The **Regulation** and **Quality Improvement Authority**

Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland

Overview Report - February 2008

informing and improving health and social care
www.rqia.org.uk

Foreword

I am pleased to introduce the first organisational governance report from the Regulation and Quality Improvement Authority (RQIA). This report reflects the findings of the reviews conducted in twenty five health and social services Boards, Trusts and Agencies in the period November 2006 to March 2007.

The review took place at a time when health and social services in Northern Ireland was undergoing one of the most radical changes in decades; it is important therefore that these reviews are seen in that context. The report highlights a number of the challenges being faced by organisations and their management and care teams at a time of transition.

The report indicates through its recommendations a potential road map that will assist the new health and social care organisations to create robust governance frameworks for the future.

This report is underpinned by a suite of organisational reports that have been forwarded to all the Boards, Trusts and Agencies reviewed. I am pleased to note that all organisations have completed work on their improvement plans arising from the reviews. These plans will form the baseline for assessment of governance arrangements in the years to come.

Dr Ian Carson
Chairman RQIA

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Acknowledgements

RQIA gratefully acknowledges the contribution and assistance provided in the development of the methodology used within the clinical and social care governance reviews. This assistance was provided by NHS Quality Improvement Scotland (NHS QIS), local reference groups populated by representatives from Health and Social Services Trusts and an external assurance group. RQIA would also wish to note appreciation to colleagues in the Department of Health Social Services and Public Safety (DHSSPS) for their support during the review programme.

RQIA gratefully acknowledges the contribution made by every reviewer in carrying out the reviews.

RQIA also expresses its thanks to the affiliates within Boards, Trusts and Agencies for ensuring the compilation and return of completed self-assessments, the collation of core evidence material and liaison with RQIA Project Managers in the scheduling of review visits.

Furthermore, RQIA acknowledges the full cooperation received from staff at all levels within those organisations that were reviewed.

Executive Summary

The clinical and social care governance review of all Health and Personal Social Services (HPSS) organisations within Northern Ireland has proven to be a valuable and challenging process, which was undertaken during a time of significant change within HPSS structures.

The findings from the review have demonstrated how the concepts and practices of clinical and social care governance and risk management are being taken forward and provide a baseline position against which progress can be assessed in the future.

Organisations provided evidence that they were making advances with the changing governance agenda and the main challenge outstanding is full implementation of new systems within the reconfigured Health and Social Care (HSC) Trusts.

The key themes and associated recommendations to emerge from the review are presented in this report and should be read in conjunction with the individual review reports of each HPSS organisation. Individual reports are available directly from the RQIA or can be accessed on the RQIA website at www.rqia.org.uk.

This overview report sets out a number of general recommendations for HSC Organisations which are related to the general themes emerging from individual reviews.

This report also sets out a number of examples of good governance practice within organisations.

Lay and Peer Reviewers attend a training event in preparation for the review programme

1 Setting the Scene

1.1 Scope of the Reviews

The role and responsibilities of the Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body, established with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is sponsored by the Department of Health, Social Services and Public Safety, with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 places a statutory duty of quality on Health and Personal Social Services (HPSS) Boards, Trusts and Agencies (organisations), and requires RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

In order to fulfil its statutory responsibilities RQIA has developed a planned three-year programme of clinical and social care governance reviews of all HPSS organisations.

Clinical and Social Care Governance

Clinical and social care governance is described as a framework within which HPSS organisations can demonstrate their accountability for continuous improvement in the quality of services and for safeguarding high standards of care and treatment. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care.

The Standard for Health and Social Care developed and published in March 2006 by the DHSSPS (www.dhsspsni.gov.uk/spsd-standards-quality-standards), reinforce this and in the introduction, regarding each HSS Board and Trust, states (Ref 1):

"…that each organisation has a legal responsibility for satisfying itself that the quality of care it provides meets a required standard. This requirement is just as important as the responsibility to demonstrate financial regularity and propriety. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to deliver, monitor and promote safety and quality improvements in the provision of health and social care. This process is known as Governance." (DHSSPS 2006, Page 2)

The Standards

The Quality Standards for Health and Social Care underpin the duty of quality on HSS Boards and Trusts. They complement standards and other guidelines already in use by organisations and give a measure against which organisations can assess themselves and demonstrate improvement.

The five quality themes on which the standards have been developed were identified through consultation with service users, carers and HPSS staff and through a review of standards developed elsewhere at local, national and international level.

The five quality themes:

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

Consideration was given to the scope of the review to ensure that the findings would be of greatest value to a service that was experiencing major significant changes. Following agreement with the DHSSPS, the review focused on the following elements of the Quality Standards:

Theme 1 - Corporate Leadership and Accountability

- Within HPSS Organisations
- Within the appraisal of medical staff.

Theme 2 - Safe and Effective Care

Specifically:

- Safe and effective discharge of older people from the acute to the community setting
- Safe and effective post-operative care of patients in the acute hospital setting
- Safe and effective care of children and young people in residential settings.

1.2 The HPSS at the time of Review

This review of clinical and social care governance arrangements within HPSS organisations (Boards, Trusts and Agencies) was the first major review of governance systems in the HPSS. It came at a time when a majority of organisations were in preparation for organisational change and merger as a result of the Review of Public Administration (RPA). Concerns and anxieties about the timing of the review and the methodology being used were expressed by HPSS Organisations to the RQIA during the planning phase of the review. One significant issue that was raised related to the fact that most organisations being reviewed would cease to exist beyond 1st April 2007. This is illustrated in Tables 1 and 2.

Table 1: List of HPSS Organisations reviewed (pre- & post-RPA changes)

Pre-RPA	Post-RPA
Belfast City Hospital Trust Royal Group of Hospitals Trust Mater Hospital Trust Greenpark Healthcare Trust North and West Belfast Community Trust South and East Belfast Health & Social Services Trust	Belfast Health and Social Care Trust
Homefirst Community Trust Causeway Health & Social Services Trust United Hospitals Trust	Northern Health and Social Care Trust
Ulster Community Hospitals Trust Down Lisburn Trust	South Eastern Health and Social Care Trust
Craigavon Area Hospital Trust Craigavon and Banbridge Community Trust Newry and Mourne Health & Social Services Trust Armagh and Dungannon Health & Social Services Trust	Southern Health and Social Care Trust
Altnagelvin Hospitals Health & Social Services Trust Foyle Health& Social Services Trust Sperrin Lakeland Health & Social Services Trust	Western Health and Social Care Trust
Northern Ireland Blood Transfusion Service	Not currently RPA affected
Northern Ireland Ambulance Service	Not currently RPA affected
Northern Ireland Regional Medical Physics Agency	Not currently RPA affected
Northern Health and Social Services Board Eastern Health and Social Services Board Southern Health and Social Services Board Western Health and Social Services Board	Awaiting Ministerial decision

As a consequence of the changes under RPA, the review teams encountered a significant number of temporary executive teams within organisations. An example of the impact of these changes is that within the 25 organisations assessed, there were 12 temporary Chief Executives in post.

In many organisations high numbers of executive directors had also vacated their positions and had been replaced by colleagues on fixed-term contracts. At times this staffing pattern adversely influenced the ability of organisations to adequately describe the historical development and processes relating to governance.

Table 2: Geographical Overview of HPSS Organisations Reviewed

1.3 The Review Methodology

Development of Methodology

RQIA is an organisation that operates within a value system that supports the belief that learning is at the heart of improvement. Therefore, it was vital that the methodology developed for clinical and social care governance reviews of HPSS organisations reflected this value of improvement through learning.

The approaches taken by equivalent organisations to reviewing health and social care organisations both nationally and internationally were examined. From this review it was evident that the methodology used by the NHS QIS was seen to match the requirements of the RQIA.

This system uses preliminary self-assessment of achievement of the HPSS Quality Standards, which is analysed by RQIA and then validated through on-site visits by reviewers.

Use of Controls Assurance Standards

As part of the development of the methodology for the reviews, RQIA engaged with a reference group made up of nominated representatives of the HPSS organisations being reviewed. As an outcome of these engagements and in order to reduce the burden of review and inspection on the organisations in transition, it was agreed that RQIA would consider the use of each organisations controls assurance returns to the DHSSPS.

The Controls Assurance Standards were launched in 2003/04 by the DHSSPS. These standards were introduced to HPSS organisations as an assurance process that was designed to provide evidence that organisations are doing their 'reasonable best' to improve and strengthen practices and governance arrangements, so that safe and high quality health and social care services are provided to all who need them.

Compliance with the core standards is subject to annual review by HPSS internal audit. The position on annual audit is being monitored by the DHSSPS as the core standards become embedded in organisations. To avoid duplication of effort, RQIA took into consideration evidence submitted by organisations to the DHSSPS in the form of Controls Assurance reports and action plans. This information was mapped with the criteria for the Quality Standards for Health and Social Care.

External Assurance Group

As part of the ongoing monitoring of RQIA processes in relation to this review, it engaged groups of experts from the field of regulation across the UK. This group also included a representative from the local Health and Social Care Councils.

The External Assurance Group maintained an overview of the efficacy of the methodology and provided continuity of approach throughout the progress of the review. In addition, the group also provided objective analysis of RQIA's findings and contributed to advancing the learning from this round of reviews to future review programmes.

The membership of the External Assurance Group was constituted as follows:

Stella Cunningham
Chief Executive
Southern Health and Social Services Council

Danny Keenan
National Clinical Advisor
Healthcare Commission, England

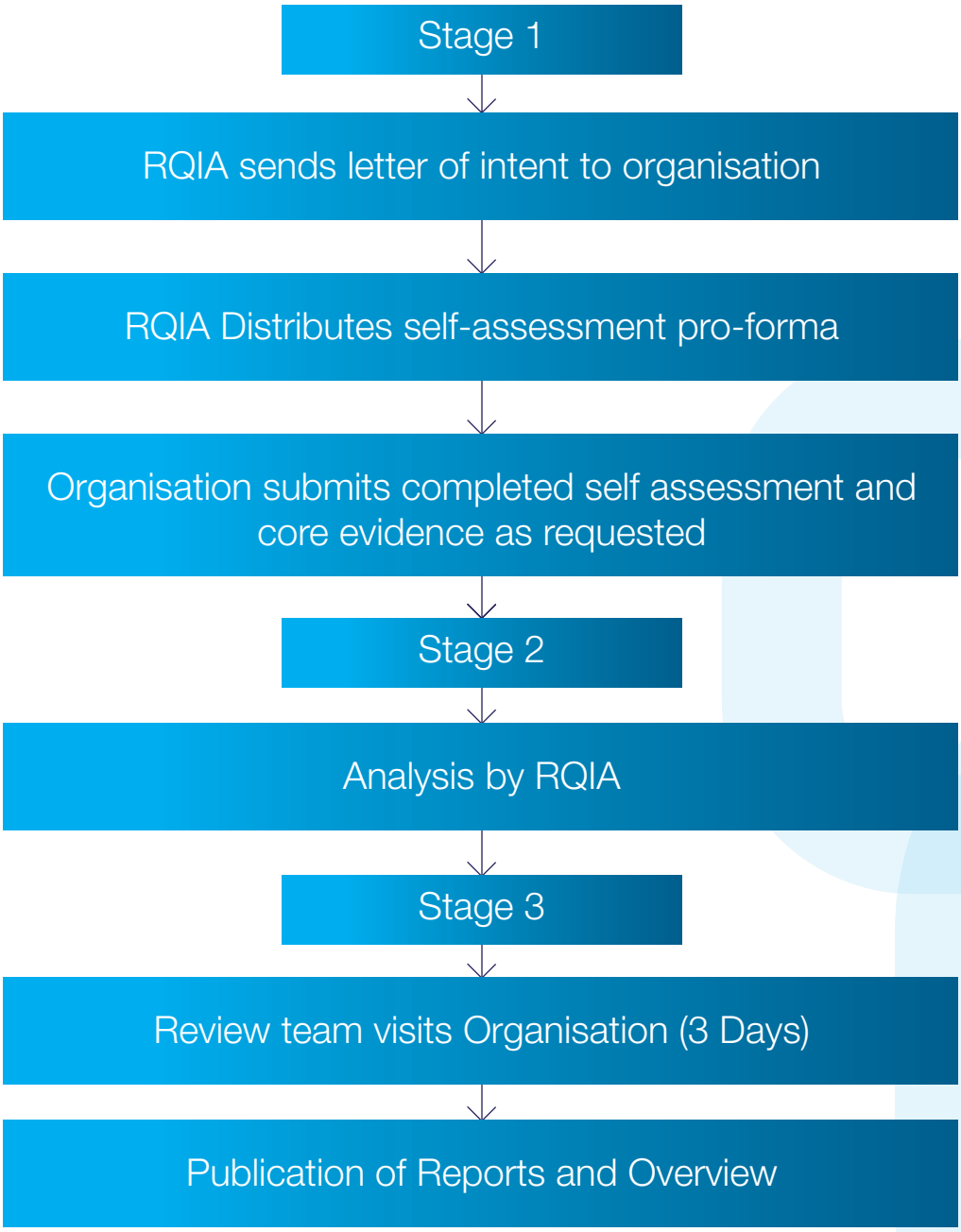
Rob Pickford
Chief Executive
Care and Social Services Inspectorate Wales

The Clinical and Social Care Governance Review Team welcome the Health Minister, Paul Goggins, MP, to RQIA headquarters at Riverside Tower

1.4 The Review Process

The process of review has three key stages: local self-assessment, pre-visit analysis and the review team visit.

Figure 1: Review Process map



Stage 1 Self-assessment

The first stage in the process of the clinical and social care governance review was that each organisation assessed its own performance against the two quality standard themes, using a self-assessment form developed by RQIA. At this stage the organisation identified a senior member of staff, 'an affiliate', with the remit to facilitate all aspects of the review process, which commenced with submission of the completed self-assessment and supplementary documentary evidence. Each Chief Executive was required to sign a declaration to confirm that the information submitted truly reflected the clinical and social care governance arrangements within their organisation.

Stage 2 Pre-visit analysis

On receipt of the completed self-assessment form, a preparatory analysis of the self-assessment narrative and core evidence submitted by each organisation was undertaken. This analysis provided reviewers with an initial analysis framework, which could then be augmented by their own findings to identify points for further exploration and clarification to be covered during the on-site visits to organisations.

Stage 3 The review visit and report of findings

The review team assessed the breadth and depth of an organisation's achievements against the standards by undertaking an on-site visit. At the start of the site visit the review team met with key personnel who had responsibility for the service being reviewed. Reviewers also spoke with local stakeholders, including staff, patients, clients and carers about the services provided. Observation of the physical surroundings and examination of documentation such as policies and procedures were included in the on-site visit. The visit concluded with the presentation of a summation of the review team's findings that included examples of good practice and particular challenges.

On completion of each review, a report of the review team's findings was drafted and forwarded to each organisation for comment on factual accuracy, prior to publication of the final report.

1.5 Compliance with Controls Assurance Standards

One key conclusion to emerge from this review relates to the level of inconsistency in compliance with controls assurance standards reports. It was notable that these reports varied in quality and quantity and ranged for example, from two page documents in bullet point format to 60 page detailed reports.

Similarly, in a number of instances, action plans arising from the assessment of the standards varied in quality and in a number of cases were absent.

Compliance with the standards was based on self-assessment, assessment by internal audit and in some instances, assessment by an external auditor.

Reviewers, supported by the external analysts, noted that there were considerable inconsistencies in the application of compliance scores across organisations. It was unclear what checks and balances had been put in place by the DHSSPS to follow-up or further assess the validity of the Controls Assurance Standard processes.

From an RQIA perspective, it is clear that for any future reviews, limited reliance can be placed on Controls Assurance Standards reporting as an aid to assessing compliance with the Quality Standards for Health and Social Care.

Recommendation:

- *It is recommended that the DHSSPS should ensure that checks and balances are in place to follow-up or further assess the validity of the Controls Assurance Standard processes.*

2.0 Findings

This document provides an overview of the high level findings contained in the reports of the review of HPSS organisations in 2006/07.

A number of local initiatives and areas of good practice are highlighted throughout this section of the report. These examples are not exhaustive as all review teams noted examples of good practice during visits.

2.1 Corporate Leadership and Accountability of Organisations

2.1.1 How the organisation demonstrates accountability

This part of the review assessed the arrangements for clinical and social care governance that organisations had in place.

Across the 25 organisations reviewed, the weight of evidence indicated that clinical and social care governance arrangements were in place, and the considerable efforts of enthusiastic and committed staff were apparent. However, in a small number of organisations, there was a lack of integration and cohesiveness within the overall governance arrangements. Formal mechanisms by which clinical and social care governance is supported at corporate level were not always evident.

Communication of governance issues within some organisations was limited and this restricted the ability to share good practice and ensure consistent outcomes.

All organisations are working towards implementing the DHSSPS Assurance Framework. However, no organisation has reached the stage of integrated governance.

Recommendations:

- *Organisations should have in place a robust corporate decision making framework and accountable committee structure.*
  (Ref. Quality Standard 4.3 a & b)

- *Organisations should have in place an appropriate, systematic approach to sharing best practice. This will be particularly important when establishing the new structures.*
  (Ref. Quality Standards - Robust Organisational Structures and Processes Principle)

2.1.2 Leadership

This part of the review assessed how organisations develop leadership at all levels, including identifying potential leaders of the future.

Reviewers found that the provision of leadership skills for staff is a key issue that is underdeveloped in organisations across the HPSS. There was however a focus on developing nurse leadership in many Trusts.

Achievements in management, education and training were given by the majority of senior management teams as examples of how Trusts support and develop staff who show potential leadership skills. Reviewers felt that the courses undertaken by staff were focused on the development of management skills rather than leadership and that the development of leadership and identifying potential leaders of the future were not fully addressed within these programmes.

Examples of Local Initiatives

Ulster Community Hospitals Trust
The Trust submitted evidence of a range of leadership development programmes that are offered to staff, examples included, Young Leaders Programme, Ward Managers' Development Programme, Balanced Scorecard Event, and the Informed Manager Programme. Leadership programmes are in place for Band 6 and 7 Nurses and there are also nursing auxiliary development programmes focusing on Essence of Care standards.

Causeway Hospital Trust
The Trust provides leadership development for staff at all levels, for example, King's Fund courses for Directors and the Institute of Leadership and Management Qualification for support services supervisors. It was reported that leaders are identified through training needs assessments.

Recommendation:

- *Leadership and management development opportunities for staff at all levels should be strengthened throughout all organisations.*
  (Ref. Quality Standard 4.3 c)

2.1.3 Financial management

This part of the review examined the internal financial control systems that organisations have in place and assessed whether these systems are based on a framework of regular financial information; administrative procedures including the segregation of duties; and a system of delegation and accountability which operates within guidelines set down by the DHSSPS.

The findings of these reviews would indicate that organisations across the HPSS have in place appropriate systems of internal financial control based on guidelines set by the DHSSPS.

Recommendation:

- *Organisations should ensure that the principles of good practice in financial management as demonstrated in legacy Trusts at the time of this review are taken forward into the new Trusts and any potential shared services arrangements.*
  (Ref. Quality Standard 4.3 f)

Reviewers being welcomed at the Royal Belfast Hospital for Sick Children

2.1.4 Compliance with legislative requirements

In order to review how an organisation meets legislative requirements, reviewers examined a range of information provided by organisations to demonstrate how legislative requirements are being met. This information included the perusal of action plans to meet any deficits and arrangements to review compliance.

The majority of organisations submitted information on compliance with controls assurance standards as evidence of compliance with legislative requirements.

There was evidence that organisations carry out rolling programmes of audit in areas such as health and safety, medicines management, fire safety, decontamination of medical devices, human resources, infection control and waste management.

In many instances within governance sub-committees there are identified, appropriately qualified key personnel who advise and inform staff of any relevant legislative requirements and ensure regular reports are provided to the Governance Assurance Working Group.

Examples of local initiatives

North and West Belfast Trust

The Trust prepares an annual report on the Delegation of Statutory Functions, which includes information on how the Trust complies with legislative requirements. This report gives insight into service improvement service activity and associated outcomes.
An accountable director and small project group have responsibility for monitoring the Trust's compliance with legislative requirements.

Recommendation:

- *A standard corporate framework should be developed and embedded in all organisations to demonstrate an awareness of, and compliance with, relevant legislative requirements.*
  (Ref. Quality Standard 4.3 g)

2.1.5 Responsibilities in relation to delegated statutory functions and inter-agency working

Reviewers examined how organisations carry out their responsibilities in relation to delegated statutory functions and inter-agency working.

Reviewers were satisfied with the arrangements in place to allow the organisations' Boards to discharge responsibilities to the Clinical and Social Care Governance Committee, Risk Management and Standards Committee together with any other sub-committees. In the majority of instances the Chief Executive has the overall responsibility in relation to delegated statutory functions.

In addition, many organisations periodically review how each programme of care discharges its statutory functions.

Where annual reports on the Delegation of Statutory Functions were prepared and submitted to Trust Boards, it was not always clear as to what actions were required to be undertaken by the Trust or those bodies to whom functions are delegated were not always clarified in the report. In a few instances there was no individual identified to take responsibility for action plans and timescales for action were omitted.

The Corporate Plan in most organisations clearly outlines strategies and forums involving inter-agency working.

Examples of local initiatives

Craigavon and Banbridge Community Trust

The Trust receives regular reports from service managers in respect of statutory functions, for example, Looked After Children Reviews and the Child Protection Panel Annual Reports. The Trust Board receives an annual Statutory Function report and the review of statutory function is a standing item on the agenda for Trust Board meetings.

Recommendation:

- *Organisations should develop a standard corporate framework for annual reporting on the delegation of statutory functions.*
  (Ref. Quality Standard 4.3 h)

2.1.6 Risk management

The review team examined how organisations carry out their responsibilities in relation to risk management of all areas.

It was evident that all organisations have arrangements in place for managing risk in accordance with Australian/ New Zealand Standard, and have made significant progress towards incorporating risk management into the overall assurance framework.

Risk management strategies are in various stages of development. Most organisations have risk management strategies detailing the operational management of risk and accountability arrangements to provide high level assurance that risk management arrangements are robust. In a few Trusts, risk management strategies were unclear and corporate accountability arrangements and communication in managing and addressing risks could be improved.

A common finding was that the links between the management of risk, performance management and the corporate objectives were not explicit. The same was true of reporting arrangements to and from directorate risk registers. Some of the risk registers submitted lacked action plans and review dates. This hindered the sharing of learning at all levels throughout organisations.

All organisations have invested considerably in staff training on risk management and incident reporting. As a result, organisations have seen an increase in incident reporting and a gradual change towards an open and learning culture. While this is commendable, there is a need for further development of mechanisms to enable learning from adverse incidents and near misses.

Most organisations have introduced specific software to facilitate risk management and this could be used more effectively for trend analysis and the production of reports.

Examples of local initiatives

Greenpark Health Care Trust

Adverse incident reporting is acting as a stimulus for clinical audit activity, with changes being made in protocols and patient management processes, for example:

- decontamination of surgical instruments
- management of medications.

Homefirst Trust

Significant progress has been made in converging risk management and governance, and in developing the risk management process at Directorate level.

Recommendations:

- *Organisations should establish appropriate links between the management of risk, performance management and business planning.*
  (Ref. Quality Standard 4.3 i)
- *Organisations should establish explicit lines of accountability, roles, responsibilities and links between committees in the management of risk.*
  (Ref. Quality Standard 4.3 b)
- *Organisations should ensure that risk registers include key information such as action plans, timescales and lead responsibility and that these are regularly monitored and acted upon.*
  (Ref. Quality Standard 4.3 i)
- *Consistent methods for capturing risk management data, including the monitoring and reporting of risk should be developed in all organisations to provide corporate assurance that departmental approaches are consistent.*
  (Ref. Quality Standard 4.3 i)
- *There should be a formalised process for ensuring that learning from risk management is properly shared throughout the organisation.*
  (Ref. Quality Standard 4.3 i)
- *Mechanisms should be established to share risk registers across organisations.*
  (Ref. Quality Standards - Robust Organisational Structures and Processes Principle)

2.1.7 Service user and public involvement

This part of the review examined arrangements that organisations have in place to ensure that service user and public involvement is a part of everyday working practice, and that it underpins all processes and decisions.

Every organisation has demonstrated their commitment to meaningful service user involvement, to taking account of service users' experiences, to meeting the needs of individuals and has provided the evidence to show the impact of this work on services.

While some organisations were able to demonstrate how they engage with service users in the planning of services, in general service user involvement at corporate level was acknowledged as an area for improvement. A further challenge for organisations will be to develop a proactive approach to the involvement of service users in the prevention of adverse incidents.

Reviewers were provided with numerous examples of how services have improved as a result of service user, carer and public involvement. This was more evident within community rather than acute settings.

Examples of local initiatives

Southern Health and Social Services Board

The Board employs a full-time Service User Facilitator. The review team were impressed with the structured approach to service user involvement and the range of strategies and activities across all service areas.

Craigavon Area Hospital

A Parent Council/Wraparound Group established to improve services for children with disabilities. The group has developed a fast-track card to improve access to services for children and young people with disabilities. A passport system has also been developed to reduce the need to provide a history to all the different professionals in contact with the family. These initiatives have raised awareness of the needs of children with disabilities and a greater recognition of parents' expertise. This work could be replicated regionally.

Sperrin Lakeland Trust

Examples of good practice were the Heads Together and the Acute Care (Mental Health) Forums. Within these forums, service users participate in audit, the development of information leaflets, policies and guidelines.

Recommendations:

- *Organisations should develop a proactive approach to the involvement of service users in the prevention of adverse incidents.*
  (Ref. Quality Standard 4.3 d)

- *Organisations should continue to seek new ways of engaging service users, carers and the public in shaping services to best meet their needs.*
  (Ref. Quality Standard 4.3 d & e)

Review team members hearing the views of a patient at the Royal Group of Hospitals

2.1.8 Human resources and workforce planning

Reviewers examined how organisations ensure that there are appropriate human resources and workforce planning processes in place and that there is compliance with departmental policy and guidance; professional and other codes of practice and employment legalisation.

Reviewers were generally satisfied with the processes in place to ensure appropriate workforce planning, skill mix, staff induction and employment of appropriately qualified staff. The processes that were in place for the validation of registration and re-registration of staff across all professions were sufficiently robust.

It was noted that in a few instances there was no workforce planning strategy, which has led to staffing and management issues and barriers between professions and disciplines throughout organisations. However, in many instances, workforce plans were being developed across Trusts to address retention issues in areas of workforce shortages. In addition, managers were continuously reviewing working practices to give greater flexibility to support efforts to reduce retention difficulties. Within programmes of care there was provision to identify any recruitment and staffing difficulties and place these on Risk Registers.

Generally there was good evidence that Trusts were committed to and provided for staff welfare.

Examples of local initiatives

NI Blood Transfusion Service

The organisation invites the Equality Commission and Labour Relations Agency to review all policies and procedures.

South and East Belfast Trust

The Trust has developed a proactive approach to managing recruitment challenges through the implementation of various recruitment initiatives, for example, internet recruitment, job fairs, open days, Dare to Care scheme and the Training for Work initiative.

Recommendation:

- *All organisations should continue to develop and implement workforce planning strategies. (Ref. Quality Standard 4.3 n)*

2.1.9 Staff training, supervision and appraisal

This review examined arrangements in place to demonstrate that there is a culture of learning, enabling staff to enhance and maintain their knowledge and skills, through appraisal and supervision systems and training and development opportunities.

It was evident that in a number of organisations, supervision and appraisal have been put on hold until the implementation of the 'Knowledge and Skills Framework (KSF) under Agenda for Change. Despite most organisations having systems in place, the provision of appraisal and supervision was patchy.

All organisations reported that clinical and social care interventions are carried out under appropriate supervision and leadership and by appropriately qualified and trained staff, who have access to support systems.

In general there was evidence of a range of induction programmes for new and existing staff moving to new posts. A small number of organisations recognised the need to improve systems for the induction of locum and agency staff.

Reviewers were impressed with the overall commitment to training and development. Organisations provided evidence of extensive training and development opportunities for staff and this is to be commended. In some organisations, however, there was lack of a corporate approach to the planning of training and development. For the majority of organisations, while departmental plans may be in existence, an overall training strategy or plan was work in progress.

There is widespread use of multidisciplinary teams in all clinical and social care areas. However, it was not always evident that the concept of multidisciplinary learning has been implemented throughout organisations.

Examples of local initiatives

NI Regional Medical Physics Agency

There are robust appraisal and supervision systems in place that provide members of staff with the opportunity to identify learning and developments needs.

Armagh and Dungannon Trust

The Trust's Personnel Department is responsible for collating and developing the Trust's training plan and has introduced a database (RTIX) which monitors the uptake of training and allows managers to ensure staff access mandatory training and that the record of staff training is accurate and up to date.

Recommendations:

- *Organisations should ensure that supervision and appraisal is maintained across all disciplines prior to and following the roll out of Agenda for Change. This is especially important where codes of practice stipulate supervision to be a requirement.*
  (Ref. Quality Standard 4.3 l)

- *The outputs of appraisal should be harmonised with the objectives and strategic direction of the organisation and should inform the corporate training and development plan.*
  (Ref. Quality Standard 4.3 l & m)

- *Organisations should improve systems for the induction of locum and agency staff.*
  (Ref. Quality Standard 4.3 l)

- *Organisations should continue to develop a corporate approach to the planning of staff training and development.*
  (Ref. Quality Standard 4.3 j)

Review Team members meeting staff on a busy ward

2.1.10 Policies and procedures

This part of the review examined the systems that were in place in organisations to ensure that policies and procedures were developed in accordance with best practice guidelines as defined by professional bodies and national standard setting organisations, approved by accountable officers, implemented and disseminated throughout the organisation and subject to regular audit and review.

This review noted that generally there were robust systems in place for the dissemination of policies, procedures and protocols throughout organisations. However, it was evident that within a number of organisations the process for development, approval and implementation of policies that included setting timescales for review and quality assurance was at the developmental stage.

Examples of local initiatives

North and West Belfast Trust

There is a robust and accountable approach to the production, approval, implementation and review of all Trust policies.

United Hospitals Trust

The Trust is to be commended for their systems of medicines governance including the rolling out of ward-based medicines initiatives, the development of a medicines management group and therapeutics committee.

Recommendation:

- *Organisations should establish a proper system for the development, approval and implementation of policies that include clear lines of accountability and specific timescales for review.*
  (Ref. Quality Standards - Quality of Service Provision Principle)

2.1.11 Appraisal of medical staff

This aspect of the review examined the systems that were in place in organisations to ensure that appraisal and supervision procedures and protocols set by an agency or body (e.g. NIMDTA) are adhered to and how recommendation 10 (see below) in the report of the RQIA Governance Review of the Northern Ireland Breast Screening Programme was implemented by organisations.

Recommendation 10
All Trusts should ensure that annual consultant appraisals are implemented as a matter of urgency (including appraisal for locum consultant staff employed for more than three months)

This review noted the appraisal and supervision procedures and protocols as set by the Northern Ireland Medical and Dental Training Agency (NIMDTA) for doctors in training are in various stages of development in all organisations. However, in some instances there was a lack of evidence that monitoring, reporting and recording arrangements are carried out.

At the time of the review there were a number of organisations that had not produced reports on Consultant Appraisal for Trust Boards. In some instances where reports were produced there was a lack of detail on key themes/issues emerging and key matters to be considered.

Significant variability was noted in the uptake of consultant medical staff appraisal throughout organisations. This is clearly an area that must be addressed and will be the subject of further scrutiny within the 2007/2008 review programme.

Examples of local initiatives

Western Health and Social Services Board

All consultants in Public Health Medicine and Medical Practitioners employed within the Family Practitioner Unit (FPU) participate in an annual appraisal scheme. This is a contractual requirement and the Board confirmed 100% appraisals completed for 2005/06.

The Director of Public Health carried out an extensive range of professional activities, thereby creating a culture of continuous learning with medical staff being encouraged to avail of opportunities within and outside of the Board's area. Appraisal documentation demonstrated that supervision and appraisal of medical staff was carefully structured and managed. Regular monthly meetings are held with medical staff to review programmes of work and to provide support.

Belfast City Hospitals Trust

There was 100% uptake in medical consultant appraisal for 2005/06 (152 consultants).

Recommendations:

- *Organisations should ensure that medical appraisal and supervision procedures and protocols include monitoring, reporting and recording arrangements.*
  (Ref. Quality Standard 4.3 l)

- *The uptake of consultant medical staff appraisal must be improved throughout all organisations.*
  (Ref. Quality Standard 4.3 l)

- *Organisations must develop a programme for training appropriate staff in medical appraisal and supervision.*
  (Ref. Quality Standard 4.3 m)

- *Organisations should develop mechanisms for reporting, within their governance framework, on the quantity and quality of appraisals undertaken against performance targets.*
  (Ref. Quality Standard 4.3 j)

- *Organisations should ensure a review and the sharing of learning from the appraisal process.*
  (Ref. Quality Standard 4.3 l)

A review team visit to the Southern Area Urgent Care Service

2.2 Safe and Effective Care

2.2.1 Promoting effective care (culture of learning, evidence-based practice)

This part of the review assessed how organisations ensure that care is delivered in a way that appropriately manages risk for service users, carers, staff, the public and visitors and is based on the best available evidence of interventions that work.

Reviewers were satisfied with the structures and processes that are in place in various services throughout organisations to promote a culture of learning and the implementation of evidence based practice. However, it was felt that in a number of instances communication should be strengthened to ensure appropriate exchange of this information.

There was evidence of multidisciplinary, cross professional working in various areas throughout all organisations. However, some of the examples given by organisations that indicate a culture of learning, were being addressed within professional 'silos'. Reviewers would encourage organisations to develop a more corporate approach to promoting a culture of learning to enable staff to enhance and maintain their knowledge and skills in the provision of safe and effective care.

Reviewers noted that many organisations had implemented evidence based practice through use of recognised standards and guidelines such as National Institute of Health and Clinical Excellence (NICE), Social Care Institute for Excellence (SCIE), the National Patient Safety Agency (NPSA) guidance and DHSSPS circulars. However, review teams could not always find evidence of a corporate approach to the promotion of evidence based guidelines and standards.

It was evident from this review that the enthusiasm and dedication of staff in organisations to campaigns such as 'Saving 100K lives', the 'Safer Patient Initiative' and 'Essence of Care' benchmarking has resulted in participating organisations being able to monitor a safer delivery of person centred care. The review team would commend the organisations on their involvement in these initiatives.

Examples of local initiatives

Mater Hospital Trust

The Trust have been involved in the 'Saving 100k Lives' Campaign that seeks to reduce the mortality rate within participating hospitals by implementing evidence-based changes in the deployment of rapid response teams, delivering reliable, evidence based care for acute myocardial infarction, preventing adverse drug events, preventing central line infections, preventing surgical site infections and preventing ventilator-associated pneumonia. Staff reported that through implementing these changes the Trust has been able to monitor a safer delivery of care and a reduced mortality rate.

Northern Ireland Ambulance Service (NIAS)

Significant work has been undertaken by the NIAS through use of clinical audit to benchmark its services against national outcomes from other home countries. This work has examined qualitative areas of service for example drug administration patterns and pain relief for patients with chest pain, as well as quantitative information, for example response times to emergency calls.

Recommendation:

- *Organisations should continue to develop a systematic approach to multidisciplinary, cross-professional working and the sharing of best practice in the promotion of a culture of learning, whereby staff are enabled to develop their knowledge and skills in the provision of safe and effective care.*
  (Ref. Quality Standard 5.3 1)

A review team on board a new ambulance during the visit to the Northern Ireland Ambulance Service

2.2.2 Safe and effective discharge of older people from the acute to the community setting

This aspect of the review examined the discharge policy and procedures for the safe and effective discharge of older people from the acute to the community settings.

From the submitted self-assessment, supporting documents and discussions with staff, reviewers noted evidence of person-centred planning and a robust approach to the safe and effective discharge of older people from acute to community settings in the majority of Trusts. However, the multidisciplinary assessment processes that were evident in other areas throughout Trusts were not always carried out for older people.

Reviewers were advised that the primary reasons for any delay in discharge of older patients needing intermediate care is usually the lack of community services in particular geographical areas and the lack of first choice places in nursing or residential care settings. This has led to the development of local initiatives, which include streamlining the discharge planning processes and preventing hospital admissions.

Reviewers suggest that organisations should continue to seek ways to streamline the discharge planning procedures and ensure continuity of care across organisational boundaries.

Examples of local initiatives

Belfast City Hospitals Trust

Within the Acute Community Link Medicine Directorate, the In Reach Rehabilitation Schemes such as Community Stroke Rehabilitation Scheme and the Community Fracture Rehabilitation Service are examples of effective discharge processes for older people.

Homefirst Community Trust

The Trust's Integrated Care of the Elderly Project is a positive example of how, on a monthly basis, nursing, social care and rehabilitation services get together to monitor quantitative and qualitative outcome measures.

Recommendation:

- *Organisations should establish discharge pathways to ensure continuity of care across organisational boundaries.*
  (Ref. Quality Standard 5.3 3 b)

2.2.3 Safe and effective post-operative care for patients in the acute hospital setting

This part of the review examined the implementation of recommendations (Nos. 2, 5, 6 and 9) made in the report 'Lessons arising from the death of Mrs Janine Murtagh' in all hospitals.

These recommendations are as follows:

Recommendation 2
A system of clinical assessment of patients that is based on recognised and validated systems such as Modified Early Warning Scoring System (MEWS) or Acute Life-threatening Events Recognition and Treatment (ALERT), should be used in all acute hospitals.

Recommendation 5
There is a very clear need to provide clinical teams with formalised protocols and guidance to support critically ill patients until critical-care outreach services are fully developed.

Recommendation 6
Leadership of any resuscitation effort must be clearly established as part of a formally determined protocol.

Recommendation 9
There should be a system whereby clinical staff including locum staff can communicate with a designated accountable senior manager at any time.

This part of the report details how each hospital has implemented these recommendations.

Implementation of Recommendation 2
A system of clinical assessment of patients that is based on recognised and validated systems such as MEWS (Modified Early Warning Scoring System) or ALERT (Acute Life-threatening Events Recognition and Treatment) should be used in all acute hospitals.

A common finding of this review was that in many hospitals, documentation associated with the implementation of the Early Warning Systems (EWS) had been developed and plans were in place for its roll out throughout the Trusts.

ALERT training has been provided in the majority of hospitals however it was not evident that this training has been fully cascaded down to all relevant staff.

The following section reports on how each hospital has developed early warning systems:

Altnagelvin Hospital Trust

The Trust has piloted and audited a Modified Early Warning Score (MEWS) across the Trust.

Causeway Hospital Trust

Reviewers were shown a policy on EWS. However, this was an aspirational document. Members of staff showed commitment to implementing the policy but at the time of the review there were no definite timeframes for implementing it.

Belfast City Hospitals Trust and Mater Hospital Trust

An EWS was developed and being uses in areas throughout the Trusts.

Craigavon Area Hospital Trust

At the time of the review, MEWS was in operation in one surgical ward and work was progressing to implement it in all other areas throughout the Trust. Training has been provided for nursing and medical staff.

Lagan Valley Hospital

There was evidence of an early warning system in use and being reviewed in surgical and medical wards throughout the Trust.

Musgrave Park Hospital

Evidence was provided to indicate that an EWS had been fully implemented in surgical wards.

Daisy Hill Hospital

An adult EWS had been in place since October 2005 and had been audited, revised and implemented across the Trust. A multidisciplinary early warning system for children, the Paediatric Early Warning System (PEWS) chart has been implemented in the Paediatric Ward. This is a validated tool based on the North Yorkshire PAWS early warning system for children.

Royal Group of Hospitals

At the time of review the Trust was in the process of implementing the Royal Advanced Warning (RAW) chart across the Trust and had also developed an audit tool for use with the chart.

Tyrone County Hospital and Erne Hospital

The Early Warning Scoring System had been introduced in Tyrone County Hospital in June 2006 and in the Erne Hospital in November 2006.

Ulster Hospital

The MEWS had been implemented and adopted across all acute areas of the Trust including medical and surgical wards and the A&E department.

United Hospitals

A MEWS is in place for all post operative patients. The use of an early warning scoring system in all clinical areas was identified as a strength by the review team. The Trust has a policy and protocols in place to support critically ill patients.

Implementation of Recommendation 5

There is a very clear need to provide clinical teams with formalised protocols and guidance to support critically ill patients until critical-care outreach services are fully developed.

This review has indicated that hospitals are at various stages of developing support services for critically ill patients as follows: -

Altnagelvin Hospitals

The Trust identified the lack of a critically ill patient pathway as a major risk for the Trust therefore extra training in ALERT has been provided for staff and a working group has been established to take forward the development of a critically ill patient pathway to support critically ill patients where critical-care outreach services are not fully developed.

Causeway Hospital

There is no outreach team in place.

Belfast City Hospital

The Trust is currently identifying opportunities to develop outreach teams within existing Trust resources to support critically ill patients until critical-care outreach services are fully developed. Protocols and guidance to support critically ill patients have been developed and implemented in conjunction with the early warning score.

Craigavon Area Hospital, Lagan Valley Hospital, Musgrave Park Hospital, Daisy Hill Hospital, Ulster Hospital and United Hospitals.

Protocols are in place and guidance is provided to clinical teams to support critically ill patients.

Mater Hospital

There is an outreach programme for A&E and also protocols are in place and guidance is provided to clinical teams to support critically ill patients.

Sperrin Lakeland Trust

The Trust operates a managed clinical network with Altnagelvin Hospital and support for critical care patients at Tyrone County is provided by Craigavon Area Hospital.

Implementation of Recommendation 6

Leadership of any resuscitation effort must be clearly established as part of a formally determined protocol.

Protocols for defining who leads a resuscitation effort within a multi-professional cross-disciplinary team have not been fully developed in all hospitals as follows:

Craigavon Area Hospital

The Trust follows the protocols provided by the European Resuscitation Council. These protocols also apply to patients who require resuscitation, but have not suffered cardiac arrest.

Musgrave Park Hospital

The Trust has a range of resuscitation programmes in place, which includes basic, immediate and advanced life support. Resuscitation training includes guidance on leadership during a resuscitation effort.

Daisy Hill Hospital

The Resuscitation Policy identifies leadership notes for all non-cardiac cases.

Royal Group of Hospitals

The Trust is in the process of developing a protocol to define who leads a resuscitation effort within a multidisciplinary team.

Ulster Hospital

The Trust has a dedicated Arrest Team from whom team leadership is selected on a daily basis. During Resuscitation Training the medical staff on the Arrest Team undergoes Cardiac Arrest Simulation, which includes working together in a team, with a team leader.

United Hospitals

Leadership of any resuscitation effort is clearly established as part of formalised protocols. Roles and responsibilities are clearly outlined in the Trust Resuscitation Policy.

Implementation of Recommendation 9

There should be a system whereby clinical staff including locum staff can communicate with a designated accountable senior manager at any time.

The majority of Trusts provided reviewers with information on the arrangements for senior management cover and contact arrangements. It was noted that generally there are 'open door' systems in place to ensure that junior staff are aware of the availability of senior staff at all times to discuss problems relating to clinical care.

Recommendations:

- *All organisations should have in place an appropriate Early Warning System (EWS) and all staff should be aware of their responsibilities within these systems.*
  (Ref. Quality Standard 5.3.1 & 5.3 3)

- *All organisations should have in place clear protocols regarding resuscitation, including who leads the resuscitation team.*
  (Ref. Quality Standard 5.3.1 & 5.3 3)

- *Trusts should continue to develop protocols and guidance to support critically ill patients in conjunction with early warning systems.*
  (Ref. Quality Standard 5.3.1 & 5.3 3)

Review team members discuss patient care at the Northern Ireland Blood Transfusion Agency

2.2.4 Safe and effective care relating to Looked After Children (LAC) and young people in residential care settings

Reviewers examined how organisations provide safe and effective care for Looked After Children and young people in residential care settings.

Whilst organisations have systems and processes in place to fulfil their statutory duties for Looked After Children, these are not always explicit enough to ensure clarity regarding delegated statutory functions.

However, there was evidence of person-centred, assessment, care planning and evaluation in the majority of organisations. Trusts were able to provide examples of how young people are encouraged and supported to participate in care planning and LAC Reviews.

Risk assessments are undertaken as part of the admission process to residential care and risk management strategies are reviewed regularly. In the majority of organisations, there are systems in place for the management of incidents and this is integrated into the overall Trust risk management process.

Reviewers were satisfied that all organisations have procedures in place for dealing with children and young people who have absconded.

The review highlighted, in a number of facilities, issues in relation to the appropriateness of placements, for example young people under 18 years of age placed in adult mental health facilities. Education provision within adolescent mental health services was another issue raised at the time of the review.

The multidisciplinary and multi-agency working within residential childcare settings was particularly impressive to reviewers.

Examples of local initiatives

Northern Health and Social Services Board

Family group conferencing is being developed and has provided some very positive outcomes for children who may have increased contact with family or resettlement back with family.

Accommodation for children with challenging behaviour has been improved in collaboration with an independent sector organisation. Reviewers felt that this was a new innovative process that served to initiate a change in the normal method of provision.

Recommendations:

- *Organisations should continue to monitor the placements of young people over 16 years of age in non-registered accommodation and those under 18 years of age placed in adult mental health facilities, and develop strategies to ensure their safe care.*
  (Ref. Quality Standard 5.3 1 c)

- *Organisations should ensure that education provision is available to meet the needs of young people within all adolescent mental health facilities.*
  (Ref. Quality Standard 5.3 1 c)

2.2.5 Follow-up on recommendations on specific reviews / incidents being dealt with by RQIA.

The review examined how organisations have implemented action plans to address recommendations made in specific reviews / incidents being dealt with by RQIA.

Findings:

Relevant organisations have drawn up and progressed action plans to address recommendations made in specific reviews / incidents being dealt with by RQIA as follows:

- Review of the lessons learned from the death of Mrs Janine Murtagh.
- Recommendations arising from the Breast Screening Review.

It was noted that the Belfast City Hospital has addressed a number of issues identified in the report of the Breast Screening Programme. However, the implementation of a number of recommendations are outstanding and require further work.

The review established that the Royal Group of Hospitals HSS Trust has appropriately demonstrated that action plans are drawn up and progressed in respect of recommendations made in RQIA reviews or inspections. These actions have demonstrated that the Royal Group of Hospitals HSS Trust, through learning from incidents, is effecting cultural and organisational changes for improving standards of care and governance processes.

All four HSS Boards appropriately demonstrated that arrangements are in place to monitor the implementation of action plans to address recommendations made in RQIA reviews / inspections.

Recommendation:

- *Trusts should continue to implement recommendations made in RQIA reviews within targets set.*
  (Ref. Quality Standard 5.3 3 d & f)

3.0 Conclusion

This overview report, which is further informed by the individual organisational reports, sets out the performance of the Boards, Trusts and Agencies against the first two quality standard themes published by the DHSSPS in March 2006.

As part of the process of the review, organisations were given immediate feedback on the findings of the individual review teams. This feedback was based on the challenges and strengths identified within each organisation. It is clear from both immediate and subsequent responses from the organisations that there has been a constructive response to the individual reviews and recommendations in the form of quality improvement plans.

These improvement plans will form the starting point for the assessment of organisations in the year 2007/2008.

As services move into the new structures for health and social care in Northern Ireland under the review of public administration, the checklist of recommendations included in this overview report (Section 4.0) aims to provide all health and social care organisations with a baseline for the further development of governance systems and processes.

4.0 Checklist of recommendations for organisations

For ease of reference, this checklist of recommendations is presented under the headings as they appear in the overview report.

1.5 Compliance with Controls Assurance Standards

It is recommended that the DHSSPS should ensure that checks and balances are in place to follow-up or further assess the validity of the Controls Assurance Standard processes.

2.1 Corporate Leadership and Accountability of Organisations

2.1.1 How the organisation demonstrates accountability

Organisations should have in place a robust corporate decision making framework and accountable committee structure.
(Ref. Quality Standard 4.3 a & b)

Organisations should have in place an appropriate, systematic approach to sharing best practice. This will be particularly important when establishing the new structures.
(Ref. Quality Standards Principle - Robust Organisational Structures and Processes)

2.1.2 Leadership

Leadership and management development opportunities for staff at all levels should be strengthened throughout all organisations.
(Ref. Quality Standard 4.3 c)

2.1.3 Financial management

Organisations should ensure that the principles of good practice in financial management as demonstrated in legacy Trusts at the time of this review are taken forward into the new Trusts and any potential shared services arrangements.
(Ref. Quality Standard 4.3 f)

2.1.4 Compliance with relevant legislative requirements.

A standard corporate framework should be developed and utilised by organisations to demonstrate an awareness of and compliance with relevant legislative requirements.
(Ref. Quality Standard 4.3 g)

2.1.5 Responsibilities in relation to delegated statutory functions and inter-agency working

Organisations should develop a standard corporate framework for annual reporting on the delegation of statutory functions.
(Ref. Quality Standard 4.3 h)

2.1.6 Risk management

Organisations should establish appropriate links between the management of risk, performance management and business planning.
(Ref. Quality Standard 4.3 i)

Organisations should establish explicit lines of accountability, roles, responsibilities and links between committees in the management of risk.
(Ref. Quality Standard 4.3 b)

Organisations should ensure that risk registers include key information such as action plans, timescales and lead responsibility and that these are regularly reviewed and acted upon.
(Ref. Quality Standard 4.3 i)

Consistent methods for capturing risk management data, including the monitoring and reporting of risk should be developed in all organisations to provide corporate assurance that departmental approaches are consistent.
(Ref. Quality Standard 4.3 i)

There should be a formalised process for ensuring that learning from risk management is properly shared throughout the organisation.
(Ref. Quality Standard 4.3 i)

Mechanisms should be established to share risk registers across organisations.
(Ref. Quality Standards Principle - Robust Organisational Structures and Processes)

2.1.7 Service user and public involvement

Organisations should develop a proactive approach to the involvement of service users in the prevention of adverse incidents.
(Ref. Quality Standard 4.3 d)

Organisations should continue to seek new ways of engaging service users, carers and the public in shaping services to best meet their needs.
(Ref. Quality Standard 4.3 d & e)

2.1.8 Human resources and workforce planning

All organisations should continue to develop and implement workforce planning strategies.
(Ref. Quality Standard 4.3 n)

2.1.9 Staff training, appraisal and supervision systems

Organisations should ensure that supervision and appraisal is maintained across all disciplines prior to and following the roll out of Agenda for Change. This is especially important where codes of practice stipulate supervision to be a requirement.
(Ref. Quality Standard 4.3 l)

The outputs of appraisal should be harmonised with the objectives and strategic direction of the organisation and should inform the corporate training and development plan.
(Ref. Quality Standard 4.3 l & m)

Organisations should improve systems for the induction of locum and agency staff.
(Ref. Quality Standard 4.3 l)

Organisations should continue to develop a corporate approach to the planning of staff training and development.
(Ref. Quality Standard 4.3 j)

2.1.10 Policies and procedures

Organisations should establish a proper system for the development, approval and implementation of policies that include clear lines of accountability and specific timescales for review.
(Ref. Quality Standards Principle - Quality of Service Provision)

2.1.11 Appraisal of medical staff

Organisations should ensure that medical appraisal and supervision procedures and protocols include monitoring, reporting and recording arrangements.
(Ref. Quality Standard 4.3 l)

The uptake of consultant medical staff appraisal must be improved throughout all organisations.
(Ref. Quality Standard 4.3 l)

Organisations must develop a programme for training appropriate staff in medical appraisal and supervision.
(Ref. Quality Standard 4.3 m)

Organisations should develop mechanisms for reporting, within their governance framework, on the quantity and quality of appraisals undertaken against performance targets.
(Ref. Quality Standard 4.3 j)

Organisations should ensure a review and the sharing of learning from the appraisal process.
(Ref. Quality Standard 4.3 l)

2.2 Safe and Effective Care

2.2.1 Promoting safe and effective care

Organisations should continue to develop a systematic approach to multidisciplinary, cross-professional working and the sharing of best practice in the promotion of a culture of learning, whereby staff are enabled to maintain their knowledge and skills in the provision of safe and effective care.
(Ref. Quality Standard 5.3 1)

2.2.2 Safe and effective discharge of older people from the acute to the community setting

Organisations should establish discharge pathways to ensure continuity of care across organisational boundaries.
(Ref. Quality Standard 5.3 3 b)

2.2.3 Safe and effective post - operative care

All organisations should have in place an appropriate Early Warning System (EWS) and all staff should be aware of their responsibilities within these systems.
(Ref. Quality Standard 5.3.1 & 5.3 3)

All organisations should have in place clear protocols regarding resuscitation, including who leads the resuscitation team.
(Ref. Quality Standard 5.3.1 & 5.3 3)

Trusts should continue to develop protocols and guidance to support critically ill patients in conjunction with early warning systems.
(Ref. Quality Standard 5.3.1 & 5.3 3)

2.2.4 Safe and effective care relating to looked after children and young people in residential care settings

Organisations should continue to monitor the placements of young people over 16 years of age in non-registered accommodation and those under 18 years of age placed in adult mental health facilities, and develop strategies to ensure their safe care.
(Ref. Quality Standard 5.3 1 c)

Organisations should ensure that education provision is available to meet the needs of young people within all adolescent mental health facilities.
(Ref. Quality Standard 5.3 1 c)

2.2.5 Follow up on recommendations on specific reviews / incidents being dealt with by RQIA.

Trusts should continue to implement recommendations made in RQIA reviews within targets set.
(Ref. Quality Standard 5.3 3 d & f)

Appendix 1 - Peer and Lay Reviewers

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Appendix 3 - Glossary

Term	Definition
Accountability	The state of being answerable for one's decisions and actions. Accountability cannot be delegated.
Adverse incident	An incident, accident or occurrence, relating to systems or procedures which results in harm, or an injury, or near miss to a patient, member of staff or the public.
Appraisal	Examination of people or the services they provide in order to judge their professional qualities, successes or needs.
Audit	The process of measuring the quality of services against explicit standards.
Clinical record	The record of all aspects of the patient's treatment, otherwise known as the patients notes.
Controls Assurance	A concept resting on best governance practice. Within the HPSS, it is a process designed to provide evidence that organisations are doing their 'reasonable best' to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds.
COSHH	Acronym for the control of substances hazards to health legislation.
Clinical and Social Care Governance (CSCG)	A framework within which HPSS is accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.
Evidence-based practice	An approach to decision-making where a health or social care professional uses the best evidence available, in consultation with patients and other health or social care professionals to decide upon the option which suits each patient best.
General Medical Council	The UK regulatory body that is responsible for registration, education, practice and conduct of medical practitioners.
Locum	A professional employed by the Trust on a temporary basis, usually through an employment agency.
NICE	Acronym for the National Institute of Health and Clinical Excellence the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.
NISCC	Acronym for the Northern Ireland Social Care Council, established to raise standards in the Northern Ireland social care workforce.
Nursing and Midwifery Council (NMC)	The UK regulatory body that is responsible for registration, education, practice and conduct of nurses and midwives.
Organisational structure	A graphical representation of the structure of the organisation including areas of responsibility, relationships and formal lines of communication and accountability.

Term	Definition
Patient survey	Seeking the views of patients through responses to pre-prepared questions and carried out through interview or self-completion questionnaires.
Peer Review	Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review.
Risk Assessment	The identification and analysis of risks relevant to the achievement of objectives.
Risk Management	A systematic process by which potential risks are identified, assessed, managed and monitored.
Risk Register	A record of residual risk which details the source, nature, existing controls, assessment of the consequences and likelihood of occurrence, action necessary to manage risk, person responsible for implementing action and timetable for completion.
SCIE	Acronym for the Social Care institute of Excellence established by Government in 2001 to improve social care services for adults and children in the United Kingdom.
Treatment and Care Plan	A document, which details the care and treatment that a patient receives and identifies who delivers the care and treatment.
Whistle-blowing	The disclosure by an employee (or professional) of confidential information which relates to some danger, fraud or other illegal or unethical conduct connected with the workplace, be it of the employer or of his fellow employees.

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