Department of Health
An Roinn Sláinte
Männystrie O Poustie
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WRITTEN STATEMENT TO THE ASSEMBLY BY HEALTH MINISTER, MIKE NESBITT – THURSDAY 19 FEBRUARY 2026 – UPDATE ON DEPARTMENTAL POLICIES IN RELATION TO QUALITY AND SAFETY

(PLEASE NOTE THE STATEMENT IS EMBARGOED UNTIL THURSDAY 19 FEBRUARY 2026 AT 3 PM)

Supporting Patient Safety Culture and Empowering Our Workforce

Over recent decades, several public inquiries have highlighted systemic failings within health and social care, particularly around openness, transparency, and accountability. These inquiries have consistently recommended fostering a culture of openness and candour to improve patient safety and to help rebuild public confidence. My Department is committed to working with partners across the health and social care sector to deliver these improvements through a comprehensive programme of cultural and legislative change.

A well-supported workforce is central to achieving better outcomes for patients and service users. Evidence clearly demonstrates that staff who feel empowered, psychologically safe and valued are better equipped and more likely to deliver high-quality, compassionate care. Our strategic plans, including the 3-Year Plan and the HSC Reset Plan, prioritise cultural transformation as a foundation for safer services, supporting and empowering our staff, and improving patient experience.

Today marks a significant milestone on that transformation journey with the launch of the Being Open Framework for Health and Social Care [Being Open Framework for Health and Social Care in Northern Ireland | Department of Health]. The Being Open Framework provides a structured yet flexible approach to embedding openness, transparency, and accountability across the HSC system. Its core objectives include promoting compassionate and open communication with patients, families, and staff; creating psychologically safe environments where staff can speak up without fear;

supporting the identification and open sharing of learning and improvement; and supporting visible and inclusive leadership at all levels.

The Framework will further support and enable staff to act in accordance with their core HSC and professional values, and help ensure that they feel supported, encouraged and confident in doing so.

Alongside publication of the Being Open Framework itself, I am pleased to also publish the outcome from the public consultation in relation to the Framework. I am reassured that the consultation has shown overwhelming support for the Framework and its underlying intent and objectives.

The launch of the Framework today marks the beginning of a familiarisation period for HSC organisations, allowing them to prepare and begin to align activity in order to support implementation which will commence from 1 April 2026. My Department will provide regional support throughout this process, working with the HSC to deliver effective implementation and oversight arrangements. While we all recognise that cultural change is a journey, the Being Open Framework represents a decisive step forward in enabling and supporting such change.

Whilst I believe that lasting and impactful progress will depend on achieving genuine cultural change, I am also clear that legislation has an important role to play in reinforcing these efforts. In that regard, the public consultation exercise also sought views in relation to a statutory Duty of Candour for Northern Ireland.

Most responses supported the need for introduction of a statutory Duty of Candour and my department is progressing two important strands of work in this area aimed at building public confidence and underpinning and further strengthening a culture of openness, transparency and accountability across our HSC. Importantly, this ongoing work seeks to align Northern Ireland with the other UK nations in relation to both an organisational and an individual Duty of Candour.

Firstly, my officials are progressing work on an Organisational Duty of Candour Bill for Northern Ireland Health and Social Care organisations. This will require organisations

to act openly and transparently when harm occurs, and to ensure that families are informed promptly, compassionately and accurately.

Secondly, officials are collaborating with counterparts across Northern Ireland government departments and with the other UK nations on the Public Office (Accountability) Bill – often
referred to as the Hillsborough Law. This Bill will apply across the UK and across the public sector, including in health and social care, and will introduce new legal duties for public officials to act with honesty and openness. The UK Government has brought forward the Bill in response to institutional failings identified in major public inquiries including Hillsborough, Grenfell, Infected Blood, and Windrush.

The key aims of the Bill are to strengthen accountability and transparency across all public services including healthcare, introducing a range of new requirements including new legal and professional duties of candour, and new mandatory Codes of Ethics which will be sector specific - reinforcing accountability across public services.

Aligning Northern Ireland with the other UK nations in relation to duty of candour helps ensure consistency, clarity, and fairness while strengthening accountability and public trust and confidence. For me such alignment is key and also helps mitigate and minimise the risk of unintended consequences - for example unintentionally hindering recruitment and retention should Northern Ireland adopt a different regime to the other UK nations.

My Department will keep policy in relation to a statutory Duty of Candour under review in the period ahead, including consideration of any further legislation that may be necessary in this area.

Another priority piece of work which my Department is progressing in support of enhancing an open, just and learning culture is a redesign of the current Serious Adverse Incident (SAI) procedure.

I am pleased to be able to announce today delivery of an important milestone in that

project with publication of a Consultation Analysis Summary Report [Consultation Analysis Summary Report] which summarises the feedback from respondents. This follows a public consultation last year on a proposed new Patient Safety Incident Framework to replace the current SAI Procedure.

The consultation responses reflect strong and thoughtful engagement with the proposed framework and supporting documentation. Overall, there was strong support for the strategic direction set out in the consultation, with respondents endorsing the proposals as a significant step in helping to foster a culture that prioritises openness and is focused on learning to improve patient safety and the quality of care. As such, the core aims and objectives of the proposed new Patient Safety Incident Framework are fully aligned with and complement the Being Open Framework.

I want to thank everyone who took the time to attend the public consultation events and to respond to the consultation process – your feedback is highly valuable and is an important source of evidence and information moving forward.

My officials are now taking time to consider the consultation responses in greater detail to inform changes to the draft strategic Framework and associated documents. I expect that final documents will be available for my consideration in April this year and I look forward to providing more detail in due course. Following publication, a period of managed transition and implementation will commence.

I can also advise that, from 1 January 2026, the HSC is responsible for implementing the new Model Complaint Handling Procedure which has been developed by the Northern Ireland Public Sector Ombudsman. This new standardised approach will simplify the complaints process for service users and staff, promote early resolution, and further foster a culture that values complaints as opportunities for learning and improvement. This is another important development which aligns with our policy agenda by promoting openness, honesty, a focus on learning and better outcomes for both staff and the public.

I wish to also provide an update in relation to proposals, arising from the McBride/Hill report which I published in October 2025, to consider independent regional services for HSC staff to raise concerns. This issue was also explored as part of the Being Open Consultation exercise with a strong level of support expressed by respondents for an Independent Speaking up Guardian.

While there are existing policies which support staff to raise concerns, and legislation in place underpinning whistleblowing arrangements and aimed at protecting those that speak-up, we must never be complacent and I am keen that we must always continue to look for opportunities to strengthen and further enhance existing systems and arrangements. As such, I have asked officials to scope proposals in relation to a regional Independent Freedom to Speak Up service, and for a dedicated regional HSC Whistleblowing mechanism. This work will examine the current policy and legislative landscape to evaluate its sufficiency, and will take account of feedback from the Being Open consultation exercise and of best practice in other nations, to consider what enhancements are needed to deliver optimal arrangements. I expect to be in a position to provide a further update on these proposals later in 2026.

Governance and Systems

To help support and embed these changes effectively within and across our HSC Trusts, I can update that my officials are working with Trusts and Trust Chairs on the establishment of dedicated Patient Safety and Quality Committees within each Trust. These committees will be formal sub-committees of Trusts' corporate boards and will operate within a regionally standardised approach to fulfilling these key governance functions and principles. While all Trusts currently have established governance arrangements in place, the aim of these dedicated committees is to support and enable enhanced oversight and assurance on matters related to patient safety and quality. Further, the establishment of dedicated Patient Safety and Quality Committees directly addresses a key recommendation from the Independent Neurology Inquiry.

To further strengthen governance supporting patient safety and quality, my Department is also working to finalise an updated HSC Board Member Handbook, which serves as a comprehensive resource to support Board members in effectively

discharging their duties. The Handbook includes updated and detailed guidance for Board members on oversight and assurance arrangements in relation to patient safety and quality. It will be complemented by an updated training programme for Board members again with a focus on safety and quality improvement and related governance. These measures will ensure that patient safety remains the highest priority across all levels of leadership and decision-making within the HSC and they are key to further supporting hard working and dedicated Board members in the delivery of their roles.

I also wish to update that, again taking account of the level of support and the feedback expressed by respondents to the Being Open consultation exercise, I have asked that my Department work with stakeholders to consider and develop proposals for a Regional Patient Safety and Quality Committee. This Committee will build upon the new Trust-level Patient Safety and Quality Committees and will bring together leaders and expertise from across the HSC and Department to support collaborative joint working and oversight on strategic matters related to patient safety and quality, including supporting a whole-system focus on safety and quality culture and supporting continuous improvements across the region. I will say more about this important strategic opportunity in the months ahead as proposals are developed. These proposals may include the appointment of a Patient Safety Advisor, who would report directly to the Minister for Health.

Embedding an open and just learning culture is essential to help rebuild and restore public confidence and trust, and to improve patient safety, quality of care, and staff wellbeing. All of the policy commitments in this package need to be seen in the context of learning and thereby reducing the likelihood of any recurrence of the quality failings. This requires continued collective effort across all HSC organisations, supported by robust frameworks, legislation, and governance. It is clear that cultural change is a journey and cannot be achieved immediately - it demands sustained commitment, ownership, and leadership at local organisational level, and with strong continued support from the Department. My Department and HSC organisations remain fully committed to this journey, ensuring that openness, transparency, and learning become hallmarks of our health and social care system.

patient safety learning

The Patient-Safe Future: **A Blueprint for Action**

Contents

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Executive Summary

Place the quality of patient care,
especially patient safety,
above all other aims.

Don Berwick, 2013[1]

Patient Safety Learning seeks to transform thinking and action for patient safety

Patient Safety Learning is a charity and independent voice for improving patient safety. We harness the knowledge, enthusiasm and commitment of health and social care organisations, professionals and patients for system-wide change.

We use what we learn to envision safer care. We recommend how to get there. Then we act to help make it happen.

A Blueprint for Action describes the path to a patient-safe future

Our previous Green Paper, *A Patient Safe Future*[3], identified systemic causes of patient safety failure.

A Blueprint for Action builds on this analysis to describe the actions needed to make the patient-safe future a reality.

5,526

Patients reported to have suffered serious, life-changing harm in the year to Sep 2018 due to unsafe care[2]

Patient safety is a major and persistent problem

Every year, avoidable harm leads to the deaths of thousands of patients, each an unnecessary tragedy. Unsafe care also causes the long-term suffering of tens of thousands and costs the health service billions of pounds.

Many people have been doing good work over the last 20 years, but patient safety remains a persistent problem. We propose that health and social care need to think and act differently to make the transformational change needed to realise a patient-safe future.

£2.2bn

direct cost to the NHS of clinical negligence in 2017/18[4]

Patient safety is part of the purpose of health and social care

Patient safety is typically seen as a strategic priority. This sounds important, but it means that, in practice, health and social care decision-makers will weigh (and inevitably trade-off) the importance of patient safety against other priorities, like finances, resources or efficiency.

We believe that patient safety is not just another priority: it is part of the purpose of health care. Patient safety should not be negotiable.

Systemic causes of unsafe care

We believe that patient safety fails for one or more of the following systemic causes:

- Patient safety is not regarded as a core purpose by leaders

- Organisations do not take ‘all reasonable and practical steps’ to improve safety.
- We don't have standards for patient safety in the way that we do for other safety issues, and those that we do have are insufficient and inconsistent.
- We focus too much on responding to, and mitigating the risk of, harm. We don’t pay enough attention and take action to design healthcare to be safe for patients and for the staff who work within it.
- We don’t learn well enough, share or act on that learning for patient safety.
- Staff working in healthcare are not ‘suitably qualified and experienced’ for patient safety and are not properly supported by leaders and specialists in safety design and human factors.
- Patients are not sufficiently engaged in their safety during care and after harm; patients need to be part of the team.
- We don’t have good ways of measuring and performance managing whether we are providing safe care.
- A culture of blame and fear undermines our ambitions to design and deliver safer care.

15%

of hospital expenditure and activity costs are estimated to be due to patient safety failure[5]

Foundations of patient safety

Patient safety is a system-wide challenge. We list below six evidence-based foundations for action to address the causes of unsafe care:

1. Shared learning for patient safety
2. Leadership for patient safety
3. Professionalising patient safety
4. Patient engagement for patient safety
5. Data and insight for patient safety
6. Just Culture

These foundations form the basis of our Blueprint for Action.

Summary of actions

The actions we are proposing build on these foundations and are described in more detail in the full report. A summary of these actions is set out below.

Action: shared learning for patient safety

Organisations should set and deliver goals for learning from patient safety, report on progress and share their insights widely.

We are creating *the hub*, an online platform and community for people to share learning about patient safety problems, experiences and solutions.

We research and report on the effectiveness of investigations into unsafe care.

Action: professionalise patient safety

Standards and accreditation for patient safety need to be developed and implemented. These need to be used by regulators to inform their assessment of safe care. We will work with the health and social care system to support the development of these standards.

A competency framework for patient safety is needed to ensure that all staff are 'suitably qualified and experienced'. We propose to work with Health Education England and others to develop this.

Health and social care organisations need specialist patient safety and human factors experts with leadership support, resources and governance. These roles must be clearly defined, with reporting lines to the Board (both Executive and Non-Executive). These specialists will help lead re-design for safety, as well as learning from unsafe care, patient engagement, complaints, near misses, clinical reviews and audits.

Guidance, resources and toolkits need to be developed and implemented with the support of specialist expertise in patient safety and human factors. We will promote and share these through *the hub*.

Action: leadership for patient safety

We call for overarching leadership for patient safety across the health and social care system. We propose a Leadership Forum for Patient Safety will lead the design and co-ordination of safe care and emphasise a systems approach and human factors. This forum should:

7-8

The number of serious harm incidents each year in which the RCGP estimates a typical GP will be involved[6]

- Develop practical models of leadership and governance for patient safety, including how patient safety risk assessments can inform decision-making and the business case for patient safety.
- Map current roles and strategic goals for patient safety.
- Co-ordinate patient safety networks and improvement programmes so that they are systemic in their implementation.
- Share learning.
- Support the development of standards, resources, tools, 'how to' guides, maturity models and self-assessment frameworks.

We recommend that all health and social care organisations publish annually their goals and outcomes for safer care.

We recommend that integrated care systems set standards for patient safety in service commissioning, care delivery and care pathway design.

We will work with the health and social care system to support strengthening leadership for patient safety.

Action: patient engagement for patient safety

We will work with the health and social care system to encourage and support the actions necessary to achieve the following:

- Patients need to be valued and engaged in patient safety at the point of care; if harm occurs; in investigating unsafe care; in the design of service improvements; and holding organisations to account for safer care.
- Organisations need to fund, recruit, train and provide ongoing support for patients engaged in patient safety advocacy.
- Organisations need to ensure that staff and leaders have the necessary knowledge, skills, attitudes and behaviours to meaningfully engage and involve patients in patient safety.

We will initiate development of 'harmed patient care pathways' for patients, families and staff following a serious incident.

We will help develop and support effective patient advocacy and governance for patient safety.

Hospitals which involved patients reported

38%

fewer harmful medical errors

46%

fewer adverse events[7]

Action: data and insight for patient safety

Models for measuring, reporting and assessing patient safety performance are needed that include quantitative as well as qualitative data. We will convene a panel of experts to identify the critical data and insight needed to measure and monitor patient safety.

We will work to ensure that patient safety is designed into digital health initiatives as a core principle, rather than an add-on.

Action: culture for patient safety

All health and social care organisations should develop programmes and publish goals to eliminate blame and fear, introduce or deepen a Just Culture and measure and report their progress.

We will celebrate great work and innovation for patient safety through our Patient Safety Learning Awards and *the hub*.

We can all play a part

Health and social care are complex systems and many organisations and people play a role in patient safety.

We need to better understand how we can all work together to address the systemic issues that cause unsafe care and harm.

It is clear that those below all have key roles in safe care:

- Health and social care leaders and managers
- Patient Safety / Risk Managers
- Frontline clinical and care staff
- System regulators, such as CQC and MHRA
- Professional regulators, such as the GMC, NMC, HCPC and many others
- Department of Health and Social Care
- Policymakers
- The Healthcare Safety Investigation Branch (HSIB)
- Networks representing provider organisations
- Think Tanks, such as the Kings Fund, Health Foundation
- Patients and the public
- Commissioners and funders

- National Patient Safety leaders, such as NHS Improvement
- Academic Health Science Networks
- Patient Safety Collaboratives
- Researchers and academics
- Human Factors experts and safety system designers
- Media
- Politicians
- Royal Colleges
- Arms-length Bodies
- NICE
- Freedom to Speak Up Guardians
- Charities
- Professional societies and associations
- Trade Unions
- Educators
- MPs and Parliament

and many others.

Only by working together can we create a patient-safe future.

1 Introduction

"To err is human, to cover up is unforgiveable and to fail to learn is inexcusable."

Sir Liam Donaldson[8]

A Blueprint for Action

Avoidable unsafe care kills and harms thousands of people each year[2]. To stand by while such suffering continues is intolerable.

A Patient-Safe Future showed that systemic action across inter-related activities is needed if we are to make patients safer. Following its publication, we consulted a range of people and organisations to get feedback on the analysis, vision and proposals it described.

This report, *A Blueprint for Action*, reflects the feedback we received and describes the actions needed to make patients safer. These include actions we call for others to take and actions that we at Patient Safety Learning will initiate.

We propose actions aimed at major causes of unsafe care. If we eliminate or reduce the causes of a problem, we eliminate or reduce the problem itself.

1 in 25

patient safety incidents result in severe harm[9]

Benefits of addressing causes of unsafe care

- If we **share learning** about patient safety, we will equip many more people with tools, insight and thinking that they can use to make patients safer.
- If we create a model of **leadership for patient safety** that is shared system-wide, we can ensure that organisations are led consistently to deliver and improve safer care for patients.
- If we **professionalise patient safety**, we ensure that everyone is informed and skilled in patient safety, including human factors and systems thinking. We can set and reasonably expect consistent standards of safer patient care.
- If we **engage patients in patient safety**, we can make health and social care safer as patients can offer continuity of insight through the stages of their care.
- If we have better **data and insight for patient safety,** we can understand our performance, make better decisions and take more effective action to improve patient safety.
- If we have a **culture for patient safety,** we greatly increase the openness and transparency needed to operate our organisations safely.

Underpinning all of these is the recognition that patient safety is part of the purpose of our care organisations. Only by making patient safety part of every decision – organisational, financial and, of course, clinical – will we achieve a patient-safe future.

The need for action

Efforts over the years attest that patient safety issues are not amenable to easy resolution. In part, this is a result of what has been termed the 'implementation gap,'[11] evidenced by the many cases that lead to well-researched and evidence-based recommendations, but from which little or no practical change obtains.

The case for action is compelling. It is made by each of the thousands of people dying or harmed each year, by the frustrations of staff working in unsafe systems and by the billions of pounds spent as a consequence of unsafe care.

Over the past 20 years, we have come to understand *what* the problems are. Various studies, including *A Patient-Safe Future*, have helped explain *why* patient safety problems exist and persist.

If we are to make the sustained, systemic changes needed to achieve a patient-safe future, we need to understand *how* to make them happen. This is the purpose of *A Blueprint for Action*.

We propose that with systems thinking, human factors and a focus on practical action, it is possible to make patient care safer. We want this report to help everyone who designs, delivers and receives health and social care to make the future safer for patients.

In this report, we describe actions that we think will make a real difference to patient safety. We have taken care to specify actions. We believe these actions are relevant, pragmatic and practical and that they will strengthen and speed up our journey to a patient-safe future.

40%

of NHS acute hospitals' core services,

37%

of NHS mental health trusts' core services, and

22%

of adult social care providers were rated as 'requires improvement' on safety at the end of July 2018[10]"

2 What we learned from *A Patient-Safe Future*

*"For me, safety cannot and should not be a distinct silo,
but run through everything we do;
for only then will it be sustained."*

Dr Matthew Inada-Kim[12]

"…patient safety is not just about statistics. Adverse events damage the lives of real people – patients and families – who are affected, harmed or die as a result of that unsafe care. Unsafe care also places a large and needless financial burden both on patients and on the health-care systems that treat them"

World Health Organisation (2013)[13]

Patient safety is a systems issue

A Patient-Safe Future showed that patient safety is a systems issue and that avoidable unsafe care has complex causes.

It identified the systemic causes of patient safety failure. It described a patient-safe future by showing what would be different if these causes were addressed. It also recommended actions to progress towards such a future.

A 90-day consultation started upon publication. Organisations and individuals were engaged directly and online to get their feedback.

A positive reception

Every response welcomed *A Patient-Safe Future* as a valuable contribution to thinking about patient safety.

Respondents said that they appreciated:

- The system-wide view.
- The use of evidence to drive conclusions.
- The concrete way in which the patient-safe future was described.
- The practical nature of the recommendations for action.
- Our proposal to develop and launch a learning platform for patient safety.

There was broad concurrence that action was needed against the five priority areas the Green Paper identified:

- Shared learning
- Professionalising patient safety
- Patient safety data
- Leadership
- Culture

Suggestions for more attention

Respondents suggested areas that they thought had been omitted or which they thought deserved greater emphasis. These included:

- More was needed about how patients can and should be involved for patient safety.
- Greater emphasis on systems thinking and human factors in addressing unsafe care
- The effect of pressure on resources on safe working
- Whistleblowing
- That 'care' encompasses health and social care

How *A Blueprint for Action* reflects what we learned

We reflect the feedback we received in a number of ways:

Patient engagement

We have added a new stream of work: *Patient engagement for patient safety*.

Systems thinking and human factors

The role of system-wide thinking is now more explicit, as is human factors.

Recognising the role of constrained resources and increasing demand in unsafe care

15%

of "…hospital expenditure and activity.." costs are due to patient safety failure[5]

The report recognises the demands on safety of what Liberati et al[14] called 'adverse structural conditions' (such as increased demand and constrained resources). It calls for decision-making about resources and the management of demand that treat patient safety as an explicit priority, minimising compromise in the pursuit of apparent efficiency or cost constraint.

Patient safety failure is itself a substantial cost. It harms patients, diverts clinical resources, increases stress for staff and generates costs that run to billions.

These additional costs can include:

- Additional care and support for patients and families.
- Time and cost associated with complaints and investigations that follow serious safety incidents.
- Time, legal costs and negligence payments to patients or families who litigate.

- Investigations that waste the time of clinicians, managers and patients because they do not lead to meaningful action.
- Duplication of the efforts of others who have already researched and resolved the same safety problems and solutions. Costs in replacing the services of staff suspended during investigation or following whistleblowing.
- Costs in replacing and training new staff where staff involved in incidents of unsafe care feel so traumatised or unsupported that they cannot return to work

Healthcare is not good at assessing and monitoring the full costs of unsafe care, despite the enormous direct costs it represents.

Unsafe care also represents a significant opportunity cost: resources consumed by patient safety failure are resources taken away from caring for others.

When demand on health and social care organisations and staff are growing, such direct and indirect costs are especially important. If resources are constrained, diverting resources from patients must affect the quality and safety of care.

We believe that a powerful business case for patient safety exists: that properly addressing the systemic causes of unsafe care will save costs and free up resources to serve patients better. We think this case needs to be made.

£2.2bn

Direct cost to the NHS of clinical negligence in 2017/18[4]

"The annual cost of…adverse events in England is equivalent to

2,000

GPs

or

3,500

hospital nurses"[5]

Value and protection of whistleblowers in patient safety

Whistleblowers have made a valuable contribution to bring patient safety issues and scandals to light. Many whistleblowers suffer unjust punishment in their professional and personal lives as a result of their decisions to do the right thing by speaking up for patient safety.

Two of our themes ('professionalising patient safety' and 'data and insight for patient safety') include actions to support whistleblowing and greater openness in raising concerns. We recognise, however, that more needs to be done and expect to see more actions to emerge as we engage on 'leadership for patient safety' and 'patient safety culture'.

We need to harness the insight of health and social care staff to improve safety and prevent harm. We should not turn our staff into whistleblowers. We need them to be able to share concerns and know that these will be welcomed, listened to and acted upon.

Patient safety in health and social care

Much work on patient safety focuses on healthcare and predominantly on acute care. More investment in research, policy thinking and design is

needed, however, for the safety of users of primary care, community care, mental health and social care.

We believe that the actions we propose to improve patient safety in health will, in large part, be relevant and valuable in social care. Safety in care needs not just to attend to absolute risks such as safeguarding and infection control but also the complex decisions that enable people to live with dignity and independence. Such thinking becomes especially important given the increasing aspirations to, and focus on, provision of integrated care.

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3 Patient Safety is a strategic purpose

"While we have, understandably, focused on specific, targeted initiatives, we have not made wholesale and sustainable progress. We have a long way to go in ensuring that safety is at the core of why every health care organization exists, and what every health care leader believes is their purpose. I describe this as moving safety from a priority to a purpose. A priority is something that we can rate . . . higher or lower. A purpose is timeless and non-negotiable."

Patricia McGaffigan, Institute for Health Improvement, 2018[15]

‘Patient Safety is a priority’ – is this the problem?

Patient safety persists as a problem because, at its heart, it is a systemic issue. We have identified six systemic reasons for patient safety failure, and we examine each of them in this report so that effective action can be taken.

But before we do, we think it worthwhile to consider another, more fundamental, factor to explain why current efforts to address patient safety are so hard to deliver and haven’t achieved the required results.

Health and social care organisations have many strategic priorities: financial priorities, policy priorities, regulatory priorities, patient safety priorities. These are weighed against each other and organisations and individuals decide which ones take precedence. The importance assigned to one in relation to another is a matter of choice.

If patient safety is considered a strategic priority, it, too, becomes a matter of choice. Health and social care organisations choose how much attention, time and resources they devote to patient safety, trading it off against their other priorities.

We know from variations in safety performance assessed by CQC[10] that some organisations pay more attention to patient safety than others. This makes patients who receive treatment in one organisation safer than patients who receive the same treatment in another.

We think it wrong that safety is negotiable. We believe that organisations need to demonstrate that they are taking ‘all reasonable and practical steps’[16] to deliver safe care.

Patient safety is part of the *purpose* of health and social care

The NHS constitution[17] makes several references to patient safety. For example, section 3a, *Patients and the public: your rights and pledges to you*, states:

“You (the patient) have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.”

It is striking, however, that this seems to fall short of stating that patients have a right to safe care, with patient safety as part of the *purpose* of care.

"Patients essentially want three things from their hospitals:
don't hurt me,
heal me,
and be nice to me.
And they want them
in that order."
Dr.Bala Chandrasekhar, 2019[18]

The shortfall is subtle, but it makes all the difference in the world. It leads to situations like these:

- How some organisations place responsibility for safety on the shoulders of clinicians and care staff, yet at the same time, they don't ensure that staff work in safe systems, they increase the volume and complexity of the clinicians' and care workers' jobs and then add insult to injury by blaming them when they make mistakes.
- How health and social care organisations measure the harm they do (for example, through the numbers of serious incidents of harm), instead of how safe they are.
- How we don't mine the rich knowledge that comes from reporting 'near misses' and other insights into opportunities for improvement to help us design safer care and to respond better when harm happens.
- How organisations say that patient safety is intrinsic to what they do, then make decisions that affect care (concerning, for example, resources, staffing, facilities or patient service) without explicitly assessing the impact on safety. If organisations don't make these assessments, then they could be making ill-informed and risky decisions without even being aware of it.

Commissioning, contracts and patient safety

Currently Clinical Commissioning Groups are the primary vehicle for the NHS England to spend its health budget.[19] CCGs plan, agree and buy ('commission') healthcare and some social care to meet local needs.

CCGs should therefore be a powerful force to ensure that healthcare is designed and delivered to enable safe care. What mechanisms do they use to commission care and ensure patient safety?

The NHS Standard Contract, published by NHS England, is used by CCGs to commission healthcare services.

The Standard Contract[20] is a template for commissioners to use with providers when negotiating contracts locally. Each contract is developed locally by each CCG and while some conditions are set centrally, CCGs have discretion to negotiate schedules, obligations and conditions within the framework of the Contract. The details of each contract therefore vary from CCG to CCG and provider to provider. Each contract is held at local level and decisions on how a particular contract is managed are made by the relevant commissioner. There is no national oversight on how patient safety is designed into these contracts although each trust has to produce a quality report covering clinical excellence, patient experience and patient safety. As part of this report, trusts are obliged to report on three

indicators of patient safety, with discretion about the ones that they choose to report.

Because the 191 CCGs spend the bulk of the NHS budget,[21] NHS England has a statutory obligation to assess the performance of each one through the CCG Improvement and Assessment Framework (CCG IAF).[22]

This assessment has consequences for each CCG. CCGs deemed to be failing or at risk of failing may be subject to legally binding direction.[23]

For 2018/19, the CCG IAF set 58 metrics against which CCG performance is to be assessed.[24]

Of these 58, only one explicitly refers to patient safety:[24] "*Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by CCGs.*"

Three more IAF metrics, it may be argued, invoke patient safety under the heading of 'Provision of high-quality care,' on the assumption that 'quality' in this instance includes patient safety.

The complexity of these funding and contractual arrangements and for monitoring and reporting appear to make variations in patient safety inevitable while at the same time making it harder to identify and address the shortfalls that result.

Safety needs to be core to commissioning and the processes and systems that it requires. It is not at all clear how this is the case today.

Planning and patient safety

The currently proposed long-term plan for the NHS is 120 pages long but mentions 'safety' only 23 times. The eight times it mentions 'patient safety' can be found all in section 6, in one paragraph (6.17.ix).[25]

Section 6 of the long-term plan also proposes major initiatives, such as standardisation of procurement; new diagnostic provision; efficiency programmes for community health, ambulance services, primary care and mental health; efficiency savings and automation for dispensing medicines; and standardisation of ambulance fleets. Each offers opportunities and challenges for patient safety.

Of these priorities, only one makes a single reference to patient safety. None emphasise safety or how these initiatives will serve to reduce avoidable harm and save lives.

And while we acknowledge that NHS Improvement has been tasked with developing a National Patient Safety Strategy, we remain struck that the long-term plan makes no reference to the need for a national strategy for

patient safety, or to the need for co-ordinated leadership with a clear map of roles and responsibilities.

If such thinking does not change, then patient safety will continue as it has until now: seen as important, yes, but clearly a secondary tier consideration.

If we are to achieve a patient-safe future, patient safety must be more than a priority for an organisation. It must be core to its purpose, reflected in everything it does.

The patient-safe future: patient safety as a purpose

In a patient-safe future, we will see patient safety as part of the purpose of health and social care:

- Organisations take responsibility for patient safety and treat it as a systems issue, owned by their leaders, patient safety experts, all clinicians and support staff.
- Health and social care organisations measure how safe they are so they can take corrective action.
- Organisations establish decision-making processes that demand explicit, evidence-based assessment of the impact on patient safety, selecting the option that offers the safest outcome for patients or explaining why.
- Health and social care initiatives explicitly include a positive impact on patient safety as an objective. They also include preventive actions to mitigate risks to patient safety.
- Strategies for patient safety are woven through every aspect of any plan for health or social care; a plan for health or social care is a plan for patient safety.

4 Shared learning

"Currently, there are few easy or straightforward ways for people or organisations to reliably share practical knowledge and lessons about safety improvement across a healthcare system.
Knowledge and improvements therefore often remain trapped in the organisations—or individual units—in which they are developed."

Carl Macrae, 2018[26]

Health and social care need to do more to learn for patient safety

In *A Patient-Safe Future*, we made the case that healthcare is systematically poor at learning from harm.

For example:

- Sometimes, when something goes wrong, we don't always analyse the issue effectively, so these investigations draw few meaningful conclusions.
- Or when we analyse an incident, we draw the wrong conclusions so that, for example, we blame people incorrectly when a problem is, in truth, the result of a systems failure.
- Or we analyse an incident correctly but don't act on the recommendations.
- Or we act on recommendations, but don't track how, or if, our actions have worked.
- Or we do investigate correctly and act effectively and track the results, but as we do not share these, no-one else can benefit from our success.
- Or perhaps we try to share our results, but others do not have a good, easy way to find out about them. This is part of what has been called the 'implementation gap' in patient safety[11] and is a feature of Sir Liam Donaldson's 'orange wire' test.[28]

This chain of failure has two effects.

The first effect is that different patients will be destined to suffer the same kinds of harm over and over.

The second effect is that even when we do find effective solutions to prevent avoidable harm, these are shared slowly, in piecemeal fashion, so that patients continue to suffer harm from problems that others have already addressed. This results in a post-code lottery of unsafe care.

Learning for patient safety is compromised further by the ways our current data gathering, analyses and action are almost entirely concerned with addressing patient harm after it happens. We believe that health and social care focuses on responding to unsafe care and the prevention of future harm. While this is welcome, a sole focus on harm means that we miss the important opportunity to design care for safety, to create the cultural, organisational and system conditions for safer care and to learn from those who have already started to do this.

Only

35%

of recommendations into safety incidents show how to reduce the chance of the incident recurring

CQC 2016[27]

"When a patient safety incident occurs, the important issue is not who is to blame for the incident but how and why did it occur. One of the most important things to ask is what is this telling us about the system in which we work?"

Charles Vincent, 2002[29]

If we are to secure a patient-safe future, we need to find ways of learning how to deliver care safely, as well as avoiding harm. In the jargon, we have to embrace and build on both Safety I and Safety II.[30]

Learning for patient safety is challenging

"There is no clear system for staff to learn from each other at a national level. Local reporting systems are often poor quality and do not support staff well. There are lessons that can be learned from other industries with simpler and more transparent reporting systems, backed up by a culture that drives good reporting."

CQC, *Opening the Door for Change*, 2018[31]

Learning, and the sharing of learning, for patient safety is a persistent problem for a range of reasons (after Carl Macrae[26]).

Improving patient safety isn't prioritised

Many staff might see the opportunity to improve safety but are either too busy to research and develop new solutions or feel disempowered or unsupported to do so.

Sharing learning isn't easy to do

"One of the serious deficits in the NHS of the past has been an inability to recognise that the causes of failures in standards of care in one local NHS organisation may be the way in which risk can be reduced for hundreds of future patients elsewhere."
Building a Safer NHS for patients, 2001[32]

Clinicians, researchers and patients in different organisations lack the facilities and time to come together to discuss incidents and issues and think through possibilities. Collaboration networks exist face-to-face and online, and there are conferences that focus on patient safety. But these are expensive in time and cost, and people find it hard to come together quickly and easily to share experience and learning.

We don't know who else has experience of a safety problem

Staff have few obvious and easy ways to locate and engage peers across the health and social care system with experience of similar problems or who may have worked on similar problems themselves.

We don't know who else has addressed a patient safety problem

Even if staff can carve out some time, they don't have quick and easy access to relevant information about similar problems, possible approaches or tested solutions. They risk duplicating work that others have already done.

Learning to improve safety is hard

Improvements and good practice are not shared

When an improvement happens, it is hard to let people in other organisations know about it. The result is that good practice can remain

isolated in one location while other organisations carry on working in old ways, exposing patients to the same avoidable harm and replicating the same investigations when patients suffer.

Introducing a change in practice is hard

To develop, trial, validate, document, secure approval for, and disseminate, change within the health and social care system takes a lot of time, effort and confidence. Many staff are too busy to take this on or lack the authority to lead such work. The Innovation Accelerator[33] and other initiatives have been set up to address this but the 'implementation gap' remains persistently wide.

We don't have a shared approach to thinking and learning about safety

Different organisations think differently about patient safety

Leaders and managers in different organisations do not have a shared and consistent understanding of patient safety. This can be seen, for example, in the different attitudes and adoption shown across health and social care for ideas such as human factors or Just Culture.

Different organisations learn differently

Mechanisms for organisations to learn from their performance and improve[34] do not operate consistently across health and social care.

We lack an easy, practical way to pass the orange-wire test

Mechanisms for rapid learning and action about safety-critical issues (to address the 'orange wire test') either do not exist, or if they do, such as with 'safety alerts',[35] there is evidence that these can struggle for attention against the avalanche of other information that bombards organisations and clinicians daily.[36]

HSIB

Concerns about a number of these issues were part of the rationale behind the establishment of the Healthcare Safety Investigation Branch (HSIB) in 2017 and some of the investigations and excellent ways of working that have followed.

The majority of investigations, however, continue to be conducted within and by individual healthcare organisations largely beyond the immediate remit of HSIB. As a result, many such investigations continue to reflect the issues described above.

Complaints are an untapped resource for patient safety

'One of the most shocking failures in NHS care was documented on 6th February 2013 when Robert Francis QC published his Public Inquiry into Mid Staffordshire NHS Foundation Trust. He found "a story of appalling and unnecessary suffering of hundreds of people" and added: "They were failed by a system which ignored the warning signs and put corporate self-interest and cost control ahead of patients and their safety."[2]

He wrote: "A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment."[3]

"A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint and undermines the public's trust in the service.'"

Ann Clwyd and Tricia Hart, A Review of the NHS Complaints System, 2013[37]

"66 per cent found their original report (of the investigation into their complaint) incorrect, inconsistent or substandard. They found levels of investigations below standard or that analysis was inconsistent or weak."

Patients Association, 2015[38]

"Having been involved in hundreds of policy and academic discussions about the quality and safety of health services over the years, I have found that the importance and value of complaints is seldom brought into the conversation."

Sir Liam Donaldson, 2018[39]

208,626

The number of written complaints made to the NHS in the year to March 2018[40]

Complaints made to the health service each year should be a powerful resource for learning about unsafe care. But complaints appear to be a largely untapped patient safety resource.

Complaints provide an opportunity to learn from something that has gone wrong. A shortfall in the quality and safety of care that led to a complaint should therefore act as a vehicle for remedial action, such as a review of processes and procedures followed by changes to the service concerned. When the service failure is of a kind that could, or did, occur in a number of similar settings, the beneficial changes that should flow from complaints need to happen both at the local level where the care was provided and throughout the NHS as appropriate.

Investigations must be better

Concerns about the quality of investigation, however, are not restricted to complaints.

"SI (Serious Incident) investigation in the NHS varies in quality and generally is done poorly."

NHS Improvement, 2017[40]

One of the best sources for learning from patient safety failure is supposed to be the investigation of serious incidents and near misses.

"Rapid, routine and systematic investigation of adverse incidents locally is essential to ensuring that local causal factors are understood and that there is local responsibility for making improvements".

Public Affairs Select Committee, *Investigating Clinical Incidents in the NHS*[41]

If the quality of these investigations is wanting, so will be the learning that follows.

Quality of investigations may fall short for a range of reasons:[42]

- Sometimes those doing the investigation lack investigative skills.
- Sometimes investigations don't properly consider the range of systems and human factors issues involved.
- It may be that investigations are not given the time they need to be thorough, especially if an incident is similar to others that have happened before.
- Or it may be that the organisation treats activities and issues other than investigation as higher priorities.

In sum, the barriers to learning from, about and for patient safety are high and not easily breached.

Only

12%

of incident investigations indicated that they had involved patients and families

Only

35%

of recommendations showed how to reduce the chance of safety incident recurring

Only

39%

of incident investigations included evidence of interviews with staff

Only

28%

of investigations recorded a risk assessment[27]

A patient-safe future: shared learning

"It is rare that organisations and professions try to learn from communities, and yet there is much to be learned from how healthy communities work."

Steve Shorrock[43]

If patients are to be safer, we need people and organisations to share learning when they respond to incidents of avoidable harm, and when they develop good practice for making care safer.

In a patient-safe future, we will see patients, clinicians, managers and health and social care system leaders share learning about safety practice and performance to make care safer.

In a patient-safe future:

People are enabled to learn

- **Learning is easy**

  When a new strategy, technique, tool, finding, method or process helps make patients safer, other organisations and individuals learn about it easily and quickly.

- **We learn how to improve performance**

  At every level in the health and social care systems, we routinely and systemically learn from their actions and so improve their own performance.

- **We know who we can seek advice from**

  When people working on patient safety want to discuss a problem or seek new ideas, they quickly and easily engage peers across the health and social care system.

Organisations enable learning

- **Comparative performance encourages improvement**

  Organisations compare their patient safety performance with similar organisations across the system.

- **Patients are engaged for learning**

  Organisations initiate, facilitate, encourage and support learning for safety with and by patients.

Improvement is supported

- **Tools and research are easy to find**

  Information about investigations, incidents, strategies, tools or solutions are found quickly and easily.

- **We learn which safety strategies work best**

  People can learn about, assess and compare different patient safety strategies, and know which ones have been proven to be effective.

- **When it works, we share how we did it**

  When a health and social care organisation develops and implements an effective patient safety strategy that makes a

difference, they share the ‘what’ and the ‘how’ with others. We close the ‘implementation gap’.

Investigations are consistently good

- **Investigations into unsafe care and responding to complaints are seen as important in learning to deliver safer care**

  Investigations have clear purposes and objectives that always include engaging with patients, families and staff with empathy, open communication, transparency and respect. When a patient formally complains, their complaint is managed promptly and respectfully.

- **Patients have informed, active participation in investigations**

  Patients have access to patient safety information and processes around patient safety, such as how investigations work and what to expect.

- **Investigations are done well**

  Investigations are efficient, prompt, rigorous and of a consistently high standard. Investigations use a range of analytic approaches, including systems thinking, critical thinking and human factors. They also, where appropriate, use idiographic techniques from the social sciences.

- **Investigations make a difference to patient safety**

  Investigations yield specific conclusions that drive action that delivers explicit improvement in patient safety performance. Investigations are reviewed to validate both their conclusions and how well the resulting actions made patients safer.

Action to enable shared learning

We seek to see:

- Organisations create a learning culture where they set and make good on goals for learning from patient safety, report on progress and share their insights widely.
- Organisations prioritise learning to improve patient safety and how they learn from:
  - Incident investigations and complaints
  - Patients and their experiences
  - Good practice within their organisations and others

    - Evaluating their actions to improve safety
    - Sharing their learning with others
- Organisations respond, and contribute, to shared learning systems such as the Patient Safety Incident Management System (PSIMS) - NHS Improvement's replacement for the National Reporting and Learning System (NRLS)[44] – and, we hope, *the hub* from Patient Safety Learning.
- Regional and local networks such as the Academic Health Science Networks (AHSNs) and Patient Safety Collaboratives (PSCs)[45] support and strengthen geographical and professional communities to share learning and build on the 'Sign Up to Safety' networks.[46]
- Organisations encourage, support and remove barriers so frontline clinicians and patients can share learning and learn from others for safer care.

Patient Safety Learning will take action for shared learning

We will:

- Publish a detailed report on shared learning to help organisations take more effective action for improving patient safety.
- Celebrate learning from patient safety success through the Patient Safety Learning Awards.
- Review current investigative practice to understand how health and social care organisations investigate (including systems and human factors thinking), how they learn from harm, turn recommendations into action and support patients, families and staff. We will publish this review and recommend action.
- Support health and social care organisations through support and practical training.

We will create *the hub*: a digital learning and community platform for shared learning

the hub will be the engine of Patient Safety Learning.

the hub will be a platform for the sharing of local, national and, in time, international knowledge, skills, learning and experiences.

the hub will enable people to learn, share and develop key ideas and techniques to improve patient safety, including:

- Accounts and narratives

- Alerts and recommendations
- Case Studies and exemplars
- Data and analyses
- Guides and guidelines
- Incidents and investigations
- Interviews and reflections
- Policies and procedures
- Processes and systems
- Reports and articles
- Safety improvement strategies and interventions
- Seminars and presentations
- Standards and regulations
- Toolkits and collections
- Tools and templates

the hub will foster communities of interest, and practice and give people a safe place to discuss issues that may be of interest or concern to them.

It will provide a collaborative environment for people to come together to build on improvements that have already begun and adapt solutions for local implementation.

Users of *the hub* can discuss learning from investigations and the effect of applying recommendations and/ or solutions to learn how to apply the same solutions effectively.

We want to maximise the reach of *the hub* and encourage as many people as possible to become involved in it, so it will be free of charge for use by everyone: clinicians, patients, managers, policy makers, regulators, researchers and members of the public.

We will nurture and grow *the hub*

We want users to find *the hub* useful, valuable and stimulating. To help, we will:

- Provide editorial support to source, curate, commission and develop content.
- Explore rapid patient safety information sharing.

- Support users in their conversations and ensure that for critical elements, such as descriptions of tools for patient safety, certain quality standards apply.
- Promote, encourage, and support the use of *the hub* to as many relevant communities as possible.
- Support and encourage communities of interest to share knowledge and support each other.
- Help communities connect within and beyond *the hub*.
- Explore ways for organisations to use and support *the hub*.
- Connect the hub to other sites to give our users the widest possible access to learning for patient safety

5 Leadership for patient safety

"The standard you walk past is the standard you accept."

Gen David Hurley, 2013[47]

"There is a strong link between the safety of services and the quality of leadership."

CQC, 2018[10]

Patient Safety needs purposeful leadership

Good leadership is seen as the most influential positive factor in shaping organisational culture in health care,[48] but *poor* leadership can have the opposite effect.[49]

While there are "…any number of ways trustees [Board Members] can improve their oversight of safety,"[50, 51] we are unaware of any agreed, up-to-date, practical guidance as to which way is best under which circumstances.

Frontline clinical staff and patients often work, and are treated, in environments poorly designed for safety that are staffed by increasingly overworked personnel. A key role of leadership is to recognise and address these challenges.

To realise a patient-safe future, we need a model for leadership and governance for patient safety in health and social care that sets and requires high and consistent standards and behaviours of our leaders.

This can happen only if we define the competencies and training for those leading for patient safety and the governance, standards and reporting for the organisations they lead.

Who owns patient safety?

The publication of *To Err is Human*[52] and of *An Organisation with a Memory*[53] put patient safety firmly onto the agenda of healthcare. One reason we are now publishing *A Blueprint for Action* is that, in the 20 years since, some progress may have been made, but not enough.

When we look at the reasons why, it is easy to blame an absence of leadership. But like the other foundations of patient safety we describe here, leadership for safety is a systemic issue.

On this topic, we can but echo the Care Quality Commission:

The current patient safety landscape is confused and complex, with no clear understanding of how it is organised or who is responsible for what tasks."

CQC, *Opening the Door to Change*, 2018[31]

In other words, it seems that in health and social care, we don't know who is leading patient safety – worse, even if we did, we have not defined what we need them to lead.

In part, this flows from our earlier observation that, currently, patient safety is not regarded as part of the purpose of health and social care. Regardless, however, we have not given our leaders a common view of what it means to lead patient safety.

A framework and common standards

It is salutary to contrast patient safety with, say, fire safety. For fire safety in healthcare organisations, we have established common purposes, aims, policies and guidance on implementation, competences, management, reporting, audit and regulation.[54] We have exemplar fire safety management systems with specified requirements for fire safety management roles, competences, responsibilities, fire safety policies and protocols, and we have standards.

We do not have such an approach for patient safety. Nor is it clear to us whose responsibility it is to create it or require it.

As a result, while the mission statements of many health and social care organisations aspire to the safe care of patients, each organisation does so in their own way. Organisations lack a common framework and standards for patient safety within which they all work.

Just as all health and social care organisations must demonstrate that they work to common standards for fire safety, we contend that they all – providers, regulators, commissioners and policymakers – should work also to common standards for patient safety.

And, just as fire safety specifies clear roles such as board members and specialists, roles for patient safety should be equally and consistently clear, specified and managed within a clear governance framework, in contrast to the situation that obtains currently.

In fire safety, risk assessment tools are developed, shared and used consistently across organisations. This is not the case in patient safety.

A common framework for leading patient safety and shared standards for governance and management of patient safety must be developed. It will need to be led and managed by a body that can reflect and meaningfully engage providers, regulators and commissioning bodies.

Without a map

Of course, if we are to implement a common framework for leading patient safety and put it into practice, we need first to understand the fragmented, disconnected patient safety landscape within which we currently work. What are the roles and responsibilities for patient safety of the different organisations who define, commission, design, deliver and manage patient safety? Where is patient safety well-defined and led? Where are the inconsistencies? Where do goals, objectives, standards

and governance work at cross-purposes, or are duplicative? Where are the gaps?

At the moment, no-one has mapped this, so we just don't know.

A patient-safe future: leadership for safety

What does leadership for patient safety look like? We propose the following:

- Leaders know the risks to safety in their organisations and attend to them. They require and support the design of safe care, not just addressing harm when it occurs. They do so through formal mechanisms of performance management, of governance frameworks, of understanding culture and patient safety, and reading and responding to reports.
- They 'walk the talk' to engage and listen to clinicians and understand the community and patients. They actively seek insight on whether staff and patients feel safe and, if not, they make sure the organisation knows this and responds.
- Leaders model behaviour that challenges a blame and fear culture. Instead. they strive to ensure a Just Culture and encourage and prioritise learning, treating peers, staff and patients with civility and kindness.[55]
- Leaders make the goals and standards for acceptable patient safety explicit for their organisations, and then resource and support their staff to deliver these.
- Culture, work and workload are discussed explicitly.[56]
- Governance and leadership frameworks for patient safety that specify standards, action and behaviour are in place.
- Leaders measure and report on their organisation's patient safety performance.
- The explicit primacy of patient safety for leaders is reflected in the time, resources and attention they give to it.
- Leaders assess and understand the effect of their decisions and behaviour on patient safety outcomes.
- Leader recruitment, development and performance management is underpinned by a competency framework that specifies the knowledge, skills, attitudes and behaviours needed to lead for patient safety.

- Leaders explicitly attend to, and seek improvement in, the foundations of patient safety, namely:
    - Shared learning for patient safety
    - Leadership for patient safety
    - Professionalising patient safety including standards for safer care and competencies for all staff
    - Patient engagement for patient safety
    - Data and insight for patient safety
    - A Just Culture that supports patient safety
- Leaders are supported by a consistent framework for all of the above, based on shared research and good practices, and underpinned by standards for effective leadership of patient safety, shared across and between health and social care organisations.

Leaders understand that problems in delivering safe care are complex and systemic in nature and, further, that specialist skills in human factors and ergonomics are part of the solution.

We call for action to develop leadership for patient safety

Below, we describe actions that we believe are essential if health and social care is to have consistent, sustained and practical leadership in order to progress to a patient-safe future.

We seek to see:

- A health and social care system-wide approach to patient safety so that all organisations are clear on their collective and individual roles and responsibilities for a patient-safe future.
- Publication of a map of health and social care organisations to support the development of this system-wide approach to patient safety. The map will identify roles, responsibilities and strategic goals for patient safety, gaps and areas where further development and clarity is required.
- Organisations prioritise patient safety, embedding clear and published goals in their leadership and governance with programmes to deliver improvements. Culture, work and workload should be explicit.
- Organisations publish patient safety outcomes as strategic and operational goals.

- Organisations have specialist patient safety and human factors experts in executive and non-executive roles on the Board and leadership teams.
- Organisations design and implement system, processes and performance reporting to manage patient safety risks.
- Organisations use risk assessments to inform the development of patient safety goals and improvement activities, including the design and implementation of solutions to prevent harm.
- Integrated care systems explicitly prioritise patient safety in their design, implementation and operation.
- Standards for patient safety are included in service commissioning and care pathway design and culture; work and workload should be explicit.
- Delivery standards for patient safety are included in service commissioning and care pathway design and delivery.
- Leaders demonstrate through their action and behaviours that they are ‘fit and proper’ people to deliver safe care, working to the standards developed as part of a patient safety competency framework.

We need effective leadership for patient safety

We believe that for health and social care to be transformed to deliver a patient-safe future, we need a mechanism to ensure that all components co-ordinate and collaborate.

We believe that an effective way to start defining such an approach is to create a body of leaders to oversee the development, implementation and evaluation of effective approaches, models and governance for patient safety.

Its members should include frontline health and social care delivery staff, setters of standards, such as commissioners, system and professional regulators and policymakers. It should also include patient representatives as full members.

This forum of leaders for patient safety may be developed from a body that already exists, or it may need to be created afresh.

The forum of leaders for patient safety should emphasise a systems approach and use of human factors.

The forum should draw on good practice from across health and social care systems and elsewhere as appropriate.

If none can be found, it will develop pragmatic good practice, such as:

- A common competency framework for leadership of patient safety.
- Standards for leadership for patient safety, including leading a Just Culture, at every level in an organisation.
- Governance mechanisms for patient safety.
- Tools for sharing and extending patient engagement for patient safety and Just Culture for patient safety in organisations.

Patient Safety Learning will initiate discussions and activities to support establishment of the forum of leaders.

Patient Safety Learning will make resources, such as *the hub*, available for the forum to access sources of good practice, to test possible solutions, to consult and to share the tools and good practice that it chooses to publish.

What Patient Safety Learning will do

Patient Safety Learning will work with other bodies, including the proposed forum of leaders, to:

- Publish a report for leaders to use to help take action to define, develop, support and maintain leadership for patient safety. This will include a leadership model and governance arrangements for patient safety.
- Call for, and help to initiate, design and develop an overarching body for patient safety (the forum of leaders for patient safety).
- Support the design, promotion, co-ordination, delivery and evaluation of leadership for safer care.
- Explore with health and social care organisations how critical leadership decisions can be more explicitly and routinely risk-assessed for patient safety. Explore the value of using decision support tools, such as safety business cases.
- Develop tools such as ‘how to’ guides, maturity models and self-assessment frameworks to support organisational leadership for patient safety and publish these on *the hub.*
- Offer consulting and training services to help boards and senior leadership teams to improve their governance, systems and capabilities to lead for patient safety.

6 Professionalising patient safety

"Have you set high standards…that make it clear what level of performance you demand?"

Tom Peters[57]

"If you always do what you've always done, you always get what you've always gotten."

Jessie Potter[58]

"All persons involved in any…safety lifecycle activity, including management activities, should have the appropriate training, technical knowledge, experience and qualifications relevant to the specific duties they have to perform."

Health and Safety Executive (2007)[16]

Who owns standards for patient safety?

In the year to September 2018, just under two million patient safety incidents were reported in the NHS using the National Reporting and Learning System (NRLS). Given such volume, we might expect practices and standards for learning from patient safety to be regular and routine.

Instead, everyday practices for patient safety learning appear inconsistent. We observe a systematic and consistent failure to implement the outcomes and learning from investigations into incidents of unsafe care and patient harm.

If we, rightly, expect standards for patient safety, we need to be clear who sets and owns these.

It is not clear where responsibility for patient safety standards rests in the NHS. The NHS Constitution offers patients:

"…the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety…"[17]

It is not clear to us what is meant by 'levels' in this phrase. What are these levels? What are the standards that should be set for patient safety? Who issues the guidelines to ensure that these standards are delivered? Who measures performance against them to ensure that they are good enough? Who ensures that these standards are met, or exceeded?

It is clear to us that no single organisation is responsible for defining, communicating or evaluating the standards of safety for patient care. In a complex health and social care system, this is not a just a regulatory gap, it is a lack of clarity about leadership for patient safety. It reflects confusion and an absence of ownership for setting standards for patient safety. This needs to change.

A lack of a common framework to underpin consistent care

The Care Quality Commission's Regulation 12 places a patient safety obligation on health and social care organisations.[59]

It states that "…the intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm."

It includes the following statements:

"Care and treatment must be provided in a safe way for service users including:

- Assessing the risks to the health and safety of service users of receiving the care or treatment
- Doing all that is reasonably practicable to mitigate any such risks"

Many organisations struggle to demonstrate how they meet these obligations. One reason is that organisations have trouble complying with another requirement of Regulation 12:

"…ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely…"

"This is not just about the education and training of clinicians. To truly have a safe NHS, all who work in it need to share a basic knowledge and understanding of what we mean by patient safety and be educated in some basic, common principles."
CQC, *Opening the Door to Change, 2018*[31]

Despite this explicit obligation, many organisations lack a requisite competence framework for patient safety. They lack the means to set and manage consistent standards for patient safety performance.

They also lack a consistent basis for defining the skills needed for patient safety, and hence to develop a training curriculum to address these for all staff.

As a result, people in similar jobs may have different skills and work to different patient safety standards. The standard of safety that patients experience may vary considerably from person to person, and from organisation to organisation.

Patients expect that they will receive consistently high standards of care. It is reasonable for these to include high standards for the *safety* of their care.

Organisations should adopt patient safety standards, identify sub-optimal performance against these and act when such performance is identified.

We believe that health and social care currently lacks the means to meet these expectations systemically and consistently. We need to professionalise patient safety.

Raising standards: professionalising safe care

A profession has:

- Standards of education and experience that must be met.
- A code of conduct to regulate professional behaviour.
- Mechanisms for disseminating knowledge of good practice.
- (the ability to) advise government and regulatory bodies about matters within their expertise.

(after Nilsson, H. *What is a profession?*[60])

Many industries use professionalisation to raise standards and make change happen in a consistent and replicable manner. It enables an organisation to ensure that, as the Health and Safety Executive stipulates, staff have the knowledge and skills they need to be 'suitably qualified and experienced' to deliver safe care.[16]

Professionalisation of patient safety will help all staff whose roles affect patients to offer safer care more consistently. Such staff include (but are not restricted to) clinicians, support staff, managers, patient safety specialists, non-executive directors, commissioners and others.

Staff need to know the key concepts, methods and practice of patient safety. Many examples of good practice for patient safety exist in individual organisations. While some of these are showcased through bodies such as Health Education England (HEE) and the 15 Patient Safety Collaboratives of Academic and Health Science Networks (AHSNs), good practice is not shared consistently throughout health and social care.

Patient Safety Learning proposes that 6 components are needed to enable patient safety to be professionalised. Each component complements the other. Together, they provide the knowledge and skills that underpin necessary attitudes and behaviours, as well as supporting organisational cultures that enable safer care.

These components are:

- Clear standards for safe care.
- Accreditation processes for safe care
- Leadership and governance for safe care
- An agreed competency framework to be used as the basis for education and training
- Evidence-based training for all staff, with continual professional development

- Specialist patient safety and human factors experts

New standards and accreditation for patient safety

Professionalising patient safety requires action across the health and social care system. We want to see:

- Standards developed and implemented for patient safety performance, including:
  - Shared learning
  - Leadership
  - Professionalising patient safety
  - Patient engagement
  - Data and insight
  - Culture
- Regulators require and use these organisational standards and that these will inform their regulation of patient safety.
- Guidance, resources and toolkits for patient safety shared across the wider health and social care systems. These are used to enable, encourage and support organisations and individuals to achieve higher standards of patient safety.
- In time, development of an accreditation framework for patient safety.

> "The development and availability of standards for patient safety can…either establish minimum levels of performance or can establish consistency or uniformity across multiple individuals and organizations…The process of developing standards can set expectations for the organizations and health professionals affected by the standards."
> *To Err is Human: Building a Safer Health System, 2000*[52]

In a patient-safe future, patient safety is a core competency

In a patient-safe future, all staff can demonstrate that they are suitably qualified and experienced to carry out their jobs.

Our vision of a patient-safe future includes a health and social care system where:

- All staff demonstrate consistent behaviours, attitudes, skills and principles for patient safety.
- All staff are managed to consistent standards of patient safety performance.
- A competency framework that defines the behaviours, attitudes, skills and knowledge required to deliver safe care to be developed and implemented for all staff.

- This competency framework is used to develop a curriculum for patient safety, so all staff working in health and social care have the knowledge they need.
- All staff working in health and social care can demonstrate their skills for safer care use (Kirkpatrick Level 4)[61] using accredited trainers.
- Health and social care organisations have sufficient access to expertise and qualified resources. As a result, they adopt proactive approaches to improving patient safety.
- Human factors and systems thinking inform the safe design, safety management and approaches to investigating unsafe care.
- Organisations use robust, scientific approaches to the design and implementation of patient safety improvement strategies.
- Core competencies for patient safety are used to define curricula and design training and CPD programmes.
- Incident investigation and implementation of improvement strategies are led to consistently high standards by people who have undertaken recognised, accredited training which includes systems and human factors expertise.
- There are sufficient staff to undertake patient safety critical tasks.

Evidence-based training for patient safety

The 2016 report by the Centre for Health Policy (CHP) at Imperial College London, *Evaluation of Education and Training Interventions for Patient Safety,* is the largest recent investigation into the evidence base for the effectiveness of training interventions for patient safety.[62]

The report made a couple of striking findings. Patient safety training should lead to demonstrably better patient safety performance, yet the CHP study found almost no patient safety training which could demonstrate that it made a difference to working practice. (Kirkpatrick Level 4).[62]

We therefore advocate that any training design includes elements that require participants to review instances of how, where and when the new skills will make a difference to their work.

Further, we propose that training design includes follow-up and reinforcement in-work within a short interval after training delivery to support and encourage use of skills.

Such follow-up will offer a further benefit: it will enable the organisation to identify, and hopefully eliminate, practical barriers to using the new skills.

Another finding of the CHP study was that respondents overwhelmingly deemed four kinds of training to be effective for patient safety training:

- Simulation
- Small group discussion / experience sharing / face-to-face
- Practical / interactive training
- Multi-disciplinary teams (MDT)

Far fewer respondents regarded other forms of delivery, such as online training, to be as effective.

The study further found that effective education and training for patient safety is realised through two equally important elements:

- Knowledge and skills for patient safety and the management of clinical risks, relevant to their role
- The ability to demonstrate the attitudes and behaviours needed for a Just Culture

If we are to professionalise patient safety, it is not enough to set standards, and define a competency framework. We need a standard of training that enables and delivers a consistent, practical and demonstrable standard of patient safety behaviour in the workplace.

Specialist patient safety and human factors experts

Professionalising patient safety requires action across the health and social care system, including the development of specialist roles. We want to see:

- Organisations have specialist patient safety and human factors experts who are supported by appropriate resources and governance. With clearly defined roles, these specialists have clear reporting lines to the Board (both Executive and Non-Executive).
- These experts should support the re-design of systems, processes and operations for safer working.
- These specialists support learning to improve safety from investigations into unsafe care and from listening to, and engaging with, patients, complaints, near misses, clinical reviews and audits.
- Local, regional and national networks of these specialists share knowledge and improvement strategies, supported by the frameworks in place to do so such as Patient Safety Collaboratives, Academic Science Networks, NHSI regional teams and others.
- These roles are underpinned by a strong competency framework and associated training programmes. Their role in setting and

modelling the highest standards for safety and human factor performance is supported by learning from specialists such as Healthcare Safety Investigation Branch (HSIB) and other industry experts and academics.

- These roles being part of a career path in patient safety and human factors with clinical and non-clinical staff encouraged to develop their expertise and into specialist roles.
- Organisations and staff will have access to expertise, support and advice on patient safety issues, with an emphasis on:
    - Developing an open and fair culture and training in patient safety
    - Identifying, managing and reporting of patient safety incidents and risks
    - Running effective, rigorous and empathetic investigations
    - Systems thinking and human factors
    - Acting on, and learning from, safety incidents and improvements
    - Encouraging openness and sharing insight on unsafe care including the support and protection to whistleblowers
    - Support and governance for whistleblowing

Patient Safety Learning will take action to professionalise patient safety

We will work collaboratively to:

- Publish a detailed report on professionalising patient safety to help identify action needed to improve patient safety.
- Identify standards for patient safety to be used by regulators, commissioners, service providers, etc.
- Support development of a competency framework for patient safety.
- Develop and provide training to address gaps in patient safety skills, knowledge, attitudes and behaviours.
- Support development of an accreditation framework for patient safety.
- Support health and social care organisations and offer practical training.

7 Patient engagement for patient safety

"Hear the patient.
Empower the voice of the people we are trying to help.
They have more information than just about anyone
else in the system."

Don Berwick[1]

"Often there is a focus on process, rather than identifying what a patient wants and needs in terms of putting the situation right. Little is known about the emotional and psychosocial harm stemming from medical errors and adverse events. Yet emerging data suggest that these secondary impacts may be just as harmful, or even more injurious, than the underlying event."

The Patients Association[63]

"You ignore at your peril the concerns of a mother."

Margaret Murphy, 2018[64]

The ways we address patient harm can compound the pain

Over the past 20 years, a common factor in many patient safety scandals has been a disregard for the voice of the patient. Patients and family members who raise concerns have had their issues ignored or discounted.

This disempowering of patients was cited as a contributory factor in the 2001 Bristol Royal Infirmary Inquiry,[65] the Mid-Staffordshire Report in 2013,[66] the 2015 Morecambe Bay Investigation in 2015,[67] and the 2018 Report of the Independent Panel for Gosport.[68]

Numerous painful stories illustrate how organisations, after incidents of harm, exclude patients and their families from investigations, learning and improvement. This failure to listen frustrates harmed patients and can make their pain worse,[69] provoke unneeded litigation[70] or require further medical intervention.

"…emerging data suggest that these secondary impacts may be just as harmful, or even more injurious, than the underlying event."

ScienceDaily, 2018[71]

"Emotional and other long-term impacts of harmful events can have profound consequences for patients and families."

Bell et al[72]

Nor is such harm restricted to patients and their families. Clinicians can also suffer psychological harm as a result of being involved in patient safety incidents.[73]

This suffering is a consequence of many of the factors we describe elsewhere:

- A failure, or unwillingness, to listen and learn
- A lack of standards for care following an incident

- A failure of the leadership necessary to put the needs of patients above, say, the desire of the organisation to avoid admitting legal liability
- An unwillingness to involve patients and families in helping to understand what went wrong
- No data recorded or analysed concerning secondary harm to the patient as an issue leading to action
- A lack of formal support for patients and families who have suffered incidents of avoidable harm
- A culture that seeks to close ranks, restrict information and manage blame

If we are serious about patient safety, we must find ways to address such causes to minimise the needless, secondary pain that patients, families and clinicians can suffer in the aftermath of an incident of avoidable unsafe care and harm.

We don't systematically engage patients in their care.

"The patient and family are the only people who are present throughout the continuum of care. They are a repository of critical information and, when engaged and empowered, can play a significant role in ensuring a positive health-care experience. For the same reason, engaging parents and families who have experienced harm can provide insights and learning concerning system failures."

WHO, Patient Engagement for Patient Safety, 2013[13]

Health and social care are still too often designed and delivered around the traditional idea that the patient is a passive participant in the care process. The systemic model of healthcare is predicated on the use of clinical expertise; a patient with a condition is moved like a passenger through the health system until they are seen by a suitably expert person.[74]

This process assumes that the patient has little expertise to offer. In many cases, this assumption is wrong. Patients with a chronic condition, for example, will often be highly informed[75]. When children are patients, their parents or guardians often have substantial information and insight into their condition.[76]

When health and social care does draw on this expertise such as, say, when a patient history is taken, too often the history does not travel with the patient, is mis-recorded or poorly communicated. This has led to many cases where the patient's own reports of their condition, or reports by parents or family members, are discounted.[77]

The assumption that patients are passengers in the care process is often reflected in how their care is managed. Even when armed with their records, patients may have limited ability to participate in their care because they aren't adequately informed about the stages of their treatment journey and what they should expect to happen.

Responsibility for safe care rests with the care provider. If patients don't know what 'good' or 'safe' looks like, in terms of the care they should

receive, they will be unable to assess the care they are themselves receiving.[78] Patients are more vulnerable to receiving unsafe care if they do not understand the care they should be receiving or if it is not explained to them. In such cases, they are unable to question or challenge the care they have received or should receive.

If patients were able to check their clinical information during the care process, such problems might be reduced. However, patients typically do not have immediate or direct access to their own medical records, test results or diagnostic imaging results. They are less able to validate their own understanding and so cannot act, should they wish to do so, as a second check that correct protocols are being followed.

Patient care information, for example, can often be handed over between clinicians and between organisations without the presence of, or any direct input from, the patient or their family. If mistakes are made or handover information is incomplete, patients can't correct them.

This needs to change. Patients need to be considered part of the team that provides safe care.

Hospitals that involved patients and families in handovers demonstrated

38%

fewer harmful medical errors, and

46%

fewer adverse events[7]

Investigations are not part of patient care

There is a special case where active patient engagement is often ignored, or discounted: the procedures that follow a serious incident of avoidable harm or death of a patient.

There is evidence that when patients are left out from investigations, the quality of investigation is compromised.[79,80] Patients and families can be a primary source of learning for safety.

Investigation and complaints processes, however, have often not been designed around patient interests or patient care. These processes are often seen to be insensitive, unresponsive and adversarial.[37]

This has a number of effects:

- Patients, families and staff may not be supported when things go wrong.
- Despite assurance and guidance from NHS Resolution and others about the need to apologise, staff often seem fearful or reluctant to do so.[81]
- Staff can be traumatised themselves by their involvement in the serious harm or death of a patient.[82,83] Few support services exist for them[84] and we know that some staff never recover and are lost to the profession as a consequence.[83]
- Families and patients can find it hard to access information or support on what options are available to them for finding out what

Only

36%

of investigations gave patients a chance to discuss the report.[27]

happened, to navigate a complex system through its various stages, such as complaints, the medical examiner's report, a coroner's inquest, serious incident investigation, litigation and inquiries.

When a serious incident of patient harm is investigated, patients too often are not invited to contribute to the investigation, are ignored or have their views discounted.

"Very few reports in our sample recorded the impact and outcome of the incident for the patient or set out how this was managed through additional care or support…reports showed a lack of perspective from the patient or their family on the incident".

CQC, *Learning from Serious Incidents in Acute Hospitals*, 2016[27]

"I cannot think of a single case I have reviewed where poor communication is not a factor leading to poor health outcomes and subsequent disputes: poor communications between patients and health professionals "

Finbar O'Callaghan, The Long and Winding Road, 2015[85]

As a result, patient and family participation in the processes following a serious incident can be a distressing, frustrating, disempowering and exhausting experience, with support, care and funding often available only through the charitable sector by organisations such as Action Against Medical Accidents (AvMA).

In too many cases, this experience causes severe distress and psychological harm to patients and families and to the clinical staff who have been involved in the incident.[86]

Far from being processes of care for people who have suffered avoidable harm, in too many cases these investigations inflict further harm to people who should be receiving healing.[87]

This should not be allowed to continue.

Patients aren't regularly considered as part of health and social care governance

Patients aren't properly involved in health and social care management and policy. Many patients are unaware of opportunities to get involved in safety at the organisational and policy level. When they do get involved, it is often tokenistic. If their contribution is actively sought, then they are often poorly supported or trained to contribute effectively.

Health and social care organisations' governance typically does not require patient engagement. Health and social care organisations require governance that creates and requires patient engagement to improve the performance of the organisations.[88]

The case for engaging patients in patient safety is strong

The case for engaging patients in patient safety is more powerful than simply evidencing the harm that poor post-incident care can cause. Simply put: patient engagement makes care better.[90]

Robust evidence shows that communication between clinicians and patients has a positive impact on health outcomes.[91,92,93,94,95,96,97,98]

Failure to adequately involve patients in their care also carries a significant financial cost. For example, in 2015 Marie Curie UK used figures from the NHS Litigation Authority to estimate that communication failures between staff, and between patients and staff, cost the NHS £200-300 million a year.[85]

Engaging patients in their care increases patient safety, reduces harm and potentially reduces costs.

As we have seen, however, much is yet to be done to ensure that patient safety can be optimised by the effective and consistent engagement of patients and families.

> "Empowering patients to be an active participant (sic) of their treatment is not only shown to improve health outcomes, but also effectively reducing safety lapses by up to 15%."
> *OECD, Flying Blind, 2018*[89]

A patient-safe future: patient engagement for patient safety

We envision a patient-safe future where patients are actively engaged throughout the care process and whenever things go wrong.

Patients and professionals are equipped and enabled to engage in safe care

- Patients and health and social care professionals enable patients, if they wish, to partner in all activities related to patient safety across the system. Staff welcome and support this in practical ways.
- Patients and healthcare professionals have the knowledge, skills and attitudes to understand why and how patients should be involved, as well as how to involve patients as active partners in patient safety activities across all levels of the health and social care system.
- Patients and families have real-time access to the information needed to allow them to engage in patient safety activities across all levels of the system.

Governance supports, encourages and enables patient engagement in patient safety

- The governance and delivery of healthcare services require patient representation in order to support patient-safe health and social care and hold healthcare organisations to account for patient safety.
- Organisations routinely measure patient engagement in patient safety and evaluate the impact this has. Results are shared within the organisation and between organisations for learning and improvement.
- Regulators, policymakers and commissioners promote and support practical mechanisms for effective patient engagement.
- Patients and patient advocates across the health and social care system are supported by a central patient safety organisation. They will be mentored and supported through an infrastructure that provides support and co-ordination. This will enable patient advocates to develop a collective voice, sharing wisdom, insight and learning.

Patients, families (and staff) are supported and cared for at every stage after an incident of unsafe care

- Investigations fully involve patients and families.
- When patients or families experience harm because of patient safety problems, health and social care systems respond to provide an apology, support, mediation and involvement in investigations, with an open and honest explanation for what happened and why.
- Patients and families feel engaged and supported whenever there is a patient safety incident. Access to appropriate support is enabled, funded and encouraged, including when such support is best provided by third parties.
- Investigations openly and transparently provide explanations and restorative justice.
- Patients and families only need to use the complaints system or instigate litigation if these systems fail.
- Mediation is more frequently used to support families and staff to find a way through the complexity of investigation and complaints processes and to come to quicker and fairer resolutions.
- Patients, families and staff are cared for and supported when there is unsafe care.

Sincere apologies offered in the wake of a medical error may lead to a lessening of suffering for both patients and physicians in coping with the error and its consequences, contribute to improved relationships between physicians and patients such that these relationships are able to continue, and reduce costs by preventing lawsuits and facilitate the settlement of valid claims.

J. K. Robbennolt, Apologies and Medical Error, 2009[99]

We call for action to engage patients in patient safety

If we are to have patients fully engaged in patient safety, organisations in the health and social care system need to act.

We seek to see:

- Health and social care systems welcome and recognise the value of patient engagement and involvement in patient safety.
- Organisations support patients to engage with them to help meet standards, goals and objectives for patient safety.
- Organisations inform patients and the public about patient safety performance against published patient safety goals, standards and metrics.
- Patients become an integral part of an organisation's governance and leadership for patient safety.
- Organisations develop governance and operational roles for patient engagement. These include, but are not limited to, patient engagement and involvement:
    - At the point of care
    - If harm occurs
    - In investigating unsafe care
    - In the design of service improvements
    - In the boardroom
    - In holding the organisation to account for delivery of patient safety standards, goals, processes and objectives
- Organisations fund, recruit, train and provide ongoing organisational and personal support for patient representatives and advocates at all levels.
- Organisations support their staff and leaders to have the knowledge, skills, attitudes and behaviours to engage and involve patients in patient safety.
- Organisations provide consistent support to patients, families and staff when there is unsafe care:
    - Physical, mental health and social care support when it's needed
    - Information and honest explanations about what happened and why
    - Genuine and empathetic apologies

"Patient safety systems are also more likely to be effective if patients are actively involved. Patients need to be encouraged to play a greater part in their care to make sure that they remain safe when treated by the NHS"
CQC, Opening the Door to Change, 2018[31]

- Advice and guidance about what to expect and the options available for support and redress

What Patient Safety Learning will do

Patient Safety Learning will take action to help patients to engage for patient safety. We will work collaboratively to:

- Publish a detailed report on patient engagement in patient safety to identify action needed for improving patient safety.
- Develop a model and governance for patient engagement and advocacy for patient safety for service providers, regulators, commissioners and others.
- Initiate the development of three ‘harmed patient care pathways’ to follow a death or serious incident of patient harm for:
  - Patients
  - Families / carers
  - Staff
- Promote, share, implement and evaluate models for patient engagement in patient safety.
- Support health and social care organisations through consultancy and practical training.

8 Data and insight for patient safety

"Health statistics represent people with the tears wiped off."

Sir Austin Bradford Hill[100]

Do we have the right data?

In practice, patient safety asks a single question of any organisation:

"How do we know that we're safe?"

Professor Alison Leary[101]

Right now, can any leader in health or social care properly answer this question?

It is not for want of trying. Many efforts have been made to give healthcare organisations useful data on patient safety. These include:

- The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports in England. Plans are on the way to replace this system with the Patient Safety Incident Management System (PSIMS).[44]
- The Clinical Practice Research Datalink (CPRD) provides anonymised patient safety records for public health research and analysis, offering reports back to primary care providers. It includes data from 6.7% of the UK population.[102]
- NHS Safety Thermometers employ point-of-care surveys that allow clinical teams to collect, analyse and act on data relating a range of specific conditions.[103]
- The Suspicion of Sepsis (SOS) Insight Dashboard gives clinicians and managers insights to admissions, survival rates and lengths of stay, enabling organisations to benchmark, prioritise improvement strategies and monitor improvements over time.[104]
- Getting it Right First Time (GIRFT) is a national data-driven programme to improve the quality of care by reducing unwarranted variation and sharing best practice. It is being rolled out in 35 surgical and medical specialties and is supported by seven regional hubs.[105]
- The Summary Hospital-Level Mortality Indicator (SHMI) is a NHS Digital programme that models the mortality outcomes of patient hospital care. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.[106]
- The Leapfrog Hospital Safety Grade is a US programme that grades hospitals according to their responses to questions concerning their procedures and practices for aspects of patient safety.[107]

Over and above these specific initiatives, individual organisations have access to a range of patient safety information. Organisations may, for example:

- Have information about the duration of investigations and outcomes after serious incidents or near misses.
- Have information collated on complaints, not just the volume, severity of concerns and response rate, but the insight from these, and the learning that can and has been taken to improve patient safety.
- See reports about the number of clinical negligence claims outstanding, the number settled and the amounts of money to be paid.
- Choose to access the narrative text of incident investigations as well as quantitative data.
- Have information about the progress of specific initiatives towards certain patient safety targets, such as infection control.
- Have potential access to significant qualitative and anecdotal information about incidents, rumours and observations.
- Have access to information about whistleblowing.

The quantity, quality and relevance of such data varies by organisation, as does the quality of analysis, review and action planning that results.

Data-rich, information-poor

Even with access to such data, an organisation's ability to answer the question, "*How do we know we're safe?"* remains limited. There are a number of reasons why:

- Almost all patient safety data refers to patient harm or performance *after* harm has already happened. They provide what is commonly termed 'lagging' information.[108] Such data supports a patient safety stance where the focus is to address harm that has already been suffered.[109]
- Many organisations do not state specific systemic patient safety objectives against which they can be measured. As a result, we consider that their measurement of patient safety can lack direction.[109]
- Only a few patient safety metrics (for example, the SHMI) offer reference information to put an organisation's performance in context. In many cases, this is when organisations have no reference information against which to compare their performance and tell them if patient safety is improving or not.[109]

- We consider that many patient safety scandals (such as Gosport or Mid-Staffs) might have been identified sooner if organisations had more effective ways of viewing and addressing the totality of patient safety performance information available.

  These include, for example, qualitative data such as the numerous reports, queries and flags raised by concerned staff, patients and families but which did not lead to meaningful action early in the events that led to these scandals.[110]

The proliferation of mobile and app technology for health and medical care might seem to offer a way to harness data for patient safety. But as few design standards for patient safety for apps exist, the challenge of finding trusted, relevant sources for patient safety data from billions of downloads is yet unmet.

When it comes to patient safety, it seems, organisations are data-rich and information-poor.

3.7bn

The number of health app downloads in 2017[111]

Setting goals for patient safety

"While we have, understandably, focused on specific, targeted initiatives, we have not made wholesale and sustainable progress."

Patricia McGaffigan, 2019[15]

Goals for patient safety are often set to reduce harm related to a specific condition or practice. Targets are set for infection control,[112] or pressure sores, or falls; actions are taken and after a time, harm levels for these conditions reduce.

Such initiatives have led to some tremendous improvements and many, many patients are alive and well today because of the great work of the innumerable, dedicated staff who made these improvements happen.

Yet, as Patricia McGaffigan asserts above, such initiatives have not led to patient safety nirvana. Despite such attention focused on specific improvements, overall numbers of patients suffering harm stay stubbornly high.[2]

Why?

When under pressure from reduced resources and increased demand, organisations tend to direct their limited resources to tangible goals for which they are obliged to be accountable.[113]

So, while we may see an improvement in specific output targets, this can be at the expense of other patient safety activity, such as addressing the systemic causes of patient safety failure.

Hard numbers drive out soft.

Of course, harm reduction must be embraced. But striving to reduce harm is not the same as striving to be safe. In the jargon, it is the difference between Safety I and Safety II.[30]

If we are to be sustainably safe, we think that initiatives with specific harm reduction targets must be complemented by others that address systemic causes of patient safety failure.

We support the setting of patient safety targets for specific issues and conditions and expect these to have clear and actionable implementation plans. We propose, however, that these are accompanied by goals that address the systemic causes of patient safety failure:

- Shared learning
- Professionalising patient safety
- Leadership of patient safety
- Patient engagement for patient safety
- Data and insight for patient safety
- Patient safety culture.

Currently, few organisations set effective goals and objectives for systemic causes of patient safety failure in a consistent and compelling way.

Three questions for patient safety performance measurement

Before we can answer the question, ‘how do we know we are safe?’, we must first answer three other questions.

1 Against which patient safety objectives are we measuring performance? What should we be measuring?

2 For whichever measures we choose to use, what level of patient safety performance should we have? (What represents good or bad performance?)

   Some may wish to set a target of zero incidents. But even if it is possible, perfect performance is likely to be many years away. Organisations need to set reference data against which they can determine if their performance is good, or not – and if they are improving safety year-on-year.

3 What information tells us if we are becoming more or less safe before harm actually happens? That is, can we have leading, as well as lagging, information about patient safety performance?

Few organisations appear to have good answers to these questions. As a result, most organisations will find it hard to understand, and so act meaningfully, on their patient safety performance.

A patient-safe future: Data and insight for patient safety

In a patient-safe future:

We measure patient safety performance effectively

- Organisations specify clear objectives for patient safety outcomes.
- They set performance standards for these objectives against which they measure performance as part of formal governance and reporting. These standards must be demanding, specific and relevant to patients.
- Organisations use data analytics to identify possible evidence of patient safety risks or potential precursors for such risks.
- They use performance information to identify, track and manage specific risks to patient safety.
- Organisations use performance information to identify, track and manage data for the active design of safety, as well as assessing and addressing the risk of harm, and recording and reporting when harm happens.
- They measure performance routinely against these standards and objectives, using both lagging and leading indicators.

We identify shortfalls in patient safety performance

- When performance is shown to fall short, organisations take specific action to address the shortfall and formally track the results.
- Organisations measure safety performance, and shortfalls in performance particularly, not to blame, but to learn and improve. Regrettably, we believe this will be challenging in the target-focused performance culture of the NHS.
- Organisations set standards for, and measure the quality and effectiveness of, the work they do to improve performance in cases of patient safety failure.

We act to improve patient safety performance

- Every level of an organisation makes better decisions by using reliable patient safety performance information.

- Organisations improve safety by raising patient safety standards regularly.
- Organisations share their safety performance with others.
- They routinely and actively capture, assess, report and act on qualitative information about patient safety from all sources, such as reporting by patients and staff, including whistleblowing.
- They require that apps that claim relevance in health or wellness demonstrate that they have been designed with patient safety as a core principle in their design, development, testing and support.
- Organisations undertake research to identify appropriate and effective metrics and data to monitor and manage safety actively, in addition to risk and harm.

We propose improvements in patient safety measurement

To improve patient safety performance, we seek to see:

- Health and social care systems develop models for measuring, reporting and assessing patient safety performance. These should also include qualitative data on performance and culture, and insights from patients, frontline staff and the wider community.
- Patient safety performance data to be incorporated into risk management systems and monitored by management teams, boards and across the system.
- Patient safety performance measurement models to develop into patient safety dashboards at department, board and system levels, and incorporated into formal governance.
- Such dashboards to include reference or baseline information to act as standards against which patient safety performance can be measured and improvement / impairment tracked.
- Dashboards to include leading and lagging indicators of patient safety.
- Dashboards to include information about reactive and proactive activities to support patient safety improvement.
- Centralised systems for collecting data on patient safety incidents to include insights and learning that follow from investigation and the impact of resulting actions.
- Patient safety to be an integral part of AI development by, for example, engaging with the Department for Business, Energy and Industrial Strategy's Grand Challenge Missions[114] and others to develop capabilities to support patient safety.

These may include, for example, identifying potential precursors to patient safety incidents to enable the development of leading indicators for patient safety.

What Patient Safety Learning will do

We will:

- Publish a detailed report on data and insight to help take action for improving patient safety.
- Convene a symposium of experts, expert users and patients to start identifying critical data and insight needed to measure, monitor and determine effective action for patient safety.
- Make recommendations for system-wide data and measurement for patient safety, including organisational dashboards.
- Seek to work with technology companies and others to develop, design and implement an effective set of patient safety standards for ‘health’ apps, together with associated regulation and governance.
- Develop associated tools, such as ‘how to’ guides, maturity models and self-assessments frameworks, to support organisational leadership.
- Work with health and social care data providers to design programmes to implement patient safety performance management and measurement.

9 Patient safety culture

(The single greatest impediment to error prevention in the medical industry is…) "…that we punish people for making mistakes."

Professor Lucian Leape, 2009[115]

"You can (and should) identify and blame the error, the 'act or omission' for the harm, but very often it is not appropriate or fair to blame the 'person' who carried out that act. There is a bigger picture when it comes to why that person made that error. This distinction needs to be made clear to everyone, the public and NHS employees."

Jo Hughes, 2016[116]

"Culture eats strategy for breakfast."

Peter Drucker (attr.)

Blame makes patients less safe

As *A Patient-Safe Future* describes, logic, research and innumerable examples all point the same way: an organisational culture that seeks to assign blame when things go wrong makes patient harm more likely to happen again.

A blame culture:

- Incentivises people to cover up mistakes.
- Motivates people to lie, either by commission or omission.
- Encourages scapegoating, especially of people lower in the corporate hierarchy.
- Makes a single person responsible for a failure while downplaying or ignoring the systemic causes behind an incident. As a result, it makes it likely that the same problem will recur with a different person.
- Sets standards for performance that are unachievable with the resources provided.
- Inhibits learning and improvement.
- Is corrosive and undermines trust between colleagues.
- Encourages organisations to exclude or ignore patients or families if things go wrong.
- Makes whistleblowing necessary, as reporting 'bad news' is discouraged.
- Increases the career risk to whistleblowers, as the culture defaults to blaming (and often, shutting down) the messenger.

> The medical paradigm demands that the practitioner practises to perfection, and if the person falls short of this high standard, then the person is to blame.
> *S Radhakrishna, 2015*[117]

Evidence shows that improving safety culture impacts on staff safety behaviours, and that improvement initiatives, in turn, improve culture. In short, they form a virtuous circle.[118,119]

A culture less centred on blame, such as a Just Culture[120] has a positive impact on patient safety.

"For a safe organisation, staff need to be confident that doing the right things – reporting incidents, near misses and concerns, being candid about mistakes and talking openly about error – are all welcomed and encouraged. They need to know that the organisation will focus on system learning, not individual blame.

Of course, there must always be accountability in the rare cases where individual healthcare staff have acted recklessly or have covered up. The term 'Just Culture' describes a culture which successfully achieves this balance."

Patient Safety Learning, *A Patient-Safe Future*, 2018[3]

A patient-safe future: Patient safety culture

In a patient-safe future, an organisation's culture encourages and supports patient safety.

The environment supports raising, discussing and resolving concerns

"Create a culture where clinicians and patients can speak openly in the same room and listen to each other."
Suzette Woodward, 2018[121]

- The working environment actively promotes and supports the improvement of patient safety. It encourages and enables learning from staff and patients within their organisations and elsewhere in the health and social care system.
- The working environment allows challenge and encourages raising concerns, including whistleblowing, by anyone.
- Health and social care organisations measure organisational culture to identify opportunities to sustain and progress an improved safety culture.
- Successful improvements in patient safety are celebrated appropriately and shared widely.
- Staff and patients feel safe and secure in reporting patient safety concerns, near misses, and incidents, knowing they will be actively welcomed and thanked for sharing their insight, and that action will be taken for safer care.

The organisation is led, and managed, to support patients and clinicians fairly and safely

- A charter of principles and standards sets fair expectations for how health and social care professionals involved in a patient safety incident are supported and treated.
- Health and social care professionals understand their responsibility for patient safety.
- Organisations 'take all reasonable and practicable steps' to improve the safety of patients.

- Work and workload are explicit so that staff are assured that what is expected of them is achievable with the resources available.
- Patient safety risk assessments ensure that resource / safety trade-offs are explicit and understood by decision-makers.

Organisations address incidents of unsafe care with empathy, respect and rigour

- Following a patient safety incident, there is open and honest disclosure to patients and their families.
- Communication and engagement with harmed patients and their family members is prompt, complete, sustained, kind, supportive and empathetic.
- Following a patient safety incident, clinicians and affected staff are given appropriate support. They are confident that the organisation, professional bodies and the wider system will treat them fairly in ways consistent with the principles of a Just Culture.
- Investigations begin with an initial intent to determine the systemic causes of an incident, rather than assuming assignment of liability or blame.
- Patient safety incidents are investigated consistently and rigorously by suitably qualified, accredited and experienced personnel.
- Learning is shared widely for safer care across the health and social care system.

"Civil work environments matter because they reduce errors, reduce stress and foster excellence". *www.CivilitySavesLives.com*[122]

We call for action to develop a culture for patient safety

There have been many reports into how a Just Culture is critical to improve patient safety. Now is the time to learn from these reports and for all, not just the few, to take concerted action.

To make progress towards an effective culture for patient safety, we seek to see:

- Health and social care organisations implement programmes to eliminate a blame culture and introduce or deepen a Just Culture.
- Health and social care organisations develop and publish goals to develop and sustain a Just Culture.
- Health and social care organisations measure and report their progress towards a Just Culture.
- Staff can feel assured that they are working in safe systems and that, when things go wrong, a system and human factors approach will inform investigations and learning.

- Patients can raise concerns and provide insights into how to make care safer, confident that their views will be welcomed and acted upon.
- These organisational goals and programmes are informed by:
    - Organisations reviewing and taking into account how external factors (regulators / policy / commissioning / media) tolerate / support / drive blame cultures in health and social care organisations.
    - Organisations reviewing how their current approaches to patient safety and behaviour tolerates or supports a blame culture.
    - Regular safety culture assessments of staff and patients.
    - Use of systems thinking and human factors.
    - Specialist expertise to inform culture changes and learn from those that are making good progress in this often challenging, but essential, ambition.
    - The design, implementation and evaluation of organisational goals and programmes is shared widely for transparency, accountability and learning.

What Patient Safety Learning will do

To help organisations develop and implement a more effective culture for patient safety, we will:

- Publish a detailed report on Just Culture to help take action for improving patient safety.
- Provide, on *the hub* and elsewhere, tools, case studies and resources to help organisations and teams learn, adopt and assess Just Culture.
- Promote a Just Culture in everything we do and across all our communications and engagement.
- Support health and social care organisations through support and practical training.

10 About Patient Safety Learning

Our vision is for a patient-safe future
with patient safety as part of the purpose
of health and social care,
not something to be negotiated.
We believe that urgent systemic action is needed
to address the causes of unsafe care.

*"We know why we need to improve patient safety. We better understand what we need to do. We need now to focus on **how** we deliver a patient-safe future."*

Helen Hughes
Chief Executive, Patient Safety Learning

We aim to make patients safer

Patient Safety Learning is a charity.

We help transform safety in health and social care, creating a world where patients are free from harm.

We help health and social care systems and organisations enable safer care for patients.

We identify the critical factors that affect patient safety and analyse the systemic reasons they fail.

We listen to learn about what is needed to make health and social care safer. We use what we learn to envision safer care and recommend how to get there. And we act to help make it happen.

One of our greatest strengths is our independence. We speak truth to power.

Evidence, vision and ambition

We are a small organisation with an ambition that stretches across the whole of health and social care.

The causes of patient-safety failure are system-wide, and we need to use and propose human factors thinking to understand them. We base our thinking and conclusions on firm evidence.

The past 20 years has secured patient safety on the agendas of health and, increasingly, social care. In this time, thousands of recommendations have been made. The need now is for effective systemic action to transform the safety of care.

Our mission matters to everyone, for every single one of us has been, or will be, a patient or care service user. All of us want to be – all of us deserve to be – cared for safely. Improvement in patient safety will come with the hundreds of thousands of people every day who provide care and try to make things better.

And so we collaborate with staff, patients and their families; those who have suffered first-hand and who want their experience, their insight and their learning to make a difference. By partnering with them, we aim to achieve the transformation we all need.

We would like to partner with you too. Contact us to find out how together we can aspire to a patient-safe future.

Learn more about us

Learn more about Patient Safety Learning and our goal of creating a patient-safe future.

Visit our website at www.patientsafetylearning.org or contact us at info@patientsafetylearning.org

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Conference Report

'Patient Safety - Public Trust
A decade of inquiries – what is the learning?'

Report of NIPSO Conference held on
Wednesday 20 March 2024 Malone House, Belfast

Northern Ireland
Public Services
Ombudsman

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Introduction

On 20th March 2024, NIPSO held a one-day conference "Patient Safety – Public Trust; A decade of inquiries, what is the learning?" The event brought together over 110 people from a wide range of backgrounds and health settings and the audience heard presentations from 13 different speakers through keynote addresses and breakouts.

This short report aims to summarise the key learning and content from the day. Copies of the full presentations are available here on our website.

The conference also shared four short videos with people talking about their patient safety experiences and who brought their health care complaints to NIPSO for investigation. These can be accessed here.

NIPSO is grateful to everyone attended and wishes to particularly thank everyone who contributed and spoke on the day.

Role of NIPSO

The Northern Ireland Public Services Ombudsman (NIPSO) was established by the Public Services Ombudsman Act (NI) 2016. NIPSO's role, is to independently and impartially investigate alleged maladministration in the administrative functions of public services in Northern Ireland and both maladministration and the exercise of professional judgement in health and social care services. The Ombudsman may also undertake investigation on her 'Own Initiative' , without an individual complaint, where there is a reasonable suspicion of widespread failings (systemic maladministration). The services provided by NIPSO play an important role in providing access to justice and redress for individuals, as well as supporting improvement and learning in public services.

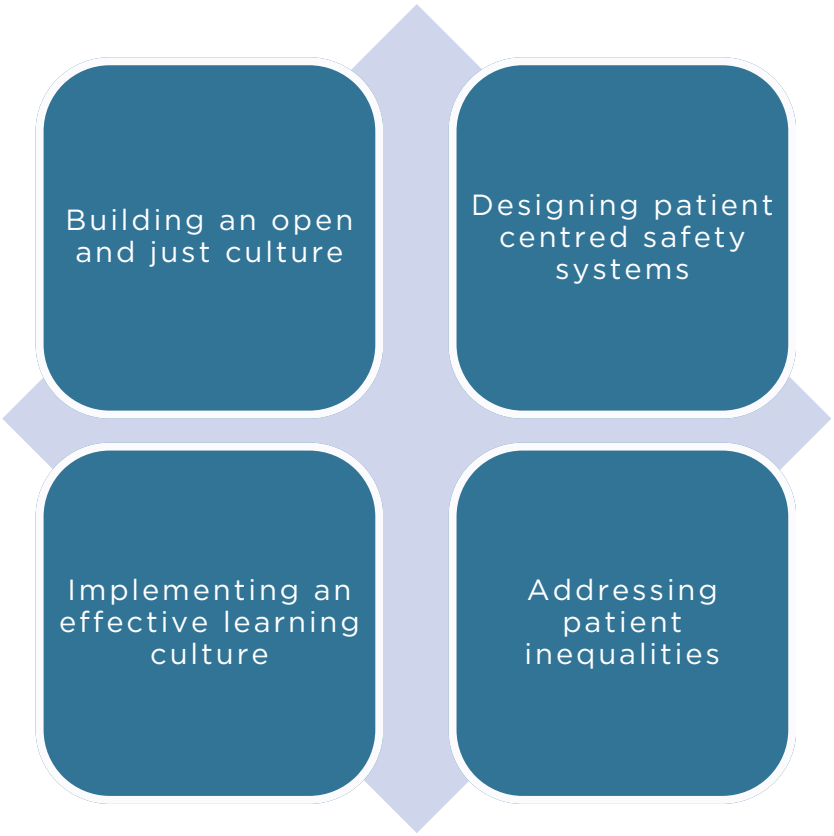
Why a Patient Safety Conference?

Complaints brought to NIPSO have doubled since the office was established in 2016. Health and social care complaints are by far the largest percentage of complaints received, as well as the largest percentage of complaints which require Further Investigation. Health and social care complaints are increasingly complex, with many highlighting failures in care & treatment, a lack of communication and poor complaints handling. Members of the public report the need to be un-necessarily persistent to navigate the complaints process and obtain the answers they seek. Mistakes and errors are unfortunately a part of life and can never be fully eradicated. However, we need to move from a culture which is sometimes defensive with a lack of openness towards a culture which values complaints and uses patient voices as an opportunity to learn and prevent future harm. A clear thread running through the findings and the recommendations of the many reports and public inquires in recent years is the importance of good complaints handling and learning from complaints. Home Truths, CPEA (Dunmurry Manor) and the Independent Neurology Inquiry all highlighted the fragmented nature of complaints handling and the importance of complaints data to ensure greater oversight and accountability. Despite multiple Public Inquiries into Patient Safety related issues across the UK, and particularly here in NI, there is concern that the same issues are consistently raised without clear evidence of improvement.

https://www.nipso.org.uk/sites/default/files/2024-09/Patient%20Safety%20Report%20%286%29.pdf

Aim of the Patient Safety Conference

The Patient Safety Conference brought together people from a wide range of backgrounds to explore potential strategies and approaches to improving Patient Safety and Public Trust in our health and social care system. The conference content looked at how to drive patient safety improvement in a complex health system and focused on four key issues:



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Welcome address from Robin Swann, Minister for Health

The event started with the first of two videos sharing the experiences of people who brought patient safety complaints to NIPSO. We are very grateful to the 5 individuals who shared their stories with us.

The Minister opened the conference by stating that people expect health and social care to be safe. However, if that care fails to meet an acceptable standard, they should experience openness and honesty and be treated with dignity and respect. His speech described how, the Department is continuing to prioritise the implementation of learning and recommendations arising from previous Inquiries and acknowledged the need to enhance patient safety and help restore public confidence.

The Minister said that significant progress has already been made towards implementation of Independent Neurology Inquiry (INI) recommendations and that the ongoing redesign of the Serious Adverse Incident procedure will address recommendations from both the INI and IHRD inquiries. The Department's Permanent Secretary chairs an Inquiries Implementation Programme Board which oversees and brings together this related work.

The Minister also stressed that the "experience" of patients and staff that must be considered alongside traditional benchmarks. Patient voices must be at the heart of health and social care design and delivery and valued as trusted sources of information on patient safety.Staff must be able to voice their views, ideas and concerns without fear. Supporting an environment that welcomes, encourages and seeks out patient and staff experience is essential in the journey of continuous improvement and culture change in this regard will take time.

Ombudsman address from Margaret Kelly

The Ombudsman outlined NIPSO's significant involvement in health and social care. On average NIPSO receives 1100 – 1200 complaints a year, 40% of these are health and social care related. 80% of all complaints that move to further investigation relate to health and social care and many of these will already have been through an SAI process. The Ombudsman highlighted that the most common areas of complaint are: poor communication, premature discharge, delays in care and treatment. Those who do complain are motivated to do so because they want to understand what happened and to make sure that it doesn't happen again.

Ms Kelly shared that unfortunately the office continues to see the compounded harm and trauma when families, patients or relatives raise issues of concern after an incident of significant harm. These have included, a failure to be open and honest about what has gone wrong, a lack of support to navigate the complaints or SAI process and a lack of compassion and empathy. There is also evidence of poor-quality investigations and a failure to really put in place the learning to reduce the risk of the incident happening again.

Pointing to the complex nature of our integrated health and social care service, the pressure the system is under and the multiple number of recent and active inquiries, the Ombudsman outline the need for a Patient Safety Strategy for Northern Ireland.

A Patient Safety Strategy would provide a framework to deliver a co-ordinated and communicative response across the system. To drive systemic improvement across a complex system will require a deeper understanding of patient safety and patient experience. It also requires that we have a culture of candour and openness - we cannot improve patient safety without the patients, and we cannot build public trust without the public.

The ombudsman closed her address by emphasising that the focus of the conference is on learning, improving and change. It is on prioritising and improving patient safety and public trust, for the benefit of all -patients, staff and communities.

Keynote Speech
Sir Robert Francis KC

Sir Robert began by acknowledging the importance of Public Inquiries – but they are only effective if we learn from them. Between 2005 – 2018 the UK spent £239 million on 19 inquiries, a figure that will be much higher today. The purpose of inquires is to establish: the facts – what happened, accountability - why did it happen? And Lessons – what can be done to prevent it happening again?

Inquiries should also listen to victims, engage stakeholders and consider mediation/ resolution. Achieving these aims is challenging, particularly the balance between accountability and the examination of often complex and disputed data. Sir Robert shared some statistics on healthcare safety and highlighted that 50% of harm is preventable. There are 3 million deaths per year due to unsafe care and half of preventable harm is due to medication. The NHS workforce survey (over 700k staff) regarding the culture amongst Health Care staff portrayed a stark picture of low morale, unrealistic expectations, pressure, bullying and concerns around how fairly those who make errors are treated.

So, what to do about this? Leaders must face reality and those with discomforting truths must be heard. Healthcare leaders must facilitate solutions to the problems, learning from failure as well as success, and review effectiveness - no solution is likely to be permanent. In all they do, leaders must prioritise the effect on those they serve – public but also staff - and promote the organisation's values. Sir Robert highlighted the key findings in Inquiries that show that patient and family voices were often ignored, incident reports and investigations ignored, transparency and candour discouraged, and whistleblowers victimised.

Key steps to improvement highlighted in the keynote were:
·Values which prioritise service purpose and which are owned and followed by all staff

- Aim to look like the organisation you want to lead
- Candour and transparency
- Freedom to Speak Up
- Measure what matters.

In relation to the Duty of Candour, Sir Robert highlighted the following key points:

- **Act in an open and transparent way** with people receiving the service
- **Tell anyone who has been harmed**, in person, as soon as reasonably practicable after becoming aware the incident and provide them with support
- **Provide an account of the incident** which, to the best of the provider's knowledge, is true and includes all of all the facts known about the incident at that date
- **Advise the affected person** what further enquiries are believed to be needed
- **Offer an apology** or context appropriate regrets
- **Follow up** by giving the same information in writing and providing updates on the enquiries
- **Keep a written record** of all communications and enquiries.

Sir Robert finished with some personal reflection on 'Good leaders' and reiterated again the essential role leaders play in patient safety. He urged leaders to:

- **role model** values
- **empower** all to exercise leadership
- **promote** candour about mistakes
- **expect** staff to speak up about concerns and celebrate those who do
- **listen** to those they serve
- **act** on their concerns and report back to those who raise them
- **set** clear goals in agreement with staff
- **measure** progress including their own
- **insist** on constructive professional development, objective appraisal & reflection
- **never be satisfied** with today's success and look for constant quality improvement.

Workshops

Breakout 1: Building an Open and Just Culture

Professor Gabriel Scally, visiting Professor at the University of Bristol spoke on his experience and the importance of the Duty of Candour. He discussed the detrimental impact on patients and their families where truth is not provided at the outset. This is then sometimes compounded if individuals go through the court system, where they must relive their experience; face sensitive (potentially humiliating) questions and ultimately are not provided with answers. Professor Scally offered several key suggestions to aid an 'Open and Just Culture' with a focus on enhanced patient/democratic engagement and participation.

Peter McBride spoke on his experience and the difficulties in introducing a Statutory Duty of Candour within an area where staff consider that the biggest barrier to an open culture is fear, particularly the fear that mistakes will be punished. He discussed how the perceived punitive nature of the Statutory duty and criminal sanctions may compound this. The 'Being Open' workstream is hoping to find ways to embed openness and support of staff to speak up when things go wrong. He suggested that workplaces should focus on encouraging reflection; constant learning; and 'openness as routine'.
The question and answer session raised several points of discussion including:

- The Government's role in introducing this new culture, and how the relationship between the Department and the Trusts will work in taking this forward.
- The potential issues of NI small size and perceived 'incestuous' nature. However, there was a view from some that transformation could happen if there was political and public will.
- An apparent focus on 'Doctors' in discussions around Duty of Candour. It was suggested that accountabilities are being placed on Doctors when they have little to no authority, with several participants sharing that Doctors do speak up.

In conclusion, the difficulties of a reform of this kind – across a whole system which is already under huge pressure - was discussed. It was again reflected that opportunities need to be created to understand the importance of being open and for this to be embedded in culture. *'This is a lifestyle move, not time limited.'*

Workshops

Breakout 2: Designing Patient Safety Centred Systems

Helen Hughes, CEO Patient Safety Learning outlined the challenges with a health system which is complex, siloed and where many staff describe experiencing a culture of fear and blame. Drawing attention to recommended changes to address avoidable deaths, preventable harm and the financial costs of unsafe healthcare, Helen highlighted the importance of viewing safety as a core priority and not one that competes with other issues. This involves reviewing cultural and leadership issues and moving from people-focused actions (telling people what to do) to a whole system approach to ensuring good practice and patient safety. Helen also pointed to the English experience to date with Patient Safety Incident Response Framework (PSIRF) – the new system replacing SAIs. This focuses more on compassionate engagement with patients and families and has transferrable learning which could be applied in NI.

Prof Lourda Geoghegan and **Kieran McAteer**, Department for Health - the presentation provided an outline of SAI Review Project, noting that even in good systems things can go wrong and it is how we respond to these which is important. The presenters set out the evidential base for the need for change and the clear mandate from the Minister and the Permanent Secretary for the programme of work to move swiftly. The current SAI process was described as process driven and resource intensive, with engagement with patient and families not always optimal. They shared that a programme of work has agreed and one of the next key stages will be consultation with the public.

The Question & Answer session raised several issues. The importance of having a framework/strategy was highlighted to facilitate a structured approach – patient safety cannot be haphazard. Leadership at all levels or organisations is required to bring about whole organisation change and improvement. Participants talked about how patient safety has become siloed and resulted in a 'technical programme' rather than a more ambitious transformation programme. It was also noted that the relationship between patient safety and quality improvement has become silo'd whereas the two, whilst needing to be distinct must also be integrated and mutually reinforcing to be effective. Staff training was also highlighted as a concern and that sometimes this was a tickbox exercise.

Workshops

Breakout 3: Implementing an Effective Learning Culture

Sean Martin, Deputy Ombudsman presented on the NIPSO Complaints Standards project which seeks to improve complaints handling process for all public bodies. At the time of the conference this was shortly commencing with the Health & Social Care Trusts (this work has now started), having worked previously with all 11 Councils in NI. In addition to describing the Model Complaints Handling Process the key issues highlighted were – the key role of leadership in setting culture and embedding learning and the essential value of listening to patient voices. Whilst the stages and processes involved in complaints handling are important and must be followed – a crucial factor is the overall culture of valuing the learning from complaints and feedback and using complaints data and information in service improvement.

Prof Annette Boaz, Kings College, London started by sharing a summary of research into the many challenges to building an effective learning culture. Even when staff are afforded time off to engage in learning, they can often face resistance from the organisation when they try to implement what they have learnt. This can be hierarchical – the learning experience is seen as deficient as it is not a clinical trial or resistance comes from peers who are resentful a colleague had 'time out' or that they have been given extra work to do. So even with good intentions, individual learning initiatives often result in little learning at an organisational level.

Prof Boaz then focused on a practical example of how investing in staff capacity to engage with research can yield positive impact. Research studies have shown that research active Trusts had lower risk-adjusted mortality for acute admissions and that high, sustained hospital-level participation in interventional clinical trials improves outcomes for patients. By being part of research, staff were able to learn from other networks, there was more collaboration, staff felt up to date and the supportive context enabled the uptake of new services.

Q&A discussion highlighted the importance of ongoing learning from a range of data and information, not just looking at complaints or when things go wrong. Participants discussed the importance of transparency and the risks of further harm if service users feel like they haven't been given the full story. However, it was also noted that in the relationship between liability and learning this can be difficult. Learning and investigations can often be too individualised – there is a need to also focus on the system and not just individual accountability.

Workshops

Breakout 4: Addressing Patient Inequalities

Graham Mockler, Director Professional Standards Authority highlighted the importance of looking at intersectionality and understanding the experience of different groups. He posed the question – how do we know whether patients from different backgrounds receive the same quality of care? Many health settings fail to collect the data needed to fully understand patient experience from the point of gender, ethnicity, and other inequalities. Without this data, how do we know where and for whom improvement is needed. For example, if we do not know who is complaining we might put energies into the wrong parts of the system. Indeed, not knowing could be counterproductive and drive an ever-bigger inequality gap.
Safer care for all. Solutions from professional regulation and beyond (professionalstandards.org.uk)

Professor Owen Barr, Ulster University focused on the inequalities experienced by people with learning disabilities to highlight the importance of data to fully understand patient experience. Owen's presentation shared research about how little data we routinely collect about this population despite the well documented disparities in health outcomes and life expectancy. Without the data – we cannot address these inequalities. This input challenged health care settings to look at where the blind spots are.

The Q&A session discussed the importance and the challenges around collecting data, especially in a complex health and social care system. The complex nature of meeting the needs of vulnerable patients was discussed and transitions for children with complex, life limiting health conditions were mentioned. One of the challenges to improving how the needs of vulnerable patients are met is the siloed and fractured nature of our health and social care system – there is a strong desire and motivation to improve outcomes in care and treatment amongst staff, but the system can make this difficult. Workshop participants also highlighted the need to better capture and share good practice in meeting the needs of those who need support.

Patient Voice

As with the morning session, the afternoon session started with a video sharing the experiences of people who brought patient safety complaints to NIPSO. This was followed by presentations from Linda Craig (Regional Lead, Patient Client Experience, PHA) and Chris McCann (Director, HealthWatch).

Linda Craig PHA

The aim of the Patient Client Experience programme (PCE) is "*...to proactively enable service users, families and carers to share their narrative/ stories of Health and Social Care through a mechanism which enables regional analysis and can lead to learning and change at all levels of the HSCNI system...*" This includes routine online, service user feedback and bespoke projects using storytelling in settings such as Care Homes. The PCE programme operates as part of a wider Statutory Duty of Quality which includes early intervention intelligence, complaints, Serious Adverse Incidents and Inquiries.

Linda stressed the importance of identifying 'touch points' for learning and the need to embed the earliest opportunity for learning. This echoed the points made throughout the day that learning is all too often retrospective and after an event or incident has occurred. PCE allows patient voice and experience to be captured and responded to in 'real time' and used to inform decision making and improvement. Linda's presentation stressed the importance of building **a culture of listening to the voices of people engaging our services – at all levels.**

Chris McCann, Healthwatch

Healthwatch is a charity in England which ensures that NHS Leaders and other decision makers hear the public's voice and use that feedback to improve care. They proactively seek people's experience of GP's, hospitals, dentists, care homes and other support services through an England wide network of local Healthwatch organisations. Key current activities include a strategic focus on equality, diversity and inclusion (EDI). This includes continuing to develop an evidence base that focuses on demographics and geographic spread to reflect the communities it represents. Involving more people from affected communities in their work and forming partnerships to help make change happen. Healthwatch research into health disparities in waiting for planned care, highlighted that the impact is not experienced equally across all patient groups and a poor experience of waiting is linked to wealth, disability, education, gender or ethnicity.

Their research highlighted that disabled people, those with lower levels of wealth, women, and people from ethnic minority backgrounds are the most likely groups to have been waiting over four months for treatment and to have experienced a delay or cancellation.

Chris ended his presentation by stressing that when informed by the views and experiences of those who use them, health care services can deliver **what people need, not what professionals think they need.** This requires a culture of openness, but, above all, listening to patients and their loved ones.

Whistleblowing and Speaking Up

Rosemary Agnew

Independent National Whistleblowing Officer for the NHS in Scotland

The final presentation of the day was from Rosemary Agnew, who is both the Scottish Public Health Ombudsman and Independent National Whistleblowing Officer (INWO) for the NHS in Scotland . In her role as Whistleblowing Officer, Rosemary investigates complaints about how whistleblowing concerns about patient safety has been handled by the Scottish NHS, and claims of detriment to individuals resulting from raising whistleblowing concerns. She also sets the principles and standards for the handling of whistleblowing concerns at local level.

The aim of this function is to ensure everyone delivering NHS services in Scotland is able to speak out to raise concerns when they see harm or wrongdoing putting patient safety or service delivery at risk. People must be able to raise concerns, confident that they can do so in a protected way, that will not cause them personal detriment. They also need to be confident they have the right to an independent review if dissatisfied with how the concern was investigated.

The INWO has the power to set out principles and a procedure for NHS Scotland providers to use in handling whistleblowing concerns and to provide an independent review stage to this procedure. The high level principles and detailed procedure for investigating concerns set out in the National Whistleblowing Standards (the Standards) were approved by the Scottish Parliament. They apply to all NHS providers in Scotland, including primary care and contracted providers. They also apply to students, trainees and volunteers as well as all temporary and permanent staff.

Conclusion and Next Steps

Across the full day of presentations, workshops and discussions there was a clear consensus on some of the key actions needed. These are summarised below:

- Address the culture of fear and blame which prevents people (but particularly health care staff) from speaking out.
- Resource more meaningful engagement with patients to learn from their experiences (good and bad).
- Collect and analyse data to better identify and understand inequalities in health and patient safety.
- Tackle the silos in the system through a strategic approach to patient safety.

Key points for change towards building an Open and Just Culture:

- Address the fear and blame culture within health settings
- Better system for complaints
- Support for Whistleblowers
- Meaningful patient involvement
- Democratic engagement with wider civic society

Key points for change in creating patient centred safety systems:

- Address the fear and blame culture within health settings
- Ambitious and brave leadership to drive culture change
- Better integration between patient safety and quality improvement
- A more strategic approach to patient safety

Key points for change in implementing an effective learning culture:

- Leadership is key in driving an effective learning culture
- Enable and resource the collection of patient feedback
- Address the fear and blame in health settings learning needs a safe space
- Share learning regionally of good practice and not only near misses / mistakes

Key points for change in Health Inequalities and Patient Safety:

- Collect data to understand inequalities in health and patient safety
- Better staff training & resources to recognise and address vulnerabilities
- Access to support for those who need it

Next Steps

Through it's investigatory and Own Initiative powers the Office of the Ombudsman will continue to use investigation findings to highlight issues affecting patient safety and make recommendations to improve public services delivering health care.

NIPSO is leading on a Complaints Standards project which aims to create more consistent and effective complaints handling across public bodies in NI. This work is currently underway with the Health & Social Care Trusts and will explore how best to listen and respond to the patient voice, how to remove barriers and fears around complaining and how to use a frontline, resolution response to address concerns and questions early in the process.

We will engage with relevant organisations, public bodies and other stakeholders to learn about and promote good practice to reduce the health inequalities experienced by patients. In 23/24 we began collecting our own EDI data to understand and improve the accessibility of the Office and ensure that anyone who needs to engage with us is supported to do so.

We will work with elected members, public bodies and government bodies to encourage the development of a Patient Safety Framework for Northern and the consideration of any further statutory powers needed to strengthen the protection of those who wish to speak out to prevent harm.

Research and existing practice in other countries indicates that a Patient Safety Strategy (or Framework) can set out a clear vision and commitment as to how the health care system will support staff and providers with the skills, structure and confidence to prioritise and improve patient safety. A public commitment to a resourced plan to invest in a Patient Safety Framework will, in the long-term not only impact on health outcomes but will help reassure the public and restore trust in health care systems.

Thank you to the following breakout facilitators for their time and expertise:

Breakout 1 – Brian O'Hagan

Breakout 2 – Dr Jennifer Hanratty

Breakout 3 – Majella McCloskey

Breakout 4 – Dr Helga Sneddon

Thank you also to our video participants, who kindly shared their personal stories to emphasise the importance of prioritising patient safety:

Shirley Quinn

Steven &

Janice Irw

Vittoria R








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https://www.nipso.org.uk/sites/default/files/2024-09/Patient%20Safety%20Report%20%286%29.pdf

Foreword from General Sir Gordon Messenger

In October 2021, the Secretary of State asked me, alongside my now good friend Dame Linda Pollard, to examine the state of leadership and management in the health and social care sector. A daunting remit, but one which recognised the impact that good leadership at every level can make in a workforce which has been under incredible pressure in recent years and where the demands on its commitment and goodwill show no sign of slacking.

As an outsider with limited sectoral experience, it was with some trepidation that I set off on our listening and learning phase; a perhaps unwelcome interloper at a time when everyone was understandably focused on the pandemic and its consequences. Yet, throughout, I have encountered nothing but friendliness, candour, self-reflection, pragmatism and support from the impressive array of experts, front-line staff, academics, service users and leaders who willingly gave us their time to share their views. I have always held our health and social care workforce in the highest regard, yet my respect and admiration has deepened through witnessing their selflessness, professionalism and resilience first-hand. My thanks go to all those we spoke to, and my apologies to those we unwittingly missed.

Of the many telling observations we have heard, 2 stand out as almost universal; firstly, the very real difference that first-rate leadership can make in health and social care, with many outstanding examples contributing directly to better service, yet; secondly, that the development of quality leadership and management is not adequately embedded or institutionalised in our health and care communities. We have consequently focused our findings on areas which improve awareness of the impact that good leadership can have, and which instil it as an instinctive characteristic in everyone, not just those with the word in their job title.

Huge variety exists in the way primary, secondary and social care is structured and governed, so it has proved difficult to identify sensible interventions that have consistent relevance and impact across the board. The NHS is itself far from a homogenous unified organisation but rather a federated ecosystem where complex tribal and status dynamics continue to exist. Given the clear benefits of cross-boundary teamwork and collaborative behaviours, everything should be done to encourage greater parity of esteem, conditions and influence between sectors and, within secondary care, a re-balancing of the focus on acute trusts to the benefit of their community, mental health and ambulance trust counterparts. The vast majority of health and care delivery never touches the acute sector, and it is in the interests of all to keep it that way, so more equitable representation

and empowerment must be a key enabler to enhanced collaboration. Equally, the more that can be done to instil locally a culture of teamwork, understanding and shared objectives across the primary, secondary and social care communities, the better will be the nation's public health outcomes.

To those of our recommendations which require time and resource to implement, I predict a partially understandable reaction that the current pressures on the system preclude investment beyond the urgent. My response is that a well-led, motivated, valued, collaborative, inclusive, resilient workforce is 'the' key to better patient and health and care outcomes, and that investment in people must sit alongside other operational and political priorities. To do anything else risks inexorable decline.

I would like to thank the review team who have supported me so energetically and ably. Without their insight, industry and support, I would still be lost in the foothills of the challenge set me and will be forever grateful for their patience and commitment over the last few months. A special mention must go to my co-lead, Linda Pollard, who has contributed so much despite also holding down a crunchy day-job. Her wisdom, decency and forthrightness have shone through every day and, if this review achieves what it sets out to, the plaudits are hers.

Sir Gordon Messenger
8 June 2022

Executive summary

For a report like this to have the impact intended, it needs to speak to the community it affects. It must be supportive but honest. It must recognise the challenges and the context faced, but it cannot duck the difficult or uncomfortable. It should respect the everyday commitment, determination and goodwill of leaders and staff at every level to improve outcomes and experience for patients and service users yet also, through well-intentioned, constructive criticism, aim to provide a framework for improvement.

In that vein, we must confront the fact that there has developed over time an institutional inadequacy in the way that leadership and management is trained, developed and valued. Collaborative behaviours, which are the bedrock of effective system outcomes, are not always encouraged or

rewarded in a system which still relies heavily on siloed personal and organisational accountability. Very public external and internal pressures combine to generate stress in the workplace. The sense of constant demands from above, including from politicians, creates an institutional instinct, particularly in the healthcare sector, to look upwards to furnish the needs of the hierarchy rather than downwards to the needs of the service-user. These pressures inevitably have an impact on behaviours in the workplace, and we have encountered too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance. We experienced very little dissent on this characterisation; indeed, most have encouraged us to call it out for what it is.

These symptoms are not, we would observe, necessarily the fault of historical or existing leadership teams or their staff. They are the result of a combination of factors over many years; some structural, some cultural, some emanating from behaviours at the top, including politicians, some born of complex inter-professional and status issues in the workplace. The important conclusion, however, is that they should not be tolerated as they directly affect care of the service-user as well as the staff, and that they can be tackled but only through determined cultural change from the top of the system to the front-line.

The recommendations of a one-off review cannot provide all the necessary ingredients for such a shift, but we do attempt to identify key interventions which we hope will deliver momentum and scale. We identify the point of entry as a critical opportunity to set cultural and behavioural expectations, and to emphasise that how one behaves is as much a component of professional acumen as what one does. We propose a locally delivered mid-career development event, designed to bring together professionals from all parts of health and social care around the triple lens of collaborative leadership, broader cross-sector awareness and understanding, and behavioural expectations. We encourage the medical profession to examine honestly their role in setting cultures, given their unique influence in the workplace dynamic. Most critically, we advocate a step-change in the way the principles of equality, diversity and inclusion (EDI) are embedded as the personal responsibility of every leader and every member of staff. Although good practice is by no means rare, there is widespread evidence of considerable inequity in experience and opportunity for those with protected characteristics, of which we would call out race and disability as the most starkly disadvantaged. The only way to tackle this effectively is to mainstream it as the responsibility of all, to demand from everyone awareness of its realities, and to sanction those that don’t meet expectations. EDI should become a universal indicator of how the system respects and values its workforce, and the provision of an

inclusive and fair culture should become a key metric by which leadership at all levels is judged.

Beyond cultures and behaviours, we chose to focus on the current absence of accepted standards and structures for the managerial cohort within the NHS. With known exceptions, it has long been a profession that compares unfavourably to the clinical careers in the way it is trained, structured and perceived, and we received strong feedback from managers at all levels that greater professional status and more consistent, accredited training and development are required. This training must be aligned to professional skills required in the future, including digital and transformation, as well as core managerial delivery. We make recommendations to that end.

This approach to career management spills over into how individuals' particular skills and talents are encouraged and developed, and we heard frequently that managers do not always feel institutionally supported in their career choices. We did not find much evidence of a systemised career management function which exists to grow the right experience and talent and to place it where it is needed most. While there are many examples of world-class leadership in the NHS, we would observe that it often exists through the endeavours of an individual rather than as a consequence of proper talent management. The flip side of this opportunistic approach to succession planning is that it lacks equity and does not guarantee that the most deserving leaders reach the top. We would include non-executive director (NED) appointing in the same bracket. Despite the pivotal governance role of boards, the selection and development of NEDs is currently too localised and arbitrary to assure the right balance of skills, experience and background around the table.

It is clear that effective leadership can be an important, but by no means the only, component in addressing the thorny issue of geographical variation in the quality of care. We welcome the ongoing efforts by the current leadership to tackle this, and provide recommendations which seek to provide effective incentives for the right talent and teams to commit to these challenges, along with a package of support to give them the best chance of success.

The last section of the report is devoted to implementation, recognising that anyone can have great ideas but, if they don't lead to action, they are for nought.

Summary of recommendations

1. Targeted interventions on collaborative leadership and organisational values.

A new, national entry-level induction for all who join health and social care.

A new, national mid-career programme for managers across health and social care.

2. Positive equality, diversity and inclusion (EDI) action

Embed inclusive leadership practice as the responsibility of all leaders.

Commit to promoting equal opportunity and fairness standards.

More stringently enforce existing measures to improve equal opportunities and fairness.

Enhance CQC role in ensuring improvement in EDI outcomes.

3. Consistent management standards delivered through accredited training

A single set of unified, core leadership and management standards for managers.

Training and development bundles to meet these standards.

4. A simplified, standard appraisal system for the NHS

A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system.

5. A new career and talent management function for managers

Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.

6. More effective recruitment and development of non-executive directors

Establishment of an expanded, specialist non-executive talent and appointments team.

7. Encouraging top talent into challenged parts of the system

Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.

1. Introduction

Effective leadership creates successful teams, and successful teams drive better outcomes. The best organisations are those which invest in their people to unlock their potential, and which build strong teams around a unifying purpose. The most successful are those which also foster leadership and accountability at every level, and where everyone is encouraged to become an agent for something bigger than themselves. This should be our goal.

There are many examples of inspirational leadership within the health and social care sector, delivered in the face of enormous pressure. From ward to board, from the manager in a care home to the receptionist in a GP surgery, great leadership and personal example are being exercised daily in pursuit of the best possible outcomes for patients and public health. But such qualities are not universal and nor are leadership and management skills engrained as the basic building blocks of organisational success, as they perhaps are in other sectors.

We need to recognise that the context for change is highly challenging. External pressures such as manifold performance metrics, stringent regulatory requirements, and short-term political demands, combine with internal pressures such as staff shortages, budget issues, sectoral disparity

and pandemic-induced backlogs to create a very difficult backdrop for compassionate leadership and collaborative, inclusive behaviour to thrive. These pressures can lead to 3 unwelcome outcomes:

- they drive a singular fixation on the task in hand, often to the detriment of nurturing the team and supporting its individuals. Over time this has certainly contributed to poorer experiences in the workplace and worsening outcomes; manifested by higher absence rates, deteriorating staff engagement and performance downturns
- they create an organisational instinct to prioritise the needs of the system and its hierarchy over a focus on the better patient and public health outcomes
- they can feed a sense of futility and helplessness in the workforce because individuals perceive they lack the tools or ability to rectify what they know is wrong

To reverse these trends requires a re-calibration towards building stronger teams and a renewed sense of respect and value amongst an empowered workforce, delivered through committed, compassionate leadership from bottom to top. The hard fact is that this must be prioritised alongside the pressing operational needs, and we should be ready to deploy the justification that spending time and resource on looking after the workforce will quickly repay the investment through improved support to patient and service users. Equally, the best way to root out inefficiency and waste is to encourage a collective accountability to tackle it, through empowerment and teamwork at all levels. In every way, investing in leadership and team-building makes economic sense.

Every opportunity must therefore be taken to embed such behaviours so that they become institutionally valued and instinctive to all. And right now we suggest a number of powerful factors combine to provide a generational opportunity to make the necessary cultural shift, owned and driven by the leadership at all levels of healthcare, social care and government:

- structurally, the introduction of the Health and Care Bill and the advent of integrated care systems (ICSs) provide greater opportunity to promote cross-sector collaborative and inclusive behaviours to deliver better system outcomes. The integration white paper further reinforces the value of close, inter-professional working at local level
- organisationally, the rationalisation over the coming months into a unitary NHS England (NHSE) provides the opportunity to align behind a core set of values and a common leadership culture, with the potential for spill-over benefits into both primary and social care.

Also, the emerging NHS operating model should provide the framework to align responsibilities, accountabilities and authorities

- internally, the NHS People Plan, People Promise and Our Leadership Way provide the manifesto for change in the health sector; they deserve time to bed in and, if owned at every level and not perceived as merely more guidance from the top, have all the right components to motivate change
- culturally, a positive legacy of the pandemic is that it has changed the workplace dynamic across health and social care; driving accountability downwards, encouraging innovation, magnifying the value of teamwork including across sectoral boundaries, and strengthening a workforce sense of community through common experience and shared hardship. This sentiment should be capitalised upon

This introduction sets out both the opportunities and challenges which face our health and social care community. A one-off review like ours is unlikely to drive the deep cultural change needed – that must be the responsibility of existing leaders at all levels – but our hope is that our recommendations can provide the necessary frameworks and momentum to take the plunge.

Methodology

We kept our approach simple; form an inclusive and diverse team, consult as widely as possible, remain transparent throughout. Our excellent team, brought together at short notice, included representatives from the Department of Health and Social Care (DHSC), NHS England, Health Education England, NHSX and social care leaders, as well as clinicians, managers and academics – all bringing their own lived experience and personal knowledge of the health and care system. An early decision to ensure very strong EDI expertise in the core team proved consistently valuable.

Our ‘listen and learn’ phase was extensive, engaging with more than 1,000 stakeholders on over 400 different occasions, plus welcoming contribution from all via an open email address. We heard from all parts of the system and across the breadth of primary care, secondary care, local government, public health, social care, charity sector, patients and people who draw on care and support. We sought to avoid speaking only to the well-performing, better-known parts of the system, and actively encouraged constructive challenge and dissent throughout, including the establishment of a

challenge board which proved highly effective. COVID measures prevented us from visiting many places personally, yet the generosity of people at every level to give up their time was highly encouraging and indicative of their desire to drive positive change.

We have attempted to limit the number of recommendations to a digestible number, recognising that implementation on too broad a front can quickly dilute impact. Instead, we have invested in working closely with those who will need to own the recommendations if they are to take root. Where appropriate, we have tried to align with existing initiatives and to support the conclusions of previous reviews. This includes Tom Kark's recommendations regarding the fit and proper persons test for directors, which we feel are necessary alongside ours to ensure poor leadership is dealt with effectively. We have tried to avoid being over-specific in framing our findings, in the knowledge that subsequent co-creation is the best way both to ensure buy-in from the communities they affect and to minimise unforeseen disruption during inception.

Scope

Our terms of reference encouraged us to examine the nature of leadership across the entirety of health and adult social care, and from the top to the bottom of both. With a remit of this scale, we have necessarily focused in on a few key themes which we hope will yield the largest impact. One challenge we faced was the very different structures, governance and accountabilities that co-exist across sectors, and it quickly became clear that the more hierarchical secondary care sector has more identifiable levers of change than the flatter, dispersed, multi-provider structures of the wider health and care landscape, particularly in primary care and social care. This can have the effect of making it harder to enact universal change in the latter sectors, and can also heighten the risk that individuals find opportunities for development more difficult to access.

We have attempted, with some success, to avoid a disproportionate focus on secondary care in our thinking and many of our recommendations are of relevance across all sectors, particularly those which address cultural and behavioural development. But we reluctantly conclude that we have not done them full justice and would advise further work to identify how the impact of better leadership and management can be applied most effectively in our primary and social care communities. Specifically, we commend the focus on developing primary care leadership in the work that Dr Claire Fuller is leading on a stocktake of primary care within ICSs. This

will provide specific and practical advice to the ICS chief executives on how they can accelerate implementation of integrated primary care and prevention ambitions in the NHS Long Term Plan, which will include focusing on the importance of nurturing primary care leadership in their own systems. On social care, we have sensed a strong appetite amongst both local government and independent providers for collective, pan-sector leadership and management development, and strongly support the need for greater parity of investment in social care leadership.

2. Findings

This section sets out the key findings from our review which ranged both widely and deeply in health and social care. We encountered many examples of outstanding practice, including the difference that good, mature, collaborative working can make. Yet we also found areas where change and improvement are necessary to ensure leaders and managers are supported to deliver the best possible care. In that respect, while some of our observations may be perceived as critical or negative, they are by no means universal. But we heard them often enough to call them out.

Cultures and behaviours

In this area of cultures and behaviours, 2 broad themes emerged: the culture of collaboration and the culture of respect. Both themes emanate from and determine how people treat each other and service users; both affect the quality of care and outcomes for service users.

The culture of collaboration

We found that the current cultural environment tends to be unfriendly to the collaborative leadership needed to deliver health and social care in a changing and diverse environment. The system is undergoing a fundamental change from a competitive to a collaborative ethic, and behaviours need to reflect this. Decision-making too often relates to a narrow and limited set of accountabilities that do not allow, encourage or reward collaboration. We recognise that this is a direct result of how performance is currently measured, but strongly believe that a re-balancing towards collaborative, cross-boundary accountability is a pre-requisite to better outcomes.

We saw that the urgent tends to eclipse the important. Staff habitually respond to pressures inherent in the workplace by prioritising the task in hand rather than the team and individuals who together complete that task. This is unsustainable. Principal among the many agents that cause reactive rather than constructive behaviours are those pressures from above that force upward-looking rather than outward-looking responses. Some staff, for example, are presented with the responsibility to meet an external metric while lacking the ability or resource to meet it, while others operate freely without oversight in isolated areas. We saw accountability without authority, and vice versa.

Finally, we saw that leadership itself is undervalued as a way of setting the context for collaboration. Leadership is viewed as the responsibility only of those in specific line manager or senior leadership positions, rather than as a quality that runs instinctively through the entirety of the workforce. We found no consistent view of principles for collaborative or systems leadership; current models extol the virtue of certain behaviours but lack a structured framework.

The culture of respect

We heard too frequently that poor inter-personal behaviours and attitudes were experienced in the workplace. Although by no means everywhere, acceptance of discrimination, bullying, blame cultures and responsibility avoidance has almost become normalised in certain parts of the system, as evidenced by staff surveys and several publicised examples of poor practice. This exists at the micro-level, in individual workplaces, and across sectors, where the enduring lack of parity of esteem, conditions and status between healthcare and social care remains a blight on effective collaborative working.

How an organisation performs and behaves in relation to EDI is a clear indicator of its maturity and openness. Further, it will be a clear determinant of how an organisation fares in a rapidly changing social and work context. In this regard, we found that EDI, which is about respectful relationships and underpins a wider culture of respect, is partial, inconsistent and elective. In some places it is tokenistic.

Improving EDI is also a way of reframing career progression. The latter frequently depends on chance, contacts, regional variation, available time and budget. By training leaders to identify where such unfairness exists, access to opportunities will become allocated more fairly, and career progression will be determined more equitably.

In the NHS, we sensed a lack of psychological safety to speak up and listen, despite the excellent progress made since the Francis Report. We would observe that the Freedom to Speak Up initiative can be narrowly perceived through the lens of whistleblowing rather than also organisational improvement, and we would encourage a broader perspective.

The improvement of organisational learning within health and social care deserves a deeper examination. Too often we encountered limits on the freedom to try without fear of failure, and a willingness to tolerate poor practice while expending energy on workarounds.

Implications of our findings

First, on collaboration. The NHS is a complex ecosystem where personal, professional and organisational accountabilities flow vertically through distinct silos. Similarly, social care is a complex landscape of overlapping public, private, and charity provision. The system needs mechanisms to build and reinforce horizontal, collaborative decision-making; within and between individual organisations, and across the full health and social care sector [see recommendations 1, 2, 3, and 4]. To deliver this, we identify 2 critical points of intervention in careers to embed the necessary behaviours and to align expectations: set culture and improve knowledge [see recommendation 1].

Second, shared greater awareness of the entirety of health and social care would lead to greater empathy and understanding. The system must improve mutual awareness and provide opportunities for staff to engage beyond their professional environment, to appreciate the totality of system, and to value diverse professional approaches. ICSs and integration at place provide excellent opportunities to test and prove the value of collaborative and inclusive leadership.

Third, we think that EDI must be embedded and mainstreamed as the responsibility of all regardless of role, and especially leaders and managers from front line to board. This must include the practice of zero tolerance of discrimination, but also greater awareness of the realities in the workplace for those with protected characteristics. Health and social care must work harder at EDI, recognising it is important in its own right, and key to how seriously an organisation treats the lived experience in the workforce and upholds practices that deliver equitable outcomes for all. Beyond mainstreaming, we also recognise the need for positive action [see recommendations 1, 2, 3, 4, 5, and 6]. We are not advocating for additional EDI professionals; indeed we would anticipate a reduction in numbers over time as leaders demonstrate that they are equipped with the

right skills to address inequality and create inclusive working cultures for all.

Standards and structures

The practice of management relies on both standards and structures; it emerged through our engagement that these are currently either insufficient or absent. Our observations cover the NHS specifically, but we recognise that many of these issues are equally relevant in wider health and social care. We recommend further work to investigate the levers to address common challenges, to ensure shared learning across health and social care can be applied with the most impact.

We found that management tends not to be perceived – formally or informally – as a professional activity. Management lacks the status enjoyed by the established professions in health and social care. We heard that this derives from the absence of acknowledged, universally applied standards to achieve agreed levels of behaviour and competence; and from inadequate, unstructured career support. Management can therefore appear as an under-valued career, rather than one at the very heart of great care.

We found inequity in how different managers are perceived; for example, the NHS Graduate Management Training Scheme (GMTS) is highly regarded, but it is unfair that participants are frequently treated as elite purely by virtue of having undertaken the scheme. Managers who do not join via GMTS, often equally talented, do not benefit from the same profile or opportunities. Lateral entrants are often inadequately inducted into leading and managing in context; and skills gained outside the sector, including those who have trained overseas, are not always fully valued. Clinicians who choose to take on leadership roles in addition to their clinical work told us they had little to no specific training to prepare them.

Management and leadership training, although excellent in some instances, is not based on any consistent or agreed universal standards, is an unhelpful mix of accredited and unaccredited courses and opportunities to access training are inequitably applied. Too much management and leadership training and development, and associated cultural transformation work, is piecemeal, partial and isolated. This whole landscape needs tidying.

There are excellent examples of talent management within organisations, but they are too widely scattered and are rarely completely inclusive. We consistently heard from managers that the lack of structure means career opportunities can appear to be linked more to who one knows and the network one is able to create, than to one's skills and experience. We saw that career management does not start early enough, and this leads to narrowing career paths to the detriment of wider experience. Career management needs to support those in their first role as much as those at mid and later career; too often individuals are recruited to jobs, rather than recruited to careers.

We found a lack of consistency with appraisals – and in some areas, these were absent altogether. Appraisals can range from a performance review and a development conversation to a simple tick-box of tasks completed. Development needs are either focused on individual wants with no relationship to organisational goals, or are neglected in favour of immediate pressures. It was rare to hear of appraisal linking individual, team, organisational and system goals effectively.

Finally, workforce data. Currently, data is not collated and exploited to the benefit of the individuals, teams, organisations, systems or regions as a whole. The result is that excellent talent remains invisible, career support remains opportunistic, talent-hoarding becomes the privileged domain of those that can, and the system struggles to deploy the best people to work where their skills are needed most.

Implications of our findings

There is a need for universal standards, covering practical, procedural and behavioural elements with the aim of ensuring a clearer set of expectations, and in turn equitable recognition and parity. Proper standards require consolidation and coordination; both are lacking in the current preference for multiple competency frameworks and lists of competencies of variable quality. These standards need to apply to and work for all, including those working part time or flexibly.

Consequently, there is a need to develop a formal training curriculum for managers, to deliver against these standards [see recommendation 3]. This requires larger-scale delivery of training to a pre-determined community, as opposed to the current system which is based on availability and opportunity. Completion of this training should be a pre-requisite to advancement to more senior roles, as current gateways can be arbitrary and inconsistently applied. The modules within this curriculum must allow for different career paths and preferences, but also be accredited to ensure high-quality consistency which is currently lacking. New accreditation could

provide alternatives to master's-level expectations stipulated in many Agenda for Change job descriptions currently and will need to take account of prior learning within the bench marking required for the NHS.

We heard that more can be done to support and guide individuals in how they make their career choices. While career and talent management should remain the responsibility of all line managers, organisations and systems, we can see real value in greater oversight at regional level. This new, regional function should have direct responsibilities as well as strategic oversight of managerial careers, working in close partnership with all parts of the system including the system chief people officers or equivalent and organisations' human resource directors [see recommendation 5]. This function becomes the focal point for the NHS human capital in the region with vital responsibility for the collection of data.

To be truly effective as a talent management function requires a more consistent and effective approach to appraisals, including better training for line managers in their delivery [see recommendation 4]. There is currently too much variability in the quality, effectiveness and outcomes [see recommendation 2].

Wider observations

As well as the findings outlined above, we have a number of other observations.

Regulation and oversight

We found that there is a positive view that the CQC can influence collaboration across the whole of health and social care through its inspections, and welcome its increasing focus on teams and systems. The well-led domain of CQC reports can develop its focus on culture and values rather than on managerial processes, and thereby reflect collaborative, compassionate and inclusive leadership in organisations. A judicious use of metrics and data can be a uniting and enabling agent, particularly if they are the basis for open and honest discussions; however, we also heard that over-emphasis on metrics can be burdensome and counter-productive. Where quality of care falls below what is required, the tone and outcome of regulatory visits can leave leaders feeling isolated and unsupported. With this in mind, we welcome the shift in emphasis from a punitive model to a remedial one.

Open, honest organisational learning here is priceless. We heard that good organisations have a positive relationship with regulators, while those performing less well often wait to be told what to improve. Transparency, and the ability to learn from mistakes and respond without blame, are all necessary for quality improvement; regulators can influence and promote both professional and organisational behavioural changes necessary. Readiness to seek help is a vital first step towards improvement and the route to external support must be clear, timely and stigma-free [see recommendation 7].

The role of the professional regulators (General Medical Council, Nursing and Midwifery Council and others) relates primarily to individuals but is increasingly important in assuring organisational quality. To ensure better read-across to professional standards, we would promote collaboration across all regulators in developing the management standards and the training materials for managers.

Clinical leadership

We found that the interaction between the clinical community and the rest of the workforce is a key element in setting the right cultures and behaviours. The authority and influence that doctors have both in society and within the NHS, means that the medical profession does have a unique responsibility for leading behavioural change where necessary and supporting a positive culture within their sector where all staff flourish.

Clinicians bring a perspective that spans patient interaction and wider population health needs. Done well, their knowledge and innate understanding of their ‘clinical tribes’ can be a huge force for good, but we have equally seen evidence that it can lead to entrenchment and loss of team ethos overall. We encountered the flawed assumption that simply acquiring seniority in a particular profession translates into leadership skills and knowledge; this both reduces the quality of leadership overall and can drive a sense of frustration for those individuals. Doctors are often co-opted for management roles, particularly early in their consultant career, for which they often feel inadequately prepared in comparison with their clinical training. An associated lack of fulfilment can set the tone for their approach to management later in careers.

We heard from allied health professionals that the lack of visibility of leaders from their professions on boards created a sense that careers in management would be limited. Senior nurses talked about ‘going to the dark side’ as a comment often made when they moved into senior management roles, although nurse postgraduate training does provide

elements of management learning. Again, the approach was felt to be ad-hoc and inconsistent.

Overall, even the most successful of clinical leaders reported that their career trajectories had been serendipitous, and that their knowledge was acquired in unstructured opportunities in comparison to their professional training.

We know the system will benefit from well trained, enthusiastic, supported clinical managers and leaders. Alongside the provision of national standards for NHS managers [see recommendation 3], education providers from undergraduate through to postgraduate education, working with professional regulators, have the opportunity to embed and align learning to prepare the clinical professions as future leaders.

The consistency of learning management and behavioural skills is often subsumed by clinical pressures. Extending access to the proposed management training bundles [see recommendation 3] provides an opportunity for a more structured and collective approach to management training for all clinicians. For the medical profession, this must include the trained medical workforce (that is, GPs, consultants and doctors in the staff and associate (SAS) grades). There are different challenges in primary care where we heard there is significant variation in leadership structures within and between GP practices, in their networks. We were told that it is unclear to a newly qualified GP which route provides the best leadership experience in comparison to the traditional clinical director to medical director pathway in hospitals. The new place partnership boards and integrated care boards should provide the outlets that are currently lacking for primary care and public health leaders. The same should be true for local social care leaders.

Leadership delivery in the future

We believe the current climate, including the move towards health and care integration and the work currently underway to merge the arms-length bodies and create a new NHSE, generates opportunity for a fresh approach to preparing leaders and managers in the future.

With regard to leadership development, it is entirely right that it is the role of the centre to demonstrate and drive the appropriate cultures and behaviours, around a set of unified values and purposes. We would observe that this is easier to achieve in the more unified structures of the NHS than in social care, and would encourage investment in setting common cultures and purposes across health and social care as a whole [see recommendation 1]. Further, as knowledge content changes with the

impact of digital health and other innovations, future leaders need access to a very different curriculum.

In the context of the NHS and social care, we heard that leadership development is currently uncoordinated and inconsistent, with a crowded landscape of different guidance, agencies and oversight. We believe that rationalisation and accreditation of training opportunities is required, at a greater scale that serves the entire system [see recommendation 3]. There are some excellent leadership development offers available, but they are offered on a ‘pull’ basis (that is, available but not expected), rather than a ‘push’ basis where there is expectation that prescribed cohorts will participate. We advocate a shift to the latter.

Collaborative action from the centre, the regions and at local level in healthcare will move the system from being an opportunistic, ‘pull’ model described above to one that sets broad, core curricula and manages accredited delivery, recognising that a strong local flavour needs to exist in the detail. The existing leadership delivery models, particularly in the NHS, require change to reflect this. Greater alignment of leadership training and development across health and social care sectors would yield immediate benefit.

3. Recommendations

We think some of the changes we recommend are gradual, subtle, and precise; we think others are immediate, radical, and wide-ranging; we think all are necessary. By driving improvement in leadership and management, we are confident that their implementation will have a positive outcome on both public health outcomes, productivity and efficiency.

1. Targeted interventions on collaborative leadership and organisational values

A new, national entry-level induction for all who join health and social care.

A new, national mid-career programme for managers across health and social care.

As the delivery of care transforms, a move to greater integration, different skills, and more collaborative behaviours is required. This includes a need

for improved, standardised training on equality, diversity and inclusion [see recommendation 2] as part of a new approach to the production of skilled managers. There are 2 critical waypoints where a significant impact can be made with new training interventions:

- at entry into a career in health and social care, by whatever route
- at mid-career where individuals often refine their ambitions and career trajectories

What is needed here does not currently exist: this is not about scaling any existing training programmes.

Entry level

The scope here is intentionally broad, capturing the breadth of those who enter a role in healthcare, social care, local government, and relevant voluntary and private sector organisations. In the NHS, around 196,000 staff joined or took up new roles between September 2020 and September 2021; in social care approximately 490,000 staff joined or took up new roles in the financial year (FY) 2020 to 2021. The potential for impact is significant, the requirement for scale imperative.

The aim of this programme is to introduce new starters to the culture and values that are expected within services and to foster a sense of belonging wider than the immediate organisation. The content of this programme should therefore be co-created by partners across health and social care, including NHS England, DHSC, Local Government Association, Skills for Care, staff networks and patient representatives. This programme should be for all new entrants including those entering formal programmes (such as the Graduate Management Training Scheme or the Assessed and Supported Year in Employment programme) and be used in combination with local inductions. The framework should be nationally set, with certain allowance for local variation, and made universally available to ensure consistency. There is scope to build on the Care Certificate standards, which already set out the introductory knowledge and skills that are important for those in non-regulated roles.

Mid-career

This programme is targeted at middle managers working in healthcare, social care, local government, and relevant voluntary and private sector organisations. We believe this needs to be 3 to 5 days and in person to get the full benefit, including ideally the creation of local alumni networks. It should work in harmony with the new national leadership programme outlined in the integration white paper. On implementation, the sectors

should work together to identify the cohort for this programme which could include, but is not limited to, GPs, mid-career clinicians, NHS middle managers, principal social workers, registered managers and so on. It is vital that the content is co-created if we are to realise the level of collaboration, system awareness and local delivery needed for the future. Again, the framework content should be nationally set to ensure consistency, with flexible and local delivery, either within ICSs or at place level across regions.

2. Positive equality, diversity and inclusion (EDI) action

Embed inclusive leadership practice as the responsibility of all leaders.

Commit to promoting equal opportunity and fairness standards.

More stringently enforce existing measures to improve equal opportunities and fairness.

Enhance CQC role in ensuring improvement in EDI outcomes.

It is the task of leaders at every level to cultivate the conditions for individuals to overcome entrenched and often unacknowledged disadvantage, by ensuring staff recognise and remove subtle exclusionary practices, and by working to remove the set of unspoken assumptions that favour certain groups in terms of career advancement [see recommendation 5]. Dedicated EDI professionals exist to enable this transition. We would anticipate the numbers of dedicated experts to reduce as they successfully instil such awareness in leadership at all levels.

If implemented effectively, we are hopeful that every one of our recommendations will improve equality opportunity. In addition, we believe the following specific measures are urgently needed to enable the necessary improvements on EDI outcomes across health and social care:

- educate leaders to ensure they understand their role in demonstrating and improving inclusive leadership. This must include a more central role for EDI in leadership training and development which, in turn, requires greater skills and understanding of the topic from those delivering the training. We would encourage the use of the Everyday Discrimination Scale as a useful, objective tool which supports leaders and teams to address this issue in the workplace
- agree and set uniform standards for equal opportunities and fairness across health and social care at entry-level and mid-career level [see

recommendations 1 and 3]. Use accredited training modules to set and maintain these standards [see recommendation 3]. Ensure organisational and individual accountability for delivery against these standards, including through appraisals [see recommendation 4]. Uniform standards should help leaders learn how to address discrimination at individual, team and systemic levels

- more stringently enforce existing measures to improve equal opportunities and fairness across all NHS functions. We would encourage similar universal targets in social care. Teams and organisations should set year-on-year goals for improvement, for example by increasing the representation of under-represented groups in training, in development opportunities, and in senior roles [see recommendation 5]
- to support such accountability, the CQC needs to reinforce the behavioural and cultural change necessary, as recommended in the Inclusive Britain policy paper. This includes ensuring that regulators take account of EDI data as part of their organisational assessments, and particularly the seriousness with which it is viewed by leaders

3. Consistent management standards delivered through accredited training

A single set of unified, core leadership and management standards for managers.

Training and development bundles to meet these standards.

While these recommendations are NHS specific, there is scope for the standards and core content of training and development bundles to be used more widely across health and social care, which should be explored in further detail. There is also good practice within social care from which the NHS can learn, such as principal social worker and registered manager standards.

The implementation next steps are as follows:

- development of the standards – the standards should be co-created, with input from across healthcare, including patient representatives, accounting for good practice that already exists, such as in the NHS People Plan. They should cover operational, strategic management and most importantly, the behavioural components and responsibilities for managers for inclusive leadership, as

underpinned by all parts of this review. Once developed collaboratively, they should be nationally led and accessible to all

- development of the training bundles to meet the standards – single, standalone training intervention is unlikely to deliver the depth and breadth required, so we propose the co-creation of training and development bundles. These bundles should include a number of consistent training modules, on areas such as inclusive leadership [see recommendation 2] and core management skills and tools (such as how to conduct an effective appraisal [see recommendation 4]). This should build on existing good practice, such as the work of Proud2BOps in this area. We believe these bundles need a single accreditation process within the NHS to ensure consistency, high quality and portability. The bundles should also offer choice and flexibility to accommodate profession-specific requirements, local needs and individual career aspirations. Flexible components could include experiential learning, job shadowing, e-learning and skills-based projects
- roll out – in the first instance, the bundles should be made available to non-clinical NHS managers at entry and at a prescribed mid-career point. This will underpin a more established career pathway and professional status for non-clinical managers; we believe that the qualification needs to be transferable, recognised across the NHS, and a pre-requisite for further advancement. Some flexibility will be required for lateral entry. Over time, this should be a mandatory requirement for NHS managers [see recommendation 5]
- expansion – following roll out, there is opportunity to expand these bundles to all NHS clinical and non-clinical managers alike. This necessitates further work with educators, commissioners and regulators to develop the read-across to postgraduate clinical curricula where leadership and management skills are required

4. A simplified, standard appraisal system for the NHS

A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system.

While appraisals were paused during COVID, all staff in the NHS should have an annual appraisal. However, some express cynicism about effectiveness, as shown in the latest NHS Staff Survey. Improvement is needed to the process and quality of appraisal, irrespective of whether individuals wish to progress to higher roles or not. The new system should be based on improvement methodology in 2 parts:

- performance in role including both technical and behavioural elements
- a career conversation around ambition and aspiration

This should enable individuals, organisations, and the system to clearly identify talented individuals and their development needs; and then link them to the wider system [see recommendation 5].

Commitment to a unified, simplified appraisal process demonstrates a move away from siloed processes, short-termism and the whims or biases of individual leaders and managers. It requires a shift from the current unwarranted variation in how performance and career aspirations are managed, to a process that is equitable and supportive for all – working at the pace of individual aspiration.

All NHS employees should be within scope for this recommendation, but this should start with a focus on non-clinical managers in the 2022 to 2023 financial year to ensure those most in need of structured career management are supported as a first priority.

The new process should assess the extent to which the individual has upheld the core values of the service and the extent to which they demonstrate a commitment to EDI and fair treatment, not just technical skill [see recommendation 2]. It should focus on how the individual has behaved, not just what they have done.

Appraisals will continue to be an annual performance and career conversation, with in-year follow up, based on a single set of documentation, which should be co-created, agreed nationally and made available to all organisations. It should be designed to sit alongside and complement documentation needed for professional revalidation. The new system should have latitude for team input, including more extensive use of 360 feedback where appropriate.

As the effectiveness of appraisal is as much to do with the appraiser as with process, the management bundles [see recommendation 3] include compulsory training for effective, fair and inclusive appraisal. It is necessary that the new appraisal system considers the appraisee’s experience of their manager, in relation to their commitment to EDI and their inclusive practices [see recommendation 2]. Appraisal data, including completion, satisfaction and outcomes, should then form part of the evidence of a well-led organisation within CQC assessments.

5. A new career and talent management function for managers

Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.

There is a need to create a more aggregated career management function to address 3 problems:

- the lack of clarity for career progression in management
- the failure of the system to utilise and encourage the diverse talent available [see recommendation 2]
- the shortage of people wanting to be managers in challenged parts of the system [see recommendation 7]

An effective career and talent management function could overcome these challenges, providing a compact between NHS managers and their organisations – both in support of the individual and to the benefit of the organisation and the system. The function should sit predominantly with NHS England at regional level; but forming part of a coordinated structure at organisation, place, system and where necessary national level. It should initially support and provide structure for non-clinical NHS management careers, with the potential to expand the remit rapidly to also cover clinical managers once established.

This needs to be inclusive, with sufficient scope, scale, and authority to perform the following functions:

- plan – give structure to succession planning wider than can be achieved in individual organisations or systems; including moving people with the right skills and experience to where they are needed most [see recommendation 7]
- support – provide individuals with career advice and support; encourage and signpost training and development opportunities; and provide clear routes to promotion for every individual, encouraging breadth of experience [see recommendation 2].
- hold and analyse data – responsibility for data collection and storage of data on all managers, categorised by profession, in each region. Such regional databases would supplement the national database of board level appointments which was recommended in Kark's Review
- manage talent – encourage and manage the talent within a geography to ensure better visibility, effective succession planning, and matching skills to role and need. Discourage talent-hoarding, where it exists

- oversee – oversee compliance with mandated managerial standards, associated training, and appraisals [see recommendations 1, 3 and 4]

6. Effective recruitment and development of non-executive directors (NEDs)

Establishment of an expanded, specialist non-executive talent and appointments team.

All boards have 3 roles: formulating strategy, ensuring accountability and shaping culture. NEDs and board chairs achieve this through bringing independent, external perspectives, skills and challenge. They make up over half of NHS board roles, yet their importance can be undervalued.

In the absence of sufficient central support, NHS organisations and latterly systems repeatedly fund private sector executive search firms at significant cost. Despite this, appointments lack the diversity and wider experience needed for this vital assurance role, sometimes presenting people already known in the system. We must improve this.

The current non-executive talent and appointments team within NHS England is highly regarded, yet too small to achieve the depth and reach needed. An expanded team could undertake a range of new and scaled up activities to support provider and system boards in close partnership with wider NHS England regional teams. These activities could include maximising attraction, setting standards and consistency in role descriptions, role preparation, induction and onboarding, management of talent pipelines and talent pools, central and regional databases and creating networks.

The team should have clear outcome measures and be accountable for evidencing a tangible shift year-on-year in diverse appointments [see recommendation 2]. A report by NHS Confederation shows the gains made in the early 2000s towards board diversity in the NHS have not been sustained, particularly in relation to women, people from black and minority ethnic communities and especially chairs and NEDs with disabilities. From the current position, we must break the mould and ensure a wider cross section of society see themself fulfilling this vital role. In short, the NHS must achieve greater diversity so that NED and chair roles more closely reflect the communities they serve and the staff they govern.

Without greater penetration into other sectors, investment will not result in the change needed nor deliver the pipeline of diverse NEDs that can provide the skills and oversight needed. An intervention based on the roles of the individual, team, organisation and system will best shape the NED contribution in the future. Therefore, forging greater links within systems, with other governmental departments, other public sector organisations and commercial providers is vital.

7. Encouraging top talent into challenged parts of the system

Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.

There are currently little or no incentives for leaders and managers to move into leadership roles in organisations in challenging circumstances. This section builds on previous recommendations in Sir Ron Kerr's Review around a 'new deal' for leaders to make improvements through the creation of "an agreed package of incentives and support for leaders that take on 'difficult to recruit to' roles".

While there is good work already in train through NHS Intensive Support Teams, an improved and more widespread offer is needed as leaders have reflected to us that the reputational risk of failure remains too high. The package of support offered to leaders and managers should consist of the following functions:

- build team capability – strategically place talented managers and clinicians into organisations and reward them with upward career progression, as being selected should be role modelled and celebrated [see recommendation 5]. Support new recruits and executive teams with a regional taskforce, which includes experienced clinicians and managers, to co-produce a sustainable improvement plan
- provide holistic support and diversity – provide support networks for executives, clinicians and managers, such as peer mentoring, coaching, training and development, and positive action programmes [see recommendation 5]
- allow time and space for improvement – NHS England, CQC and others to reduce reputational risk and target pressures by bolstering support for leaders, championing progress, and accepting that failure is a normal component of service improvement and transformation, thus allowing leaders the psychological 'freedom to fail'

- ensure pragmatism – develop realistic improvement plans with appropriate structural support. These should be explicit and set out the expectations of the team, resource and support available - including funding to improve the quality of digital, estates, and equipment (as identified in Kerr's Review). The plan should be peer reviewed by provider chief executives to ensure it is pragmatic
- attract top talent – use flexibility in available terms and conditions to attract and deploy talented individuals at Very Senior Manager level, including relocation support where available and appropriate for staff moving to rural and coastal areas where unwarranted variation tends to be greatest

4. Implementation

We strongly believe our recommendations should transform health and social care leadership and management and drive the cultural and structural changes necessary to future-proof it. But we also recognise that previous reviews have reached equally sensible conclusions but failed to have the impact they deserve. To avoid a similar fate, we would highlight the following key components of successful implementation:

- Review Implementation Office (RIO): this group, comprised of multi NHS, social care and local government members, and with the highest agency, is essential to provide and drive the pace and scale of the implementation of this review. Its task is to deliver beyond anything that we have in the system at the moment; and to foster sector-wide co-creation to set achievable deadlines and apportion appropriate responsibility. This group should have direct mandate from the Secretary of State and support from the leadership in NHS and local government to deliver the review's recommendations
- ownership and accountability by example from all leaders: for any recommendation to have a chance of making an impact, the leadership must buy into its provenance and live by its virtues. Indeed, the NHS Leadership Compact – 'Our Leadership Way' could easily be used: it has resulted from deep and wide consultation and aligns with the NHS People Plan and People Promise. We get a strong impression from the new leadership at the top of the NHS and from local government that this is an agenda they are prepared to own, incentivise and live by. But buy-in and co-creation from those most affected is also key, and we would encourage a collaborative approach to implementation, drawing on experience and insight from

all leaders and the workforces they lead. There should be a strong local, frontline representation, and service users must be incorporated

- allocated time and resource: while we recognise the continuous pressure that the system will remain under, we strongly recommend a re-balancing of time and resource towards supporting and developing the workforce and argue that this will quickly repay the investment in the form of greater productivity, efficiency and quality
- data to support decision-making: workforce data is not yet sufficiently mature to support rapid implementation of some of our findings. While service-user data initiatives are clearly the priority for the time being, we would encourage resource being available to deliver the data necessary to facilitate workforce planning and support
- firm policy on participation: we believe our recommended training and development elements should be mandatory for selected cohorts. Making participation optional will effectively de-prioritise it and, while sensible flexibility will be necessary especially in the primary care and social care arenas, we would advise a firm policy on participation
- associated rationalisation: a common symptom of change in hard-pressed organisations is that new initiatives are bolted on to, rather than merged into, existing frameworks. This only adds to complexity and inefficiency and inevitably lessens impact. There is certainly scope for rationalisation in the current approach, and we would encourage a root and branch re-alignment of leadership and management development as part of the ongoing re-organisation, with as much integration between health and social care as is organisationally feasible

We recognise that change cannot happen overnight, and that resources and staff effort are necessary pre-requisites to reform programmes. To that end, we have offered the Department and NHSE a number of recommendations for a resourced FY 2022 to 2023 programme to set the conditions for a fully-funded and supported programme of leadership and management investment programme in FY 2023 to 2024. This includes the formation of multi-disciplinary implementation teams and a number of proposals for early wins.

5. Acknowledgments

The review team was made up of a plethora of health and social care sector subject matter experts, who were a great source of knowledge and guidance:

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Clinical and Social Care Governance Review

Final Draft Report

November 2019

Report Compiled by: **Mrs J Champion, Associate HSC Leadership Centre**

Contents

Executive Summary

In April 2019 the Southern Health and Social Care Trust (the Trust) requested that the Health and Social Care (HSC) Leadership Centre undertake an independent review of clinical and social care governance within the Trust, including governance arrangements within the Medical Directorate and the wider organisation.

The independent review (the Review) was undertaken during the period from mid-May to end August 2019. A total of 15 days were allocated for the Review. The Review was undertaken using standard methodology; review and analysis of documentation and stakeholder meetings (Section 2).

During the course of the Review senior stakeholders provided the context to the development of integrated governance arrangements from the Trust's inception in April 2007 and from recommendations arising from an internal Clinical and Social Care Governance Review undertaken during 2010 and implemented in 2013 and a subsequent revisit of the 2010 Review in April 2015. Senior stakeholders identified that there had been many changes within Trust Board and the senior management team over a number of years which had had a destabilising impact upon the organisation. They cited the number of individuals who had held the Accountable Officer/Chief Executive in Interim and Acting roles as having the most significant impact and welcomed the appointment of the Chief Executive in March 2018. It was also noted that the role of Medical Director had also been in a period of flux since 2011.

The Report provides analysis (and recommendations) throughout Section 4 on what constitutes a good governance structure. Good governance is based on robust systems and processes by which the organisation directs and controls their functions in order to achieve organisational objectives. As a legal entity the Trust has in place the required elements of a good governance framework; Standing Orders, Standing Financial Instructions and a Scheme of Delegation. There is a well-defined high level Board governance structure (Board Committees Section 4.1.3) and terms of reference. The Trust Board sub-committee structure is less well defined and requires revision (Section 4.1.9). Senior stakeholders identified a lack of connectivity across the existing Governance Structure and a lack of a robust assurance and accountability framework which added to the perception that the core elements of integrated governance were being delivered in silos with various reporting lines (corporate, directorate, professional and expert/advisory committee). The proposed revised good governance structure will provide the Trust with an assurance and accountability framework which will also address the concerns expressed in respect of existing accountability/ reporting lines to Trust Board.

The Trust Board is responsible for ensuring that the Trust has effective systems in place for governance which are essential for the achievement of organisational objectives. It is also responsible for ensuring that the Trust consistently follows the principles of good governance applicable to HSC organisations and should work actively to promote and demonstrate the values and behaviours which underpin effective integrated governance. The revised assurance and accountability framework will improve connectivity by bringing together the full range of corporate,

clinical, social care, information and research governance activities into an integrated governance assurance and accountability framework through a single point of first level assurance, the Senior Management Team, to Trust Board.

There were many areas of good practice outlined during interviews with senior stakeholders; leadership walk rounds conducted by members of Trust Board, a Controls Assurance Group to continue to focus on maintaining sound systems of internal control and patient and service user initiatives including a lessons learned video on patient engagement with a mother who was involved in a Serious Adverse Incident Review following the death of her child. The video has been shared as an example of best practice by the Department of Health Inquiry into Hyponatremia-related Deaths Implementation programme at stakeholder events.

The core elements that underpin a good governance framework, strategic and operational systems of internal control and processes, were evaluated against best practice guidance (Sections 4.2-4.23). They were also evaluated for clarity of accountability, roles and responsibilities. The analysis demonstrated that many of the building blocks for good governance are in place e.g. a Board Assurance Framework, Corporate Risk Register, Risk Management Strategy and operational policies e.g. adverse incident reporting, health and safety management, claims and complaints management. However, gaps in controls and assurances in these systems and processes have been identified and recommendations made. A number of the policies and procedures are dated and require revision and updating with extant guidance. There is variation from Directorate to Directorate the application of operational policies e.g. management of complaints. Senior stakeholders identified examples of best practice in some areas, as identified above, which have not necessarily been shared or applied across the organisation. There have been changes in the roles and responsibilities at Executive Director level and these will need to be defined in revised strategy and policy documents, this will clarify the lines of assurance and accountability which will underpin the Framework as above.

Stakeholders identified lack of resources (staff and information management systems) in integrated governance structures at both a corporate and directorate level. They also identified the ever increasing demand on the existing resource for example in the management of serious adverse incidents and complaints, clinical standards and guidelines and implementation of the Regional Morbidity and Mortality System. Analysis and recommendations have been made throughout Section 4. The Corporate Clinical & Social Care Governance structure has been benchmarked against a peer Trust corporate team who provide a similar function and support an assurance and accountability framework as above (Section 4.23).

In considering recommendations for the Trust the Reviewer took account of the Inquiry into Hyponatraemia-related Deaths (IHRD) Report and Recommendations and the ongoing work of the IHRD Implementation Group and Department of Health (DoH) Workstreams.

The Trust may wish to consider constituting a task and finish/director's oversight group to oversee the implementation of the action plan to implement the findings of this Review.

There are a total of 48 recommendations contained within Section 4 which are broadly categorised under the following themes;

- Corporate Good Governance (Trust Board including Board Committees and Sub-Committees;
- Culture of Being Open;
- Controls Assurance;
- Risk Management Strategy;
- Management of SAIs, Complaints and Legal Services;
- Health & Safety;
- Standards and guidelines;
- Clinical Audit;
- Morbidity & Mortality;
- Learning for Improvement;
- Governance Information Systems including Datix;
- Clinical and Social Care Good Governance Structures.

A summary of the Recommendations is provided in Appendix 1. The summary of Recommendations should be considered in line with the related analysis and narrative in Section 4.

1.0 Introduction

In April 2019 the Southern Health and Social Care Trust (the Trust) requested that the Health and Social Care (HSC) Leadership Centre undertake an independent review of clinical and social care governance within the Trust, including governance arrangements within the Medical Directorate and the wider organisation.

The independent review (the Review) was undertaken during the period from mid-May to end-August 2019. A total of 15 days were allocated for the Review. The Review was undertaken using standard methodology; review and analysis of documentation and stakeholder meetings (Section 2).

2.0 Scope of the Clinical and Social Care Governance Review

2.1 Terms of Reference

The purpose of the review is to ensure the Trust has a robust governance structure and arrangements in place which offers assurance on patient safety and that help people learn.

The following terms of reference were agreed with the Medical Director of the Southern Health and Social Care Trust (SHSCT):

Objectives

- The Trust is seeking to undertake a comprehensive review of the current governance structure including the formulation of recommendations on what a good structure should look like;
- The Review will consider existing governance processes and particularly governance assurance, moving the Trust towards a position where there is a whole governance approach to the organisation rather than in two reporting lines. It will include a review of both clinical and social care governance;

Specifically the work will include;

- *gaining an understanding of the current governance structure and processes in place;*
- *meeting stakeholders to identify what works well and areas for improvement;*
- *undertaking a benchmarking exercise to identify best practice;*
- *reviewing existing and draft documentation including a new Governance Assurance Strategy.*

The outcome will be a written report outlining key findings from the review and recommendations.

2.2 Limitations to Review

As defined within the terms of reference above, the review of integrated governance arrangements within the Trust excluded financial governance. Given the breadth of

the terms of reference and the timeframe allocated to complete, the review does not claim to provide an exhaustive or exclusive list of all potential gaps in controls or assurance across the organisation at local level which may have arisen during the period of fieldwork.

3.0 Methodology

For the purposes of the Governance Review a standard methodology was adopted which entailed the examination and analysis of documentary evidence and meetings with key stakeholders.

Key to the consideration and analysis of documentary evidence was the evaluation and benchmarking of the Trust's core governance systems and processes of internal control, which underpin a good governance structure, against extant national/regional and best practice guidance and policy. An evaluation of existing accountability/reporting lines was also considered in the review of documentary evidence and during stakeholder meetings and recommendations to improve the Trust's overarching governance structure and internal processes are outlined throughout Section 4 (Analysis and Findings).

3.1 Analysis of Documentary Evidence

A detailed examination and analysis of a large number of policy and supplementary evidence was undertaken as part of the fieldwork for this Review.

Regional Documents:

- The Inquiry into Hyponatraemia-related Deaths, Volume 3, January 2018;
- Procedure for the Reporting and Follow up of Serious Adverse Incidents, HSCB, November 2016.

Core SHSCT Documents/Evidence:

- Annual Report and Accounts 2017/18;
- Board Assurance Framework, May 2018 and June 2019;
- Clinical Audit Strategy, June 2018;
- Clinical Audit Workplan, June 2018;
- Clinical and Social Care Governance Assurance Strategy, March 2019 (Draft only);
- Clinical and Social Care Governance; Children and Young Peoples Service Directorate;
- Clinical and Social Care Governance Indicator Suite, March 2019 (Draft only);
- Controls Assurance Self-Assessments, February 2019 (Emergency Planning, Governance, Risk Management and Health & Safety);
- Corporate Plan 2017/18 and 2020/21;
- Corporate Risk Register, December 2018;
- Directorate Governance Meetings Sample Agendas;
- Directorate Risk Registers;
- Governance Committee Agendas and Minutes (May & December 2018);
- Governance Arrangements for Social Work & Social Care, SHSCT, February 2019;

- Health & Safety Policy, December 2014;
- Health & Safety Risk Assessment, Version 3, H & S Department, November 2019;
- Incident Management Procedure, October 2014:
- Integrated Governance Framework, September 2017;
- Internal Audit Report, Management of Standards and Guidelines, 2018/19;
- Internal Audit Report, Morbidity & Mortality 2018/19;
- Medical Leadership Review, June 2019;
- Patient Safety Programme SOP, January 2019;
- Policy for the Management of Litigation Claims, November 2018;
- Procedure for the Management of Complaints, November 2018;
- Risk Management Strategy, 2014;
- Risk Management Strategy 2019-2022 (Draft only);
- RQIA Review of Serious Adverse Incidents Process in NI Questionnaire (Draft only);
- Senior Management Team Minutes (Sample from March 2019);
- Social Workers & Social Care Workers: Accountability and Assurance Framework February 2019;
- Standards and Guidelines Monitoring Process – Change Leads;
- Terms of Reference;
    - Audit Committee, February 2018;
    - Governance Committee, February 2018;
    - Health & Safety Committee,
    - Lessons Learned Forum;
    - Quality Improvement Steering Group;
    - Senior Management Team;
- Trust Board Minutes September 2018 - January 2019;
- 'Your Right to Raise a Concern (Whistleblowing) Policy.

3.2 Meetings with internal stakeholders

The following key stakeholders were interviewed as part of this review:

- Chairman of Trust Board;
- Nominated Non-Executive Directors;[1]
- Chief Executive, Executive Directors and Directors and members of the Senior Management Team;
- Director of Pharmacy;
- Interim Assistant Director Clinical and Social Care Governance and key related staff including the Clinical Audit Management and Governance Coordinator;
- Board Assurance Manager;

[1] The Chairman of Trust Board nominated three Non-Executive Directors to participate in the Review. The nominated Non-Executive Directors included the Chair of the Governance Committee.

- Directorate Clinical and Social Care Co-Ordinators;
- Patient Safety & Quality Manger (Standards & Guidelines), Acute Services
- Project Manager, Medical Directorate.

4.0 Findings and Analysis

4.1 Governance Structures

4.1.1 Trust Board

The purpose of a Trust Board is to govern effectively and in doing so build patient, public and stakeholder confidence that their health and social care is in safe hands. Effective Boards demonstrate leadership by undertaking three key roles; formulating strategy, ensuring accountability by holding the organisation to account for the delivery of strategy by being accountable for ensuring the organisation operatives effectively and with openness and by seeking assurance that systems of control are robust and reliable.[2] The role of the SHSC Trust's Board is defined in a number of key documents which are outlined below.

The Trust has an extant approved Standing Orders, Standing Financial Instructions and Scheme of Delegation which in line with best practice is available to staff and the public via the Trust's website.

As defined in the Trust's Standing Orders (SOs), the Trust Board is required to have in place integrated governance structures and arrangements that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, social care, information and research governance activities. From 2006, HSC organisations have been encouraged to move away from silo governance and take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and organisational objectives.[3]

The Trust Board is responsible for ensuring that the objectives of the organisation are realised. The Trust has communicated its strategic purpose and corporate objectives in its Corporate Plan 2017/18 to 2020/21.

The Trust Board is responsible for ensuring that the Trust has effective systems in place for governance which are essential for the achievement of organisational objectives. It is also responsible for ensuring that the Trust consistently follows the principles of good governance applicable to HSC organisations and should work actively to promote and demonstrate the values and behaviours which underpin effective integrated governance.[4]

[2] NHS Leadership Academy '*The Healthy NHS Board: Principles for Good Governance'*. 2013.
[3] Department of Health '*Integrated Governance Handbook'* February 2006.
[4] SHSCT '*Draft Integrated Governance Framework'*, September 2017, Section 4.

4.1.2 Trust Board Meetings

In line with recommendations from the Francis Report,[5] and best practice, the agenda for Public Trust Board meetings includes an account of a service improvement or learning from a service user experience. Post-Francis, HSC Trust Boards were encouraged to put quality, safety and learning for improvement at the heart of the Board agenda. Learning from service user experience defines the Trust Board agenda, reminding Members of the organisation's vison and values and acts as a catalyst to continue to strive to improve the quality and safety of care provided.

The Board Assurance Framework, outlining the organisation's principal risks is required to be reviewed by Trust Board and tabled for discussion at public meetings on a six monthly basis (see Section 4.4 below). This is evidence that the organisation is committed to being open and transparent. It was noted that the Trust has a busy Board agenda and this may not allow for full discussion by the Board of Directors. It was noted however, that the Corporate Risk Register, is also reviewed at the Governance Committees of Trust Board and Senior Management Team meetings (see also Sections 4.2.2 and 4.9.2). Stakeholders indicated that the linkages between the Board Assurance Framework and the Corporate Risk Register could be strengthened (see Sections 4.4 and 4.8).

The Trust holds monthly Board Meetings (with the exception of July) which are held alternatively in public session and workshop format. Confidential sessions, when required are held immediately prior to the Board meeting. Senior stakeholders advised that Trust Board and Board Committee agendas are very busy and throughout the year there are a significant number of Board reports, covering a wide range of complex issues, which are presented for approval or assurance.

Trust Board workshops allow for detailed discussion on a range of strategic matters including detailed reports for example the Statutory Functions Report and service developments. The Workshops are essential for providing the Board of Directors the time and background information they require to make strategic decisions and fulfil their scrutiny and challenge function. This will be a particularly important in implementing the IHRD recommendations on the Board's Statutory Duty of Quality/Board Effectiveness which have highlighted the need for time for Board effectiveness, development and for understanding patient safety objectives.[6]

The Reviewer has noted that Internal Audit have provided the Trust with a 'Satisfactory Assurance' level for Board Effectiveness. Senior stakeholders advised that they would wish the Internal Audit Board Effectiveness Action Plan to be formally reported and reviewed by a Board Committee for assurance.

There is a time allocation for Trust Board Agenda items. It was noted from the minutes of those Trust Board meetings held in public session, that Patient and Client Safety and Quality of Care Reports are included in a standing agenda which also

[5] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* February 2013. HC 947 London. The Stationery Office.

[6] IHRD Recommendation 55 ~ '*Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objective'*.

includes Strategic and Operational Performance Reports thus demonstrating a balanced agenda. There is evidence of Non-Executive Director challenge in the area of patient and client safety and quality for example in relation to infection prevention and control training performance and complaints response performance targets. Given the proposal to constitute a Performance Management Trust Board Committee ***it is recommended that the Trust Board review the cycle of Trust Board Reports and the Board of Directors' public meeting agenda.***

The Reviewer can confirm that Trust Board agendas and minutes are readily available on the Trust's website from April 2009 to date.[7]

4.1.3 Trust Board Committees

The Trust Board exercises strategic control over the organisation through a system of good governance which includes Trust Board Committees:

- Audit Committee;
- Endowments and Gifts Committee;
- Remuneration Committee;
- Governance Committee;
- Patient and Client Experience Committee.

It is recognised that Accounting Officers and Boards have many issues competing for their attention. One of the challenges they and their members face is knowing whether they are giving their attention to the right issues. Key to addressing this is 'assurance', defined as: "an evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework".[8]

Assurance draws attention to the aspects of risk management, governance and control that are functioning effectively and, just as importantly, the aspects which need to be given attention to improve them. An effective risk management framework and a risk-based approach to assurance helps an Accounting Officer and Board to judge whether or not its agenda is focussing on the issues that are most significant in relation to achieving the organisation's objectives and whether best use is being made of resources.

At the heart of a good governance structure is the constitution of Trust Board Committees and Sub-Committees. The Trust Board Committees, and in particular the Audit and Governance Committees, can help the Accounting Officer and Board to formulate their assurance needs, and then consider how well assurance received actually meets these needs by gauging the extent to which assurance on the management of risk is comprehensive and reliable. Assurance cannot be absolute so the Committees (and Trust Board sub-committees) will need to know that the organisation is making effective use of the finite assurance mechanisms at its

[7] IHRD Recommendation 70 ~ *'Effective measures should be taken to ensure that minutes of board and committee meetings are preserved'*. The Department of Health IHRD ALB Board Effectiveness Workstream are reviewing this recommendation and are also considering the ease of access to board and committee information.

[8] Department of Finance '*Audit & Risk Assurance Committee Handbook NI*' April 2018.

disposal, targeting these at areas of greatest risk. The Board Assurance Framework and Corporate Risk Registers and their functions in supporting a risk-based approach are considered in Section 4.9.

4.1.4 Audit Committee

The Audit Committee is the Trust's statutory committee which deals with all aspects of financial governance.[9] The Audit Committee has no executive powers, other than those specifically delegated within the Terms of Reference. The Audit Committee is a non- executive committee of Trust Board and the Director of Finance and representatives from Internal and External Audit will normally attend the meetings. In line with best practice, the Chief Executive is invited to attend at least twice annually to discuss the process for assurance that supports the annual Governance Statement. In addition, other directors are required to attend when the Audit Committee is discussing areas of risk that fall within their area of responsibility or accountability.

It was noted from stakeholder meetings that the non-financial risk-based Internal Audit Reports (e.g. Management of Standards and Guidelines) would be tabled at the Governance Committee (see below) for more detailed discussion. The Trust should consider revising the terms of reference for the Audit Committee to enable the Interim Assistant Director for Clinical and Social Care Governance to be in attendance to facilitate the triangulation of integrated governance information.

The Trust has an Internal Audit Forum chaired by the Executive Director of Finance and Procurement. The Internal Audit Forum has successfully significantly increased the number of Internal Audit Plan recommendations that have been follow-up by Management (90% actions were reported as 'undertaken' at the time of Review).

4.1.5 Governance Committee

The Governance Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in the Terms of Reference. The Committee is appointed by the Trust Board from amongst the non-executive directors following recommendation by the Trust Chair and is required to consist of no less than three members. The Trust Board Chair confirmed that she attends Governance Committee meetings when there is a particular item on the agenda that she wants to review in more detail. The following are currently invited to attend; the Chief Executive, Executive Directors (with the exception of the Director of Finance and Estates), members of the Senior Management Team and the Director of Pharmacy. The [Interim] Assistant Director of Clinical and Social Care Governance also attend the committee and provide papers. ***It is recommended that the Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director***.

[9] Financial governance is not included within the terms of reference for this Review, however, an understanding of the role of the Audit Committee was required to gain an insight into the overall management of integrated governance within the Trust.

The remit of the Committee is to ensure that there are effective and regularly reviewed structures in place to support the effective implementation and continue development of integrated governance and that timely reports are made to Trust Board. The Committee is also responsible for a number of assurance functions including; assessment of assurance systems for effective risk management, ensuring there is sufficient independent and objective assurance as to the robustness of key processes and for ensuring that principal risks and significant gaps in controls and assurance are considered by the Committee and escalated to Trust Board as required. The Chair of the Governance Committee provides an annual report on the undertakings of the Committee to Trust Board which is an example of best practice.

The Agenda for Governance Committee is approved by the Senior Management Team. ***It is recommended that the Chair of the Governance Committee is fully involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020***.[10]

The annual Governance Statement is brought to Governance Committee for review and approval. The Statement indicates that the Trust adopts an integrated approach to governance and risk management and has an Integrated Governance Framework in place which covers all domains of governance associated with the delivery of health and social care services (see Integrated Governance Section 4.4).

The Corporate Risk Register is presented to Governance Committee on a quarterly basis. From senior stakeholder meetings and review of minutes it is planned to review a small number of corporate risks on a rolling basis to enable a more detailed discussion and afford the Non-Executive Directors the opportunity for scrutiny and challenge is a secure environment (see also Risk Registers Section 4.9).

Regular reports on integrated governance functions are reviewed at Committee including Adverse Incidents, Morbidity and Mortality, Management of Serious Adverse Incidents (SAIs), Claims, Whistleblowing Cases. The Medical Director and Interim Assistant Director Clinical and Social Care Governance are reviewing the format and content of reports to provide high quality intelligence and not just hard data. The Interim Assistant Director has also developed a draft suite of key performance indicators for clinical and social care governance which will help 'triangulate' data with different information sources and should form a key component of future governance reports to Committee. It is recognised that the collation and analysis of this data is labour intensive and resource dependant and currently there is insufficient managerial and administrative support and ITC infrastructure to support this governance function (see also Sections 4.22 and 4.23). ***It is recommended that the clinical and social care key performance indicators are further developed and submitted for approval through the Senior Management Team.***

The Governance Committee also receives a report on Freedom of Information (FOI), Environmental Regulation and Subject Access Requests (SARs). The Report

[10] Senior stakeholders suggested that a three year plan should be developed.

contains information on performance against timescales for processing requests and information on the nature of the requests which is good practice and there is evidence within the minutes of discussion stimulated by Non-Executive Directors. [11]

The Chief Executive advised that the Trust are to constitute a Performance Management Trust Board Committee (see below). The Governance Committee should therefore review its Terms of Reference. There is a need to focus on the detail of the Board Assurance Framework as well as the Corporate Risk Register on at least an annual basis at either a Trust Board workshop or at Governance Committee.

In line with best practice, the Chairs of the Audit and Governance Committee should meet annually to ensure an integrated approach to governance within the Trust and no overlap with agenda items.

4.1.6 Patient and Client Experience Committee

The Patient and Client Experience Committee was established as a subcommittee of the Trust Board. It has no executive powers, other than those specifically delegated in the Terms of Reference. The role of the Committee is to provide assurance that the Trust's services, systems and processes provide effective measures of patient, client and carer experience and involvement and to identify gaps and areas of opportunity for development to ensure continuous, positive improvement to the patient, client and carer experience and to ensure that patient, client and carer experience improvement initiatives are in place to address identified shortcomings and that these are monitored.

The Chief Executive advised that the terms of reference were being considered in the short term, with a view to refocus the role and responsibility of this Committee.

4.1.7 Performance Management

It has been agreed that a new subcommittee of Trust Board will be constituted during 2019/20 to ensure a strategic focus on performance management.

4.1.8 Senior Management Team/Governance Management Board

The Trust has a Senior Management Team (SMT) that is accountable to the Chief Executive. The Terms of Reference stipulate that the SMT is responsible for the leadership, strategy and priorities of the Trust and to oversee all aspects of Operational activities to ensure that the Trust meets its Statutory Requirement and provides high quality and effective services.

The Terms of Reference provided to the Reviewer are not dated. The Terms of Reference stipulate that all members of the SMT are individually and collectively responsible for the leadership of the following; Strategy and Planning, Delivery and Performance, Communication and Engagement, Governance and Risk Management The Terms of Reference define a model agenda of standing items in Section 8

[11] This will assist the Trust by forming a basis for implementing IHRD Recommendation 72 ~ *'All Trust publications, media statements and press releases should comply with the requirements for candour and be monitored for accuracy by a nominated non-executive Director'.*

'Cycle of Business' do not include quality and safety with the exception of Infection Controls within Performance and Delivery. A review of sample agendas confirm that quality and safety is discussed.

The Terms of Reference stipulate that papers, reports and presentations for submission to the Board of Directors will be considered by the SMT at the meeting one week prior to the Board meeting which is standard practice. In respect of Trust Board papers, SOs stipulate that the 'Agenda will be sent to members at least 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency'.

For SMT meetings the Terms of Reference stipulate that the collation of the agenda, issuing papers/reports are required at least 24 hours in advance of the meeting. Senior stakeholders advised that on occasion there may be a requirement to table an agenda item for urgent consideration and approval after the deadline. The Reviewer recognises that this should be avoided wherever possible to ensure that SMT members have time to review the information, this should be balanced with potential loss of opportunity and the Terms of Reference should allow for an urgent provision. (See also Weekly Governance Meeting/Debrief Section 4.23.2).

It is recommended that the SMT Terms of Reference are reviewed, including providing a provision for tabling urgent papers for consideration after the deadline [in exceptional circumstances].

The Terms of Reference also stipulate that once a month the SMT will meet as a Governance Management Board with the staff from the Governance Department in attendance. Section 2 of the SMT Terms of Reference constitute the terms of reference for the Governance Board. Roles and responsibilities include; ensuring the governance framework is fully implemented, monitoring and reviewing the Trust Risk Register and identifying Corporate Risks, reviewing and updating the Board Assurance Framework, escalating risk management issues to Trust Board and approving and reviewing policies that need to go to Trust Board for approval. The SMT Governance Board is also required to monitor patient safety and ensure continuous improvement and receive and approve reports/action plans for presentation to the Governance Committee. ***It is recommended that the remit and responsibilities of the SMT Governance Board are reviewed and a separate Terms of Reference developed to include the purpose, membership and reporting lines to Trust Board via the Governance Committee of Trust Board see Sub Committee Structure proposals at Section 4.1.9). The role of the SMT Governance Board should also be clearly defined in the Integrated Governance Framework/Strategy.***

4.1.9 Good Governance Structure: Trust Board Sub Committees

The Integrated Governance Framework contains an organogram depicting the organisation's high level governance structure including Trust Board, Board

Committees, SMT and Directorate and Professional forum. [12] The Reviewer is unable to provide a definitive list of all subcommittee and advisory groups from the written evidence considered. However, from the evidence provided by stakeholders and the review of a range of policies and procedures a number of other integrated Governance Trust Committees, Steering Groups and Advisory Groups have been constituted e.g. Quality Improvement, Health and Safety, Outcomes Review and a Directors' Oversight Group for the implementation of the IHRD Recommendations (see also the Trust's Integrated Governance Framework Section 4.4 below).

Senior stakeholders advised that current arrangements appeared to lack connectivity. From the evidence it is difficult to clearly define the accountability linkages and reporting arrangements between and from the various sub groups and advisory committees to Trust Board via the Senior Management Team. Stakeholders identified a number of accountability/reporting lines including; operational and corporate directorates, professional and expert committee. Clear lines of accountability are crucial to provide the Board of Directors with the assurance that there are robust and transparent governance arrangements in place. Additionally, it is important that staff and stakeholders have clarity on the lines of accountability within the organisation's assurance framework model.

Key to a good governance framework (structure) is the establishment of a robust assurance and accountability framework underpinned by sound systems of internal control the structure which supports the Trust Board and its Committees. ***It is therefore recommended that the Trust's existing Governance Structures are reviewed as a matter of urgency and Trust Board Sub Committee/Steering Groups are constituted to which integrated governance steering groups and committees will report and provide the organisation with a robust assurance framework (see below and Appendix 2) and a single line of assurance reporting to Trust Board through SMT.***

A Quality Improvement Steering Group has recently been constituted which pulls together some of the integrated management functions. The remit of that Steering Group is defined in the draft Terms of Reference provided as being responsible for ensuring that the Quality Improvement Framework is developed and delivered by the SMT and Trust Board.

It is recommended that the constitution of Executive Directors/Directors oversight/ steering groups should be considered with the following remits:

- Clinical and Social Care Governance – Quality Improvement and Safety;
- Corporate Governance;
- Patient and Client Experience and Engagement.

This will effectively group many of the existing sub committees and specialist advisory groups that exist within the organisation and provide a single accountability/ reporting line through the Governance Board of SMT to the respective Trust Board

[12] Integrated Governance Framework 2017, Figure 2.

Committees. In considering this sub-committee structure the Trust should ensure that there is no duplication of functionality of groups, forums or advisory committees. The Steering Groups should review the terms of reference of the sub groups and advisory groups on an annual basis and should also provide oversight of progress of any action plans or work plans. (The list of functional areas, advisory and expert groups potentially providing reports to the Steering Groups in Appendix 2 are examples only and do not indicate the need to constitute additional sub groups). ***Terms of Reference and annual work plans/action plans, where applicable should be held centrally (See Role of Board Secretary Section 4.2)***.

In response to all stakeholders who believed that there was a gap in the current framework regarding shared learning the Chief Executive advised that the proposed Steering Groups should be required to report on learning within their Terms of Reference and this would be a vehicle to bring together all aspects of learning from across the integrated governance arrangements including user experience. Senior stakeholders also advised that the role and function of the Lessons Learned Forum should be reviewed as a matter of urgency (see Section 4.20).

It is also recommended that any short term Director's Oversight Groups are added to the Governance Structure for the duration of their remit as 'Task and Finish Groups' e.g. IHRD Directors Oversight Group. This will provide staff and other stakeholders with clarity about the governance assurance and accountability arrangements.

It is recognised that the development and maintenance of an improved governance structure and assurance framework will require the oversight/ input of someone with expertise in Board Governance and Assurance. Additional resources (administrative and ITC support) will also be required to implement this recommendations (see also Section 4.2 Role of Board Secretary, and Section 4.23 Clinical and Social Care Governance Structures).

4.1.10 Committee Terms of Reference

A range of terms of reference (ToR) were analysed during the Review. The Audit and Governance Committees use a common template which meet good practice standards. Minutes of Board meetings reflect that their terms of reference are reviewed annually. ***To ensure that all committees provide clarity in their terms of reference, delegated powers and reporting requirements the Trust should consider developing a standard template to define the terms of reference for all Board Sub Committees, Steering Groups and Advisory/Specialist Groups***.

The terms of reference as a minimum should include the following:

- Constitution;
- Membership (Including chair, deputies and administrative support);
- Remit or high level purpose;
- Frequency of meetings;
- Authority/Delegated Powers;
- Quorum;

- Duties and responsibilities;
- Reporting arrangements;
- Revision dates.

All terms of reference should be reviewed annually and submitted to the relevant overarching Committee for approval. Approved terms of reference should be submitted to the Corporate Clinical and Social Care Governance Department and held in a shared folder. It is recognised that this will be an additional function for the Corporate Clinical and Social Care Department whose resources are already stretched (See Section 4.23). This function could be overseen by the creation of a Board Secretary as described below.

4.2. Role of Board Secretary/Head of Office

The Trust should consider introducing the role of Board Secretary/Head of Office to support the Trust Board and the Assurance Framework (incorporating the integrated governance strategy Sections 4.1.9 and 4.4).[13] This individual would be required to have a high level understanding of board assurance and board governance and would have the responsibility for ensuring that all Trust Board committees and sub committees are fully serviced and functioning and that their terms of reference are annually reviewed. They should be fully informed of the activity of committees and assist in making decisions on which issues can be resolved at subcommittee level and which issues may represent a high level risk to the organisation and may need to be escalated to the Board for debate and decision.

The Board Secretary/Head of Office should work closely with the Chief Executive, the Chairman of Trust Board and the Non-Executive Directors. They should be a high level appointment with the skills to act at Board level and be an expert in discharging their functions. They should be conversant with the Trust's Standing Orders/Standing Financial Instructions and the Scheme of Delegation. The post holder would hold line management responsibility for the Administrative Team in Trust Headquarters.

4.3 Professional Executive Directors – roles and responsibilities

The Northern Ireland Audit Office (NIAO) Guidance[14] acknowledges that role ambiguity can effect the function and effectiveness of the Board of Directors. As described above, concerns were expressed about the multiple reporting lines to Trust Board. Staff and other stakeholders should be clear on the roles and responsibilities of Executive Directors. The description of Executive Director functions are, by nature, generic in SO/SFIs therefore it is important that the full range of their accountability and responsibility are adequately outlined in the Trust's strategy and policy documents e.g. the Integrated Governance Framework and Risk Management Strategy. The Chief Executive indicated that the Job Descriptions for the recently appointed Executive Directors (Medical Director and Interim Executive

[13] The role of Company Secretary is described in the DoH (2006) *op. cit* pages 68 and 69 . The evidence for the efficacy of the role were based on discussions that took place with FTSE 100 companies.
[14] NIAO 'Board Effectiveness ~ Best Practice Guidance', November 2106.

Director of Nursing) were strengthened in respect of their integrated governance functions.

The role of the Executive Director Social Work is detailed in a framework entitled 'Governance Arrangements for Social Work and Social Care' for the Trust, which includes clinical and social care governance arrangements in the Children and Young Peoples Services Directorate' dated February 2019 (Section 4.5). The framework sets out clearly the legislative context that underpins social work governance and the Accountability and Assurance Framework for social work and social care. Clarity of role function is particularly important where an executive director has a dual role and has also operational management accountability and responsibility.

The Medical Director is the Executive Director with responsibility for providing assurance to Trust Board that effecive systems and processes for good governance, including those arrangements to support good medical practice. The strategic role of the Executive Medical Director in respect of risk management and clinical and social care governance is considered in more detail below.

The [Interim] Executive Director of Nursing is the lead Director for Nursing and Allied Health Professionals Governance and has responsibility for the strategic leadership for patient and client experience. The Exectuive Director of Nursing provides an annual Professional Nursing and AHP report to Trust Board and also provides a report on Quality Indicators (Nursing) to the Governance Committee. During the Governance Review, she advised that she was developing her strategic vision for Nursing and Midwifery Governance Structures and will be reviewing the Terms of Reference for the Nursing and Midwifery Governance Forum.

4.4 Integrated Governance

The context for integrated governance in healthcare has its origins in 2004[15] when NHS organisations were urged to; move governance out of individual silos into a coherent and complementary set of challenges, require boards to focus on strategic objectives, but also to know when and how to drill down to critical areas of delivery, require the development of robust assurance and reporting of delegated clinical and operational decision making in line with well-developed controls and to be supported by board assurance products, which provide board members with a series of prompts with which to challenge their objectives and focus.

The Good Governance Institute 'Integrated Governance Handbook' recognised that in simple terms there is only one governance and that this is the primarily the business of the board. Apart from clinical practice at the point of patient care the board is the key place where all the aspects of governance (clinical, quality, cost, staffing, information etc.), come to play at the same time.[16] Effective governance requires that organisations do not dissipate the composite whole into fragments that never realign. In 2006, integrated governance was defined as the 'systems,

[15] NHS Confederation Conference Paper by Professor Michael Deighan [and others]: '*The development of integrated governance, NHS Confederation*', May 2004 as summarised by John Bullivant.
[16] *Ibid*.

processes and behaviours by which Trusts lead and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community and partner organisations'.[17] Key to delivering a good governance model and to delivering these systems, processes and behaviours is an Integrated Governance Strategy or Framework which clearly articulates the organisation's assurance and accountability framework.

The Trust's strategy for integrated governance is defined in the Integrated Governance Framework 2017/18 – 2020/2021 (the Framework) which is marked as 'Draft' however, during the Review, the Board Assurance Manager confirmed that the Framework was endorsed by the Governance Committee. The document is set out in a standard strategy format and details the organisation's governance arrangements to implement an integrated governance model that links financial governance, risk management and clinical and social care governance into one framework. The Framework describes the overarching governance structure, the accountability and responsibility arrangements for the management of governance including the role and function of Trust Board and Board Committees. The document clearly indicates that the Framework should be should be considered with other key Trust documents, in particular the Trust's Risk Management Strategy. It is less definitive about the integrated governance assurance and accountability arrangements (complaints, serious adverse incidents, findings of independent review/inquiries and case management reviews etc.) to Trust Board and the operational/directorate governance reporting arrangements through to the Senior Management Team and this may have added to the perception of dual reporting lines. The Framework should provide an electronic link to the key supporting strategic and policy documents, which have been reviewed and described below Sections 4.5 – 4.22.

The Governance Controls Assurance standard requires that there are clear accountability arrangements in place for governance throughout the organisation. The Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation provide an overview of Trust Board and Board Committees, however, as described above these documents by their nature only provide generic descriptions of roles and responsibilities of Executive Directors. The Reviewer acknowledges the challenges in maintaining a dynamic Integrated Governance [Framework] as roles and responsibilities of Committees and individuals evolve and change as a result of a number of factors. Senior managerial functions have changed since the Framework was developed in 2017, therefore the extant version does not accurately reflect the accountability or current roles and responsibilities of the Executive Directors.

It is recommended that the Strategy/ Framework is reviewed as a matter of urgency and provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Strategy/Framework provides electronic links to related /key corporate Trust Strategies and Policies and extant guidance where applicable.

[17] DoH 'Integrated Governance Handbook' 2006.

The review of the Strategy/Framework will have to take account of any revision of the Trust Board's governance structures which will underpin good governance through an improved assurance and accountability framework, as recommended above (Section 4.1.9). [18]

4.5 Social Care Governance

The Integrated Governance Strategy indicates that the Executive Director of Social Work has a dual role also holding operational responsibility for the Children and Young People's Directorate and is responsible to the Chief Executive for the Trust's social work/social care governance arrangements and for the delegation of statutory social care functions and corporate parenting responsibilities. Within the Trust' High Level Governance Structure (Integrated Governance Framework) the only current reference to a social care governance framework is a forum entitled 'Social Work and Social Care Governance Forum'.

In the early stages of the Governance Review the Executive Director Social Work shared a framework entitled 'Governance Arrangements for Social Work and Social Care' for the Trust which includes clinical and social care governance arrangements in the Children and Young Peoples Services Directorate' dated February 2019. The framework sets out clearly the legislative context that underpins social work governance and the Accountability and Assurance Framework. This Framework also identifies roles and functions within the Directorate and across the interfaces. This key document should be cross-referenced and electronically linked with the Integrated Governance Framework (see above).

A review of Trust Board agendas and minutes confirm that the Annual Delegated Statutory Functions Report is tabled at a public meeting of the Trust Board meetings prior to submission to the Health and Social Care Board. During the Review, the Trust Board Chair outlined the process for review by the Non-Executive Directors. Minutes also confirm that the Corporate Parenting Report is also tabled at public Trust Board meetings. The Executive Director also presents a report every two months to Trust Board which provides a summary of activity and developments. Also tabled is the Corporate Patenting Report.

Senior stakeholders expressed some concern regarding Adult Safeguarding arrangements. ***It is recommended that this area of concern is reviewed to identify any potential risks/gaps in control or assurance in this area.***

4.6 Being Open

As outlined in Section 4.1, the Trust Board play a key role in ensuring the organisation operates effectively and with openness and transparency. The National Patient Safety Agency (NPSA) first issued the 'Being Open Framework' national

[18] SHSCT '*Integrated Governance Framework'* Figure 2 page 23.

guidance in 2005.[19] In recognition of changing context in NHS organisations and the altered context, infrastructure and language of patient safety and quality improvement they revised the guidance in 2009. The revision was also based on a listening exercise with healthcare professionals and patient representatives on how organisations could strengthen the principles of being open.

The Trust does not have a current Being Open Policy but has researched existing policies and has established a working group to develop the guidance. The Chair of the IHRD DoH Being Open Sub Group is scheduled to attend the Trust to meet with Board members. The Trust has also participated in the IHRD Programme Duty of Candour/Being Open Stakeholder Events.

The NHS Leadership Academy indicate that effective boards shape a culture for the organisation which is caring, ambitious, self-directed, nimble, responsive, inclusive and encourages innovation. A commitment to openness, transparency and candour means that boards are more likely to give priority to the organisation's relationship and reputation with patients, the public and partners as the primary means by which it meets policy and/or regulatory requirements. As such the Board holds the interest of patients and communities at its heart.[20]

Sir Robert Francis defined openness, transparency and candour as follows:

- Openness: enabling concerns to be raised and disclosed freely without fear and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public;
- Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.[21]

Post-Francis, the Care Act 2014 introduced a Statutory Duty of Candour for health and social care providers in England i.e. an organisational Duty of Candour.[22] Duty of Candour was introduced by legislation for NHS Trusts in England and the IHRD Report 2018 calls for a Statutory Duty of Candour to be enacted in Northern Ireland (Recommendation 10). The DoH IHRD Duty of Candour Workstream and Being Open Sub Group have delivered a series of stakeholder events to build on the principles of 'being open'. They are also considering the implications of the proposed individual Statutory Duty of Candour. Recommendation 2 seeks for a sanction of "criminal liability" to be attached to a "*breach of this duty and criminal liability should attach to the obstruction of another [member of staff] in the performance of [his/her duty]*". The Duty of Candour is inextricably linked to the policy of 'being open'.

[19] On 1 June 2012, the key functions of the NPSA were transferred to the NHS Commissioning Board Special Health Authority.[5], later known as NHS England. In April 2016, the patient safety function was transferred from NHS England to the newly established NHS Improvement.
[20] Leadership op cit. Section 2 Roles of the Board – Ensure Accountability
[21] The Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Sir Robert Francis, February 2013
[22] The details of the duty were subsequently set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In respect of developing Trust policy on 'Being Open', the Reviewer is aware that the DoH IHRD Being Open Sub Group are currently developing regional 'Being Open' policy/guidance with an aim to publish within the current financial year. It is envisaged that this policy directive/guidance will deliver the spirit of the IHRD recommendations on openness and candour until such times that a statutory duty of candour is enacted. The Trust will also have to consider the implication of the implementation of Recommendation 69 (i) and ***it is recommended that the Trust consider the implications of implementing the Regional 'Being Open' framework which includes appointing and training an Executive Director with specific responsibility for 'Issues of Candour'***. [23] The Trust has Non-Executive representation on the ALB Board Effectiveness Sub Group where this matter is being considered.

4.7 Controls Assurance

The requirement to report annually on Controls Assurances standards ceased in April 2018 and the Trust was required to put in place internal assurance arrangements for each area previously covered by the former Controls Assurance Standards. The Chief Executive outlined the importance of continuing to monitor and review action plans and advised that a Controls Assurance Group had been constituted, he advised that 2018/19 would be a transition year. The Terms of Reference will be reviewed for 2019/20.

The Controls Assurance Group is currently a sub-group of the Senior Management Team and was initially chaired by the Chief Executive and is now chaired by the Director of Finance, Procurement & Estates. The remit of the Group is to drive an implementation plan in the Trust to deliver on the governance framework and assurance model in relation to Controls Assurance. The implementation plan is linked to the annual Governance Statement and Mid-Year Assurance Statement reporting cycles.

Stakeholders raised a concern about a potential gap in the management of medical devices and equipment at operational level. The Reviewer was advised that there were Equipment Controllers in Acute Services. ***It is recommended that the Trust undertakes an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation***.

It is the responsibility of the Controls Assurance Group to monitor compliance with best practice guidance, policies and legislation previously contained within the former Controls Assurance Standards regime and agree the process for ensuring assurance on this to the Chief Executive and the Board (and onwards to the Department of Health, where required). Therefore, it is a key component of the Trust's systems of internal control and the integrated governance and assurance framework.

[23] IHRD, Loc.cit. Recommendation 69(i). Volume 3, Page 93.

It is recommended that the Trust develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards.[24] This will offer additional assurance that core standards and related legislation and statutory duties are embedded across the organisation (see also Section 4.1 Health and Safety Management and Medical Equipment as above). This development would also underpin the Risk Management Strategy and the Medical Directorate should provide corporate oversight of this process.

4.8 Risk Management Strategy

Managing risk is a key component of good governance and is fundamental to how an organisation is managed at all levels. The Trust's extant Risk Management Strategy is dated January 2014, and the Strategy was based on extant guidance at the time. It is linked to the Corporate Objectives and Values. In line with the Controls Assurance Standard, it contains a Risk Management Policy statement and key definitions including a brief definition of risk appetite. Since 2013/14 there has been more guidance available on how risk appetite should be applied in HSC organisations (see Draft Risk Management Strategy below). As the Strategy was approved 2014, it does not accurately reflect the roles and responsibilities of Committees and Executive Directors within the current governance accountability arrangements. Analysis and evaluation of risk are based on the Regional Matrix including the Regional Impact Table 2013, however, the Regional Risk Matrix was revised in 2016.

At the commencement of the Governance Review 2019, the Reviewer was made aware of a Draft Risk Management Strategy for 2019 – 2022 developed by the Interim Assistant Director of Clinical and Social Care Governance. This version of the Strategy is pending completion of the Review before further consultation and submission to Trust Board for approval.

The Draft Strategy (2019-2022) is based on ISO 31000: 2018, current legislation, and regional and national guidance. It contains a narrative detailing the roles and responsibilities of staff and related processes associated with risk management, including the management of risk registers and the process for the escalation and de-escalation of risk. It defines the role of the Senior Management Team in respect of risk management, including the management of the Corporate Risk Register. The Draft Strategy also provides a clear description of the risk assessment process utilising the most recent version of the Regional Risk Matrix.

The Draft Strategy outlines the role of the Medical Director as the Executive Director with delegated responsibility for risk management and clinical and social care governance. The role encompasses:

- The effective co-ordination of clinical and social care risk and governance – specifically this relates to the functional areas of patient/service user safety,

[24] The Trust's Health and Safety team have developed a Health and Safety risk audit tool. Comprehensive risk audit and assessment tools have been developed by other HSC Trusts for example Risk Audit and Assessment Tool Northern Trust (RAANT).

patient/service user liaison, litigation, effectiveness and evaluation, risk management and multi-disciplinary research;
- The provision of risk management support to Trust Directors via the clinical and social care governance structures of the medical directorate;
- Clinical and social care governance support for clinicians, nursing staff, social workers and allied health professionals;
- Regional and national initiatives related to clinical and social care governance are addressed and brought to the attention of appropriate staff;
- Regular clinical and social care reports/information are brought to the Governance Committee (in line with the Governance reporting framework) and to Trust Board.

The Draft contains a detailed Risk Acceptance Framework which includes a Risk Appetite Matrix.[25] The Trust must take risks in order to achieve its aims and deliver beneficial outcomes to stakeholders. Risks should be taken in a considered and controlled manner and exposure to risks should be kept to a level deemed acceptable to the Board. The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to achieve its strategy over a given time frame. Risk Appetite levels should form the background to the discussion in relation to risk and are nationally considered under four headings; risk to patients, organisational risk, reputational risk and opportunistic risk. Nationally Trusts make an annual statement on risk appetite.

The Draft Risk Management Strategy should show clear links with the Integrated Governance Framework (which should also be revised and updated as outlined in Section 4.4).

It is recommended that the Draft Risk Management Strategy is submitted for approval as a matter of urgency.

It is recommended that the Trust Board consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register. This will enable risks throughout the organisation to be managed within the Trust's risk appetite or where this is exceeded, action taken to reduce the risk. This item is also addressed in the Trust's Board Assurance Framework at June 2019.

Some stakeholders identified a current gap in provision of risk management training, which stakeholders have also highlighted that this is in part as a result of the lack of the resources to provide training in-house. Therefore, ***it is also recommended that a risk management training programme should be developed and delivered to underpin the publication of the approved strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers*** (see Section 4.9 and 4.23 Corporate Clinical and Social Care Governance structures).

4.9 Risk Registers including Board Assurance Framework

[25] Good Governance Institute **Risk Appetite** for NHS Organisations: A **Matrix** to support better risk sensitivity in decision taking. January 2012.

The Trust is required to be aware of its risk profile and to identify the key areas for investment in risk treatment. The Risk Management Strategy defines the framework for risk registers that comprises both the Directorate and Corporate Risks which underpin the Board Assurance Framework. Well managed risk registers are dynamic documents which log, quantify and rank the risks that threaten the Trust's ability in achieving its aims and objectives.

Currently risk registers are based on Word and Excel documents. The Trust has recently purchased the Datix Risk Register Module which will facilitate risk register reporting at Directorate and Corporate levels.

4.9.1 Board Assurance Framework

In line with extant guidance the Trust has a Board Assurance Framework.[26] The purpose of the Framework is 'to ensure that the Board can be effective in the delivery of [the Trust's] objectives'. An Assurance Framework seeks to identify and map the main sources of assurance in the Trust and co-ordination them to best effect. The Board Assurance Framework articulates the principal risks to achieving the Trust's objectives and enables the Board to assure itself that all significant risks are being managed effectively and appropriate controls are in place and are place. The Board Assurance Framework should be reviewed by Trust Board on a six-monthly basis. Analysis of Trust Board agendas indicate that the Framework was tabled in June 2018. A review of the minutes does not reflect levels of discussion.

The Board Assurance Manager, on the delegated authority of the Chief Executive, is responsible for maintaining the Corporate Risk Register and Board Assurance Framework and for supporting the Governance Committee and Trust Board in ensuring the provision of regular risk reporting and monitoring information and assurances.[27]

The Board Assurance Framework provides an organisational context and makes a clear link with the delivery of corporate objectives and is underpinned by the Integrated Governance Framework, Risk Management Strategy, Corporate Risk Register and Controls Assurance processes. The figure in Section 5 of the Board Assurance Framework demonstrates the combined 'top down' and 'bottom up' approach to identifying principal risks.

The Board Assurance Framework contains a high level summary of the Corporate Risk Register, which is also reviewed by the Governance Committee of Trust Board (see below). The Revised Risk Management Strategy provides clarity on the relationship between the Board Assurance Framework and the Corporate Risk Register and in particular the decision-making process on how risks are escalated to the Board Assurance Framework. The format of the Board Assurance Framework has been revised and now includes information on levels of assurance and where independent assurance had been provided i.e. by and Internal Audit or externally by RQIA or Royal College visit etc.

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[26] DHSSPS *'An Assurance Framework: a Practical Guide for Boards of DHSSPS Arm's Length Bodies'.* March 2009. www.dhssps.gov.uk

[27] SHSCT *'Draft Risk Management Strategy'* April 2019.

An assessment of the effectiveness of each control measure, based on a RAG rating is included in the Framework.

4.9.2 Corporate Risk Register

The Trust's Corporate Risk Register is linked to the Corporate Objectives as identified within the Trust's Corporate Plan 2017/18 – 2120/21. The Corporate Risk Register is reviewed on a quarterly basis by the Governance Committee. It is the remit of the Senior Management Team to ensure that there is an effective risk register and that risks are escalated to the Board Assurance Framework as appropriate.

The Senior Management Team review the Corporate Risk Register on a six weekly basis and stakeholders advised that there was robust debate and challenge at these meetings. In addition, the Chief Executive advised that at a Directors workshop during 2018/19 members had undertaken an in-depth analysis of two risks (Infection Prevention and Control (HCAI) and Cyber Security) which had proven to be a useful exercise. It was agreed by the Governance Committee in May 2018 that the Committee would also consider one/two risks in detail on a rotational basis. The minutes of the Governance Committee (September 2018) demonstrate this new approach and capture discussion and challenge by the Non-Executive Directors.

The Chief Executive further advised that the Corporate Risk Register template had also been revised during 2018/19 and that the Senior Management Team continue to monitor the process and seek ways to improve the format e.g. defining the risk description. Senior stakeholders indicated that the revised format was more user friendly. It was noted however, that currently the recorded risk rating is the inherent risk and not the residual risk after the control measures have been applied.

The Register provides a useful summary table of Corporate Risks and in line with best practice the summary table contains trends on the movement of risk levels. It provides a summary of the Risk Assessment Matrix and does not currently contain the impact grid as reviewed by the HSCB in 2016 (see Risk Management Strategy Section 4.8). The Reviewer acknowledges that when the Corporate Risk Register is underpinned by Datix Risk Register software a further review of the risk register process will be required.

It is recommended that the management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy.

4.9.3 Directorate Risk Registers

Each Directorate maintains a risk register which is owned by the Director. The Directorates each have a forum in which these Risk Registers are monitored. The Directorate Risk Register is owned by the Director. The Directorate Risk Registers

form the basis of the 'bottom up' approach to identifying principal risks as outlined in the Board Assurance Framework.

Directorate Risk Registers are currently in different formats. ***It is recommended that a standardised Directorate risk register template is considered when Datix risk register module is implemented.***

4.10 Management of Adverse Incidents including Serious Adverse Incidents

4.10.1 Management of Adverse Incidents

The Trust Policy supplied to the Review is entitled 'Incident Management Procedure', a 'working draft' dated October 2014. The Procedure sets the context for the management of incident reporting as a fundamental element of the Trust's Risk Management Strategy and focuses on the need to monitor trends and learn from incidents and it does promote the Trust's corporate priorities and values including the need for staff to be open and honest and act with integrity. However, the Procedure does not accurately reflect the current roles and responsibilities of Trust Officers in respect of the management of adverse incidents. The Reviewer was advised that the 2014 Policy was not reviewed as work was ongoing to develop a Regional Adverse Incident Policy which is due to be issued during 2019/20.

The Procedure provides guidance on the risk assessment process which should be applied to all incidents at the time of occurrence to decide the level of investigation that is required. This links with the Procedure for the management of Serious Adverse Incidents outline below.

Adverse incident reports form a key component of the Clinical and Social Care Governance Report to the Trust's Governance Committee. The Governance Committee review incident reporting including serious adverse incidents on a quarterly basis. Senior stakeholders indicated that the report format had been revised during 2017/18. However, the Interim Assistant Director Clinical and Social Care Governance advised that she was currently reviewing and developing the content of reports to provide higher quality intelligence (not just data) that is high level but also allows for appropriate scrutiny and challenge by the Board of Directors.

The Trust mechanism for recording all incidents is Datix web using an electronic incident form. The Trust uses Datix Common Classification System (CCS) codes for the categorisation of incidents. During 2018/19 work was undertaken to align Datix systems and the use of Datix CCS codes across the Region as part of the 'Delivering Together Programme'.[28] The Datix alignment programme was completed by March 2019. Stakeholders advised that there were currently insufficient staff in the Corporate Clinical and Social Care Governance team (Medical Directorate) to quality assure adverse incident data (see Section 4.23.1). This is a function undertaken in the other HSC Trusts. The Reviewer was informed that there were a significant number of incidents in the category 'In Review' which needs to be addressed in the short term.

[28] Department of Health, "*Health and Wellbeing 2026: Delivering Together",* October 2016.

It is recommended that a Trust flow chart is developed that underpins the Regional Adverse Incident Reporting Policy/Procedure (when disseminated) which accurately reflects local/ Trust roles and responsibilities especially at Executive Director level.

It is recommended that the corporate oversight of the management of adverse incidents is strengthened to include a quality assurance component which will be dependent upon the resources and skills available within the Clinical and Social Care department (see Section 4.23.1)

4.10.2 Serious Adverse Incidents

The extant procedure for the management of Serious Adverse Incidents (SAIs) is the Health and Social Care Board (HSCB) Regional 'Procedure for the Reporting and Follow up of Serious Adverse Incidents'[29]. Stakeholders indicated that the Directorates have adopted local procedures for the management of SAIs and some concern was expressed about a lack of consistency in approach. Stakeholders also advised of a backlog in SAI Reports being submitted to the HSCB within the required timescales which requires urgent attention.

The Reviewer is aware that the Regional Procedure is subject to imminent review to take account of the recommendations of the IHRD Report in respect of the Management of SAIs. There is also a significant link with the work of the Being Open Workstream (see Section 4.6). Three of the DoH IHRD Implementation Workstreams are considering these recommendations which are summarised as follows;

- *Duty of Quality ALB Board Effectiveness and Quality Clinical and Social Care Subgroups* – learning and trends should form programmes of clinical audit (See Section 4.15), relevant reaching authorities should be informed if findings of investigations show inadequacies in current medical or nursing education programmes and information from investigations should be assessed for potential use in training and retraining, Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths are brought to the immediate attention of every Board member (see Section 4.23.1);
- *SAI Workstream* – family engagement, investigations should be subject to multi-disciplinary peer review, each Trust should publish Policy detailing how it will respond to and learn from SAI related patient deaths and each Trust should publish in its Annual Report details of every SAI related patient death.
- *Education and Training* – training in SAI investigation methods and procedures should be provided to those employed to investigate and clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours (see Section 4.21 Medical leadership);

[29] Health and Social Care Board '*Procedure for the Reporting and Follow up of Serious Adverse Incidents'*, November 2016.

- *Preparation for Inquest and Death Certification* – Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation (See Sections 4.15 and 4.21).

It is appreciated that for some of these recommendations there have been challenges in defining the objective or principle of the recommendation and for some a Regional approach is being sought, however there are some early indications of travel in terms of family engagement and scrutiny and challenge (see also Section 4.23 for resource implications).

To enable the Trust meets the action required, the following is recommended.

It is recommended that the Trust constitutes an SAI Review Group and/or SAI Rapid Review Group which should provide independent scrutiny and challenge to the SAI process including review of level of investigation, independence of review panel and approval of terms of reference when SAIs are initiated. In addition, the Review Group should oversee completed reports before submission to the HSCB. The Review Group should be chaired by the MD or his/her Deputy and report to a Trust Board Sub Committee. The Review Group should meet on a four weekly basis initially.

It is recommended that the Trust develops a database of SAI Review Panel Chairs who have undertaken SAI/Systems Analysis Training.

The Governance Coordinator highlighted the investment in a recent SAI training programme delivered by an external provider. She also advised that the training programme provided staff with a wide range of investigation tools, techniques and best practice guidance.[30] ***It is recommended that the Trust develops a SAI RCA/Systems Analysis toolkit based on the training provided by the external provider.***

Given the importance and focus on family/service user engagement, IHRD workstreams have been considering the role of an SAI Review Liaison Officer. Discussions during IHRD workstream meetings have highlighted some of the challenges for staff fulfilling this role (emotional resilience, communication skills and time commitment), in addition to existing work commitments. ***It is recommended that the Trust considers how the role of a Service User Liaison Officer [or similar] for engagement with families throughout the SAI process would be implemented.***

4.11 Health and Safety Management

The Trust has a Health and Safety at Work Policy dated December 2014 which was due for review by December 2016. The Policy indicates that the Chief Executive has delegated responsibility for establishing an monitoring the implementation of the Health and Safety at Work Policy to the Director of Human Resources and Organisational Development with support from the Assistant Director of Estates/Head of Health and Safety. More recently, the responsible was delegated to

[30] Training was provided by CLS Educate @ www.clseducate.com

the Director of Finance, Procurement and Estates and the Health and Safety Team are currently part of the Estate Risks and Sustainability Department and report to the Director of Finance and Estates.

The Team aim to maintain a high visibility and engagement in clinical, non-clinical and social care areas. System based on HSG65 (Health & Safety Executive Managing for Health and Safety) and is centred around: Plan, Do, Check and Act.

The Trust has a Joint Health and Safety Committee and the Chair rotates between the Lead Director and Trade Unions. The Terms of Reference for the Committee are included in Appendix 1 of the Health & Safety Policy and are therefore circa 2014. The membership is indicated as being made-up from Directorate Representatives and Representatives from Trade-Union/Professional Bodies within the Trust. The quorum is four members however, the Terms of Reference do not specify the requirement for an equal representation of staff and management. The current Terms of Reference do not indicate the reporting arrangements to Trust Board and the extant Governance Committee Structure (Integrated Governance Framework Figure 1) does not clearly indicate the reporting and assurance arrangements of this key statutory Committee (See Section 4.2.6). The Lead Director advised that a review of committee membership and agenda was planned. ***It is therefore recommended that the Health and Safety Committee review their Terms of Reference and submit to the relevant Board Sub Committee for approval.***

The Annual Health and Safety Report 2017/18 was provided in evidence to the Review. The 2017/18 Report was presented to the Governance Committee for noting and with a request for feedback on the content and structure of the report so that reports going forward can be reviewed and be as 'meaningful and informative' for the Committee as possible.

Stakeholders indicated that attendance at training remains a challenge and this was highlighted in the Annual Report. The 2017/18 Report indicates that Health & Safety audit activity was constrained due to a lack of resources from within the Committee.

The Health & Safety Team have developed a Health & Safety audit tool to evaluate Trust compliance with key areas of health and safety legislation including; accountability, risk assessment, Display Screen Equipment, Management of Violence and Aggression and Slips, Trips and Falls. The aim of the audit is to provide assurance to the Lead Director for Health and Safety. The audit tool is based on a three year cycle which aims to audit all areas of the Trust and cover 15 legislative areas. All audit results are presented to the relevant Director, the Health and Safety Committee and the Governance Committee.

The audit tool is emailed to all Heads of Service (100) within the Trust. The Heads of Service are then required to issue the question sets to their Departmental/Service/Team leads for completion and scoring. Responses are completed on the basis of full compliance, partial compliance or no compliance options for each question. The return rate for the audits at year end 2018 were 78%. Results are collated by Directorate, indicating that 22% of Heads of Service did not

submit a return. The Health and Safety Team complete verification audits of 10% of returned audit compliance levels.

From the interviews with stakeholders, the Reviewer found a limited knowledge of the purpose and use of this audit tool. The audit process was evaluated during 2018 using Survey Monkey. A total of 22 Heads of Service responded and some issues were identified including the challenges of competing priorities. This is a useful audit tool which ***could be further developed and used to form the basis of a more comprehensive risk audit and assessment tool as highlighted above (see Section 4.7).***

Senior stakeholders identified some concern regarding assurance of compliance with Health and Safety risk assessments across the organisation. In particular, it was believed that an assessment of compliance with the Control of Substances Hazardous to Health (COSHH) Regulations was required. ***It is recommended that an organisational COSHH audit is undertaken during 2019/20 to be completed before end March 2020.***

4.12 Management of Complaints

The Trust has a Policy for the Management of Complaints which was approved in July 2018. The Policy indicates that the Medical Director is responsible for ensuring that the complaints procedure and approach ensures that appropriate investigations and actions have been competed before a response sent following a formal investigation of a complaint. Further, the Policy indicates that the responsibility for managing the requirements of this policy is delegated to the Assistant Director of Clinical and Social Care Governance. However, the Policy clearly indicates that the Medical Director must maintain an overview of the issues raised in complaints and be assured that appropriate organisational learning has taken place and that action is taken. Stakeholders indicated that the line of corporate oversight by the Medical Director's Office was now less robust than the Policy envisaged and that this should be revisited.

The [Interim] Assistant Director for Clinical and Social Care Governance is required to work with the Trust's 'operational, executive and corporate Governance leads and support leads on the ongoing development of systems and procedures to monitor the implementation and effectiveness' of changing practice, taking regard of evidence based practice, lessons learned from reviews, complaints, incidents and public inquires and to provide recommendations and advice to SMT Governance on the Governance Action Plan and priorities for action.

The Corporate Clinical and Social Care Governance Team receive complaints and log them into the Datix Complaints module and they are then forwarded to the Operational Directors. The Policy indicates that the Corporate Complaints Officer (CCO) is responsible for screening service user contacts and determining if these are enquiries or complaints and should facilitate either resolution of the enquiry or complaint or facilitate the complainant in the use of the formal complaints procedure. ***It is recommended that the remit of this important role (CCO) is reviewed in line with the Trust's Complaints Management Policy and as part of the***

recommended Corporate Clinical and Social Care Governance Department restructure (this will include consideration of resources required to deliver this improvement, see also Section 4.23). The Policy also indicates that the CCO should alert the Directorate governance teams to significant issues. ***It is recommended that the process of screening of complaints is reviewed and parameters for alerts to be clearly defined to include alerts to professional Executive Directors***.

The Operational Directors are responsible and accountability for the proper management of accurate, effective and timely responses to complaints received in relation to the services they manage. There is some variation across the Directorates in approach to the management of complaints. At interview, senior stakeholders outlined continuing challenges in meeting response timescales and in particular within those areas where a larger volume of complaints are received e.g. Acute Services. It was also identified that some complaint responses remained outstanding for significant periods of time. Senior stakeholders also indicated that there was a significant variation in the quality of responses received for review by the Director, with many responses being returned for further consideration/amendment. This was cited as a particular challenge when a cross Directorate response was required or when an accurate oversight of complaints involving independent sector providers was required.

A recent NI Public Services Ombudsman Report confirmed the concerns expressed by internal stakeholders reiterating the importance of timeliness in responding and the requirement for clear cross directorate/sector linkages, accurate grading of complaints and corporate oversight to ensure that appropriate linkages are made with the Regional SAI process.

There are some good examples of complaints management for example, the CYPS governance team undertook an IHI Quality Improvement Personal Advisors programme which resulted in significant improvement the management of complaints within the Directorate. The improvement initiative included service user feedback on the complaints process from 353 complaints investigated and responded. The Directorate also undertook an audit from January 2017 to December 2018 from which learning has been identified. A process to improve the management of complaints should be replicated across the organisation to ensure equality in response to service users.

Directorate staff were positive about the use of the Healthcare Complaints Analysis Tool (HCAT) which was developed by the London School of Economics Report July 2018. HCATs is an analytical tool for codifying and assessing the problems highlighted by patients and their families of advocates in letters of complaints. The HCAT codes are considered by Trust staff to be more effective than the Datix CCS Codes and the Reviewer has been advised that it is possible to add an additional field to Datix to capture both sets of codes to facilitate data analysis.

As has been indicated in other key areas of governance (incidents, legal services and M&M), stakeholders indicated a gap in sharing lessons from this process and the need to create a more robust process (see also Section 4.20).

It is recommended that the Trust constitutes a Director's Oversight Complaints Review Group as a short term 'task and finish group' to focus on reviewing Policy and Procedure and improving the management of complaints and experience of the service user. Membership should include a Non-Executive Director and/or a Service User(s).

4.13 Litigation Management

The Policy and Procedure for the Management of Litigation Claims provided for the Review indicates that it is operational from November 2018 and due for review in 2021. The Policy does not indicate that it is in draft status however, the Reviewer has been informed that the draft Policy has been submitted to the Policy Scrutiny Committee for approval and subsequent circulation.[31] The Policy provided in evidence states that the Executive Medical Director is the designated officer with responsibility for Clinical Negligence claims and Coronial Services and the Director of Human (HR) and organisational Development (OD) is the designated Director with responsibility for Public and Employer Liability Claims. Each have the associated delegated financial authority accordance with the Trust's SFI and Authorisation and Approvals Framework. From a managerial perspective the Litigation Management Team/Department is the responsibility of the Director of HR and OD.

The Policy is a best practice document that clearly articulates the roles and responsibilities of key stakeholders, line managers and staff and in particular the Policy highlights the need for shared learning, being as honest and open with patients/service users and their relatives/carers and the need for staff support in the event of their being involved with a litigation process.

The Litigation team provide reports to the Governance Committee. The Litigation Manager attends Interface Meetings with the Directorates. Stakeholders advised that the opportunities for learning from claims and Inquests both internally across the organisation and externally with the wider health service could be improved.

The Head of Communications is notified of pending Coroner's Inquests and Preliminary Hearings. The system will readily allow for compliance with IHRD Recommendation 50 (*The Health and Social Care ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved),* when it is formally implemented through the IHRD Implementation Programme.

Senior stakeholders highlighted the proposal to appoint two Medical Leads for litigation management (see Sections 4.21). The paper outlining proposals for Medical Leadership was presented to SMT in June 2019. It is proposed that there will be a Medical Lead for Coroners Services who will work with the Legal Services Manager and Clinical Directors to provide professional and clinical input into the management of Coroner's cases. The role will include the following areas of responsibility; support in the process of obtaining statements from involved staff and advise on action to be taken, support in deciding from whom statements and reports

[31] Policy Checklist indicates that the November 2018 Policy Version supersedes the 'Policy for the Management of Litigation and Claims 2007'.

should be sought and review reports and provide a direct liaison and efficient communication with the Coroner's Office. In this respect, the Medical Lead and Legal Services Manager should follow IHRD Recommendation 51 (*Trust employees should not record or otherwise manage witness statements made by Trust Staff and submitted to the Coroner's Office*). As above, more definitive guidance on this Recommendation will be issued via the IHRD Implementation Programme.

The Medical Lead will also provide an extremely important role in supporting Trust staff who are to appear in the Coroner's Court which may mean attending that Court. The Reviewer, acknowledges the challenge that fulfilling this role will entail i.e. balance the Duty of Care to support staff during a stressful experience with any perception that such support could be viewed as unduly influencing staff. Therefore, clear rules of engagement should be developed.

A second Medical Lead for Litigation Services is also proposed. The area of responsibility is not defined in the Medical Leadership Review paper, however, it is understood that this Medical Lead will provide support for the management of professional negligence (clinical negligence) claims and provide a separate line of support and leadership within the Trust's Legal Services Management arrangements.

Stakeholders raised the issue of the management of legal services within the Trust being compliant with IHRD recommendation 36 ~ *Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation.* The Reviewer is aware that the IHRD Death Certification and Preparation for Inquest Workstream have debated this requirement and are currently considering how this recommendation should be implemented in practice. However, the proposed arrangement for appointment of two separate Medical Leadership Management posts is a model which is currently viewed as being reasonable.

Senior stakeholders advised that given the existing workload, delegated authorisation framework for clinical (professional) negligence and the proposed model of providing medical leadership that the Legal Services team would be best placed with the Corporate Clinical and Social Care Governance team, Medical Directorate.

It is therefore recommended that the management of Legal Services should be reviewed. This recommendation should be taken in the context of any DoH policy directive arising from the IHRD programme which may indicate a best practice model for the management of serious adverse incidents, clinical negligence and Trust Coronial Liaison Services.

4.14 Policies, Standards and Guidelines

4.14.1 Policy Scrutiny Committee

The Trust has a Policy Scrutiny Committee. Stakeholders involved in the Committee indicated the challenges in maintaining oversight of review and renewal dates given the sheer volume and diversity of Trust Policies and Procedures. Another challenge is that on occasion the Trust Policy has reached the review date and there is a delay as new legislation or regional guidance is pending and/or a regional policy is being developed. In these instances the Trust should consider amending the Policy Procedure Checklist to indicate an extension to review/revision date due to external factors. Some policy authors advised the Reviewer of delay in time from submission to date of approval and dissemination of policies, especially when external deadlines were a factor. During the Review it was noted that version control was not always robust indicating the potential for staff to be working from a dated or draft version of a policy or procedural document. ***It is recommended that the Trust consider options for an electronic policy and procedure management system that is accessible, easy to navigate, contain a search facility and includes the capacity for email notification of new/changed policy and automates a review/revise reminder.***

4.14.2 Management of Standards and Guidelines

Each HSC Trust is accountable and responsible for ensuring that clinical standards and guidelines are effectively managed so that the required recommendations are embedded within local health and social care practice.

The Trust has a process for the management of standards and guidelines which is reliant on both Corporate and Directorate based systems. Standards and guidelines are logged onto the Trust's database system centrally by the Corporate Governance Team and then forwarded on a weekly basis to Directorate Governance Co-Ordinators, Pharmacy Governance and the Medical Directors Office. Each Directorate have developed their own processes for the management of Standards and Guidelines. During the Review stakeholders expressed concern that were there was evidence that Standards and Guidelines were disseminated, however, there was a lack of assurance that they were being implemented as subsequent audit of practice had not always taken place (see Section 4.15). This concern was reiterated by the Chairman and Non-Executive Directors, who identified that this was an area that required focus.

Internal Audit carried out an audit of the Management of Standards and Guidelines during May 2015 when 'Satisfactory' assurance was provided. They audited the process again in September 2018 and provided a Limited level of assurance identifying that although the Trust had good controls to record corporately the receipt and subsequent dissemination of Standards and Guidelines to the directorates there is no corporate overview and reporting of the Trust's overall compliance against Standards and Guidelines.

The Internal Audit also identified weaknesses in relation to the completeness of data held on the Trust's Standards and Guidelines Register and limited ongoing audit/follow up of compliance (as above).

Stakeholders described the challenges in managing the large volume of standards and guidelines that are received from external agencies. During 2017/18, a total of 230 guidelines were received from external agencies, 23 were not applicable to the Trust of the remaining 207 there were 39 that were not applicable to Acute Services. Senior stakeholders identified the challenges in managing standards and guidelines which have cross directorate applicability.

In April 2012, the Trust established a Corporate Standards and Guidelines Risk and Prioritisation group. The aim of this group was to provide a corporate forum to ensure that the Trust has in place a systematic and integrated approach for the implementation, monitoring and assurance of clinical standards and guidelines across all of its care directorates. The Reviewer understands that the Group was stood down in January 2017 to be replaced by monthly meetings between the Corporate Assistant Director Clinical and Social Care and Directorate Governance leads.

All of the Directorates have systems in place for the management of Standards and Guidelines. Acute Services have a robust system in place for the dissemination of Standards and Guidelines which represents a best practice model. The system was developed and is managed by a Patient Safety and Quality Manager (Standards & Guidelines) who is a NICE Scholar and a member of the Acute Services Clinical and Social Care Governance Team. The system includes a Standards and Guidelines Operational Procedures Manual, a reporting schedule, process maps including a process map for clinical change leads and an Accountability Reporting system for Acute Services. The downside of this system is that it is person dependent. The Patient Safety and Quality Manager also identified that the lack of clinical audit in providing assurance that standards and guidelines had been implemented was a systems issue.

Other challenges include identifying a clinical/managerial lead for guidelines – as there is an apprehension surrounding taking on the responsibility/accountability for change lead role.

Positive assurance statements go directly back to HSCB via the Corporate Clinical and Social Care Governance team. Previously they would have been approved by SMT prior to issue. ***It is recommended that a level of corporate oversight is reinstated (in line with the Assurance & Accountability framework S4.1).***

An 'Accountability Report' of the Trust's compliance with Standards and Guidelines had previously been reported to the Governance Committee on a twice yearly basis. ***It is recommended that the Accountability (Compliance) reporting arrangement is reinstated***.

The Trust will be required to comply with IHRD Recommendation 78 ~ *Implementation of clinical guidelines should be documented and routinely audited*. The challenges in respect of clinical audit are outlined in Section 4.15. It is anticipated that as part of the final stage of the IHRD Implementation Programme Assurance Framework HSC organisations will be required to provide independent

assurance of compliance with policies and procedures arising from the recommendations (see also Section 4.15 and 4.23).

The Trust, as a matter of urgency, should review the overarching corporate arrangements and resources to provide assurance regarding the effective management of Standards and Guidelines and to facilitate a risk based approach from the triangulation of data from incidents, complaints, claims, service reviews, Morbidity and Mortality reviews and Clinical Audit.

It is recommended that the Trust take the Standards and Guidelines model developed within Acute Services and provide a central management system within the Corporate Clinical and Social Care Team under the leadership of the Medical Director. The Reviewer understands that the IT system currently used within Acute Services may not have the capacity to deal with Trust-wide information.

4.15 Clinical Audit

The Trust's Clinical Audit Strategy was presented to the SMT on 20 June 2018 and was then presented to the Governance Committee on 6 September 2018. The Strategy defined clinical audit as 'a quality improvement cycle that involves the measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes'. Clinical audit is an integral part of the good governance framework.

Senior stakeholders advised that Internal Audit had provided Clinical Audit with a 'Limited' assurance level. The Clinical Audit Strategy outlined the strategy and structure for overseeing clinical audit processes to provide an assurance to SMT and Trust Board that clinical audit activity would be appropriately managed and delivered. The paper clearly outlined the key issues and challenges for the organisation which include; ensuring that clinical audit is delivered consistently across all operational directorates, in line with national guidance and ensuring that there is a sufficient number of staff in the corporate clinical audit team and in the operational Directorates to support the delivery of the approved clinical audit programme. The Strategy also describes the prioritisation of clinical audit in line with Healthcare Quality Improvement Partnership (HQIP) proposals that clinical audit programmes are categorised into 4 distinct elements with 'external must do' audits being assigned the highest priority as Level 1 projects.

Clinical Audit will have an increasing and key function in providing corporate assurance that IHRD Recommendations have been implemented. Clinical Audit and the Morbidity and Mortality Process are intrinsically linked (see Section 4.16). Clinical Audit will be required to provide assurance that clinical standards and guidelines have been implemented (IHRD Recommendation 78 as outlined in Section 4.14). Also Recommendation 76 ~*Clinical standards of care, such as patients might reasonably expect should be published and made subject to regular audit*. Clinical audit will also be required to provide assurance of organisational compliance with clinical standards in IHRD Paediatric Clinical (Recommendations 10-30) for example, patient transfer, on-call rotas and clinical record keeping.

Stakeholders described the dilution of the clinical audit function over a period of time, this experience is similar to that of other HSC Trusts. The Clinical Audit Strategy 2018, identified that the current [administrative] staffing levels in the corporate Clinical Audit and M&M team and operational directorates as insufficient to support and deliver the clinical audit work programme. The Reviewer would concur with this statement and would add that the demand on this governance function is set to increase significantly as described above. This is covered in more detail in Section 4.23. Clinical and Social Care Governance Structures.

The Medical Director has also identified resource issues in the paper entitled 'Medical Leadership Review submitted to SMT in June 2019 (see Section 4.21). The appointment of a Clinical Standards and Audit Lead who will lead the coordination and monitoring of systems and processes to ensure maximum compliance with clinical standards as endorsed or mandated by regional or professional bodies is key.

Stakeholders advised that there was a need to demonstrate more robust linkages between clinical audit and quality improvement and the management of serious adverse incidents. ***It is recommended that the integration between quality improvement and the integrated governance function is reviewed to ensure optimum connectivity.***

The 2018 Clinical Audit Strategy and Action Plan should be reviewed and updated.

It is also recommended that the Clinical Audit Committee is reinstated and the reporting arrangements considered in the review of the Trust Board Committee Structure (Assurance & Accountability Framework Section 4.2.6 and Appendix 2.

Given the potential increase in focus and demand on clinical audit as outlined above ***it is recommended that the resource implications are reviewed, see Section 4.21 Medical Leadership and Section 4. 23.1 Corporate Clinical and Social Care Governance Department).***

4.16 Clinical Outcomes - Morbidity and Mortality (see also 4.21 Medical Leadership)

Morbidity and Mortality (M&M) reviews are primarily a tool for identifying opportunities for system level improvement. There was a focus during the IHRD Inquiry into the rationale and mechanics of M&M Review and the significant role this process has in improving outcomes through learning. In November 2016, the DoH issued guidance on a Regional Mortality and Morbidity Review (RM&MR) process. The aim of the guidance was to provide specific direction for M&M leads and a regional approach as to how M & M meetings should be established, structured managed and assured. RM&MR is hosted on the Northern Ireland Electronic Care Record (NIECR)

As part of the 2018/19 Annual Internal Audit plan, Internal Audit carried out an audit of M & M during October to December 2018. The SHSC Trust was one of four

Trusts audited during this period. The Reviewer has noted that the audit focused specifically on the mortality aspects of this guidance. Internal Audit provided a Limited Assurance in respect of the M&M processes. The Internal Audit Report recognised that there were processes however, timescales for Consultant review and discussion at M&M groups was not routinely followed and some deaths had not been reviewed or discussed. Internal Audit did recognised from their observational audit (attendance at three meetings) that deaths were discussed in detail with a level of robust and challenging professionalism among teams visited. Senior stakeholders within the Board of Directors noted an improving culture in the ethos of utilising M&M for shared learning within the organisation.

As a result of the Internal Audit review of four Trusts, a number of concerns have been raised regionally about the adequacy of the regional M&M process and in particular the need for significant investment in order to ensure M&M regional processes are fit for purpose, especially around Learning Lessons. Trust stakeholders have also identified a lack of resources (see also Sections 4.15 and 4.23.1). If the appropriate staff are to attend specialty meetings, they need time out to learn (as indicated above this is also a recommendation from the IHRD Report), this was identified as a particular challenge for non-medics without job plans. Trust senior stakeholders identified that the lack of multidisciplinary participation was a concern and that that was partially as a result of the culture.

In addition, there is a risk in the context that all deaths must be reviewed, that sufficient time will not be spent on those deaths which provide the most opportunity for learning. This would require a screening/risk assessment process to be built into the regional process. There is no central IT system's overview, so the Trust cannot interrogate the system to generate reports and this lack of reporting functionality was a concern raised by Trust officers.

The Trust established an Outcome Review Group, which met for the first time in June 2018. The remit of this Review Group is to provide an assurance that all hospital deaths are monitored and, reviewed and reported, in line with regional guidance and to ensure that lessons learned and actions are implemented to improve outcomes. It is recommended that the Outcome Review Group (see also Board Governance Structures Section 4.1.9 and Appendix 2).

M&M Chairs have a key function in delivering the RMMR process. Within SHSCT they are responsibility for setting and maintaining the agenda for M&M meetings and for determining, supporting and developing patient safety inputs. They also have a monitoring role which includes; attendance, timely completion of screening templates and medical staff participation in Case Presentation. An M&M Chairs meeting has also been developed with the purpose of informing the ongoing development of M&M meetings and processes. The M&M Chairs should report to the Outcome Review Group.

Within the Trust, stakeholders highlighted the need for IT and administrative support for the process. With the right investment administrative staff could also reconcile deaths with SAIs thus providing another line of assurance that the process is being implemented. The Internal Audit Report indicates that the minutes and presentations

at M&M meetings are held centrally by the Corporate M & M team and Clinical Audit team (see Section 4.23.1).

The M&M Review Process is a core element of the Trust's integrated governance arrangements and patient safety framework. The Clinical Audit/M&M team within the Medical Directorate are a crucial element of the Process. The Outcomes Review Group is an important component of the Trust's assurance framework. I***t is recommended that they are adequately resourced and supported to ensure optimum outputs and clinical engagement. The support will include the development of administrative systems for the central suppository of minutes and attendance logs***.

4.17 Raising Concerns

The Trust's Policy for raising concerns is entitled 'Your Right to Raise a Concern' (Whistleblowing) and is based on Regional guidance. There is no indication of the date the Policy was approved/became operational on the Front Cover. The Lead Director is the Director of Human Resources and Organisational Development.

Board Effectiveness guidance increasingly highlights that the Board of Directors have a role in creating the culture which supports open dialogue. This should include Directors personally listening to complaints, concerns and suggestions from patients and staff, and being seen to act on them fairly (see also Section 4.6 Being Open). The Board should be assured that there is a framework which indicates how staff should raise their concerns and a key element is a clear whistleblowing policy, with support and protection for bona fide whistle blowers. The Reviewer was advised that a Non-Executive Director has been nominated to take a lead in this area.

The aim of the Trust policy is to promote the culture of openness, transparency and dialogue which at the same time; reassures staff that it is safe and acceptable to speak up, upholds patient confidentiality and contributes toward improving services, demonstrates to all staff and the public that the Trust is ensuring its affairs are carried out ethically, honestly and to high standards. The Policy also aims to assist in the prevention of fraud and mismanagement and contains specific guidance and contact details in this respect. The Trust Policy compliments extant Professional Codes and Guidance on responsibilities in raising concerns and clearly states that it is not intended to replace professional codes and mechanisms which also questions about professional competence to be raised.

The Director of HR advised that a gap in awareness training had been identified which would be addressed. She also advised that the use of advocates would be implemented in the medium term. Stakeholders who had participated in investigation cases indicated that this process was another source of learning for the organisation. The Policy contains a template entitled 'Record of Discussion regarding Confidentiality' which is a very useful tool in those situations where confidentiality is an issue for the member of staff raising the concern.

4.18 Information Governance

The Trust has identified that safeguarding the Trust's information is a critical aspect of supporting the delivery of its objectives. Effective management of information risk is a key aspect of this. The Trust has arrangements in place to manage the risk including; an Information Governance Strategy incorporating Framework, Framework, a Personal Data Guardian to approve data sharing (Medical Director and Director of CYP), a Senior Information Risk Owner (Director of Performance and Reform) and Information Asset Owners in place to reduce the risk to personal information within the Trust and training and advice provided to ensure they were aware of their responsibilities. The Senior Information Risk Owner (SIRO) provides an annual report to the Governance Committee which provides a summary of key aspects of the role, the minutes confirm that the Report was last presented in February 2019.

The Information Governance Strategy incorporating Framework is dated 2014/15 – 2016/17 and is underpinned by a suite of policies, procedures and guidance. The Information Governance Policy is dated January 2015 with a two year default for review. ***The Policy should be reviewed to take account of extant legislation and guidance in particular General Data Protection Regulations 2018.***

Information Governance breeches are required to be reported in line with Trust's Incident Reporting Procedure. Stakeholders have identified that learning from information governance incidents should be included in the Lessons Learned Forum (Section 4.20).

As identified in Section 4.1 Freedom of Information and Data Protection summary compliance data is reported to Trust Board on a quarterly basis to ensure completion within statutory timeframes. An information sharing register is in place which records the details of all episodes of sharing of Trust data with other bodies. Information governance training is mandatory within the Trust.

The Trust had taken action to ensure it was prepared for the General Data Protection Regulations (GDPR) in May 2018. Internal Audit provided 'satisfactory' level of assurance in relation to General Data Protection Regulations (GDPR) Readiness within the Trust during the 2017/18 audit cycle.

Cyber Security remains as a 'High' risk rating on the Corporate Risk Register.

4.19 Emergency Planning and Business Continuity

The Trust has a Corporate Emergency Management Plan incorporating Major Incident and Business Continuity. The Plan was approved by Trust Board in January 2013 and was revised during 2018/19 and is dated 15 February 2019. The lead Director is the Executive Medical Director. The Emergency Planning Policy is dated November 2015, approved by SMT on 9 December 2015 and circulated in February 2016 by the Medical Director. The Business Continuity Policy is dated 2012. An Annual Report on Emergency Planning and Business Continuity is submitted to Trust Board.

The Trust's Controls Assurance Emergency Planning Framework self-assessment has identified that the Trust is largely fully compliant with the core standard. Some

actions have been identified including; provision of appropriate resourcing for the Emergency Planning Office; developing an ongoing exercise programme/schedule at directorate and corporate level and a process for implementing actions arising from major incidents/exercises. A training needs analysis is required to identify any gaps in the key competencies and skills required for incident response including chemical, biological, radiological and nuclear defense (CBRN) training. These actions will be monitored by the Trust's Controls Assurance Group (See Section 4.7).

Stakeholders indicated that the development of Business Continuity plans at Directorate level could be improved.

4.20 Shared Learning for Improvement

All of the stakeholders expressed the need for HSC organisations to learn from service user experience and from the analysis of adverse incidents, complaints and claims. The commitment to learn is expressed in the Trust's 'Values' and Corporate Objectives. In the Trust's strategic priority 'Promoting safe, high quality care' the Trust has stated its commitment to 'be a learning and continually developing organisation, where professional standards, best practice and learning from experience share how we improve our services'.

The Trust has a Lessons Learned Forum whose purpose is to provide a corporate cross directorate interface for the identification and sharing of lessons learned from incidents (including near misses), complaints and litigation cases. The Forum is also responsible for identifying areas for improvement in the Trust' management of adverse incident and complaints and if appropriate propose system changes and to provide challenge and scrutiny to the Trust's adverse incident processes. The Forum members are responsible for presenting potential sharing lessons learned from their service areas and for assisting in disseminating the learning within their respective service areas. Stakeholders suggested 'casting the net wider' in respect of sources e.g. systems failures identified in Whistleblowing cases and HR Grievance and Disciplinary investigations (subject to the same rules of working within information governance parameters, maintaining confidentiality and limitations due to ongoing legal processes). Senior stakeholders wanted to see a stronger link between 'Lessons Learned' and Quality Improvement. (See also Section 4.1.9 Board Governance structures.)

Senior stakeholders advised that at times it seemed like the processes for learning were disparate and there was a lack of connectivity for example the learning identified through M&M and learning provided for the Forum. Stakeholders were therefore were keen to ensure that as various Sub Groups are developed within the Trust's integrated governance/assurance framework that duplication of purpose is minimised and the process for shared learning was escalated and disseminated through the proposed Assurance and Accountability framework (Section 4.1.9 and Appendix 4).

During the Review a meeting of the Lessons Learned Forum was held and stakeholders stated that it had been an excellent agenda and provided the organisation with a valuable opportunity to learn. However, the stakeholders were

also disappointed at the lack of attendance by medical staff. It is recognised that time to learn is a challenge for clinical staff. This was recognised in the IHRD Report and Recommendation 66 states *'Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours'*. The Education and Training Workstream have interpreted clinicians in the boarder term to include nursing, Allied Health Professionals and Social Workers. (See also Medical Leadership Section 4.21). Stakeholders were keen to explore alternative forms of sharing learning through e.g. annual safety events, learning lunches, learning letters and safety newsletters shared on Trust's intranet.[32]

Stakeholders also indicated that the challenge and scrutiny function within the Forum's Terms of Reference in respect of the management of adverse incidents had not yet been embedded. However, there may be a more appropriate forum for the Trust to undertake the scrutiny challenge and quality assurance of serious adverse incidents (see Management of SAIs Section 4.10).

In reviewing the Terms of Reference the Trust should consider how the Forum could contribute to the implementation of IHRD Recommendation 40 'Learning and trends identified in SAI investigations should inform programmes of Clinical Audit' (see also Management of SAIs Section 4.10).

4.21 Medical Leadership

Medical leadership was last reviewed in the Trust in 2011 and as the related paper indicates, given the length of time since this review and the changes in the health and social care landscape it was agreed that a further review and potential revision of the medical leadership form and function was required.

The findings were presented to the SMT on 11 June 2019. The 'case for change' highlighted three key areas:

- Performance of Frontline Teams;
- Providing a Link from Ward to Board;
- Supporting and influencing Service Planning.

The review emphasised the importance of implementing a Collective Leadership Model and the need to move on from a concept of command and control leadership. The review report also recognises that due to the power and control which doctors possess they may block potential change efforts and confound improvement initiatives. Engaging doctors within the collective leadership model therefore is crucial.

The review process included an independent survey of medical leaders which was carried out to identify the barriers and enablers. Many of these findings reflect the comments from stakeholders during the Governance Review and included the need to clearly define the roles and accountabilities of medical leaders and provide protected time to deliver in their roles and greater integration with operational management teams.

[32] An example of a Trust serious adverse incident/never event learning letter 'Nevermore' is available to view at www.yorkhospitals.nhs.uk

The Medical Leadership Review indicated that if the proposals were approved, all Medical Leadership management posts would be vacated and reappointed collectively.

To support the Medical Director who carries responsibilities in a wide area including; Medical Professional Governance, Clinical and Social Care Governance, Quality Improvement and Audit and Infection Prevention and Control, it is proposed that two Deputy Medical Directors should be appointed. One of the post holders, Deputy Medical Director Quality Improvement will focus on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, developing a clinical governance strategy and participating in education and training programmes as required. The Deputy Medical Director will work with the [Interim] Assistant Director Clinical and Social Care Governance in a Collective Leadership model and will provide stronger corporate integrated governance oversight and leadership.

As outlined in Sections 4.14 and 4.15 Standards and Guidelines and Clinical Audit and Sections 4.13 Coroners Service and Litigation Management and Section 4.16 M&M the investment in these Medical Leadership management roles is core to delivering clear accountability arrangements that will provide a robust assurance framework for effective integrated governance. In addition, the structure will facilitate the Trust meet the recommendations arising from the IHRD Implementation Programme. To achieve maximum outputs from the Medical Leadership model, the Trust should recognise the need to provide additional administration and clerical support (see also Section 4.23). [33]

4.22 Governance Information Management Systems

The Trust currently uses a commercial risk management/patient safety software programme called Datix. Datix is used in all of the Health and Social Care Trusts and the Health and Social Care Board. The Trust currently uses the Incident reporting, Complaints and Claims modules and has just purchased the Risk Register module.

Stakeholders advised that the Clinical and Social Care Governance Coordinator, Mental Health Service had developed statistical reports/Datix dashboards for his own and other operational Directorates which was a much welcomed tool to support data analysis and provision of governance reports.

All of the stakeholders in the Governance and Patient Safety Department and the Directorates who were interviewed were keen that the collective software system was utilised to the maximum capacity to support the patient safety/integrated governance agenda. They were also keen to explore the advantages that more advanced patient safety software can achieve for example Datix Cloud IQ. This is

[3333] SHSCT 'Medical Leadership Review' June 2019. Section 14.11, page 29.

currently being considered by the IHRD DoH Clinical and Social Care Sub Group in respect of the implementation of Recommendations 67, 68 and 80 (see below).[34]

The Reviewer is aware that the IHRD DoH Clinical and Social Care Sub Group have identified regional issues in respect of Recommendation 80 ~ "*Trusts should ensure that health care data is expertly analysed for patterns of poor performance and issues of patient safety*". Through the initial benchmarking data the DoH workstream identified that HSC Trusts reported various levels of data analysis and various approaches including expert analysis through Data Triangulation Groups. Strong links with existing systems i.e. QI data were identified (dashboards and statistical run charts) and some data from traditional clinical coding e.g. CHKS. Regional variance with commercial systems on trial or in use were also identified e.g. two Trusts use Alamac which consists of 4 models including analytics and governance reporting, service redesign and improvement and operational performance improvement and governance which includes real time data analysis e.g. heat map.

An indication of the direction of potential regional guidance in this matter is not available at present. The DoH workstream have accepted that Encompass will be integral in the future, however it is accepted that they will have to consider a short to medium term solution and are seeking to influence the Regional Data Strategy. During this Review Trust stakeholders also identified issues with the existing ICT infrastructure and the expert and administrative support required to provide the required level of information to provide assurance to Trust Board (see also Section 4.1 and Section 4.23). ***It is recommended that the Trust consider the information management systems and administrative support required to support the implementation of the Governance Review recommendations.***

To ensure that the Trust maximises it's information for integrated governance it is ***vital that a dedicated Datix systems administrator who can ensure the quality of data provided as this has been identified as a gap at present*** (see also Clinical and Social Care Governance Structures below).

4.23 Integrated Governance Structures

4.23.1 Corporate Clinical and Social Care Governance, Medical Directorate

The Executive Medical Director is the Executive Lead for Corporate Clinical and Social Care Governance. The Corporate Clinical and Social Care Governance Team is managed by the [Interim] Assistant Director for Corporate Clinical and Social Care with the support of one very recently appointed Senior Manager (Head of Patient Safety & Improvement). The Team support a large range of integrated governance functional areas including; delivering the Risk Management Strategy, incident reporting including Serious Adverse Incident reporting, complaints, patient

[34] Recommendation 67 ~ ' *Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed'*. Recommendation 68 ~ '*Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining'*. Recommendation 80 ~ '*Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety'*.

safety data and reporting on Clinical and Social Care to the Governance Committee of Trust Board.

Stakeholders advised and as is described in the Sections above that some of the functions are 'light touch' and limited to initial screening or signposting (e.g. complaints). The Reviewer was advised that the Management of Infection Prevention and Control would transfer to the Interim Director. In addition, during the review, the management of Clinical Audit and the M & M system was also transferred from within the Medical Directors Office to the Interim Director and as a result of the Review potentially the management of legal services (with exception of HR legal services),[35] the Board Assurance Framework and Corporate Risk Register would also be considered for transfer.

This centralisation of corporate integrated governance functions under the leadership of the Executive Medical Director represents a best practice 'good' governance structure and will be crucial for effective delivery of the proposed integrated governance assurance and accountability framework (see Section 4.1.9). The revised corporate clinical and corporate governance structure will create a more robust first line of assurance to the Board of Directors on the systems of internal control (including gaps in control and assurance). However, there are concerns for the staffing of this resource in respect of meeting the current demands and more crucially in meeting the increased demands of delivering a more robust assurance framework and in delivering the improvements required in the systems of internal control (Sections 4.4 – 4.22).

The Reviewer has benchmarked the existing corporate clinical and social care governance structure within the Trust with the Northern Health and Social Services Trust (NHSCT) structure who have a similar organisational profile and successfully implemented a robust accountability and assurance framework as recommended above in Section 4.1. [36] The NHSCT corporate governance structure is described below.

The Trust (SHSCT) have recently appointed a Senior Manager (Head of Patient Safety Data and Improvement). This post holder will focus on safety, quality and innovation as key drivers to deliver improved outcomes for patients and clients. This post is responsible for managing the timely and effective provision and communication of a corporate quality and safety analysis service.

The post holder will be responsible for setting the strategic direction for a range of analysis services provided at corporate organisational level within the Trust. This will include Patient Safety, Clinical Audit, Mortality & Morbidity and Trust clinical guidelines, in line with statutory requirements and national, regional benchmarks, peer accreditation frameworks and standardising Trust best practice.

[35] As outlined in Section 4. 13 the management of legal services is subject to review by the IHRD DoH Preparation for Inquest and it is anticipated that there will be a Regional Policy Directive on the management of clinical (professional) negligence and Trust Coronial Services.

[36] Information kindly provided by the NHSCT Assistant Director Governance & Risk Management. The Reviewer recognises that the NHSCT portfolio includes the management of Health and Safety.

The Patient Safety Manager will support the Head of Patient Safety Data and Improvement. The post holder is one of the original Institute for Healthcare Improvement (IHI) HSC Safety Forum members and maintains and updates the Forum Extranet and contributes to regional work. There are examples of best practice improvement initiatives in this area for example the Patient Safety Falls Walking Stick and the Pressure Ulcer Safety Cross. The Patient Safety Manager undertakes a large volume of data analysis activity supporting the Trust's Patient Safety Programme. The role is currently supported only by one Band 3 (24 hours). Therefore, this service is dependent on a single manager which is not sustainable. The post holder has limited time to use his expertise at ward/department level in quality improvement initiatives for example Sepsis6.

Clinical Audit (including M&M) is managed by an Acting Band 7 Manager who during the Review demonstrated commitment to providing a quality service and provided insight into the challenges of delivering both current and future clinical audit and M&M activity. The team to support Clinical Audit has reduced following the Review of Public Administration (RPA) and currently consists of a B5 WTE x 1 and Band 3 WTE x 3 plus 1 part time.

As outlined above, (Sections 4.15) clinical audit is 'back on the radar'. The role of the team is to support the delivery of the Trust's clinical audit programme which includes key national, regional and local drivers for clinical audit (described as 'top-down') balanced against directorate/service priorities and the interests of individual clinicians (bottom-up) initiatives.[37] The team screen audit proposals prior to registration. The post holder advised that there were also challenges in relation to supporting National Confidential Enquiry into Patient Outcome and Death (NCEPOD) activity which is currently person dependent within the Trust and needs to be re-focused.

Also as above (Section 4.15) the Clinical Audit team have a key role to play in delivering the Regional M&M Review system. Within the current resource there is very limited time for support for M&M Chairs which ideally would include pre and post meeting support and support for the Chairs Forum which meet on a quarterly basis. The rolling audit calendar is a particular challenge as support is required for six meetings at the same time.

The third key challenge for the Clinical Audit team with the current resources is supporting the linkages with quality improvement, the management of standards and guidelines (Section 4.14) and Serious Adverse Incidents (Section 4.10) and providing the SMT and Trust Board with assurance that improvement in practice has been implemented and sustained.

Stakeholders have indicated resource challenges in supporting the Trust to respond to the demands arising from the existing work plan of the Regulation and Quality Improvement Authority (RQIA) e.g. thematic reviews. In addition, the Corporate Clinical and Social Care Governance team will have to prepare for the increase in

[37] Healthcare Quality Improvement Partnership (HQIP) propose that clinical audit programmes are categorised into 4 distinct elements with 'external must do' audits being assigned the highest priority as Level 1 projects.

demand as the RQIA fulfil their functions in providing external assurance of compliance with the policies, procedures and guidelines arising from the final stage of the IHRD Implementation Programme, the Assurance Framework. The various workstreams and subgroups are currently working toward this final stage and more explicit information is not available at this time however, the Trust should seek feedback through their Director's Oversight Group from their workstream representatives. In addition, there is also likely to be more Internal Audit activity in respect of integrated governance functions arising from this same phase of the IHRD Programme.

The Governance Coordinator provided insight into core elements of the Clinical and Social Care Governance agenda including; complaints management, adverse incident management (including SAIs) and the use of Datix. She highlighted the lack of the corporate resource required to provide systems-wide quality assurance of these systems.

The range of functional areas for the Corporate Clinical and Social Care Governance team is wide and if proposed corporate governance functions are further integrated these functional areas will increase significantly. In addition to the day-to-day remit of the functional areas, the Clinical and Social Care Governance Team have to respond to a number of external demands for example the DoH IHRD Workstreams and stocktaking exercises, the RQIA (as above) and an ever increasing number of FOI and Media Enquiries. Normally these activities are required in very tight timeframes.

It is the opinion of the Reviewer and senior stakeholders, at director level that the corporate clinical and social care governance function has been under resourced over the past number of years. This underfunding represents a lack of investment in staff and the necessary information technology systems to support a good governance structure.

To deliver a similar portfolio of corporate clinical and social care governance functions the NHSCT have an Assistant Director Governance & Risk Management supported by three Senior Managers for;

- Risk Management;
- Quality, Standards and Learning;
- Assurance, Data and Systems Management.

The Risk Management function is supported by three managers (Band 6 and 7 excluding their Back Care Managers) and 13 support staff (Band 5 x 2, Band 4 x 3, Band 3 x 6 and Band 2 x 1). The Quality, Standards and Learning Function is supported by three managers (excluding their Health and Safety Manager, Resuscitation Officers and Research and Development Manager) and six supporting administrative staff (Band 5 x 1, Band 4 x 4 and Band 3 x 1). The Assurance, Data

and Systems Management function is supported by three managers and 5 administrative staff (Band 4 x 2 and Band 3 x 3).[38]

It is recommended that as a matter of urgency the Corporate Clinical and Social Care Governance team is re-structured and two additional Senior Manager posts are considered to provide leadership to related functional areas. It is proposed that there should be a Senior Manager for Clinical and Social Care which will include; management of Serious Adverse Incidents, Complaints and Claims and a Senior Manager for Corporate Governance which will include Risk Management, Risk Registers, Datix Administration, Controls Assurance and training (see Appendix 3). It will be essential to also consider the administrative support required to support the corporate function areas as has been highlighted throughout the report if the Trust is to meet the ever increasing level of scrutiny and demands to provide assurance to Trust Board and external stakeholders of the efficacy of its internal control systems. ***Therefore, it is further recommended that there is an urgent review of the Corporate Clinical & Social Care Governance structure and business case development for consideration by SMT.***

Given the wider remit of the corporate team it is important that each functional area has an annual action plan/work plan which will underpin the Corporate Clinical and Social Care Governance management plan and which can be linked to Corporate Objectives and staff appraisal.

4.23.2 Directorate Governance Arrangements

It was evident that Directors had invested in their Governance structures, however, they all advised that there was still not the capacity to meet the demands of providing information and assurance to internal and external stakeholders on the wide range of integrated governance elements e.g. standards and guidelines, serious adverse incidents and complaints. Additionally, there is an ever growing demand under RQIA, FOI, Media Inquiries etc.

The extant Integrated Governance Framework requires that each Operational Directorate Governance Forum is responsible for considering all aspects of the Trust's 'Model of Integrated Governance'.[39] Each directorate have developed governance structures which includes an overarching governance forum/group with terms of reference and sub groups which vary from directorate to directorate. The Reviewer was provided with examples of the structures which show clear lines of accountability and communication lines within the Directorate e.g. Mental Health Services. Governance forum sub groups meet at varying intervals within each Directorate. There is also a slight variation in the directorate governance forum/group meeting agendas and again this is not unusual in a Trust that consists of a range of programmes of care.

[38] The Reviewer is aware that the information shared by the NHSCT represents total head count for posts and not detail of whole-time equivalents. The Assistant Director has indicated she will share further detail with the Interim Assistant Director SHSCT as required.

[39] SHSCT 'Draft Integrated Governance Framework 2017/18 – 2020/21'. Section 5 page 21 and Figure 1 page 23.

The high level governance structure, Figure 2 in the extant Integrated Governance Framework, depicts the directorate governance forum reporting 'organisational and directorate intelligence' to the SMT. It is less clear from a review of the SMT Terms of Reference and Agendas how this operates in practice. ***It is recommended that the directorate governance reporting arrangements are included in a review of Trust Board Sub Committee Structure and the review of the SMT Terms of Reference as above (Sections 4.5 and 4.6).*** Also less clear within the Integrated Governance Framework is the role/link between the Executive Lead for Integrated Clinical and Social Care Governance (Medical Director) and the [Interim] Assistant Director for Clinical and Social Care Governance and the Operational Governance Arrangements (see also Section 4.4). This lack of clarity was confirmed by comments from stakeholders during the Review. In addition, some stakeholders indicated concern in dual reporting lines (see also Section 4.4) ***Clarification of lines of accountability, roles and reporting responsibilities should be considered as part of the recommended review of the Integrated Governance Accountability and Assurance Framework following approval of the Governance Review recommendations.***

The operational Directorates have appointed Clinical and Social Care Governance Coordinators. They fulfil a key role in supporting Directorates and in collating the Directorate intelligence. There is some variation in the demanding roles and responsibilities of the post holders which have evolved over time to meet the needs of the Directorates. There is also variation from Directorate to Directorate, in the resources allocated to provide support to the Directorate Clinical and Social Care Governance Coordinators. As above, the Directorate Clinical and Social Care Governance Coordinators and teams carry a wide range of roles and responsibilities at local level across the integrated governance functional areas and demand invariable exceeds capacity. Within Acute Services, the Director of Pharmacy has been supporting the role on a temporary basis. This should be reviewed to enable the post holder fulfil her regional role as Chair of the Regional Pharmaceutical Contracting Executive Group for Northern Ireland.

As previously outlined, there are examples of best practice across the Directorates for example work on complaints management, service user engagement and the model for dissemination of standards and guidelines. The Trust should consider how to share the best practice.

4.23.3 Interface between Corporate C&SGC and Directorates

Weekly Governance Meeting

The Medical Director and Interim Assistant Director Clinical and Social Care Governance have reinstated a weekly Governance Meeting with Directorate Clinical and Social Care Governance Coordinators. The meetings are short, lasting approximately one hour. Currently, the Medical Director where possible, either attends the meeting or joins by teleconference. The Reviewer has been advised that the rationale is to provide an opportunity for both a briefing (e.g. learning and internal safety alerts) and debriefing on newly emerging issues e.g. serious adverse incidents or complaints. These meetings meet the spirit of 'no surprises'. The

meetings are currently held on a Thursday and members can currently 'dial in'. There is a mixed reaction to the weekly Governance meeting with stakeholders identifying that the 'dial in' facility is not conducive to debrief meetings. Stakeholders have also identified that due to the nature of Acute Services the agenda can, at times be described as Acute centric.

The interface meetings are an important development and will underpin the integrated governance arrangements of the Trust's assurance and accountability framework. It is important that this interface meeting continues and develops to meet the needs of all concerned. The Interim Assistant Director advised that the process was at an early stage and the agenda was still being tested and evolving. She further advised that maintaining the efficacy of the interface meetings had resulted in increased workload for both corporate and directorate clinical and social care governance teams. More recently, the membership has increased to include safeguarding, medicines management, litigation management and standards and guidelines and this addition was being positively evaluated.

The Trust has systems in place to brief the Board of Directors of emerging issues in a timely fashion. The output of this meeting will complement existing systems and should be further developed to provide a summary briefing note which when ratified by SMT can be circulated to the Chair and Non-Executive Directors. This will assist the Trust meet IHRD Recommendation 81 ~ *Trust's should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within he Trust are brought to the immediate attention or every Board member*.

It is recommended that the agenda, membership and timeliness of the weekly Governance Meeting is reviewed and terms of reference developed. The meetings should be kept as short briefing meetings and held face to face with members. There should be a short summary template report developed which can then be used as an internal communication to NEDs.

Monthly Clinical and Social Care Governance Meeting

The monthly governance meeting provides an opportunity to consider a wider range of integrated governance issues in more detail. In light of the weekly governance meeting, ***it is recommended that a review of the terms of reference including purpose, membership and frequency is undertaken.***

Appendices

Summary of Recommendations **Appendix 1**

Theme/ Rec No	Recommendation	Timescale[40]
Good Governance Structures – Board Governance		
1	The Trust Board should review the cycle of Trust Board Reports and the Board of Directors' public meeting agenda by April 2020. .	M
2	The Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director.	M
3	The Chair of the Governance Committee should be involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020	S
4	The clinical and social care key performance indicators should be further developed and submitted for approval through the Senior Management Team.	S
5	The SMT Terms of Reference should be reviewed including the provision for tabling urgent papers.	M
6	The remit and responsibilities of the SMT Governance Board should be reviewed and a separate Terms of Reference developed to include the purpose, membership and reporting lines to Trust Board via the Governance Committee of Trust Board. (See also Assurance & Accountability Framework proposals at Section 4 1.9). The role of the SMT Governance Board should also be clearly defined in the Integrated Governance Strategy.	M
7	The Trust Governance Structures should be reviewed and Trust Board Sub Committee/Oversight/Steering Groups constituted to which the various integrated governance steering groups, forum and committees will report and provide the organisation with a first level of assurance (see Appendix 2).	S-M
8	The Terms of Reference and annual work plans/action plans (where applicable) for Board Committees and Sub Committees should be held centrally.	M
9	Any short – medium term Director's Oversight Groups should be added to the Governance Structure (Integrated Assurance Framework) for the duration of their remit as 'Task and Finish Groups' e.g. IHRD Directors Oversight Group.	S

[40] Short Term (S) action within 3 months, Medium Term (M) action within 6 months, Long Term (L) action within 9-12 months.

Theme/ Rec No	Recommendation	Timescale[40]
10	To ensure that all committees provide clarity in their terms of reference, delegated powers and reporting requirements the Trust should consider developing a standard template to define the terms of reference for all Board Sub Committees, Steering Groups and Advisory/Specialist Groups.	M
11	The Trust should consider introducing the role of Board Secretary/Head of Office to support the Trust Board and the Integrated Governance Framework.	M
12	The Integrated Governance Framework should be reviewed as a matter of urgency to ensure it provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Framework provides electronic links to key corporate Trust Strategies and Policies and extant guidance where applicable.	S
13	Arrangements for Adult Safeguarding should be reviewed to identify any potential risks/gaps in control or assurance in this area.	S
'Being Open'		
14	The Trust should consider the implications of implementing the Regional 'Being Open' framework which includes compliance with IHRD Recommendation 69 (i) ~ Trusts should appoint and train Executive Directors with specific responsibility for 'Issues of Candour'.	M
Controls Assurance		
15	The Trust should undertake an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation.	S-M
16	The Trust should develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards.	M-L
Risk Management Strategy		
17	The Draft Risk Management Strategy should be submitted for approval as a matter of urgency.	S
18	The Trust Board should consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register.	M
19	A risk management training programme should be developed and delivered to underpin the publication of the approved Risk Management Strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers	L

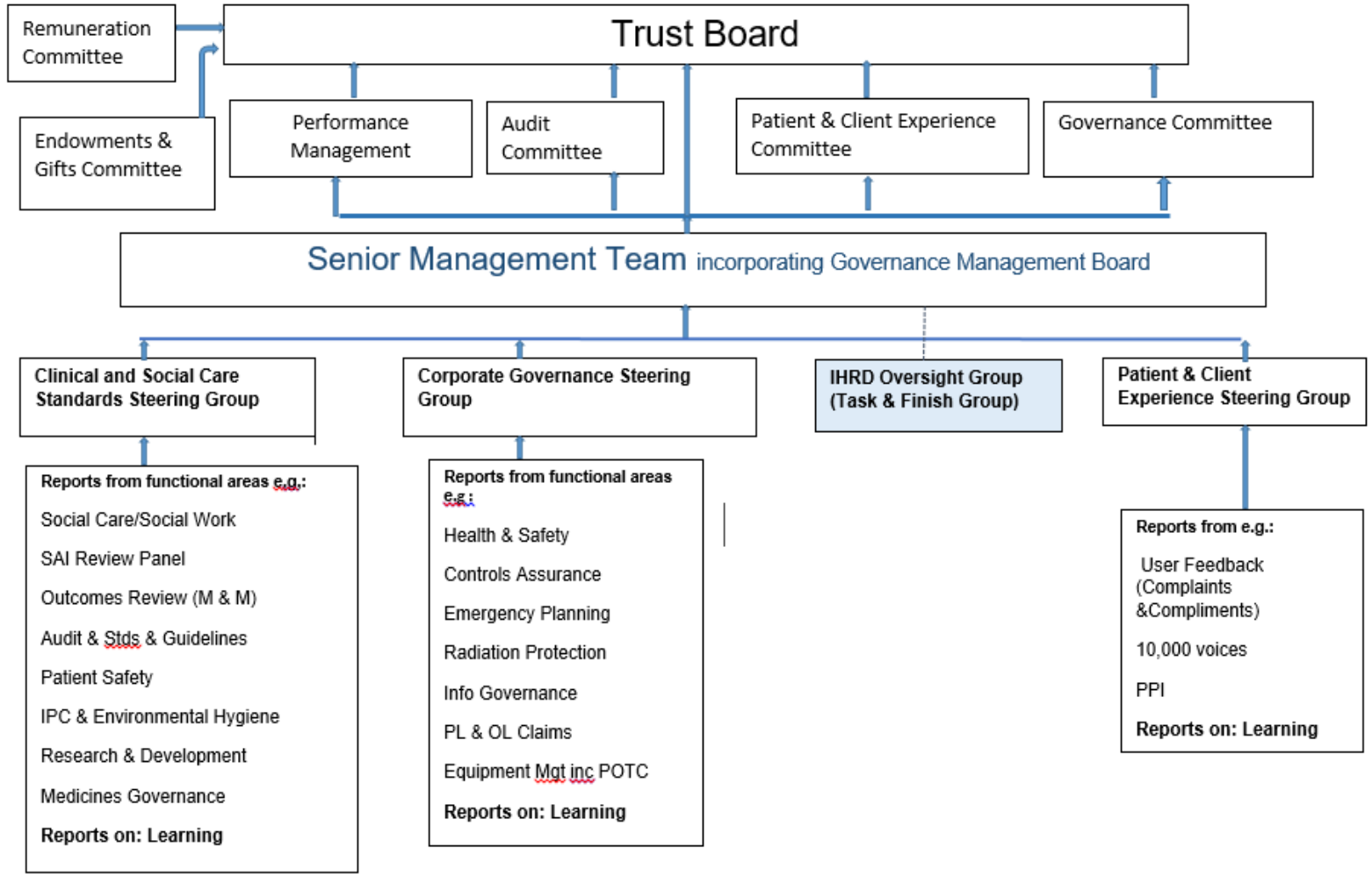
Theme/ Rec No	Recommendation	Timescale[40]
20	The management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy.	M-L
21	A standardised Directorate risk register template should be considered when Datix risk register module is implemented.	M
Management of Adverse Incidents including SAIs		
22	A Trust flow chart should be developed to underpin the Regional Adverse Incident Reporting Policy/Procedure (when disseminated) which accurately reflects local/ Trust roles and responsibilities especially at Executive Director level.	L
23	Corporate oversight of the management of adverse incidents should be strengthened to include a quality assurance component which will be dependent upon the resources and skills available within the Clinical and Social Care department (see Section 4.23.1)	S-M
24	The Trust should constitute an SAI Review Group and/or SAI Rapid Review Group [or similar] which should provide independent scrutiny and challenge to the SAI process including review of level of investigation, independence of review panel and approval of terms of reference when SAIs are initiated. In addition, the Review Group should oversee completed reports before submission to the HSCB. The Review Group should be chaired by the MD or his/her Deputy and will report to a Trust Board Sub Committee. The Review Group should meet on a four weekly basis initially.	S
25	The Trust should develop a database of SAI Review Panel Chairs who have undertaken SAI/Systems Analysis Training.	L
26	The Trust should develop an SAI RCA/Systems Analysis toolkit based on the training provided by external provider.	L
27	The Trust should consider developing the role of a Service User Liaison Officer [or similar] for engagement with families throughout the SAI process.	S
Management of Health & Safety		
28	The Trust Health and Safety Committee should review their Terms of Reference and submit to the relevant Board Sub Committee for approval.	S
29	The Trust should review and revise the existing H & S audit tool for use as outlined above in Recommendation 16.	M-L
30	The Trust should undertake an organisational audit of	M

Theme/ Rec No	Recommendation	Timescale[40]
	compliance with COSHH Regulations.	
Complaints Management		
31	The remit of the Corporate Complaints Officer should be reviewed in line with the extant Trust Complaints Management policy.	M
32	The current process of screening of complaints should be reviewed and parameters for alerts to be clearly defined to include alerts to professional Executive Directors	S-M
33	It is recommended that the Trust constitutes a Director's Oversight Complaints Review Group as a task and finish group to focus on reviewing Policy and Procedure and improving the management of complaints and experience of the service user. Membership should include a Non-Executive Director and/or a Service User(s).	M
Litigation Management		
34	The management of Legal Services should be reviewed in line with IHRD Recommendations 36, 51 and 52.	S-M
Policies, Standards and Clinical Guidelines		
35	The Trust should explore the options for an electronic policy and procedure management system that is accessible, easy to navigate, contains a search facility and includes the capacity for email notification of new/changed policy and automates a review/revise reminder.	L
36	The Corporate oversight of the management of Standards and Guidelines should be reinstated and the former Accountability (Compliance) reporting arrangements are also reinstated.	S
37	The Trust should further develop the Standards and Guidelines model developed within Acute Services and provide a central management system within the Corporate Clinical and Social Care Team under the leadership of the Medical Director.	
38	The Trust should review the Sub Committee Structure to include an oversight committee for the management of Standards and Guidelines either a full time committee or a Task and Finish Sub Committee (see also Recommendation 7).	M-L
Clinical Audit		
39	The 2018 Clinical Audit Strategy and Action Plan should be reviewed and updated.	S
40	The Clinical Audit Committee should be reinstated and	M-L

Theme/ Rec No	Recommendation	Timescale[40]
	the reporting arrangements considered in the review of the Trust Board Committee Structure Section 4.2.6 and Appendix 1.	
Morbidity & Mortality – link with Medical Leadership below		
41	The resource implications for the delivery of the RMMR should be considered in line with the proposals for the Medical Leadership model. (Section 4.21 Medical Leadership and Section 4. 23.1 Corporate Clinical and Social Care Governance Department).	S
42	The RMMR process should be adequately resourced and supported to ensure optimum outputs and clinical engagement. This includes the resources required within the Corporate Clinical and Social Care Clinical Audit team to ensure the development of administrative systems for the central suppository of minutes and attendance logs (see also Recommendation 44 and 45 below).	M
Shared Learning for Improvement		
43	The Trust should review the Terms of Reference, including membership, and strengthen the purpose of the Lessons Learned Forum.	S-M
Governance Information Management Systems (Datix)		
44	1) It is recommended that the Trust consider the information management systems and administrative support required to support the implementation of the Governance Review recommendations. 2) To ensure that the Trust maximises the potential for the use of patient safety software it is vital that a dedicated Datix systems administrator is appointed who can ensure the quality of data provided as this has been identified as a gap at present (see also Clinical and Social Care Governance Structures below).	M
Corporate Clinical and Social Care Governance Structures		
45	It is recommended that the Corporate Clinical and Social Care Governance team is re-structured and two additional Senior Manager posts are considered to provide leadership to related functional areas. It is further recommended that there is an urgent review of the Corporate Clinical & Social Care Governance structure and business case development for consideration by the SMT.	S
46	The Trust should ensure that the directorate governance reporting arrangements are included in a review of Trust Board Sub Committee Structure and the review of the SMT Terms of Reference as above	M
Corporate & Directorate CSCG Interface		

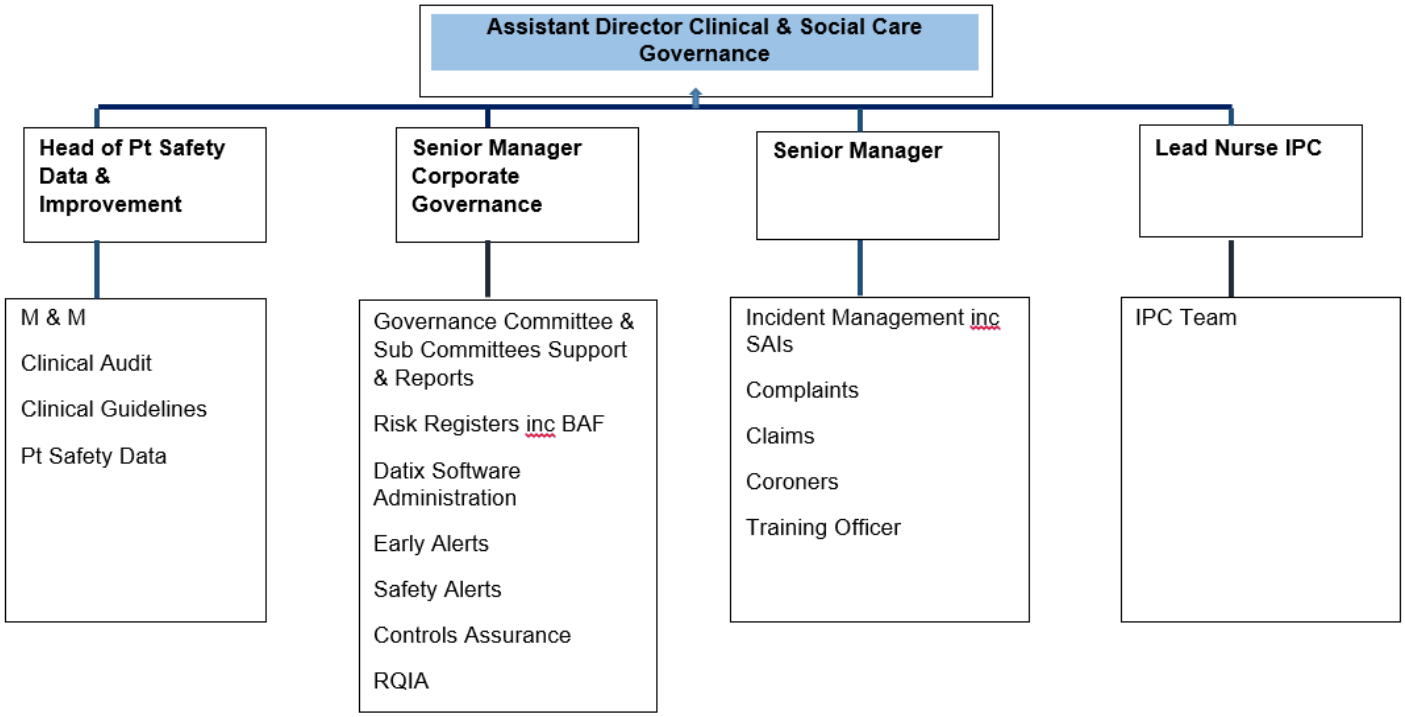
Theme/ Rec No	Recommendation	Timescale[40]
47	It is recommended that the agenda, membership and timeliness of the weekly Governance Meeting is reviewed and terms of reference developed. The meetings should be kept as short briefing meetings and held face to face with members. There should be a short summary template report developed which can then be used as an internal communication to NEDs.	S-M
48	In light of the weekly governance meeting, it is recommended that a review of the terms of reference including purpose, membership and frequency is undertaken.	M

Appendix 2 Governance Committee and Sub Committee Structures underpinned by Directorate Accountability Arrangements



Directorate Accountability Arrangements

Appendix 3 Corporate Clinical & Social Care Governance Department Structure reporting to Executive Medical Director



- Vivienne further advised that Dr O'Kane had indicated to the Board that the Findings contained in the Staff Survey platform would also be shared with everyone affected by the potential action that would now be developed from the insights emerging from the survey. Vivienne explained to the Meeting that there were three Questions contained in the Staff Survey, which she believed were particularly important for the meeting to note.

  1. Is the care of the Patients and Service Users in my Organisation its top priority?
  2. Would I recommend my organisation as a place to work?
  3. Would you be happy for your friend or relative to receive care in this Trust?

  Vivienne explained that Dr OKane had indicated to the Trust Board in her Presentation that the graphic charts contained in the Survey Report reflected that the staff responses to these questions (percentages) are slightly under the NI HSC average.

- Vivienne shared with the meeting the Findings from the Culture and Leadership Sub Group which Dr O'Kane had shared with the Trust Board. She explained that the Findings were derived from the meeting between the Senior Leadership Team (SLT) and a number of staff. The staff Dr O'Kane had explained to the Board, reflected that the Southern Trust needed to "draw a line in the sand" in relation to this very difficult and challenging period. The view of the staff was that the Trust needed to move forward to what had the potential to be a much more positive future. To build

such a future however, the staff had indicated it was essential that the culture of the Trust needed to change. A transition that would be central to such a change, it was agreed at the meeting with staff would be a change of culture from a Performance driven top down culture to a Safety and Quality Culture built on commitment by leadership of the Trust Board and Senior Management engaging with staff at every level of the Trust.

- Vivienne continuing with her account of Dr O'Kane's Presentation said that the Chief Executive had informed the Board that she had now asked Elaine Wilson the Director for Planning, Performance and Informatics to begin to draft a new Organisational Vision for the Trust that would be underpinned by a new 5 years Strategic Plan. She advised the meeting that the Chief Executive had asked the Trust Board to agree that these two critical pieces of work should be commenced immediately. She said that Dr O'Kane had emphasised to the Board that we needed to commit leadership to co-produce the Vision and Strategy by involving **all Stakeholders**.
- Vivienne advised the meeting that the Senior Leadership Team were now examining the development of the Principles that should inform how this important strand of work would be developed. She advised that in progressing this discussion that to date Senior Leadership had agreed the following Key Principles:
    - Safe and Quality Care
    - Investing our resources where they add most value

	➢ I can also see now how the busyness of the service and the constant tension between demand and capacity meant there may have been little time or room to become aware of issues or to triangulate information about issues or even to address issues. The pressure on various services across the Trust (not only Urology) may also have had an impact on some of the processes involving Mr. O'Brien (such as the MHPS process) given that they often involved a range of people, all of whom were carrying significant workloads.

49 What do you consider the learning to have been from a Board governance perspective regarding the issues of concern within urology services, and regarding the concerns involving Mr. O'Brien in particular?

49.1

Culture	➢ An open and honest culture that is psychologically safe begins in the Boardroom. That culture then needs to penetrate throughout the organisation, no matter your role or perceived/actual level of authority or seniority. ➢ I have, since taking up the role of Chair, prioritised the issues of culture and how the Board works. I was very mindful that I was taking on a team of Directors who felt damaged and hurt. There was a need to build trust with each other and as a team. This work continues. ➢ The bringing of urgent issues to the attention of Trust Board can happen through a variety of ways.