significant challenge for the Trust.

Though in most areas the environment and equipment within outpatients was satisfactory and well maintained, some areas were in need of upgrading. Work should be undertaken to review signage (particularly within the Belfast City Hospital) to assist patients in locating the correct clinics. When planning outpatient services to meet the current and future needs of its population, the Trust should give consideration to the full range of alternative models of care such as virtual clinics and remote monitoring. This may optimise the use of limited hospital space for those clinics that must be provided within a hospital setting.

Recommendation 24	**Priority 2**
Belfast Trust should further develop and expedite new models of working in outpatients services, such as the use of telephone and video appointments, remote monitoring, outreach clinics; new models for service delivery should be agreed with commissioners and consistently evaluated to demonstrate impact.	

Section 5: Compassionate Care

Governance systems should also ensure that care delivered by Belfast Trust is compassionate. Compassionate care ensures staff in outpatients services treat people with kindness, dignity, respect and empathy.

We examined the systems and process which ensure patients are fully informed about their treatment and that their views and the views of their relatives are gathered, analysed and used in a meaningful way to inform improvement in service. We also engaged specifically with patients and relatives to understand their experience of the care delivered and the extent to which their needs were met.

In its Corporate Management Plan 2018-2021, the Trust describes, "treating everyone with respect and dignity"[55] as one of its five core values. The Trust requires all staff to adopt a person-centred approach in their delivery of care. We looked for evidence that patients' needs were met, that patients were involved in decisions affecting their care, that information concerning their care was provided and that services actively sought feedback from patients with a view to improving care delivered.

Our findings are presented under the following areas: meeting patient needs; providing patient information; personal and public involvement (PPI) and; patient feedback.

5.1 Meeting Patient needs

An essential aspect of providing compassionate care is recognising and addressing patient needs. The Trust advised that all staff in outpatients services are required to adhere to policies and procedures which protect patient privacy and dignity and submitted copies of policies relating to Intimate Care, Examination and Chaperoning (November, 2012); Adult Protection Policy and Procedures (April, 2013); and Regional Core Child Protection Policy and Procedures (December, 2017).

Inspection observations

During our inspections, we observed staff displaying courtesy and respect to patients. We noted staff were informative, friendly and respectful towards patients; even when working under pressure.

In Musgrave Park Hospital, we observed kindness shown towards patients by reception staff. We observed staff helping patients obtain transport home and/or re-arranging appointments if they had arrived at the wrong clinic / location.

In the Royal Belfast Hospital for Sick Children we spoke to many relatives who told us they were treated with respect and felt they had privacy to fully discuss their child's condition during outpatients appointments. In the Royal Belfast Hospital for Sick Children, the Expert Review Team found evidence of "What Matters to You…" cards, designed to understand what was important to patients in respect of the care delivered to them.

Patient Survey

As part of our patient survey, we asked patients about their care and treatment. The majority of people who responded reported having had adequate time to discuss problems with professionals, felt they had been involved in their treatment and care, and had the reasons for treatment and next steps explained to them in a way in which they could understand. The results are presented in Table 11.

[t] The Butterfly Scheme aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.

Table 11: Patient and relatives perception of care

Question (answered by 526 respondents)			
Did you have enough time to discuss your health and/or medical problem with the doctor or nurse?	68%	25%	7%
Were you involved as much as you wanted in decisions about your care and treatment?	68%	21%	11%
Did the doctor or nurse explain the reasons for any treatment and / or next steps in a way that you / your relative could understand?	76%	18%	6%

We asked if patients and/or relatives felt that the level of care received during their most recent visit to outpatient services in the Trust had been compassionate; 86% (449 people of the 522 who responded to this question) stated that the care received had been compassionate. The full results are presented in Table 12.

Table 12: Do you think care was compassionate?

Question (answered by 522 respondents)	Very Satisfied	Satisfied	Neither Satisfied or Dissatisfied	Dissatisfied	Very Dissatisfied
Do you think the care you and/or your relative received was compassionate	56%	30%	6%	4%	4%

We also asked if the doctor and/or staff member had listened to what they had said during their appointment; 96% (501 people of the 522 who responded) agreed that this was the case. In addition to feeling listened to, 84% of respondents (438 people out of 522) indicated that the doctor and/or other staff asked them / their relative what was important to them in managing their condition or illness. The results are presented in Table 13.

Table 13: Did the nurse/ Doctor listen to what you had to say and what was important to you?

Question (Answered by n=522)	Yes, definitely	Yes, to some extent	No
During your/ your relatives appointment did the doctor or nurse listen to what you had to say	80%	16%	4%
Did the nurse / Doctor ask what was important to you in managing the condition or illness	57%	27%	16%

Further feedback from respondents described interactions with staff as “being helpful” and/or “going the extra mile”.

Patient Focus Groups

Patients and relatives who took part in our focus groups told us that they felt they had been treated with dignity and respect. They described feeling that their voices had been heard, that they had been understood and that family members had been facilitated to attend appointments with them.

The majority of feedback received from our focus groups was positive. However, there were examples where patients and their relatives felt their experience had not been as compassionate as they would have liked.

We heard of a few examples where patients reported they were treated by staff who were too busy, with limited time to spend with them and/or their relatives resulting in patients and/or their relatives feeling that staff were, at times, impersonal.

We concluded that most staff were providing compassionate care across the Trust's outpatients services and endeavouring to meet patients' needs and we acknowledged this achievement in the context of services being extremely busy.

5.2 Providing Patient Information

Providing appropriately tailored information is vital to enabling a person to be an active participant in their care and treatment. Information about care, treatment procedures and investigations should be delivered in a way that meets the individual patient's needs and preferences.

Verbal Information

During our inspections we often observed patients being provided with verbal information on their care and treatment from a consultant or nurse. We were advised that interpreters would be arranged for patients whose first language was not English.

Written Information

The Trust told us that it uses EIDO Healthcare UK[u] to source the specific patient information leaflets which it uses. We examined one such example of a leaflet for Laparoscopic Hysterectomy which included patient information on consent. It also included details of the surgery, complications and expectations on returning to normal activities post-surgery.

The Expert Review Team agreed that this type of information leaflet was comprehensive and provided clear information for the patient.

[u] EIDO Healthcare is a commercial company that provides resources and support to help health professionals and has a library of approximately 400 treatment-specific informed consent patient information documents.

Written information was also found to be provided about referrals for joint injections in rheumatology clinics however, in general, it was noted that little formal written information was provided to those patients attending outpatient services.

Other Information

We noted the Trust also utilised additional information services provided by many voluntary and charitable organisations. We heard an example of Brainwaves Northern Ireland, which provides tailored information leaflets for patients with brain tumours and offers patients additional information through its Facebook and Internet site.

Additional Information Services

In our patient survey we asked patients and relatives about the amount of information they had received about their / their relatives' treatment during their outpatient appointment and 86% (451 out of 526 respondents to this question) felt they had received the right amount of information. The provision of formal written information provided to patients attending outpatient services was discussed during our meetings with senior managers. They recognised that provision of written information could be enhanced and the Medical Director told us that the review of all patient information leaflet requirements would be undertaken over the next six months with the aim of embedding a standardised approach. This work was already in progress as part of Personal and Public Involvement (PPI) activities and utilising a co-production approach involving service users.

We concluded that additional high quality written information would be valuable in ensuring greater involvement of patients in their care and treatment would be helpful for patients. (This would complement our earlier recommendation in Section 2.8 on directly including patients in clinical correspondence about their attendances at outpatients.)

We welcomed the Trust's plans to review and standardise patient information leaflets, using a co-production approach and agreed that the use of technology, such as videos and producing information online was valuable and should be further explored as part of this work.

Recommendation 25	Priority 2
Belfast Trust should optimise various communication media as a means of providing information about conditions, procedures and treatments to patients across its outpatients services.	

Information Resources Developments

During our inspections and meetings, we heard of examples of specific information resources being developed. In the Royal Belfast Hospital for Sick Children all staff in outpatients services had undergone basic training in Makaton[v]. This is a language programme designed to provide a means of communication to individuals who cannot communicate effectively by speaking. Feedback from staff indicated an improvement in communication was achieved.

In the Mater Infirmorum Hospital, we heard about Eye Clinic Liaison Officers who are able to provide advice and help patients understand their situation, for example: when advised that they will no longer be able to drive due to their eye condition. The Expert Review Team agreed that these Liaison Officers provide a useful, supportive service in outpatients in the Mater Infirmorum Hospital.

5.3 Enabling Personal and Public Involvement (PPI)

To deliver healthcare which meets the needs of the population, it is essential that the Belfast Trust include patients and relatives in design and commissioning of services. Patients and their relatives provide vital insight into how the service is operating and offered examples of how it may be improved.

The Health and Social Care Reform Act of 2009 requires PPI as a legal requirement for HSC services[56]. PPI is defined as "…the active and effective involvement of service users, carers and the public…" in HSC services[57].

PPI enables organisations to ensure that its patients and their cares or relatives are fully involved and can influence the commissioning, delivery and evaluation of services. PPI has been shown to result in services becoming more responsive, with a reduction in complaints and an increase in the levels of satisfaction[58].

[v] Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order.

Trust Structures

The Belfast Trust provided documentation detailing its organisation-wide framework to enable PPI and the Expert Review Team was informed of a number of mechanisms the Trust had in place. We heard about a number of active patient forums for PPI. For example, the Gynaecological User's Forum, the Human Immunodeficiency Virus (HIV) Service User's Forum and the Prosthetics Service User Forum. Other PPI committees and groups in operation included the Maternity Services Liaison Committee and the "Tell It Like It Is" groups in Learning Disability services.

It was apparent that not all Directorates have clearly established service user/ carer/ forums representing the range of specialties within it and we determined that further work is required in order to fully embed PPI within outpatients.

Specifically in relation to neurology, the Neurology Patient and Carer Forum provides opportunities for regular engagement for patients and families who access the neurology service. This Forum meets every three months, provides input regarding neurology and neurology disability services from a client perspective across Northern Ireland and helps to inform service planning within Belfast Trust.

The Expert Review Team concluded that the Trust's PPI arrangements were adequate in terms of the Trust assurance structure. We agreed that the Trust had begun its journey of developing an organisational wide PPI culture and we would encourage the Trust to continue to develop its' PPI activities into all Directorates and specialties including those delivering outpatients.

5.4 Seeking Patient Feedback

Patient feedback is an important source of information that drives improvements in the patient experience. The Trust told us about its' Service User Experience Feedback Group (SUEFG), created within the Trust's assurance framework structure. Established in 2018 and chaired by the Medical Director/ Non-Executive Director, this group, which meets six times a year, is tasked with providing assurance to the Learning from Experience Steering Group. The SUEFG collates information from compliments, complaints and 10,000 voices projects with Divisional representatives receiving reports detailing service user feedback on a monthly basis.

The Trust reported that outpatient services use a range of tools to engage with patients and relatives in order to obtain feedback. These included; patient focus groups facilitated by external organisations for example: the Patient Client Council and the Royal National Institute for the Blind; an electronic questionnaire for patients with pelvic floor conditions in the Royal Victoria Hospital. Staff in Royal Victoria Hospital demonstrated the use of several patient satisfaction surveys, the most recent of which examined information received in relation to appointments.

We also heard about the regular use of patient satisfaction surveys in the orthopaedics outpatient service in Musgrave Park Hospital.

A group of Consultant Neurologists we spoke to informed us of collaboration between the Trust and Parkinson's UK. This collaboration had facilitated qualitative feedback from neurology patient groups.

In our meeting with the Trust Medical Director, we heard about a system, which supported real-time user feedback, implemented across inpatient wards, in the first instance as part of national collaborative work within the NHS. The next phase of implementation was anticipated to involve outpatients Surgical Divisions.

Service Developments Informed by Feedback

Area of Good Practice

Trust Senior Managers updated the Expert Review Team about a service development undertaken in 2016, whereby patient and staff feedback collected through a patient survey had resulted in improvements to services provided by Nephrology outpatient services in Belfast City Hospital in 2015.

When exploring satisfaction amongst patients attending the clinic, initial feedback indicated low levels of satisfaction amongst patients being treated in Nephrology: only 41% of patients sampled described being "very satisfied" with their outpatients appointment, while 72% described their experience at the clinic as "fair" as consequence of overcrowding and the waiting times (this document omitted sample size at baseline).

Additional feedback from staff working in the clinic identified its limited two-day a week schedule as a contributory factor and expansion of clinic days as a mechanism of improving patient experience.

In direct response, in 2016 the Nephrology service was moved from its' original location within Belfast City Hospital to the hospital's Renal Unit and appointment times were distributed throughout the week.

During follow-up in 2017, feedback from 41 patients sampled demonstrated that the service development had reduced over-crowding and patient waiting times. Patient satisfaction had also improved; 67% of those sampled at the time reported being "very satisfied" with their experience at the clinic. Additional feedback commended the clinic on its cleanliness and facilities.

The Expert Review Team was encouraged by opportunities in some services / locations for patients to provide real time feedback, but was unable to find evidence of uniform strategic mechanisms in place to ensure feedback is harnessed in a cohesive and strategic way in order to obtain feedback across all of outpatients services in the Trust.

Recommendation 26	**Priority 1**
Belfast Trust should develop and implement arrangements to obtain patient feedback in a co-ordinated and systematic way across all outpatient sites. Feedback received should be used to evidence quality of care delivered and to underpin service improvements as required.	

Section 6: Conclusion

This review of governance in outpatients services in the Belfast Trust has provided detailed insights into the arrangements in place in respect of the governance of the care delivered within these services. The large number of individual specialities and number of sites visited as part of this review has enabled a comprehensive assessment across the Trust's outpatients services.

We inspected over 60 outpatient clinics across Belfast City Hospital, Mater Infirmorum Hospital, Musgrave Park Hospital, Royal Belfast Hospital for Sick Children and the Royal Victoria Hospital. We enlisted a comprehensive methodology, including engagement with a wide range of key stakeholders and site inspections and we can be confident that the findings of this review present an accurate reflection of the governance arrangements at the time of this review and their impact on patient care.

We observed many good examples of compassionate and patient-centred care being delivered and good compliance in respect of infection prevention and control practices and we received positive feedback from patients and relatives in this regard.

We recognise much work has been undertaken by the Trust with regard to implementing a comprehensive governance structure and quality assurance framework which has included its outpatients services. The new collective Leadership Model and its' focus on delivering a programme of Quality Improvement across the organisation was well regarded by Trust staff and the Review Team and showed early evidence of improvements across some services with potential for wider impact through greater involvement of clinical leaders and frontline service managers.

Though we commend the efforts of the Trust in relation to reforming its clinical governance and management structures, we found that outpatients services span a range of Directorates and specialties, involving multiple professional groups from a range of Directorates, often contributing to the same service.

As such, oversight arrangements can be complex and there is a risk of poor cohesion in the oversight and monitoring of the quality of care delivered to a specific group of patients by either an individual professional or a discrete clinic / service.

Many of the recommendations from this review relate to the use of information and data. We identified opportunities to improve the use of the available information about referrals to clinics, non-attendances at clinics and outcomes achieved for patients in respect of their condition, to drive improvements in the service delivery. We agreed that standardising and formalising mechanisms for patient feedback could ensure gathering of useful intelligence to support change and improvement in services.

Improved oversight and monitoring of services could be achieved by further developing systems for the collection, interrogation and communication of

data. This would enable the Trust to improve both its operational service planning and plans to reform and modernise services. Better use of data would also improve oversight in relation to referrals from the Independent Sector and monitoring of activity relating to the treatment of private patients within the trust.

Another key finding related to the prescribing recommendation(s) made to GPs through the use of paper based TAN's. The current system provides very limited assurance to the Trust regarding the prescribing practices of individuals or individual services delivering outpatient care compared to that which could be realised through investing in developing an electronic system.

This review highlighted the need for stronger team working within the outpatients service and the nurturing of a culture of constructive challenge between professionals. In these particular settings, individuals may be more susceptible to working as single clinicians, with fewer opportunities for peer challenge and review, than in the inpatient settings where multidisciplinary working is embedded to a greater extent.

We note that there are a considerable number of recommendations contained within this report and that in order for change to be meaningful and have desired impact they should be implemented in a co-ordinated and cohesive way with strong leadership and robust oversight.

Based upon our experience of regulating services across the HSC system, it is our view that the opportunities for strengthening governance highlighted within this review are applicable across the entire region. A regional approach to the reform and modernisation of outpatient services across the five HSC Trusts would ensure system wide change in line with the 2016 policy Health and Wellbeing 2026: Delivering Together.

We anticipate that the Belfast Trust will now fully consider these recommendations and the best mechanisms of implementing these in order to provide assurance of the quality, safety and effectiveness of the outpatients services it provides.

Recommendations

Number	Recommendation	Priority
1	Belfast Trust should review and streamline its systems and process for receiving and managing referrals to its outpatients services. Accurate data and intelligence arising from streamlined referral systems should be used to inform oversight and assurance of the Trust's referral processes.	1
2	Belfast Trust should develop and implement a wider team approach to assure best practice in the triaging of referrals received for its outpatient services; a team approach is particularly important for referrals received to high risk specialties such as antenatal obstetric care.	2
3	Belfast Trust should strengthen its systems for validation of lists of patients currently awaiting review and / or assessment through outpatients services; validation should include risk stratification, by clinical need and priority, of patients currently on waiting lists.	1
4	Belfast Trust should review its systems for identifying and recording information on patients transferring from the Independent Sector to Trust services; the Trust should ensure there is robust governance and oversight of all processes relating to transfer.	2
5	a) Belfast Trust should ensure that all outpatients services receive and actively use up-to-date information relating to productivity lost through clinics which are cancelled and / or not attended (DNAs and CNAs); b) The Trust should expedite its work to improve productivity and reduce the impact of cancellations and non-attendances at outpatient clinics.	1
6	Belfast Trust should urgently review the content and format of appointment letters issued to patients attending orthopaedic outpatients services.	1

Number	Recommendation	Priority
7	a) Belfast Trust should review its current practice in relation to communication with General Practitioners and other referrers, following patients' attendance at outpatients services; b) The Trust should agree, implement and monitor a standard set of key performance indicators across its outpatients services to underpin improvement in its written communication following outpatients review; and c) The Trust should evaluate the impact and effectiveness of directly including patients in clinical correspondence following outpatients review, to determine if implementing this approach would be of benefit across all its outpatients services.	1
8	Belfast Trust should identify and strengthen mechanisms to engage Sisters / Charge Nurses across outpatients services in its work programmes addressing collective leadership and organisational accountability.	1
9	a) Belfast Trust should complete a mapping exercise to understand in detail the operational, management and governance arrangements across all outpatients services it delivers; and b) The Trust should assure itself that operational arrangements for all outpatients services are appropriately aligned across service Directorates and divisions, so that care delivered in outpatients is consistency well governed.	1
10	a) Belfast Trust should specify how its collective leadership strategy and model will specifically strengthen the delivery of safe, effective and compassionate care across outpatient services; and b) The Trust should identify key measures to demonstrate the impact of its collective leadership strategy and model on outpatient services.	2
11	Belfast Trust should develop and implement a set of key indicators to assure its performance in relation to the care it delivers through outpatients services. The Trust should not limit these indicators to activity data; these should be shared with the Trust Board and the Executive Team on a regular basis.	1

Number	Recommendation	Priority
12	Belfast Trust should adopt a strategic approach to audit and quality improvement work involving outpatients services, to align with the Trust's organisation-wide approach to quality improvement and to focus on both specific service or site improvement and system level improvement.	2
13	Belfast Trust should strengthen its approach to the identification and management of risk within and across the outpatients services it delivers by necessity this will include: a) A mechanism to ensure sharper focus for the known risks across the full range of Trust services delivered in outpatients settings; b) Progressing work to understand and mitigate new or previously unidentified risks, such as those described in this review; c) Ensuring that all staff delivering outpatients services are proactive in their approach to identifying risks as they emerge and to implementing systems to manage these risks; and d) Ensuring that the Executive Team and Trust Board are regularly updated and receive robust assurance regarding risks as they relate to outpatients services.	1
14	Belfast Trust should expedite work to develop its internal information systems so that data on clinical activity and patient outcomes (by service, by team and by consultant) are routinely reported and shared; this information should be available to support annual whole-practice appraisal and revalidation, as well as service planning and development.	1
15	Belfast Trust should strengthen its use of information and intelligence relating to incidents and complaints occurring in the context of outpatients services it delivers; the Trust should analyse this data and intelligence in a way that promotes a proactive approach to identifying risk and improving the quality and safety of outpatients services.	1

Number	Recommendation	Priority
16	a) Belfast Trust should develop and implement a targeted action plan to improve knowledge and awareness of staff in relation to the safeguarding of adults and children receiving care and treatment in its outpatient services; b) The Trust must ensure it receives robust assurances in respect of compliance with best practice as advised by regional and local policies in this regard; and c) The Trust should review its risk register to ensure it is accurately capturing current risks relating to the knowledge and awareness of staff safeguarding roles and responsibilities.	1
17	Belfast Trust should ensure information relating to outpatient activity (by service, by team, by consultant) is collected, analysed and routinely shared; this data should be used to enable robust capacity planning and to inform future service development and modernisation of outpatient services across the Trust.	1
18	a) Belfast Trust should ensure it develops and implements a robust system for oversight and monitoring of the quality of care delivered by Specialist Nurses and the related patient outcomes achieved across its outpatients settings; b) Specialist nurses should be appropriately supported to undertake their roles through effective supervision, professional development and support for annual appraisal and revalidation.	1
19	Belfast Trust should develop, implement and assure a systematic approach to clinical peer review across its outpatients services.	1
20	Belfast Trust and the Health and Social Care Board should establish clear mechanisms by which the Trust and General Practitioners can engage and communicate in relation to outpatient services delivered by the Trust. The Trust should also assure itself that General Practitioners who may have a concern relating to services delivered have been provided with clear information regarding how to raise their concern.	2

Number	Recommendation	Priority
21	Belfast Trust should develop a system or systems to enable appropriate oversight and assurance of prescribing and prescribing advice across the Trust's outpatient services. This should include the development and implementation of an interim electronic system to replace the current paper based Treatment Advice Notes.	2
22	Belfast Trust should cease the practice of retaining separate paper-based notes for particular outpatients specialities; the Trust should develop a system whereby patient notes for all specialities as retained as part of an integrated hospital-wide record.	1
23	a) Belfast Trust should agree a range of key performance indicators across all its outpatient services; b) It should assure and govern these systems for service improvement; and c) It should communicate these to services through specialty level dashboards.	1
24	Belfast Trust should further develop and expedite new models of working in outpatients services, such as the use of telephone and video appointments, remote monitoring, outreach clinics; new models for service delivery should be agreed with commissioners and consistently evaluated to demonstrate impact.	2
25	Belfast Trust should optimise various communication media as a means of providing information about conditions, procedures and treatments to patients across its outpatients services.	2
26	Belfast Trust should develop and implement arrangements to obtain patient feedback in a co-ordinated and systematic way across all outpatient sites. Feedback received should be used to evidence quality of care delivered and to underpin service improvements as required.	1

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Appendix One: Contributors

Membership of Expert Review Team

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Mrs Patricia Crofton	Clinical Quality Lead / Specialist Neuroscience Nurse, The Walton Centre National Health Service Foundation Trust, Liverpool, England
Dr David Evans	Former Medical Director and Interim Chief Executive Northumbria Healthcare National Health Service Foundation Trust, England
Dr Donagh MacDonagh	GP, Elmwood Medical Practice, Dunluce Health Centre, Belfast and Primary Care eHealth Clinical Advisor, Health and Social Care Board
Mr Trevor Reaney	Former Chief Executive to the Northern Ireland Assembly
Mrs Amanda Stanford	Deputy Chief Inspector of Hospitals, Care Quality Commission, England

Membership of Core RQIA Team

Dr Lourda Geoghegan	Director of Improvement and Medical Director (Chair)
Mrs Olive Macleod	Chief Executive
Dr Richard Gamble	Research Analyst
Mrs Jessica Greenaway	Administrative Assistant
Mrs Emer Hopkins	Deputy Director of Improvement
Ms Jennifer Lamont	Head of Business Support Unit
Mr Robert Mercer	Support Project Manager
Mrs Jacqui Murphy	Senior Project Manager
Mrs Rachel Stewart	Head of Information

Membership of RQIA Inspection Team

Mr Hall Graham	Assistant Director, Improvement Directorate (Retired)
Mrs Sheelagh O'Connor	Senior Inspector, HSC Healthcare Team
Ms Jean Gilmour	Inspector, HSC Healthcare Team
Mr Thomas Hughes	Inspector, HSC Healthcare Team
Mrs Lynn Long	Senior Inspector, Independent Healthcare Team (until December 2018) and Assistant Director, Improvement Directorate (from May 2019)
Mrs Carmel McKeegan	Inspector, Independent Healthcare Team
Dr Leanne Morgan	ADEPT Fellow, Northern Ireland Clinical Leadership Fellows Programme (2018/2019)
Mrs Lorraine O'Donnell	Inspector, HSC Healthcare Team
Mrs Una O'Hagan	Inspector, Children's Team
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Assurance, Challenge and Improvement in Health and Social Care

SPPG Assessment Overview

(February 2023)

TRUST	RED	AMBER	GREEN	Quarterly return	Trust meeting date
Belfast	3	4	19	Sept	21/2/23
Northern	6	7	13	Sept.	27/2/23
Southern	5	20	1	June	tba
SEastern	14	7	5	Sept	22/2/23
Western	3	13	10	Sept	27/2/23

Reports for December received from all Trusts except Southern Trust expected w/c 13/2/23

SPPG assessments of December returns to be completed by end of February with Trust engagements completed by early March.

Core team meets Thursday 16 Feb 2pm

SPPG/PHA core team / RQIA tba early March

DELIVERY PLAN RQIA REVIEW OF THE GOVERNANCE OF OUTPATIENT SERVICES (comments deleted)

Leads: [redacted], Assistant Director, Commissioning, Strategic Planning and Performance Group, Department of Health (SPPG, DoH)
[redacted], Assistant Director, Nursing, Public Health Agency (PHA)
Co-chairs RQIA Review of the Governance of Outpatient Services Working Group

RAG Status Key:

Red = Not on track
Amber = On target to be completed
Green = Completed
Blue = No longer appropriate

RECOMMENDATION	SPPG RAG ASSESSMENT	REQUIRED ACTION(S)	DATE FOR COMPLETION
Recommendation 1 Trusts should review and streamline systems and process for receiving and managing referrals to outpatient's services. Accurate data and intelligence arising from streamlined referral systems should be used to inform oversight and assurance of the Trust's referral processes.	BHSCT	• The BHSCT have been asked to provide more detail on the progress of their plan. • Trust colleagues are engaging with BSO and roll out is expected later this month but it was noted there have been previous delays. • Assurances to be provided by the Trust that all specialities are using CCG before further communication to GP's can take place. It was noted that around 10 specialities are still receiving paper referrals. Trust to confirm when all specialities are using CCG and it was agreed a reminder would be issued to all GP's to ensure there are no further paper referrals. • The Trust are to share a copy of the letter that has been sent to Dan West with regards to the delays and this is to be shared with Paul Turley and Denise Boulter cc: Emma Davison	December 2022

		Challenge(s): *(a) BHSCT colleagues advised there have been delays for the roll out of the referral system with BSO which could delay work being completed within the timescale. Issue has been escalated a number of times by Trust colleagues to BSO* *(b) The Trust noted no additional resource has been confirmed for this work which could cause delays as staff continue to deliver alongside their core work commitments.* Update *Belfast Trust Update.* *BSO have advised of a planned release for eTriage scheduled for Sat 6th August* *The Trust is reviewing comms and training required to facilitate implementation.* *BHSCT/GP Partnership working continues*	
	SEHSCT	• The Trust has been asked to provide more evidence on the processes they are putting in place for referrals and an update on how this recommendation will be delivered. Update Roll out of refresher IEAP raining commencing within the admin teams in Sept 22. Aim for completion in Dec22. Ongoing work within teams to process and document ambulatory hubs. Work has commenced within GI and Resp in UH and Cardiology in UH. This work will be shared and rolled out to hubs in LVH also. Early discussions commenced with SET GPs Lead for more engagement events with GP practices.	

		OP Mgmt team have evidence of sharing info at meetings with Sp Leads & AD's Sp Leads/ Ad's can provide evidence of onward conversations/ actions (through agendas, minutes and performance presentations). OP and admin are building on their existing monthly meetings with speciality leads to discuss their performances / DNA / CAN rates in OPs. RENAL and Macmillan unit (chemo) are augmented areas and hold monthly management meeting at which OP / daycase activity are discussed. Minutes held at Unit level. Renal pharmacy and Macmillan pharmacy communicate all medication changes via EDT This remains work in progress for Dec target	
	NHSCT	• The Trust has been asked to provide more evidence of systems used to extract data. • Assurance to be provided that a review of this process has been undertaken Update ETriage is being used by all acute specialties. This includes the electronic transfer of a primary care referral being received via CCG and sent to the triaging consultant. This allows for the referral to be tracked and triaged with an associated pathway for the patient. Etriage facilitates the turnaround times for triaged referrals which in line with the Integrated Elective Access Protocols (IEAP) should be within 48 hours of receipt of the referral. Triage time is monitored by the central booking offices by using the Primary Targeting Lists (PTL's).	

		Referral letters and triage outcomes are available on NIECR.The consultant typically refers to ECR and patient history to inform the consultant on the pathway for the patient. The ability to analyse Etriage data in terms of volumes, clinical priority and pathway for the patient i.e. Direct to Test prior to the first OP appointment. The ICT systems also supported by PAS provides the Trust with an oversight of referrals, clear streamlined processes which are underpinned by controls assurance measures.	
	WHSCT	• The Trust has confirmed it has completed a review and streamlined systems and processes for receiving and managing referrals to outpatients' services.	
	SHSCT	• The Trust has been asked to provide more detail and evidence the roll out to all specialities within outpatient services and to provide a timeline of when this will be in place	
Recommendation 2 Trusts should develop and implement a wider team approach to assure best practice in the triaging of referrals received for outpatient services; a team approach is particularly important for referrals received to high risk specialties such as antenatal obstetric care.	BHSCT	• The Trust has been asked to provide an update on their progress and assurances that a plan is in place across all specialities. • A paper has been drafted which BHSCT colleagues are to present to their Chairs of Division detailing their approach to triaging referrals. Update to be provided once paper has been considered. ***Challenge(s):*** *(a) Implementation across all specialities could extend beyond target date* Update *Belfast Trust Response* *Belfast Trust has established a new Divisional structure to include an Outpatients Directorate:*	December 2022

		• *Director -* [redacted] • *Chair of Division -* [redacted] *(Consultant Cardiologist)* • *Co-Director -* [redacted] *As part of the Programme of Work under the Outpatients Modernisation Programme Steering Group and its Governance Workstream, the Divisional team are assessing the current triaging processes across Outpatient Services. The outcomes of this scoping will include the development of a Standard Operating Procedure for Triage.* *The Trust is assessing use of the Lothian Active Clinical Referral Triage model and using learning from partnerships with other Trusts including Aneurin Bevan in Wales, University College London Hospitals and the Northern HSCT, through the Timely Access work with HSCQI, to inform its goals for triage.* *There are a number of triage models used across the Trust currently, including;* - *Consultant of the Week (most common),* - *Restricted – trialled in ENT with 3 of the 10 consultants carrying out all triage to an agreed protocol,* - *Peer triage review – used in Dermatology for red flag photo triage, if there is any uncertainty, particularly around those that are being discharged without being seen in person.* *A variety of triage models are being tested in services to ensure most appropriate outcomes for referrals received. There has been a focus on Genomics, Immunology, Gynae and ENT and it is intended to share learning from these pilots across services.* *In Gynae an audit has been completed assessing 20 random referrals triaged by each consultant to assess the appropriateness of the triage*	

		outcome. A project has been established in Gynae to trial an Enhanced Triage model and to provide further training for the consultants in this area. *The Regional Immunology Service is a small team with a significant waiting list. The Consultant Immunologists currently discharge approx. 30% of incoming referrals with advice, 20% of referrals go to Nurse Led clinics, and the remainder go on to the waiting list for Consultant Led clinics. The team are reviewing communication with referrers and GPs to enhance education to reduce referrals.* *NIECR functionality is limited in supporting best practice triage processes. Funding to optimise NIECR remains a concern and clarification is required relating to Epic functionality in supporting enhanced triage models.* *Further discussions are required regarding protected time in consultant job plans to support enhanced triage.* *The potential for using Nurse Specialist involvement in enhanced triage is also being explored.*	
	SEHSCT	• Trust has been asked to provide an update on the processes they have under review. Update Regional eTriage enhancements to go live on the 6th Aug22. Next specialities to start are - Rheum and cardiology This is part of the training plans and SOP's above Scoping exercise under way to ascertain what volume of booking currently sits within the Medical Directorate secretarial teams with a view to moving this from secretaries into a booking office environment.	

		RENAL- eTriage weekly and advice given through an Emed generated letter. Changes made to treatment at the Renal Anaemia clinic are communicated to GPs on the same day via EDT system.	
	NHSCT	• Trust to provide a timeline to give assurances of implementation. No references provided for antenatal outpatient services. Update There are processes in place for monitoring paper referrals for triage within 48 hours (IEAP Guidance). Triage outcomes are monitored using Primary Targeting Lists to monitor compliance with triage turnaround. Escalation processes are in place for referrals not triaged within the agreed timescales. Acute specialties have agreed processes for triaging, i.e. consultant of the day / week. These are local agreements held within the clinical teams.	
	WHSCT	• The Trust provided detail to confirm they have successfully completed this recommendation.	
	SHSCT	• Trust has been asked to provide an update on the processes they have under review.	
Recommendation 3 Trusts should strengthen systems for validation of lists of patients currently awaiting review and / or assessment through outpatient services; validation should include risk stratification, by clinical need	BHSCT	• The Trust confirmed an administrative validation process is in place but assurances need to be provided that a strengthened process is in place to ensure clinical validation is taking place. Update *Belfast Trust Update.* *Actions outlined above are ongoing including OP WL validation.* *The Trust is engaging with the Regional Group led by the WLMU regarding validation activities and other areas including mechanisms to address cross Trust duplicate referrals on the Trusts waiting lists.*	September 2022

and priority, of patients currently on waiting lists.		*The Trust has an ongoing project to review internal OPWL duplicates* Clinical validation and re-triage: - The Trust has been testing clinical validation of OPWL patients in some specialties. Dermatology outcomes for clinical validation resulted in 50% of referrals validated merged or discharged. - Following this, the Enhanced Validation process has commenced with 27% of patient validated being discharged with the main reason being that their condition had resolved. PAS Centralisation Project: - The Trust programme of merging specialties that record Waiting Lists on more than 1 PAS onto a single PAS in Belfast in continuing. This should assist with reduction of duplicate referrals on Trust Waiting Lists. Ophthalmology, Paediatric Cardiology, Rheumatology and Endocrinology have already been completed. Neuro-rehab, General Medicine and Dermatology are underway. Risk stratification: - The Trust is using the PAS EPISODE NUMBER to identify the patients who attend more frequently. - The Trust will be exploring further use of risk stratification across all specialties. - The Trust is exploring the opportunity for use of PROMS to provide for the ongoing management of patients with assessments flagging when patients need to be seen as a result of a deterioration in symptoms. Standardisation within services and clear criteria will be necessary to enable a move to PROMs for long-term conditions. This has been captured in the OP Modernisation Group programme of work and will require short-term non recurrent investment to support the resource needed to establish new ways of working	

		- ENT, Rheum and Derm are keen to use PROMs and have set up projects to bring this to fruition. There is the potential to use the BSO *Patient Portal (My Care Record) for PROMs or to use the Envoy platform which is already used for SMS reminders.*
	SEHSCT	• Trust to provide an update on the progress of their validation process and ensure clinical validation is evidenced. • Assurances to be provided that a robust plan for validation is in place. Update 4 specialities have undergone validation – focusing on long waits for new routine patients. 4481 ENT patients contacted – 1728 removed from WL (39%). 2141 DERM patients contacted – 833 removed from WL (39%). 154 UROL patients contacted – 59 removed from WL (38%). 995 GASTRO patients contacted – 274 removed from WL but validation not yet completed (28%). Gynae has now commenced. This is part of the training plans and SOP's above
	NHSCT	• More detail to be provided and in particular evidence of compliance with guidance. Evidence of continuous training to be provided. Update In 2021/2022 HSCB through data standards issued PAS Technical Guidance which allows all validation i.e. clinical or administrative to be recorded on PAS for ease of reference instead of free text In 2022 we commenced administrative validation on routine and urgent OP waits by time bands waiting – greater than 3 years (in line with 2021/2022 guidance).

		Progression to validation of IPDC waiting lists will require clinical oversight before any patients are discharged from the waiting lists.	
	WHSCT	• Trust to provide an update on the progress of their validation process and ensure clinical validation is evidenced. Update 1. **13/7/22:** Validation is routinely reviewed by the core elective group which meets on a weekly basis and shared with Service Managers on a monthly basis at respective accountability meetings. 2. **13/7/22:** Further discussion at the core elective group will consider how validation is consistently applied across all services and directorates (currently mainly focused within acute) based SPPG guidance.	
	SHSCT	• The Trust has been asked to provide more detail on risk stratification and evidence strengthening of systems.	
Recommendation 4 Trusts should review systems for identifying and recording information on patients transferring from the Independent Sector to Trust services; the Trust should ensure there is robust governance and oversight of all processes relating to transfer.	BHSCT	• The Trust submission advised the system was to be implemented in June. Confirmation and evidence to be provided. Update ***Belfast Trust Update*** *The Trust has implemented from June 2022 the new software package for electronic PP-NHS consultant declaration and patient change of status recording. This new system is facilitating more robust governance and oversight of all processes relating to procedures that medical staff need to follow in identification of patients transferring PP-NHS.* *Guidance has been issues to all consultants regarding the above.*	September 2022

		The quarterly spot check audits are continuing as above. *Quarterly reports also continue to be send out as above.*	
	SEHSCT	• The SPPG felt the Trust provided enough evidence of robust systems in place however the Trust would like to ensure regular audits are being carried out before this recommendation is confirmed as completed. The Trust to provide SPPG with an update on the progress of the audits. Update SPPG thought this was Green – SET keen to remain amber until verified by spot checks	
	NHSCT	• The Trust has been asked to provide assurances of robust governance and oversight of this process. Update All systems and processes that govern how we send patients to the independent sector are overseen by Assistant Director, Performance, Innovation and Quality Improvement Monthly and weekly meetings have been established to monitor and report across all associated processes in the IS including incidents and complaints. Issues are escalated as required. WLI Business Manager, General Manager Patient Access and Finance Manager hold monthly contract review meetings to oversee all aspects of clinical and financial governance.	
	WHSCT	• The Trust has been asked to review their submission to reflect how patients are received from the independent sector	

		Update **13/7/22**: RAG Changed to Amber by SPPG. Further detail from work of newly established IS Governance Group require here to demonstrate processes	
	SHSCT	• The Trust has been asked to review their submission to reflect how patients are received from the independent sector	
Recommendation 5 a) Trusts should ensure that all outpatients services receive and actively use up-to-date information relating to productivity lost through clinics which are cancelled and / or not attended (DNAs and CNAs); b) Trusts should expedite work to improve productivity and reduce the impact of cancellations and non-attendances at outpatient clinics.	BHSCT	• Trust confirmed that some system have been introduced and are currently being piloted. The Trust has been asked to provide an update on the ongoing work to implement this recommendation. Update ***Belfast Trust Update*** *Actions outlined above are ongoing* ***Data & Intelligence to Drive Improvement*** *In relation to activities across specialties to identify improvements to maximise available capacity – a quality improvement project has commenced for identify improvements in the process for short notice booking arrangements to maximise available capacity. (Gynaecology clinics initially and the learning will be spread to other specialties)* ***Use of Technology*** *The Trust is piloting a live OP clinic booking application which is currently in user acceptable testing stage which will facilitate booking staff to maximise clinic slot booking.*	September 2022
	SEHSCT	• The Trust to provide more detail on further communication to members of the public Update OP Mgmt team have evidence of sharing info at meetings with Sp Leads & AD's	

		Sp Leads/ Ad's have evidence of onward conversations/ actions through minutes agenda and presentations at speciality meeting level. Renal- OP are an agenda item at monthly management meetings. Performance reports received by the Lead nurse and forwarded to each Consultant. Medical secretary and OP sister review for potential concerns. Trust needs to invest in BI – Qlikview Planning and performance team have worked with hospital services to produce a dashboard which allows interrogation of OP activity at Trust level, site level, speciality level, priority level and individual level. This is used by specialities and clinical leads, ADs and operational managers to target areas requiring improvement. LVH and DH have returned to full Partial Booking. UH have returned in 3 specialties - Rheumatology, Pain and Endocrine returned in July 22. A plan is in place for all other specialities in UH. Renal – Urgent patient appts will be rebooked to other Consultant clinic if the clinic is cancelled at short notice. Annual leave is planned well in advance so any clinic can be rescheduled to cover the lost appts with that particular Consultant. Trust to consider investment in Bookwise EMT have approved the ALLOCAT E system for job planning and this should be progressed in the next few months	
	NHSCT	• The Trust has been asked to provide more detail against each part of this recommendation. Update	

		A number of specialties have undertaken retrospective audits and contacted patients who DNA'd to ascertain the reasons for non-attendance and take corrective measures as necessary. The Trust in 2022/2023 are actively tracking the level of hospital initiated OP cancellations and to reduce these In Year. There will be a renewed focus on the need to comply with the Annual Leave and Study Policy which demands 6 weeks' notice of leave as a minimum. There is a component of cancellations which is not controllable i.e. sick leave however there are a number of steps identified to reduce the significant levels for example "understanding the pathway" Text reminder service is in place which means the patient is contacted 3 days before their appointment date as a reminder of their appointment.	
	WHSCT	• The Trust has been asked to provide a timeline to confirm delivery against this recommendation. Update **13/7/22:** The Trust is currently undertaking a focused piece of work to reduce the level of hospital initiated cancellations. This work is led by Patient Access who generate a monthly report by speciality by reason for cancellations. This report is issued to the service managers on a monthly basis for review and action. Further discussion at the core elective group will consider how this work can be applied across all services and directorates (currently mainly focused within acute) based SPPG guidance. **13/7/22:** Patient Access are currently developing a KPI to monitor clinic capacity with a view to mitigating the level of DNA and CAN, which will be reported to and actioned by the core elective group.	
	SHSCT	• The Trust has been asked to provide more detail against each part of this recommendation.	

Recommendation 6 Trusts should urgently review the content and format of appointment letters issued to patients attending orthopaedic outpatient services.	BHSCT	• The Trust has confirmed it has completed a review of appointment letters issued to patients attending orthopaedic outpatient services.	June 2022
	SEHSCT	• The Trust has confirmed it has completed a review and samples of letters were provided.	
	NHSCT	• The Trust has confirmed it has completed a review and a sample letter was provided.	
	WHSCT	• The Trust has confirmed it has completed a review of appointment letters issued to patients attending orthopaedic outpatient services.	
	SHSCT	• The Trust has been asked to provide evidence and more detail that the work to complete this recommendation is complete.	
Recommendation 7 a) Trusts should review current practice in relation to communication with General Practitioners and other referrers, following patients' attendance at outpatients services; b) Trusts should agree, implement and monitor a standard set of key performance indicators across their outpatients services to underpin improvement in their	BHSCT	• 7(a) The Trust have been asked to progress further work on the quality of communication with GP's. The Trust has been asked to consider introducing one point of contact in the Trust who would work to secure answers to individual GP queries. • The Trust should sample survey GP practices seeking feedback on the quality of communications from outpatient clinics. • 7(b) The Trust acknowledged that there is significant work to be taken forward for both 7(b) and 7(c). All Trusts have been asked to consider a coordinated approach in relation to the development of KPI's for implementation, colleagues are asked to consider linking with Trust colleagues regionally to take Rec 7(b) forward. • 7(c) When a patient is advised that they will be copied into a letter to their GP it offers an important additional safety check against critical clinical information being lost. This recommendation should be advanced as a priority and all Trusts are asked to provide detail on the correspondence that has been issued to patients.	December 2022

written communication following outpatients review; and c) Trusts should evaluate the impact and effectiveness of directly including patients in clinical correspondence following outpatients review, to determine if implementing this approach would be of benefit across all their outpatients services.		***Belfast Trust Update (refer to above)*** *a)The Trust Chairs of Division have agreed that patients should be either copied into correspondence to GPs OR written to directly with copy to GPs.* *The following form of words has been agreed to form part of the Trust IEAP Mecical staff Checklist.* *The Trust now expects that all letters to GPs (including ED discharge letters) are copied to patients as a matter of course unless consultant medical staff explicitly state that the letter must not be. It is also acceptable to write to patients and copy to GPs.* *.Writing letters directly to patients is in keeping with Good Medical Practice, which states, 'You must give patients the information they want or need to know in a way they can understand'.* *The Academy of Medical Royal Colleges have also produced guidance on writing to patients from an outpatient setting (https://www.england.nhs.uk/medical-revalidation/ro/info-docs/roan-information-sheets/quality-improvement-best-practice-for-clinical-letters/).* *A consultant/doctor's letter must be dictated at the time of the patient's outpatient consultation. The letter must be typed and then verified on Patient Centre, so that it can be electronically transferred to the patient's GP via EDT. A letter is still required to be sent via the post/email to a referring consultant either internally or externally as this will not go electronically through EDT.* *(b)Electronic Direct Transfer (EDT) letter target is 95% - run charts and specialty level information is reviewed on a weekly basis by Executive Team. There has been significant work in the development of CCG banners/advice information; advice and guidance roll out; with GP recognition of success seen in dermatology.*	

		Updates on outpatients are shared widely with GPs through both the BHSCT/GP partnership and the GP Portal/Links Newsletter. *There are 3 GP representatives on the OP modernisation group with GPs being represented on the working groups involved in process mapping and testing of solutions.* *Request for Advice through CCG/ ECR is being rolled out across a number of specialties This area could be developed with further investment at a regional level*	
	SEHSCT	• 7(a) The Trust have been asked to progress further work on the quality of communication with GP's. The Trust have been asked to consider introducing one point of contact in the Trust who would work to secure answers to individual GP queries. • The Trust should sample survey GP practices seeking feedback on the quality of communications from outpatient clinics. • 7(b) The Trust acknowledged that there is significant work to be taken forward for both 7(b) and 7(c). All Trusts have been asked to consider a coordinated approach in relation to the development of KPI's for implementation, colleagues are asked to consider linking with Trust colleagues regionally to take Rec 7(b) forward. • 7(c) When a patient is advised that they will be copied into a letter to their GP it offers an important additional safety check against critical clinical information being lost. This recommendation should be advanced as a priority and all Trusts are asked to provide detail on the correspondence that has been issued to patients. Update SPPG have asked for a point of contact for GP's and for a feedback survey on the quality of communication with GP's to be undertaken ????who	

		Barbara/ Julie to link with NHSCT re KPI's SPPG have asked for Trust to consider patients being cc'd to GP letters Julie to add impact and Trust to confirm to proceed Patients are cc'ed into GP letters in some sp[ecilaties but not all. This is a work in progress. Renal- Patient view is an IT based portal that patients can sign up to which allows them to view some of their GP correspondence and blood chemistry results. Not all patients engage with it as it requires IT knowledge and access at home but it is available. OP sisters and pharmacists are available should High risk patients (Transplant&Low Clearance) have any queries or issues to clarify. They in turn can speak to the Consultant if necessary and contact the patient directly.	
	NHSCT	• 7(a) The Trust have been asked to progress further work on the quality of communication with GP's. The Trust have been asked to consider introducing one point of contact in the Trust who would work to secure answers to individual GP queries. • The Trust should sample survey GP practices seeking feedback on the quality of communications from outpatient clinics. • 7(b) The Trust acknowledged that there is significant work to be taken forward for both 7(b) and 7(c). All Trusts have been asked to consider a coordinated approach in relation to the development of KPI's for implementation, colleagues are asked to consider linking with Trust colleagues regionally to take Rec 7(b) forward. • 7(c) When a patient is advised that they will be copied into a letter to their GP it offers an important additional safety check against critical clinical information being lost. This recommendation should be advanced as a priority and all Trusts are asked to provide detail on the correspondence that has been issued to patients.	

		No update	
	WHSCT	• 7(a) The Trust have been asked to progress further work on the quality of communication with GP's. The Trust have been asked to consider introducing one point of contact in the Trust who would work to secure answers to individual GP queries. • The Trust should sample survey GP practices seeking feedback on the quality of communications from outpatient clinics. • 7(b) The Trust acknowledged that there is significant work to be taken forward for both 7(b) and 7(c). All Trusts have been asked to consider a coordinated approach in relation to the development of KPI's for implementation, colleagues are asked to consider linking with Trust colleagues regionally to take Rec 7(b) forward. • 7(c) When a patient is advised that they will be copied into a letter to their GP it offers an important additional safety check against critical clinical information being lost. This recommendation should be advanced as a priority and all Trusts are asked to provide detail on the correspondence that has been issued to patients. Update **13/7/22:** These three recommendations will be further explored with Consultants to agree specific actions	

	SHSCT	• 7(a) The Trust have been asked to progress further work on the quality of communication with GP's. The Trust have been asked to consider introducing one point of contact in the Trust who would work to secure answers to individual GP queries. • The Trust should sample survey GP practices seeking feedback on the quality of communications from outpatient clinics. • 7(b) The Trust acknowledged that there is significant work to be taken forward for both 7(b) and 7(c). All Trusts have been asked to consider a coordinated approach in relation to the development of KPI's for implementation, colleagues are asked to consider linking with Trust colleagues regionally to take Rec 7(b) forward. • 7(c) When a patient is advised that they will be copied into a letter to their GP it offers an important additional safety check against critical clinical information being lost. This recommendation should be advanced as a priority and all Trusts are asked to provide detail on the correspondence that has been issued to patients.	
Recommendation 8 Trusts should identify and strengthen mechanisms to engage Sisters / Charge Nurses across outpatient services in work programmes addressing collective leadership and organisational accountability.	BHSCT	• The Trust has confirmed they have strengthened mechanisms to engage Sisters / Charge Nurses across outpatient services in work programmes addressing collective leadership and organisational accountability.	June 2022
	SEHSCT	• The Trust has confirmed they have strengthened mechanisms to engage Sisters / Charge Nurses across outpatient services in work programmes addressing collective leadership and organisational accountability.	
	NHSCT	• The Trust has confirmed they have strengthened mechanisms to engage Sisters / Charge Nurses across outpatient services in work programmes addressing collective leadership and organisational accountability.	
	WHSCT	• The Trust has been asked to review their submission and provide a further update as SPPG felt this was a very informed response.	

	SHSCT	• The Trust has been asked to provide an update on new arrangements it was to establish	
Recommendation 9 a) Trusts should complete a mapping exercise to understand in detail the operational, management and governance arrangements across all outpatients services it delivers; and b) Trusts should assure themselves that operational arrangements for all outpatients services are appropriately aligned across service Directorates and divisions, so that care delivered in outpatients is consistency well governed.	BHSCT	• The Trust has been asked to provide more detail on the plan and implementation across all of the outpatient services which it delivers. Update *Belfast Trust Update* *As set out in the introductory section of this paper, the Trust has robust organisational and governance structures in place which include daily, weekly and monthly safety huddles attended by staff and senior managers to be able to officer advice and support in relation to all matters relating to patient safety and governance concerns or risks identified*	September 2022
	SEHSCT	• The Trust confirmed they are reviewing its governance arrangements at present and are to provide an update on the progress. Update Renal, MDCA and Macmillan unit (chemo) – OP activity / daycase activity is discussed as part of monthly management meeting. Agenda follows an SQE format. Admin reps input into these meetings. Lead nurse / clinical manager provides any relevant feedback from AD/Clinical manager meetings Renal Pharmacist Independant prescriber are accountable to NMP guideline set out by SE Trust. OP sister and pharmacist see patients at Renal Anaemia clinic administering IV Iron and Epo. Governance facilitators are included in the structure of the sub – directorates. There is clear evidence of the benefit of having a clinical governance coordinator (B7) to monitor and review processes and practices.	
	NHSCT	• Trust to provide evidence of mapping exercise and operational arrangements No update	

	WHSCT	• The Trust has been asked to provide an update on its progress to deliver against both parts of this recommendation. Update **13/7/22:** Service directorates will be asked to undertake this mapping exercise through their own governance arrangements with a view to test drill at a Trust Workshop.	
	SHSCT	• The Trust has been asked to provide an update on its progress to deliver against both parts of this recommendation. • Evidence of mapping exercise and operational arrangements to be provided by the Trust	
Recommendation 10 a) Trusts should specify how their collective leadership strategy and model will specifically strengthen the delivery of safe, effective and compassionate care across outpatient services; and b) Trusts should identify key measures to demonstrate the impact of their collective leadership strategy and model on outpatient services.	BHSCT	• The Trust has been asked to confirm what safety checks are in place and evidence that key measures are in place to ensure patients are safer within the outpatient services they deliver. Update *Belfast Trust Update* *The Collective Leadership Team is embedded into all service areas. The dynamic approach ensures that each Service has a dedicated and empowered team to ensure that patient safety and governance arrangements are at the forefront of patient care and treatment. This leadership team work "collectively" and simultaneously to bring about change and improvements for service delivery.*	December 2022
	SEHSCT	• The Trust has been asked to confirm what safety checks/ measures are in place? Metrics provided related to activity but assurance needs to be provided on clinical assessments. • The Trust has been asked to consider conversations with clinical and medical directors should take place and assurances provided that the NI Formulary and NICE guidance is being followed. • The Trust has been asked to consider spot checks/ audits of the decisions of clinical colleagues to ensure patients are safer within the outpatient services they deliver. Update	

		SET have an elective oversight group established. This will include the SPPG recommendation of conversations with clinical / medical directors re NI formulary and NICE guidance / spot checks	
	NHSCT	• The Trust to provide an update on the 'draft' action plan they have detailed in their submission Update All Outpatient Managers ensure that safe and effective care is delivered as a standard within OPD areas. OPD managers works closely with professional nursing team and ensure a strong engagement with education providers to deliver leadership courses for all OPD managers.	
	WHSCT	• The Trust has been asked to confirm what safety checks/ measures are in place Update **13/7/22:** The Trust will promote the establishment of an Outpatient Oversight Group which will include representation from across the MDTs and Patient Access team.	
	SHSCT	• The Trust has been asked to confirm what safety checks/ measures are in place? Metrics provided related to activity but assurance needs to be provided on clinical assessments. • The Trust has been asked to consider conversations with clinical and medical directors should take place and assurances provided that the NI Formulary and NICE guidance is being followed. • The Trust has been asked to consider spot checks/ audits of the decisions of clinical colleagues to ensure patients are safer within the outpatient services they deliver.	
Recommendation 11	BHSCT	• The Trust has confirmed implementation of this recommendation. Update *Belfast Trust Update*	December 2022

Trusts should develop and implement a set of key indicators to assure performance in relation to the care delivered through outpatient services. The Trust should not limit these indicators to activity data; these should be shared with the Trust Board and the Executive Team on a regular basis.		- *The individual teams also produce QMS data to review information such as Datix incidents, complaints (feedback and learning), compliments, staffing levels, SAIs and any emerging issues or concerns.* - *The identified KPIs are reviewed weekly so as areas of development are quickly and efficiently identified.* - *The teams use a MS Teams channel to record their information and ensure that this is accessible for other team members to review.* - *Daily morning huddles identify pressures within the systems and promote an opportunity for staff to problem solve together*	
	SEHSCT	• Trust to confirm that all the data, including measures of clinical quality, is being shared with the executive team and the Trust's board members. Update Measures of clinical quality are shared at executive team and trust board. Operational manager and clinical managers have access to respective regional dashboards for their specialities. Trusts are awaiting access from SPPG / PMSID to the OP dashboard. Exploration of processes in Northern Trust for sharing of learning has been arranged for September 2022. Can be evidenced through compliments and Care Opinion Minutes , agendas and actions can be evidenced for meetings of monthly sub directorate, and clinical directorate and hospital services wide meetings / forums. Renal- Further work will need to be done on specific KPIs related to Renal OP services specifically Transplant Clinic. We report set data annually to the	

		Renal Registry which benchmarks SET Renal Unit against all other UK Renal Units using UK Kidney Association Standards. The results are published across the UK. We participate in Patient-reported experiences measures (PREMs) annual survey which is a national survey of Renal Patient experience. Returns from patients have been low during covid. We are planning to revive the OP Patient satisfaction survey before March 23.	
	NHSCT	• Trust to provide evidence that the data collected is shared with the Trust Board needed • Evidence of clinical quality indicators to be provided Update IPC, hand hygiene and environmental cleanliness are monitored and shared. Supervision and Appraisal monitored and shared.	
	WHSCT	• The Trust has been asked to provide confirmation that all the data, including measures of clinical quality, is being shared with the executive team and the Trust's board members. • The Trust have been asked to evidence that SWAH is included in this process Update **13/7/22:** SQW 2021/22 focus on patient access to services. Showcase event recently demonstrated various QI projects to include improved access **13/7/22:** Plan for focused OPD Care Opinion user experience feedback Both of the above sets of information and improvement will be shared with the Trust Outpatient Oversight Group	

	SHSCT	• The Trust has been asked to provide more detail to confirm that indicators do not just relate to activity. • Trust has been asked to ensure evidence is more than activity; qualitative data needs to be measured. • Trust has been asked to consider regional agreement with colleagues on KPI's?	
Recommendation 12 Trusts should adopt a strategic approach to audit and quality improvement work involving outpatient services, to align with the Trust's organisation-wide approach to quality improvement and to focus on both specific service or site improvement and system level improvement.	BHSCT	• The Trust has been asked to confirm that all clinical decision makers involved in outpatient clinics are required to participate in QI work *Belfast Trust Update* *This document in its entirety outlines the commitment to audit and quality work / modernisation which been undertaken at both local, service and Trust level.* *QMS data is recorded and presented so as to identify areas for improvement and development. The QMS data is also used to keep staff appraised and informed of service needs.*	September 2022
	SEHSCT	• The Trust has provided strong evidence with a good focus on quality improvement to confirm this recommendation has been implemented. Update SET will have a continued focus on QI and can provide evidence of staff numbers who participate in QI projects and training. Renal – Recent QI project completed with Transplant patients concentrating on medicines administration. Full report presented back to HSC. Other examples of QI available.	
	NHSCT	• The Trust has been asked to detail how clinical performance is measured • The Trust has been asked to confirm prescribing is in line with regional formulary and NICE guidance. • Trust to confirm if training for clinicians is mandatory and what protocols are in place to ensure quality clinical review	

		Update No update provided have marked themselves green	
	WHSCT	• The Trust has been asked to provide more detail on the progress against this recommendation and evidence a strategic approach to QI and detail levels of training • The Trust has been asked to evidence a regional approach not just the approach within Altnagelvin. • The Trust have been asked to confirm that all clinical decision makers involved in outpatient clinics are required to participate in QI work Update **13/7/22:** Data of staff uptake of levels 1,2 and 3 QI training and OPD associated projects to be reviewed by the Trust Outpatient Oversight group and used to direct further improvements	
	SHSCT	• The Trust has been asked to detail how clinical performance is measured • The Trust has been asked to confirm prescribing is in line with regional formulary and NICE guidance. • Trust to confirm if training for clinicians is mandatory and what protocols are in place to ensure quality clinical review	
Recommendation 13 Trusts should strengthen approaches to the identification and management of risk within and across the outpatient services it delivers by necessity this will include:	BHSCT	• The Trust has been asked to provide an update on progress of implementation. *Belfast Trust Update* - *Outpatients representation is mandatory at weekly safety governance huddles to discuss key performance indicators which include incident reporting and the identification of emerging issues and any risks.* - *Staff attend daily safety huddles to identify key areas of pressure within the Service and problem solve together.* - *Belfast Trust has strengthened its approach to the identification and management of risk within and across the outpatients services by ensuring that all risks are clearly identified on both local and Trust risk*	Plan in place by September 2022 Completion December 2022

a) A mechanism to ensure sharper focus for the known risks across the full range of Trust services delivered in outpatients settings; b) Progressing work to understand and mitigate new or previously unidentified risks, such as those described in this review; c) Ensuring that all staff delivering outpatients services are proactive in their approach to identifying risks as they emerge and to implementing systems to manage these risks; and d) Ensuring that the Executive Team and Trust Board are regularly updated and receive robust assurance regarding risks as they relate to outpatients services.		*registers. The risk register is reviewed in line with service developments.* - *Outpatients staff are proactive in their approach to identification of risk and use the Datix Web system to record appropriate incidents, learning and outcomes.* - *The Collective Leadership team meet on a monthly basis to review assurance measures. The Executive Team and Trust Board are regularly updated with assurance regarding any / all risks in relation to all services that use the Outpatients Department.*	
	SEHSCT	• Trust to provide a further update on the implementation of this recommendation. Update Renal- prescribing and supply of red list medications in OP is tightly regulated.	
	NHSCT	• Trusts to provide updates on all parts of this recommendation. • Trust to provide evidence of a plan in place by the end of September 2022 with a view to completion by the end of December 2022. Update No update provided marked themselves green	
	WHSCT	• The Trust has been asked to evidence that these reports are shared with the Trust Board. • Trust to provide evidence of a plan in place by the end of September 2022 with a view to completion by the end of December 2022. Update **13/7/22:** The proposed Trust Outpatient Oversight group will review outpatient and patient access related risks within each Directorate Risk Register. They will also review themes from Datix, SAIs and Complaints. Themes will be identified and potential for shared learning corrective measures.	

	SHSCT	• Trusts to provide updates on all parts of this recommendation. • Trust has been asked to ensure the management of risk for clinical assessment and clinical decision making is evidenced • Trust to provide evidence of a plan in place by the end of September 2022 with a view to completion by the end of December 2022. • Trust to provide evidence that the Trust Board and Executive team are kept informed.	
Recommendation 14 Trusts should expedite work to develop internal information systems so that data on clinical activity and patient outcomes (by service, by team and by consultant) are routinely reported and shared; this information should be available to support annual whole-practice appraisal and revalidation, as well as service planning and development.	BHSCT	• It was noted that activity detail has been provided but evidence around clinical outcomes needed to give assurances • The Trust has been asked to provide updates regarding prescribing decisions. It was recommended that spot checks may be useful to ensure adherence to guidance. ***Belfast Trust Update*** *Actions outlined above are ongoing*	September 2022
	SEHSCT	• Trust to provide further evidence of clinical outcomes. Update Clinical outcomes are available through M7M reports, readmission rates and complications rates which are shared are audit meetings. Covid has hampered audit meetings but a plan is in place to recommence. Renal- As per recommendation 11 report to Renal Registry; data collected reflects patient outcomes. Medical staff participate in M&M meetings. NI Nephrology forum and Regional Audit is a MDT meeting provides focus on patient outcomes/future practice/innovation etc. Topics span all services within the Renal spectrum including OP. Following the Low Clearance clinic we hold a MDT meeting to discuss each patient, their journey and management plan. This assists with communication and smooth transition to patient chosen treatment option.	

	NHSCT	• Trust to provide further evidence on clinical outcomes Update No update provided	
	WHSCT	• Trust to provide further evidence on clinical outcomes Update **13/7/22:** Further discussion required through the Trust Outpatient Oversight Group .	
	SHSCT	• Trust to provide further evidence on clinical outcomes and asked to provide a sample report • Trust to evidence measures taken and monitoring in place	
Recommendation 15 Trusts should strengthen the use of information and intelligence relating to incidents and complaints occurring in the context of outpatient services delivered; Trusts should analyse this data and intelligence in a way that promotes a proactive	BHSCT	• More detail needed on the weekly governance meetings and how this contributes to identifying risk and improving the quality and safety of outpatient services. • The Trust has been asked to consider surveys and discussions with nursing staff could be useful to provide feedback on individual clinicians' assessments, treatment of patients and approach to other staff. *Belfast Trust Update* *All staff are fully conversant with the use of the Datix incident reporting systems. All Datix's are discussed at the weekly governance huddles and*	September 2022

approach to identifying risk and improving the quality and safety of outpatient services.		*present these to the Collective Leadership Team and Governance Management team.* *The Outpatients team collectively review the Datix incident reporting for their areas and are able to identify all key themes and trends within the Service. These are further discussed at Governance huddles to identify key learning.*	
	SEHSCT	• More detail and evidence needs to be provided on process for incidents and complaints that occur in the outpatient services and detail how this process improves the quality and safety for patients. • The Trust has been asked to consider surveys and discussions with nursing staff could be useful to provide feedback on individual clinicians' assessments, treatment of patients and approach to other staff. Update Sharing learning is initiated through governance systems that are currently in place. Some specialties have initiated journal clubs and learning platforms.	
	NHSCT	• Trust to provide more detail on the development of a dashboard • The Trust has been asked to consider surveys and discussions with nursing staff could be useful to provide feedback on individual clinicians' assessments, treatment of patients and approach to other staff. Update No update provided	
	WHSCT	• The Trust has been asked to consider surveys and discussions with nursing staff could be useful to provide feedback on individual clinicians' assessments, treatment of patients and approach to other staff.	

		Update **13/7/22:** As per update in section 13 above	
	SHSCT	• More detail and evidence needs to be provided on process for incidents and complaints that occur in the outpatient services and detail how this process improves the quality and safety for patients. • The Trust has been asked to consider surveys and discussions with nursing staff could be useful to provide feedback on individual clinicians' assessments, treatment of patients and approach to other staff.	
Recommendation 16 a) Trusts should develop and implement a targeted action plan to improve knowledge and awareness of staff in relation to the safeguarding of adults and children receiving care and treatment in their outpatient services; b) Trusts must ensure they receive robust assurances in respect of compliance with best practice as advised by regional and local policies in this regard; and c) Trusts should review their risk register to ensure it is accurately capturing current risks relating to	BHSCT	• The Trust have been asked to provide more detail needed against each part of this recommendation as no details of a review of the risk register has been noted. No update provided	September 2022
	SEHSCT	• The Trust provided detail to confirm they have successfully delivered on this recommendation. Update Renal- OP staff are RA trained. RA held at Unit level. Safeguarding training for all staff via Trust training; Board in the Unit but we will work on a board for the OP area. Children transferring from the RVH Nephrology service to Adult Nephrology at the SET are accompanied by a member of the Paediatric Nephrology team for first and on occasion second visit to our OP service.	
	NHSCT	• The Trust have been asked to provide more detail needed against each part of this recommendation Update All safeguarding training data is recorded on a training matrix for all OPD nursing staff, which allows managers to plan for 3 yearly training updates in a timely manner, throughout the year.	

the knowledge and awareness of staff safeguarding roles and responsibilities.			
	WHSCT	• The Trust have been asked to provide more detail and outline their safeguarding processes Update 13/7/22: While there has been significant work done in outpatient settings, the Trust Oversight Group will review the training figures of child and adult safeguarding across the range of out patient settings	
	SHSCT	• The Trust provided a very informed response to evidence it has delivered against this recommendation.	
Recommendation 17 Trusts should ensure information relating to outpatient activity (by service, by team, by consultant) is collected, analysed and routinely shared; this data should be used to enable robust capacity planning and to inform future service development and	BHSCT	• Trust asked to provide more detail to evidence this process being used across outpatient services. ***Belfast Trust Update*** *Actions outlined above are ongoing*	September 2022
	SEHSCT	• The Trust has been asked to provide more evidence that this data is collected, analysed and routinely shared. Update Planning and performance team have worked with hospital services to produce a dashboard which allows interrogation of OP activity at Trust level, site level, speciality level, priority level and individual level. This is used by specialities and clinical leads, ADs and operational managers to target areas requiring improvement.	

modernisation of outpatient services across the Trust.		Renal – currently using the data from Transplant clinics and UK Kidney Association recommendations to prepare a position paper for service improvement.	
	NHSCT	• Trust asked to provide more detail to evidence this process being used across outpatient services. No update provided	
	WHSCT	• The Trust has been asked to review their submission as SPPG felt this was a very informed response. Trust to provide a further update on delivery against this recommendation. Update **We had noted from our meeting that the SPPG group were content that this recommendation would be green. We will include the detail above in our assessment.**	
	SHSCT	• Trust asked to provide more detail to evidence this process being used across outpatient services.	
Recommendation 18 a) Trusts should ensure they develop and implement a robust system for oversight and monitoring of the quality of care delivered by Specialist Nurses and the related patient outcomes achieved across their outpatients settings;	BHSCT	• Trust has been asked to provide more detail on the quality of care that is being delivered. *Belfast Trust Update* *Line management/Reporting Structures are already in place for Specialist Nurses in their Speciality Teams and Peer Review and Audit is in place for these nurses.* *Staff appraisals, revalidation and any service specific competency frameworks are completed by the Speciality Team with standard operating procedures developed in line with governance arrangements* *Patient experience/service user feedback on quality of care delivered and patient outcomes are shared through existing structures to the Speciality Team and within the Outpatients Services.*	September 2022

b) Specialist nurses should be appropriately supported to undertake their roles through effective supervision, professional development and support for annual appraisal and revalidation.	SEHSCT	• The Trust has been asked to provide a wider view of those nurses managed under a different structure. • Evidence of robust systems in place against all the specialities to be provided. Update The clinical managers who manage specialist nurses have strong links with the sub directorates through monthly professional meetings and also through a Trust Wide Nursing and Midwifery Forum. This enables a robust system and cross learning to ensure those specialist nurses can be keep appraised of necessary professional issues.	
	NHSCT	• The Trust provided detail to confirm they have successfully implemented this recommendation.	
	WHSCT	• The Trust has been asked to provide a wider view of those nurses managed under a different structure to ensure there are robust systems in place against all the specialities. • SPPG felt relevant evidence was provided in relation to part (b) but have asked for a further update on the progress against this recommendation in full. Update **13/7/22:** For further discussion via the Trust Outpatient Oversight Group	
	SHSCT	• Trust to provide an update to confirm this is in place for all specialities across the outpatient services.	
Recommendation 19 Trusts should develop, implement and assure a systematic approach to	BHSCT	• The Trust has been asked to provide further detail on their approach to clinical peer review across their outpatient services and an update on the ongoing work. *Belfast Trust Update* *A Clinical Record Review (CRR) template using a structured judgment review methodology is in use within the Belfast Trust. This has enabled clinical peer review. A copy of a CRR template is available at local and*	September 2022

clinical peer review across their outpatient services		*service level to inform individuals clinical practice. Whilst this is mainly used for clinical review within the medical team the Belfast Trust is in the process of rolling this out throughout all healthcare professional teams.*	
	SEHSCT	• The Trust has been asked to provide more evidence that clinical peer review takes place in all specialities. Update Peer review is undertaken in cancer services for 13 tumours sites. M&M meetings, directorate governance meetings, appraisals and MDTs all provides forum for peer review. Renal- no formal peer review but NI Nephrology Forum and Regional Audit allows for discussion on practice and service improvement. Not specific to OP services but the nature of the patient journey naturally feeds OP these discussions.	
	NHSCT	• The Trust to provide position in relation to this recommendation Update *Whilst the logic for this recommendation is valid there needs to be agreement on implementation;* - *What is a statistically acceptable review 5* - *All specialties – some have less ambiguous diagnostics than others* - *Impact on capacity/waiting lists/commissioning*	
	WHSCT	• The Trust to provide evidence that clinical peer review is taking place in all specialities across its outpatient services. Update **13/7/22:** Needs further discussion with Medical Director and Trust Outpatient Oversight Group	

	SHSCT	• The Trust to provide evidence that clinical peer review is taking place in all specialities across its outpatient services.	
Recommendation 20 Trusts and the Health and Social Care Board should establish clear mechanisms by which Trusts and General Practitioners can engage and communicate in relation to outpatient services delivered by Trusts. Trusts should also assure themselves that General Practitioners, who may have a concern relating to services delivered, have been provided with clear information regarding how to raise their concern.	BHSCT	*Rec 7(a) is relevant.* • The Trust has been asked to provide more detail on the communication platform for Trusts and General Practitioners. How do individual GP Practices clarify queries? • Engagement with leaders of the GP Federations is recommended in order to enhance communication. • A single point of contact for each practice in relation to outpatients would be important to establish. *Belfast Trust Update* *The Trust has set up a number of channels to communicate with GPs about services provided by the Trust. These methods of communication include:* • *GP Portal/ Links newsletter* • *GP Trust Partnership Forum every 2 weeks* • *Tailored education sessions/ webinars with GPs provided by services* • *Posting information on GPNI website* • *Email can be sent out directly to practices via BSO as the Trust does not have access to GP's email addresses.*	September 2022
	SEHSCT	*Rec 7(a) is relevant.* • The Trust has been asked to provide more detail on the communication platform for Trusts and General Practitioners. How do individual GP Practices clarify queries? • Engagement with leaders of the GP Federations is recommended in order to enhance communication. • A single point of contact for each practice in relation to outpatients would be important to establish. Update	

		Early discussions commenced with SET GPs Lead for more engagement events with GP practices.	
	NHSCT	*Rec 7(a) is relevant.* • The Trust has been asked to provide more detail on the communication platform for Trusts and General Practitioners. How do individual GP Practices clarify queries? • Engagement with leaders of the GP Federations is recommended in order to enhance communication. • A single point of contact for each practice in relation to outpatients would be important to establish. Update No update provided marked themselves as green	
	WHSCT	*Rec 7(a) is relevant.* • The Trust has been asked to provide more detail on the communication platform for Trusts and General Practitioners. How do individual GP Practices clarify queries? • Engagement with leaders of the GP Federations is recommended in order to enhance communication. • A single point of contact for each practice in relation to outpatients would be important to establish. Update **13/7/22:** This will form part of the Trust Outpatient Oversight Group which will include a GP representative in its membership	
	SHSCT	*Rec 7(a) is relevant.*	

		• The Trust has been asked to provide more detail on the communication platform for Trusts and General Practitioners. How do individual GP Practices clarify queries? • Engagement with leaders of the GP Federations is recommended in order to enhance communication. • A single point of contact for each practice in relation to outpatients would be important to establish.	
Recommendation 21 Trusts should develop a system or systems to enable appropriate oversight and assurance of prescribing and prescribing advice across the Trust outpatient services. This should include the development and implementation of an interim electronic system to replace the current paper based Treatment Advice Notes.	BHSCT	• The Trust has been asked to confirm its interim processes that are in place before Encompass is rolled out. • Pending the development of digital prescribing systems it is essential that the Trust, through its relevant clinical leaders, develops a system to monitor and assure the prescribing and treatment decisions of all clinicians working in outpatient services. *Belfast Trust Update* *Non-medical Prescribers (NMPs) use this eTaN and each year are required to produce data to reflect on their practice. This information is reviewed by clinical peers and provides assurance as to how standards of care is maintained.*	December 2022
	SEHSCT	• The Trust has been asked to confirm its interim processes that are in place before Encompass is rolled out. • Pending the development of digital prescribing systems it is essential that the Trust, through its relevant clinical leaders, develops a system to monitor and assure the prescribing and treatment decisions of all clinicians working in outpatient services. Update Patients on specialist drugs and SACT drugs have a robust system in place to monitor and assure the prescribing and treatment decisions of all clinicians working in outpatient services.	

		Renal – Renal Pharmacy Team have systems in place to ensure seamless communicating with primary care with regard to all medication changes. All prescribing is initiated via eMed. Communication to primary care via EDT	
	NHSCT	• The Trust has been asked to confirm its interim processes that are in place before Encompass is rolled out. • Pending the development of digital prescribing systems it is essential that the Trust, through its relevant clinical leaders, develops a system to monitor and assure the prescribing and treatment decisions of all clinicians working in outpatient services. Update No update provided marked themselves	
	WHSCT	• The Trust has been asked to confirm its interim processes that are in place before Encompass is rolled out. • Pending the development of digital prescribing systems it is essential that the Trust, through its relevant clinical leaders, develops a system to monitor and assure the prescribing and treatment decisions of all clinicians working in outpatient services. Update ***13/7/22:*** *For ongoing review of how to further develop via Pharmacy lead and Chief Information Officer and Trust Outpatient Oversight Group*	
	SHSCT	• The Trust has been asked to confirm its interim processes that are in place before Encompass is rolled out. • Pending the development of digital prescribing systems it is essential that the Trust, through its relevant clinical leaders, develops a system to monitor and assure the prescribing and treatment decisions of all clinicians working in outpatient services.	
Recommendation 22	BHSCT	• The Trust has been asked to provide an update on the progress against this recommendation.	December 2022

Trusts should cease the practice of retaining separate paper-based notes for particular outpatient specialities; Trusts should develop a system whereby patient notes for all specialities are retained as part of an integrated hospital-wide record		***Challenge(s):*** *(a)* BHSCT noted resource challenges around the delivery of this recommendation. ***Belfast Trust Update*** *The Trust has set out its proposed arrangements for records management pending the implementation of Encompass. Under these proposals, the Trust will need to retain some separation of records (ie majority of specialty notes will be retained within a RVH or BCH library based record, and some separate notes will be retained for a smaller number of specialties. There would be significant resources required to fully address the recommendation, which are unlikely to be available with the introduction of Encompass from 23/24. Encompass will deliver an integrated record and fully address the recommendation.* *The Trust can discuss the recommendation and Trust response in more details with the RQIA*	
	SEHSCT	• The Trust has been asked to provide an update on the progress against this recommendation. Update OP Admin and Specialty Lead are working on systems and processes in advance of Encompass to mitigate against the risk of retaining separate paper based notes Renal- Currently electronic notes on eMed. But will be moving to Emcompass. OP is run paperlight but not paperless.	
	NHSCT	• The Trust has been asked to provide an update on the progress against this recommendation. Update No update provided	

	WHSCT	• The Trust has been asked to provide an update on the progress against this recommendation. Update **13/7/22** – *For review by Trust Outpatient Oversight Group in line with ongoing Encompass workstreams*	
	SHSCT	• The Trust has been asked to provide an update on the progress against this recommendation.	
Recommendation 23 a) Trusts should agree a range of key performance indicators across all of their outpatient services; b)They should assure and govern these systems for service improvement; and c) They should communicate these to services through specialty level dashboards.	BHSCT	• The Trust have been asked to confirm what KPI's are in place and to consider what risks there are and how could these could be avoided. • Response to each part is needed in more detail to provide assurances. ***Belfast Trust Update*** *Actions outlined above are ongoing*	September 2022
	SEHSCT	• The Trust have been asked to confirm what KPI's are in place • The Trust have been asked for more detail around its dashboard Update Exploration of processes in ~~Northern~~ Trust for sharing of learning has been arranged for September 2022 with further discussion with local and regional groups to follow. Renal – as per previous comments	
	NHSCT	• The Trust have been asked to confirm what KPI's are in place and to consider what risks there are and how could these could be avoided. Update No update provided	
	WHSCT	• The Trust have been asked to confirm what KPI's are in place • The Trust have been asked to evidence a dashboard in place	

	SHSCT	• The Trust have been asked to confirm what KPI's are in place and to consider what risks there are and how could these could be avoided. • Response to each part is needed in more detail to provide assurances.	
Recommendation 24 Trusts should further develop and expedite new models of working in outpatients services, such as the use of telephone and video appointments, remote monitoring, outreach clinics; new models for service delivery should be agreed with commissioners and consistently evaluated to demonstrate impact.	BHSCT	• This recommendation has been implemented and it was noted that the Covid outbreak has accelerated progress across the region. ***Belfast Trust Update*** *Actions outlined above are ongoing*	June 2022
	SEHSCT	• This recommendation has been implemented and it was noted that the Covid outbreak has accelerated progress across the region. ***Challenge(s):*** *(a)* SEHSCT noted resource challenges around the continued delivery of this recommendation. Update OP Admin and Specialty Leads will review and collate additional info in respect of costs/ commissioning of services as required	
	NHSCT	• This recommendation has been implemented and it was noted that the Covid outbreak has accelerated progress across the region Update No update provided marked themselves as green	
	WHSCT	• This recommendation has been implemented and it was noted that the Covid outbreak has accelerated progress across the region	

	SHSCT	• The Trust has been asked to provide more evidence of implementation of this recommendation.	
Recommendation 25 Trusts should optimise various communication media as a means of providing information about conditions, procedures and treatments to patients across their outpatient services.	BHSCT	• It is recognised that communication with patients will always remain as ongoing but the Trust have been asked to evidence a plan in place to confirm delivery of this recommendation *Belfast Trust Update* *The Trust has identified that is that it is not possible to bulk upload patients on to the Patient Portal system – currently patients need to be manually added with a unique email address and this is not feasible within existing resources.* *The Trust has requested BSO to link with Orion re costs associated with this development.* *A number of services have existing patient facing portals with general information about the services, including:* • *Renal* • *Paediatric Ophthalmology* • *RFC/ GUM – videos about the conditions* • *Royal Jubilee Maternity – info about the service/ what to expect/ tour of the facilities* *Direct messaging between consultants and patients as part of the Patient Initiated Follow Up/ Flexible Review pathway would provide a more responsive service for patients and the Trust is assessing the viability of this and the tools that would enable this*.	September 2022
	SEHSCT	• It is recognised that communication with patients will always remain as ongoing but the Trust have been asked to evidence a plan in place to confirm delivery of this recommendation Update	

		OP Admin and Specialty Leads can provide evidence in relation to communication with patients – in line with IEAP principles, condition/ procedure related, signposting to other services and support networks Renal – Renal specific PILS available for high risk drugs. Would need to develop multi language and other forms of information to meet needs of registered blind/hearing patients	
	NHSCT	• Trust to provide more information on the communication media used for patients across outpatient services Update No update provided	
	WHSCT	• It is recognised that communication with patients will always remain as ongoing but the Trust have been asked to evidence a plan in place to confirm delivery of this recommendation Update **13/7/22:** For further discussion via the Trust Outpatient Oversight Group	
	SHSCT	• It is recognised that communication with patients will always remain as ongoing but the Trust have been asked to evidence a plan in place to confirm delivery of this recommendation	
Recommendation 26 Trusts should develop and implement arrangements to obtain patient feedback in a co-ordinated and systematic way across all outpatient sites. Feedback received should be used to evidence	BHSCT	• The Trust has been asked to provide an example of what difference feedback makes to their outpatient services • The Trust has been asked to confirm what is the follow up process and communication with patients after their appointment *Belfast Trust Update* *A pilot of a patient satisfaction survey is currently underway within the Belfast City Hospital Outpatients Department. The operational management of this will be reviewed before being rolled out across all outpatient areas. The Belfast Trust has secured resources to be able to maintain this*	September 2022

quality of care delivered and to underpin service improvements as required.	SEHSCT	• The Trust provided detail to confirm they have successfully delivered on this recommendation Update OP Admin and Specialty Leads can provide evidence in relation to patient feedback – QI projects, complaints/ improvement action plans, compliments and care opinion stories received Renal – OP participate in PREMS, we are reviving OP survey.	
	NHSCT	• The Trust has been asked to provide an example of what difference feedback makes to their outpatient services • The Trust has been asked to confirm the frequency of patient feedback No update provided	
	WHSCT	• The Trust has been asked to provide an example of what difference feedback makes to their outpatient services	
	SHSCT	• The Trust has been asked to provide an example of what difference feedback makes to their outpatient services • The Trust has been asked to confirm the frequency of patient feedback	

Southern Health and Social Care Trust

Quality Care - for you, with you

20th February 2022 Ref: MOK/ec

Via email [redacted]

Briege Donaghy
Chief Executive
Regulation and Quality Improvement Agency
9th Floor BT Tower
Belfast

Dear Briege,

RE: UROLOGY STRUCTURED CLINICAL RECORD REVIEW PROCESS

As you will be aware, the Southern Trust is conducting a lookback exercise regarding our Urology services. The purpose of the lookback exercise is to review patients who were under the care of an individual consultant no longer employed by the Trust.

Following the completion of an initial nine Serious Adverse Incident (SAI) reviews in 2021 and as advised by the Department of Health, the SAI process will not be used to review subsequent potential issues in care identified as a result of the lookback process. However remaining cognisant of regional parameters and requirements for the identification, review and learning from Adverse and Serious Adverse Incidents (SAI) as set out in the HSCB *Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016,)* the Trust has sought to provide an alternative, proportionate and robust review structure that can be utilised to review these incidents in a timely manner.

As a result of this the Trust has developed a *'Structured Clinical Record Review'* (SCRR) process founded on Structured Judgement Review methodology as developed by the

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: [redacted] Email: [redacted]

Royal College of Physicians. The SCRR process has been designed to allow the Southern Trust to identify if there is any learning or areas where patient safety can be improved.

I understand the Department of Health Sponsor Branch has made contact with you regarding support to the Trust through conducting a review relating to the SCRR process. Specifically we are asking for RQIA to undertake the following please:

- A review of the choice of SJR methodology to underpin the SCRR process
- A review of the SCRR process in relation to its effectiveness in identifying learning

In terms of output from this, it would be useful to have a statement to assure the Urology Assurance Group on the effectiveness of the SCRR process please. If in the event that the SCRR process is not found to be satisfactory, I would be grateful if you could recommend an alternative approach please.

I look forward to hearing from you.

Yours sincerely

Personal Information redacted by the USI

Dr Maria O'Kane
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI Email: Personal Information redacted by the USI

The Regulation and Quality Improvement Authority

Our Ref: 845

2 March 2022

Dr Maria O'Kane
Medical Director
SHSCT

Email only: [redacted]
Personal Information redacted by the USI

Dear Dr O'Kane

Urology Structured Clinical Record Review Process

Thank you for your letter of the 20 February and the detail provided about the work undertaken so far by the Trust in relation to the Urology Structured Clinical Record Review Process. I note also the specific request you are making of RQIA.

We have considered this and agree that providing external independent assurance of your approach in respect of these cases would be an appropriate task for us to undertake.

I have requested that our Director of Hospital Services, Independent Health Care, Audit and Reviews, Mrs Emer Hopkins take forward this piece of work with the support of our Clinical Lead for Medicine, Dr Leanne Morgan, and other members of our review programme as required. Emer will be in touch over the next few days and it is likely she will ask for a meeting with your team, to discuss the scope, your approach to the record review and how it fits in the overall context of the Urology Inquiry. She can also discuss possible methodologies and timescales and have a first sight of the SCRR tools you have produced.

In the meantime, we will develop a methodology for this work and prepare confidential information request for relevant documents under Article 41 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. This means that these documents can be prepared in good time for consideration by any panel/team we may appoint to assist us with our review and in advance of meeting with appropriate members of the Trust team undertaking this work if required.

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Belfast BT1 4LS

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The Regulation and Quality Improvement Authority

If you would wish to discuss any of this further, please do not hesitate to contact Emer Hopkins at [redacted]

Yours sincerely

[redacted]

Chief Executive

cc Emer Hopkins, Director of Hospital Services, Independent Health Care, Audit and Reviews, RQIA
Andrew Dawson, Director of Quality Safety and Improvement, DoH
Dr Leanne Morgan, Clinical Lead, RQIA

The Regulation and Quality Improvement Authority

Ref: HH/EH/BD

13 September 2022

Dr Maria O'Kane
Chief Executive
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

BY EMAIL ONLY: [redacted] Personal Information redacted by the USI

Dear Dr O'Kane

RQIA Review of the Urology Structured Case Record Review Southern Health and Social Care Trust

I enclose for your attention the report of the above mentioned review. This report sets out the findings of the Expert Review Team and makes 18 recommendations for improvement.

RQIA would like to acknowledge the amount of time and effort that Southern Health and Social Care Trust staff have given to this piece of work and commend their openness, candour and willingness to learn from the expertise of the Expert Review Team. This positive engagement and 'buy in' will assist SHSCT in implementing the necessary improvements.

This report will be of interest to Urology Assurance Group and the Urology Inquiry and as such RQIA would seek to confirm if the Trust will be sharing the report with them or if we should make the necessary arrangements to share onward. I would be grateful if you could confirm your intentions.

We look forward to continuing to engage with the Trust Urology Services to provide both independent assurance and improvement support as it continues its efforts to urgently address deficits in care whilst improving the quality and safety of patient care.

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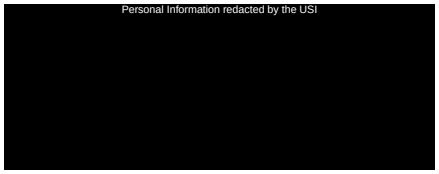
The Regulation and Quality Improvement Authority

Yours sincerely



Briege Donaghy
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Enc.

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The Regulation and Quality Improvement Authority

RQIA Review of the Urology Structured Case Record Review Southern Health and Social Care Trust

May 2023

The Regulation and Quality Improvement Authority

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- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

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Appendix 1: Terms of Reference for the Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Appendix 2: Structured Judgement Review

Section 1 Introduction

1.1 Background and Context

On 31 July 2020, the Southern Health and Social Care Trust (SHSCT) contacted the Department of Health (DoH) to report an early alert concerning the clinical practice of a Urology Consultant (referred to in this report as Consultant A).

An initial review, which considered cases over an 18-month period of the consultant's work in SHSCT from 1 January 2019 to 30 June 2020, focussed on whether patients had had a stent inserted during a particular procedure and if the stent had been removed within the clinically recommended time frame. The initial review identified concerns with 46 cases out of a total of 147 patients who had the procedure and were listed as being under the care of the consultant during the period addressed by the initial look-back exercise[i]. The findings were significant and led the Minister for Health, Robin Swann MLA, to announce on 24 November 2020 that a statutory public inquiry would be established under the Inquiries Act 2005.

The Urology Services Inquiry, which is currently ongoing, is chaired by Ms Christine Smith QC has been charged with: (a) reviewing SHCT's handling of relevant complaints or concerns identified or received prior to May 2020 and its participation in processes to maintain standards of professional practice; (b) evaluating the corporate and clinical governance procedures and arrangements within the Trust in relation to the circumstances which led to the Trust conducting a "lookback review" of patients (c) examining the clinical aspect of the cases identified by the date of commencement of the Inquiry as meeting the threshold for a Serious Adverse Incident (SAI) and any further cases which the Inquiry considers appropriate; (d) afford those patients affected, and/or their immediate families, an opportunity to report their experiences to the Inquiry; (e) To review the implementation of the Department of Health's "Maintaining High Professional Standards Policy" by the Trust in relation to the investigation related to Mr O'Brien; (f) To identify any learning points and make appropriate recommendations as to whether the framework for clinical and social care governance and its application are fit for purpose and (g) examine and report on any other matters which the Chairman considers arise in connection with the Inquiry's investigations.

In parallel, yet entirely separate, to the work of the Urology Services Inquiry, SHSCT subsequently established a review group to assess the further findings of the initial review exercise and to explore the need for a further look-back review in the context of additional concerns.

Areas of concern were identified relating to:

- Elective and emergency activity;
- Radiology;
- Pathology and cytology results;
- Patients whose cases were considered in multidisciplinary team meetings;
- Oncology; and

[i] Ministerial Statement by Health Minister to the Northern Ireland Assembly, 24th November 2020

- The safe prescribing of an anti-androgen drug outside established NICE guidance in the management of prostate cancer.

Nine cases were identified that met the threshold for a Serious Adverse Incident (SAI) review. Following the completion of these initial nine SAI reviews in 2021, the Trust was advised by DoH that the SAI process should not be used to review subsequent potential issues in care identified by the lookback process.

As a result, SHSCT developed a Structured Case Record Review (SCRR) process based on the Structured Judgement Review methodology as developed by the Royal College of Physicians. The aim of the SCRR process was to identify any areas of learning where patient safety could be improved.

In March 2022 SHSCT asked RQIA to undertake:

- A review of the choice of Structured Judgement Review methodology to underpin their SCRR process.
- A review of the Trust SCRR process in relation to its effectiveness in identifying learning.

It was further agreed that, in the event that the SCRR process was not considered to be appropriate the Trust would like RQIA to suggest an alternative approach.

1.2 Terms of Reference

Although RQIA was requested to review the suitability of the Trust's SCRR process, we considered that the scope of the review should be wider. It would not be appropriate to only assess the tools involved but we should also assess the surrounding process within which the SCRR operates. Therefore, the following Terms of Reference were agreed with SHSCT.

1. To assess the suitability of the Structured Judgement Review methodology as the basis for the Trust SCRR process.

2. To assess the specific Trust SCRR methodology in relation to its effectiveness in identifying learning.

3. To assess the overall trust process/framework for conduct of its record review.

4. To make recommendations in relation to the overall process and if the SCRR process is not considered to be appropriate suggest an alternative approach.

1.3 Review Methodology

RQIA used a PRINCE project management approach to underpin this review. The review utilised a range of methodologies to obtain supporting information to inform our assessment:

- We undertook a review of the literature around the use of the Structured Judgement Review Method to help identify key themes and areas of focus.

- We designed and issued structured questionnaires to the Southern Health and Social Care Trust.
- We analysed information returned to us and used this to develop Key Lines of Enquiry for meetings with the Trust.
- Our Expert Review Team (ERT) conducted focus groups and meetings with the independent panel of reviewers, senior staff and other relevant staff from the Trust.
- We analysed the information gathered through our structured pre review questionnaires, meetings, focus groups and staff questionnaire responses in order to determine our key findings and recommendations.

Section 2 Findings

In assessing the effectiveness of all aspects of the SCRR process we considered the overall process in respect of a number of component parts.

2.1 OVERALL TRUST PROCESS AND FRAMEWORK FOR SCRR

2.1.1 Background to the Structured Case Record Review

The provision of background and contextual information is vital to the understanding of the rationale and purpose of the Structured Clinical Records Review process. This information was provided by SHSCT, in conjunction with a Structured Case Review proposal document and was explored further by the Expert Review Team during fieldwork sessions with Trust representatives.

During fieldwork, the Expert Review Team heard the Urology Services Inquiry was announced unexpectedly in November 2020 during what was a difficult time for SHSCT, when it was grappling not just with the emerging issues within Urology Services but also with the COVID-19 pandemic and its associated pressures for service; this contextual information provided the Expert Review Team with a valuable insight into the challenges faced. At the point of announcement of the Inquiry Terms of Reference (see Appendix 1) SHSCT had already commenced a Lookback Review and through this had identified a significant number of patients meeting the threshold for an SAI review under the regional SAI procedure[1].

Due to the volume of patients identified, the time and resource required to progress SAI reviews, and the limited additional value of repeatedly reviewing the same type of incident via the SAI process, it was suggested that an alternative methodology is used to derive learning from these cases. The decision to use the SCRR approach, as an alternative to SAI methodology, was taken in conjunction with SPPG and DoH's Urology Assurance Group. The Expert Review Team considers that this decision was the correct one, and that Structured Judgement Reviews methodology, such as that developed by the Royal College of Physicians, is a robust method of assessing the quality of care and treatment of individual cases, when applied as intended. As such, the Expert Review Team endorses the decision to adopt an alternative approach to undertaking repeated SAI reviews in such circumstances.

Although the decision to proceed with the SCRR was taken prior to the announcement of the Urology Services Inquiry, the Expert Review Team noted that SHSCT continually referenced the SCRR process within the context of their broader work to meet the requirements of the Inquiry. However, the Expert Review Team understands that the Inquiry and the SCRR are separate processes and that these references to the Inquiry were likely to give rise to confusion.

The Urology Services Inquiry is an independent statutory process, supported by underpinning legislation, to deliver on its Terms of Reference; whereas the SCRR is a Trust and DoH-initiated process to establish themes of learning with a view to improving Trust systems to reduce the likelihood of similar incidents happening in the future. Whilst running in parallel to the Inquiry, the SCRR is an entirely separate process and is intended to derive learning and implement the necessary improvement to protect current patients.

During fieldwork, Trust representatives accurately described this distinction between the differing roles and purposes of the Urology Services Inquiry and SCRR, the relationship between the differing processes and the arrangements for sharing information with the Inquiry Team. However, upon reviewing Trust documentation, although the rationale for the SCRR is clearly stated, the Expert Review Team identified a lack of clarity in the documentation explaining the role, purpose and remit of the SCRR and, in particular, reinforcing that it is an entirely separate process to the Urology Services Inquiry.

Similarly, SHSCT SCRR documentation does not make clear whether the cases selected for SCRR are being reviewed on behalf of the Urology Services Inquiry.

This lack of clarity has potential to cause confusion since the Urology Services Inquiry Terms of Reference (ToR) include:

> (c) To examine the clinical aspect of the cases identified by the date of commencement of the Inquiry as meeting the threshold for a Serious Adverse Incident (SAI) and any further cases which the Inquiry considers appropriate, in order to provide a comprehensive report of findings related to the governance of patient care and safety within SHSCT's urology specialty.

The Expert Review Team considered that, although Trust representatives demonstrated a good understanding of the distinction between these two processes, the patient / family information materials and Trust documentation were not clear. In the current format, the versions provided to the Expert Review Team do not adequately inform patients and families of the clear distinction between the Urology Services Inquiry and SCCR process, thus, have the potential to inadvertently cause confusion and compound anxiety and distress.

We were informed that SHSCT, in light of recent criticism regarding factually inaccurate information contained in patient letters, regarding the Urology Services Inquiry's purpose, has sought to improve the clarity and accuracy of documentation. The Expert Review Team was provided with a copy of a "Patient Letters Investigation" report which outline a thorough investigation undertaken by an experienced Director independent from the SHSCT and is accompanied by a number of sensible

recommendations. The Expert Review Team commends this report and welcomes these improvement efforts. In addition to these, the Expert Review Team is of the view that SHSCT would benefit from improving their systems for developing and quality assuring patient / family information or indeed any documentation that is publicly accessible or likely to enter the public domain. Such arrangements should include the involvement of a lay person / service user representative and those with communications expertise within SHSCT. Where there is a pending or ongoing Public Inquiry, legal input could be considered to avoid confusion in interpretation of roles and remits.

Recommendation 1

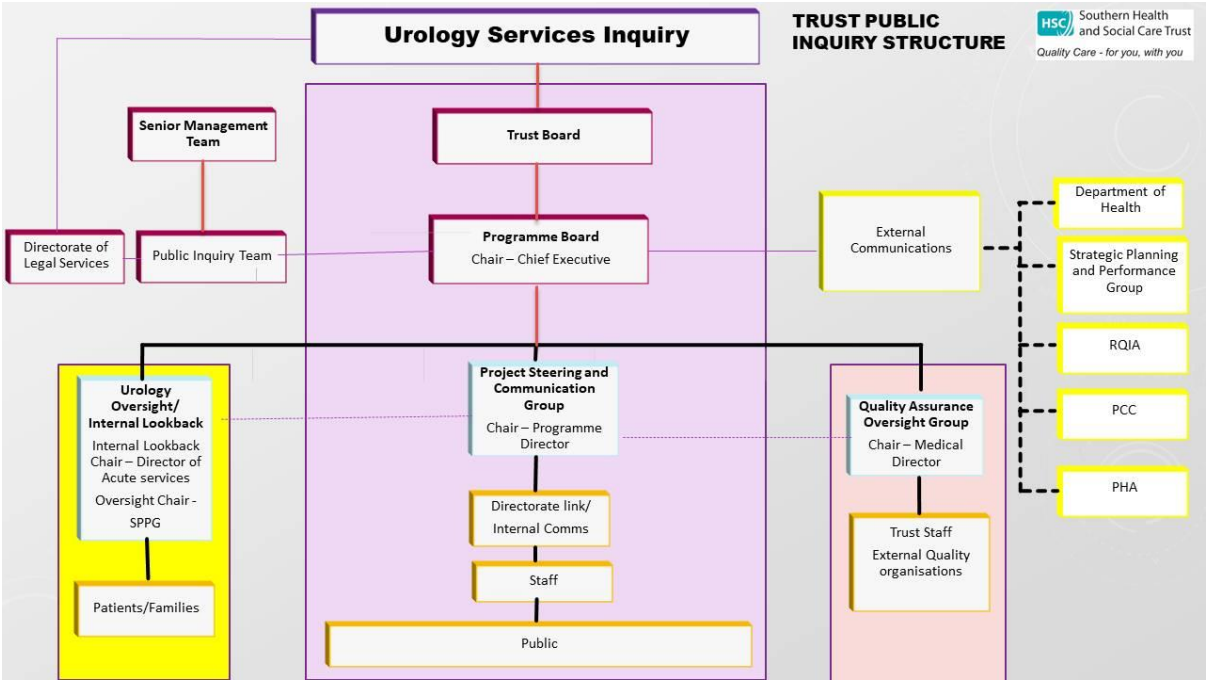
SHSCT should urgently update all relevant documentation to ensure that there is clarity regarding the SCRR including a description of the SCRR purpose, remit and process; explicitly stating that it is a separate process to any parallel Inquiries or investigations.

SHSCT should review their arrangements for developing and quality assuring patient / family information materials and publicly accessible information to ensure there is adequate lay / service user involvement, communications expertise and, where beneficial, legal input.

2.1.2 Review Structure

Robust structures are essential for ensuring effective delivery, assurance and accountability. SHSCT provided details of the Review Structure and advised that the SCRR process sits within its current Trust governance structures.

Figure 1. Current Review Structure



We were informed that the Review Structure is presently overseen by SHSCT Internal Urology Lookback Group. SHSCT Public Inquiry Programme Board is chaired by the Chief Executive. The Programme Board members act on behalf of SHSCT Board to oversee the work of the:

- Public Inquiry Response and Communications Group;
- Public Inquiry Urology Oversight / Lookback Steering Group; and
- Quality Assurance and Improvement Oversight Group

The Lookback Review is included on the Corporate and Acute Services Risk Registers. External oversight of the process is provided by the fortnightly Service

Planning and Performance Group (SPPG) Meeting and Department of Health led Urology Oversight Group.

ToR were provided for the Urology Services Inquiry Programme Board, Trust Internal Urology Lookback Group and Health and Social Care Board[ii] (HSCB) Urology Group. The Expert Review Team noted the broad remit of oversight and co-ordination groups and considered that some of the committees were very large, with overlapping membership. The Expert Review Team noted that the composition of the Lookback Review Steering Group (referred to as the Urology Oversight / Internal Lookback Group) does not reflect the Regional Guidance for Implementing a Lookback Review Process (July 2021)[2] which suggests inclusion of:

> "a Non-Executive Director, the Director of service/speciality concerned, relevant professional Executive Director(s), Risk and Governance representative, Head of Communications, Information Technology manager, Medical Records manager and senior service, representatives with expertise Public Health Agency (PHA) representative and an Health and Social Care Board (HSCB) representative (in the case where the Lookback Review has been identified as an SAI, the role on the Steering Group will be clearly identified to ensure that the independence of the PHA/ HSCB is not jeopardised). The organisation may also wish to consider a member of a relevant service user representative/advocacy group is included as a member of the Steering Group."

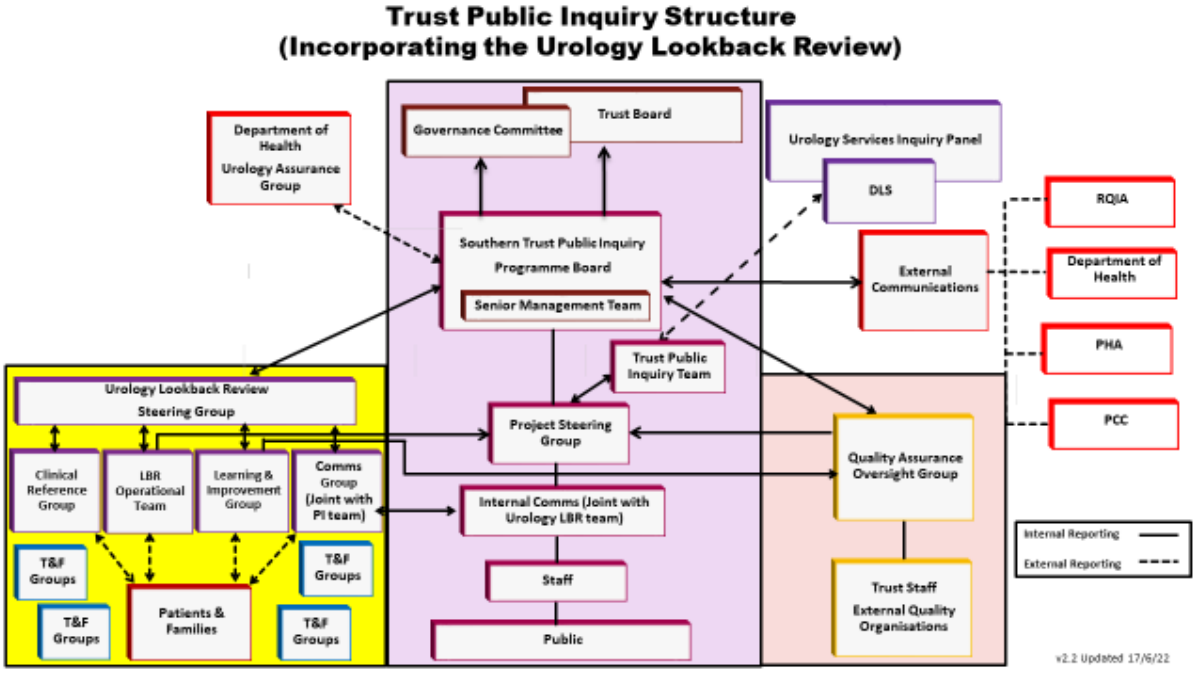
The Expert Review Team acknowledged the challenges and sensitivities of including a service user / advocacy representative who has been impacted by or has a vested interest in the matter of concern. However, the inclusion of a lay member, not impacted by SHSCT Urology concerns, but nonetheless with previous experience of representing the interests of service users / the public on similar pieces of work, can be hugely valuable and should be considered by SHSCT. The benefits include enhanced public confidence in the process, improved adherence to the statutory duty of Personal Public Involvement (PPI), provision of advice on patient / family / public messaging and on the fulfilment of a duty of candour.

The Expert Review Team considered that there was a lack of clarity surrounding leadership / responsibility and arrangements for accountability and reporting. During fieldwork, we were advised that the Chief Executive has ultimate accountability for the SCRR and that recent work had been undertaken to improve oversight, reporting and ensure clear lines of accountability. This resulted in a proposed new structure for oversight of the SCRR process. The Expert Review Team is of the view that any new structure should also be designed to support SHSCT to fulfil its responsibilities in respect of all Urology work, to deliver on SCRR objectives and should avoid creating unnecessary duplication or complexity.

The Expert Review Team was informed that the new structure exists in shadow form at present with the Operational Team being chaired by the seconded Director in a holding position until the new Director responsible for surgery takes up post.

Figure 2. Proposed New Review Structure (draft document at the time of the Review)

[ii]The Health and Social Care Board was replaced by the Service Planning and Performance Group (SPPG) April 2022.



Although the Expert Review Team welcomes improvements to the overarching review structure, it is of the view that, given the sizeable undertaking and complexity of the work, the operational arrangements for management and co-ordination of the SCRR and potentially the Lookback Review itself, would benefit from the establishment of a dedicated project team. It was noted that one individual was seconded from another Trust to support SHSCT with its work and this was a welcome development; however, no other Trust representative attending the fieldwork sessions reported having experience of conducting Lookback Reviews. This represents a considerable lack of skill and experience, which can occur when there has been recent turnover or change within the management structures of an organisation. In light of this shortfall, the dedicated project team should include people with previous experience in undertaking similar work, who can draw upon a wide network of 'critical friends' to provide support, advice and guidance.

Recommendation 2

SHSCT should consider reviewing the composition of Lookback Review steering group to reflect that which is stated within Regional Guidance for Implementing a Lookback Review Process; in particular, consideration should be given to the inclusion of a lay representative.

SHSCT should establish a dedicated project team for the management and co-ordination of SCRR. SHSCT should recruit people with the skills and experience who, if required, can seek the advice and guidance of experts from across the region.

2.1.3 Project Management

Effective project management is crucial in ensuring a well-co-ordinated delivery of objectives within acceptable timescales; this is best implemented with the support of a project manager accredited in using validated project management methodology such as PRINCE / PRINCE 2.

SHSCT SCRR project is currently managed as a sub-workstream of SHSCT corporate lookback process rather than by an individual with project management expertise supported by dedicated project team. Furthermore, the process does not use a specific project management methodology and has followed an iterative approach in terms of its design, signoff and deployment.

To ensure identified project actions are undertaken, minutes are kept of screening and lookback meetings and these are carried forward into future meetings. Individual case records for SCRR are tracked to the relevant Expert Reviewer; ensuring updates can be sought on progress.

The Expert Review Team considered that, whilst these arrangements might suffice for small numbers of cases, they are not sufficiently robust for managing a large volume of work. The Expert Review Team is of the view that a dedicated project team for the co-ordination and management of the Lookback Review and SCRR process, should include a Project Manager; ideally such an individual should have previous experience in managing a Lookback Review or, in the absence of previous experience, should have an understanding of the process and should be supported by a network of people who have the requisite skills and expertise.

The Expert Review Team was advised that a proposal paper outlining an updated Lookback Review structure, process and accountability has been submitted to SHSCT Programme Board. In this paper it states that the Urology Lookback Review is a project and should be constructed as such in terms of purpose, ToRs, reporting lines, risk register etc., including the identification of / clarity on who is the Senior Reporting Officer (SRO) for the project; suggesting this should sit at Director level.

SHSCT further advised that this includes a review of the associated Project Management arrangements in order to ensure that the project progresses swiftly and with clear accountability. The Expert Review Team welcomes this approach.

Recommendation 3

Considering the need for dedicated co-ordination and management of the Lookback Review and the SCRR process; SHSCT should prioritise the appointment of a suitably qualified Project Manager.

2.1.4 Terms of Reference / Objectives of the SCRR

A clear Terms of Reference (ToR) or, in lieu of a ToR, a set of specific objectives serves to focus the minds of those undertaking the Structured Clinical Record Review process on the purpose, remit and what needs to be achieved during the course of the

process. Providing a framework for monitoring progress and accountability for delivery, it is also helpful in communicating the scope of work in a clear, open and transparent way; a Terms of Reference can also assist in conveying information about the process to interested parties, such as DoH, SPPG / PHA, Health and Social Care (HSC) Trusts, patients / families / carers and the public.

Unfortunately, there were no ToR / Objectives provided by SHSCT relating to the SCRR process itself. The Expert Review Team considers that a ToR should be drafted and agreed as soon as possible. Trust representatives were keen that this should adequately convey the clinical elements of the SCRR.

In light of this, a possible ToR could include:

1. To assess the quality of care and treatment provided by Consultant A, using Structured Judgement Review methodology which gives specific consideration to the following:

- Triage;
- Initial assessment;
- Diagnostic investigations;
- Outpatient care;
- Inpatient care;
- Perioperative care;
- Care during any medical or surgical procedure (excluding IV cannulation);
- Communication with colleagues, MDT and primary care;
- Communication with patient and families; and
- Discharge plan and follow-up arrangements.

2. To review the findings of the individual Structured Judgement Reviews and produce a thematic analysis report.

3. To identify learning and make recommendations for improvement.

The Expert Review Team also considered that it would helpful for SHSCT to explicitly state the purpose of the SCRR. It is referenced within the Review Methodology Section of the proposal document provided by SHSCT that “the objective of the SJR method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well and to identify points where there may be gaps, problems or difficulty in the care process”. This is closely aligned to the purpose of the SCRR, which is ultimately for SHSCT to define, but may best be described as serving “to assess the quality of care and treatment, in order to identify learning and implement improvement”.

Recommendation 4

SHSCT should define and explicitly state the purpose of the SCRR process. Furthermore, a clear Terms of Reference / set of objectives should be agreed and referenced within the relevant Trust documentation.

2.1.5 Time period for inclusion of cases for SCRR

All cases reviewed as part of the current Lookback Review undergo screening for consideration for inclusion in the SCRR process; those meeting the SAI threshold are 'screened in'. The scope of the Lookback Review pertains to all patients that were under the care of Consultant A during the time period 1 January 2019 – 30 June 2020. The Expert Review Team explored the rationale for this time period with Trust representatives. When concerns first came to light, this period was chosen as it was believed that this was when patients were most at risk from aberrant clinical practice.

The Expert Review Team acknowledges that no lookback exercise can review all cases at once, that there has to be a starting point, and that a phased approach is preferable in order to expedite learning and facilitate reflection; furthermore, to start with those patients identified as being most at risk is sensible, justified and in keeping with regional guidance. However, the Expert Review Team was informed that since then, it has been identified, by examination of historical care through the Patient Casenote Review process, that patients treated by Consultant A prior to 2019 may also have received substandard care. This is unsurprising; it is the Expert Review Team's experience that problems with a clinician's practice tend to be longstanding and not restricted to a particular period of time. We were advised that in light of this finding, the Royal College of Surgeons (RCS) is currently undertaking a review of a sample of 100 cases from 2015 in order to identify whether there were problems present at this stage

The Expert Review Team is of the view that if there is already enough evidence to inform a risk assessment that patient groups receiving treatment prior to 2019 are at risk of harm, SHSCT should not wait for the RCS work to conclude and should proceed as a matter of urgency to extend their Lookback Review to identify and recall at risk patients under the care of Consultant A prior to 2019. This can be done using a phased, risk-stratified approach based on the learning gathered to date. It can then be extended and scaled up further, following receipt of the RCS findings, should this be required. However, regardless of the approach adopted, given the risk posed to live patients, it is imperative that a further phase of the Lookback is commenced as a matter of priority.

Since this is likely to be a considerable undertaking, requiring suitable expertise to offer advice and guidance, it is vital that SHSCT is adequately supported by its partners across the HSC system, including DoH/ Urology Assurance Group / SPPG and PHA. As this work is scaled up, an independent assessment of the current Urology Lookback Review arrangements would serve to provide assurance regarding its effectiveness and identify any areas that need strengthened; this assessment could be undertaken by RQIA as a 'Part 2' to this review of the SCRR. Assurance of the current lookback arrangements would serve to strengthen the foundations in place for extending the time period and scaling up to include additional patient subgroups.

Recommendation 5

SHSCT should give urgent consideration to extending their Lookback Review to identify and recall further groups of patients. DoH / Urology Assurance Group / SPPG, PHA and RQIA should work together to support SHSCT with the Lookback Review.

RQIA should consider undertaking an independent assessment of Trust arrangements for the Urology Lookback Review in order to provide assurance on its effectiveness and identify any areas for improvement.

As there is a need to prioritise the Lookback Review, to ensure that patients at risk are promptly reviewed and that ongoing care and treatment is arranged, it may be preferable for an external body, such as the Royal College of Physicians, to undertake the SCRR on behalf of SHSCT. Not only would this allow Trust teams to focus on the Lookback Review whilst maintaining a safe level of care provision for its current and new patients, it would mean that the SCRR is conducted by an independent organisation that has the requisite expertise, governance structures, well tested processes and quality assurance mechanisms in place to support this type of work; consequently, the output may be more expedient and performed to a higher standard. However, the Expert Review Team acknowledges that commissioning an independent body may not be possible either due to a lack of agreement, resources or time, in which case the recommendations outlined in this report should support SHSCT itself to facilitate the SCRR.

Recommendation 6

SHSCT should consider commissioning an independent body to undertake the SCRR process on its behalf.

2.1.6 Case selection

Appropriate case selection is important to ensure effective use of time and resources, which should be prioritised towards cases where there is likely to be learning.

During fieldwork, Trust representatives outlined the process for case selection. All service users who were under the care of Consultant A between January 2019 and June 2020 were reviewed using a 10-question Patient Review form either internally by SHSCT or an external consultant urologist commissioned for this purpose. This 10-question Patient Review Form explored current as well as historical care. At a point in time, this list of questions was shortened to 4 questions which explored current care, following discussions with SPPG (formerly HSCB) who were keen that it mirror the approach used by the Belfast HSC Trust Neurology recall. It reverted back to 10 questions at the request of the Trust (and with agreement by SPPG) with all relevant case notes being assessed retrospectively to ensure consistency.

Where concerns regarding the quality of care are identified, these cases are then considered at a screening meeting, attended by the Trust's acute directorate governance and clinical staff, to establish if the concerns meet the threshold set out in

the regional SAI procedure. Where the case meets the criteria for an SAI, it is progressed as an SCRR.

The Expert Review Team considered that if the aim is to identify all cases where there is likely to be learning, the use of SAI thresholds may not be the most effective method. This was explored with Trust representatives who were in agreement. We were advised that cases considered for inclusion in the SCRR included the following:

1. SAI threshold met; concerns around the care and treatment in keeping with a theme already identified
2. SAI threshold met; concerns around the care and treatment in keeping with an emerging theme, not previously identified
3. SAI threshold not met; nonetheless, learning identified
4. SAI threshold not met; care and treatment "reasonable"

The Expert Review Team is of the view that it is acceptable to include cases from Group 3. Although a case may not meet the criteria for an SAI review, it may still contain valuable learning from a patient experience or service quality perspective.

To date, 53 cases have been identified that meet the criteria for SCRR. This number is likely to increase further, particularly if the care and treatment of additional patient groups is going to be subject to an extension of the Lookback Review; a total in excess of 90 cases is expected to be identified from this phase alone.

During fieldwork the Expert Review Team heard that of the 53 SCRRs passed to the external SCRR urologists between February and May this year only 20 have been returned to date. This prolonged process poses challenges for the Trust as they are keen to establish the full extent of learning in relation to these cases.

Given time constraints and limited availability of expert reviewers, the Expert Review Team was keen to explore whether a sampling approach had been considered by SHSCT. Such an approach would seek to maximise learning within the constraints of available resources and may lead to improvements being implemented at an earlier stage.

During fieldwork, Trust representatives remarked on the similarity of themes across the cases that have already been reviewed. We were informed that there was very similar learning arising from 19 out of 20 cases reviewed to date. This supports an argument that a point of saturation might be reached and there may be limited additional benefit to reviewing all cases, as was initially intended.

The Expert Review Team recognises that a pragmatic approach to sampling would mark a departure from the original intention and direction of the SCRR. It would be the Expert Review Team's view that such a departure requires a clear rationale to be agreed by the DoH; this would require the purpose, scope and Terms of Reference for the SCRR review to be clearly articulated and defined. DoH should ensure that such an approach is justified when taking into consideration the wider context, including the planned work and emergent findings of the Urology Services Inquiry. The Expert Review Team's view is that a sampling approach would expedite learning and would allow an opportunity for earlier improvement to be implemented. However, there are

ethical considerations and SHSCT should take steps to ensure that the sampling framework is robust and should be open and honest with patients and families about the approach and its rationale.

Understanding that some patients and families may be disappointed that their case is no longer going to be reviewed, SHSCT may wish to include an option for patients and families to request inclusion in the SCRR. If it is not feasible or reasonable to grant such a request, then the patient or family should be informed of the additional routes available to them, such as submitting a concern to the SHSCT Complaints Department, GMC, PSNI or any redress scheme. They should additionally be informed about the Urology Services Inquiry and directed to it's website for further information.

Recommendation 7

SHSCT should consider implementing a sampling approach to case selection for SCRR. Such an approach should be agreed with DoH / Urology Assurance Group / SPPG. SHSCT should be clear on the rationale, its benefits and limitations and ensure that there is openness and transparency in communication with patients, families and the public. SHSCT should engage the Clinical Ethics Committee to consider any ethical issues arising from such an approach which can then be addressed and mitigated by SHSCT.

2.1.7 Ethical Considerations

The application of ethical principles when conducting reviews of a complex and sensitive nature is invaluable to guide decision-making and ensure that the review is conducted in an open, transparent, fair and sensitive way. It can be helpful in ensuring a rigorous approach, adherence to a duty of candour, respect for confidentiality but also autonomy (i.e. right not to know) and in ensuring that specific patient groups are not inadvertently disadvantaged. It is also helpful when considering specific ethical issues that may arise from the process of reviewing patient cases, such as circumstances where previously undiagnosed or undisclosed hereditary conditions are identified.

SHSCT advised that no Clinical Ethics issues were identified for discussion with SHSCT Clinical Ethics Committee. The Expert Review Team is of the firm view that given the scale and sensitivity of the work involved, and the potential for inadvertent harm to be caused by the process, SHSCT would benefit from giving due consideration to the application of Ethical Principles. Advice from SHSCT Clinical Ethics Committee should be urgently sought and, if deemed necessary, this could be assisted by the HSC Regional Clinical Ethics Committee.

We refer SHSCT to a recently issued Ethical Framework[3], developed specifically for RQIA's Expert Review of Deceased Patients of Dr Watt, which contains overarching themes that are applicable to any lookback or review of this nature:

1. Respect for Persons (which includes Privacy, Confidentiality and Data Protection, and the Right to Know and the Right Not to Know)
2. Transparency and Candour

3. Fairness
4. Responsibility

It was RQIA's experience that the process of discussing ethical principles and deliberating the potential for ethical issues is as valuable as the end product of any framework or ethical paper. In the context of the Expert Review of Deceased Patients of Dr Watt, it had wider benefits beyond ensuring that the methodology and the approach were ethically rigorous, and greatly assisted with the drafting of correspondence to families, and in the interactions with families by the RQIA Family Liaison Team.

Recommendation 8

SHSCT should request SHSCT Clinical Ethics Committee to review both current and proposed arrangements for the Lookback Review and SCRR. Where ethical issues are identified, SHSCT should give this due consideration and, where required, adapt the methodology and approach for the review.

2.1.8 Legal Considerations

A legal perspective on review proposals and arrangements is prudent when undertaking work of this nature.

The Expert Review Team's experience is that it can be helpful across a number of areas including:

- Identifying previously unconsidered pitfalls in relation to correspondence with interested parties, proposed review methodology and approach;
- Ensuring there is appropriate indemnity for reviewers undertaking the SCRR;
- Managing data protection issues;
- Managing legal challenges from solicitors acting on behalf of patients / relatives;
- Managing legal challenges from Consultant A's legal team; and
- Requesting clinical records of patients reviewed by Consultant A in a private a capacity

Trust representatives advised that the Directorate of Legal Services (DLS) is supporting SHSCT with the Urology Services Inquiry and that an opinion could be sought if required. However, SHSCT advised that legal advice had not been sought as the SCRR is being utilised as an alternative of SAI to establish learning from the situation. The Expert Review Team considered that legal input would be required in order to make this determination and also to consider the potential for future legal ramifications.

It is the Expert Review Team's view that given the significance and scale of concerns, the likelihood of negligence and that this is a departure from the regional SAI process, a legal perspective should be sought in relation to the arrangements for SCRR.

Recommendation 9

SHSCT should engage with Trust legal representation to obtain a legal perspective on the arrangements for the SCRR.

2.2 METHODOLOGY AND IDENTIFICATION OF LEARNING

2.2.1 Patient and Family Engagement

There is a statutory duty of Personal Public Involvement as set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009[4]. Best practice in involvement is to seek the input of service users and families to help shape the review process, particularly around sensitive person-centred communication, the provision of support and a mechanism for sharing concerns. There may be additional valuable information from affected service users / families that will not be evident in the clinical documentation of the clinician under investigation; information from families and carers is particularly vital in those cases where a patient has sadly deceased. Importantly, effective patient and family engagement is crucial in order to adhere to the principles of candour and 'being open'.

The regional SAI procedure stipulates the requirements for patient and family engagement. On 7 July 2022, the report of the RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland[5] was published; this has relevant findings on effective engagement and involvement of families and recommendations for strengthening the regional approach and procedure. Furthermore, a draft 'Statement of Rights' as an output of the O'Hara Inquiry may be helpful in focussing HSC Trusts on the importance of appropriate and sensitive interaction with patients and their families.

Although the SCRR is not an SAI process, the Expert Review Team is of the view that, as a minimum, patients and families should be informed of the purpose of the SCRR, and that those affected should have an opportunity to provide additional information about their care and treatment. SHSCT outlined their process for engaging and involving families. The Expert Review Team is impressed with and commends the significant efforts SHSCT has made in contacting all impacted families, which, given the scale, is a huge undertaking. However, we note recent issues arising regarding the quality of patient information and consider that the arrangements for patient and family involvement in both shaping the process and sharing concerns require improvement.

The Expert Review Team considers that SHSCT PPI team and those external to SHSCT, such as the PHA and Patient Client Council, have been underutilised in ensuring that there are robust arrangements for PPI as part of the Lookback Review and SCRR.

Recommendation 10

SHSCT should review their arrangements for the involvement of patients and families to ensure that it fulfils its statutory duty of Personal Public Involvement. SHSCT should consider engaging those with Personal Public Involvement expertise and external

partners such as the PHA who have PPI training resources for staff and the PCC who could provide advice and support in the involvement of patients and families as part of the Lookback Review and SCRR.

SHSCT outlined its arrangements for following up and sharing the findings of the SCRR with patients and family members. Although there is a Family Liaison Officer (FLO) available to support patients and families, the findings are primarily shared through postal correspondence. Whilst this may be the preference of a large number of families, many may require additional support to understand and emotionally cope with the findings.

The Expert Review Team consider the following to represent good practice[6,7,8]:

- As far as possible, reports should be quality assured, checked for factual accuracy, and should be written in easy to understand lay language;
- Patients / families should be provided with a range of options on how they wish to receive the report; one option should be a face to face meeting. They also have a right "not to know" the findings;
- The Family Liaison Officer should be accompanied by a medical doctor in relaying the findings of the report;
- Psychological support should be made available to those impacted by the process and findings of the SCRR;
- If further medical follow-up is required by patients or relatives, there should be Trust arrangements in place to facilitate this in a timely manner; and
- There should be opportunities for the FLO to debrief with colleagues and timely access to psychological support for the FLO and any others involved in family engagement.
- Independent advocacy should be considered for patients or families, particularly when cases are complex. The PCC have extensive experience in this area through previous work on SAIs and other Inquiries.

During fieldwork, the Expert Review Team explored the support available for those staff members involved in the review and, in particular, the patient and family engagement. SHSCT described effective provision of support including: senior and peer support, psychological support and access to Inspire Wellbeing Counselling service. The Expert Review Team is content that the arrangements for support appear sufficient but cautions that a substantial proportion of the work appears to be undertaken by one FLO. Given the large number of cases identified, it may be beneficial to increase the capacity of the Family Liaison Team to provide support to those impacted by the Lookback Review and SCRR.

Recommendation 11

SHSCT should review their arrangements for sharing SCRR findings with patients and families giving consideration to good practice as outlined by the Expert Review Team in this report.

2.2.2 Methodology & Tool

Structured Judgement Review methodology is a reliable, well validated tool that has been developed by the Royal College of Physicians. It allows for the blending of traditional, clinical-judgement based, review methods with a standard format. The approach requires reviewers to make safety and quality judgements on particulars of care, to make explicit written comments, and to assign a score for the quality of care at each phase. This produces a rich set of information about each case in a form that can be aggregated to produce knowledge about clinical services and systems.
SHSCT discussed the use of this tool with the Royal College of Physicians and opted for this methodology to underpin the SCRR process.

The Structured Judgement Review methodology was adapted for the SCRR in order to take into consideration the relevant phases of care. The phases of care assessed are:

- Triage;
- Initial assessment or review;
- Review of Diagnostics;
- Ongoing Outpatient Care;
- Admission and Initial Management;
- Ongoing Inpatient Care;
- Care during a procedure (excluding IV cannulation);
- Perioperative care; and
- Discharge plan of care.

The Expert Review Team is not privy to all the specific clinical concerns therefore cannot be certain that the tool adequately scrutinises all relevant aspects of care. With this caveat in mind, the SCRR tool generally appears reasonable. However, the Expert Review Team did note some areas that SHSCT may wish to address. There is some divergence from the RCP methodology in terms of the data collection instrument. There is no section to assess:

- Quality of documentation in the records;
- Communication between Consultant A and the patient / carer / family; and
- Communication between colleagues, MDT and primary care.

Whilst we were advised that deceased patients are included in the review, there are no sections outlining a review of the death certification or whether a referral to the coroner's service was required.

Of particular value in relation to deceased patients, but of great value for all cases, is the consideration of patient and family concerns. In general, there is a lack of patient

and family input into the SCRR process. Patients and families were not engaged with in order to shape the review. Equally, there is no consistent mechanism to proactively seek the concerns of patients and families for consideration as part of the individual SCRR. This marks a considerable deficit in the information available to formulate findings. The experience of the Expert Review Team is that, where concerns from patients and families are taken into account, this greatly enhances the learning process and provides information and context that is often not present in the notes. RCP has successfully incorporated patient / family concerns into its review process by asking expert reviewers to review the notes firstly without knowledge of the patient / family concerns and then a second time taking the patient / family concerns into consideration. The complaint can then be judged to be 'upheld', 'partially upheld' or 'not upheld'.

RQIA's experience from the Expert Review of Deceased Patients of Dr Watt is that there is a close correlation between the views of family members and the judgement of the structured judgement tool (SJR), strengthening the argument that there is great benefit in attaining patient and family input. Where there is little or no correlation between the patient / family story and the clinical picture documented in the records, the Review Panel may determine that the family concern is 'not upheld'; of note, this only occurred for two (out of 44) patients included in Phase 2 of the Expert Review of Deceased Patients of Dr Watt.

Recommendation 12

SHSCT should liaise with RCP and consider amending the Structured Clinical Record Review tool to include an assessment of the quality of documentation and an assessment of the documented communication with patients and families; the clinical team, MDT and primary care. SHSCT should consider facilitating the consideration of patient / family concerns as part of the SCRR to mirror the approach undertaken by RCP.

Whilst Structured Judgement Tools provide an objective assessment of the care and treatment documented within the clinical records, it can only allow for a partial systems perspective. For example, it may tell a story of care and treatment according to the national standards of the time, of the standard and quality of documentation, multidisciplinary involvement, communication between colleagues and communication with family members. Of direct relevance, it will not examine factors such as caseload, working relationships and peer review.

Furthermore, it will not tell us about the governance systems within Urology Services or within SHSCT as a whole. It will not examine the role of external bodies and the wider system in providing oversight and assurance of quality and safety of care.
With this in mind, DoH or SHSCT Board may wish to commission RQIA to undertake a Review of Governance within Urology in Southern Health and Social Care Trust. This would provide an opportunity to identify and remedy any deficits, and to share learning within SHSCT and across the system so that governance systems may be strengthened and future harm prevented.

Recommendation 13

DoH should commission RQIA to undertake a Review of Governance Arrangements within Urology Services in Southern HSC Trust.

2.2.3 Expert Reviewers

Each case is reviewed independently by a 'Subject Matter Expert' (or Expert Reviewer) utilising the SCRR methodology. SHSCT provided details of Expert Reviewers, including a description of the job role and a copy of the guidance provided to reviewers at the outset of the work. The Expert Reviewers are nominated via the British Association of Urological Surgeons (BAUS) for their subject matter expertise. SHSCT ensures that each reviewer is appropriately registered and of good standing with their professional regulator, the General Medical Council (GMC). The Expert Review Team is content that reviewers appeared suitably independent and qualified.

In total, SHSCT approached 13 reviewers of which four Expert Reviewers have been recruited to support this work. Given the difficulty recruiting Consultant Urologists and the time consuming nature of the SCRR process, the Expert Review Team considered whether specialist nurse reviewers or urologists in training could be used instead. A clearly defined protocol with consultant oversight of the process would facilitate this. It was considered that a hierarchical culture within HSC, associated with perceptions amongst the Northern Ireland public that attaches particular significance to reviews undertaken by a consultant, may be a barrier to implementing a non-consultant review process. Therefore, if the work cannot be supported by specialist nurses or trainee urologists, consideration should be given to the use of doctors working outside the specialty of urology.

The Expert Review Team noted that no training was provided to Expert Reviewers, who instead were stated to be familiar with SJR tool methodology. In addition, there was no specific manual provided to reviewers; albeit the following guidance was provided:

- Using the Structured Judgement Review method - A guide for reviewers; National Mortality Case Record Review Programme 2019[9]; and
- Structured Judgement Review - Frequently Asked Questions 2019.

Additionally, the process had not been piloted and there was no method of calibration between reviewers to ensure inter-reviewer reliability and consistency. Importantly there is no mechanism for quality assuring the work of reviewers, either by assigning two reviewers to each case or by second-reviewing a sample of the cases.

The Expert Review Team notes that 20 SCRRs had been completed at the time of fieldwork; and while we understand the challenges in delivering quality assurance of reviews within the current limited pool of reviewers it may be beneficial to conduct an independent review by a second expert reviewer to ascertain the degree of reliability and consistency in assessing the quality of care. A panel should then be convened to discuss any significant discrepancies in judgement, to gain consensus and provide expert reviewers with an opportunity to standardise their approach.

Even in the absence of discrepancies, it can be helpful for clinical reviewers to have a forum to discuss cases, debrief and avail of emotional or psychological support. Although it was reported that each reviewer can contact SHSCT Deputy Medical Director for Quality and Safety if issues arise, the Expert Review Team is of the view that SHSCT is missing an opportunity to proactively support reviewers, seek feedback on the process and seek reviewers' views on the learning arising.

Recommendation 14

SHSCT should not be limited to consultant urologists when recruiting clinical reviewers to undertake the SCRR process. All Expert Reviewers should be provided with guidance and support, including an opportunity to debrief, feedback and avail of emotional / psychological support if required.

A document should be drafted specific to this particular piece of work to guide reviewers through the process of conducting the SCRR; this should include a defined protocol for the assessment of the quality of care and treatment.

A sample of cases already reviewed using the SCRR methodology should undergo a second review to ensure inter-reviewer reliability and consistency. Consideration should be given to quality assurance of a defined sample of cases for the remainder of the SCRR.

2.2.4 Review Panel

Good practice dictates that in undertaking a review, an expert panel to deliberate findings and attain consensus on recommendations is preferable to the judgement of one individual expert. A forum for discussion between panel members allows for a sharing of expertise and perspective, brings a deeper and broader understanding of issues, mitigates bias and derives learning more effectively.

SHSCT stated that there is no specific review panel for the SCRR; however, the Trust Lookback Group oversees the overall lookback process that includes the SCRR. On completion of the initial batch of SCRRs, an independent Consultant Urologist will develop a thematic report on the findings.

The Expert Review Team considered that, as SHSCT has rightly identified that a key outcome of the SCRR is a thematic analysis in order to identify learning and inform system improvements, the process would benefit from a dedicated review panel rather than relying on the professional judgement of one individual to collate findings, identify themes and make recommendations. This was explored with Trust representatives during fieldwork, who advised that the RCS and BAUS had both been approached to undertake an independent quality assurance of the SCRR but SHSCT had not been able to secure agreement from either of these bodies. Subsequently SHSCT considered convening a multidisciplinary panel comprising eight individuals but due to limited resource and availability of staff this had not progressed. The Expert Review Team considers that a smaller panel, including urology, governance and lay expertise would suffice; encouragingly, Trust representatives were amenable to this model.

The Expert Review Team is of the view that any learning and evidence-based recommendations made by the review panel would require a commitment from SHSCT to implement a clear prioritised action plan within acceptable timescales.

Recommendation 15

A review panel should be constituted, for the specific purposes of identifying learning and determining recommendations arising from the SCRR process. This panel should include individuals with expertise in urology and governance, and include a lay member.

2.2.5 Identification and Dissemination of Learning

Dissemination of learning is crucial in order to improve systems for delivery of care both within SHSCT and across the region. Any strategy for the dissemination of lessons learned should be supported by DoH / SPPG / PHA and should incorporate an action log of the system improvements required, along with timescales for follow up and review.

SHSCT stated that each SCRR report will be reviewed by a Trust clinician who will identify if there is any previously unidentified learning. The thematic analysis report will also be considered by SHSCT in respect of broader system issues.

SHSCT advised that returned SCRRs are reviewed by a Trust clinician who will decide on the appropriateness of sharing learning more widely; this includes learning that should be shared beyond Trust boundaries. Mechanisms for sharing learning were stated to include:

- Using SHSCT local shared learning template;
- Regional shared learning template;
- Morbidity and Mortality Meetings (Patient Safety Meetings);
- Acute Governance Meetings (Directorate wide); and
- Urology and Cancer Services team meetings.

The Expert Review Team considered that the arrangements for identifying, implementing and disseminating learning required strengthening. The reliance on the professional judgement of one clinician to undertake a thematic analysis, in the absence of a mechanism for the reviewers to discuss and feedback, compounded by the lack of quality assurance of individual reports, risks that important system issues may go unidentified. Similarly, the reliance on a Trust clinician to determine whether learning should be shared wider, lacks independence, and runs the risk that one person acts as a gatekeeper to the implementation of improvement and dissemination of lessons learned.

As stated previously, a review panel with representation from urology, governance and a lay member would serve to ensure that there is a robust mechanism for deriving, implementing and making determinations on the dissemination of learning. Where learning is derived, the Expert Review Team would expect that recommendations are made and clear prioritised time-specific action plans are put in place with arrangements for monitoring and accountability. A follow-up review, with defined

parameters for assessment around implementation, would provide assurance around the implementation of sustainable improvements.

The information provided by SHSCT indicates that the consideration of dissemination of learning is confined to within Trust boundaries; although a regional shared learning template is referenced, it is not clear whether this in itself would be sufficiently robust to disseminate learning to the relevant stakeholders across the system. SHSCT representatives were of the view that the previous HSCB process for sharing learning from SAIs needs to be adapted or replicated for the SCRR process but that this had not yet commenced. The Expert Review Team is of the view that the mechanisms for sharing learning should be discussed urgently with DoH / SPPG / Urology Assurance Group. Recipients should include Urology Services Inquiry, SHSCT Board, Urology Assurance Group, DoH / SPPG, PHA, and RQIA; under duty of candour principles, it should be considered whether there is an onus to share learning with the public. In any case, an effective strategy for communication with stakeholders would serve to underpin arrangements for the effective dissemination of learning.

Recommendation 16

SHSCT should work with DoH / SPPG / PHA to develop an effective dissemination strategy for the Lookback Review and SCRR so that learning is shared regionally with all relevant stakeholders and the public is effectively informed under duty of candour principles.

2.3 GOVERNANCE OF THE SCRR

2.3.1 Risk Management

Effective risk management relies on the identification, assessment, mitigation and monitoring of risk. All projects incur risks, such as risks associated with timescales, available expertise, budgetary constraints and data protection vulnerabilities. However, projects of this nature can carry considerable additional risk, such as the risk of causing harm to patients / families / public and reputational risk to the health service. It is vital that the structures, systems and processes in place support effective recognition and management of such risk.

The Expert Review Team was advised that the project does not keep a formal risk log; however, risks are recorded and discussed through meetings. At the time of review, there were three risks identified with mitigation actions identified for each.

When the Expert Review Team explored the issue of risk it was advised that the risks associated with the SCRR had progressed to both the directorate risk register for Acute Services and to the Corporate Risk Register.

The Regional Guidance for Implementing a Lookback Review Process (July 2021) states that:

> "When scoping the nature, extent and complexity of the Lookback Review Process (Section 2.6 – 2.7) the Steering Group should evaluate and escalate the risk in line with the organisation's Risk Management Strategy. This will

ensure that the risk(s) identified will be included in either, the organisation's Board Assurance Framework, Corporate Risk Register or Directorate Risk Register and managed in line with the Risk Management Strategy."

The Expert Review Team was further advised that SHSCT is currently transitioning to a revised organisational structure, designed to fully support SHSCT to fulfil its function in respect of the SCRR objectives; this is currently operating in in shadow form. As a consequence, the project will operate under more robust governance structures with a live risk register maintained specifically for the Lookback Review. Issues of risk will also be included in the ToR for the new Urology Lookback Review Steering Group and SHSCT Public Inquiry Programme Board (note these are working titles which may change when the new structure is finalised). The Expert Review Team welcomed these improvements which will serve to strengthen the current arrangements for risk management.

2.3.2 Records Management

Effective management of clinical records requires protocols for retrieving, scanning and sharing records, underpinned by strong governance arrangements. SHSCT described robust arrangements for accessing and sharing of clinical records, which was in keeping with good information governance.

A list of patient names and health and care numbers of those cases identified for SCRR is shared with a dedicated administrator. When a decision is made to proceed with SCRR, the relevant patient records are obtained through normal hospital processes by request of hardcopy notes via the medical records team. Notes in patient charts which are not available on NIECR are copied, scanned and uploaded to Egress Secure Workspace, an electronic platform, for sharing with expert reviewers. Expert reviewers also have secure access to NIECR.

There is a dedicated member of the clinical governance team assigned to support the SCRR process, who is responsible for obtaining the charts, extracting the records for scanning and who also uploads to Egress Secure workplace and notifies and liaises with the external expert reviewers. The Expert Review Team considered this approach to be acceptable.

2.3.3 Data Considerations

SHSCT outlined their arrangements for data protection. Document transfer is managed via SHSCT Egress document sharing platform and also via secure VPN access to NIECR records. Each Expert Reviewer is required to complete a Trust confidentiality agreement and Data protection agreement prior to accessing records.

The Expert Review Team identified a potential General Data Protection Regulation (GDPR) issue with the arrangements for contacting families. SHSCT would benefit from further consideration of information governance, and in particular, data protection issues in relation to SCRR.

Given the sizeable number of patients involved, a database is beneficial to track progress of the Lookback Review / SCRR, to analyse demographic and clinical

information, and to monitor outcomes. SHSCT is presently developing a new database to store and analyse information in relation to the selected cases. Unlike the previous database which relied on manual population, the new database allows for automatic population, reducing the risk of input error. The Expert Review Team welcomes this development and advises that a statement of purpose should be drafted for the new database, outlining the rationale for transferring data; a copy of the old redundant file should be retained in case it needs to be examined at a later stage. If deemed to be helpful, SHSCT could be signposted to regional experts who recently developed a database as part of the neurology live patient recall.

Recommendation 17

SHSCT should draft a statement of purpose for the new database, outlining the rationale for transferring data and should retain a copy of the redundant file on record.

2.3.4 Communication with Stakeholders

Effective communication with stakeholders ensures that there is clear, consistent messaging on the purpose, remit, progress and findings of any review. It also facilitates liaison and co-operation regarding specific aspects of the work where external input is required in order to achieve a particular outcome. The need for robust stakeholder communication is referenced within the Regional Guidance for Implementation of a Lookback Review which highlights that the principle of 'no surprises' should be adopted and outlines that there should be:

- An agreed communication plan/liaison plan for other HSC organisations or independent/private providers which might be affected;
- An agreed media/communications management plan if required, that aims to be proactive in disclosure to the general public and considers responses to media enquiries; and
- Engagement with PSNI and coroner's service in line with standard procedures.

In addition to the above stakeholders, there should also be a channel of communication established with the GMC via the HSC Trust's Responsible Officer. All these elements are best considered as part of a comprehensive Communications Strategy developed for the specific Lookback Review.

SHSCT advised that when completed, the SCRRs are planned to be shared with the Urology Services Inquiry along with the thematic review of cases. Additionally, DoH will be provided with updates on the process via the Urology Assurance Group. SHSCT advised that the Coroner will be notified if there is a potential issue identified via the SCRR processes which has not previously been identified via Trust processes.

The Expert Review Team considers that there is an absence of an overall communication and stakeholder engagement strategy. It is also noted that there is no channel of communication established between SHSCT and PSNI or GMC. The GMC is likely to be interested in the findings, which will be relevant to the Fitness to Practice (FTP) investigation of the consultant concerned. In addition, there is a possibility that the harm found could be of PSNI interest in terms of possible assault, gross negligence, or in extreme cases, manslaughter. The Expert Review Team considers

that a Communications Strategy should be developed and examples from recent lookback exercises or similar review work across the region may assist SHSCT in expediting this.

Recommendation 18

SHSCT should urgently develop and implement a communication strategy specific to the Lookback Review and including the SCRR process.

A channel of communication specific to Urology work streams should be established between SHSCT, PSNI, GMC and Coroner's office; SHSCT should ascertain the thresholds for referral in respect of specific concerns arising out of cases reviewed as part of the SCRR.

Section 3 Conclusion and Recommendations

3.1 Conclusion

RQIA acknowledges the commitment of SHSCT to ensuring that this work is undertaken a manner that is robust and effective in deriving learning and informing improvements. This was evident, not only by the fact that SHSCT approached RQIA to request this review, with the aim of providing assurance, but also in the Expert Review Team's engagement with Trust representatives and staff during fieldwork. We acknowledge the amount of time and effort that SHSCT staff have given to this piece of work and commend their openness, candour and willingness to learn from the expertise of the Expert Review Team. This positive engagement and 'buy in' will assist SHSCT in implementing the necessary improvements.

RQIA was initially approached to provide independent assurance of the SCRR methodology. During preliminary discussions with SHSCT, we determined that this assurance should be broadened to include the wider process, governance and framework surrounding the SCRR process. This was felt to be particularly important given that the SCRR arose as a result of a significant number of SAIs which were identified through SHSCT Lookback Review, at which point the decision was made to adopt alternative methodology to the SAI process. The Expert Review Team endorses this decision. Structured Judgement Methodology, when applied appropriately, is a reliable, validated methodology which offers an effective means of deriving learning and implementing improvements.

However, when examining the SCRR process within the context of the Lookback Review, it was apparent to the Expert Review Team, that the Lookback in itself is not only a significant undertaking for SHSCT but its progression is a matter of urgent priority. An assessment of the historical care of patients, whose cases had undergone the screening process for SCRR, identified deficits in care and treatment prior to 2019. SHSCT is presently conducting a risk assessment and has commissioned RCS to undertake a review of cases relating to 2015 which should assist SHSCT in determining the future scope and scale of their Lookback. The Expert Review Team is of the firm view that SHSCT should not wait until this work concludes, and based on the evidence SHSCT has gathered to date should proceed to review and recall further groups of patients which it has identified to be at risk of harm.

Understanding that this is a considerable undertaking and that issues have already been identified regarding the availability of expertise and resource to support the Lookback Review, SHSCT will require significant support from the wider HSC system: DoH, SPPG, PHA and RQIA. A dedicated, appropriately resourced and experienced project team should be established as soon as possible to support this work. This may require secondment of additional individuals with the relevant skills and experience to SHSCT. RQIA recognises the efforts SHSCT has already undertaken to improve its lookback arrangements and is keen to support SHSCT with further improvements. As RQIA is best placed to provide assurance on the current arrangements to ensure strong foundations for scaling up and extending the Lookback time period, we recommend that RQIA undertakes a follow-up piece of assurance work looking specifically at the Lookback Review. Going forward, in order to allow SHSCT to focus on the Lookback Review, ideally the SCRR should be undertaken by an independent

body. The Expert Review Team understands that SHSCT may not be able to secure the support of an external organisation; therefore, we make a number of recommendations to strengthen the existing SCRR process and arrangements.

SHSCT should explicitly state the purpose of the SCRR and draft a Terms of Reference as soon as possible. Caveated with the fact the Expert Review Team is not privy to all specific clinical concerns, the tool itself appears reasonable, but it does deviate from the tool used by RCP and leaves a number of areas unexamined such as quality of documentation. In addition, given that a proportion of patients are deceased, it would be judicious to update the tool to take into consideration death certification and the need for coronial referral. The Expert Review Team advises that SHSCT liaise with RCP to ensure the tool is appropriately aligned and that SHSCT mirrors RCP's approach to considering patient and family concerns as part of the SCRR process.

The arrangements for patient and family involvement require significant strengthening. Inclusion of lay membership on the relevant project groups would ensure SHSCT meets its statutory duty of patient and public involvement. The Expert Review Team also provides advice on best practice in involving, listening to and supporting patients and families through processes such as these in a way that reduces the potential for further harm and serves to restore faith in the health service. Given the scale, complexity and sensitivity of the work involved, due consideration should be given to seeking an ethical perspective on arrangements through SHSCT Clinical Ethics Committee.

RQIA notes the large number of cases that have been identified for SCRR and the difficulty this poses in terms of conducting SCRRs within reasonable timescales, compounded by the limited number of expert reviewers. A sampling approach is pragmatic and effective in deriving learning within the constraints of time and resource. However, this requires a clear purpose; ToR; agreement with DoH / Urology Assurance Group; due consideration of ethical considerations; and considered and sensitive engagement with patients and families. Importantly, where cases are selected for review, this should be done to a high standard.

A document should be developed to guide reviewers through the SCRR process and there should be a mechanism for calibration between reviewers to ensure consistency and inter-reviewer reliability. Additionally, a sample of the cases should be subject to second review for quality assurance. Understanding that this is challenging to achieve within reasonable timescales with a limited number of reviewers, the Expert Review Team recommends that SHSCT considers recruiting non-urology consultants to review the cases, guided by a defined protocol and with appropriate expert oversight.

Whilst the outcome of individual case reviews will be valuable to patients and families in terms of understanding what went wrong and why, it is the overall learning derived from the SCRR process that will assist SHSCT and the region in improving its systems. Therefore, it is vitally important that SHSCT strengthens its arrangements for identification and dissemination of learning. A review panel comprising members with expertise in urology and governance, and a lay representative should be established to deliberate findings, derive learning and make evidence-based recommendations. Equally, the mechanisms for sharing learning require an effective dissemination

strategy to be agreed with DoH / SPPG and PHA. Underpinning this, communication with stakeholders including GMC, Coroner's Service and PSNI requires to be underpinned by a Communication Strategy and established channels of communication. Furthermore, the arrangements for sharing information with the public under a duty of candour and for developing patient and family information require considerable strengthening. Encouragingly this is already being explored by SHSCT in light of concerns surrounding factual accuracy of previously issued patient correspondence.

On the whole, the challenges facing SHSCT are considerable, complex and require a concerted effort with appropriate involvement of a number of organisations; DoH / SPPG, PHA and RQIA. Retaining the focus on patient safety, the Lookback Review requires urgent support and upscaling. Whilst SCRR will be valuable in establishing deficits within the care and treatment of this patient population, it is limited in terms of deriving systems and governance learning. As such, RQIA advises that a Review of Governance of Urology Services would be crucial in terms of providing assurance around the current service. RQIA is committed to providing both independent assurance and improvement support to SHSCT as it continues its efforts to urgently address deficits in care whilst improving the quality and safety of SHSCT urology services.

3.2 Summary of Recommendations

Recommendation 1

SHSCT should urgently update all relevant documentation to ensure that there is clarity regarding the SCRR including a description of the SCRR purpose, remit and process; explicitly stating that it is a separate process to any parallel Inquiries or investigations.

SHSCT should review their arrangements for developing and quality assuring patient / family information materials and publicly accessible information to ensure there is adequate lay / service user involvement, communications expertise and, where beneficial, legal input.

Recommendation 2

SHSCT should consider reviewing the composition of Lookback Review steering group to reflect that which is stated within Regional Guidance for Implementing a Lookback Review Process; in particular, consideration should be given to the inclusion of a lay representative.

SHSCT should establish a dedicated project team for the management and co-ordination of SCRR. SHSCT should recruit people with the skills and experience who, if required, can seek the advice and guidance of experts from across the region.

Recommendation 3

Considering the need for dedicated co-ordination and management of the Lookback Review and the SCRR process; SHSCT should prioritise the appointment of a suitably qualified Project Manager.

Recommendation 4

SHSCT should define and explicitly state the purpose of the SCRR process. Furthermore, a clear Terms of Reference / set of objectives should be agreed and referenced within the relevant Trust documentation.

Recommendation 5

SHSCT should give urgent consideration to extending their Lookback Review to identify and recall further groups of patients. DoH / Urology Assurance Group / SPPG, PHA and RQIA should work together to support SHSCT with the Lookback Review.

RQIA should consider undertaking an independent assessment of Trust arrangements for the Urology Lookback Review in order to provide assurance on its effectiveness and identify any areas for improvement.

Recommendation 6

SHSCT should consider commissioning an independent body to undertake the SCRR process on its behalf.

Recommendation 7

SHSCT should consider implementing a sampling approach to case selection for SCRR. Such an approach should be agreed with DoH / Urology Assurance Group / SPPG. SHSCT should be clear on the rationale, its benefits and limitations and ensure that there is openness and transparency in communication with patients, families and the public. SHSCT should engage the Clinical Ethics Committee to consider any ethical issues arising from such an approach which can then be addressed and mitigated by SHSCT.

Recommendation 8

SHSCT should request SHSCT Clinical Ethics Committee to review both current and proposed arrangements for the Lookback Review and SCRR. Where ethical issues are identified, SHSCT should give this due consideration and, where required, adapt the methodology and approach for the review.

Recommendation 9

SHSCT should engage with Trust legal representation to obtain a legal perspective on the arrangements for the SCRR.

Recommendation 10

SHSCT should review their arrangements for the involvement of patients and families to ensure that it fulfils its statutory duty of Personal Public Involvement. SHSCT should consider engaging those with Personal Public Involvement expertise and external partners such as the PHA who have PPI training resources for staff and the PCC who could provide advice and support in the involvement of patients and families as part of the Lookback Review and SCRR.

Recommendation 11

SHSCT should review their arrangements for sharing SCRR findings with patients and families giving consideration to good practice as outlined by the Expert Review Team in this report.

Recommendation 12

SHSCT should liaise with RCP and consider amending the Structured Clinical Record Review tool to include an assessment of the quality of documentation and an assessment of the documented communication with patients and families; the clinical team, MDT and primary care. SHSCT should consider facilitating the consideration of patient / family concerns as part of the SCRR to mirror the approach undertaken by RCP.

Recommendation 13

DoH should commission RQIA to undertake a Review of Governance Arrangements within Urology Services in Southern HSC Trust.

Recommendation 14

SHSCT should not be limited to consultant urologists when recruiting clinical reviewers to undertake the SCRR process. All Expert Reviewers should be provided with guidance and support, including an opportunity to debrief, feedback and avail of emotional / psychological support if required.

A document should be drafted specific to this particular piece of work to guide reviewers through the process of conducting the SCRR; this should include a defined protocol for the assessment of the quality of care and treatment.

A sample of cases already reviewed using the SCRR methodology should undergo a second review to ensure inter-reviewer reliability and consistency. Consideration should be given to quality assurance of a defined sample of cases for the remainder of the SCRR.

Recommendation 15

A review panel should be constituted, for the specific purposes of identifying learning and determining recommendations arising from the SCRR process. This panel should include individuals with expertise in urology and governance, and include a lay member.

Recommendation 16

SHSCT should work with DoH / SPPG / PHA to develop an effective dissemination strategy for the Lookback Review and SCRR so that learning is shared regionally with all relevant stakeholders and the public is effectively informed under duty of candour principles.

Recommendation 17

SHSCT should draft a statement of purpose for the new database, outlining the rationale for transferring data and should retain a copy of the redundant file on record.

Recommendation 18

SHSCT should urgently develop and implement a communication strategy specific to the Lookback Review and including the SCRR process.

A channel of communication specific to Urology work streams should be established between SHSCT, PSNI, GMC and Coroner's office; SHSCT should ascertain the thresholds for referral in respect of specific concerns arising out of cases reviewed as part of the SCRR.

Appendix 1: Terms of Reference for the Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

(a) To review the Southern Health and Social Care Trust's (the Trust) handling of relevant complaints or concerns identified or received prior to May 2020 and its participation in processes to maintain standards of professional practice. The Inquiry shall determine whether there were any related concerns or circumstances which should have alerted the Southern Trust to instigate an earlier and more thorough investigation over and above the extant arrangements for raising concerns and making complaints.

(b) To evaluate the corporate and clinical governance procedures and arrangements within the Trust in relation to the circumstances which led to the Trust conducting a "lookback review" of patients seen by the urology consultant Mr Aidan O'Brien (for the period from January 2019 until May 2020). This includes the communication and escalation of the reporting of issues related to potential concerns about patient care and safety within and between the Trust, the Health and Social Care Board, Public Health Agency and the Department. It also includes any other areas which directly bear on patient care and safety and an assessment of the role of the Board of the Trust.

(c) To examine the clinical aspect of the cases identified by the date of commencement of the Inquiry as meeting the threshold for a Serious Adverse Incident (SAI) and any further cases which the Inquiry considers appropriate, in order to provide a comprehensive report of findings related to the governance of patient care and safety within the Trust's urology specialty.

(d) To afford those patients affected, and/or their immediate families, an opportunity to report their experiences to the Inquiry.

(e) To review the implementation of the Department of Health's "Maintaining High Professional Standards Policy" by the Trust in relation to the investigation related to Mr O'Brien. The Inquiry is asked to determine whether the application of this Policy by the Trust was effective and to make recommendations, if required, to strengthen the Policy.

(f) To identify any learning points and make appropriate recommendations as to whether the framework for clinical and social care governance and its application are fit for purpose.

(g) To examine and report on any other matters which the Chairman considers arise in connection with the Inquiry's investigations in fulfilment of these Terms of Reference.

The clinical practice of Mr O'Brien is being investigated by the General Medical Council (GMC) and it would, therefore, be inappropriate for the Inquiry to encroach on the GMC's remit. The Inquiry shall submit a report as soon as practicable to the Minister for Health. Should the Inquiry as part of its investigation establish any issue of concern which it believes needs to be brought to the Minister's immediate attention, then this will be done.

Appendix 2: Structured Judgement Review[10]

Case note review remains a prime means of retrospectively assessing quality of patient care. Implicit review is based on clinical judgement and is judged to be effective in identifying and recording the detail and nuance of care (both unsatisfactory and good).

Unstructured implicit review was criticised for low inter-rater reliability (high variability) and for potential reviewer bias. Structured implicit review methods require reviewers to use a judgement based structured explicit scale to rate quality of care from very poor to excellent. However, this form of review only provides a scale based quantitative result giving no indication of why a reviewer made a particular judgement. This means that it is useful for large scale monitoring or epidemiological studies of adverse events but is less effective for more detailed review at ward or hospital level of why an event occurred.

To increase the value of structured review in reviewing the whole spectrum of care quality, rather than focussing only on adverse event rates, a methodology was developed where reviewers were required to provide implicit clinical judgements and to write explicit comments to support judgement based quality of care scores: this forms the basis of Structured Judgement Review.

Structured Judgement Review requires reviewers to make safety and quality judgements over phases of care, to make written comments about care for each phase and to score care for each phase.

The objective of this review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about hospital systems where care goes well and to identify areas where there may be gaps, problems or difficulties with the care process. It can be used for a wide range of hospital based safety and quality reviews across services and specialties and not only for those cases where patients die in hospital. The quality and safety of care may be judged and recorded whatever the outcome of the case and good care is judged and recorded in the same detail as care that may have been problematic.

There are two stages to the review process.

Stage One

Carried out by ‘front line’ reviewers who are trained in the method and who undertake reviews within their own services, for example in Morbidity and Mortality Reviews.

Phases of care – the ‘structure’ part of the process.

Phases of care are shown below but may be varied depending on the type of care or service being reviewed:

- Admission and initial care – first 24 hours
- Ongoing care
- Care during a procedure

- Perioperative/procedure care
- End of life care (or discharge care)
- Overall assessment of care

Explicit Judgement Comments

Explicit judgement commentaries provide:

- The means for the reviewer to concisely describe how and why they assess the safety and quality of care provided.
- A commentary that other health professionals can really understand if they subsequently look at the completed review.

Phase of Care Scores

Care scores are recorded after judgement comments have been written and the score is itself an overall judgement of the reviewer. Scores range from excellent to very poor.

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Judging the quality of recording in the case notes.

As part of the overall assessment, the reviewer is also asked to record their judgement on the quality and legibility of the records again using a score of 1-5.

Second Stage Review

A score of 1 or 2 is given when the reviewer assesses that care has been poor or very poor. A score at this level should trigger a second stage review through the hospital governance process.

A second stage review also uses the structured judgement method and takes place if a patient has died. If the second stage reviewer broadly agrees with the initial case review a decision may be taken to carry out a further assessment concerning the potential avoidability of the patient's death.

The judgement is framed by a 6 point scale. A score of 1,2 or 3 on the avoidability scale would indicate a governance 'cause for concern'.

1. Definitely avoidable
2. Strong evidence of avoidability
3. Probably avoidable (more then 50:50)
4. Possibly avoidable, but not very likely (less than 50:50)
5. Slight evidence of avoidability
6. Definitely not avoidable.

Structured Judgement Review can produce learning at two levels:

- The detail captured can identify both poor practice and good practice of individual clinicians.
- When multiple reviews are undertaken within a clinical area or a hospital, a thematic analysis can be performed that may highlight systemic issues in a system.

Quantitative data identify very poor to excellent care in a number of care phases. Qualitative data from explicit judgements may be analysed, for example using word detection software, to identify recurrent themes.

References

[1] Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016. Available at https://hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf Cited July 2022

[2] Regional Guidance for Implementing a Lookback Review Process (July 2021). Available at https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-reg-guide-lookback-reveiw.pdf Cited July 2022

[3] Ethical Framework to Inform Phase Two of the Expert Review of Records of Deceased Patients of Dr Watt April 2021. Available at b996b934-f707-4206-b1c9-1e7d706bd5ec.pdf (rqia.org.uk) Cited July 2022

[4] Health and Social Care (Reform) Act (Northern Ireland) 2009. Available at Health and Social Care (Reform) Act (Northern Ireland) 2009 (legislation.gov.uk) Cited July 2022

[5] RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents In Northern Ireland (June 2022). Available at RQIA Review of Systems and processes | Department of Health (health-ni.gov.uk) Cited July 2022

[6] IHRD Workstream 5: What you should expect in relation to a Serious Adverse Incident Review in a Health and Social Care setting (Version 2: February 2019). Available at IHRD Workstream 5 - Serious Adverse Incidents - What to Expect irt SAI Review.pdf (health-ni.gov.uk) Cited July 2022

[7] NHS Resolution: Saying Sorry (June 2017) Available at NHS-Resolution-Saying-Sorry.pdf Cited July 2022

[8] Involvement Tools and Guides. Available at Involvement Tools and Guides - Engage (hscni.net) Cited July 2022

[9] Using the structured judgement review method. Guide for reviewers (England). 2019. Available at INMCRR guide England_0.pdf (rcplondon.ac.uk) Cited July 2022

[10] Information taken from the Royal College of Physicians: Using the structured judgement review method. Guide for reviewers (England). Available at https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20guide%20England_0.pdf Cited July 2022

The Regulation and Quality Improvement Authority

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Southern Health and Social Care Trust

Quality Care - for you, with you

30 September 2022

By email: [redacted]

Ms Briege Donaghy
Chief Executive
RQIA
7th Floor Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Dear Briege

RQIA REVIEW OF UROLOGY STRUCTURED CASE RECORD REVIEW

Thank you for the RQIA report on the Structured Case Record Review process which is an integral element of the Southern Trust's Urology Lookback Review.

I have shared the report internally with my team and we will proceed to agree an action plan to progress the recommendations contained within the document. I will provide you with a copy of the action plan as soon as possible and will endeavour to keep you informed on the progress we make.

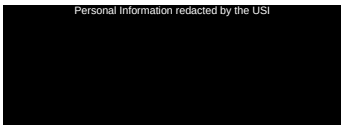
I am able to confirm that we have shared the report with the Urology Assurance Group in the Department of Health and also the Urology Services Inquiry team.

Finally, I would be grateful if you would pass on my thanks to your team for the supportive way they have engaged with the Trust in completing the review.

Trust Headquarters, Craigavon Area Hospital site, 68 Lurgan Road, Portadown, Craigavon BT63 5QQ
Tel: [redacted] Email: [redacted]

I would welcome RQIA's independent assurance and improvement support for the Urology Lookback Review and to that end I have asked that RQIA is represented in the membership of the Lookback Steering Group. Margaret O'Hagan will be touch with Emer Hopkins directly regarding this.

Yours sincerely



DR MARIA O'KANE
CHIEF EXECUTIVE

RQIA SCRR Review Recommendations

Action Plan

Summary

Total Number of Trust Actions Required = 25

Date	RAG Rating	Number
24/10/22		8
		14
		3
18/11/22		9 ↑
		13 ↑
		3 =
16/12/22		18 ↑
		5 ↓
		2 ↓
03/02/23		18 =
		6 ↑
		1 ↓
20/03/23		20↑
		4↓
		1=

Southern Health and Social Care Trust

Quality Care - for you, with you

RQIA SCRR REVIEW RECOMMENDATIONS IMPLEMENTATION PLAN

RECOMMENDATION 1				
1 (a) SHSCT should urgently update all relevant documentation to ensure that there is clarity regarding the SCRR including a description of the SCRR purpose, remit and process; explicitly stating that it is a separate process to any parallel Inquiries or investigations.				
Action Required to Deliver Recommendation(s)	**Responsible Officer[1]?**	**Update**	**Status RAG**	**Evidence pf Completion**
Update PID – with detail and purpose of SCRR,	LBR Project Manager (LE)	**20/10/22** – work commenced on this **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report
Draft a "stand-alone" summary of the background, purpose, objectives and process of SCRR	LBR Project Manager (LE)	**20/10/22** – work commenced **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report
1(b) SHSCT should review their arrangements for developing and quality assuring patient / family information materials and publicly accessible information to ensure there is adequate lay / service user involvement, communications expertise and, where beneficial, legal input.				
Add lay representation to the Urology Lookback Review steering and operational group.	Head of the Lookback Review (SW)	**20/10/22** – Lay representation sought via PPI team in Trust **18/11/22** - no further progress **16/12/22** – Two lay reps identified and joining Operational & Steering Groups	Complete	Emails confirming TOR
Patient / family information materials required for Phase 2 to be activity considered by Lay representatives and tested within other PPI forums either internal or external to Trust.	This is an action for the future – will be addressed and evidenced in phase 2			

[1] Responsibility for delivery this action plan sits with the SRO for the LBR who is chair of the LBR Steering Group (MOH)

RECOMMENDATION 2				
2(a) SHSCT should consider reviewing the composition of Lookback Review steering group to reflect that which is stated within Regional Guidance for				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Reorganise structures for the LBR process and reset role and function of steering group including membership	Chair of Steering Group (MOH)	**20/10/22** – complete	Closed	- Terms of Reference for Steering Group - Diagram of new structure
2(b) SHSCT should establish a dedicated project team for the management and co-ordination of SCRR. SHSCT should recruit people with the skills and experience who, if required, can seek the advice and guidance of experts from across the region.				
Lookback Review in line with project management principles and processes. Draft PID to summaries the LBR process	Chair of Steering Group (MOH)	**20/10/22** – complete – new structure and process	Closed	- PID - New structure and process in place to include clarity on reporting and accountability

RECOMMENDATION 3				
Considering the need for dedicated co-ordination and management of the Lookback Review and the SCRR process; SHSCT should prioritise the appointment of a suitably qualified Project Manager.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Appoint project manager to oversee the implementation of the Lookback Review in line with project management principles and processes	Chair of Steering Group (MOH)	**20/10/22** – complete LE in post from 1 September 2022 **27/02/2022** – LE completed PRINCE2 Foundation and Practitioner Training	Closed	- Staff in post - Certificate of P2 completion

RECOMMENDATION 4				
4(a) SHSCT should define and explicitly state the purpose of the SCRR process. Furthermore, a clear Terms of Reference / set of objectives should be				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Same as per recommendation 1(a) above	See recommendation 1(a) above	**20/10/22** – work commenced **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report

RECOMMENDATION 5				
5(a) SHSCT should give urgent consideration to extending their Lookback Review to identify and recall further groups of patients. DoH / Urology Assurance Group / SPPG, PHA and RQIA should work together to support SHSCT with the Lookback Review.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Draft options paper for extending the Urology Lookback Review and progress with option agreed by UAG.	Chair of Steering Group (MOH)	**20/10/22** – work commenced **18/11/22 –** Options paper shared with UAG on 17 November	Complete	Options paper
5(b) RQIA should consider undertaking an independent assessment of Trust arrangements for the Urology Lookback Review in order to provide assurance on its effectiveness and identify any areas for improvement.				
RQIA to action not Trust				

RSC requested – not accepted SCRR process is currently outsourced to individual external urologists accessed via BAUS. Request to be made to RCP	Dep MD (DG)	**20/10/22** – unable to secure RCS to undertake this work, **18/11/22 –** IS (3FiveTwo) sourced – IS contract being urgently drawn up to commission this work **16/12/22 –** IS now being utilised		Emails from RSC Emails with BAUS First tranche (14 cases) passed to IS on 13 December

RECOMMENDATION 7				
SHSCT should consider implementing a sampling approach to case selection for SCRR. Such an approach should be agreed with DoH / Urology Assurance Group / SPPG. SHSCT should be clear on the rationale, its benefits and limitations and ensure that there is openness and transparency in communication with patients, families and the public. SHSCT should engage the Clinical Ethics Committee to consider any ethical issues arising from such an approach which can then be addressed and mitigated by SHSCT				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Sampling approach to case selection for SCRR to be included in the options paper on progressing with the SCRR process for consideration by UAG	Chair of Steering Group (MOH)	**20/10/22** – work commenced – **18/11/22** – to be further clarified when IS contract in place **16/12/22** – All of the outstanding cases (29) of the original 53 cases will be passed to IS. Consideration will be given to sampling the remaining 38 plus any new SCRRs added at screening in the NY **03/02/23** – Now 125 SCRR in total (potential for up to a further 9 which are	Closed	

		planned for screening – which when compete finishes screening for cohort 1. A paper to be drafted for UAG to consider sampling of the current outstanding 72 SCRR cases. **20/03/23 –** All original 53 index SCRR cases are now completed. Comparative review has been completed. Direction from UAG as of **13.02.23** is to move to a "targeted" approach to the remaining SCRR cases. This was supported by the SCRR Options paper. LBR Team currently assessing those remaining cases for determination of issue and if this is a new theme.		

RECOMMENDATION 8				
SHSCT should request SHSCT Clinical Ethics Committee to review both current and proposed arrangements for the Lookback Review and SCRR. Where ethical issues are identified, SHSCT should give this due consideration and, where required, adapt the methodology and approach for the review.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Papers on SCRR and extending the Lookback Review to be shared with Trust ethic committee when complete	TBA	**20/10/22** - Not yet commenced – to discuss with new Medical Director when he takes up post **18/11/22 –** no update **16/12/22** – no update **03/02/23** – a seating of the ethic committee to be arranged to consider ethical considerations of Cohort 2	Commenced	

Share SCRR related papers with DLS	Chair of Steering Group (MOH)	**20/10/22** - Current SCRR process arrangement shared with DLS. The options paper on the way forward re SCRR will be shared with DLS when complete and prior to discussion with UAG. **18/11/22** – to be further considered if SCRR to change when IS contract in place. **16/12/22** – unchanged **03/02/23** – paper referred to above under recommendation 7 to be shared with DLS when complete		

RECOMMENDATION 10				
SHSCT should review their arrangements for the involvement of patients and families to ensure that it fulfils its statutory duty of Personal Public Involvement. SHSCT should consider engaging those with Personal Public Involvement expertise and external partners such as the PHA who have PPI training resources for staff and the PCC who could provide advice and support in the involvement of patients and families as part of the Lookback Review and SCRR.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
As per recommendation 1(b) add Lay representation to the Urology Lookback Review steering and operational group.	Head of the Lookback Review (SW)	**20/10/22** – Lay representation sought via PPI team in Trust	Complete	Meeting with Head of LBR and 2 lay reps

Provide information and bespoke induction of new Lay representatives to assist in contributing to the Lookback Review		**18/11/22 –** no update while Head of LBR is unavailable **16/12/22** – Two lay reps identified and joining Operational & Steering Groups		Information pack

RECOMMENDATION 11				
SHSCT should review their arrangements for sharing SCRR findings with patients and families giving consideration to good practice as outlined by the				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Share current process for communicating with patients / families re SCRR outcomes with DLS for feedback and advice.	Chair of Steering Group (MOH)	**20/10/22** – [redacted]	Completed & Closed	Email from DLS (21/7/22)

RECOMMENDATION 12				
SHSCT should liaise with RCP and consider amending the Structured Clinical Record Review tool to include an assessment of the quality of documentation and an assessment of the documented communication with patients and families; the clinical team, MDT and primary care. SHSCT				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider the above recommendation	Chair of Steering Group (MOH)	**20/10/22** – recommendation considered and decision taken not to change SCRR inter-process as calls into question the validity the work done previously.	Closed see below re next phase of LBR	
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applies at that time.	This is an action for the future – will be addressed and evidenced in phase 2			

RECOMMENDATION 13				
DoH should commission RQIA to undertake a Review of Governance Arrangements within Urology Services in Southern HSC Trust.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
DOH to action not Trust				

RECOMMENDATION 14				
14(a) SHSCT should not be limited to consultant urologists when recruiting clinical reviewers to undertake the SCRR process. All Expert Reviewers should be provided with guidance and support, including an opportunity to debrief, feedback and avail of emotional / psychological support if required.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Establish if RCP can facilitate the SCRR process	DMD (DG)	**20/10/22** – await feedback from RCP **18/11/22 –** no further feedback – response chased **16/12/22 –** Complete – IS contract in place	Complete	Contract Returned reports from IS
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applies at that time.	This is an action for the future – will be addressed and evidenced in phase 2			
14(b) A document should be drafted specific to this particular piece of work to guide reviewers through the process of conducting the SCRR; this should include a defined protocol for the assessment of the quality of care and treatment.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Review the document that currently exists for the SCRR reviewers and update it in terms of good practice identified in RQIA review document as the basis for further review should SCRR continue to be utilised in the extended Lookback Review.	Project Manager (LE)	**20/10/22** – This work has commenced **18/11/22 –** Being prepared to support IS contract **16/12/22** – draft guideline shared with IS as part of contracting process	Closed	IS Contract Contract monitoring notes

14 (c) A sample of cases already reviewed using the SCRR methodology should undergo a second review to ensure inter-reviewer reliability and				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider this action	Chair of Steering Group (MOH)	**20/10/22** – recommendation considered – due to lack of SCRR reviewers it is not possible to undertake a second review of a sample of the returned SCRR reports. For this cohort of patients a comparative analysis of reasons for SCRR verse findings from SCRR has been undertaken and both align	Closed see below re next phase of LBR	SCRR theming analysis
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applied at that time.	This is an action for the future – will be addressed and evidenced in phase 2			

RECOMMENDATION 15				
A review panel should be constituted, for the specific purposes of identifying learning and determining recommendations arising from the SCRR				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Commission a "Thematic Review" undertaken when all 53 SCRR reports and complete.	Medical Director	**20/10/22** – an external urologist identified to complete this work when the report are returned. Currently on 24 of the 53 reports have been returned. **18/11/22 –** no further SCRR returned **16/11/22** – Meeting with Dr Sally Williams on 13/12 – Dr William agreed to coordinate a thematic Review when SCRR complete **03/02/23** – five outstand SCRR returns. Dr Williams to be contacted to start process for undertaking a thematic review **20/03/23-** Contract pending with Dr Sally Williams with support of the IS SME's who undertook the completion of the SCRR reports.	Ongoing	
Provide an analysis of the themes identified by Trust senior doctors through the internal "SCRR Screening" process and complete to themes identified external SCRR urologists	Head of the Lookback Review (SW)	**20/10/22** – Complete and will be kept up to date as reports are returned	Closed	Up to date report available

RECOMMENDATION 16				
SHSCT should work with DoH / SPPG / PHA to develop an effective dissemination strategy for the Lookback Review and SCRR so that learning is				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Agree and document the process(s) for disseminating regional learning following the Lookback Review for consideration by UAG	Head of the Lookback Review (SW)	**20/10/22** – work commenced **18/11/22 –** no update to report **16/12/22** – no further progress **03/02/23** – no further progress as cohort 1 still to complete. **20/03/23 –** date agreed for Learning and Development Group this month. HOS will attend to disseminate from LBR Process. (Update from meeting will be reflected in next action plan update)	Ongoing	
Update Communication plan to include this aspect of communication	Project Manager (LE)	**20/10/22** – cannot commence until above action completed **16/12/22** – no change **03/02/23** – no change **20/03/23** – no change	Not started	

RECOMMENDATION 17				
SHSCT should draft a statement of purpose for the new database, outlining the rationale for transferring data and should retain a copy of the redundant file on record.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Draft a "Statement of Purpose"	Project Manager (LE)	**20/10/22** – Copy in draft awaiting review and sign-off	Complete	Statement of Purpose document

		18/11/22 – no update to report **16/12/22** – not signed off until cross-reference against template requested from BOH (via RQIA) – not yet received **03/02/22** – database developer completing – request made for draft to be shared **20/03/23** – Document Finalised		

RECOMMENDATION 18				
18(a) SHSCT should urgently develop and implement a communication strategy specific to the Lookback Review and including the SCRR process				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Draft communications strategy including communication plan	Communications Manager (PT)	**20/10/22** – draft plan complete – awaiting review and sign-off **18/11/22 –** no update to report **16/11/22** – Phase 1 plan complete – will be revised for Phase 2	Complete and closed	PID including phase 1 comms plan
18(b) A channel of communication specific to Urology work streams should be established between SHSCT, PSNI, GMC and Coroner's office; SHSCT should ascertain the thresholds for referral in respect of specific concerns arising out of cases reviewed as part of the SCRR.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider above recommendation		**20/10/22** – channel of communication currently exists with GMC and USI. Communication with PSNI and / or coroner not warranted at this time – this will be established if required in the future.	Complete and Closed	Emails and documents shared with GMC and USI.

From the Chief Medical Officer
Prof Sir Michael McBride

Department of Health
An Roinn Sláinte
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BY EMAIL

Ms Briege Donaghy
Chief Executive
Regulation and Quality Improvement Authority

Your Ref:
Our Ref:
Date: 11 August 2022

Dear Briege

RQIA REVIEW OF SOUTHERN HSC TRUST UROLOGY SERVICES AND LOOKBACK REVIEW

I understand discussions between officials from RQIA and the Department of Health (DOH) have taken place regarding the requirement for an independent review of SHSCT Urology Services and Lookback Review, which relates to potential concerns for patient safety. I am writing to formally direct RQIA to undertake this review.

Please find attached a draft Terms of Reference for this work. I also attach some background information which I hope you will find helpful.

Robbie Davis will be in touch as the policy lead contact, to discuss appropriate timeframes and to finalise the Terms of Reference. In the meantime, please do not hesitate to contact Robbie Davis (Personal Information redacted by the USI) in the first instance if you have any queries.

Yours sincerely

Personal Information redacted by the USI

PROF SIR MICHAEL McBRIDE
Chief Medical Officer

Encs

cc Peter May
Jim Wilkinson
Andrew Dawson
Donna Ruddy
Paula Ferguson
Lourda Geoghegan
Robbie Davis
Brigitte Worth
Anne-Marie Bovill

RQIA REVIEW OF SOUTHERN HSC TRUST UROLOGY SERVICES AND LOOKBACK REVIEW

Terms of Reference

The Terms of Reference for this RQIA Review have been developed within the context of the patient safety concerns raised by the Urology Services Inquiry (USI), and to ensure that the concerns for patient safety are addressed in an appropriate and timely manner, whilst ensuring the Review does not infringe on the work of the USI.

1. **Undertake an assessment of the current Southern Health and Social Care Trust Urology Lookback Review process, to include arrangements for its delivery and oversight.**

   To include:

   - Progress on the implementation of the recommendations made by the Southern Health and Social Care Trust's earlier investigation relating to the Urology Lookback Review and assess the robustness of the current Lookback Review.
   - Identify learning which can be applied to any further extension to the current Lookback Review.
   - Assess the extent to which Southern Health and Social Care Trust members of the Urology Assurance Group (UAG) have fulfilled requirements set out within the UAG Terms of Reference.

2. **Assess the effectiveness of current arrangements to assure the delivery of safe care within Urology Services in the Southern Health and Social Care Trust.**

   To include:

   - An assessment of the arrangements to monitor the delivery of care against all relevant standards.

3. **To seek the views and experiences of patients in relation to the care provided from Urology Services in the Southern Health and Social Care Trust, in so far as they relate to item 2.**

4. **To provide a report on the findings and, where relevant, make recommendations to the Department of Health by report at the earliest point.**

5. **To escalate any emerging concerns identified during the course of the Review to the Department of Health and to notify the Southern Health and Social Care Trust on any emerging patient safety concerns.**

The Regulation and Quality Improvement Authority

Interim Report on Findings in Respect of Term of Reference 1. RQIA Review of Southern HSC Trust Urology Services and Lookback Review

July 2023

The Regulation and Quality Improvement Authority

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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services in Northern Ireland. RQIA's reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Reviews are supported by a core team of staff and by independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews, taking into consideration our four key domains:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

Membership of the Expert Review Team (ERT)

Emer Hopkins	Director of Hospital Services, Independent Health Care Audit and Review, Reviews, RQIA.
Professor Aneez Esmail	Professor of General Practice (Emeritus), Centre for Primary Care and Health Services Research, University of Manchester.
Mr Hall Graham	Professional Advisor, Regulation and Quality Improvement Authority.
Mr Brian O'Hagan	Lay Representative and Independent Expert Advisor to the review.

Membership of the Project Team

Mr Hall Graham	Professional Advisor, Regulation and Quality Improvement Authority
Emer Hopkins	Director of Hospital Services, Independent Health Care Audit and Review, Reviews, RQIA
Richard Gamble	Project Manager
Lheanna Kent	Project Support Officer

1. BACKGROUND

On 31 July 2020, the Southern Health and Social Care Trust (the Trust) submitted an Early Alert (Ref EA 182/20) to the Department of Health (DoH) Northern Ireland, in relation to urology services in the Trust. The basis for this Early Alert, was to describe early findings from scoping of records and identify any further work required to identify the scope and scale of any further look back.

The Early Alert advised that on 7 June 2020, the Trust had become aware of potential safety concerns related to delays in the treatment of surgical patients. These patients had been under the care of a consultant urologist, Mr Aidan O'Brien, who had been employed by the Trust from 6 July 1992 until his retirement on 17 July 2020.

The Early Alert described a lookback covering a 17-month period, (1 January 2019 - 31 May 2020) which had identified a number of concerns. The Trust became aware that:

- two out of 10 patients listed for surgery under the care of the consultant had not been recorded on the hospital's patient administration system at that time
- there were concerns with 46 patients who had had a procedure to insert a stent
- 120 of 334 elective inpatients patients with a delay in dictation of up to 41 weeks
- 36 patients with no case record on Northern Ireland Electronic Care Record.

A number of cases had subsequently been identified as meeting the threshold for investigation under the Serious Adverse Incident (SAI) procedure.

On 11 August 2022, the Chief Medical Officer wrote to RQIA requesting they undertake an independent review of the Trust's Urology Services and Lookback Review of patients previously under the care of Consultant A (Mr O'Brien) as a matter of urgency.

This is an interim report outlining findings in respect of Term of Reference 1 which requested we: *Undertake an assessment of the current Southern Health and Social Care*

Trust Urology Lookback Review process, to include arrangements for its delivery and oversight. Further Fieldwork is planned to explore the remaining terms of reference.

2. TERMS OF REFERENCE

The Terms of Reference for this review were developed within the context of the range of concerns raised by the Urology Services Inquiry (USI) to the Urology Assurance Group (UAG) within the Department of Health. The Department of Health sought to ensure the concerns raised were addressed in an appropriate and timely manner, whilst ensuring the Review did not infringe on the work of the USI.

Following discussion with the Department of Health, it was agreed that the Review would be undertaken in Two Phases. Phase I as detailed in this report focuses on Term of Reference item 1.

Term of Reference 1

Undertake an assessment of the current Southern Health and Social Care Trust Urology Lookback Review process, to include arrangements for its delivery and oversight.

To include:

1. Progress on the implementation of the recommendations made by the Southern Health and Social Care Trust's earlier investigation relating to the Urology Lookback Review and assess the robustness of the current Lookback Review.
2. Identify learning which can be applied to any further extension to the current Lookback Review.
3. Assess the extent to which Southern Health and Social Care Trust members of the Urology Assurance Group (UAG) have fulfilled requirements set out within the UAG Terms of Reference.

3. METHODOLOGY

Initiating Phase I, on 18 January 2023, RQIA shared its review questionnaire with the Trust, with a completed return requested for 8 February 2023. Following a request from the Trust, an extension to this date was granted to 22 February 2023.

On 14 February 2023, the Trust alerted RQIA that they would not be in a position to return the information requested. In follow up, on 10 March 2023, the Chief Executive of the Trust wrote to RQIA to advise that in preparing to respond to the questionnaire and provide the documentary evidence requested, as it had become evident that there was a significant overlap in detail contained in personal witness statements that Trust officers submitted to the Urology Services Inquiry (USI) under Section 21 of the Inquires Act 2005. The Trust had shared the terms of reference and review questionnaire with BSO's Department of Legal Services, Trust Counsel and the Urology Services Inquiry for advice. RQIA continues to await an updated position in respect of the Trust's legal advice, as of 22 June 2023 it has not received this. Given the potential patient safety concerns and acknowledging the further delay to the Trust questionnaire return, RQIA in order to support the requirement for independent assurance, adapted its planned methodology. RQIA informed the Trust it was committed to proceeding with the Review even in the absence of the questionnaire return.

Whilst unusual for the Expert Review Team (ERT) not to have the detailed responses to a review questionnaire and associated documentation in advance of the meeting, in an endeavour to progress with the Review, RQIA and its ERT attended the Trust Headquarters on the 22 of March 2023 to meet with the Director who was currently responsible for the Lookback Review and her team of admin and senior nurses. At this meeting a presentation was delivered.

At this short engagement, the Trust described the processes involved in the delivery of Lookback for Cohort 1 current Lookback Review and preparations to date being made to extend the Lookback to a second cohort.

After consideration of the information shared during the meeting with the Trust, a follow-up meeting was held with the Lookback Review Responsible Trust Director to explore progress made against the recommendations from the previous RQIA review of the Trust's Structured Clinical Record Review (SCRR) which had been undertaken in 2022. Documents that were requested and those received are listed in Appendix 1. RQIA have also undertaken further engagement with members of the Trust's Urology Lookback Steering Group and its Chair and a range of documents were requested by RQIA and provided by the project team.

Data sources which contributed to this report include:

- Review Questionnaire: Issued but not returned by SHSCT.
- Engagement Session: Two-hour engagement session with Accountable Director and Team delivering the Lookback Review which took place on 22 of March 2023.
- Documents requested and issued are detailed in Appendix 1
- Minutes from Urology Assurance Group Meetings: Supplied by the Department of Health.
- Follow-up engagement session with Lookback Review Responsible Director: One-hour meeting to explore progress made against the SCRR recommendations, which took place on 4 May 2023.
- Engagement session: With two external members of the Urology Lookback Steering Group.

4. FINDINGS

ASSESSMENT OF LOOKBACK REVIEW PROCESS

The Terms of Reference for this review required RQIA to consider the robustness of the Trust Lookback Review and to make recommendations for future phases. The ERT, having received a verbal account of the Lookback Review process and decision making stages directly from the clinical nurse specialists undertaking it and having examined the triage forms, were satisfied with the methodology described and how it had been described as deployed. The ERT considered that the process was likely to have correctly identified those patients who required further review and changes to their care and treatment.

The ERT were satisfied with the level of competence and knowledge of the Lookback Team which, at the time of our field work, consisted of:

- The leadership of a Responsible Director
- A separate Head of Service with operational responsibility for the process.
- An independent Consultant Urologist from England
- a Trust based Consultant Urologist
- Urology Clinical Nurse Specialists
- Senior Nurses who contribute on an 'as and when required' basis.
- Administrative support from a Project Manager; and an
- Administration Manager.

Overall, the Project Team undertaking the review demonstrated a good understanding of the management and oversight of the processes underway. Additionally, an options paper was provided which set out clear plans for the process to be applied on the assessment of future cohorts of patients and the ERT were very satisfied that there was a clear and rationale process for the proposals for undertaking this work.

INITIATION AND EARLY DECISION MAKING

The project team, who were not in place when the Lookback process commenced, described to the best of their knowledge the informal scoping phase which started in July 2020, and was formally initiated as a Lookback review procedure at this time. Key actions cited in the Early Alert issued in July 2020, included contact being made with the Royal College of Surgeons regarding an Invited Service Review and consideration of the potential scale and scope of any *future* lookback, the Early Alert was not specific in that this was the point of initiation of a formal Lookback in line with the earlier version of the Regional Guidance for Undertaking a Lookback. Within the meeting notes of the UAG, the first mention of formal Lookback as a defined subheading was May 2022, prior to this, the work was referred to as a record scoping exercise. There was discussion in May 2021, about the pending issue of the new Regional Lookback Guidance (which was subsequently formally issued as guidance across the Region in July 2021) and its relevance to the process the Trust was undertaking. There was an expectation expressed by a member of the Urology Assurance Group, and shared by the ERT, that the new regional guidance would have been already followed by the Trust because the document was widely available in draft form. Evidence was not found to support this had occurred, or when and how the new regional guidance for undertaking a lookback was formally adopted by the Trust as its reference point.

It was also noted that within Early Alerts issued in May and June 2022, almost a year later, the Trust was still in the process of writing to a number of patients in respect of notifying them about the Lookback Review. An Early Alert of 12 of May 2022 (EA 187) makes reference to changing management structure within the Trust and the resultant impact on internal stability. It also noted the significant impact of the pandemic coupled with preparations for the Urology Services Inquiry. The ERT considers these factors, and the resources and expertise available to the Trust, also had the potential to impact the progress of the Lookback Review. The period of scoping, as documented, was complicated by multiple parallel learning exercises such as the Invited Case Record Review by the Royal College of Surgeons and the Serious Adverse Incident and

Structured Case Record Reviews. The ERT considered the range of parallel activities had contributed to the protracted nature of the Lookback Review.

Within the pre-review questionnaire, RQIA sought information which would demonstrate good, planning, oversight and scrutiny of decision making within the Trust at the important early stages of the lookback process. The ERT had intended to review documentation describing the formation of the key early decision making structures, to benchmark these against the Lookback Review Policy (reissued in July/June 2021 and understood to be available in draft form in advance of this) and actions described in Early Alerts. This information was not provided by the Trust for reasons previously detailed.

It is noted that several significant processes were established by the Trust in parallel to the Look Back Review. These included the Royal College of Surgeons invited case record review and the Structured Clinical Case Review, a number of audits and reviews. Though these efforts to seek immediate early learning and system improvements are commended, the existence of multiple parallel learning exercises, in the early stages, had the potential to impact the degree of focus and resources available for the most critical task, to identify as quickly as possible all current patients that may be at risk or require recall.

APPROACH

A presentation provided by the Trust, described at a high level the approach used which identified 2,112 patients between January 2019 and July 2020.

This was developed through review of emergency elective patients, review of oncology outpatients, review of case backlogs, a regional audit on prescription of biclutamide, review of pathology results, review of Multi-Disciplinary Meeting outcomes and review of radiology results. There was no opportunity for the ERT to sample completed Patient Review Forms, or directly access patient information to reach a view on the effective application of the process described by the project team. The documents provided, such as the Lookback Review End of Year Report (January 2023) did not contain sufficient

details of the precise methodology used to identify the 2,112 patients or defined inclusion criteria for the first cohort. Subsequently, it was not clear to the ERT what specific inclusions, and whether any exclusions, had been applied or whether this number represented all identified patients of the Doctor during the specified time period or a select high risk group. The ERT considered that it was important for the Trust to be able to demonstrate the process used to enable assurance on who had been included in the cohort, i.e. new patients, patients who had been reviewed/ admitted, patients scheduled for review within or outside the time period, non-attenders or discharged patients. The ERT were not given a document to provide full details of all sources of data which were identified and searched and therefore all patients captured. The ERT considered that records of these early scoping stages and criteria used are critical for quality assurance of the process, as is the definitions used for inclusions in the cohort. In contrast, the project documentation for the next stage of the Lookback Review, Cohort two, provides greater detail on various criteria including inclusions and exclusions criteria to arrive at the proposed numbers.

Recommendation 1

For the previous Cohort, the Trust must provide the Urology Look Back Steering Group, the UAG and RQIA, with a document outlining the precise methodology used to identify the initial Cohort of 2112 patients, to include a clear set of inclusion and exclusion criteria, and a reproducible search methodology. In addition, this should be available for all future Cohorts.

The ERT sought to determine the chronology of the Lookback Review and identify exactly when a decision to formalise the process in line with the regional procedure was taken. Following our engagement meeting, the Trust provided an outline timeline of commencement and completion of the various stages.

The Lookback Review end of year report (January 2023) identified November 2021 as the formal initiation of the Lookback Review. However, the timeline provided by the

project team indicated that the initial planning and preparation commenced in July 2020 and lasted nine months. Stage 2, the Review of Clinical Records, had commenced in March 2021 (not November 2021 as in the end of year report), suggesting that the process took 22 Months to complete. The triage of patient review forms had to date taken nine months and the recall of over 500 patients, had taken 25 Months and had not yet been completed. At the UAG meetings in the Autumn of 2020, reference is made to a record scoping exercise rather than Lookback Review. It was noted by the ERT that in the Lookback Review end of year report that the first outcomes are listed against September 2022 (18-19 months after initiation of scoping. No outcome reporting before September 2022 was identified and the point of initiation of outcome reporting and analysis was not clear.

The responsible Director explained that Activity Reports were presented regularly at several sub-group meetings. Initially a narrative report was presented to an Operational sub group in July 2022. In September 2022, the Director for Lookback Review established the official Activity Report template to be used to capture the progress going forward. These reports were not viewed by RQIA

It is therefore not possible to determine the timing of when the process became regarded by the Trust as formalised as a Lookback Review. It is the view of the ERT that the formalisation of the Lookback Review ought to have been clearly documented earlier and ideally in parallel with the issuing of the initial Early Alert, to ensure rapid mobilisation of expertise to the Trust and, full oversight of the process in line with the developing new guidance, from that point forward.

Recommendation 2

The Trust should ensure, for previous and future cohorts of the Lookback Review, that end of cohort reports include clear dates of initiation of various stages of the Lookback review, to identify key decision points and milestones within the process in order to support effective oversight and scrutiny.

The Project Team described that the pace of the Lookback Review increased between July and November 2022, aligning with the mobilisation of resource and expertise and the appointment of a dedicated project team. During our engagement session it was noted that the Trust was focussed on completing the final stages of Cohort One. There were still a small number of patients (28 patients as of 7 March 2023, with the potential to increase to 38 patients when final Triage is complete) who were still awaiting their appointment. The ERT were assured that efforts were also being made to contact next of kin of deceased patients to inform them of the outcome of the review of their case.

The decision, in the initial phase of the Lookback Review, to take a comprehensive approach to case review of the cohort of 2,112 patients, rather than a stratified/targeted approach was a significant one, which impacted on the complexity of the work. This is likely to have contributed to the excessive time taken to complete these stages, particularly in view of the challenges in securing Urology consultant capacity which are well documented in the UAG meeting minutes. The ERT considered that had a decision instead been taken for early stratification, it would have had to be balanced against the risk of missed learning and opportunities to remedy treatment decisions across the whole mix of cases. The documents that have been provided/ reviewed do not indicate if or when, consideration was given to alternative options for a stratified approach, rather than a sequential/linear/chronological one and how these decisions were reached or balanced. It is the view of the ERT that these complex decisions are those most likely to have benefited from the external critique or the perspective of an advisory or ethical panel such as the Trust Ethics Committee or the Department of Health's Ethical Forum.

The ERT strongly endorsed the approach suggested for subsequent phases of the Lookback Review using case stratification on the basis of risk, with the exclusion of deceased patients from future phases. Moving forward, the focus should remain on ensuring living patients are on correct treatment regimens, to minimise potential for harm, with an alternative process potentially being considered for deceased patients.

CAPACITY AND PLANNING

Another factor contributing to the elongated timescales for progressing the Lookback Review was adequacy of capacity and resource planning. The ERT considered that it is critical at the outset to dedicate and then ring fence resource for such an important piece of work, using expertise from external sources if not available internally. An example was when a single urology consultant had been undertaking recall appointments. The ERT considered that it was not appropriate to place such reliance on a single consultant, which aside from impact on core delivery of services, had reduced the opportunities for peer review and consistency checking and is likely to have resulted in competing demands between providing care to current patients and those recalled under the Lookback Review.

It was established that the Trust identified an external Consultant who undertook a review of the patient's case and completed a Patient Review Form to record this review. He returned the Patient Review Form to the Trust but he did not himself make a determination/ recommendation on whether a recall appointment was required. The Urology Specialist Nurses to assessed / triaged the returned Patient Review Forms to identify which patients needed a recall appointment and with whom, a consultant or specialist nurse. The ERT considered there may have been merit in reversing this process with an initial review being undertaken by a Nurse Specialist and then final review on a subset of more complex cases to be completed by the consultant. This may have reduced the time taken to complete this stage of the review and reduced the overall workload for the consultant.

For cohort 2 an improved process has been agreed. The now electronic form will include a recommendation for recall and the consultant cannot return it until the requirement for a recall or other action is determined.

The Lookback Review Project Team confirmed that additional external support had recently been sourced through the South Eastern Health and Social Care Trust. In its report of 7th March 2023, over two years after commencement, the Trust indicated that

28 (with the potential to raise to 38) living patients were still awaiting a third level triage. The responsible Director reported that the team complied, at all times, with the Integrated Elective Access Protocol guidelines in managing and monitoring the appointments to attend the recall clinic, and that recall appointments were anticipated to be completed by April 2023.

Recommendation 3

For future cohorts, the Southern Health and Social Care Trust should give consideration to adopting a process for the triage of clinical records which requires a first review of cases by Clinical Nurse Specialists against defined criteria, and with clear guidance to identify those most likely to require, further recall and review by a consultant.

INFORMATION MANAGEMENT

Section 3.2 of the current Regional Guidance describes the requirement for a service user database, at initiation, to assist with the identification of patients at risk and this required the support of a robust information management system. This topic had been previously explored in detail within RQIA's previous Review of the Urology Structured Case Record Review. The ERT sought evidence of the Trust's response to RQIA's previous recommendations in relation to the system utilised during the early initiation stages of the Lookback Review. The Trust team described the transition in recent months from an original Excel spreadsheet to a more robust system based on Microsoft Access which was supporting systems of reporting. The new system was reported to be fully meeting the needs for the Lookback Review. The ERT were also assured that during the transition to the new system, there had been no risk of data loss or corruption and that robust information governance practices were in place around the use of this data. On reviewing the project plan for future phases of the Lookback Review, the ERT considered that there was clear evidence of the significant attention being given to the maintenance of this database and there were information management systems in place to aid the oversight, planning, delivery and reporting of the work.

OVERSIGHT

The updated Guidance for Implementing a Regional Lookback Review Process (Regional Guidance) was reissued in July 2021, after commencement of the record scoping phase of the Lookback Review. The Regional Guidance describes the role, purpose and membership of an internal Trust Lookback Review Steering Group.

This group should be established as part of Stage 1 activities, early in the Lookback process, to scrutinise regular Sit-Reps and oversee action plans. The ERT noted that the new updated guidance was published after the stage 1 had commenced and the date provided by the Trust for the establishment of its internal (Oversight) Steering Group was September 2020, 3-4 months following the notification of the concerns within the Early Alert. During this time, the Department of Health the Health Social Care Board and The Public Health Agency, were participating in weekly meetings. Terms of reference for an initial SPPG-chaired Oversight and Co-ordination Group were approved on 19 of November 2020.

The last meeting of the HSCB Chaired co-ordination took place on 8 September 2022 to allow the establishment of the Trust's Urology Lookback Steering Group. Aligned to the closure of the Health and Social Care Board and the transfer of its functions to the new Strategic Planning and Performance Group as a function of the Department of Health, this change sought to streamline and clarify reporting and accountability arrangements.

The ERT was provided with a Draft Version of the Terms of Reference for the Trust's Urology Lookback Review Steering Group, but noted that on examination of these Terms of Reference its status was not clear (remains marked as draft). This is a critical document setting out the role of the Lookback Review Steering group in overseeing the programme of work and establishes lines of accountability and communication with other aligned groups under the umbrella of the Public Inquiry Programme Management Board. It references reporting outcomes to the Urology Services Inquiry and to the Trust's Public Inquiry Programme Board.

The Terms of Reference included:

- *Responsibility for the commissioning of appropriate groups and sub-groups to complete the Lookback Review in a way that is compassionate, timely and comprehensive.*
- *Oversee the undertaking and communication of all stages and phases of the Urology Lookback Review.*
- *Responsibility for the commissioning of appropriate groups and sub-groups to complete the Lookback Review in a way that is compassionate, timely and comprehensive.*

The first duty listed in the Lookback Review Steering Group Terms of Reference relates to ensuring discovery of all aspects of the Lookback Review to the Urology Service Inquiry; however, this is not in keeping with the primary purpose as described by the project team or in the view of the ERT. The Purpose of the Lookback Review was well described in the Standard Operating Procedure for Data Migration as follows:

"The key objective of the Urology Lookback Review is to ensure that patients under the care of the Urology Consultant obtain appropriate treatment, support and care in an effective and timely way. The Review and Recall stages of the Lookback will evaluate the whole range of care provided to a patient; holistic care approaches, nuances of case management and the outcomes of interventions".

This definition clearly delineates the role and purpose of the Lookback Review as separate from the Trust's legal duties to the Urology Services Inquiry and is better aligned to the description provided by the Trust during the engagement session. The prime focus of the Lookback Review must be the identification of individuals who may require changes to their treatment, and such a process would be required irrespective of the existence of The Urology Services Inquiry. During our meeting with project team members, they articulated overlapping and perhaps competing interests across both Lookback Review and Urology Services Inquiry Response processes.

However, they also noted that both will identify learning and opportunities for improvement which will require implementation with oversight being provided by both the Trust Executive Team and Trust Board.

The ERT considered the Terms of Reference for the Lookback Review Steering group which are still in draft, are not fully comprehensive when benchmarked against the updated Regional Guidance for Implementing a Lookback Review Process. They are not sufficiently detailed or clear on with whom and where authority for key decision making rests within the Trust's multi-layered structure.

The Regional Guidance for Implementing a Lookback Review Process indicates that a nominated Non-Executive Board Member should be part of the steering group; this would contribute to the assurance of the effectiveness of the group, but this is omitted from the current draft.

The ERT endorsed the external Critical Friend role as described by the project team. A critical friend is an individual who offers to provide honest and candid feedback in a supportive manner. These external, independent individuals who have been selected because of their significant health service experience are important but, the relationship between Critical Friend and the Steering Group was not outlined in the Terms of Reference. The Project documentation supporting the Lookback Review should be specific about the added value of the role of Critical Friends and how they engage with and support the Lookback Review Steering group.

The ERT welcomed the fact that the Draft Lookback Review Steering Group Terms of Reference, detail the need to ensure appropriate support is in place for service users and their families who may be impacted by the Lookback Review. However, there is not a Service user representative identified within the membership of the steering group, as outlined in the updated Regional Guidance for Implementing a Lookback Review Process. As identified in RQIA's previous review, the ERT considers that the Lookback Review Steering Group should ensure that the Trust meets its obligation to appropriately involve Service Users at key decision points in the lookback process. During our

engagement session, the Trust project team described how it had accessed its local user group to seek their views on aspects of its work for example providing input and feedback to the drafting of letters to family and relatives. However, they confirmed that the benefit of this engagement had been limited; and that they were committed to strengthening Personal and Public Involvement throughout its programme of work and they would continue to seek service user input into the Lookback Review Steering Group, as it moves forward into future phases.

An opportunity exists, to strengthen the Terms of Reference for the Trust's Lookback Review Steering Group and bring them into closer alignment with the updated Regional Guidance for Implementing a Lookback Review Process by clearly describing the mechanisms for Service User involvement.

Recommendation 4

The Trust should update the Lookback Review Steering Group Terms of Reference and Project Documentation to bring it fully in line with the Regional Guidance for Implementing a Lookback Review Process and reflect the prime focus of the Lookback Review. These should outline the arrangements for securing expertise in Communication, Information, Legal Advices, Ethics and Public Patient Involvement and the Input of Critical Friends. It should be formally approved by the Steering Group and kept updated with appropriate version control.

UROLOGY ASSURANCE GROUP (UAG)

The Terms of Reference for this Review include an exploration of how The Trust has fulfilled its requirements as set out in the UAG Terms of Reference. The establishment of the Urology Assurance Group was announced in a ministerial Statement issued on 27 October 2020. The first meeting of the UAG took place on 30 October 2020 and the group's Terms of Reference were approved on 6 November 2020 and updated in May 2022.

It is noted within the Terms of Reference that UAG will:

- *review the progress of the initial scoping exercise;*
- *consider emerging strategic issues;*
- *commission and direct further work as necessary;*
- *monitor the impact on urology and related services;*
- *ensure coordination with other associated reviews/investigations; and*
- *oversee communication across all stakeholder groups.*

The key expectation listed in the terms of reference for The Trust is as Follows.

"The UAG will receive updates from the Southern Urology Oversight Steering Group as appropriate. The Steering Group will continue to review the findings of the initial Lookback exercise and scope the potential need for a further Lookback exercise."

The Terms of Reference, minutes of the UAG and a sample of progress updates were reviewed by the ERT. Typically, the Trust provided a progress report under the following headings: Urology Services Inquiry, Urology Lookback Review, Lookback, Stage 1 – Cohort, Stage 2 – Review, Stage 3 – Recall, Cases Closed, Review Outcomes Report and a section on Finance.

The length of time taken by the Trust to complete the phases and provide data on the end outcomes of those patients recalled, had, in the ERT's view, the potential to concern the UAG in relation to the pace of progress. The Action Log associated with the UAG indicated timescales associated with actions remaining open for up to six months.

In November 2021, the UAG was advised that an Outcomes Report would be available by May 2022. In February 2022, the UAG was further advised that the Outcomes Report was to be developed after the conclusion of the current lookback review. In May 2022, it was noted it would be provided in June 2022 by the Trust to the Strategic Planning and Performance Group.

Subsequent progress reports received by the UAG contained quantitative information on the numbers of people progressing through the various stages of the review. An Early Draft of the Outcomes Report was noted to have been shared with DoH officers before the UAG meeting of November 2022. The final report "Lookback Review Summary and End of Year Position" is dated January 2023.

The Terms of Reference for the UAG clearly describe its role as providing assurance and external oversight for the Lookback Review. During the engagement meetings with the Trust, the Responsible Director indicated that the UAG had not been overly directive, nor made decisions on behalf of the Trust but indicated that it had been helpful in endorsing Trust decisions.

Detailed and timely reporting to the UAG by the Trust, underpins its oversight and assurance functions and provides evidence to the DoH, of effective internal programme management, oversight and corporate governance within the Trust. The UAG relies therefore on sufficiently detailed evidence of robust decision making and internal scrutiny, to satisfy itself that the Trust is identifying and mitigating all key risks. As the Lookback Review proceeds, the ERT considers that the UAG could be more specific and directive within its terms of reference regarding the mechanisms, frequency and content of future reporting. This would support it in executing its important oversight role, thus setting clear expectations for the Trust in respect of compliance.

Recommendation 5

The Southern Health and Social Care Trust should expand its progress reporting template and agree with the UAG on the content, format and frequency of reports to be provided throughout future phases. This should mirror the content of internal reporting and include sufficient details on all material risks and their mitigations.

PROGRESS WITH THE IMPLEMENATION OF RECOMMENDATIONS FROM THE RQIA REVIEW OF THE TRUST STRUCTURED CASE RECORD REVIEW

The ERT assessed the extent to which Southern Health and Social Care Trust members of the Urology Assurance Group (UAG) and the wider Southern Health and Social Care Trust have implemented the Recommendations from the RQIA review of the Trust Structured Case Record Review Process.

During our engagement meeting, the ERT was provided with a progress update on the work to implement these recommendations. Appendix 3 in this report shows the tracking of the completion of 25 actions that span the 18 recommendations for improvement contained in the Structured Case Record Review Report. It shows 22 actions are substantially complete, 2 in progress and 1 outstanding.

Although this position provided some assurance for the ERT, due to limited time for discussion during the meeting with the Trust, the strength of evidence to support this position was further explored during a follow up meeting with the Chair of the Lookback Review Steering Group. The Chair provided more detailed explanations and examples to support the assurances provided in the progress update, including where appropriate that the Trust had elected to take alternative approaches to those recommended. It was confirmed that good progress had been made across the majority of recommendations including work to secure a clinician to undertake the thematic review of SCRR cases.

Further amendments were requested to the progress update for the recommendations, at the time of writing to strengthen the evidence and assurance provided these are still awaited. Sampling and further testing of the evidence underpinning these assurances is required may continue into Phase 2 of this review.

5. CONCLUSION

The ERT considers that the commitment and dedication of Trust staff should be commended at the end of this first stage of their Lookback Review. In particular, a significant burden of work has fallen to one consultant who was also responsible for raising initial concerns. The Lookback Review Policy (reissued in 2021) recommends that personnel directly involved in the event/hazard that triggered the Lookback Review, should not normally be involved in the composition of the Lookback Steer group, but it makes no suggestions on their inclusion in conducting the actual Lookback Review activities. Given the burden of work which has fallen upon a single individual, the Trust should assure itself that the size and composition of the team responsible for conducting the Lookback Review is sufficient to ensure the delivery of all the activities in a reasonable period of time.

The identification of the concerns in June 2020 leading to the decision to undertake the Royal College of Surgeons Record Review, followed by a number of SAI reviews and the Trust Structured Case Record Review and the subsequent recall of patients and formal Lookback Review, demonstrates the seriousness with which the Trust took its responsibility to identify all individuals at risk.

At the point of completion of Cohort One of the recall, 527 patients, from the cohort of 2112, will have been recalled. The ERT is mindful of the documented challenges faced by the Trust in undertaking the Lookback Review in respect of staffing, changing management structures and the pandemic. However, at almost three years following the first Early Alert, it is clear that it will still take a considerable amount of time to complete the recall of patients. Though Trust staff involved in the latter stages of the review process, have sustained momentum, gained significant experience and developed important skills and capability, the ERT considered that a greater mobilisation of resources and expertise was required much earlier, to produce a more rapid assessment

of risk and to define numbers to be recalled. Ring-fencing of these resources would likely have led to the Lookback Review being completed within a shorter timescale.

Attention must continue to be given by all concerned, to the effective internal and external scrutiny and oversight of the Lookback Review process, as well as its operational activities and outcomes. Attention to properly constituted operational and oversight groups, with appropriate authority and skills and resources, will deliver a disciplined approach, supporting the Trust to meet all its obligations. The role of and terms of reference for each of these groups should also be made absolutely clear and explicit. There was also an important opportunity to draw significant learning and experience from the planning and organisation of the Belfast Trust's recall of Neurology patients which may have occurred to some extent. Additionally, it is considered that significant learning as identified from this Lookback process and those in other Trusts, should be documented and shared widely for the benefit of those faced with undertaking such activities in future, and to inform future versions of the Lookback Review Regional Guidance.

Knowing the scale of the numbers involved and the limited resources available to the Trust, early stratification of high-risk groups, and limiting the size of the recall is likely to have been a defendable approach. Having completed a large recall, and examined the suboptimal care themes within audits, case record reviews, Structured Case Record Reviews and Serious Adverse Incident Investigations, the opportunity to implement this learning across all Trust services is expected to result in strengthened internal governance and patient safety. Through the remainder of this Review, the ERT will continue to seek evidence of the governance systems and processes in place to assure the safety of patients within the Urology Services and expects they will find evidence of this learning being applied.

The Regulation and Quality Improvement Authority

6. SUMMARY OF DRAFT RECOMMENDATIONS

Recommendation 1

For the previous Cohort, the Trust must provide the Urology Look Back Steering Group, the UAG and RQIA, with a document outlining the precise methodology used to identify the initial Cohort of 2112 patients, to include a clear set of inclusion and exclusion criteria, and a reproducible search methodology. In addition, this should be available for all future cohorts.

Recommendation 2

The Trust should ensure, for previous and future cohorts of the Lookback Review, that end of cohort reports include clear dates of initiation of various stages of the Lookback review, to identify key decision points and milestones within the process in order to support effective oversight and scrutiny.

Recommendation 3

For future cohorts, the Southern Health and Social Care Trust should give consideration to adopting a process for the triage of clinical records which requires a first review of cases by Clinical Nurse Specialists against defined criteria, and with clear guidance to identify those most likely to require recall and review by a consultant.

Recommendation 4

The Trust should update the Lookback Review Steering Group Terms of Reference and Project Documentation to bring it fully in line with the Regional Guidance for Implementing a Lookback Review Process and reflect the prime focus of the Lookback Review. These should outline the arrangements for securing expertise in Communication, Information, Legal Advices, Ethics and Public Patient

Involvement and the Input of Critical Friends. It should be formally approved by the Steering Group and kept updated with appropriate version control.

Recommendation 5

The Southern Health and Social Care Trust should expand its progress reporting template and agree with the UAG the content, format and frequency of reports to be provided throughout future phases. This should mirror content of internal reporting and include sufficient details on all material risks and their mitigations.

Appendix 1: An Overview of the Documents Requested by RQIA and returned from SHSCT during Review Phase I

RQIA Requested (Described in letter 6 April 2023)	SHSCT Provided: Name of File, Link and Date Received	Document Title
A timeline (breakdown by month) which sets out key events for example: the date that each stage in Cohort One began and ended (if completed); the dates when key groups assigned with oversight/ assurance of the Lookback Review were established, first met; the date the first internal outcome report was provided to the Lookback Review Project Steering group and when key members of the lookback process jointed the Lookback Team.	1.Timeline Cohort 1.pdf *Received 07.04.2023* Staffing Changes for the Urology Lookback Review 20230505 Updated File: Staffing Changes for the Urology Lookback Review 20230505 *Received 09.05.2023*	UROLOGY LOOKBACK REVIEW GANTT CHART FOR COHORT 1 Staffing Changes for the Urology Lookback Review 20230505
Confirmation that the outcomes and appropriate data are shared through to Board Level within the Trust.	December 2022 Trust Board Cover Sheet USI.pdf January 2023 Trust Board Cover Sheet USI.pdf March 2023 Trust Board Cover Sheet USI.pdf October 2022 Trust Board Cover Sheet USI.pdf September 2022 Trust Board Cover Sheet USI.pdf *Received 24.04.2023*	Update on Governance Concerns within Urology (Separate papers for respective dates)
A statement of purposed for the Access databased developed to store patent data involve in the Lookback Review (as per the presentation).	3. Statement of Purpose.pdf *Received 07.04.2023*	Standard Operating Procedure for Data Migration
Document titled - RQIA SCRR Review Recommendations Action Plan Summary.	4. RQIA SCRR Recommendation Action Plan Summary.pdf *Received 07.04.2023*	RQIA SCRR Review Recommendations Action Plan Summary Appendix Three

RQIA Requested (Described in letter 6 April 2023)	SHSCT Provided: Name of File, Link and Date Received	Document Title
	Updated Version Received 04052023	
Documents titled - Urology Lookback Review Private Patients Pathway (Patients in receipt of private health services provided by Mr Aidan O'Brian) Final Draft 23rd January 2023.	5 and 7. LBR Private Patient Pathway v7 230120.pdf *Received 07.04.2023*	UROLOGY LOOKBACK REVIEW PRIVATE PATIENTS PATHWAY (PATIENTS IN RECEIPT OF PRIVATE HEALTH SERVICES PROVIDED BY MR AIDAN OBRIEN) FINAL DRAFT 23 JANUARY 2023
Document titled - Southern Health and Social Care Trust Urology Public Inquiry Programme. Report for Urology Assurance Group (UAG, 17th November, 2022.	6a. UAG Update for 17 Nov Meeting.pdf *Received 07.04.2023*	Southern Health & Social Care Trust Urology Public Inquiry Programme Update Report for Urology Assurance Group (UAG) 17 November 2022
	6b. Annex A LBR Activity Report 20221104.pdf *Received 07.04.2023*	Annex A ACTIVITY REPORT (Summary of Lookback Detail / Outcomes)
	6c. Annex A cont'd LBR Update Narrative Report to Support Data 20221104.pdf *Received 07.04.2023*	Annex A Cont'd Urology Lookback Review - Update Report Summary of Progress 07 November 2022
	6d. Annex B Sub-Optimal Care Analysis 25102022.pdf *Received 07.04.2023*	Annex B SUMMARY OF SUB-OPTIMAL CARE REPORTED IN

RQIA Requested (Described in letter 6 April 2023)	SHSCT Provided: Name of File, Link and Date Received	Document Title
		PATIENT REVIEW FORMS1
Document titled - Urology Lookback Review Phase Two Options Paper as presented, 15 November 2022.	8. Options Paper for Urology Lookback Phase 2.pdf *Received 07.04.2023*	UROLOGY LOOKBACK REVIEW PHASE TWO OPTION'S PAPER 15 November 2022
Document tilted - Urology Lookback Review Cohort 2 – Project Plan, 23rd January 2022.	9. LBR Phase 2 - Project Plan v8.pdf *Received 07.04.2023*	Urology Lookback Review Cohort 2 - Project Plan 23 January 2022
Document titled - Southern Health and Social Care Trust Urology Public Inquiry Programme. Update report for Urology Assurance Group (UAG, 27th January, 2023.	10a. UAG Highlight Report - Activity Narrative for 27 Jan 2023 Meeting.pdf *Received 07.04.2023*	Southern Health & Social Care Trust Urology Public Inquiry Programme Update Report for Urology Assurance Group (UAG) 27 January 2023
	10b. LBR Summary - End of 2022 Year Position updated with 20 January activity.pdf *Received 07.04.2023*	UROLOGY LOOKBACK REVIEW SUMMARY & END OF YEAR POSITION (DECEMBER 2022) 12 JANUARY 2023 (Updated 23 January 2023 in line with new activity figures)
Document titled - Urology Lookback Review Activity Update- Narrative, 8th March 2023.	11a. LBR Activity Report for Steering Group Meeting.pdf *Received 07.04.2023*	TABLE A - ACTIVITY REPORT (Summary of Lookback Detail / Outcomes)

RQIA Requested (Described in letter 6 April 2023)	SHSCT Provided: Name of File, Link and Date Received	Document Title
	11b. LBR Activity Report Narrative.pdf *Received 07.04.2023*	Urology Lookback Review Activity Update – Narrative 8 March 2023
The first progress update report provided to the UAG.	20201029_RE CONFIDENTIAL UAG papers (30 Oct 2020)_ATTACHMENT *Received 09.05.2023*	Report for Urology Assurance Group 30 October 2022
	LBR Update Narrative Report to Support Data 20221104.docx.pdf *Received 24.04.2023*	Urology Lookback Review - Update Report Summary of Progress 07 November 2022
	UAG 230522 - STATS TABLE.pdf	N/A
	UAG Highlight Report - Activity_Narrative_for 7 March 2023_Meeting.pdf *Received 24.04.2023*	HIGHLIGHT REPORT Urology Public Inquiry Programme Update Report for Urology Assurance Group (UAG) 7 March 2023
	UAG Update 20052022 .pdf *Received 24.04.2023* *Received 24.04.2023*	Urology Assurance Group Update 23rd May 2022 Southern Health & Social Care Trust Urology Public Inquiry Programme Update Report for Urology Assurance Group (UAG) 17 November 2022

RQIA Requested (Described in letter 6 April 2023)	SHSCT Provided: Name of File, Link and Date Received	Document Title
	UAG Update for 20 Sept Meeting.pdf *Received 24.04.2023* Urology Lookback Review Activity Report 12092022.pdf *Received 24.04.2023*	Update Report for Urology Assurance Group (UAG) 20 September 2022 ACTIVITY REPORT (Summary of Lookback Detail / Outcomes)
A copy of the communication strategy put in place for all patients of the Lookback review by the Lookback Review Lay Reference Group or, confirmation if not available.	*102020 FAQs for Review in Urology* Urology LBR Communications Engagement Plan v1 Urology LBR Phase 2 outline Comms Plan 20230424 *Received 26.04.2023*	FAQs Urology October 2020 SOUTHERN TRUST UROLOGY LOOKBACK REVIEW COMMUNICATIONS AND ENGAGEMENT PLAN Urology Lookback Review. Phase 2 Corporate Communications Strategy 2023
A copy of the template used to review / triage patients as part of the Lookback Review (as per image in presentation) .	14. Patient Review Form Triage Outcomes Form V2 (002).pdf *Received 07.04.2023*	Patient Review Form Triage Outcomes Pro-forma (version 3 as of April 2023)
A copy of the template used to review / triage patients as part of the Lookback Review (as per image in presentation) .	15. Revised Terms of Refefence Urology Assurance Group.pdf *Received 07.04.2023*	UROLOGY ASSURANCE GROUP TERMS OF REFERENCE
Urology Lookback Project Steer Group- Terms of reference.	16. Draft ToR Urology Lookback Steering Group.pdf *Received 07.04.2023*	TERMS OF REFERENCE LOOKBACK REVIEW (LBR) STEERING GROUP

RQIA Requested (Described in letter 6 April 2023)	SHSCT Provided: Name of File, Link and Date Received	Document Title
Urology Services Programme structures: Public Inquiry Structure; Lookback Review and Quality Assurance; Operational and accountability framework.	17. Programme structure.pptx *Received 07.04.2023*	Public Inquiry Programme Structure (Incorporating the Urology Lookback Review & Quality Assurance); and Urology Lookback Review Operational and Accountability Framework
Requested during 22 March 2022 Meeting – Copy of presentation on screen	22032023 RQIA Presentation.pdf *Received 24.03.2023*	Urology Lookback review RQIA Presentation
Outcomes and Data shared with Trust Board	*Trust Board Cover Sheet USI: October 2022, September 2022, December 2022, January 2023, March 2023* *Received 24.03.2023*	September 2022_ Trust Board Cover Sheet USI October 2022_ Trust Board Cover Sheet USI December 2022_ Trust Board Cover Sheet USI January 2023_Trust Board Cover Sheet USI March 2023_Trust Board Cover Sheet USI
Update Reports provided to UAG	*Update Report provided to UAG* *Received 24.04.2023*	20201029_RE CONFIDENTIAL UAG papers (30 Oct 2020) ATTACHMENT (Received 09.05.2023) LBR Update Narrative Report to Support Data 20221104.docx UAG 230522 - STATS TABLE

RQIA Requested (Described in letter 6 April 2023)	SHSCT Provided: Name of File, Link and Date Received	Document Title
		UAG Highlight Report - Activity Narrative for 7 March 2023 Meeting UAG Update 20052022 UAG Update for 17 Nov Meeting UAG Update for 20 Sept Meeting Urology Lookback Review Activity Report 12092022

Appendix 2. Further Evidence SHSCT may wish to share before Review End Proper

	Evidence type
1.	Documentation on methodology for identification of 2112 patients, where was this scrutinised endorsed and documented in Trust

Appendix 3. Southern Trust action plan against SCRR Review Recommendations Summary

Updated Version Received 04052023

Total Number of Trust Actions Required = 25

Date	RAG Rating	Number
24/10/22		8
		14
		3
18/11/22		9 ↑
		13 ↑
		3 =
16/12/22		18 ↑
		5 ↓
		2 ↓
03/02/23		18 =
		6 ↑
		1 ↓
20/03/23		20↑
		4↓
		1=
24/04/23		22↑
		2↓
		1=

RQIA SCRR REVIEW RECOMMENDATIONS IMPLEMENTATION PLAN

RECOMMENDATION 1				
1 (a) SHSCT should urgently update all relevant documentation to ensure that there is clarity regarding the SCRR including a description of the SCRR purpose, remit and process; explicitly stating that it is a separate process to any parallel Inquiries or investigations.				
Action Required to Deliver Recommendation(s)	**Responsible Officer[1]?**	**Update**	**Status RAG**	**Evidence pf Completion**
Update PID – with detail and purpose of SCRR,	LBR Project Manager (LE)	**20/10/22** – work commenced on this **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report
Draft a "stand-alone" summary of the background, purpose, objectives and process of SCRR	LBR Project Manager (LE)	**20/10/22** – work commenced **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report
1(b) SHSCT should review their arrangements for developing and quality assuring patient / family information materials and publicly accessible information to ensure there is adequate lay / service user involvement, communications expertise and, where beneficial, legal input.				
Add lay representation to the Urology Lookback Review steering and operational group.	Head of the Lookback Review (SW)	**20/10/22** – Lay representation sought via PPI team in Trust **18/11/22** - no further progress **16/12/22** – Two lay reps identified and joining Operational & Steering Groups	Complete	Emails confirming TOR
Patient / family information materials required for Phase 2 to be activity considered by Lay representatives and tested within other PPI forums either internal or external to Trust.	This is an action for the future – will be addressed and evidenced in phase 2			

[1] Responsibility for delivery this action plan sits with the SRO for the LBR who is chair of the LBR Steering Group (MOH)

RECOMMENDATION 2				
2(a) SHSCT should consider reviewing the composition of Lookback Review steering group to reflect that which is stated within Regional Guidance for				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Reorganise structures for the LBR process and reset role and function of steering group including membership	Chair of Steering Group (MOH)	**20/10/22** – complete	Closed	- Terms of Reference for Steering Group - Diagram of new structure
2(b) SHSCT should establish a dedicated project team for the management and co-ordination of SCRR. SHSCT should recruit people with the skills and				
Lookback Review in line with project management principles and processes. Draft PID to summaries the LBR process	Chair of Steering Group (MOH)	**20/10/22** – complete – new structure and process	Closed	- PID - New structure and process in place to include clarity on reporting and accountability

RECOMMENDATION 3				
Considering the need for dedicated co-ordination and management of the Lookback Review and the SCRR process; SHSCT should prioritise the				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Appoint project manager to oversee the implementation of the Lookback Review in line with project management principles and processes	Chair of Steering Group (MOH)	**20/10/22** – complete LE in post from 1 September 2022 **27/02/2022** – LE completed PRINCE2 Foundation and Practitioner Training	Closed	- Staff in post - Certificate of P2 completion

RECOMMENDATION 4				
4(a) SHSCT should define and explicitly state the purpose of the SCRR process. Furthermore, a clear Terms of Reference / set of objectives should be				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Same as per recommendation 1(a) above	See recommendation 1(a) above	**20/10/22** – work commenced **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report

RECOMMENDATION 5				
5(a) SHSCT should give urgent consideration to extending their Lookback Review to identify and recall further groups of patients. DoH / Urology Assurance Group / SPPG, PHA and RQIA should work together to support SHSCT with the Lookback Review.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Draft options paper for extending the Urology Lookback Review and progress with option agreed by UAG.	Chair of Steering Group (MOH)	**20/10/22** – work commenced **18/11/22 –** Options paper shared with UAG on 17 November	Complete	Options paper
5(b) RQIA should consider undertaking an independent assessment of Trust arrangements for the Urology Lookback Review in order to provide assurance on its effectiveness and identify any areas for improvement.				
RQIA to action not Trust				

RSC requested – not accepted SCRR process is currently outsourced to individual external urologists accessed via BAUS. Request to be made to RCP	Dep MD (DG)	**20/10/22** – unable to secure RCS to undertake this work, **18/11/22 –** IS (3FiveTwo) sourced – IS contract being urgently drawn up to commission this work **16/12/22 –** IS now being utilised		Emails from RSC Emails with BAUS First tranche (14 cases) passed to IS on 13 December

RECOMMENDATION 7				
SHSCT should consider implementing a sampling approach to case selection for SCRR. Such an approach should be agreed with DoH / Urology Assurance Group / SPPG. SHSCT should be clear on the rationale, its benefits and limitations and ensure that there is openness and transparency in communication with patients, families and the public. SHSCT should engage the Clinical Ethics Committee to consider any ethical issues arising from such an approach which can then be addressed and mitigated by SHSCT				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Sampling approach to case selection for SCRR to be included in the options paper on progressing with the SCRR process for consideration by UAG	Chair of Steering Group (MOH)	**20/10/22** – work commenced – **18/11/22** – to be further clarified when IS contract in place **16/12/22** – All of the outstanding cases (29) of the original 53 cases will be passed to IS. Consideration will be given to sampling the remaining 38 plus any new SCRRs added at screening in the NY **03/02/23** – Now 125 SCRR in total (potential for up to a further 9 which are planned for screening – which when	Closed	

		compete finishes screening for cohort 1. A paper to be drafted for UAG to consider sampling of the current outstanding 72 SCRR cases. **20/03/23 –** All original 53 index SCRR cases are now completed. Comparative review has been completed. Direction from UAG as of 13.02.23 is to move to a "targeted" approach to the remaining SCRR cases. LBR Team currently assessing those remaining cases for determination of issue and if this is a new theme.		

RECOMMENDATION 8				
SHSCT should request SHSCT Clinical Ethics Committee to review both current and proposed arrangements for the Lookback Review and SCRR. Where ethical issues are identified, SHSCT should give this due consideration and, where required, adapt the methodology and approach for the review.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Papers on SCRR and extending the Lookback Review to be shared with Trust ethic committee when complete	TBA	**20/10/22** - Not yet commenced – to discuss with new Medical Director when he takes up post **18/11/22 –** no update **16/12/22** – no update **03/02/23** – a seating of the ethic committee to be arranged to consider ethical considerations of Cohort 2 **24/04/23** – not considered necessary as both agreed by UAG.	Closed	Minutes of UAG from 7 March 2023

Share SCRR related papers with DLS	Chair of Steering Group (MOH)	**20/10/22** - Current SCRR process arrangement shared with DLS. The options paper on the way forward re SCRR will be shared with DLS when complete and prior to discussion with UAG. **18/11/22** – to be further considered if SCRR to change when IS contract in place. **16/12/22** – unchanged **03/02/23** – paper referred to above under recommendation 7 to be shared with DLS when complete **23/3/23** – shared with DLS and USI		Email to DLS dated 23/3/23 & in document in USI discovery folder

RECOMMENDATION 10				
SHSCT should review their arrangements for the involvement of patients and families to ensure that it fulfils its statutory duty of Personal Public Involvement. SHSCT should consider engaging those with Personal Public Involvement expertise and external partners such as the PHA who have PPI training resources for staff and the PCC who could provide advice and support in the involvement of patients and families as part of the Lookback Review and SCRR.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
As per recommendation 1(b) add Lay representation to the Urology Lookback Review steering and operational group. Provide information and bespoke induction of new Lay representatives to assist in contributing to the Lookback Review	Head of the Lookback Review (SW)	**20/10/22** – Lay representation sought via PPI team in Trust **18/11/22 –** no update while Head of LBR is unavailable **16/12/22** – Two lay reps identified and joining Operational & Steering Groups	Complete	Meeting with Head of LBR and 2 lay reps Information pack

RECOMMENDATION 11				
SHSCT should review their arrangements for sharing SCRR findings with patients and families giving consideration to good practice as outlined by the				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Share current process for communicating with patients / families re SCRR outcomes with DLS for feedback and advice.	Chair of Steering Group (MOH)	**20/10/22** – [redacted]	Completed & Closed	Email from DLS (21/7/22)

RECOMMENDATION 12				
SHSCT should liaise with RCP and consider amending the Structured Clinical Record Review tool to include an assessment of the quality of documentation and an assessment of the documented communication with patients and families; the clinical team, MDT and primary care. SHSCT				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider the above recommendation	Chair of Steering Group (MOH)	**20/10/22** – recommendation considered and decision taken not to change SCRR inter-process as calls into question the validity the work done previously.	Closed see below re next phase of LBR	
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applies at that time.	This is an action for the future – will be addressed and evidenced in phase 2			

RECOMMENDATION 13				
DoH should commission RQIA to undertake a Review of Governance Arrangements within Urology Services in Southern HSC Trust.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
DOH to action not Trust				

RECOMMENDATION 14				
14(a) SHSCT should not be limited to consultant urologists when recruiting clinical reviewers to undertake the SCRR process. All Expert Reviewers should be provided with guidance and support, including an opportunity to debrief, feedback and avail of emotional / psychological support if required.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Establish if RCP can facilitate the SCRR process	DMD (DG)	**20/10/22** – await feedback from RCP **18/11/22 –** no further feedback – response chased **16/12/22 –** Complete – IS contract in place	Complete	Contract Returned reports from IS
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applies at that time.	This is an action for the future – will be addressed and evidenced in phase 2			
14(b) A document should be drafted specific to this particular piece of work to guide reviewers through the process of conducting the SCRR; this should include a defined protocol for the assessment of the quality of care and treatment.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Review the document that currently exists for the SCRR reviewers and update it in terms of good practice identified in RQIA review document as the basis for further review should SCRR continue to be utilised in the extended Lookback Review.	Project Manager (LE)	**20/10/22** – This work has commenced **18/11/22 –** Being prepared to support IS contract **16/12/22** – draft guideline shared with IS as part of contracting process	Closed	IS Contract Contract monitoring notes

14 (c) A sample of cases already reviewed using the SCRR methodology should undergo a second review to ensure inter-reviewer reliability and				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider this action	Chair of Steering Group (MOH)	**20/10/22** – recommendation considered – due to lack of SCRR reviewers it is not possible to undertake a second review of a sample of the returned SCRR reports. For this cohort of patients a comparative analysis of reasons for SCRR verse findings from SCRR has been undertaken and both align	Closed see below re next phase of LBR	SCRR theming analysis
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applied at that time.	This is an action for the future – will be addressed and evidenced in phase 2			

RECOMMENDATION 15				
A review panel should be constituted, for the specific purposes of identifying learning and determining recommendations arising from the SCRR				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Commission a "Thematic Review" undertaken when all 53 SCRR reports and complete.	Medical Director	**20/10/22** – an external urologist identified to complete this work when the report are returned. Currently on 24 of the 53 reports have been returned. **18/11/22 –** no further SCRR returned **16/11/22** – Meeting with Dr Sally Williams on 13/12 – Dr William agreed to coordinate a thematic Review when SCRR complete **03/02/23** – five outstand SCRR returns. Dr Williams to be contacted to start process for undertaking a thematic review **20/03/23-** Contract pending with Dr Sally Williams with support of the IS SME's who undertook the completion of the SCRR reports. **24/04/23** – DAC being drafted – delayed due to checking if an external urologist would complete negating need for a DAC	Ongoing	
Provide an analysis of the themes identified by Trust senior doctors through the internal "SCRR Screening" process and complete to themes identified external SCRR urologists	Head of the Lookback Review (SW)	**20/10/22** – Complete and will be kept up to date as reports are returned	Closed	Up to date report available

RECOMMENDATION 16				
SHSCT should work with DoH / SPPG / PHA to develop an effective dissemination strategy for the Lookback Review and SCRR so that learning is				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Agree and document the process(s) for disseminating regional learning following the Lookback Review for consideration by UAG	Head of the Lookback Review (SW)	**20/10/22** – work commenced **18/11/22 –** no update to report **16/12/22** – no further progress **03/02/23** – no further progress as cohort 1 still to complete. **20/03/23 –** date agreed for Learning and Development Group this month. HOS will attend to disseminate from LBR Process. (Update from meeting will be reflected in next action plan update) **24/04/23** – learning to be shared following completion of Cohort 1 outcomes report.	Ongoing	
Update Communication plan to include this aspect of communication	Project Manager (LE)	**20/10/22** – cannot commence until above action completed **16/12/22** – no change **03/02/23** – no change **20/03/23** – no change **24/04/23** – no change – Outcomes report due end May for discussion and agreement at UAG on 7 June 23	Not started	

RECOMMENDATION 17				
SHSCT should draft a statement of purpose for the new database, outlining the rationale for transferring data and should retain a copy of the redundant				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Draft a "Statement of Purpose"	Project Manager (LE)	**20/10/22** – Copy in draft awaiting review and sign-off **18/11/22** – no update to report **16/12/22** – not signed off until cross-reference against template requested from BOH (via RQIA) – not yet received **03/02/22** – database developer completing – request made for draft to be shared **20/03/23** – Document Finalised	Complete	Statement of Purpose document

RECOMMENDATION 18				
18(a) SHSCT should urgently develop and implement a communication strategy specific to the Lookback Review and including the SCRR process				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Draft communications strategy including communication plan	Communications Manager (PT)	**20/10/22** – draft plan complete – awaiting review and sign-off **18/11/22 –** no update to report **16/11/22** – Phase 1 plan complete – will be revised for Phase 2	Complete and closed	PID including phase 1 comms plan
18(b) A channel of communication specific to Urology work streams should be established between SHSCT, PSNI, GMC and Coroner's office; SHSCT should ascertain the thresholds for referral in respect of specific concerns arising out of cases reviewed as part of the SCRR.				

Action(s) Required to Deliver Recommendation(s)	Responsible Officer?	Update	Status RAG	Evidence pf Completion
Consider above recommendation		**20/10/22** – channel of communication currently exists with GMC and USI. Communication with PSNI and / or coroner not warranted at this time – this will be established if required in the future.	Complete and Closed	Emails and documents shared with GMC and USI.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
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EA 01/17

RECEIVED 04/01/2017

ANNEX A

Initial call made to (DHSSPS) on (DATE) Dr Michael McBride informed by letter — 30th December 2016

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name	Dr Richard Wright	Organisation	SHSCT
Position	Medical Director	Telephone	Personal Information redacted by the USI

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - please confirm report has been forwarded to Chair of Regional CPC.***

Under the Terms of Maintaing High Professional Standards the Southern Health and Social Care Trust has excluded a Doctor to allow a four week period to scope out the scale of potential issues in relation to the Doctors administraive practices, which may have had an impact on patients.

In the event of the identification any signifiant concerns resulting from the scoping process the Trust will provide a further update. Please do not hestiate to contact me if you require any further information.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact | Dr Richard Wright

Contact details:

Telephone (work or home) ..... Personal Information redacted by the USI .....

Mobile (work or home) .... Personal Information redacted by the USI .....

Email address (work or home) Personal Information redacted by the USI

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

---

FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable)

.....

General Medical Council

Information Sharing Template

Please find below an allegation of a system concern that the GMC has received, which we are sharing with you to support the Regulation and Quality Improvement Authority (RQIA) inspection programme and intelligence monitoring.

Date of complaint	03/04/2019
Date of incident	28/09/2018 – issues ongoing
Location:	Southern Health and Social Care Trust (Northern Ireland)
Category	N/A
Summary of concern	**Allegations include:** ■ A range of managers clinical and non-clinical staff (including senior managers and Directors) within the Acute Service Directorate were aware of concerns relating to a doctor not completing triage appropriately dating back several years. ■ The Trust carried out a local MHPS investigation (*Maintaining High Professional Standards Formal Investigation - Case Manager Determination*, dated September 2018) which found systemic concerns. A recommendation was made that the Trust should carry out an independent review of their admin processes at all levels with a view to improving them. However, to date it appears the Trust has not yet taken any action and the independent review of their admin processes has not yet started.
Sector **Concern Number**	**Secondary care** **CN1-2492851411**

Reason for information being shared:	The allegation provides details of potential system concerns which the RQIA may want to know about to supports its inspection programme
Contact information:	[redacted] **Safeguarding Referral Officer** **Fitness to Practise Directorate** General Medical Council 3 Hardman Street Manchester M3 3AW Direct line: Personal Information redacted by the USI Email: [redacted] Personal Information redacted by the USI

I would be grateful if you could notify us of any action taken in relation to this concern, so that we may ensure that our process for information sharing is effective and update our records accordingly.

Thank you for your co-operation, please do not hesitate to contact me should you have any queries.

CC:

Please note: The information shared is an allegation and therefore may be unproven. The system concern shared with RQIA colleagues is to support the RQIA inspection programme and intelligence monitoring and this information should not be shared further without first contacting the GMC.

The Regulation and Quality Improvement Authority

Assurance, Challenge and Improvement in Health and Social Care

Our ref: EH/LG/GM 020225

09 January 2020

Dr Maria O'Kane
Medical Director
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

Dear Maria

I write further to our telephone call which took place on Friday 8 November 2019 as RQIA have now been informed of a number of matters relating to services provided by the Southern Health and Social Care Trust. The particular service areas in the Trust which have come to our attention include obstetrics and gynaecology services, acute services and mental health services delivered in the Bluestone Unit. You have also indicated that the Trust has been managing an increased incidence of *Clostridium difficile* infection (CDI) on the Craigavon Hospital site, with CDI implicated in the deaths of two patients. We have also noted a recent Early Alert (EA 06/20) issued on the 7 January 2020 relating to the death of a patient with a suspected pulmonary embolism who presented in Daisy Hill Hospital Emergency Department.

Obstetrics and Gynaecology Services

On 8 November 2019 you advised RQIA that the Trust has made a request to the Royal College of Obstetricians and Gynaecology to undertake an Invited Service Review (ISR) of obstetrics and gynaecology services delivered in Daisy Hill and Craigavon Hospitals. We understand that this request follows a review of information brought to your attention through the Trust's whistleblowing arrangements and following receipt of feedback from NIMDTA. Your request for an ISR was also informed by internal discussion relating to the Trust's caesarean section rates and management of post-partum haemorrhage in one of the Trust's obstetric units.

I would ask that you keep us updated regarding the timing of, and progress in relation to, this Invited Service Review. I would also ask the Trust to share with RQIA the learning arising from this ISR, as well as the detail of any improvement plans emerging from this work, at your earliest opportunity.

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BT1 3BT

tel: 028 9536 1111
email: info@rqia.org.uk
web: www.rqia.org.uk
twitter: @RQIANews

Clostridium difficile Infections (CDI)

During our telephone call on 8 November 2019 you advised that the Trust has identified an increase in *Clostridium difficile* infections (CDI) in patients nursed on particular wards in Craigavon Hospital, CDI having been implicated in the deaths of two patients. You have confirmed that the Trust is managing this incident as if it were an outbreak and we note that the Trust submitted an Early Alert on 8 November 2019.

I would ask that you please provide us (RQIA) with a summary of the Trust's management of this incident, including a summary of all actions progressed. Please also detail any further actions the Trust intends to take to strengthen infection control practices and/or antimicrobial stewardship arrangements within the affected service areas or more widely across the Trust in general.

Concern Shared by the General Medical Council

As you are aware, we (RQIA) were contacted by the General Medical Council (GMC) on 6 December 2019. GMC shared information with us as the health and social care system regulator in Northern Ireland and in the context of the MoU jointly agreed between our two organisations. Information shared by the GMC indicated the Trust undertook a local MHPS investigation (Maintaining High Professional Standards Formal Investigation - Case Manager Determination) in September 2018, which identified what the GMC's note describes as 'systemic concerns'. The GMC's Employer Liaison Adviser (ELA) has recommended that the Trust share two reports with RQIA (in redacted form) in relation to this investigation.

I would ask that you please provide us (RQIA) with the details relating to the concern raised by the GMC. To date we have received no information from the Trust to enable us to assess this concern. Please include detail on the investigation undertaken by the Trust in 2018 and the full detail of specific actions that the Trust has taken and/or intends to take to address the concerns reported and the learning identified through that investigation. The information provided should also include details of any plans to undertake a review of the administrative processes within the Trust or the rationale underpinning a decision not to proceed with such a review (if this is/was the case).

Bluestone Unit

Following completion of our inspection of the Bluestone Unit on the 8 May 2019 we received a number of concerns and notifications relating to this unit and services delivered therein. We shared information on these with the Trust's Director of Mental Health & Disability (Mr B McNeany) by letter on 8 August 2019.

We have also been advised of completion of an Invited Service Review (ISR) of the Bluestone Unit undertaken by the Royal College of Phychiatrists in July 2019, following an ISR request made by the Trust. We met with Mr McNeaney and colleagues on 6 September 2019 to discuss the main themes emerging from this ISR and plans for delivering improvements within acute inpatient mental health services delivered by the Trust in Bluestone.

On 29 November 2019 we received the Trust's action plan relating to the recommendations advised by the ISR. Following receipt and assessment of both the ISR report and the related action plan shared by the Trust, we have determined the Trust's action plan (as currently set out) lacks detail and does not at this stage provide clarity about how the Trust will deliver the necessary improvements.

I would ask the Trust to please review the current action plan as shared with RQIA and to submit a comprehensive and sufficiently detailed plan to outline how each of the recommendations advised through the ISR, and the additional matters discussed during our meeting on the 6 September 2019, will be addressed going forward.

Early Alert (EA 06/20)

We have noted the information within the Early Alert and reference to the patient being suspected of having suffered a pulmonary embolism. We also note the recent surgical intervention within the Obstetrics and Gynaecology service which preceded her symptoms. We are concerned about a potential failure to identify the risk of postoperative thrombosis during the initial presentations. We understand that this will be investigated as a Serious Adverse Incident and would ask that you keep RQIA fully informed of the outcome of the investigation, any important learning identified and any plans to assure that learning is fully implemented.

In Summary

RQIA have been informed of a number of matters relating to services provided by the Southern Health and Social Care Trust on which we seek further clarity and/or updates; these are as outlined above. It would be most helpful if we could receive one single response from the Trust with regard to the above matters. We would therefore ask that the Trust's response is coordinated through you as Medical Director.

We would ask that this information be returned to us no later than 31 January 2020 to the following email address: [insert HSC programme email address] and copied to myself at Personal Information redacted by the USI and Ms Emer Hopkins, Deputy Director Improvement Directorate at Personal Information redacted by the USI.

Thank you in advance for your assistance with the above. It is our intention to review the above information and action plans in early February with a view to determining what further action we may need to progress.

Should you have any further queries please do not hesitate to contact my office on Personal Information redacted by the USI or through my email as advised above.

Yours sincerely

Personal Information redacted by the USI

Emer Hopkins
Deputy Director of Improvement obo
Dr Lourda Geoghegan
Director of Improvement & Medical Director

cc

Barney McNeaney, Director of Mental Health & Disability, SHSCT
Esther Gishkori, Director of Acute Services, SHSCT
Emer Hopkins, Deputy Director, RQIA
Lynn Long, Assistant Director, RQIA

Southern Health and Social Care Trust

Quality Care - for you, with you

14th February 2020 Ref: MOK/lw

Via email: [redacted] **and** [redacted]

Dr Lourda Geoghegan / Ms Emer Hopkins
Regulation and Quality Improvement Authority
5 Lanyon Place
Belfast

Dear Lourda / Emer,

RE: MATTERS RELATING TO SERVICES PROVIDED BY THE SOUTHERN HEALTH AND SOCIAL CARE TRUST

In response to your correspondence dated 9th January 2020 in relation to our telephone call that took place on Friday 8th November 2019 I have provided itemised responses to the matters raised below.

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Obstetrics and Gynaecology Services

As noted in your correspondence the Trust has made a request to the Royal College of Obstetricians and Gynaecologists to conduct an Invited Service Review (IRS) of the Trust's obstetrics and gynaecology services at both Craigavon Area and Daisy Hill Hospitals during 2020/21.

By way of context, the rationale IRS request is multifactorial which includes consideration of trainee feedback from NIMDTA, a recent ongoing whistleblowing concern investigation and internal discussions surrounding clinical data. Although to date there is no single item identified that specifically requires an IRS to be undertaken we believe that an external

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Tel: [redacted] Email: [redacted]

holistic review of our obstetrics and gynaecology services will help us provide a safer and increasingly patient centred service.

The Trust has written to the Mr Richard Pengelly, Department of Health Permanent Secretary for permission to proceed with engaging the Royal College of Obstetrics and Gynaecology IRS service, currently it is likely that at earliest this will take place is quarter 2, 2020/21 following the conclusion of Trust internal whistleblowing investigations. At a local level, the Trust has formed a senior Obstetrics and Gynaecology Oversight Group chaired by the Director of Acute Services to coordinate, support and oversee actions and responses with regard to feedback received and clinical data reviewed to ensure any areas that may require immediate response are tackled in a timely fashion.

The Trust will continue to communicate with RQIA regarding the timing of, and progress in relation to the IRS. Following the outcome of the IRS we will gladly share learning and details of improvement plans when available.

***Clostridium difficile* Infections (CDI)**

Also discussed on our telephone call on the 8th November I advised that the Trust had experienced an increase in Clostridium difficile Infections (CDI) during October 2019. To ensure an effective and appropriate response the Trust utilised the Trust Outbreak protocol and formed a CDI Action Group chaired by myself and the Director of Acute Services to oversee and implement actions to reduce CDI occurrence. To ensure awareness the Trust also raised an Early Alert on the 8th November 2019 regarding this increase. In summary, the actions taken to strengthen infection prevention and control practices include:

- Enhanced Environmental Cleaning
- Estate Services Environmental Improvements
- Review of Timeliness of Treatments for CDI Patients
- Enhanced Clostridium difficile Ward Rounds
- Review of Antimicrobial Stewardship Guidance
- Review of the Trust Dress Code Policy

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Tel: Personal Information redacted by the USI Email: Personal Information redacted by the USI

- Review of the Trust Infection Prevention and Control (IPC) Equipment Cleaning Guidance
- Coordinated Communications Strategy for Staff Regarding Good IPC Practices

The full Trust action plan in response to the CDI increase can be found attached as Appendix 1, a sustainability plan is also in draft which can be shared in due course. In addition to the immediate actions the Trust has also engaged the services of Dr [redacted], Consultant Microbiologist who is leading a short life CDI quality improvement review with a view to implementing long term, sustainable reduction in CDI occurrence. I would be happy to share the learning from this work with you when completed.

Since our discussion on the 8th November 2019 the Trust has experienced a significant reduction in CDI occurrences (Appendix 2, attached), however we remain vigilant and continue to monitor both Trust compliance with the CDI action plan and our CDI rates closely.

Concern Shared by the General Medical Council

The Trust undertook a local Maintaining High Professional Standards (MHPS) investigation in February 2017 in response to concerns regarding a member of Trust medical staff. This investigation was completed and recommendations made at the end of September 2018. The recommendations were in respect of the individual staff member and also about the relevant systems and processes. The recommendations included measures to monitor the timely management of clinical caseloads and assurance on the implementation of appropriate triage processes.

However, subsequent to the investigation the member of staff who is subject to the investigation has raised concerns regarding the MHPS process; these concerns are currently being managed via a relevant review mechanism. In the interim the Trust has taken steps to triangulate information from service user complaints, adverse incidents, serious adverse incidents and other local feedback regarding this member of staff to ensure any variations in clinical practice are identified in a timely manner.

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While the process to manage the concerns raised is still ongoing, there was a significant lookback exercise undertaken following an initial Serious Adverse Incident (SAI) review which lead to a further 5 SAIs in relation to this area of concern. These have concluded and have been approved by the Trust Acute Governance Team in association with the Medical Director. The recommendations from these SAIs are being combined with the suggested independent internal review highlighted in the MHPS process and is currently under discussion regarding timelines for completion.

The GMC Employer Liaison Service is aware of the status of this MHPS case and is being advised on progress as part of regular communications with the Trust.

Bluestone Unit

You correspondence refers to quality and service improvement activities with regard to the Trust Bluestone Unit for Mental Health and Disability Services. In particular these relate to:

- RQIA Inspection of the Bluestone Unit, 8th May 2019
- Royal College of Psychiatrists IRS, July 2019
- Meeting with Mr [redacted] and senior team 6th September 2019
- Trust action plan with regard to IRS submitted to RQIA 29th November 2019

In order to provide a comprehensive and detailed update on current improvement progress and planned activities please find attached an action plan (Appendix 3) regarding IRS recommendations, additional matters discussed with Mr [redacted] on the 6th September 2019 and RQIA feedback on the action plan received.

In relation to ongoing improvement work in the Bluestone Unit the Trust has recently implemented the NHS Safety Thermometer Tool for Mental Health and Disability Services which allows teams to measure service user harm and the proportion of service users that are 'harm free' during their working day. The information from this tool is used by Mental Health and Disability Services senior managers to further inform areas for service improvement and management of risk, a sample of this information is provided in Appendix 4.

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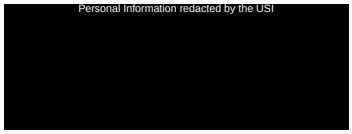
Early Alert (EA 06/20)

In relation to the early alert with reference to a suspected pulmonary embolism, the Trust is undertaking a Serious Adverse Incident review and will keep RQIA informed of the outcome, any learning identified and action plans required to implement learning in due course.

Finally, I would like to take this opportunity to further provide assurance that patient safety and quality of care remains the highest priority of the Southern Health and Social Care Trust. I welcome the opportunity to share learning from our experiences and will provide you with updates as our work progresses in due course.

Should you have any queries, please to not hesitate to contact me.

Yours sincerely



Dr Maria O'Kane
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI Email: Personal Information redacted by the USI

The Regulation and Quality Improvement Authority

Our ref: EH/GM/SHSCT

20 April 2020

Dr Maria O'Kane
Clinical Director
Southern Health and Social Care Trust

By email only

Dear Dr O'Kane

SHSCT Concerns

Thank you for your response received on the 14 February relating to a number of areas of concern which RQIA have been monitoring within the Southern Health and Social Care Trust.

We have analysed the information provided and acknowledge the actions that you have taken in respect of Obstetrics and Gynaecology Services and the Clostridium Difficile cases. We are broadly satisfied with the approach outlined and welcome the Trusts commitment to providing updates to RQIA as appropriate.

In relation to the concerns shared with RQIA on 6 December 2019 by the GMC relating to a Maintaining High Professional Standards Investigation between February 2017 and September 2018, we appreciate the detail you have provided on actions taken by the Trust in response to the concerns raised. We have not, as yet, been briefed on the full detail of these concerns; however we trust that you will make us aware of any issues impacting on the current care delivery and effectiveness of the governance arrangements within this service.

In respect of concerns relating to Bluestone unit, you will be aware that RQIA recently conducted an inspection of this unit 14 February 2020 and the Trust received feedback in relation to our findings on the day of the inspection (14 February 2020). The Trust will be provided with an Inspection Report and Quality Improvement Plan in due course.

We recognise the continued challenges that exist within this unit and we will continue to monitor the effectiveness of the Trust's actions through our follow-up inspections and your response to the Quality Improvement Plan.

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The Regulation and Quality Improvement Authority

Yours Sincerely

[redacted]
Personal Information redacted by the USI

Emer Hopkins
Acting Director of Improvement

Cc [redacted], Assistant Director, RQIA
[redacted], Senior Inspector, RQIA

The Regulation and Quality Improvement Authority

Our ref: BD/CS

10 August 2023

Professor Sir Michael McBride
Chief Medical Officer
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

By Email: [redacted] Personal Information redacted by the USI

Dear Professor Sir Michael

Regulation of the Independent Healthcare Sector: Independent Clinics

As discussed with Christine Collins, Authority Chair, I am writing formally to advise the Department of Health of a change to RQIA's current practice in respect of the registration and regulation of Independent Medical Clinics under the HPSS Quality, Improvement and Regulation (Northern Ireland) Order 2003 and relevant regulations made under that Order; and to ask for urgent consideration to be given to the making of new Fees Regulations, to increase the fees levied to the full cost recovery levels mandated by Managing Public Money Northern Ireland.

This follows an extensive review of RQIA's current procedures and processes in this area, prompted by concerns raised, inter alia, by the operations of "Pregnancy Advice Centres"; by the findings of the Public Inquiry into Neurology; and by consideration of the practices revealed by the investigations around Dr Aidan O'Brien's activities, now subject of the Urology Public Inquiry.

RQIA's historic approach to regulation of the independent health sector provides a "de facto" exemption from registration of Independent Medical Clinics or Agencies where the **doctors** providing the **service** had an established connection of some kind with HSC bodies - either through contracts of employment with one of the Trusts; or by way of a contract with the HSCB/ SPPG, as a member of the General Practitioners Performers List.

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However, recent independent Legal Advices from Counsel show that this approach is flawed, as it does not comply with the primary legislation, the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, or subordinate legislation, The Independent Health Care Regulations (Northern Ireland) 2005.

The Legal Advice is clear that the key consideration in deciding whether or not registration of an establishment is required is whether the services to be provided there are "for the purposes of the 1972 Order" (i.e. ultimately, are provided by the Department in pursuance of its duty to provide health services for the public in Northern Ireland).

Any services which are not provided for "the purposes of the 1972 Order" are required to be registered. Considerations around any employment/contractual relationship there may be elsewhere, between a clinician concerned and an HSC body are irrelevant.

The Authority has considered this matter most carefully, and having read the legislation, it is clear that the Legal Advices must be accepted. To protect patient safety, purposeful remedial action must be taken, through a carefully managed programme bringing RQIA into compliance with its legislative mandate and duty.

The Authority recognises that this remedial action has to be taken forward with sensitivity, in liaison with the key stakeholders, including other regulators and representative bodies. The Chair and I would value your support as Chief Medical Officer in approaching this exercise; and the Chair has asked that a meeting be arranged with you to consider the broad thrust.

A first step in the process will be to scope the scale of the sector, followed by the need to update RQIA's current Registration Decision Making Protocols. It will be necessary to plan and commence an information and engagement exercise for these services, in close collaboration with the other regulators and other interested parties. Further steps will be needed in due course to promote publicly the requirement to register.

Obviously, this will increase RQIA's workload. Initially at least, additional resources will be required, and I will submit a Business Case for this, for the current year and for the 2024/5 year, as soon as possible.

Of course, once underway, registration itself will bring in some additional fee income. As Accounting Officer I am mindful of the requirements of Chapter 6 of Managing Public Money NI; and its requirement for Full Cost Recovery (including, in the case of regulators, of the ongoing costs of regulation) for services provided by the public sector to the independent sector. Full Cost Recovery is a long-established policy position, with few exceptions.

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Clearly, the full cost recovery element in the current 2005 'Fees and Frequencies' Regulations can be readily distinguished from the "frequency of inspection" element.

The Authority accepts that the "frequency of inspection" element raises distinct policy questions around the preferred methodology to achieve satisfactory levels of public assurance that standards are being met, and this requires fresh public engagement, as the previous consultations in 2015/16 must now be considered outdated.

However, if the costs of RQIA's carrying out its statutory functions cannot be met from other sources, is it possible (indeed, necessary) to meet them by making amending Fees Regulations by negative resolution procedure without requirement for further consultation or prior Ministerial approval? As I understand it, such Regulations would do nothing more than implement the existing, well established MPMNI policy and directive, and help provide funds for RQIA to perform its statutory functions, as set out in its founding legislation.

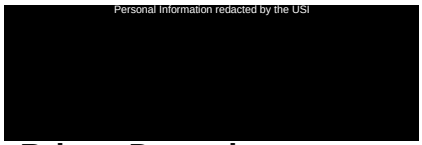
I plan to commission work to establish the costs concerned, across the gamut of RQIA functions, drawing on the Strategic Outline Case previously submitted to the Department in August 2022. I will provide the Department as soon as possible with the results and a suggested scheme for new Fees Regulations, which would bring RQIA into compliance with the requirements of MPMNI.

The Private Health Care Sector in Northern Ireland is growing rapidly and is now a regular provider of services on which people in Northern Ireland rely. It is, in the view of the Authority, essential that RQIA provides an equivalent level of scrutiny over this sector to that provided by its fellow regulators across the UK. Accordingly, it is essential that RQIA has access to funds (ideally through fee income, as provided for in the 2003 Order and in MPMNI) to enable it to do so.

The Authority appreciates that the required corrective action to regulate independent clinics must be taken forward expeditiously. As agreed with the Chair, I look forward to discussing the issues and the way forward with you and your CMO Team as soon as possible.

In view of the Accounting Officer, MPMNI and financial elements, I am copying this to Peter May, and to Chris Matthews. With thanks.

Yours sincerely



Briege Donaghy
Chief Executive and Accounting Officer

The Regulation and Quality Improvement Authority

Copy to:

Peter May, Permanent Secretary
Chris Matthews, Deputy Secretary Corporate Governance and Finance
Professor Lourda Geoghegan, Deputy Chief Medical Officer
Kieran McAteer, Director Quality, Safety and Improvement Directorate

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ANNEX 1 DEFINITION

Extract from The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

"independent clinic" means, subject to paragraph (8), an establishment of a prescribed kind (not being a hospital) in which services are provided by medical practitioners (whether or not any services are also provided for the purposes of the establishment elsewhere), **but an establishment in which, or for the purposes of which, services are provided by medical practitioners in pursuance of the Health and Personal Social Services (Northern Ireland) Order 1972 (NI 14) is not an independent clinic**

5.—(1) For the purposes of the definition of independent clinic under Article 2(2) of the Order, establishment of the following kinds are prescribed –

(a)a walk-in centre, in which one or more medical practitioners provide services of a kind which, if provided in pursuance of the 1972 Order, would be provided as primary medical services; and

(b)a surgery or consulting room in which a medical practitioner who provides no services in pursuance of the 1972 Order provides medical services of any kind (including psychiatric treatment) otherwise than under arrangements made on behalf of the patients by their employer or another person.

(2) Where two or more medical practitioners use different parts of the same premises as a surgery or consulting room, or use the same surgery or consulting room at different times, each of the medical practitioners shall be regarded as carrying on a separate independent clinic unless they are in practice together.