HSC Public Health Agency

Personal and Public Involvement (PPI) in the PHA

Overview Report

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Personal and Public Involvement (PPI) · Involving you, improving care

Background

Introduction

Personal and Public Involvement (PPI) is a process whereby service users, carers and the public are empowered and enabled to inform and influence the commissioning, planning, delivery and evaluation of services in ways that are relevant and meaningful to them. People have a right to be involved and increasingly they expect to be actively involved in decisions that affect them.

The Public Health Agency (PHA) has responsibility for leading implementation of policy on PPI across the Health and Social Care (HSC) system. As part of this role the PHA has responsibility for ensuring the effective implementation of PPI policy across the HSC. There is therefore a dual responsibility; at HSC wide level to promote consistency and co-ordination in the approach to PPI; and at an internal level to establish appropriate organisational governance arrangements to meet the Statutory Duty of Involvement.

This report outlines an overview of the PHA's compliance with and progress of PPI and the Statutory Duty to Involve and Consult. The report contains a summary of the findings which have been extracted from self-assessment monitoring returns and presents recommendations to support the organisation to truly embed PPI into practice.

Legislative Context

PPI is a statutory responsibility as detailed in the HSC (Reform) Act (NI) 2009 through the Statutory Duty to Involve & Consult. Each HSC organisation, to which the legislation applies, is required to involve individuals in the planning and delivery of HSC Services. Specifically, sections 19 and 20 of the above legislation require that service users and carers are involved in and consulted on:

1. The planning of the provision of care
2. The development and consideration of proposals for change in the way that

care is provided.

3. Decisions that affect the provision of care.

Rationale for PPI

PPI is underpinned by a set of values and principles, but at its core, is the drive to achieve truly person centred services, where service users, the carers and the public are fully engaged in a partnership based approach to health and wellbeing, whether that is at the strategic, or individual level of care planning and provision.

The impact of PPI has been demonstrated in a range of areas from efficiency, and effectiveness, where services have been tailored to need, reducing wastage and duplication, to improvements in quality and safety, to increased levels of self-responsibility for one's own health and wellbeing.

PPI Standards, Monitoring and Performance Management

As part of its leadership role for HSC, the PHA has for the first time in Northern Ireland, established a set of Standards for involvement, helping to embed PPI into HSC culture and practice, supporting the drive towards a truly person centred system. The five PPI Standards and associated Key Performance Indicators (KPIs) were formally launched in March 2015 (appendix 1) and provide the basis for the structure of the monitoring and performance arrangements, which have been developed by the PHA.

A pilot monitoring exercise for PPI was conducted at the end of 2013/14. The results of this were used to inform the development of the first formal internal PPI monitoring arrangement within the PHA which was initiated in late 2014/15. It is anticipated that the PHA monitoring report will be available for the PHA Board meeting in June 2015 and the Accountability meeting with the DHSSPS also in June 2015.

Methodology

The monitoring process has used the PPI Standards and associated KPIs as a framework to gather information to help assess progress against compliance with PPI. A direct assessment has not however been made against all KPIs for this report as the PPI Standards were only recently endorsed in March 2015.

The monitoring mechanisms and arrangements were developed in partnership with members of the Regional HSC PPI Forum including service users and carers. Further discussion and input from the Health and Social Care Board (HSCB), the Patient and Client Council (PCC) and in particular, Regional Quality Improvement Authority (RQIA) helped shaped the final format of these arrangements. They were then shared with and agreed by the DHSSPS.

The key components of the monitoring process are outlined below, with the associated timeline detailed in appendix 2.

1. An initial baseline self-assessment questionnaire is completed by each Division within the PHA, which helps inform assessment of progress in embedding PPI into the culture and practice of the organisation.
2. The self-assessment reports are reviewed and analysed by the PHA PPI staff.
3. All information is then reviewed and a final report produced for the PHA AMT and also for use in discussions with the DHSSPS as part of the accountability arrangements.

Scope of the Report

There are a number of factors which have influenced the range and depth of this monitoring exercise.

In the main, this monitoring exercise represents a review and analysis of PPI in the PHA and in particular, its integration into the PHA corporately and within its Divisions, rather than a critique of the range and impact of the work undertaken by the PHA's PPI team which has both a HSC wide and internal PHA remit. The bi-annual Board update reports provide an in-depth overview of the range and extent of

PPI work across HSC. This monitoring report does not set out to duplicate this, but focus more on the internal workings within the PHA. Reference is on occasion however made to the resources that the PPI team has developed, and support which has been provided, which collectively support HSC organisations, including the PHA to meet their statutory duty.

It is recognised that the PPI Standards, whilst having been under development primarily during 2014, were only formally launched in March 2015. It will take some time for these to be embedded into internal practices and processes. Moving forward, it is anticipated however, that compliance against the KPIs set down under each Standard will be expected and formally monitored.

Having now completed the monitoring process and understood the dynamics of the exercise and the level of input required from a number of stakeholders, including staff, service users and carers, a debate needs to be had about a number of aspects, including the timeframe to undertake the assessment, how compliance is evidenced, the resources required and support for service users and carers participating in the process.

The review team also made a number of observations in relation to the adherence to the monitoring process that would need to be factored into consideration, for future arrangements:

- The nature of the work of the PHA and its responsibilities, means that some Divisions / functions provide a facilitative / supportive role for the organisation / other partners. It is noted that this this does not lend itself as readily to the production of evidence of PPI in action.
- Not all Divisions fully completed all sections within the self-assessment questionnaire.
- Evidence was not readily forthcoming from colleagues for a number of the PPI Leads to facilitate their completion of the returns.
- A limited number of examples of good PPI practice were written up and shared, when it was clear that significantly more had been undertaken.

All of these factors will feed into subsequent discussions with Divisional PPI Leads and senior managers, in respect of building and improving upon the monitoring conducted in future, to ensure that the best possible arrangements, mechanisms and processes are in place to assess compliance against PPI responsibilities and the Statutory Duty to Involve and Consult.

The Review Team:

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Findings and Recommendations

Standard 1 – Leadership

HSC Organisations will have in place, clear leadership arrangements to provide assurances that PPI is embedded into policy and practice.

Findings

- The PHA has a named executive Director and Assistant Director who carries responsibility for PPI.

- The organisation has not appointed a non-executive PPI lead.

- The PHA has appointed 2 full time PPI officers to progress the PHA leadership remit both internally and across HSC.   One of these officers is the Regional Lead for PPI across the HSC. The remit of these officers is wide ranging. An Internal Audit report had previously recommended that the PHA consider the infrastructural capacity and programme resources to enable it to deliver on its responsibilities.

- Directorate leadership arrangements are in place. This is evidenced by the establishment of an internal PPI Leads Forum. A PPI Lead and Deputy are appointed in each Directorate/Division. The nominated Deputy is in place to ensure consistency of engagement with the Leads group in the case of non-attendance by the Divisional Lead. A Terms of Reference is in place for the group, setting out the expectations from members, but no specification is set down for what the nominated PPI lead would require to be able to fulfil the functions of the appointment.

- The PHA in its strategic leadership role, has in response to a PfA target, created the Regional HSC PPI Forum, which it Chairs and facilitates. This body as specified in the most recent Departmental Circular on PPI is the primary vehicle through which the PHA exercises its leadership function in

PPI. The body comprises representatives from all HSC organisations and of service users, carers and advocates.

- Divisional service user / carer reference groups have not in the main been established, rather, the Divisions work to ensure that they use tailored structures and mechanisms aligned to specific projects, programme areas, to enable the voice of the service user / carer to be heard. Examples of how service users / carers are involved with the PHA include R&D PPI Panel, the nurse led EITP programme has a Participation and Engagement sub-group, a Safety Forum PPI Panel is in place, an AAA Patient Reference Group and a Drugs Service User Group is in place in Health & Social Wellbeing Improvement.

Recommendations

1. The PHA should appoint a Non-Executive PPI Lead at Board level.

2. The PHA in line with the internal audit report findings and subsequent capacity reviews and strategy commitments ensure that it allocates sufficient resources to deliver on these areas of work.

3. In relation to the PPI leads model that the PHA has in place, it would be important to:

   - Ensure that the PPI leads have or are supported to acquire the appropriate level of knowledge, expertise and skill in PPI to be in a position to perform their role.
   - Ensure that the individual PPI lead has capacity (protected time) to provide the advice and guidance in PPI to their Directorate colleagues. The PHA also needs to monitor the levels of demand on their time.
   - The PPI leads are clear what their role entails, setting out what they are expected to do and also ensure that others in the Directorate are aware of who the PPI lead is and what support is available through them.

4. In relation to service users and carer involvement with Directorates, the PHA should review the mechanisms that operate in each Directorate, to ensure that there are clear and transparent arrangements for involvement. The mechanisms and processes for involvement should be checked out with service users and carers to ensure that they are accessible, purposeful and encouraging for service users and carers.

Standard 2 – Governance

HSC Organisations will have in place, clear corporate governance arrangements to provide assurances that PPI is embedded into policy and practice.

Findings

- PPI has been integral to the development of PHA Corporate plans, both past and present. PPI is committed to in the Corporate Plan as a key approach to how the PHA does its business. The PHA has a PPI Strategy (2012 to 2015) which guides and directs the work of the organisation and its staff in this field.

- An annual action plan is also developed for the Regional Forum and this alongside the PPI Strategy covers all the strategic roles and responsibilities that the PHA carries in this area across the HSC. A range of monitoring is undertaken against the Strategy and Action Plan including quarterly Directorate Update Reports, bi-annual Board update reports and update reports to the DHSSPS. PPI is reported on formally twice a year to the PHA Board however it is not a standing item on AMT or Board meetings.

- The Planning and Operations Division working with the PPI team have taken steps to ensure that PPI is now an integral element of business cases, procurement /tendering processes and contract monitoring arrangements.

- The PPI team, working with the Regional HSC PPI Forum produce an Annual PPI Report reflecting primarily on the work undertaken to progress PPI across the HSC on a partnership basis. Specific PPI Strategies or Action Plans for some Divisions in the PHA are in place including Research & Development, the Safety Forum and Health Protection. Others have PPI built into their plans and AHPs have developed a PPI Plan which is incorporated into the regional AHP Strategy which applies to AHPs across the HSC including the PHA, Trusts etc.

- PPI is a standing item on many of the Divisional meetings.

- There is no consistency in how individual Divisions have captured, recorded and reported on PPI to date.

- The PPI Leads reported that they were not clear on the consultation process and the guidance regarding when they should be engaging in consultation and what is required.

Recommendations

1. The PHA needs to ensure through its arrangements on PPI in commissioning and planning of services, proposals and investments, that PPI is an active consideration in the decision making process rather than only when the PPI bi-annual update report is tabled. It is critical that PPI is not isolated in this way, but becomes integral to the business of the PHA, to help embed it into the culture and practices of staff and the organisation.

2. The PHA, through the PPI Leads group, should map where and how PPI is factored into internal governance, planning and reporting arrangements to ensure that service users, carers and the public are effectively involved in the work of the PHA.

3. The PHA needs to develop and appropriately resource a new PPI Strategy for the period 2015 to 2018, which should be undertaken in partnership with internal PPI Leads, service users, carers, voluntary / advocacy organisations and the public.

4. PHA should review the operation and effectiveness of the internal monitoring and reporting arrangements in partnership with the PPI leads.

5. In line with this, where Divisions do not have PPI Action Plans, they need to evidence how PPI is integrated into their Divisional objectives and work plan

6. Where Divisions have specific PPI Action Plans, these need to be monitored and reported on.

7. The PHA needs to review and update its Consultation Scheme, to provide clarity to staff and the public alike, (a requirement under the legislation on PPI) and ensure that it is meaningful and effective.

Standard 3 – Opportunities and Support for Involvement

HSC organisations will provide clear and accessible opportunities for involvement at all levels, facilitating and supporting the involvement of service users, carers and the public in the planning, delivery and evaluation of services.

Findings

o There are a range of opportunities and ways in which service users, carers, voluntary / advocacy organisations and the public can become involved with the work of the PHA, helping to inform, shape and develop plans and priorities. At present, the PHA does not have a central register of opportunities, at either Divisional or Corporate level.

o Each Division has evidenced the involvement of service users, carers, voluntary sector partners and the public, including:

- Use of Social media such as Facebook and Twitter

- One off responses to surveys / questionnaires

- Public consultations

- Attendance at and contributions to Public meetings

- Attendance at and contribution to Workshops & Focus Groups

- Development of case studies

- Membership of Task & Finish Groups

- Membership of Steering Groups

- Reference Groups

- o A range of support available to involve service users/carers was outlined which included:

  - Induction training

  - Production of a Terms of Reference, detailing role of the group, expectations

  - Use of the Out of Pocket Re-imbursement Guide for Service Users & Carers

  - Practical guidance on running meetings and partnership working.

- o Other Divisions referred to providing "easy read" versions of their documentation, and individual mentoring provision for service user and carer members of groups. Both the Research & Development Division and the Safety Forum supported service users / carers to attend conferences and training to support their acquisition of relevant subject matter knowledge to help equip them to more fully participate as equal partners in the work in which they were engaged.

- o Evidence would indicate that feedback is not systemic throughout the organisation. Of the Divisions that advised that they did engage in feedback, there was inconsistency of approach. Some Divisions provide named points of contact for feedback for every involvement exercise, others provide it for thematic areas of work, but not necessarily for every engagement exercise and others did not detail anything in respect of it. There is no clear evidence of mechanisms in place to record how feedback is taking place.

- o In terms of the perceived barriers to Involvement, most of the responses identified barriers from an organisational or staff perspective, rather than those faced by service users, carers or the public. A key barrier that came across in the monitoring exercise was the capacity of staff to undertake meaningful involvement. Other things such as time and financial cost associated with it were also identified. Some Divisions flagged up the need for practical hands on support, guidance and training to provide them with the personnel resources and to equip them with the knowledge and skills to involve people and in particular marginalised and excluded communities. Finally, the concept of there being "no sanction" if people weren't involved was also identified as a barrier.

It should be noted that the PHA working with Research & Development colleagues and the PCC has commissioned a team led by Queen's University and the Ulster University to examine the barriers to involvement and to look at ways in which these might be addressed. The finding will feed into a report that the PHA is tasked with producing for the DHSSPS in line with a recent PfA target.

Recommendations

1. The PHA should develop, manage and promote a central register of opportunities for involvement which is updated across all Divisions (where appropriate) and readily accessible by the public.

2. The PHA needs to consider the development of a PR / Marketing campaign, utilising social media etc. to evidence that the PHA is a listening organisation which effectively encourages involvement, debate and discussion and which brings the commitment to Involvement to the fore.

3. The PHA should develop a range of guidance materials on essential support that should be made available for the involvement of service users and carers.

4. The PHA should work to ensure that costs associated with the operational aspects of PPI, are an integral element of service planning, development or commissioning activities which the organisation is involved in, or responsible for.

5. Feedback must be embedded as standard practice at all levels across the organisation. The PHA needs to consider how it can embed feedback and also determine how this can be monitored.

Standard 4 – Knowledge and Skills

HSC organisations will provide PPI awareness raising and training opportunities as appropriate to need, to enable all staff to deliver on their statutory PPI obligations.

Findings

- PPI is a part of the generic corporate induction arrangements for the PHA but not currently built into the formal induction arrangements for most of the individual Divisions. A number of Divisions have advised however, that they are planning to utilise material from the upcoming generic PPI awareness raising and training programme into future inductions.

- All PHA Divisions were aware that the PHA's PPI Team provided PPI awareness raising and training programmes on request and a number have availed of this on several occasions. This has taken the format of presentations, interactive planning sessions, workshops etc.

- Divisions noted the forthcoming regional PPI training programme currently being developed by the PHA in conjunction with the Regional HSC PPI Forum. This has included service users/carers in the development of the programme which includes the following training options, including:

  - Taught modules

  - PPI Coaching

  - PPI Team Briefing

  - PPI Train the Trainers

  - PPI e-learning programme

- A number of staff participated in the piloting of a number of aspects of the above programme during 2014/15 and running into the start of 2015/16. A

number of Divisions suggested that the core component of the PPI training should be mandatory in nature.

- A manual system is currently in place to capture the up-take of training.

- Some of the feedback received as part of the internal monitoring queried where the proposed Engage website was at, recognising its potential value as a one stop resource for involvement.

- PPI being part of Continuing Professional Development, the Knowledge and Skills Framework and also being part of job descriptions were also identified as part of the discussion with PHA Divisions.

Recommendations

To inform and equip staff with the understanding, knowledge and skills to effectively involve and engage with service users, carers and the public, it is recommended that the PHA takes steps to:

1. build PPI into all future job descriptions and any review of existing job descriptions.

2. ensure PPI is a part of individual job induction processes.

3. ensure PPI is factored into staff development plans and appraisals.

4. support the roll out of the PPI training programme which is currently under development.

5. ensure PPI training is availed of by all staff, with the training targeted to role and level of responsibility.

6. deliver the proposed Engage website as a one stop resource for Involvement and the associated PPI development programme.

Standard 5 – Measuring Outcomes

HSC organisations will measure the impact and evaluate outcome of PPI
activity.

Findings

- The PHA were able to evidence a number of good practice examples of PPI
  being undertaken across the organisation which have resulted in tangible
  benefits for service users, carers and indeed staff and the PHA itself.   A
  number of these have potential for replication and transferability both within
  the organisation itself and indeed across the region. At a strategic level, the
  PHA's PPI Strategy and PPI funding programme that was operated in
  previous years, service users and carers were heavily involved in advising on
  and setting Strategy priorities and in assessing applications for funding
  respectively. Service users and carers have most recently been co-producers
  in the monitoring mechanism that the PHA introduced for Trusts and were
  also partners in both the monitoring exercise itself and the development of the
  subsequent reports.

- In terms of service user and carer involvement in monitoring and evaluation,
  Research & Development colleagues in particular, were able to identify a
  number of achievements in this area including:

  - Involvement in developing criteria for evaluating PPI in research
    proposals

  - Participation in the actual evaluation of research proposals

  - Monitoring of the implementation of PPI by researchers through their
    reports.

- A number of Divisions were unclear as to how the concept of service user and
  carer involvement and monitoring might work in practice, or what opportunities
  might lend themselves to this type of approach.

- In relation to where and how PPI has influenced / informed policy, investments, decisions and or service delivery and in detailing good PPI practice a significant number of examples were provided across the PHA. Of particular note from the responses received were the shaping of the Review of AHP Support for Children with Special Educational Needs as a result of the intensive PPI engagement with children, parents, schools and other direct stakeholders.

- Nursing colleagues provided a range of examples of direct impact as a consequence of PPI including work in Nursing Homes; IMROC which used co-production to bring about a number of service improvements and helped co-design and deliver educational courses for mental health; and in collaboration with Communications colleagues referred to work in the area of Cancer services, whereby service users and carers were instrumental in the development of plans to take forward a regional cancer awareness raising campaign.

- In Service Development and Screening, PPI approaches have been instrumental in informing and shaping the development of the AAA screening programme and also in areas such as the modernisation of Diabetic Retinopathy Screening and helping to examine issues such as poor uptake of cancer screening amongst ethnic minorities.

- Health Protection identified the value of PPI in their work on hand Hygiene in schools and Immunisation and Vaccination work in respect of TB, Measles etc.

- The Health & Social Wellbeing Improvement Division cited a number of examples where PPI was key to decisions, improvements in outcomes etc. Good practice examples were provided in their work on Transgender issues, work with Drug users and Suicide and Self Harm. In the final example, evidence of co-production in the development of an education booklet & DVD to be used in EDs alongside the joint development of Care Pathways were detailed.

- Planning & Operations highlighted how PPI changes brought about to PHA practice are now impacting right across the organisation, with all publically tendered services now needing to evidence how PPI has been accounted for in determining the shape and scale of the services being commissioned.

- Safety Forum colleagues detailed how their pro-active support for the development of members of their PPI Panel through attendance at a training programme on Quality Improvement and Patient Safety had resulted in the introduction of a "Teach Back" initiative whereby the knowledge and insights gained are brought back and formally shared with the wider group.

Recommendations

1. The PHA needs to work though the Internal PPI Leads group to ensure that at Divisional level, that there are effective and efficient monitoring mechanisms to record and capture evidence of PPI in practice across the organisation on an on-going basis. It is also advised that the development of such a mechanism / process needs to be verified with the recipients of services.

2. Senior Management need to ensure that PPI (where appropriate) has been factored into plans, proposals etc which are presented for consideration, without which, approval should not be forthcoming. These arrangements need to be reviewed and tested on a regular basis to ensure that this is what actually happens in practice.

Conclusions

The PHA recognises that it has both a Statutory Duty to Involve and Consult with Service Users, Carers and the public and that it also has a range of leadership responsibilities in respect of PPI across the HSC. This report primarily focuses on the progress of the PHA as an organisation, in terms of complying with the Statutory Duty of Involvement utilising an assessment against the 5 PPI standards which were developed under the leadership of the PHA

The organisation has taken a number of key steps to build and incorporate PPI into its structures and operations. There are excellent examples of good PPI practice in the organisation, which have made a real and tangible difference to the work of the organisation and its HSC partners, but most importantly to the lives of service users and carers bringing about brought a range of improvements in a number of areas including quality, safety and efficiency.

There is however a significant amount of work yet to be done right across the 5 areas discussed, in order to report that the Statutory Duty of Involvement is being comprehensively and consistently met within and throughout the organisation.

There are a variety of challenges which the organisation faces which are contributing to this gap, between where the PHA needs to be to fully meet its Statutory Duty in a comprehensive and consistent fashion and where it currently is. A key challenge is the capacity constraint in terms of the dedicated resources made available to drive PPI forward, which needs to be addressed. The need for widespread understanding amongst staff of what PPI is the rationale for it and how to undertake it is a major challenge. The need to build awareness of and provide tailored and accessible PPI training for staff, the need for access to advice and guidance, the need for structured and meaningful involvement mechanisms, the need for robust monitoring and the need to inspire and encourage participation by service users and carers, are among some of the other more notable challenges.

The recommendations outlined above and their outworking, should help progress the drive to embed PPI into the PHAs culture and practice, with the aim of achieving the optimum outcome for service users, carers and the public.

Appendix 1: Personal and Public Involvement (PPI) Standards and Key Performance Indicators

Standard One – Leadership

Health and Social Care (HSC) Organisations will have in place, clear leadership arrangements to provide assurances that PPI is embedded into policy and practice.

Key Performance Indicators:

- PPI Leadership structure in place across the organisation to include:
    - Named Executive and Non-Executive PPI lead at Board Level, with clear role descriptions and objectives;
    - PPI Operational Lead;
    - PPI leadership structure throughout the organisation.

Standard Two – Governance

HSC Organisations will have in place, clear corporate governance arrangements to provide assurances that PPI is embedded into policy and practice.

Key Performance Indicators:

- Governance and corporate reporting structures are in place for PPI.
- Action plan with defined outcomes developed to demonstrate the impact of PPI.
- Annual PPI report produced, demonstrating evidence of compliance with PPI responsibilities and work undertaken to address challenges in this area.

Standard Three – Opportunities and Support for Involvement

HSC organisations will provide clear and accessible opportunities for involvement at all levels, facilitating and supporting the involvement of service users, carers and the public in the planning, delivery and evaluation of services.

Key Performance Indicators:

- Maintain an up-to-date register of existing and future opportunities for involvement at all levels across the organisation, which is accessible by the public.
- Support the involvement of service users, carers and the public to include:
    1. Provision of clarity on roles/responsibilities for those who are participating.
    2. Provision of training/support.
        - Advocacy support provided if required.
    3. Use of accessible/user friendly communications, mechanisms/procedures. E.g. use of plain English, easy read, jargon free etc.
    4. Good meeting etiquette.
    5. Application of Interim Service User, Carer and Stakeholder Reimbursement Guidelines and Procedures for HSC Organisations.
- Named HSC points of contact for each individual engagement exercise.
- Provide feedback to those involved on each engagement as standard practice.
- As part of your Action Plan, identify barriers to involvement and develop actions to overcome these.

Standard Four – Knowledge and Skills

HSC organisations will provide PPI awareness raising and training opportunities as appropriate to need, to enable all staff to deliver on their statutory PPI obligations.

Key Performance Indicators:

- Integrate basic PPI awareness raising into induction arrangements for all new staff.
- Evidence compliance with any annually agreed regional targets for the provision of/access to PPI training.
- Ensure a mechanism is in place to capture information on the up-take of PPI training.
- Demonstrate service user and carer involvement in the design, delivery or evaluation of PPI training.

Standard Five – Measuring Outcomes

HSC organisations will measure the impact and evaluate outcome of PPI activity.

Key Performance Indicators:

- Evidence service user and carer involvement in the monitoring and evaluation of PPI activity.
- Demonstrate through the Annual Report:
    - How the needs and values of individuals and their families have been taken into account, in the development and delivery of care;
    - The outcomes/impact (positive/neutral/negative) achieved by using PPI approaches in respect of policy, investments, decisions and service delivery across the organisation.

Appendix 2: PHA PPI Internal Monitoring Process

Stage 1	Stage 2	Stage 3	Stage 4
PPI Monitoring Report	**Initial Review**	**Directorial Review**	**Final Report**
PHA Divisions complete PPI monitoring pro-forma.	PHA PPI Team review and analyse PPI returns producing summary assessment report for each Division.	Summary assessment reports are shared with appropriate Directors for comment and/or drafting of actions to address issues if appropriate.	Overall Final summary report is submitted to the PHA Chief Executive for consideration.
8 weeks	4 weeks	6 weeks	2 weeks