The Regulation and Quality Improvement Authority

Review of Clinical and Social Care Governance Arrangements in Health and Social Care Trusts in Northern Ireland, 2008

Northern Health and Social Care Trust

informing and improving health and social care
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CONTENTS

1 SETTING THE SCENE

1.1 The Role & Responsibilities of the Regulation & Quality Improvement Authority

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

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) organisations, and requires the RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

In order to fulfill its statutory responsibilities the 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.

1.2 Context for Review

Published in March 2006, The Q*uality Standards for Health and Social Care*, underpin the duty of quality on Health and Social Services 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 are:

- Corporate Leadership and Accountability of Organisations
- Safe and Effective Care
- Accessible, Flexible and Responsive Services
- Promoting, Protecting and Improving Health and Social Well-being
- Effective Communication and Information

The 2007/2008 review has assessed the achievement of HPSS Organisations against three themes of the HPSS Quality Standards [2006]:

- Theme 3 - Accessible, Flexible and Responsive Services
- Theme 4 - Promoting, Protecting and Improving Health and Social Well-being
- Theme 5 - Effective Communication and Information

Within these three themes, a detailed review has been undertaken focusing on the following seven criteria, as it was deemed that these were a representative sample of service user/patient engagement.

Under Theme 3 "Accessible, Flexible and Responsive Services" criteria:

- 6.3.1 (a) The organisation has service planning processes which promote an equitable pattern of service provision or commissioning based on assessed need, having regard to the particular needs of different localities and people, the availability of resources, and local and regional priorities and objectives.
- 6.3.2 (a) The organisation ensures that all service users, carers and relatives are treated with dignity and respect and that their privacy is protected and promoted, including, where appropriate, the use of advocates and facilitators.
- 6.3.2 (b) The organisation has systems in place to ensure that service users, carers and relatives have the appropriate information to enable them to make informed decisions and choices about their treatment and care, or service provision.

Under Theme 4 " Promoting, Protecting and Improving Health and Social Well-being" criteria:

- 7.3 (a) The organisation has structures and processes in place to promote and implement effective partnership arrangements, to contribute to improvements in health and social well-being, and promote social inclusion and a reduction in inequalities.
- *7.3 (b) The organisation actively involves the services users and carers, the wider public, HPSS staff and the community and voluntary sectors, in the planning and development of local solutions to improve health and social well-being and to reduce inequalities.*

Under Theme 5 "Effective Communication and Information" criteria:

- 8.3 (a) The organisation has active participation of service users and carers and the wider public. This includes feedback mechanisms appropriate to the needs of individual service users and the public.
- *8.3 (g) The organisation has effective training for staff on how to communicate with service users and carers and, where needed, the public and the media.*

Organisations were asked to provide information regarding all thirty–eight criteria under the three Themes, and this formed part of the overall report by RQIA. However, unless through the analysis, or as part of the review process, there was an issue that needed to be addressed, these other criteria were not subject to the same level of scrutiny as the seven noted above.

1.3 The Review Methodology

The RQIA operates within a value system that supports the belief that learning is at the heart of improvement. To ensure a clear focus on improvement, organisations need to have effective systems which can identify performance standards and support the learning necessary for improvement.

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the HPSS Quality Standards. The distilled information from the self-assessment will be subjected to reality testing when review teams visit organisations.

This review was undertaken following a period of major transition for organisations further to the Review of Public Administration (RPA). The management structures within the new organisations, in the main, are now in place. The review team have taken account of these developments within this report.

In developing the methodology, consideration was given to review methodologies previously used by RQIA.

1.3.1 The Review Team

Review teams are multidisciplinary, and include both Health and Social Care professionals (Peer Reviewers) and members of the public (Lay Reviewers) who have undertaken training provided by the RQIA. Review teams are managed and supported by RQIA Project Managers and Project Administrators.

Lay Reviewers
Lay reviewers come from a range of backgrounds and from all over Northern Ireland. They play a vital role in review teams, bringing with them new insights and helping the team look at how things are done from a lay person's point of view.

Peer Reviewers
Peer reviewers work at a senior level in both clinical and non-clinical roles in the HPSS. They have a particular interest in the area of governance and a commitment to improving health and social care.

There is an identified leader for each review team who works closely with the RQIA Project Manager during the review to guide the team in its work and ensure that team members are in agreement about the assessment reached.

1.3.2 The Review Process

The review process has three key parts; local self-assessment (including completion of self declaration), pre-visit analysis and the validation visit by the review team.

1.3.3 Self-Assessment

Self-assessment is based on the Statutory Duty of Quality as enshrined in the legislation and the underpinning requirement for HSC organisations to self assess their progress against the quality standards for health and social care. Self-assessment as a technique is used widely in health and social care regulation, accreditation and licensing across the UK and internationally. The completed self-assessment proforma and evidence documents were submitted to the RQIA for analysis.

This report reflects information submitted from all Directorates within the Northern Trust except for the Acute and Elective Directorate which submitted a partial response covering the corporate services aspect. The Trust reported that this was due to various reasons including annual leave and workload pressures during the agreed timescale for submission of the self-assessment documentation. However, it was stated by the Trust that the Directorate "...is fully committed to the full corporate agenda and plays a significant role in delivering it.." and "..undertakes sterling work in Surgery, Theatres, ICU and Day Procedures to improve patient outcomes and there has also been very significant developments in improving access to services."

Article 34 of the HPSS (Quality Improvement and Regulation) (NI) Order 2003, places a statutory duty of quality on statutory organisations to: "put and keep in place arrangements for the purpose of monitoring and improving the health and personal social services that it provides to individuals; and the environment in which it provides them. In meeting this legislative responsibility, the Trust's Chair and Chief Executive signed a declaration confirming the accuracy of the self-assessment return to RQIA.

1.3.4 Pre-visit Analysis of Self-Assessment

On receipt of the completed self-assessment form, an analysis is made of the self-assessment information and evidence, and a pre-visit analysis report is produced which is sent to the review team, together with the self-assessment and any documentary evidence.

1.3.5 The Review Visit

The review team assessed the breadth and depth of an organisation's achievements against the standards by undertaking a site visit. At the start of the site visit, the review team met key personnel responsible for the service under review.

At the time of this review visit, the Northern Trust was facing a challenging situation, namely the outbreak of *Clostridium Difficile*, and acknowledgement must be made of the continued welcome the review team received and openness of staff during this period.

Reviewers then speak with local stakeholders, including staff, patients, clients and carers about the services provided. Information was also obtained by observation of the physical surroundings and by examining documentation such as policies and procedures.

After these meetings, the team assessed the performance of the organisation against the standards, based on the information gathered during both the self-assessment exercise, pre-visit analysis and the on-site visit.

The visit concluded with the team providing feedback on its findings to the organisation. This included specific examples of good practice drawn to the attention of the review team, together with an indication of any particular challenges.

1.3.6 The Report

The findings in this report are based both on the Trust's self-declaration and written submission to RQIA, as well as observations made by, and views expressed to, the members of the review team during the validation visit to the Trust.

Following each review visit, the RQIA Project Manager, with input as appropriate, drafted a local report detailing the findings of the review team and recommendations for improvement.

This draft report was sent to the review team for comment, and then to the organisation to check for factual accuracy.

The overview report will be made available to the general public in hardcopy, the RQIA website and other formats on request.

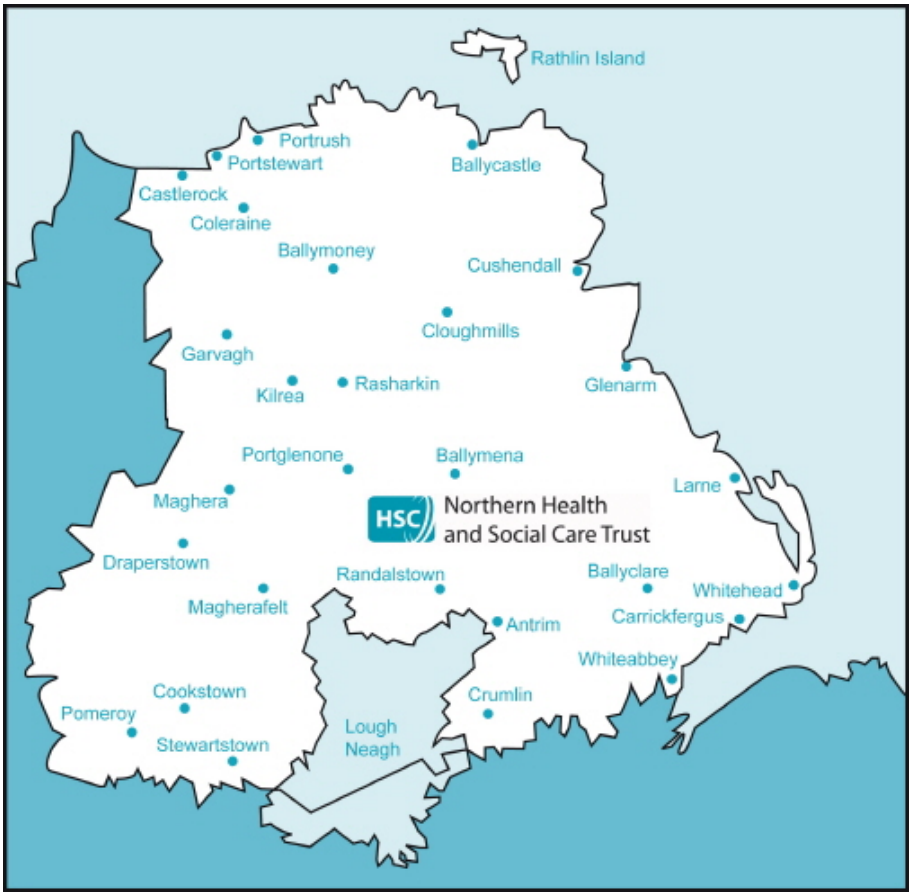
2 SERVICES WITHIN THE TRUST

2.1 GENERAL OVERVIEW OF SERVICES

The Northern Trust was established on 1st April 2007 following the amalgamation of the following legacy trusts:

- Causeway Health and Social Services Trust
- Homefirst Health and Social Services Trust
- United Hospitals Health and Social Services Trust

The Trust provides services for a population of around 440,000 and covers the geographical area depicted below.



In 2007/08 the Trust had a budget of £500 million and employed approximately 13,000 staff.

The Trust provides an integrated and comprehensive range of health and social care for the people in its area to a set of service level agreements as established with commissioners and key stakeholders.

Main hospital services are located at:

- Antrim Area Hospital
- Causeway Hospital
- Mid Ulster Hospital
- Whiteabbey Hospital

Additional hospital services are provided at:

- Braid Valley Hospital
- Dalriada Hospital
- Holywell Hospital
- Moyle Hospital
- Robinson Hospital

The Trust also provides a wide range of services in community-based settings. Services are provided for children and older people, and include nursing and support services at home, outreach mental health services and work with general practitioners in the primary care sector to support people outside a hospital setting.

2.2 PLACES AND PEOPLE

The review team visited a variety of sites within the Trust and spoke with staff and service users. The observations made were presented to staff at the end of the visit.

Despite ongoing uncertainties throughout the Trust in terms of the effects of Agenda for Change and the Review of Public Administration, reviewers were impressed by the open approach of staff and by their enthusiasm, commitment, devotion and vocation to work on the frontline and were pleased to note that staff showed immense pride in their work and have demonstrated a real commitment to provide high quality, responsive services.

This was also reflected in discussion with service users who spoke, in the main, of their satisfaction with the services they were receiving and the dedication of the staff in providing good quality care.

The review team acknowledged the difficulties which the amalgamation of the legacy Trusts had brought and recognised the work carried out to date around planning and improving health and social well-being.

The well developed independent and voluntary sector working arrangements in partnership with the Trust was evident, as was the Trust's continued commitment to progressing user/carer involvement.

The review team was structured in such a way as to incorporate three smaller teams (Team 1, Team 2 and Team 3) which undertook to concentrate on individual themes within the quality standards being assessed. A list of the areas visited is included in Appendix (iii).

3 ACCESSIBLE, FLEXIBLE AND RESPONSIVE SERVICES

The DHSSPS Quality Standards cite Theme 3 as: "Services are sustainable, and are flexibly designed to best meet the needs of the local population. These services are delivered in a responsive way, which is sensitive to individual's assessed needs and preferences, and takes account of the availability of resources. Each organisation strives to continuously improve on the services it provides and/or commissions."

There are a total of 13 criteria within this theme and the Trust was asked to make a self-assessment against these criteria under a level of achievement measure as illustrated in Table 3.

Code	Level of Achievement	Definition
1	Unlikely to be Achieved	The criterion is unlikely to ever be achieved. *(A reason must be stated clearly in the Trust response)*
2	Not Achieved	The criterion is likely to be achieved in full but after March 2008. For example, the Trust has only started to develop a policy and implementation will not take place until after March 2008.
3	Partially Achieved	Work has been progressing satisfactorily and the Trust is likely to have achieved the criterion by March 2008. For example, the Trust has developed a policy and will have completed implementation throughout the Trust by March 2008.
4	Substantially Achieved	A significant proportion of action has been completed to ensure the Trust performance is in line with the criterion. For example, a policy has been developed and implemented but a plan to ensure practice is fully embedded has not yet been put in place.
5	Fully Achieved	Action has been completed that ensures the Trust performance is fully in line with the criterion. For example, a policy has been developed, implemented, monitored and an ongoing programme is in place to review its effectiveness.

TABLE 3

Table 3 (a) illustrates how the Trust has self assessed it's performance against the criteria under the standard of 'Accessible, Flexible and Responsive Services'.

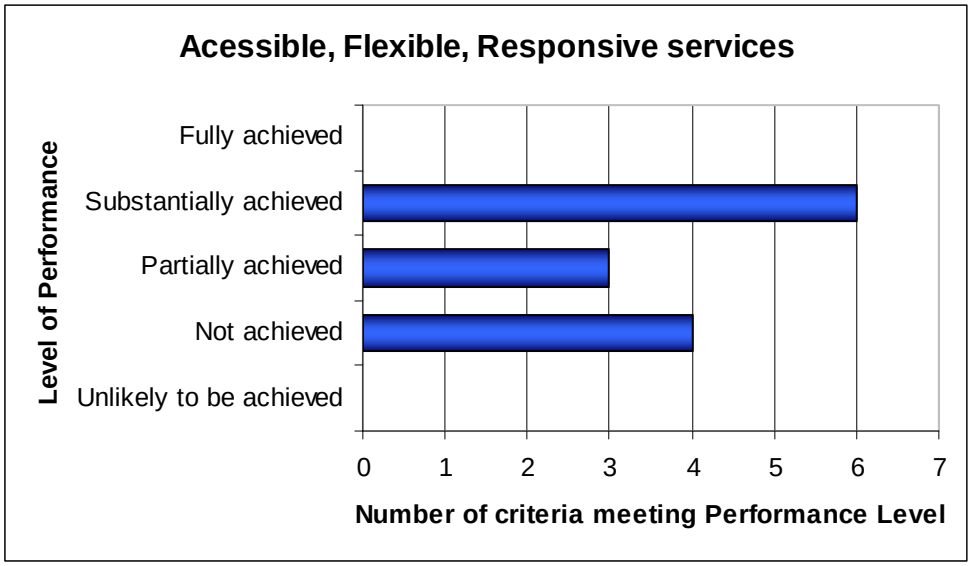


TABLE 3 (a)

The Trust also provided narrative under the headings of:

- Corporate
- Operational
- Personal and Public Involvement

regarding each criterion to describe how it has achieved the stated level of achievement.

3.1 CRITERIA EXAMINED BY REVIEW TEAM

The RQIA selected three specific criteria within this standard for review teams to examine and substantiate the Trust's submission. The findings in this section are based on the information provided by Trusts in their self-assessment submission and on observations made by, and views expressed to, the members of the review team during visits. Areas visited are listed in Appendix (iii) of this report.

The criteria in this section includes:

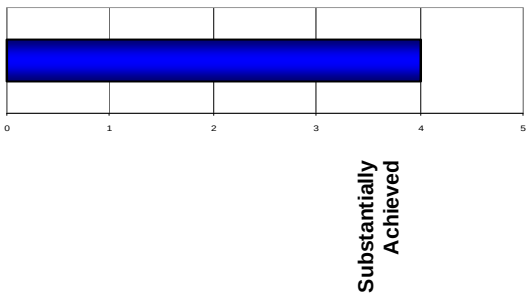
- 6.3.1 (a) - Service planning processes
- 6.3.2 (a) - Service user dignity, respect and privacy and the use of the advocates and facilitators
- 6.3.2 (b) - Service user information regarding treatment and care

3.1.1 Service Planning Processes

This sub-section relates to criterion 6.3.1 (a).

DHSSPS Quality Standard Criteria - Self assessed score

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



As required by Circular HSS (PPM) 06/2006 the Northern HSC Trust has outlined its service planning processes in the Trust Delivery Plan 2007/08. The Trust Delivery Plan responds to the principle standards and targets outlined in Priorities for Action (PFA) 2007-08 and details these as the key challenges and major issues the Trust faces over the planning period.

These are:

- Improving health and well-being
- Safer, better quality services
- Reduction in hospital waiting times
- Significant improvements in emergency care
- Fully integrated care and support in the community
- Improvements in children's services
- Better mental health and learning disability services
- Effective financial control and improved efficiency
- Reforming the workforce
- Infrastructure investment

The Trust delivery plan states that the Trust is committed to the delivery of safer, better quality services and indicates they will actively engage with service users to continually improve the services they deliver. The Trust has outlined its intention to build on the work of its legacy Trusts to develop a public involvement strategy that puts users at the centre of decision-making and care.

The plan also outlines a commitment to working across all sectors to ensure local communities are engaged in identifying opportunities to improve and protect their health and well-being and it has given specific examples of work across legacy Trusts. The Trust further states that it will continue to build the capacity of staff to integrate community development approaches into current work practices.

Several measures to be undertaken to assess user experience in terms of the level, quality and method of delivery of services have been identified. Examples include, lessons learned from complaints; service user questionnaires; suggestion boxes; consulting service users and

the public on a range of issues; one-to-one discussions; focus groups; participation of users on a number of groups within the Trust and the Acute Hospital Complaints Forum.

The Trust's 'Planning and Performance Management Framework' sets out the structures which the Trust has put in place to facilitate planning and performance management of services. It provides clear information on the function of:

- Service Programme Strategies
- Corporate Plan
- Trust Delivery Plan
- Directorate Plan
- Service Plan
- Workplan
- Individual Performance Review (IPR)

and shows the link from corporate activities to the activities of individual members of staff.

The Trust also submitted a document entitled 'Corporate Planning Cycle Draft v1 (21-01-08)' which provides similar information to the 'Planning and Performance Management Framework' document and included details of the annual planning cycle in the Trust. The Trust uses a balanced scorecard approach to measure performance of service delivery.

In its self-assessment, the Trust stated that the various factors outlined in Criterion 6.3.1 (a) are embedded within the service planning processes and that all modernisation programmes have undertaken an analysis, resulting in service re-design which reflects local needs. Various examples of this throughout the directorates were given. At the user involvement level, there are a range of carers and focus groups established and the Trust stated that full cognisance is given to feedback from service users.

During the review visit, senior executives stated that, like other Trusts, they worked towards meeting regionally set targets. The Trust has a large geographical spread and travel time throughout rural areas is a major issue. The Trust aims to provide services locally with outpatients services in nine locations and four day case sites. Staffing levels have been set to allow for rurality and, the commissioning body (the Northern Health and Social Services Board (NHSSB)), was reported to allow for this in the allocation of resources.

Senior executives believed that there was a good planning framework in place which allowed all involved in the planning process to take relevant information into consideration during the planning cycle. The Trust engages with staff, non-executive Board members and service providers (including charity and volunteer groups) through workshops. Whilst there appeared to be several examples of user involvement, it was not evident to the review team if there was a strategy for user involvement at a corporate level, although, it was reported that user involvement was incorporated at the complaints forum to share learning.

At a meeting with representatives from advocacy services, reviewers found that, whilst these personnel accepted that their views had been considered throughout the planning process in the legacy Trusts, they felt it was too soon to determine how this was being taken forward in the new Trust. However, they were optimistic that their views would continue to be heard.

Throughout the site visits, the review team found several examples of involvement in service planning and design from both staff and service users. For example, the Chemotherapy/Cancer Unit in Laurel House, Antrim Hospital, had been opened in June 2006 and it was reported that both service users and staff had been heavily involved in the process from development to tendering. Staff went on to say that they had good input in terms of planning and developing the service, and it was evident that equality and equity issues had been given consideration. In the Breast Screening Unit in Antrim Hospital a multidisciplinary meeting is held every month which the Trust Chief Executive attends and at which operational and strategic issues are discussed.

Nevertheless, it was reported to reviewers in other areas that staff felt they were not involved nor had a forum to discuss suggestions for improvement.

RECOMMENDATION 1:

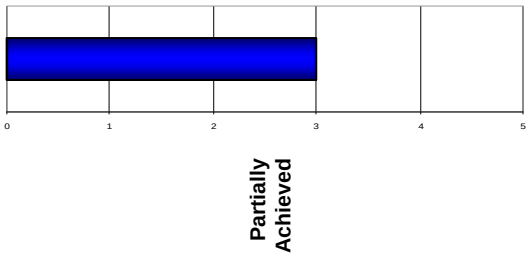
The Trust should ensure there are mechanisms in place whereby all staff are able to contribute to service planning and service improvements.

A service user in the Breast Screening Unit at Antrim Hospital with whom reviewers spoke displayed a good knowledge of the service and its future plans and commented that she welcomed the extension of the age limit for screening as her cancer had been diagnosed at her last 'official' screening visit. Close partnership with the Breast Screening Unit at Altnagelvin ensured service users had a choice of referral to either hospital and took into account the needs of people from different localities.

The review team are uncertain that the Trust has "substantially achieved" this criterion and based on the small numbers of services reviewed, a "partially achieved" level of achievement may be a more realistic overall assessment.

3.1.2 Service User Dignity, Respect and Privacy and the Use of Advocates and Facilitators

This sub-section relates to criterion 6.3.2 (a)

DHSSPS Quality Standard Criteria - Self assessed score	
6.3.2 (a) The organisation ensures that all service users, carers and relatives are treated with dignity and respect and that their privacy is protected and promoted, including, where appropriate, the use of advocates and facilitators.	

In relation to this criterion, the Trust, in its self-assessment, stated that the above-mentioned criteria are included in all service level agreements with independent service providers and are promoted via the Trust's "Living the Values" Plan and Corporate Plan which includes the values of:

- Patient/Client Centred – where "patients and clients' interests will be at the centre of all decision-making processes".
- Openness and Honesty – where it is stated that the Trust "will be responsive to the needs of patients and clients" and its "…staff will be open and honest in their dealing with the public and each other."
- Respect for Others – where "...the views of staff will be listened to, valued and taken into consideration".

In addition, the Trust stated that all professional staff are expected to adhere to their relevant codes of conduct.

When asked as to how the organisation promotes and protects patients', clients' and service users' privacy and confidentiality, both at and between care locations, the Trust focused on confidentiality of data. In relation to transferring data at or between locations, a policy is in operation for the transfer of notes/files from one facility to another and staff were reported to transfer notes between settings personally within the Directorate of Mental Health and Disability Services.

The Trust gave definitive examples of its commitment to the principles of displaying respect for, and valuing the dignity of, all individuals and this is taken into consideration throughout the directorates by:

- Accommodation - use of private accommodation for client contact at clinics and consultations; baby changing facilities; private facilities for breast feeding, disabled toilets; single bedrooms are provided in residential/children's homes.
- Standards - regarding the provision of services which incorporate values such as dignity and respect, eg: domiciliary care services.
- Policy - current development of a policy concerning mixed sex accommodation.
- Induction Programmes - which incorporate specific reference to privacy and dignity and which all staff attend.

Service User Dignity, Respect and Privacy

In General

Senior executives re-affirmed that the principles of service user dignity, respect and privacy are adhered to throughout the Trust and reported that the Trust continues to endeavour to balance adherence to service delivery targets against the privacy and dignity of service users, whilst respecting their wishes.

Those representatives from advocacy services with whom reviewers spoke confirmed that staff throughout the Trust have a high regard for patient dignity and respect and, again, there was a general feeling that these values were not compromised while endeavouring to meet service delivery targets.

In the areas visited, it was clear to reviewers that the values of dignity and respect were deemed a high priority by staff and were not influenced by the demand on the service to meet targets or to provide treatment quickly.

Whilst visiting the Chemotherapy/Cancer Unit in Antrim Hospital, it was noted that the Outpatients and Chemotherapy Day Treatment Unit were in close proximity although there were two waiting areas available for different services. Nevertheless, the appropriateness of this in relation to patient privacy and dignity was questioned by reviewers.

Mixed Sex Accommodation

During their meeting with representatives from advocacy services, reviewers were told that the Trust is presently reviewing its policy on single sex accommodation following several complaints. Representatives felt that this had been a problem area for some time. However, this was balanced with the view that whilst the "gold standard" of single rooms was an aspiration, this view was qualified, as loneliness and safety can present problems as well.

The issue of mixed sex accommodation was also noted in Wards A3 and C6 in Antrim Hospital.

Ward A3 had been designed for 24 beds but currently had 25 patients as an extra bed had been placed in the middle of one bay. Evidence of mixed sex bays was seen and there were no dedicated male/female washing or toileting facilities. Staff spoken with felt that although this created some pressure, they tried to respect patient dignity and privacy. One service user expressed some concern that he was being nursed in a ward with women and found this uncomfortable and felt that this did not facilitate his privacy.

Ward C6 was found to be a very busy ward and full capacity had been reached on the day of the review visit. A reduction in surgical beds had led to difficulties in separating male and female patients which had previously been possible. Originally one side of the ward was male and the other female. However, on the day of the review visit, two of the four bays had mixed genders.

Facility for "Breaking Bad News"

The issue of providing a room or private space for "breaking bad news" was highlighted to the review team on a number of occasions. For example, in the Chemotherapy/Cancer Unit in Laurel House, Antrim Hospital, a private room which had previously been used for breaking "bad news" had been re-allocated as office space for staff not connected with the Unit. At the time of the review visit, a consulting room was used for breaking "bad news" – however this room was not always available and, again, in Ward C6, Antrim Hospital, a room that had been allocated for breaking "bad news" was being used for another purpose at the time of the visit. Reviewers witnessed two doctors dealing with distressed relatives in a busy corridor.

In contrast, in the Breast Screening Unit in Antrim Hospital, arrangements in place for those clients who may receive "bad news" enabled them to leave the unit without moving back through the waiting area.

Private Space
Examples of the provision of "private space" were seen in the Respiratory Outpatients Department in Whiteabbey Hospital which was housed in a building which promoted privacy and dignity. The Unit had a general waiting area (for those patients who arrived early) and smaller recessed areas for patients waiting to see the consultant/nurse. In the Breast Screening Unit at Antrim Hospital patients were provided with a separate room in which to change before seeing the consultant and the review team commended this as facilitating patient dignity and privacy.

Nevertheless, there were some instances where private space was not adequately provided, eg: patients being weighed in corridors between waiting areas where there was a constant flow of traffic in the Chemotherapy/Cancer Unit in Antrim Hospital and lack of side wards to accommodate terminally ill patients and patients with infections who required isolation nursing in Ward A3, Antrim Hospital, as well as lack of a relative's room in this ward.

In the Chemotherapy/Cancer Unit in Antrim Hospital there were a few single rooms which could be used if a patient required privacy or needed to lie down although staff reported that only a few patients would request this private space. Nevertheless, the review team felt that patients had limited choice with regard to a private room. In the Renal Unit only one side ward was available and it was felt that patients had no real choice of using a side room due to the limited availability.

RECOMMENDATION 2:

The Trust should endeavour to ensure that dignity and privacy of service users is maintained across all programmes of care, particularly taking into consideration the provision of single sex accommodation and private space.

Respect for Patients
Throughout the review visit, reviewers were impressed by the enthusiasm of the care teams and they observed good interaction between patients and staff and evidenced good listening skills by staff who had clearly given consideration to issues surrounding patient dignity and respect and who displayed a continued effort to improve these aspects for patients. At the Respiratory Outpatients Clinic in Whiteabbey Hospital and the Breast Screening Unit in Antrim Hospital, those service users with whom reviewers spoke to were very happy with their experience of care.

In the Breast Screening Unit especially, it was evidenced that staff showed regard to patient flow and were sensitive to the needs of patients. The number of patients booked into a specific clinic was controlled to ensure that best practice was adhered to in terms of ensuring that adequate time is given to service users in what can potentially be an anxious situation for them.

Service users in the Renal Unit (Dialysis) at Antrim Hospital had a choice of appointment time and staff aimed to provide a "best fit" for the patients' lifestyle. The unit remained open until 2:00 am. Reviewers were impressed by the flexibility of the unit and found an excellent team of staff who displayed ownership of this service. However, some service users reported to reviewers that they found their surroundings to be noisy.

Use of Advocates and Facilitators

This sub-section relates in particular to the use of advocates and facilitators.

In its self-assessment, the Trust cited several examples of the use of advocates and facilitators, to include:

- The Older Persons Panel
- Support Workers for Carers
- The Carer's Steering Group
- Advocacy for the learning disabled via Compass and Mencap
- The Interpreting Service
- The Eye Help Desk
- The Disability Forum and Disability Consultation Panel
- Voice of Young People in Care (VOYPIC)
- The Alzheimer's Society
- The Peer Advocacy Training Programme
- The Patient Advisory Group

During the review visit, reviewers met with several representatives from advocacy services in the Trust to include those from:

- Accident and Emergency
- Day Rehabilitation Unit
- Mental Health Advocates (both Patient Lay Advocate and Trainee Peer Lay Advocate)
- Older People's Services
- The Public Advisory Group at Holywell

Reviewers appreciated and wished to acknowledge the effort made by these representatives to meet with them.

Representatives confirmed that the current advocacy provision is centred in mental health services and the Trust is currently examining how to extend this throughout acute services and older people's services where there are no advocates at present. Whilst advocacy is not widespread throughout the Trust, the review team agreed that lessons could be learned from the good practice evidenced within mental health services.

The review team also met with Trust senior executives who acknowledged the value of advocacy services within the Directorate of Mental Health and Disability Services and agreed that this model could further be expanded throughout the Trust if responsibility for its development was administered at a corporate level.

RECOMMENDATION 3:

The Trust should roll out the model of advocacy services which is already working well within mental health services and ensure all staff are made aware of the role of advocacy.

In terms of training advocates, reviewers were told that a new course has been provided for those wishing to train as advocates and had been found to be valuable. The course had been

accredited through the Open College Network. The trainee advocate present had completed 9 out of the 10 modules currently available and was due to undertake a practical session which would involve shadowing an experienced advocate.

Overall the commentary received from advocates was encouraging in that the representatives felt that their views were being acknowledged and patient care plans were being influenced as a result of this.

In other areas visited, the review team found that the role of advocate or facilitator had fallen to other staff, even though most of these staff did not see themselves fulfilling this role. For example, in the Breast Screening Unit in Antrim Hospital, an example of a good patient facilitator was found in the Breast Care Nurse, although she did not immediately recognise this as a role she fulfilled and in the Renal Unit (also in Antrim Hospital) the Pre-Dialysis Nurse provided education for both patients and their carers/relatives and acted as a patient facilitator. The Unit also had a dedicated Social Worker. Reviewers evidenced, and staff confirmed, that due to good relationships throughout the Unit, patients were able to raise concerns with any member of staff. A patient informed reviewers that service users in the Breast Screening Unit were also able to avail of help via a support group linked to the Ulster Cancer Foundation.

In the Chemotherapy/Cancer Unit at Laurel House, Antrim Hospital, the “named nurse” concept was in use and each patient had a named nurse assigned to them. There was a feeling amongst nursing staff that they acted as the advocate for the patient, communicating with medical staff on behalf of the patient, as needed. In Ward A3, Antrim Hospital, nursing staff also acted as the patient’s advocate – although, there was no named nurse allocated to patients.

AREA OF GOOD PRACTICE: The review team wished to commend Antrim Hospital on a service which was seen as a model of good practice for health services throughout Northern Ireland in that, on arrival at the Hospital, patients were welcomed by a member of the League of Friends who provided a “meet and greet” service for patients. Reviewers found that volunteers also escorted patients within the hospital and offered a befriending service for those patients who have no relatives or visitors.

Interpreting Service

In its self-assessment the Trust indicated that an interpreting service to include non-English and sensory impairment strands was in place and reviewers were able to evidence that the service was being used throughout the areas visited.

Staff in the Respiratory Outpatients Department in Whiteabbey Hospital and in the Chemotherapy/Cancer Unit and Renal Unit at Antrim Hospital displayed a good knowledge of this service and were able to book a translator to attend the relevant clinics. Staff's experience of using the service was positive.

In Antrim Hospital reviewers also evidenced the availability of an information leaflet entitled “If You Do Not Speak English” which was used for ad hoc visits and which provided translation of basic sentences.

However, in the Breast Screening Unit in Antrim Hospital, staff were unaware of the procedure by which an interpreter could be acquired, although were able to demonstrate to reviewers the use of laminated cards which provided written translation of several questions allowing staff to obtain basic information such as name, address, date of birth, etc, without the aid of an interpreter.

RECOMMENDATION 4:

Information on how to access the Interpreting Service should be disseminated throughout the Trust.

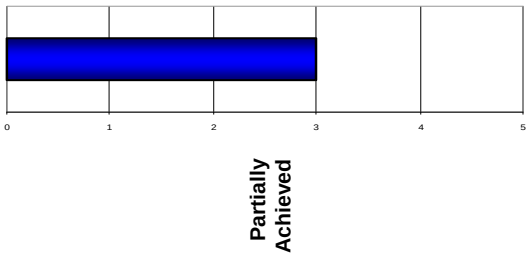
Reviewers were in agreement that the Trust's self-assessment score of "partially achieved" accurately reflected the partial achievement of this criterion.

3.1.3 Service User Information regarding Treatment and Care

This sub-section relates to criterion 6.3.2 (b).

DHSSPS Quality Standard Criteria - Self assessed score

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



In the self-assessment, the Trust reported there was an extensive range of information leaflets in place specifically designed to inform service users, carers and relatives with regard to their treatment, care and service provision. Within each directorate specific information leaflets are targeted to the particular service and the Trust provided examples of these. Service users have also been involved in the development of information leaflets throughout the Trust, eg: the Patient Advocacy Group within the Directorate of Mental Health and Disability Services were involved in the design of the hospital information leaflet.

Consent Process

The Trust was asked what action has been taken to ensure compliance with the regional guidelines on consent. In response, the Trust stated that the three legacy Trusts had adhered to these regional guidelines.

The legacy Trust policies on consent are currently being reviewed and a Trust Consent Working Group has been established in order to review, develop and implement a new Trust-wide consent policy and to ensure the recommendations from the Regional Consent Audit

(August 2007) have been fully implemented across the Trust. This was confirmed by Senior Executives during the review visit.

Reviewers noted the use of a variety of consent processes in the areas they visited.

In the Respiratory Outpatients Department in Whiteabbey Hospital the consultant was responsible for the consent process. However, reviewers were unable to evidence that consent was obtained at the Outpatients Clinic. The current procedure is that consent is obtained on the day of surgery following attendance at the Outpatients Clinic and following a visit to the Pre-Operative Clinic. This process could mean that patients may not be fully informed about the procedure until the day of surgery and reviewers felt that this would not provide sufficient time for the patient to reflect and make an informed decision with regard to the procedure. Again, in Ward C6, Antrim Hospital, written consent was obtained on the morning of surgery.

An adequate consent process was evidenced in the Breast Screening Unit at Antrim Hospital which incorporated both verbal and written consent. Although surgery would usually be considered to be urgent, the patient would be given the necessary time and opportunity to discuss their treatment with the surgeon, breast care nurse and radiologist. The review team expressed concern with regard to the appropriateness of verbal consent only being sought for certain radiological procedures, although were advised by staff that this was considered best practice.

Reviewers also noted a tagging system in use in Ward A3, Antrim Hospital, for those patients inclined to wander and verbal consent for this would be sought from the patient in the first instance or alternatively relatives. Reviewers felt that the tagging system itself was effective, in that if a patient tried to exit the ward, the system bleeped and staff reported that this was valuable as a preventative measure.

Training on Consent

The Trust was asked to describe the training provided to staff in relation to consent. In response, the Trust stated that all directorates provided training on consent at induction. At a meeting with senior executives, this was re-affirmed. The Trust's Consent Working Group are to review and develop a standardised consent training programme throughout the Trust which will include the development of a rolling audit programme on consent.

Throughout the areas which the review team visited (Respiratory Outpatients in Whiteabbey Hospital, Breast Screening Unit at Antrim Hospital, Chemotherapy/Cancer Unit at Antrim, Renal Unit (Dialysis) at Antrim) staff reported that no training had been provided with regard to consent. Notwithstanding, it was reported that information had been disseminated when the new consent procedures were introduced by the Department of Health and Social Services and Public Safety (DHSSPS).

RECOMMENDATION 5:

The Trust should progress the implementation of an informed consent policy consistent with DHSSPS guidelines and inclusive of training by 1st January 2009.

Enabling Service Users to Make Decisions and Choices

The Trust was asked how it ensures that service users are enabled to make informed decisions and choices about their own treatment and care and the Trust's response to this stated that staff have been trained in relation to consent and on the use of information leaflets available which enable service users to make informed decisions and choices. The Trust also provides advocacy services to support service users regarding decision-making.

During the review visit, there were a wide range of mechanisms being utilised to enable service users to make decisions and choices.

In discussions with representatives from advocacy services, those interviewed from Accident and Emergency (A&E) cited the following information leaflets as being available to service users, eg: Head Injury, Back Injury and Care of Plaster. A range of information was also available in care of the elderly services for patients who have had a stroke and included details of the rehabilitation service.

In the Outpatients Department in Whiteabbey Hospital there was a wide variety of information leaflets available in various locations to cover conditions such as diabetes, respiratory disease and clostridium difficile. There was also a digital display screen being used to display a decorative picture and reviewers felt that better use could have made of this screen to provide information on waiting times, for example.

The level of information provided was good in the Breast Screening Unit in Antrim Hospital, in that leaflets were available to service users in the waiting area and a small hard-bound folder was given to patients upon diagnosis of breast cancer. As far as possible, information was sent to patients in advance of clinics – however, some patients had been telephoned at short notice to attend the clinic and thus it was not always possible to send this advance information. Reviewers did recognise that in a potentially distressing situation, patients felt it was good that they attend the clinics as soon as possible. The patient was also provided with supplementary information on a laminated card and via discussions with staff. Those service users spoken with indicated that they were happy with the level of information they had received.

Verbal and written information was provided to patients attending the Chemotherapy/Cancer Unit at Antrim Hospital and a period of one week given in order for the patient to reflect on this information and help aid the process of making an informed decision before proceeding with treatment.

AREA OF GOOD PRACTICE: The review team commended the practice of distributing business style contact cards to include information concerning hours and out-of-hours contact as well as direct line numbers for the support team.

Further information such as when to call the doctor, the role of the patient support team and advice on fatigue was provided in care plans which patients were encouraged to sign in agreement, although the language used was found to be very technical.

In the Renal Unit (Dialysis) in Antrim Hospital a variety of patient information was utilised that included commercial information and regionally designed leaflets. The pre-dialysis nurse was responsible for ensuring patients had sufficient information to enable patient choice. She also provided at least one hour's education for the relatives of the patient.

Reviewers noted a lot of general patient information and leaflets on display and there did not appear to be specialist information on disease types on Ward A3, Antrim Hospital.

Information Leaflets on Diabetes

Patient information leaflets can act as a useful supplement to discussions between patients and healthcare professionals. The Trust was asked to submit examples of leaflets which would be given to a patient who had recently been diagnosed with Type II Diabetes. A sample of these leaflets was audited against criteria covering details about their origin, evidence of being up-to-date and provision of contact details, as well as basic information provided on the condition and management of the disease and the availability of support and further information for the patient. The Trust submitted a range of leaflets, which included a mixture of information produced by commercial organisations and charities. All leaflets clearly identified the origin of the leaflet and were dated.

The selection of leaflets provided information on a range of subjects including:

- General information on Type II Diabetes
- Healthy lifestyle
- Tablets for diabetes
- Preparing to start insulin
- Your eyes
- Travel
- Driving and employment
- Complications
- Blood testing
- Impact on sexual health
- Hypoglycaemia
- Keeping active
- Alcohol
- Insurance

Two leaflets with an adolescent focus were submitted and these leaflets provided information on 'Hypos' and 'Exercise' in a 'teenage friendly' format. A Diabetes UK information leaflet on 'When your child has diabetes' provided information to the parent of a child with diabetes and included contact details of organisations which could provide advice and support to families.

All the commercially produced leaflets included pictures. Information sheets from Diabetes UK consisted entirely of text and did not have any diagrams or pictures.

All leaflets provided the company or charity contact details for further information. No local details were provided, although some leaflets did have a box for service users to take a note of local contact details.

Reviewers were in agreement that the Trust's self-assessment score of "partially achieved" accurately reflected the partial achievement of this criterion.

3.2 CRITERIA EXAMINED THROUGH TRUST SELF-ASSESSMENT

This section reports on the information provided by Trusts in their self-assessment submission.

The criteria in this section includes:

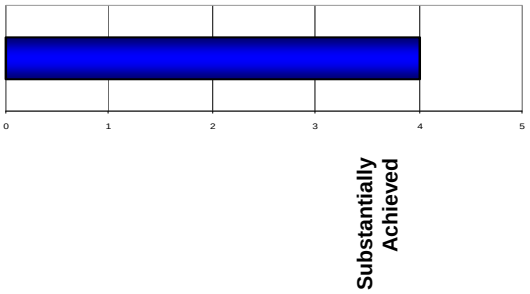
- 6.3.1 (b), (c), (d) - Service Planning and Design
- 6.3.1 (e) - Standards for Commissioning of Services
- 6.3.1 (f) - Access to Services
- 6.3.2 (c) - Availability of Information in Alternative Formats
- 6.3.2 (d) - Service User Right to Choose for Themselves
- 6.3.2 (e) - Confidentiality of Service User Information
- 6.3.2 (f) - Minimising the Need to Repeat Information
- 6.3.2 (g) - Opportunity to Comment on Service Delivery

3.2.1 Service Planning and Design

This sub-section relates to criteria 6.3.1 (b), (c) and (d).

DHSSPS Quality Standard Criteria - Self assessed score

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



The Trust's self-assessment reported that integration of views from service users, carers, local communities and front line staff is facilitated within:

- Trust Policies – whereby a robust process is in place to ensure that consultation is embedded during policy development stage when the needs of both internal (within departments, working groups, directorates, etc) and external (with the public, affected representative groups and other public authorities, etc) stakeholders and particular

groups and localities are determined. The Trust's policy approval proforma details all consultation that has taken place on the policy. Representative groups and individuals have been consulted regarding several Trust policies since the establishment of this process and this has led to the amendment of policies in light of feedback received.

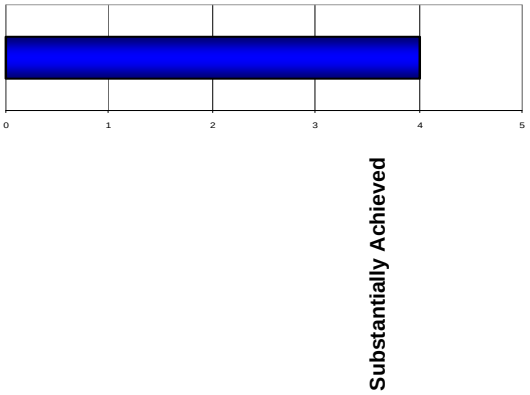
- ❖ A consultee database – which holds the details of over 700 community, voluntary and statutory organisations within its area.

The Trust also gave examples of how views were obtained within each Directorate to include the use of: user satisfaction surveys; open forums with users and other stakeholders; engagement with the new Locality Commissioning Groups (LCGs); meetings with service users in relation to complaints to ensure lessons are learned and engagement with local voluntary groups and independent sector providers.

A particular example was that of the Trust's Disability Consultation Panel where its recommendations feed directly into the development and review of Trust services. The Panel has developed an action plan to ensure the Trust is fully responsive to the needs of disabled people and all services are fully accessible.

DHSSPS Quality Standard Criteria
- Self assessed score

6.3.1 (c) The organisation promotes service design and provision which incorporates and is informed by: -
- Information about the health and social well-being status of the local population and an assessment of likely future needs;
- Evidence of best practice and care, based on research findings, scientific knowledge, and evaluation of experience;
- Principles of inclusion, equality and the promotion of good relations;
- Risk assessment and an analysis of current service provision and outcomes in relation to meeting assessed needs;
- Current and /or pending legislative and regulatory requirements;
- Resource availability; and
- Opportunities for partnership working across the community, voluntary, private and statutory sectors.

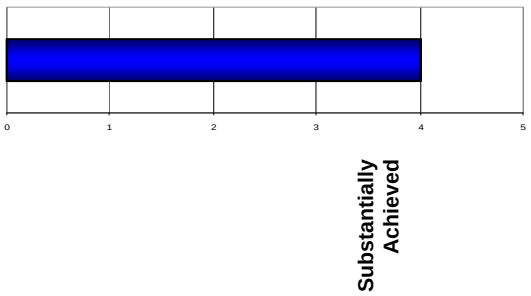


The Trust had developed a governance and assurance framework (within its Corporate Plan) which the Trust believes will help to ensure that strategy informs separate planning and service design and provision. This is based on need and best practice.

The Trust used the Directorate of Mental Health and Disability Services to provide examples whereby the promotion of service design and provision incorporates and is informed by:

- ❖ Research initiatives
- ❖ Evidence-based practice, instructed by various professional bodies
- ❖ A Risk register and risk assessments

- ❖ Policies in line with legislative requirements
- ❖ Implementation of Safeguarding Vulnerable Adults Guidance and Discharge of Statutory Functions under the relevant statute and actively engaging in meeting new regulations
- ❖ A range of contracts are in place with independent sector providers and partnerships

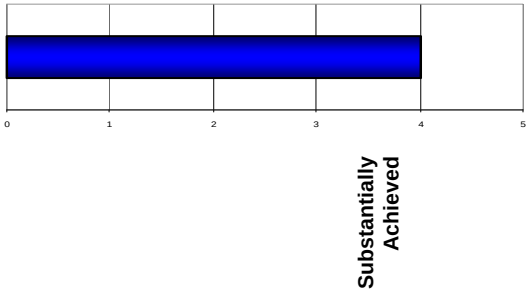
DHSSPS Quality Standard Criteria - Self assessed score	
6.3.1 (d) The organisation has service planning and decision-making processes across all service user groups, which take account of local and/or regional priorities.	

The Trust stated that service planning is established across all service areas and included within the Trust's Directorate Plans. These were reported to take account of local and regional priorities, taking cognisance of relevant programme strategies and performance against regional and local targets. A corporate planning cycle had been developed and was expected to be in place by the end of the 2007/2008 year.

The Trust gave examples of how this worked in directorate service plans reflecting regional Priorities for Action (PFA) targets, ministerial targets and involvement of service users in service planning and design.

3.2.2 Standards for Commissioning of Services

This sub-section relates to criterion 6.3.1 (e).

DHSSPS Quality Standard Criteria - Self assessed score	
6.3.1 (e) The organisation has standards for the commissioning of services which are readily understood and are available to the public.	

The Trust's self-assessment reported various instances where standards are used in the commissioning of services. These included:

- ❖ Contracts/service level agreements (SLA's) specify care standards and processes, eg: within sample homecare and sample nursing home care contract
- ❖ Standards were reported to be in place (in line with regional guidelines) for the commissioning of nursing and residential care and the commissioning of domiciliary home care and a directorate scorecard has been established to monitor standards against established targets.

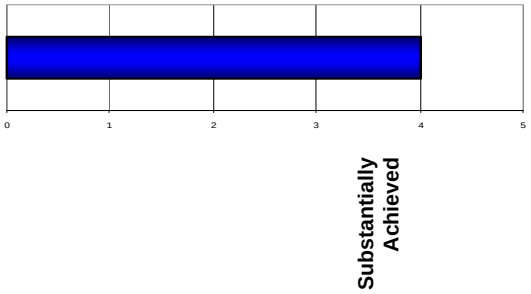
The Trust stated that work was ongoing in terms of harmonising and consolidating a common contract format and standards which will be supported by regional work to standardise this information. The Trust Board performance report sets out access targets and other standards and the outcome on their achievement. Within the Trust, formal monitoring of commissioned services takes place and service user complaints have been addressed through this formal mechanism.

3.2.3 Access to Services

This sub-section relates to criterion 6.3.1 (f)

DHSSPS Quality Standard Criteria
- Self assessed score

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



In its submission, the Trust stated that monthly Trust Board reports and directorate scorecards are used to demonstrate progress and achievement in this area against the DHSSPS Priorities for Action (PFA) Targets.

The Trust reported that all directorates work to regionally determined targets within available resources. At an operational level, all directorates operate within the Patient's Charter and waiting list targets, eg: allied health professional targets and social care targets.

Throughout those areas visited in Antrim Hospital, storage was an issue which had led to items (for example, yellow clinical bins) being stored inappropriately in corridors and adjoining areas which had the potential to cause a problem with safety and difficulty in relation to access. This made movement around the Hospital site difficult and has the potential to become an infection control issue.

RECOMMENDATION 6:

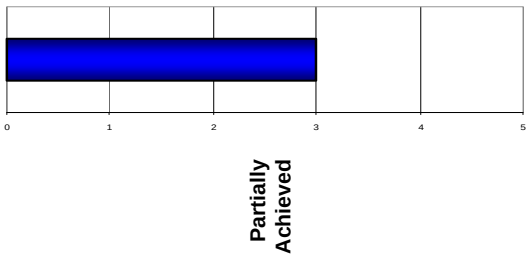
Antrim Hospital should ensure that equipment and other items are stored appropriately throughout the site.

3.2.4 Availability of Information in Alternative Formats

This sub-section relates to criterion 6.3.2 (c)

DHSSPS Quality Standard Criteria
- Self assessed score

6.3.2 (c) The organisation ensures that information, where appropriate, is provided in a number of formats, which may include, large print, audio format on tape or compact disc, computer readable format, Braille, etc. and is:
- written in easy to understand, non-technical language;
- laid out simply and clearly;
- reproduced in a clear typeface;
- available on the internet; and
- in the preferred language of the reader, as necessary.



In its self-assessment the Trust reported that it had processes in place to ensure that information is provided in a number of formats, to include:

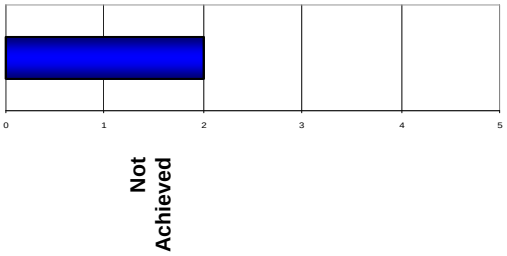
- Translation of material via qualified translators into alternative formats
- Large print and audio tape is facilitated by the Equality Unit
- Installation of hearing induction loops in all of the main conference and meeting rooms and installation of text phones in reception areas
- Provision of sign language and interpreting support, as well as a Brailler
- Guidance on Policy Development with regard to appropriate fonts and formats including keeping the policy to a minimum length and using easy to read and plain language
- Guidelines for written, visual and oral communication to meet the needs of disabled users as per the Disability Action Plan
- Monitoring of Trust website to ensure it is fully accessible

3.2.5 Service User Right to Choose for Themselves

This sub-section relates to criterion 6.3.2 (d)

DHSSPS Quality Standard Criteria
- Self assessed score

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



The Trust's self-assessment reported that there were various mechanisms in place to support individual service user rights, views and choice in the assessment, planning, delivery and review of his/her treatment and care. For example:

- Care planning processes within the Directorate of Mental Health and Disability Services which involve the user/carer and assessment processes to include review
- Supported living tenancy arrangements and eligibility criteria for community services within the Directorate of Mental Health and Disability Services

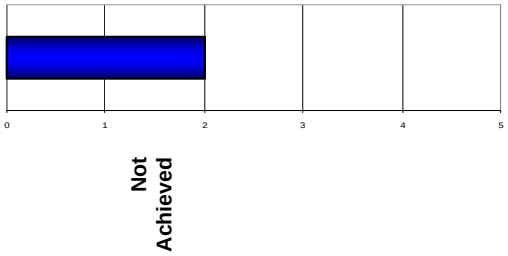
An extensive range of information leaflets specifically designed to inform service users, carers and their relatives about their treatment, care and service provision, as well as the consent leaflet entitled "It's Up To You" were also provided to help ensure that the patient's rights, views and choice are considered.

3.2.6 Confidentiality of Service User Information

This sub-section relates to criterion 6.3.2 (e)

DHSSPS Quality Standard Criteria
- Self assessed score

6.3.2 (e) The organisation ensures that individual service user information is used for the purpose for which it was collected, and that such information is treated confidentially.



In its self-assessment, the Trust reported that its draft policy on processing personal information ensures that individual service user information was used for the purpose it was collected and treated in a confidential manner. Procedures for staff which will provide practical guidelines on processing personal information were under development and, in the interim, the Trust adheres to the regional guidance "The Protection and Use of Patient and Client Information". Following completion of the new procedures, training will be re-introduced into the Trust's Training Directory and practice assessed to further refine procedures. Leaflets outlining how the Trust uses personal information were also provided to service users.

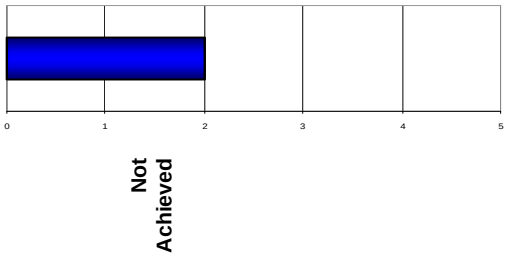
The Trust identified other mechanisms by which the criterion is assured to include:

- Identification of a Personal Data Guardian
- Information governance function
- Procedures for dealing with requests for access to personal information
- Policy on Information Management and Records Management
- Awareness of relevant policies through staff induction

3.2.7 Minimising the Need to Repeat Information

This sub-section relates to criterion 6.3.2 (f)

DHSSPS Quality Standard Criteria - Self assessed score
6.3.2 (f) The organisation promotes multidisciplinary team work and integrated assessment processes, which minimise the need for service users and carers to repeat basic information to a range of staff.



In the self-assessment, the Trust stated that it promotes multidisciplinary team working and seeks to minimise the need for service users and carers to repeat basic information to a range of staff. The Trust gave the example of a central referral process for community services.

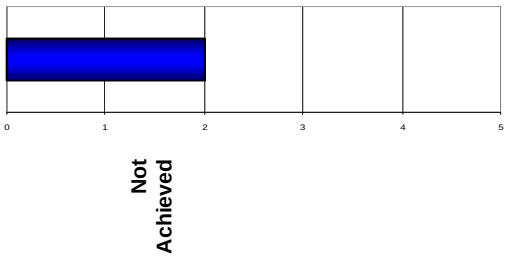
The Trust was asked to provide an example of multidisciplinary teamwork within diabetic services and reported that, within the Directorate of Primary Care, Emergency Care and Older People's Services, there is multidisciplinary team working to include podiatrists, nurses, dieticians and general practitioners. This acts as a "one stop shop" for patients.

Also, within the Directorate of Children's and Women's Services, the children's diabetic service has a framework in place involving consultants, nurses, dieticians, laboratory staff and other staff, as necessary. The antenatal specialised clinic in Antrim Area Hospital involves a diabetic specialist nurse, midwife, obstetrician, consultant diabetologist and anaesthetist.

3.2.8 Opportunity to Comment on Service Delivery

This sub-section relates to criterion 6.3.2 (g)

DHSSPS Quality Standard Criteria - Self assessed score
6.3.2 (g) The organisation provides the opportunity for service users and carers to provide comment on service delivery.



In its submission, the Trust reported that it provides the opportunity for service users and carers to provide comments on service delivery through a range of options, to include:

- Complaints Leaflets
- Complaints Policy
- Comments Policy
- Patient Feedback Cards and Surveys
- User Groups and Committees
- Care Planning and Review Process

Whilst patient feedback cards and surveys were in operation in the legacy Trusts and were distributed to wards and departments, this was currently being reviewed with the intention of harmonisation into one Northern Trust patient feedback process.

The Trust also has a User Feedback Committee and, on behalf of the Trust Board, seeks assurance that complaints and other forms of user feedback are managed in line with best practice and informs service improvements and business decisions.

4 PROMOTING, PROTECTING AND IMPROVING HEALTH AND SOCIAL WELL-BEING

The DHSSPS Quality Standards cite Theme 4 as: “The HPSS works in partnership with service users and carers, the wider public and with local and regional organisations to promote, protect and improve health and social wellbeing, and to tackle inequalities within and between geographic areas, socio-economic and minority groups, taking account of equality and human rights legislation.”

There are a total of 13 criteria within this theme and the Trust was asked to make a self assessment against these criteria under a level of achievement measure as illustrated in Table 4.

Code	Level of Achievement	Definition
1	Unlikely to be Achieved	The criterion is unlikely to ever be achieved. *(A reason must be stated clearly in the Trust response)*
2	Not Achieved	The criterion is likely to be achieved in full but after March 2008. For example, the Trust has only started to develop a policy and implementation will not take place until after March 2008.
3	Partially Achieved	Work has been progressing satisfactorily and the Trust is likely to have achieved the criterion by March 2008. For example, the Trust has developed a policy and will have completed implementation throughout the Trust by March 2008.
4	Substantially Achieved	A significant proportion of action has been completed to ensure the Trust performance is in line with the criterion. For example, a policy has been developed and implemented but a plan to ensure practice is fully embedded has not yet been put in place.
5	Fully Achieved	Action has been completed that ensures the Trust performance is fully in line with the criterion. For example, a policy has been developed, implemented, monitored and an ongoing programme is in place to review its effectiveness.

TABLE 4

Table 4 (a) illustrates how the Trust has assessed it's own performance against the criteria under the standard of 'Promoting, Protecting and Improving Health and Social Well-Being'.

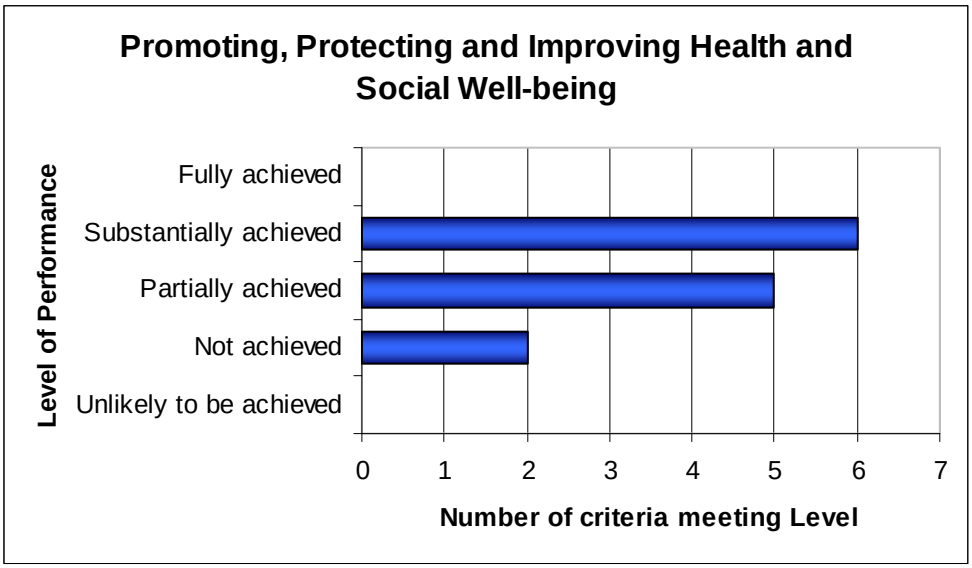


TABLE 4(a)

The Trust also provided narrative under the headings of:

- Corporate
- Operational
- Personal and Public Involvement

regarding each criterion to describe how it has achieved the stated level of achievement.

4.1 CRITERIA EXAMINED BY REVIEW TEAM

The RQIA selected two specific criteria within this standard for review teams to examine and substantiate the Trust's submission. The findings in this section are based on the information provided by Trusts in their self-assessment submission and on observations made by, and views expressed to, the members of the review team during visits. Areas visited are listed in Appendix (iii) of this report.

The criteria in this section includes:

- 7.3 (a) - Trust Partnership Arrangements in Place
- 7.3 (b) - Personal and Public Involvement

In general, senior executives acknowledged the difficulties of the amalgamation of the legacy Trusts and recognised the work that done to date around planning and improving health and social well-being. Patient safety and well-being was recognised as a priority for the Trust, together with user involvement in all aspects of the delivery of services. The directors reported undertaking a safer patient walkabout.

Staff within the Health Promotion Department demonstrated a good awareness of the reporting arrangements and systems within the Trust up to the Director of Children and

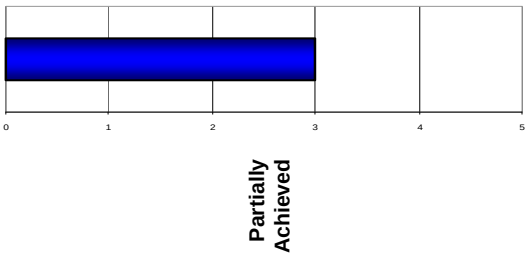
Women's Services who had responsibility for health promotion. Some directorates had identified their key priorities under Health Promotion and identified staff had links within each directorate. However, staff were unsure about a Trust strategy for improving health and well-being across the new Trust area as staff were working to the legacy Trusts agenda and some examples of health promotion appear to be driven from Board level.

4.1.1 Trust Partnership Arrangements in Place

This sub-section relates to criterion 7.3 (a).

DHSSPS Quality Standard Criteria - Self assessed score

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



In the Trust's self-assessment examples were given of various structures and processes in place contributing to effective partnership arrangements. A few examples included:

- Disability Panel
- Older People's Panel
- Mental Health User Engagement Group
- Trust GP Liaison Forum
- Monthly meetings with the Northern Health and Social Services Board (NHSSB)
- Learning Disability Day Care and Older People's Strategic Reviews
- Health Improvement/Community Development Workshop, resulting in the development of a Health Improvement/Community Development Service Plan

At an operational level, the Trust stated that all directorates have a range of partnerships with voluntary and independent providers, as well as participation in regional consultations. Again, the Trust gave the following examples of partnership working:

- Chest, Heart and Stroke Association
- British Lung Foundation
- Diabetes UK
- Housing Executive
- Fold Housing Association
- Northern Area Supporting People Services
- Northern Education and Library Board
- MENCAP
- Barnardos
- Crossroads

At a user involvement level, processes which were in place included individual review, service user feedback and stakeholder involvement in the development and rollout of strategies, as well as carer's assessment and opportunities for review and feedback, focus groups and user committees.

During their meeting with senior executives, reviewers were informed that a legacy Trust had established an effective partnership with the Health Action Zone (HAZ) and, in order to ensure continuity, work was needed to ensure this was mainstreamed into the work of the Trust.

Examples of partnership arrangements that existed in legacy Trusts were cited which have been brought forward into the new Trust and at the time of the review there was well developed independent and voluntary sector working in partnership with the Trust.

During their meeting with representatives from community projects, the review team noted that whilst one person had been identified as the lead for community development within the Trust, various representatives feed into the different directorates. The challenge for the Trust was to ensure that community development is incorporated into all aspects of the business development and a need was identified for the creation of a community development strategy which should take into consideration:

- Support of self-help groups
- Collaborative work with marginalised groups
- Engagement with young people and looked after children
- Liaison with Accident and Emergency Departments
- Support and development of new community initiatives in the area of Mental Health, eg: suicide prevention, self-harm, etc.

RECOMMENDATION 7:

The Trust should develop a Community Development Strategy and ensure this is incorporated into all aspects of service delivery.

During their visit to the health promotion department, the review team evidenced some good examples of partnerships within older people's services, eg: work with Help the Aged and also Good Morning Magherafelt and other examples within Mental Health Services.

AREA OF GOOD PRACTICE: The review team were impressed by the continuing work with the "Good Morning Magherafelt" Initiative and commended this as an area of good practice.

With regard to taking forward the Investing for Health Strategy, whilst there was representation of staff from Health Promotion on various working groups at Board level, there was a recognition amongst Health Promotion staff that more robust links need to be established between the Trust and the Board.

The review team met with a representative employed by the NI Council for Ethnic Minorities whose remit included providing information and support to ethnic groups on health, employment, housing and immigration issues. Reviewers were impressed with the work undertaken and agreed that the contribution of these posts within the groups supporting ethnic minorities and migrant workers in respect of their health and social care needs, was

invaluable. Although the challenge remained for the Trust to ensure that this valuable resource was retained.

The representatives from community projects presented an excellent example of the work of small community groups which were having an impact on the health and well-being of the population. The willingness of community groups to engage with the Trust was noted during the meeting with representatives from a range of community projects such as Community Development Antrim Town, Good Morning Magherafelt and the Early Years and Community Development Teams. Reviewers were able to evidence the impact these projects had made to date in meeting health and well-being needs of their particular communities.

AREAS OF GOOD PRACTICE: Reviewers noted the following partnership work as examples of good practice within the Trust's area:

- Community Development Project within Antrim town including working with Ethnic minorities
- Sure Start and Early Years

Representatives from the Home from Hospital team with whom reviewers met were very enthusiastic and committed to the specialist scheme. The review team noted this as an area to be commended. The staff spoken to gave examples of partnership working with health promotion eg: Falls Prevention and Warmer Homes Scheme. They also had an input into the Falls prevention booklet and demonstrated involvement with health promotion in respect of fuel poverty and links with community groups to assist with home security.

During their visit to the Robinson Hospital, reviewers were informed that the Trust has a good relationship with the Robinson Trust Board and representatives from the Trust Board meet with the Robinson Trust on a regular basis to discuss issues in relation to the Hospital facility. The Hospital staff have links with Health Promotion staff in relation to health promotion initiatives eg: Falls prevention, medicines management and smoking cessation.

Partnerships Contributing to Health and Social Well-Being

Trust senior executives reported that the Trust had recently launched an initiative in partnership with staff called U-Talk, to encourage creativity of staff in contributing to ideas and suggestions in improving health and social well-being.

The review team also learnt of the GP Forum which was the responsibility of the Northern Health and Social Services Board (NHSSB), however there were no examples of user involvement or representation into this Forum. The Trust to date has not re-established this forum in respect of interface issues, although partnership arrangements with general practitioners were seen as important.

Within the Trust, staff from the various directorates had responsibility for community development and health promotion. Senior executives recognised that health promotion and community development needed to be mainstreamed in the directorates. Each directorate had identified key priorities within its business plans and intended to undertake further work to achieve these objectives. Those spoken with acknowledged that health promotion staff face the challenge of how they work across all directorates and how they link corporately.

Staff from the Health Promotion Department provided evidence of good partnership working, with staff representatives sitting on various groups aimed at improving health and well-being. There are links with the Northern Board groups, Education and Library Boards and an example was provided of community engagement in respect of the health promotion physical activity programmes.

The Home from Hospital team spoke to reviewers of effective partnership working and shared care with GP's in respect of the step down beds, where agreed joint protocols had been put in place, as well as work carried out in relation to developing stroke services.

The representative from the ethnic minority groups spoke of good links having been established with community nurses regarding maternity issues for migrant workers, as well as effective liaison with GP's in respect of awareness of interpretation services.

Staff in the Robinson Hospital gave examples of strong partnerships with palliative care support organisations such as Marie Curie, MacMillan and CRUSE. Also, worthy of note was the Palliative Care Support team and the employment of nine full time palliative care nursing auxiliaries, to assist discharge and reduce hospital admissions.

Partnerships Contributing to the Promotion of Social Inclusion and Reduction in Inequalities

Senior executives gave examples from within learning disability and mental health programmes of resettlement projects and partnerships with the NI Association of Mental Health. The Advocacy Project at Holywell Hospital also led to the re-shaping of hospital services and provision of community alternatives. Partnership working and representation of staff on Northern Board working groups was confirmed, as were arrangements of interagency working with the Education and Library Boards in respect of improvements in health and social well being eg: within children's services.

Within children's and women's services, health promotion staff re-affirmed established links and partnership working with the Education and Library Boards. However, the review team found little evidence of ethnic minorities input to health promotion within this directorate.

Representatives from the Home from Hospital Team were able to demonstrate a good awareness of their responsibilities under Section 75.

Reviewers evidenced established links with AWARE, Ballymena Inter Ethnic Forum (an inter-agency group consisting of staff from the Trust), the PSNI, the Housing Executive, Local Councils and the Education and Library Board. The Equality Manager reported that through her there was good communication to the appropriate heads of service in respect of issues raised by these groups. The Equality Manager reports directly through the Planning Department but is able to bring quality issues to Trust Board, when necessary.

AREA OF GOOD PRACTICE: A good example of social inclusion was the development of the Disability Consultation Panel. This group had produced a development plan and the Panel had presented an action plan to Trust Board to assist the Trust with regard to access to

services for people with a disability. This had been endorsed and linked into the various directorates.

Another good example of social inclusion is the Older People's Strategy. Nominees for representation for the Older Peoples' Panel were to have been decided at a workshop in April. However reviewers were unable to evidence any links with GP's regarding the establishment of the Older People's Panel.

The Equality Manager gave a good example of a meeting with the Chinese Welfare Association and the Assistant Director of Mental Health and, as a result of this, approved social workers have been trained in the use of interpreting services in completing mental health assessments.

The review team evidenced inter-agency working with representatives from the Trust sitting on multi-cultural and interagency forums eg: Ballymoney Migrant Network, Coleraine Multi-cultural, Magherafelt Forum and Ballymoney Interagency. The floating support worker sits on the Domestic Violence Partnership representing migrant workers.

RECOMMENDATION 8:

The Trust should ensure effective support is provided for the maintenance of partnership arrangements with stakeholders, including primary care, community and voluntary organisations across all programmes of care.

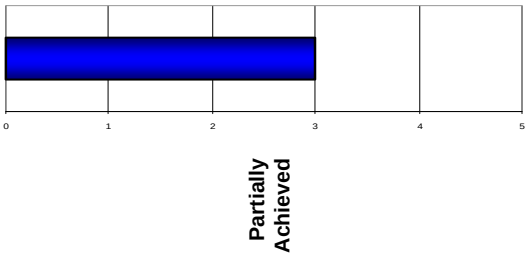
Reviewers were in agreement that the Trust's self-assessment score of "partially achieved" accurately reflected the partial achievement of this criterion.

4.1.2 Personal and Public Involvement

This sub-section relates to criterion 7.3 (b).

DHSSPS Quality Standard Criteria - Self assessed score

7.3 (b) The organisation actively involves the service users and carers, the wider public, HPSS staff and the community and voluntary sectors, in the planning and development of local solutions to improve health and social well-being and to reduce inequalities.



In its self-assessment, the Trust was reported that its Equality Scheme approved by Trust Board in September 2007 committed the Trust to consulting in a way that reflected the particular needs and circumstances of different groups. The Trust's continued involvement in a range of regional and local forums provided established channels for consultation and an

extensive consultation database is held which includes both regional and local groups and which is used when consulting on new or reviewed policies and practices.

Various examples of personal and public involvement were provided which included:

- The Trust continued to support its Disability Consultation Panel to ensure that people with a disability were involved in planning and development of services. In January 2008, the Trust Board approved an Action Plan developed by the Panel which detailed how the Panel would work with the Trust to improve accessibility to its services.
- The Trust involved representatives and individuals in the development of its Strategy for Older People 'Living Well – Ageing Better' and was in the process of developing an Older People's Panel to monitor the Implementation of the Strategy. Development of the Trust's Strategy for Mental Health Services for Older People involved service users and carers as members of a User and Carer Advisory Panel.
- The User Initiative Project at Holywell Hospital was a collaborative project with the Northern Ireland Association for Mental Health and provided service users the opportunity to provide feedback on services. Sixteen Public Advisors have been appointed to participate in the planning, implementation, monitoring and evaluation of Mental Health Services. When fully implemented, members will be invited onto the Directorate's planning, policy, management and governance groups. User Panels have also been established for day support and crisis response services. Trust staff worked closely with local ethnic minority communities in Ballymena and Cookstown to ensure access to services.

Personal and Public Involvement
This review set out to examine how, in the first year, Trusts had adopted the principles set out in the 'Guidance on Strengthening Personal and Public Involvement in Health and Social Care' DHSSPS Circular HSC (SQSD) 29/07 issued by DHSSPS in September 2007 to help Trusts strengthen and improve personal and public involvement (PPI) in the planning, commissioning, delivery and evaluation of services as part of their clinical and social care governance arrangements and to what extent a systematic process of self-evaluation to strengthen PPI has been developed.

The Trust was questioned in the following two areas:

Responsibility for implementing the Guidance
Whilst the Trust's self-assessment submission omitted to answer this question, the review team were told that the Medical Director had been appointed as the executive lead.

Progressing the Guidance
The Trust did not submit any information in relation to a progress report of action to implement personal and public involvement or any information in relation to plans in relation to a Service User, Carer and Wider Public Involvement Strategy.

At a meeting with senior executives, it was confirmed that there was no PPI strategy. However, there were legacy Trust user/carer strategies and all directorates have a PPI agenda. A major challenge for the Trust was the integration and mainstreaming of public participation in the different directorates and of user input into service delivery.

However, the Trust stated its intention to develop a Public Involvement Strategy and has established a Public and Personal Involvement Group. Senior executives also recognised the need to audit PPI involvement to ensure a consolidated approach to driving this area forward in the Trust.

RECOMMENDATION 9:

The Trust should continue to develop and implement a Personal and Public Involvement Strategy involving key stakeholders.

In its Delivery Plan, the Trust indicated a commitment to working across all sectors to ensure local communities are engaged in identifying opportunities to improve and protect their health. The Northern Trust intends to build on the work of its legacy Trusts to develop a Public Involvement Strategy that puts users at the centre of decision-making and care. The Trust stated it would continue to build the capacity of staff to integrate community development approaches into current work practices.

Within the Delivery Plan, the Trust identified several measures to be undertaken to assess user experience in terms of the level, quality and method of delivery of services. These included: lessons learned from complaints; patient/user questionnaires; suggestion boxes; consulting users/public on a range of issues; one-to-one discussions; focus groups; participation of users on a number of groups within the Trust and the Acute Hospital Complaints Forum.

In the Trust Corporate Plan, submitted as evidence, reference is made of the Trust's commitment to support Personal and Public Involvement and to work with local communities and service users and carers. It was stated that user and carer involvement is promoted through this Plan and involvement of service user representatives in the governance structures of the Trust as well as at an operational level in the directorates. Users have had significant involvement in the three service strategies developed and approved by the Trust Board.

During their visit to the Health Promotion Department, staff re-affirmed that there is no PPI strategy and they are currently working to the legacy Trust User Carer Strategy. Whilst all Directorates appear to have a PPI agenda, it was unclear as to how this fed back into the organisation and staff felt that formal arrangements needed to be inclusive of staff involvement. Therefore, a major challenge will be the integration of mainstreaming of PPI in different directorates.

During their visit to the Robinson Hospital, reviewers noted that there was no carer's co-ordinator in place and no identified carer's advocacy service. However, it was reported to reviewers that the Trust had established a Carer Strategy Steering Group to take forward its Carer Strategy.

RECOMMENDATION 10:

Work on the Carer's Strategy should be progressed to include an identified Carer's Co-Ordinator and improvement in carer's advocacy services.

Involvement in Planning and Development within the Trust Services
At the review team's meeting with the senior executives, an example was given of the establishment of stroke services as evidence of user involvement and a partnership approach with the Chest, Stroke and Heart Association. The Glenfield Project was also noted as an example of effective public involvement and a result of partnership arrangements and public involvement in a socially deprived community where health needs analysis was completed. This resulted in a change to the way services were delivered to the community in that there is now a first contact care centre with a nurse practitioner/prescriber.

Senior executives indicated that active participation of service users was demonstrated in the User Experience Group which is chaired by the Trust Chairman and has representatives from the Health and Social Care Council.

Representatives from the Home from Hospital team spoke of the extensive consultation and engagement of older people in respect of the strategy for older people and confirmed that the Trust had plans to establish an Older People's Panel to implement the strategy.

At an operational level, the Home from Hospital team gave examples of feedback from service users through use of questionnaires and, as a consequence, some of the impact was the review of meal-times in regard to step down beds in the Dalriada Hospital. Also, the recent consultation with users on the policy on access to domiciliary care had resulted in the policy being amended due to comments received.

The representative from the Ethnic Minority Group told the review team of the welcome fare which had been held in February 2008 and was cited as a good example of inter-agency working and the Trust input into this area. The representative went on to say that she had established inter-agency contacts and was clear about the reporting mechanisms in the Trust through to the Equality Officer.

In the Robinson Hospital, staff gave examples of active participation of service users in the successful Essence of Care Nutrition Project and the improvements in service provision as a direct result of service user's comments and inputs into provision of meals and nutrition. Staff spoken with were also aware of the user representation on Trust committees, both at operational and strategic level.

Reviewers were in agreement that the Trust's self-assessment score of "partially achieved" accurately reflected the partial achievement of this criterion.

4.2 CRITERIA EXAMINED THROUGH TRUST SELF-ASSESSMENT

This section reports on the information provided by Trusts in their self-assessment submission.

The criteria in this section includes:

- 7.3 (c) - Human Rights

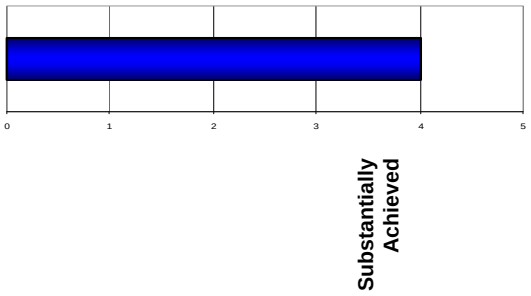
- 7.3 (d) - Equality Screening with Section 75
- 7.3 (e) - Responsibility and Ownership with regard to Health
- 7.3 (f) - Arrangements in Place for Collection, Collation, Development and Use of Health and Social Care Information
- 7.3 (g) - Major Incident and Emergency Planning Policy and Procedures
- 7.3 (h) - Environmental Health Policies and Procedures
- 7.3 (i) - Chronic Disease Management Programmes
- 7.3 (j) - Healthier, Safer, Family Friendly Workforce
- 7.3 (k) - Screening and Immunisation Programmes
- 7.3 (l) - Public Health and Social Care Reports in the Development of Priorities, Planning and Delivery of Services
- 7.3 (m) - Use of Volunteers

4.2.1 Human Rights

This sub-section relates to criterion 7.3 (c)

DHSSPS Quality Standard Criteria - Self assessed score

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

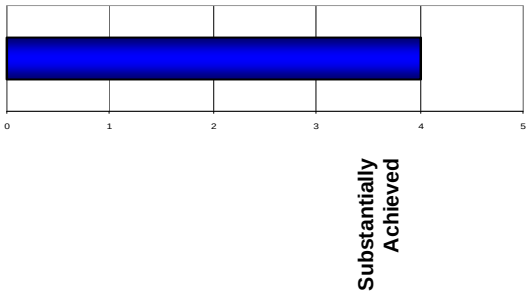


In its self-assessment, the Trust indicated the existence of a robust process for the development, approval, implementation and review of Trust Policies which complies with various legislative requirements such as Section 75 and human rights. The completion of the associated screening template before policies are approved ensures that human rights implications are considered as an integral part of the policy development and decision making process. The Trust's policy database maintains a record of all policies screened and Trust Board and Senior Management Team only approve policies that have been appropriately screened. The Trust's mandatory Equality and Diversity Training Programme includes awareness training on the Human Rights Act and the implications for staff. Specialist screening training ensures policy makers have the necessary skills to screen policies for human rights compliance.

4.2.2 Equality Screening with Section 75

This sub-section relates to criterion 7.3 (d)

DHSSPS Quality Standard Criteria - Self assessed score
7.3 (d) The organisation actively pursues equality screening and, where appropriate, equality impact assessment in compliance with section 75 of the Northern Ireland Act 1998.



As noted under 4.2.1, the Trust's self-assessment stated that the process in place for developing, approving, implementing and reviewing Trust policies ensures that the Trust complies with various legislative requirements such as Section 75 and human rights. The process incorporated the screening of all policies and procedures to determine whether an equality impact assessment was required and the Trust Board and the Senior Management Team will only approve policies that have been appropriately screened. The Trust reports annually to the Equality Commission on the screening of policies.

A screening template and guidance has been developed to ensure that staff have access to appropriate and specific advice when screening a policy or procedure. Completion of this template ensures that Section 75 is considered at an early stage of policy development and decision making. This has been disseminated to all policy makers within the Trust.

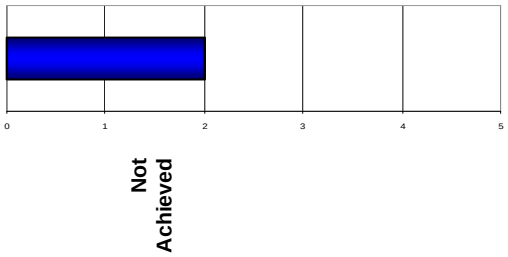
Specialist Screening Training is being held in February 2008 and March 2008 for policy makers and the Trust's Equality Unit provides advice and support on screening and equality impact assessments. The screening process involved consultation with affected groups and individuals. Any adverse impact identified during the screening process resulted in the Trust examining mitigating actions to ensure that it promotes equality of opportunity and good relations.

4.2.3 Responsibility and Ownership with regard to Health

This sub-section relates to criterion 7.3 (e)

DHSSPS Quality Standard Criteria - Self assessed score

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



The Trust health improvement/community development service is currently under review. Examples of health promotion programmes provided by the Trust included: the Cook It Project; Health Promotion through Day/Adult Care; Floating support and Supported House have a health and well-being focus; VIP Project; Smoking Cessation Services; Medicines Management; Footcare; Epilepsy Management; Encouraging and Promoting Uptake of Direct Payments; Health Screening activities: Gateway; Special Olympics and an MS Group.

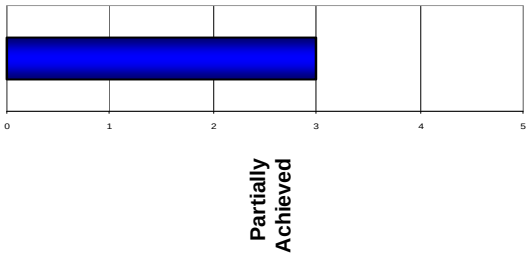
In its self-assessment, the Trust reported that its process for the development, approval, implementation and review of all Trust policies include external public consultation (with affected representative groups, other public authorities, etc), thereby helping to promote ownership of these policies by external stakeholders.

Whilst the Trust has an extensive range of information leaflets specifically designed to inform service users, carers and relatives about their treatment, care and service provision, the consent leaflet entitled “It’s Up to You” is also provided for service users.

4.2.4 Arrangements in Place for Collection, Collation, Development and Use of Health and Social Care Information

This sub-section relates to criterion 7.3 (f)

DHSSPS Quality Standard Criteria - Self assessed score
7.3 (f) The organisation collects, collates, develops and uses health and social care information to assess current and future needs of local populations, taking account of health and social well-being inequalities.



In the self-assessment, the Trust reported that the various factors outlined in the above criterion are embedded within service planning processes. All modernisation programmes have undertaken an analysis, resulting in service redesign which reflected local needs, eg: the Directorate of Mental Health and Disability Services undertook a review of service provision to adults with mental health problems and consequently established community mental health teams that reflected local need.

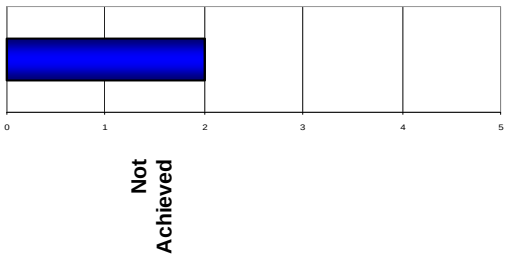
Teams within the Directorate of Primary Care, Emergency Care and Older Peoples Services support the provision of information through robust data collection.

At an operational level, the Trust provided several examples of developments which have taken account of health and social well-being inequalities, but it was not clear from the submission as to how the organisation collected, collated, developed and used health and social care information to assess current and future needs of local populations.

4.2.5 Major Incident and Emergency Planning Policy and Procedures

This sub-section relates to criterion 7.3 (g)

DHSSPS Quality Standard Criteria - Self assessed score
7.3 (g) The organisation has effective and efficient emergency planning processes and co-ordinated response action plans in place, as appropriate, to deal with major incidents or emergency situations and their aftermath. The planning processes and action plans are compliant with Departmental guidance.



In its self-assessment, the Trust reported that it was working to complete an integrated Northern Trust emergency planning policy based on the three legacy Trust policies (Major Incident Plans). A SARS Plan has been developed for the new Northern Trust. Emergency Planning processes are undertaken in co-operation with other emergency services, ie: PSNI, Ambulance and Fire Service and major incident plans policies (from the legacy Trusts) are compliant with Departmental Guidance.

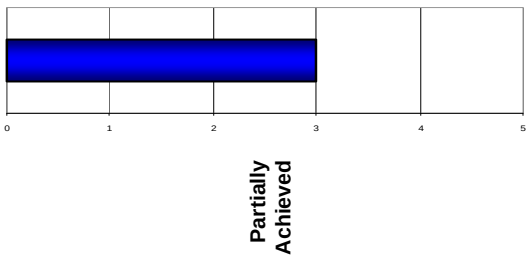
The Trust was asked to provide, as an example, information regarding the planning process for a flu pandemic and the Trust responded by reporting that all directorates comply with the emergency planning policies.

4.2.6 Environmental Health Policies and Procedures

This sub-section relates to criterion 7.3 (h)

DHSSPS Quality Standard Criteria - Self assessed score

7.3 (h) The organisation has processes to engage with other organisations to reduce local environmental health hazards, as appropriate.



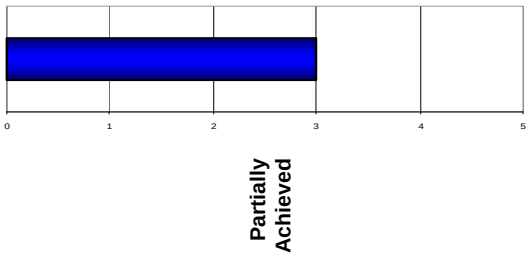
The Trust reported that processes were in place to engage with other organisations to reduce local environmental health hazards in that several facilities across the Trust have been audited and accredited with ISO 14001. In 2008/2009 the Trust plans to roll this programme of ISO 14001 across all sites. An action plan can be evidenced via the Environmental Management Controls Assurance Standard. The Trust works closely with the Environmental Health Department to fulfil requirements to adhere to set standards.

4.2.7 Chronic Disease Management Programmes

This sub-section relates to criterion 7.3 (i)

DHSSPS Quality Standard Criteria - Self assessed score

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



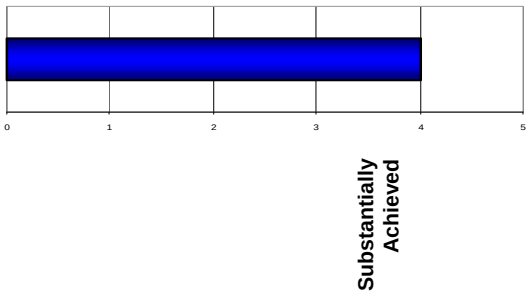
At a corporate level, the Trust stated in its self-assessment that the Trust Health Improvement/Community Development Service was currently under review. Current health promotion/community development programmes included Smoking Cessation and Emergency Life Support in the community. The Trusts 'Living Well - Ageing Better Strategy' 2006-2012 identified provision of services that manage and reduce risk factors of degenerative conditions as an action within 2008-2009. Other examples provided by the Trust included: Condition Management Programme; Breathe Easy Project and Epilepsy Management Programme.

4.2.8 Healthier, Safer, Family Friendly Workforce

This sub-section relates to criterion 7.3 (j)

DHSSPS Quality Standard Criteria - Self assessed score

7.3 (j) The organisation has systems to promote a healthier, safer, and "family friendly" workforce by providing advice, training, support and, as appropriate, services to support staff.



In its self-assessment, the Trust indicated an intention to establish a health and well-being steering group for the Trust which will bring together health and well-being initiatives across the new organisation and ensure continued development through provision of a Health and Well-being Strategy and Action Plan. Liaison has taken place with representatives from Antrim Borough Council to initiate working in partnership in relation to opportunities for health and well-being initiatives aimed at staff, especially fitness initiatives, using council facilities. A no smoking policy has also been implemented across the Trust and the first audit to review its impact was being analysed at the time of the review. The Trust states that it actively consulted with, and involves, staff representatives on a range of issues when drafting human resource policies.

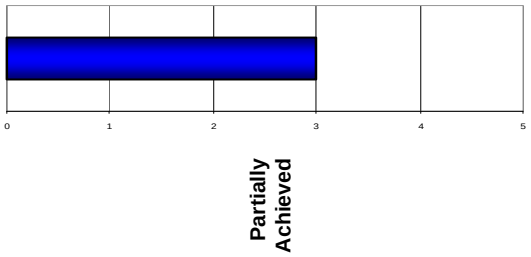
The Trust has senior human resource professionals in place who are responsible for ensuring that it is an employer of choice in terms of work-life balance issues. The Trust has worked with other Trusts and staff organisations to progress policies aimed at improving the workplace for employees eg: harassment, grievance. The Trust's Organisational Development Department provides a range of training and development courses and advice to managers and staff at all levels. All Review of Public Administration (RPA) appointed posts at levels 2–4 have been advertised with flexible working as an option at recruitment stage. The Trust has in place a contract for staff counselling and support with an independent provider organisation, as well as an existing occupational health service which provides for self-referral.

The Trust was asked to provide an example of a 'family friendly' policy with regard to flexible working and the Trust responded by indicating it has legacy policies on term time working and, on an annual basis, operates summer schemes for children of Trust employees.

4.2.9 Screening and Immunisation Programmes

This sub-section relates to criterion 7.3 (k)

DHSSPS Quality Standard Criteria - Self assessed score
7.3 (k) The organisation has quality assured screening and immunisation programmes in place, as appropriate, and promotes active uptake among service users, carers and the public.



The Trust reported in its self-assessment that a range of quality assured screening and immunisation programmes are in place, eg: TB Screening; childhood immunisation; breast screening and cervical screening. The Trust also promotes uptake of the flu programme for the elderly and high risk groups and offers the flu vaccination for staff through its occupational health service.

Active uptake with regard to these programmes is promoted through a variety of measures, namely via the health visiting programme; via close links with GP practices; and via the Northern Health and Social Services Board (NHSSB). At the time of the review work was ongoing with the Department of Health and Social Services and Public Safety (DHSSPS) to agree the implementation of the new Human Papilloma Virus (HPV) (Cervical) immunisation through the school health programme.

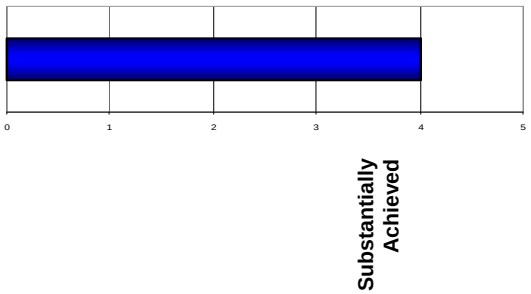
At an operational level, the Trust was asked to provide a response indicating how it is promoting a higher uptake of childhood screening and immunisation programmes.

The Trust responded by stating that this has been undertaken via partnership arrangements with the Public Health Department at the Northern Board, GPs and through the child health information system. Involvement in the NHSSB Immunisation Group has helped to identify key targets and problem areas for attention. Targeting of localities with low uptake has been a priority and relevant information was distributed to parents via leaflets, verbal contact and press releases.

4.2.10 Public Health and Social Care Reports in the Development of Priorities, Planning and Delivery of Services

This sub-section relates to criterion 7.3 (l)

DHSSPS Quality Standard Criteria - Self assessed score
7.3 (l) The organisation uses annual public health and social care reports in the development of priorities and planning the provision and delivery of services.



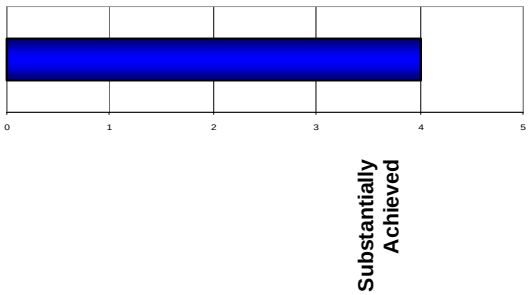
In the Trust's self-assessment, it reported that planning processes reference appropriate strategies including commissioner reports which then influence priorities for the Trust. However, the Trust did not state the nature of these commissioner reports and whether, in particular, these included annual public health and social care reports.

Again, the Trust indicated that any bids for funding must be accompanied by a rationale which refers to policy documents, and whilst the Trust mentioned Board policy documents, it is unclear as to whether the annual public health and social care reports are being referred to.

4.2.11 Use of Volunteers

This sub-section relates to criterion 7.3 (m)

DHSSPS Quality Standard Criteria - Self assessed score
7.3 (m) The organisation provides opportunities for the use of volunteers, as appropriate.



In its self-assessment, the Trust explained that the three legacy Trusts had systems whereby members of the public could apply to volunteer, where appropriate, within the Trust. These systems are still in operation. Examples of volunteering were provided where volunteers support the service at the Villa, Holywell Hospital and also are involved via the Volunteer

Bureau, the Eye Help Desk and the Magilligan Prison Volunteer Scheme within the Directorate of Mental Health and Disability Services.

POCVA checks have been undertaken for volunteers in accordance with the same principles that apply to employee recruitment processes**.**

5 EFFECTIVE COMMUNICATION AND INFORMATION

The DHSSPS Quality Standards cite Theme 5 as: “The HPSS communicates and manages information effectively, to meet the needs of the public, service users and carers, the organisation and its staff, partner organisations and other agencies.”

There are a total of 12 criteria within this theme and the Trust was asked to make a self assessment against these criteria under a level of achievement measure as illustrated in Table 5.

Code	Level of Achievement	Definition
1	Unlikely to be Achieved	The criterion is unlikely to ever be achieved. *(A reason must be stated clearly in the Trust response)*
2	Not Achieved	The criterion is likely to be achieved in full but after March 2008. For example, the Trust has only started to develop a policy and implementation will not take place until after March 2008.
3	Partially Achieved	Work has been progressing satisfactorily and the Trust is likely to have achieved the criterion by March 2008. For example, the Trust has developed a policy and will have completed implementation throughout the Trust by March 2008.
4	Substantially Achieved	A significant proportion of action has been completed to ensure the Trust performance is in line with the criterion. For example, a policy has been developed and implemented but a plan to ensure practice is fully embedded has not yet been put in place.
5	Fully Achieved	Action has been completed that ensures the Trust performance is fully in line with the criterion. For example, a policy has been developed, implemented, monitored and an ongoing programme is in place to review its effectiveness.

TABLE 5

Table 5 (a) illustrates how the Trust has assessed it's own performance against the criteria under the standard of 'Effective Communication and Information'.

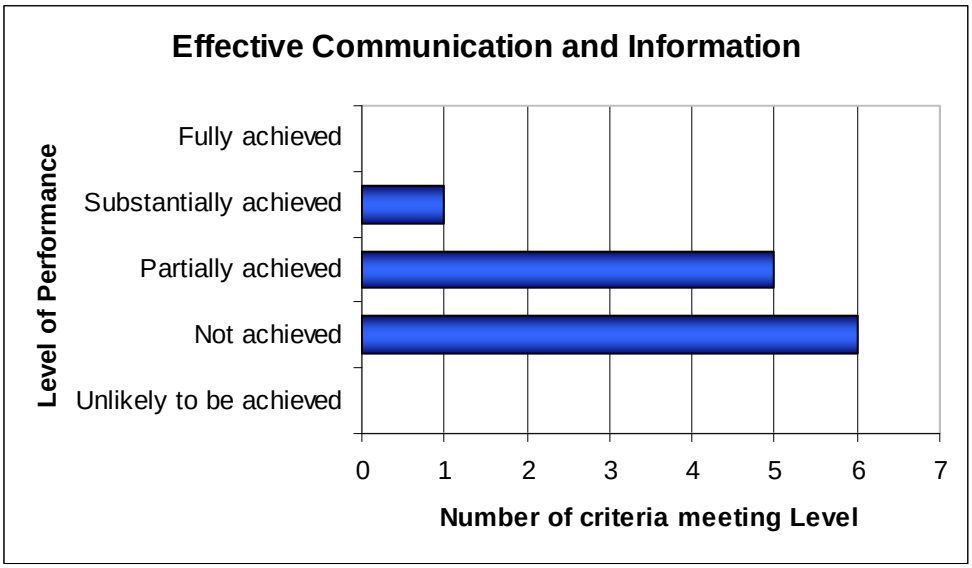


TABLE 5 (a)

The Trust also provided narrative under the headings of:

- Corporate
- Operational
- Personal and Public Involvement

regarding each criterion to describe how it has achieved the stated Level of Achievement.

5.1 CRITERIA EXAMINED BY REVIEW TEAM

The RQIA selected two specific criteria within this standard for review teams to examine and substantiate the Trust's submission. The findings in this section are based on the information provided by Trusts in their self-assessment submission and on observations made by, and views expressed to, the members of the review team during visits. Areas visited are listed in Appendix (iii) of this report.

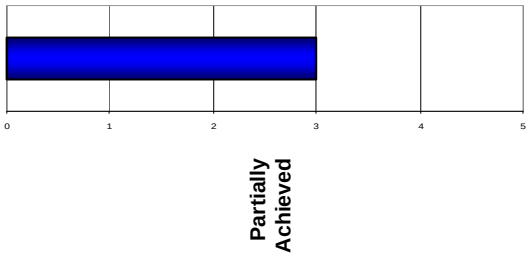
The criteria in this section includes:

- 8.3 (a) - Participation of Service Users and Carers and the Public
- 8.3 (g) - Effective Training in Communication

5.1.1 Participation of Service Users and Carers and the Public

This sub-section relates to criterion 8.3 (a).

DHSSPS Quality Standard Criteria - Self assessed score
8.3 (a) The organisation has active participation of service users and carers and the wider public. This includes feedback mechanisms appropriate to the needs of individual service users and the public.



The Northern Trust's Corporate Plan 2007-2010 cited the following as one of its Core Values:

1. Engagement
"A culture of engagement with patients, clients, carers and their nominated representatives will be fostered."

The Trust also stated that two of its Corporate Goals under the titles of Safer, Better Quality Services (4.2) and Personal & Public Involvement (6.6) would be "*to also engage with service users to continually improve services"* (4.2) and *"to work together with local communities and service users to improve the quality, safety and effectiveness of services in the Trust by:*

- *Development and implementation of Personal and Public Involvement (PPI) Strategy*
- *Development of an external communication strategy*
- *Development of peer advocacy services through public representatives for mental health*
- *Maintenance and support of the Disability Consultation Panel"*

Various initiatives of how the Trust is encouraging active participation were noted in the Trust's self-assessment submission.

In its Service Delivery Plan 2007/08, the Trust stated a commitment to deliver safer better quality services and indicated that it will engage actively with service users to continually improve the services it delivers. The Trust also cited its commitment to working across all sectors to ensure local communities are engaged in identifying opportunities to improve and protect their health. The new organisation intends to build on the work of the legacy Trusts to develop a Public Involvement Strategy that puts users at the centre of decision-making and care and stated that it will continue to build the capacity of staff to integrate community development approaches into current work practices.

In the Plan, the Trust identified several measures to be undertaken to assess user experience in terms of the level, quality and method of delivery of services. These included:

- Lessons learned from complaints
- Patient/user questionnaires
- Suggestion boxes
- Consulting users/public on a range of issues
- One to one discussions
- Focus groups
- Participation of users on a number of groups within the Trust and The Acute Hospital Complaints Forum

The draft communications strategy also enlists the core values of: engagement; openness and honesty; and respect for others through some of its objectives.

In particular, for the target group service users, the Trust stated that it will consult with service users on communications principles and seek feedback from service users through complaints/compliments and a dedicated email address.

Active Participation

The Trust was asked specifically to describe how it promotes and supports service user and carer involvement. The following is the Trust's response:

User and carer involvement is promoted through the Trust's Corporate Plan and involvement of service user representatives in the governance structures of the Trust, as well as at an operational level in the directorates. Mental health services have user/carer representatives involved in operational management meetings and policy groups and users have had significant involvement in the three service strategies developed and approved by Trust Board. A Public and Personal Involvement Group has been established to develop the Trust's Strategy.

Various methods are utilised, to include:

- Staff Training Programme
- Partnership in assessment, care planning and review
- Patient Advisory Group
- Disability Advisory Group
- Equality Impact Assessments
- Community Development
- User Surveys

During their meeting with Trust senior executives, it was reported that the Trust was in the early stages of establishing structures and processes to aid active participation of users, carers and the public at a strategic level. This area was progressed to a larger extent within legacy Trusts and several areas of good practice from these organisations have been identified whereby the Trust intends to build upon these foundations to ensure that all service needs are incorporated.

User participation within the individual service areas was ongoing with focus groups and systems for involving users in mental health services, for example, and in particular, the Disability Panel which was originally set up by Homefirst legacy Trust.

AREA OF GOOD PRACTICE: The Trust Chief Executive has proactively developed connections with Members of the Local Assembly (MLAs) and local council representatives and, in the case of a complaint being made to the Trust, face-to-face meetings with users, their MLA/local representative and the Chief Executive are facilitated.

In the areas visited, the review team found evidence of good examples of active user participation which are continuing to be progressed.

In the Rheumatology Outpatients Clinic in Causeway Hospital, one of the consultants in the department is involved in support groups and the appointment of a second Rheumatology Nurse Specialist brings with it the opportunity for focus group development.

Feedback from an operational manager corroborated what senior executives had indicated which was a need to further examine active participation of those with specific needs and the Dementia Project was noted as an example of how the Trust was beginning to address this. Staff acknowledged that proactively involving service users is an area in which work needs to be progressed.

In the Diabetic Outpatients Clinic staff who spoke to reviewers cited some examples of active user participation within the department that included a diabetic service meeting (which is held monthly and which has had user representation for several years) and a Diabetic Support Group with user representation which had been successful in helping to secure additional clinics for patients. An information booklet entitled “Hearty Voices” a British Heart Foundation publication was identified by staff as a good resource and detailed specific service user training on how to be an active user and how to develop effective influencing skills.

Following discussion with clients, reviewers found an untapped resource in involving service users and harnessing their views and comments. One of the service users spoken to outlined a few suggestions for improvement in terms of effective communication and information and, as a new patient, would have appreciated having an information pack with contact numbers being made available to him. Other service users felt it would be helpful to have more information online via the Trust website with a Frequently Asked Questions (FAQ) section on specific conditions and a two-way feedback process via email.

RECOMMENDATION 11:

The Trust should harness views from service users and carers across all directorates whilst progressing its work in service user involvement.

In the Stroke Unit in Braid Valley Hospital, staff who spoke with reviewers recognised the need to involve service users more and cited a few examples of active participation such as the establishment of the Older Services People Panel and a workshop which had been held during February to develop a response to the stroke strategy. This Workshop had attracted good representation from users and had provided a strong message for the need for patients, their carers and relatives to be involved more, especially the young stroke patients to take account of employment and behavioural issues.

Community nursing staff in Slemish community services displayed an awareness of initiatives currently ongoing to involve users within the Trust and they also acknowledged that this area is a challenge for the new Trust. Due to the nature of their work, these nurses engage with service users on a one-to-one basis and found this to be effective in terms of two-way communication.

The Wilson Home Day Centre in Broughshane is a day care facility, well adapted to suit the services currently provided. It boasts a pleasant outside environment where service users have contributed to the enhancement of the gardens. There is access to numerous activities, eg: computer skills, art, etc, and reviewers were told of liaison with external educational establishments. The Centre plays a strong role in the local community with regard to the annual floral competition.

Staff are committed and dedicated and help to encourage both service users and the community to interact with each other. The arrival of an enthusiastic and innovative manager in recent months has introduced new ways of working which both staff and service users commended.

Reviewers were encouraged to evidence several initiatives underway to actively involve service users. The review team spoke with service users who gave examples of these new initiatives which had been introduced in recent months. Examples included the inclusion of the key worker and manager in home assessments where the user would also have the opportunity to visit the Centre prior to admission. Various activities had been introduced to suit individual needs, which users were keen should continue, for example, a workshop to facilitate woodcraft had been set up.

Staff reported that activities are purpose-led and integrated into community events as far as possible, eg: sale of work at Christmas. Reviewers evidenced a good link into the local community and noted the example of the centre providing hanging flower baskets for the annual floral competition. Service users and staff reported a more relaxed approach with service users over recent months, providing them with a greater voice in choice of activity and in choice of equipment.

As noted previously, it was recognised by senior executives that more work needs to be undertaken in the area of active user participation and a Trust-wide approach initiated to involve users and carers, not only in general, but also those with specific needs. The review team confirmed that, whilst there was some evidence of active user participation throughout the areas visited, there was also an ethos amongst staff and management to involve users more.

Feedback Mechanisms

In its self-assessment, the Trust reported that it has established a user feedback committee which is chaired by a non-executive director and users are members of this Committee. The user feedback committee, on behalf of the Trust Board, seeks assurance that complaints and other forms of user feedback are managed in line with best practice, and informs service improvements and business decisions. The scope of the Committee includes the Trust's Complaints Procedure and the Children's Order Complaints Procedure. Patient feedback

cards/surveys (legacy Trusts) are distributed to wards/departments and this was being reviewed to merge as one Northern Trust patient feedback process.

The Trust listed various methods and mechanisms for obtaining feedback and in particular for obtaining the views of service users and carers on the quality of services provided. The Trust stated that community services provided users with a leaflet seeking views/feedback on services throughout the Trust. This included complaints as well as suggestions/comments. A mapping exercise has been carried out to identify the patient survey activity in hospitals and community services. A group chaired by the Trust's Chairman has been identified to develop the work of patient experience within the Trust. All hospital patients have a survey form given to them and a commissioned hospital survey was carried out in Causeway Hospital in 2006.

Other mechanisms were stated as being in place throughout the directorates, which included:

- Complaints, comments process
- Audits
- Reviews
- Advocacy Service
- Service User Satisfaction Surveys
- Complaints review/action planning
- Root Cause Analysis
- Incidents Sub Group
- Staff feedback
- Directorate Governance Meetings

The Trust also identified learning from complaints at directorate level which has been shared to improve practice. The Trust's Complaint's Procedure was being reviewed and central collation of learning will be part of this procedure.

When questioned about feedback mechanisms, senior executives focused in the main on complaints and explained that the Trust adheres to relevant guidance from the DHSSPS and is currently meeting the Departmental targets. The Chief Executive "signs off" all complaints and directors are provided with copies of relevant cases. The Datix System has been integrated on a Trust-wide basis and stores information relating to complaints, claims, incidents and risk management.

In the case of serious adverse incidents, patients and families are involved at an early stage and this contact is maintained throughout the process while reports are awaited. Senior Executives explained that the Trust is not insular in its approach and takes the opportunity to take note and learn from what is happening on a regional basis.

There were also systems being established to provide feedback both from:

- STAFF - who will be able to use the new "U-Talk System" - a scheme for staff to provide comments to senior management via email. The comments will be sent to the Chief Executive and can be anonymised should the member of staff wish this. The Scheme is new and will be launched during March 2008 to all staff within the Trust.

and

- SERVICE USERS/CARERS/MEMBERS OF THE PUBLIC - any compliments provided are directed to the Senior Executive Team to include the Chief Executive and are also fed

In areas visited, when questioned about feedback mechanisms, the complaints process was highlighted by staff in the main and staff reported that complaints were examined and learning gathered in ways to facilitate positive change. Staff in the Outpatients Clinics at Causeway Hospital said that one-to-one appointments, as appropriate, as well as a written response to complaints, were offered.

The review team found a strong reliance upon complaints as a feedback mechanism with a few other methods being utilised to support this.

RECOMMENDATION 12:

The Trust should review all of its feedback mechanisms to ensure these are being utilised fully.

Service users interviewed at the Outpatients Clinic in Causeway Hospital indicated that they had never been asked to provide their views/opinions/comments on Trust services, but highlighted that they would be keen to offer these, if approached. The review team found no evidence of patient satisfaction surveys. Nevertheless, correspondence from management regarding a compliment from a patient had been fed back to staff and displayed on a noticeboard.

In Causeway Hospital, a suggestion box scheme was also cited as a method of obtaining feedback from service users – although the issues raised and being dealt with were mainly within the areas of hospitality and car parking. Upon examination of the suggestion box in the Hospital's Main Reception Area, no feedback cards were available to make comment nor were staff aware of how to obtain these, when asked.

Reviewers were able to evidence in several places visited, that the monthly update letter sent from the Trust Chief Executive was welcomed by staff who felt it to be both informative and effective.

In the Stroke Unit at Braid Valley Hospital reviewers found that feedback cards to capture user's compliments and complaints were used. Staff recognised the heavy reliance on feedback cards and there was an acknowledgement of the need to examine other methods of feedback as well. Although staff referred to suggestion boxes, reviewers were unable to evidence these on the ward. Staff in the Unit reported that the proactive approach to complaints whereby the Trust will endeavour to resolve these at a local level and learning from complaints has been shared at the Senior Manager's meeting.

The complaints process was cited as an effective feedback mechanism by community nursing staff at Slemish community services and changes to improve practice had been made as a result of this. For example, more suitable times for the treatment room had been implemented, as had a change in the provision of continence pads. Team meetings were used to ensure issues are fed back and shared within the team context and then escalated to management, if necessary. There was also a strong ethos of sharing the learning from

serious adverse incidents within nursing – both within the team and across the wider Trust. Staff indicated that all patients have been given “Your Views Matter” leaflet with regard to complaints and suggestions, etc.

Service users spoken to at the Wilson Home Day Centre were not aware of a formal complaints procedure nor of formal mechanisms for feedback. They were, however, able to outline mechanisms whereby concerns could be raised with a key worker. Reviews were also in place and these provide opportunity for both carers and family to give feedback. Although management indicated the availability of a suggestion box, service users were not aware of this.

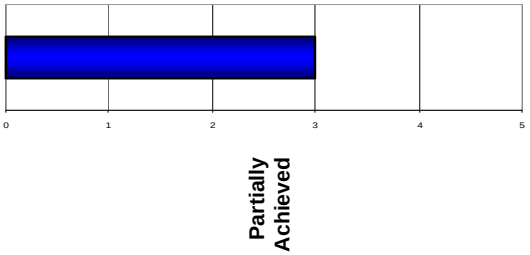
In the Chemotherapy/Cancer Unit in Laurel House, Antrim Hospital, comment books were available in both waiting areas and reviewed by staff twice a week. Both appeared to be well used. Staff reported that patient satisfaction surveys were undertaken yearly, and a group meets to review these. Staff felt patients had made a valuable contribution to improvements in the service and staff appeared sensitive to patient views.

Reviewers were in agreement that the Trust's self-assessment score of "partially achieved" accurately reflected the partial achievement of this criterion.

5.1.2 Effective Training in Communication

This sub-section relates to criterion 8.3 (g).

DHSSPS Quality Standard Criteria - Self assessed score
8.3 (g) The organisation has effective training for staff on how to communicate with service users and carers and, where needed, the public and the media.



In the Northern Trust’s Corporate Plan 2007-2010 learning is noted as one the Trust’s Core Values, in that it states:

> *“We will promote life long learning and will make sure that staff are supported through a process of continuing professional development linked to appraisal.”*

The Trust’s Delivery Plan 2007/08 also outlines that “*The Trust will continue to actively support learning in the workplace ensuring that its workforce, professional and non-professional, is equipped with appropriate and relevant qualifications, knowledge and skills*.”

The Trust was requested to provide a copy of the Trust-wide Training & Development Strategy and, where a final document was not available, to submit the current draft document

or action plan. The Trust's draft Human Resources Strategy 2007-2012 was submitted as evidence.

In the introduction to this document, it is stated that staff will be able to apply *"the right skills in the right way at the right time".* The Trust stated that the Knowledge and Skills Framework (KSF), developed under Agenda for Change, will provide a guiding framework for the development of staff to meet the changing needs of health and social care and the needs of patients and clients will ultimately guide what is required of the workforce.

The strategy also stated that lifelong learning and development for staff in the Trust is key to delivering a modern patient and client focused service and it detailed an action plan with timescales and a lead person responsible and an annual learning and development plan; implementation of KSF; e-learning strategy; identification of training needs; evaluation of training/development; training database; etc.

The Trust also submitted a copy of its Annual Learning and Development Plan and reviewers commended this document which includes a directory of courses linked to the Knowledge Skills Framework (KSF) and individual courses which incorporate communication skills.

Effective Training in how to Communicate with Service Users/Carers

The Trust's self-assessment submission gave examples of training currently undertaken in how to communicate with service users/carers within various directorates.

The Trust reported that training in communications skills required by staff was identified in various ways such as via an annual training needs analysis and the performance review process; via annual commissioning plans and management/staff feedback and the knowledge and skills framework.

Evaluation of this type of training has taken place via different methods to include feedback from participants, supervision, evaluation and observation.

The Trust's draft communication strategy highlights various methods throughout in the form of action plans to aid the external communication process and, in particular, for the target group service users, and stated that training will be designed for front line staff communicating with service users.

At a meeting with Trust senior executives, it was reported that training in communication skills has been identified within the Trust's Training Plan, although it is acknowledged that a consistent approach to identifying gaps in training or undertaking training needs analysis is required. Reviewers commended the Trust on its Training Plan and the associated links with the KSF Framework.

Reviewers were assured that, when introducing a new policy or procedure within the Trust, implications for training are always considered. Senior executives confirmed that training in communications skills was identified by line managers through staff appraisals, whilst medical staff use a variety of methods to determine training needs in this area to include: feedback from colleagues, appraisal systems and learning from complaints which highlight issues in communication.

During their visits around specific sites in the Northern Trust, the review team evidenced how training needs were identified as well as the range of training in communication skills available.

Identification of Training Needs in Communications Skills
In the Rheumatology Outpatients Clinic in Causeway Hospital staff explained that the issue of communication has been addressed via staff appraisal systems. However, they did point out that if a member of staff was noted to be having difficulty in communicating with service users/carers, line managers would address this by providing appropriate training. In the Stroke Unit, Braid Valley Hospital, staff appraisal was used to identify training needs and it was reported that training needs will be assessed to take into account the Knowledge Skills Framework (KSF).

Within the community nursing services based at Slemish community services on the Braid Valley site, the review team found evidence of an appraisal system which encompasses a two-way identification of training needs. Staff reported that they had no difficulty in accessing training and acquiring time away from their routine duties to accommodate this. They also agreed that there was a proactive approach in identifying specialist training needs to meet individual specialist complex nursing needs.

In the Wilson Home Day Centre in Broughshane both staff appraisal and staff supervision has been used to identify training needs and training can be accessed through the Trust Training Course Directory. Staff reported that they found no difficulty in being released to attend training.

During the visit, reviewers found that identification of training needs in communication skills relies heavily on staff supervision and staff appraisal, as had already been affirmed by Trust senior executives, as had the acknowledgement of the need for a consistent approach to identifying gaps in training or undertaking a training needs analysis.

Types of Training
Staff in the Diabetic Outpatients Clinic in Causeway Hospital pointed out that it had been recognised that different communication skills were needed when a member of staff worked on the wards as opposed to in the Outpatients Department. Reviewers were told that specific training, and tailoring of training to meet the needs of staff, was in operation and this would be addressed in the induction process with staff.

The Stroke Unit in Braid Valley Hospital has taken a strategic approach in this area in that the Head of Education in the Trust has helped to develop links to the Acute Dementia Education Training Project. This project is in operation in England and Scotland and it has been agreed that the Trust should become a pilot site. The programme will run over a 2-day period and 15 places are available to include the medical, nursing and allied health professionals (AHP) disciplines. The Trust was identifying members of staff who may find this relevant.

Community nurses in the Slemish Community Centre reported that a staff nurse development programme will be in place from April 2008. This programme was developed via focus group

work with staff nurses and a similar approach will be taken with Healthcare Assistants. This programme will include communications skills as part of its content.

In the Wilson Home Day Centre, Broughshane, reviewers found that an opportunity had been afforded for a member of staff to enhance their professional development by experiencing the working environment in another day centre. This was seen as a proactive way by which communication skills could be enhanced and reviewers commended this practice.

Whilst specific examples of training methods were provided to reviewers by staff, there was no substantial evidence provided to consolidate how effective this training had been.

RECOMMENDATION 13:

The Trust should now develop a corporate approach to training in communication skills to include a process for identifying relevant staff requiring training and a robust mechanism to evaluate how effective the training has been.

Communication with Service Users and Carers

Overall, the review team evidenced examples of good communication with service users, carers and relatives.

In the Diabetic and Rheumatology Outpatients Clinics in Causeway Hospital there was a personalised quality service in terms of providing information to, and communicating with, service users and carers. In the Rheumatology Clinic, reviewers were told of an incident which took place involving a patient with sickle cell disease where a member of staff was able to gain further knowledge and understanding of the disease by direct contact with the patient. This had resulted in training being tailored to enable to staff to communicate with patients with this specific disease.

Community nurses on the Braid Valley site explained that communication with service users/carers is intrinsic within this team and their way of working, and reviewers noted that a cluster system had been set up that was linked to GP practices which helped to facilitate and contribute to good communication.

As part of the communication process in operation in the Stroke Unit at Braid Valley Hospital, every patient received a communication questionnaire as part of the patient assessment. This included subject areas such as hobbies, etc and the questionnaire was shared across all disciplines which helped to further facilitate communication with the patient and build upon the rapport between staff and service user. Reviewers had the opportunity to speak with service users and their carers in this unit and it was reported that they felt fully informed and there was in place a key nurse who is able to provide all the necessary information and with whom any concerns or issues could be raised.

Effective Training in how to Communicate with the Media

In its submission, the Trust reported that training in communicating with the media had been identified in its draft Communications Strategy with a roll-out programme listed. The Chief Executive and relevant directors had received this training.

In terms of communicating with the public and the media, the draft Communications Strategy states that the following will be used: briefings, pro-active communications, reactive communications and actions will be undertaken to progress this such as:

- Develop database of all media
- Set up rolling process to brief all key journalists
- Develop, through the Communications Group, an annual timetable of features/good news stories which reflect the themes in the corporate plan and which can be distributed to the local, regional and national media on a weekly basis
- Develop process to ensure timely and accurate responses to all media enquiries
- Identify and train a panel of experts within the Trust to respond to operational media issues
- Media training to be rolled out to all relevant staff

During the visit, senior executives confirmed to reviewers that a programme of effective training in how to communicate with the media was being rolled out and relevant staff requiring training were being identified. Directors had undertaken media training which had subsequently been evaluated and any gaps highlighted. This had then been tailored to ensure these gaps are covered and any experiences of recent media contact was used to help inform re-training. The Trust reported that the panel of experts presently being set up should go some way to help enable the Trust to react quickly to media queries and to proactively promote positive messages.

The Trust was also identifying individual “experts” within particular areas, eg: those expert in *C. Difficile* or fostering, who would be responsible for briefing staff before interviews with the media. Senior executives also reported that work was underway to ensure liaison is in place via the DHSSPS and other Trusts to identify experts throughout Northern Ireland who could be approached to give a balanced view on media issues. Both of these initiatives were commended by reviewers as strengths.

In those areas visited by the review team, robust evidence was found that staff have a good knowledge and are aware of relevant protocols for handling the media and adhere to these. In general, staff interviewed were aware of what to do when a media situation arises and this included being approached informally by the media. Staff would ensure the person’s identification is checked and no information would be given out. The media contact would then be referred immediately to the Communications Department.

Reviewers were in agreement that the Trust's self-assessment score of "partially achieved" accurately reflected the partial achievement of this criterion.

5.2 CRITERIA EXAMINED THROUGH TRUST SELF-ASSESSMENT

This section reports on the information provided by Trusts in their self-assessment submission.

The criteria in this section includes:

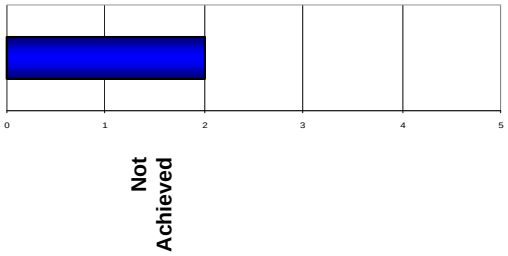
- 8.3 (b) - Information and Communication Strategy
- 8.3 (c) - IT and Information Systems
- 8.3 (d) - Urgent Communications, Safety Alerts and Notices, Standards and Good Practice Guidance
- 8.3 (e) - Communication Principles
- 8.3 (f) - Information Principles
- 8.3 (h) - Records Management
- 8.3 (i) - Protecting Information
- 8.3 (j) - Consent Procedures
- 8.3 (k) - Complaints and Representation Procedures
- 8.3 (l) - Published Information

5.2.1 Information and Communication Strategy

This sub-section relates to criterion 8.3 (b).

DHSSPS Quality Standard Criteria - Self assessed score

8.3 (b) The organisation has an effective information strategy and communication strategy, appropriate to the needs of the public, service users and carers, staff and the size, functions and complexity of the organisation.



Information Strategy

The Trust did not submit its Information Communications Technology (ICT) Strategy, but stated that it was under development.

In establishing its organisational structure, the Trust reported that it has opted for an integrated informatics function encompassing information technology, information and records management and information systems programme management. Such a structure supports a cohesive and integrated approach to the development of information technology and information systems.

The Trust is, to a large extent, following the Regional ICT Strategy (March 2005) and the Regional Programme which clearly prioritises the development of technology that will benefit patients and clients. The Trust's work programme for the year demonstrated a commitment to the improvement of services to patient and clients through ICT and to the harmonisation of its systems across the new organisation.

Communication Strategy

The Trust submitted a draft Communications Strategy (2008-2010) as well as terms of reference for the Trust's Communications Project Group. This group is chaired by a non-executive director and its membership represents all areas of the Trust. The group reports on a quarterly basis to the Trust Board and, in the main, its role and remit is to ensure a strategic approach to internal and external communications within the Trust, which supports the business objectives of the organisation and embraces its values. A particular objective is that of developing, implementing and evaluating a Corporate Communications Strategy.

The three-year Strategy submitted had been developed using an all-inclusive process and was due to be rolled-out during March 2008. The document sets out a vision for communications within the Northern Health and Social Care Trust and it reinforces the Trust's commitment to being an open and honest organisation engaged in a two way process of communication.

The core values of: engagement; openness and honesty; and respect for others particularly support this Communications Strategy and its aim is to ensure that there are mechanisms in place to support and maintain the Trust's relationships with organisations and individuals both inside and outside the organisation who can have an influence on how the business is done. It outlines the communications channels which will be used and cites various legislation which has been used to inform it. Aims and objectives are outlined and key messages for specific audiences identified. The strategy will be evaluated annually against agreed objectives.

There are various communications activities included throughout the document in the form of two action plans (external and internal) to aid the communication process over the next three-year period. The plans indicate the action necessary to implement the communication activity identified to meet the varying needs of its target groups and have the scope to add those responsible and the action required and taken during years one, two and three.

RECOMMENDATION 14:

The Trust should ensure that both the draft ICT Strategy and the draft Communications Strategy are finalised as soon as possible and progress their implementation within the current financial year.

During the review visit, two areas of good practice were noted, namely:

AREA OF GOOD PRACTICE: During the visit, a strength noted by the review team was with regard to a general progress update on Trust-wide issues, whereby the Chief Executive sends a letter to staffs' home addresses on a monthly basis. This letter is also posted on the Trust intranet. Staff spoken with during the review visit agreed that this communication was useful and the review team commended this practice.

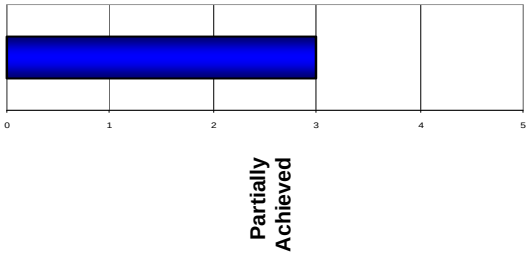
AREA OF GOOD PRACTICE: The Diabetic Nurse Specialist uses the system of a patient hand-held diary which enables notes to be added on a regular basis both by nurse specialist and patient and thus aids good communication.

5.2.2 IT and Information Systems

This sub-section relates to criterion 8.3 (c).

DHSSPS Quality Standard Criteria - Self assessed score

8.3 (c) The organisation has effective and integrated information technology and information systems which support and enhance the quality and safety of care and provision of services.



In its self-assessment, the Trust reported that information systems which support the services delivered in acute hospital settings are, in the main, integrated although there is now work to be done to merge like systems from the Legacy Trusts.

During 2007/2008 a range of systems have been implemented/improved in support of patient and client care. These included systems for accident and emergency, genito-urinary medicine, allied health professionals, theatre management and the implementation of the UNOCINI Assessment. A number of these systems are now integral to the functioning of departments. There are also plans to roll-out a range of systems currently used to support service delivery in parts of the organisation on a Trust-wide basis. Examples include the Diabetic System and the EPICS (Pharmacy) System. Patients are benefiting directly from the improved management of services in areas where systems support real-time operations, eg: Accidence and Emergency Departments, Theatres, etc.

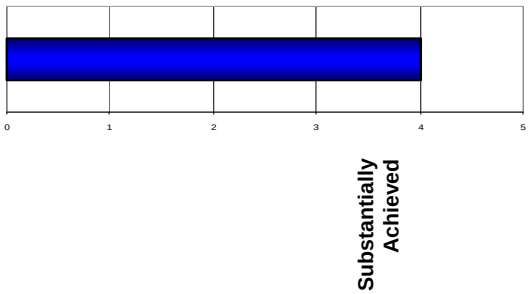
The Trust's work programme for the year demonstrated a commitment to the improvement of services to patients and clients through ICT and to the harmonisation of its systems across the new organisation.

5.2.3 Urgent Communications, Safety Alerts and Notices, Standards and Good Practice Guidance

This sub-section relates to criterion 8.3 (d).

DHSSPS Quality Standard Criteria - Self assessed score

8.3 (d) The organisation has systems and processes in place to ensure that urgent communications, safety alerts and notices, standards and good practice guidance are made available in a timely manner to relevant staff and partner organisations; these are monitored to ensure effectiveness.



In its self-assessment, the Trust reported that it has systems in place to ensure urgent communications, safety alerts, notices, standards and circulars, etc, are made available in a timely manner through the Chief Executive Officer's (CEO) office and Estates Department (NIAIC), and are circulated directly to directors and the Governance Department for action. Currently the Trust has a manual system in place and plans to move to an electronic system in April 2008.

At an operational level, there has been an increase in the use of information technology, eg: email being used to circulate alerts. The Trust gave an example of how this process operates within the Directorate of Children's and Women's Services in that IT is increasingly used and systems are gradually improving following the Trust re-structuring.

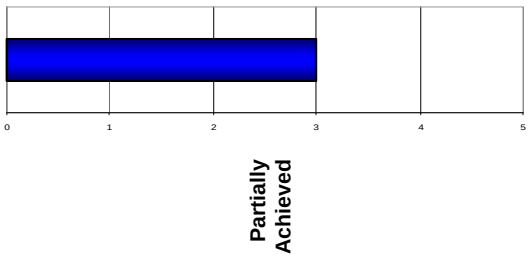
5.2.4 Communication Principles

This sub-section relates to criterion 8.3 (e).

DHSSPS Quality Standard Criteria - Self assessed score

8.3 (e) The organisation has clear communication principles for staff and service users, which include:

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



In September 2007 the Trust Board approved the Trust's Organisation Development Plan and a framework for managers based on the 12 key values adopted by the Trust. Those values

included: openness and honesty; patient/client centred; respect for others and engagement. A framework 'Living the Values' also identified the indicative behaviours (in keeping with the values as outlined above) which all levels of management are expected to display. At an operational level, each directorate was preparing an action plan based on this 'Living the Values' framework in order to give life to the values and this will be cascaded down through the directorates. The Trust stated that its organisational principles are complemented by professional standards.

The draft Trust Communications Strategy (2008-2010) also outlined the principles underpinning the Trust's communications process which state that communications should be:

- Targeted
- Timely
- Two-way
- Appropriate
- Accurate
- Easily Understood
- Accessible
- Up-to-Date
- Those which respect confidentiality and which
- Promote Mutual Respect

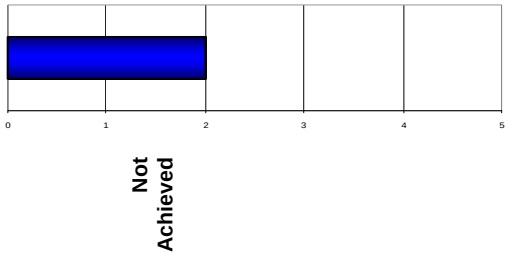
5.2.5 Information Principles

This sub-section relates to criterion 8.3 (f).

DHSSPS Quality Standard Criteria - Self assessed score

8.3 (f) The organisation has clear information principles for staff and service users, which include:

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



The Trust's submission stated that the principles as mentioned in the criterion above are also clearly presented in the Regional ICT Strategy which the Trust follows and are implicit within the Trust's approach to the delivery of informatics services. A number of similar principles underpin the organisational structures for the informatics function and the Trust has taken forward a significant work programme in support of the aforementioned principles in parallel with establishing new structures and maintaining routine information and ICT services.

In terms of security and confidentiality of information and the appropriate sharing of personal information, this has been prioritised in the development of policies and procedures to include:

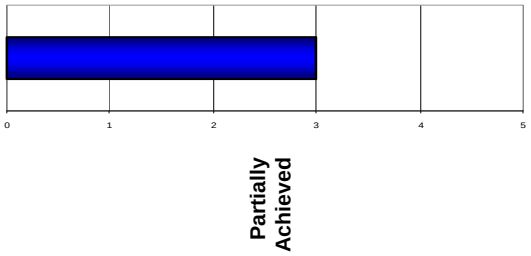
- Draft Policy and Procedures on Processing Personal Information
- Draft Information Security Policy
- Server, Desktop and Portable Computing/Teleworking Security Policy

The European Computer Driving Licence (ECDL) Health Module has recently been evaluated and found that it could be used as a training tool to raise awareness and provide education of these information principles. It is intended that, subject to Senior Management Team approval, this training will become mandatory with all users completing the course in the next 12-24 months.

5.2.6 Records Management

This sub-section relates to criterion 8.3 (h)

DHSSPS Quality Standard Criteria - Self assessed score
8.3 (h) The organisation has effective records management policies and procedures covering access and the completion, use, storage, retrieval and safe disposal of records, which it monitors to assure compliance and takes account of Freedom of Information legislation.



The Trust's Records Management Policy was in draft form when the Trust submitted its self-assessment. Elements of good records management practice are contained within the draft Policy and Procedures on Processing of Personal Information, on Making Information Available to the Public and in other documents extant in legacy Trusts. A Trust-wide Records Management Project was to be established early in the 2008/2009 year with a view to establishing good practice on a Trust-wide basis and ensuring standardisation, as well as the development of a corporate file plan. Extant policy and procedures from the legacy Trusts continue to be used until such time as their harmonisation is complete.

The Trust had clearly incorporated responsibility for records management into the informatics organisational structure (eg: Head of Information and Records, Information and Records Managers, information governance function). Compliance with the Records Management Controls Assurance Standard is monitored annually and in terms of safe disposal of records, the services of an accredited company are used.

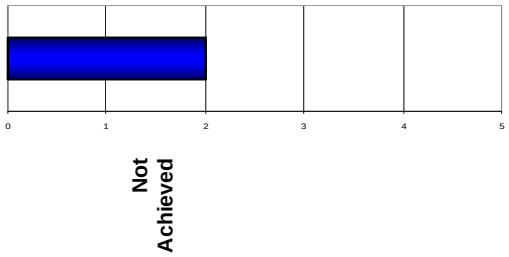
There was a clear process, centrally managed, for the entire Trust in relation to the management of requests for information under the Freedom of Information Act. All requests are logged and tracked using the Datix Risk Management System. The Trust stated that, in general, it is meeting the requirements of the Freedom of Information Act in relation to requests for information from the public.

5.2.7 Protecting Information

This sub-section relates to criterion 8.3 (i).

DHSSPS Quality Standard Criteria - Self assessed score

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



In its self-assessment, the Trust stated that its draft policy and associated procedures for processing personal information is in accordance with the above-mentioned criterion. A training programme will be established when these documents are finalised.

However, at the time of the submission of the self-assessment, the Trust continued to operate under the legacy Trusts' Data Protection Policies which cover management of records, electronic data and staff duty of confidentiality. In 2008/2009 the Trust Policy will be merged and audited. In all Directorates staff must adhere to the Trust's Confidentiality Policy and Records Management Policy.

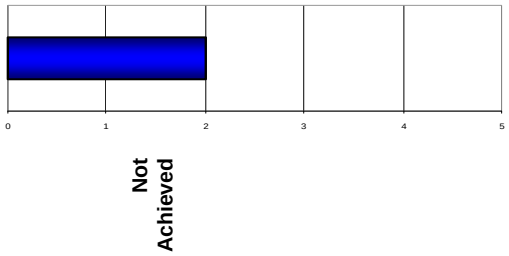
The legacy Trusts had been de-registered and the new Trust registered under the Data Protection Act as required by that legislation and the Trust had also signed information sharing protocols with a number of partner organisations such as the PSNI.

5.2.8 Consent Procedures

This sub-section relates to criterion 8.3 (j).

DHSSPS Quality Standard Criteria - Self assessed score

8.3 (j) The organisation has effective and efficient procedures for obtaining valid consent for examination, treatment and/or care.



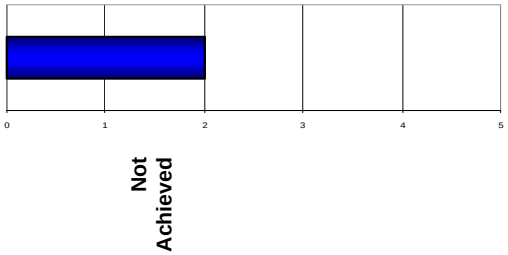
The consent issue is also examined in this report within Section 3.1.3 under the theme Accessible, Flexible and Responsive Services and cross-references the DHSSPS Quality Standard 6.3.2 (b).

The Trust reported in its submission that the three legacy Trusts adhered to the Regional Consent Guidelines and the new Trust is currently reviewing these legacy policies on consent. A Trust Consent Working Group has been established and met for the first time in February 2008 with the aim to review, develop and implement a Northern Trust Consent Policy and implement the recommendations of the Regional Consent Audit. It is intended that this working group will also develop a Trust-wide training programme on consent and will build upon the consent training provided as part of the induction process within the legacy Trusts. A further part of the remit of this working group will be to set up a rolling audit programme.

The Trust reported that staff are trained on consent issues and the use of information leaflets also enables service users to make informed decisions and choices with regard to their treatment and care. The Trust also provides advocacy services to support service users whilst making decisions.

5.2.9 Complaints and Representation Procedures

This sub-section relates to criterion 8.3 (k).

DHSSPS Quality Standard Criteria - Self assessed score	
8.3 (k) The organisation has an effective complaints and representation procedure and feedback arrangements, which is made available to service users, carers and staff and which is used to inform and improve care, treatment and service delivery.	

The issue of feedback arrangements is also examined within this report in Section 5.1.1 and cross-references the DHSSPS Quality Standard 8.3 (a).

The Trust reported that an interim procedure approved by the Senior Management Team is in place for the management of various forms of service user feedback to include complaints, enquiries and compliments. A new policy and procedure was under development for implementation during April 2008. Information regarding the complaints process is available for service users and carers and detailed quarterly reports are currently produced to inform directors, senior managers and other staff in order to help improve care.

A Service User Feedback Committee has been established and has user representation from the Northern Health and Social Services Council. The Committee's terms of reference are

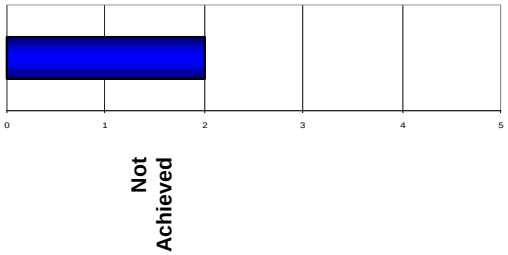
wide-ranging and the scope of this committee also includes the Trust's Complaints Procedure and the Children's Order Complaints Procedure.

Staff are encouraged to resolve complaints raised informally by patients and carers as quickly as possible and also to liaise with managers and complaints staff, if required.

With regard to formal complaints, staff are involved in investigations as required and in the identification and implementation of learning. Meetings involving directors, senior managers, various staff and the patient and their carer(s) are held to resolve complaints and harness the learning from these. Directorates review formal complaints received with regard to following up whether learning has been implemented. Complaints are also discussed at senior management meetings within directorates.

5.2.10 Published Information

This sub-section relates to criterion 8.3 (l).

DHSSPS Quality Standard Criteria - Self assessed score	
8.3 (l) The organisation has a range of published up-to-date information about services, conditions, treatment, care and support options available, and how to access them both in and out of service hours, which are subject to regular audit and review.	

The Trust, in its submission, stated that whilst services are still relying on information from legacy Trusts, there are plans in place to address this criterion. A specific example to outline how this was being addressed was cited as the Trust's Disability Action Plan which describes various methods whereby published information for disabled service users is accessible by all. Various activities are in place to drive this forward to include the establishment of a Regional Working Group; the identification of models of good practice for communicating effectively with disabled people and its roll-out across the Trust in guidelines for written, visual and oral communication; consideration of the recommendations from the Equality Commission's investigation into the accessibility of health information and ensuring that the Trust's website is fully accessible. The Trust anticipated that this plan will be implemented over the next three years.

The Trust cited other examples of published information throughout its Directorates of Primary Care, Emergency Care and Older People's Services and that of Mental Health and Disability Services.

6 SUMMARY OF KEY RECOMMENDATIONS

Summary of Key Recommendations within the Theme of Accessible, Flexible and Responsive Services

Recommendation 1: The Trust should ensure there are mechanisms in place whereby all staff are able to contribute to service planning and service improvements.

Recommendation 2: The Trust should endeavour to ensure that dignity and privacy of service users is maintained across all programmes of care, particularly taking into consideration the provision of single sex accommodation and private space.

Recommendation 3: The Trust should roll out the model of advocacy services which is already working well within mental health services and ensure all staff are made aware of the role of advocacy.

Recommendation 4: Information on how to access the Interpreting Service should be disseminated throughout the Trust.

Recommendation 5: The Trust should progress the implementation of an informed consent policy consistent with DHSSPS guidelines and inclusive of training by 1st January 2009.

Recommendation 6: Antrim Hospital should ensure that equipment and other items are stored appropriately throughout the site.

Summary of Key Recommendations within the Theme of Promoting, Protecting and Improving Health and Social Well-Being

Recommendation 7: The Trust should develop a Community Development Strategy and ensure this is incorporated into all aspects of service delivery.

Recommendation 8: The Trust should ensure effective support is provided for the maintenance of partnership arrangements with stakeholders, including primary care, community and voluntary organisations across all programmes of care.

Recommendation 9: The Trust should continue to develop and implement a Personal and Public Involvement Strategy involving key stakeholders.

Recommendation 10: Work on the Carer's Strategy should be progressed to include an identified Carer's Co-Ordinator and improvement in carer's advocacy services.

Summary of Key Recommendations within the Theme of Effective Communication and Information

Recommendation 11: The Trust should harness views from service users and carers across all directorates whilst progressing its work in service user involvement.

Recommendation 12: The Trust should review all of its feedback mechanisms to ensure these are being utilised fully.

Recommendation 13: The Trust should now develop a corporate approach to training in communication skills to include a process for identifying relevant staff requiring training and a robust mechanism to evaluate how effective the training has been.

Recommendation 14: The Trust should ensure that both the draft ICT Strategy and the draft Communications Strategy are finalised as soon as possible and progress their implementation within the current financial year.

Section 5 - Declaration of Self Assessment

Regulation and Quality Improvement Authority
Clinical and Social Care Governance Review of Health and Social Care Trusts (2007/2008)

Name of Trust	NORTHERN HEALTH AND SOCIAL CARE TRUST
Address	THE COTTAGE 5 GREENMOUNT AVENUE BALLYMENA
Chief Executive's Name	MS NORMA EVANS
Chief Executive's Contact Details (Telephone and Email)	028 2563 3701 chief.executive@northerntrust.hscni.net
Chairperson's Name	MR JAMES STEWART
Chairperson's Contact Details (Telephone and Email)	028 2563 3701 marsha.mcdowell@northerntrust.hscni.net
Date Self Assessment Form was Completed	4 February 2008

In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this Trust.

Signature of Chief Executive:	Date:	Signature of Chairperson	Date:
Norma Evans	11.02.08	J Stewart	11.02.08

Appendix (ii)

Review Team - Northern Health and Social Care Trust

Date of Review:	4-6 March 2008
Project Managers:	Jacqueline Murphy & Zoe Hunter
Administrative Support:	Anthony Hanna

TEAM 1 – ACCESSIBLE, FLEXIBLE RESPONSIVE SERVICES		
Peer Reviewer	Angela Boyle	South Eastern Trust
Peer Reviewer	Richard Wray	Western Trust
Lay Reviewer	Eileen Wright	Lay

TEAM 2 – PROMOTING, PROTECTING AND IMPROVING HEALTH AND SOCIAL WELL-BEING		
Peer Reviewer	Geralyn Ainsworth	Belfast Trust
Peer Reviewer	Aisling Bonner	Western Trust
Lay Reviewer	Janice Molloy	Lay

TEAM 3 – EFFECTIVE COMMUNICATION AND INFORMATION		
Peer Reviewer	Therese Brown	Western Trust
Lay Reviewer	Josephine Burch	Lay
Peer Reviewer	Yvonne Kirkpatrick	Belfast Trust

Appendix (iii)

Areas visited by the Review Team

TEAM 1 – ACCESSIBLE, FLEXIBLE RESPONSIVE SERVICES

ANTRIM AREA HOSPITAL:

- Breast Screening Unit
- Chemotherapy/Cancer Unit
- Renal Unit (Dialysis)
- Ward A3 – General Medicine
- Ward C6 – General Surgery

WHITEABBEY HOSPITAL:

- Respiratory Outpatients Department
- Representatives from Trust-wide Advocacy Services

TEAM 2 – PROMOTING, PROTECTING AND IMPROVING HEALTH AND SOCIAL WELL-BEING

BRAID VALLEY HOSPITAL

- Health Promotion Department

COMMUNITY SERVICES, including:

- Coleraine Community Clinic
- Representatives from Community Projects
- Representative from Ethnic Minority Group
- Representatives from Home from Hospital Team

ROBINSON HOSPITAL

- Representatives from User Committee

TEAM 3 – EFFECTIVE COMMUNICATION AND INFORMATION

BRAID VALLEY HOSPITAL

- Stroke Unit

CAUSEWAY HOSPITAL:

- Rheumatology Outpatients Department
- Diabetes Outpatients Department

COMMUNITY SERVICES, including:

- District/Community Nursing, Slemish Centre, Braid Valley Site
- Wilson House Day Centre, Broughshane

Appendix (iv)

Glossary of Terms & Abbreviations

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 a near miss to a patient, member of staff or the public .
Advocate	A person who speaks or acts on behalf of another.
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 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.
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.
Comprehensive Spending Review (CSR)	A complete reassessment of the government's spending priorities.
DHSSPS	Acronym for Department of Health, Social Services and Public Safety - the Northern Ireland Government Department with responsibility for health.
EIDO	An organisation that provides patient information leaflets.
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.
Health Improvement Plan	A document which describes the action an organisation will be taking to address the identified health and well being needs of their local populations in order to meet the strategic aims and objectives of 'Investing for Health'.
HPSS	Acronym for Health and Personal Social Service.
HSC	Acronym for Health and Social Care.
Investing for Health	The public health strategy of the Northern Ireland Executive. It contains a framework for action to improve health and well-being and reduce health inequalities which is based on partnership

	working amongst Departments, public bodies, local communities, voluntary bodies, District Councils and social partners.
IT	Information Technology
Lay reviewer	A member of the public, who brings a public perspective to the review process.
Legacy	A phrase used to describe the health care organisational structure that was in place before 1st April 2006.
Multidisciplinary team	A group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients.
Organisational structure	A graphical representation of the structure of the organisation including areas of responsibility, relationships and formal lines of communication and accountability.
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.
Performance Scorecard	A collection of key indicators of performance which aims to give an overall picture of how well an organisation is doing.
POVA	Acronym for the Protection of Vulnerable Adults (NI) Service [POVA (NI)]). POVA aims to improve existing safeguards for vulnerable adults by preventing unsuitable people working with them in paid or voluntary positions.
POCVA	Acronym for the Protection of Children and Vulnerable Adults (NI) Order 2003 (POCVA). POCVA aims to improve existing safeguards for children and vulnerable adults by preventing unsuitable people working with them in paid or voluntary positions.
PPI	Acronym for Personal and Public Involvement
Priorities for Action	A planning framework which sets key regional priorities for the management and planning of health and personal social services.
Quality Assurance	Improving performance and preventing problems through planned and systematic activities including documentation, training and review.
Review of Public Administration (RPA)	A major reform programme which aims to rationalise the number of local authorities and public bodies within Northern Ireland, including health and social care organisations.
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.
Satisfaction survey	Seeking the views of patients through responses to pre-prepared questions and carried out through interview or self-completion

	questionnaires.
Self assessment	The process of self examination of an organisation by itself, usually by measuring performance against standard criteria.
Trust Delivery Plan	An annual document that sets outs the main aims and objectives of service delivery for a health and social care organisation. It includes details of the Trust plans to address the regional 'Priorities for Action' and a summary of the Trust financial resources.
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.

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

The Regulation and Quality Improvement Authority
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