ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Mary Hinds
Date: 17 April 2024

I, Mary Hinds, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

This statement is made on behalf of the Public Health Agency in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be “Exhibit 1”.

Qualifications and positions

1. I am a Registered nurse. I hold a degree in Professional Development in Nursing and a Master’s Degree in Business Administration.

2. From 2009 to 2019 I was appointed as the first Executive Director of Nursing and Allied Health Professions of the Public Health Agency (PHA).

3. During this period I was seconded from my substantive role as Executive Director of Nursing and Allied Health Professions out of the PHA to support a number of initiatives:

    a. From January 2012 to March 2012 I was on full time placement to Northern Health and Social Care Trust.
    b. From April 2012 to April 2013 I was seconded on a part time basis, from the PHA to lead the regional Improvement Action Group for Unscheduled Care. During this time I retained some direct reporting arrangements,

within the PHA including, the Centre for Connected Health, Allied Health Professions and the HSC Safety Forum. I also provided professional support to the Deputy Director of Nursing who took on additional responsibilities in relation to nursing during that time.

c. From May 2013 to May 2015, I was seconded on a full time to support the Northern Health and Social Care Trust as part of a Turnaround Team, this included a short period in 2015 supporting work in the Department of Health.

4. I retired from the post of Executive Director Nursing and Allied Health Professions in the PHA in September 2019.

5. In preparing this statement, I have relied on my memory and my personal review of the information available to me, facilitated by the Public Health Agency. I have made every effort to provide a fulsome and factually accurate statement to this Inquiry. There may be gaps in the information I am able to provide, for which I apologise.

6. I have been asked to provide a statement of purpose of M8: Professional Organisation and Oversight.

7. My evidence relates to paragraphs 9, 10-13, 17 and 18-19 of the Inquiry's Terms of Reference.

8. In this statement I will address issues relating to module 8: Professional Organisation and Oversight.

9. To provide some context to the role of Executive Director of Nursing and Allied Health professions I have outlined my understanding of the background to the establishment of the role in 2009 and the integrated nature of the work with the Health and Social Care Board.

10. The Health and Social Care (Reform) Act (Northern Ireland) 2009 established the Public Health Agency (PHA) and Health and Social Care Board (HSCB).

The PHA's primary role was to exercise, on behalf of the Department of Health, health improvement functions including for example screening and health protection functions. The Health and Social Care Board (HSCB) functions included commissioning health and social care, performance management of Trusts and ensuring that resources were used in the most economic, efficient and effective way.

11. While I was the Executive Director of Nursing and Allied Health Professionals, part of the PHA's role was to provide professional leadership and advice to the HSCB. The HSCB were required to publish a commissioning plan annually in response to a Commissioning Plan Direction issued by the Department of Health. In doing this, the HSCB was required, in statute, to consult the PHA, have due regard to any advice or information provided by it, and it could not publish the plan unless it was approved by the PHA.

12. When designing the PHA and HSCB, I understand that the aim was to create complementary advisory professional Executive Director roles. The Executive Director of Nursing and Allied Health Professions and the Executive Director Public Health were employed and based in the PHA but also attended the senior management team and board meetings of the HSCB. In a similar fashion the Executive Director of Social Work and Children's Services was employed by and based in the HSCB but also attended the senior management team and boards of the PHA.

13. The Executive Director of Nursing and Allied Health Professions, PHA and their teams contributed advice to the commissioning process through the provision of professional nursing, midwifery and public health advice to Local Commissioning Groups and regional commissioning teams. The regional commissioning teams were broadly based at the time on Programmes of Care which included:

    a. POC 1 Acute Services
    b. POC 2 Maternity and Child health
    c. POC3 Family and childcare including CAMHS

d. POC4 Older peoples services
e. POC5 Mental Health
f. POC6 Learning disability
g. POC7 physical disability and sensory impairment
h. POC8 Health promotion and disease prevention
i. POC9 Primary health and adult community (includes GP's)

14. In these roles the nursing and AHP consultants contributed, for example, professional advice to the development of the Commissioning plan, reviewed Trust Delivery Plans and scrutinised Investment Proposal Templates (IPTs). Scrutiny of the IPT process was particularly important as these templates detailed specific investment proposals including information such as staffing levels for new services. It is my understanding that these arrangements have subsequently changed as a result of the dissolution of the HSCB.

15. The Health and Social Care Act (Northern Ireland) 2022 provided for the dissolution of the Regional Health and Social Care Board and the transfer of its functions to the Northern Ireland Department of Health. The Strategic Planning and Performance Group (SPPG), part of the Department of Health, accountable to the Minister for Health, is now responsible for planning, improving and overseeing the delivery of effective, high quality, safe health and social care services within available resources.

16. I have been asked to address a number of questions/issues for the purpose of my statement. I will address those questions in turn.

Serious Adverse Incidents and concerns regarding Muckamore Abbey Hospital

Q1. What was the role of the PHA Nurse Consultants in the investigation of level 3 serious adverse incidents?

17. The PHA nurse consultant's role in the Serious Adverse Incident process was as a Designated Review Officer (DRO) through the provision of professional

advice to the HSCB, working in partnership with the HSCB to identify regional learning and disseminating this learning with the aim to prevent incidents recurring.

18. PHA Nurse consultants did not undertake investigations of level 3 SAIs. They were involved in the SAI process as a DRO as detailed in the following paragraphs.

19. The Serious Adverse Incident process is one part of a number of processes in place to enable Trusts and organisations such as the PHA and HSCB to discharge their responsibilities under the Duty of Quality.

20. The key aim of the Serious Adverse Incident (SAI) procedure is to learn from SAI's, improve services, and reduce the risk of incident recurrence, both within the reporting organisation and across the Health and Social Care (HSC) system as a whole.

21. The operational responsibility for the implementation of the SAI policy was initially transferred from the Department of Health to the HSCB working in partnership with the PHA in 2010, as outlined in, Health, Social Services and Public Safety Policy Circular HSC(SQSD) 8/2010 **[Exhibit 1].** Over the years the Procedures for the Reporting and Follow up of Serious Adverse Incidents have continued to be subject to amendment and change, with revised procedures published in October 2013 **[Exhibit 2]** and November 2016 **[Exhibit 3**]. I understand that the SAI process is currently under Departmental review.

22. An adverse incident is defined in the guidance as, *Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.* The SAI guidance provides criteria which must be used when determining whether or not an adverse incident constitutes a SAI. This judgment is made by the reporting organisation. This is detailed in Exhibits 5 and 6 Page 13**.** If the incident meets the threshold for a SAI, a health and social care organisation such as a Trust must report, review and follow up the

incident identifying both local and regional learning. The decision about whether an incident meets the threshold of an SAI is made by the reporting organisation.

23. Within the SAI procedures there are three levels of review. Level one reviews are the most common. At this level, a Significant Event Audit (SEA) will immediately be completed by the organisation reporting the incident. This review uses a template provided in the procedure document to assess what has happened, why it happened, what went wrong, what went well and identify local and regional learning. The organisation then completes a SEA learning summary report signed by the relevant professional or operational Director, and forwards this to the HSCB. Any SEA can be escalated to a level 2 or 3 review at any stage if it is found through the SEA process to be more complex.

24. A level two review is a more complex situation which for example may include two or more organisations. In these cases, reviews must be conducted to a higher level of rigour. Methodologies for investigation such as Root Cause Analysis (RCA), ensure a consistency of approach and rigour. On completion, the final report must be submitted to the HSCB within 12 weeks of the date the incident was notified.

25. A level three review must be considered for SAIs that are particularly complex involving for example multiple organisations, have a degree of technical complexity that requires independent expert advice, and/or are very high profile attracting a high level of both public and media attention. In some instances the whole review team may need to be independent.

26. In addition, the Regulation Quality Improvement Authority (RQIA) have a statutory obligation to investigate specific incidents reported under the SAI procedure. To facilitate this, all mental health and learning disability SAIs reportable to RQIA under Article 86.2 of The Mental Health (Northern Ireland) Order 1986 were notified to RQIA by the governance team of the HSCB. In these cases when the review / learning report is returned to the HSCB governance team, from the reporting Trust, this is forwarded to RQIA advising of a 3 week timescale for RQIA to forward comments. When the SAI is closed

by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

27. A PHA nurse consultant does not undertake the actual SAI investigation. An SAI investigation is the responsibility of the reporting organisation such as a Trust. A PHA nurse consultant's role in the procedure is as a Designated Review Officer.

28. A Designated Review Officer (DRO) is most often a professional officer of the HSCB or PHA. They are generally a social worker, doctor, nurse or allied health professional. The DRO role includes:

    a. Liaising with reporting organisations on any immediate action required to reduce the risk of harm.
    b. Agreeing the level of review being undertaken.
    c. Agreeing terms of reference (for level 2 and 3 cases)
    d. Reviewing the completed reports and liaising with organisation re the robustness of level 2 and level 3 RCAs
    e. Identifying and regional learning, trends or patterns.

29. A full outline of the DRO role can be found at **[Exhibit 4]**.

30. For a level 3 review, if a Nurse Consultant is identified as a DRO they would be involved from the initial notification, receipt and review of the SAI report ensuring any regional learning has been identified.

31. Initially for a level 3 review the DRO would liaise with reporting organisations on any immediate action to be taken. The DRO would consider the membership of the review team with the reporting organisation, with particular attention paid to the independence of the panel. The DRO may feel the entire panel must be independent. The DRO would then agree the terms of reference and timescales for the reporting of the review with the reporting organisation.

32. When a level 3 SAI review is completed, the DRO decides if they are satisfied with the robustness of the review and that any appropriate learning has been identified. When a DRO informs an organisation that the SAI review can be closed, the organisation is advised that if additional information becomes available to the reporting organisation, for example Coroner Reports which impact on the outcome of the SAI review, this must be communicated to the DRO.

33. In addition a DRO may request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring will be followed up via the HSCB Governance team.

Q2. Did the PHA Nurse Consultants have any role in post investigation actions regarding serious adverse incidents? If they did, please describe their role?

34. The key aim of the SAI procedure is to improve the quality and safety of procedures and reduce the risk of harm due to recurrence of similar incidents, either within the reporting organisation or across the HSC as a whole. The dissemination of learning following a SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided. PHA Nurse Consultants, in their role as DRO, may have a role in post investigation actions regarding serious adverse incidents as outlined below.

35. The role of the DRO in post investigation action focuses on identifying regional learning from the incident, highlighting this learning to the Quality Safety Experience Group, (QSE) who will in turn agree a method of disseminating the learning and refer to the Safety and Quality Alerts (SQAT) Team. The DRO working with colleagues in the PHA and HSCB will also help identify any emerging themes, which may prompt a thematic review to identify further regional learning.

36. While the PHA and HSCB worked in partnership to disseminate regional opportunities for learning, Trusts are responsible for ensuring they have in place mechanisms for cascading and implementing local learning from adverse incidents and SAIs internally within their own organisations.

37. The structures that supported this work are detailed in **[Exhibit 5].** This structure was in place from 2010/11 to 2020.

38. The identification of learning from SAI was led by the SAI Review Sub Group (SAIRSG). This group considered reports and identified themes and learning. **[Exhibit 6]**.

39. An overarching HSCB-PHA Quality Safety and Experience (QSE) Group considered the issues identified by the SAIRSG and agreed actions and assurance arrangements. **[Exhibit 7]** This group was jointly chaired by the PHA/HSCB and provided an opportunity to bring various indicators of quality and safety together. This multi-disciplinary group met on a monthly basis to consider learning, patterns/trends, themes or areas of concern, and agreed appropriate actions to be taken, from a wide range of sources of safety and quality information received by the HSCB and PHA.

40. When areas for regional learning from SAIs were identified and discussed at QSE they were passed to the Safety and Quality Alerts (SQAT) Team. **[Exhibit 8]** The SQAT group, was closely aligned to the work of QSE, and was responsible for performance managing the implementation and assurance of Regional Safety and Quality Alerts / Learning Letters / Guidance issued by HSCB/PHA in respect of SAIs.

41. The Safety and Quality Alerts Team was a multidisciplinary group chaired by the PHA Medical Director/ Director of Public Health. The Group met fortnightly to co-ordinate the implementation of regional safety and quality alerts, letters and guidance issued by the DHSSPS, HSCB, PHA and other organisations. This group provided a mechanism for gaining regional assurance that, for

example, alerts guidance have been implemented or that Trusts have taken action with regard to regional learning from SAIs.

42. Regional learning was disseminated in a number of ways including learning letters or reminders of best practice, learning newsletters, and an annual SAI learning event where examples of lessons to be learnt and good practice were shared. I have shared an example of a Learning Letter template. **[Exhibit 9]**

43. Where trends were identified, through information gathered and intelligence shared thematic reviews were completed. These were in-depth consideration of for example both adverse incidents and serious adverse incident to identify recurring themes, consider regional learning, highlight areas of good practice and to determine if regional actions are required to reduce/prevent reoccurrence of these incidents. An example is attached at **[Exhibit 10]**

44. In relation to mental health and learning disability services, during the months of September and October 2017 three SAIs were received, two relating to learning disability services and one relating to mental health services. All had allegations of violence against patients in two Trusts, one in a mental health setting and two SAIs relating to a learning disability setting, Muckamore Abbey Hospital.

45. While these incidents had been reported as SAIs and would be subject to the rigour of review and oversight by DROs, I felt that more timely regional action in relation to professional nursing practice was required.

46. I contacted the Chief Nursing Officer (CNO), and following a briefing to CNO on the initial information available in relation to these SAIs, she shared my concerns.

47. We agreed that while the SAIs would go through the normal reporting and investigation processes overseen by a DRO, there was a need to take immediate action in relation to the assurance mechanisms in place within Trusts for mental health and learning disability nursing.

48. We were concerned that the similarity of SAIs could signal cultural issues within these services that could require prompt and ongoing support to improve. We both felt it was not appropriate to wait until the outcome of the SAI procedure but were mindful not to take any action that would negatively impact on that process.

49. The Chief Nursing Officer then corresponded with me on the 24 November 2017 and asked me to provide a scoping report on the systems, professional structures, policies and procedures in place to provide assurance to the Executive Directors of Nursing in Trusts and ultimately to their Chief Executive of the quality of nursing care. The correspondence from CNO, along with the final report is attached at **[Exhibits 11-14].** The request focused on mental health and learning disability nursing services.

50. The report was shared by the CNO with Executive Directors of Nursing and the Chief Executive of the Northern Ireland Practice and Education Council at CNO's regular Executive Directors of Nursing meeting.

51. Following discussion and debate a prioritised action plan was developed and followed up through the CNO business meeting. This action plan reflected the issues for consideration detailed in the report. A draft interim action plan is attached, unfortunately I cannot locate a final version. **[Exhibit 15].**

52. I recall some of the outcomes of this plan included; the commissioning of the Foundation of Nursing studies to complete two cohorts of 'Creating Caring Cultures', the inclusion of an Executive Director Nursing as a co-chair to Strengthening the Commitment Group and the development of links to the Nursing and Midwifery Task Group work, that was progressing at that time.

Q3. Were you informed about the number and type of incidents? If so, how were you informed?

53. The PHA and HSCB are not routinely informed of all adverse incidents within Trusts, the majority of these are recorded and managed locally. The PHA and

HSCB were informed of Serious Adverse Incidents as outlined at paragraphs 22 to 25.

54. All serious adverse incidents are reported to the HSCB through a DATIX system utilising a standard reporting form. Datix is an information system which allows the reporting Trust to communicate incidents directly to the HSCB Governance team. It provides a system for updating information, logging requests or queries, storing reports and identifying trends or patterns.

55. As the Executive Director of Nursing and Allied health Professions, I received information on every SAI reported to the HSCB, on a daily basis, from the HSCB governance team through circulation of an SAI Notification Form. **[Exhibit 16]**. This form was circulated to a wide range of staff from the HSCB and PHA.

56. This process enabled a DRO to be assigned by the HSCB Governance team, officers of the HSCB/PHA to be made aware of the SAI, and helped ensure that any immediate actions were taken.

57. In addition, the Senior Management Team of the HSCB was provided with a summary of all SAIs submitted in the previous week. The aim of this process was to help ensure that all senior officers were made aware of incidents, that immediate actions were taken, any additional intelligence shared and any initial trends identified. This was a standing item on the weekly senior management team agenda.

Q4. If the answer to question 3 is yes, was this reported to the PHA Board? If so and by whom was this reported?

58. The process for managing the SAI process was led by the HSCB. The PHA Board received a report on Serious Adverse Incidents, prepared by the HSCB governance team. From 2012, this report, having been considered by the Governance and Audit Committees, was also submitted to the PHA and HSCB

Boards. This report was presented by myself or one of my team at the PHA Board an example is included at **[Exhibit 17]**.

59. Over time the reports and reporting arrangements were adapted and amended. The standalone SAI report was replaced by an annual Quality Report. This report was significantly more comprehensive than the SAI report and aimed to improve the ability of the PHA Board to fulfil its Duty of Quality obligations.

60. The safety and quality nursing team within the Nursing and Allied Health Professions Directorate took the lead in compiling this report which included information on SAIs and a wide range of other indicators of quality and safety. This afforded a greater focus on learning not just from SAIs but complaints and patient feedback. The report also highlighted initiatives which were undertaken to support the wider workforce, for example, quality improvement training and projects such as 'RETAIN', which aimed to support Trusts retain nursing staff working in older people's services. This report was presented by myself or one of my team. **[Exhibit 18]**.

Q5. Did you have concerns about safeguarding at MAH before September 2017 and, if so, what was the nature of your concerns? What action, if any, was taken in relation to those concerns?

61. There were a number of ways that safeguarding concerns could be drawn to my attention, through for example the SAI process or through the Early Alert process managed by the Department of Health.

62. It is my understanding that the majority of safeguarding concerns would not have been highlighted through either of these processes but would have been managed through the existing Trust safeguarding procedures.

63. Prior to September 2017, information in relation to potential safeguarding concerns at MAH, was highlighted through the Department of Health's Early Alerts system. Further details are provided at paragraph 73.

64. I have provided some detail of the policy and procedures to provide some context to the management of adult safeguarding concerns.

65. The arrangements for the delivery and oversight of adult safeguarding procedures has also changed over time. In 2009 the DHSSPS, working with the Northern Ireland Office (NIO) issued a consultation document*, 'Reforming Northern Ireland's Adult Protection Infrastructure'*. **[Exhibit 19]**. Following this in 2015 a joint policy document, *'Adult Safeguarding Prevention and Protection in Partnership '* was issued. [**Exhibit 20]**.

66. This guidance established the Northern Ireland Adult Safeguarding Partnership (NIASP) and five Local Adult Safeguarding Partnerships (LASPs). NIASP. The HSCB had lead responsibility for the effective working of the NIASP, which is chaired by the Executive Director of Social Care and Children's Services, or a nominated deputy. There were approximately twenty-four members including a nurse consultant and an allied health profession consultant from the PHA. The membership was drawn from the main statutory, voluntary, community, independent and faith organisations involved in adult safeguarding across the region and included representation from service providers and users.

67. The chair was accountable to the HSCB and was responsible for ensuring that there were robust governance arrangements in place and compliance with the HSCB's responsibility for Delegated Statutory Functions. A Delegated Statutory Functions report was compiled by the social care team HSCB and reported to the HSCB annually.

68. Each member representative was accountable to their employing organisation and should have been of sufficient seniority to bring adult safeguarding issues to the attention of NIASP and to make decisions on behalf of their organisation. Each representative should have ensured that any actions and decisions taken by the NIASP were shared and implemented as appropriate within their organisation.

69. The five LASPs were located within, and accountable to, their respective HSC Trusts. Their role was to implement the NIASP Strategic Plan, policy and operational procedures locally. The LASP was chaired by the HSC Trust's Executive Director of Social Work or a senior designated nominee. It was responsible for ensuring that there were robust governance arrangements in place and ensuring compliance with the agreed statutory functions delegated by the HSCB. PHA staff had no role in LASPs.

70. In 2016 the HSCB issued a paper which outlined the operational procedures for adult safeguarding*, Northern Ireland Adult Safeguarding Partnership, Adult Safeguarding Operational Procedures. Adults at Risk of Harm and Adults in Need of Protection (2016)* **[Exhibit 21]**. This paper outlines for example definitions, roles and responsibilities, how to manage a concerns and regionally agreed templates.

71. It is my understanding that NIASP was stood down by the Department of Health in 2019/20 replaced with an Interim Adult Protection Board (IAPB). This group was established to protect and safeguard adults at risk of harm or in need of protection in Northern Ireland by co-ordinating the work and ensuring the effectiveness of each person or body represented on the Board.

72. At the same time the Department of Health aimed to move towards the establishment of an Independent Adult Protection Board (IAPB) at arm's length from the DoH. As Northern Ireland remains the only jurisdiction within the UK that does not yet have specific adult safeguarding legislation, this independent structure will require a statutory footing. The Interim Board will remain in place until the Bill has become law. The Executive Director of Nursing and Allied Health Professions, PHA is a member of that Interim Board.

73. In the case of MAH, prior to September 2017, while I was not advised of specific adult safeguarding referrals, I was advised through the Department of Health's Early Alerts system of potential safeguarding concerns. This Early Alert was circulated on the 9 November 2012 from the DoH to HSCB and PHA as per normal process. **[Exhibit 22]**.

74. The circulation list for this alert included the senior management team of the HSCB and the Executive Director Nursing and Allied Health Professions and Director Public Health, PHA.

75. The Early Alert Process is detailed in **[Exhibit 23]**. The Early Alert System is a Departmental process which aims to provide a mechanism which will enable Chief Executives and their senior staff (Director level or higher) in Health and Social Care (HSC) organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by a Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department. Trusts are asked as a matter of good practice to update senior DoH senior officers on any changes or developments.

76. While the Early Alert system is primarily a DoH process, at that time the HSCB circulated an Early Alert and identified a lead officer whose role was to determine if any immediate action was required, and also, to consider based on the information available, if a SAI should be submitted or if no further information was required that the Early Alert could be closed on DATIX.

77. In relation to Muckamore Abbey Hospital an Early Alert was received on the 9 November 2012. This was circulated to Assistant Director for Mental Health and Learning Disability (HSCB) the Regional Lead Nurse Consultant for Mental Health and Learning Disability and a Consultant in Public Health Medicine (PHA). The HSCB identified these staff as the leads officers.

78. The Assistant Director for Mental Health and Learning Disability (HSCB) and the Regional Lead Nurse Consultant for Mental Health and Learning Disability (PHA) made contact with the Senior Nurse MAH and met her on the 14 November 2012. This meeting was to get an update on actions taken by the Trust. At that meeting it was confirmed that a single agency investigation was ongoing with the PSNI in the lead. The Senior Nurse MAH also detailed the actions taken to date including staffing levels, training and support for staff

wishing to raise concerns. The PHA/HSCB staff were advised of previous incidents reported through the 'vulnerable adults' protocols.

79. I received a briefing from the Deputy Director of Nursing PHA and Regional Lead Nurse Consultant for Mental Health and Learning Disability on the 15 November 2012. **[Exhibit 24]**. I was advised that these allegations were being managed through the adult safeguarding procedures.

80. Over the next few weeks and months, the Regional Lead Nurse Consultant for Mental Health and Learning Disability worked in partnership with the Assistant Director for Mental Health and Learning Disability (HSCB) and the Trust staff to better understand the pressures within the Trust and receive updates on the actions taken by the Trust to ensure the safety of patients.

81. Over this period, given I was leading the Implementation Action Group (outlined at paragraph 3), the Deputy Director of Nursing and Lead Nurse Consultant for Mental Health and Learning Disability, convened a number of meetings with Executive Directors of Nursing, the Chief Executive of NIPEC and Professor of Nursing Ulster University. These meetings focused on the role of learning disability nurses in light of the changes in service provision and concerns about quality of care highlighted through the Early Alert and RQIA reports. I have attached draft notes from two meetings held in January 2013 and February 2013. **[Exhibit 25-26]**.

82. While I cannot source any further documents it is my understanding that the issues raised other than the actions identified for Trusts, were progressed through the group leading action planning for 'Strengthening the Commitment, Northern Ireland' supported by the Northern Ireland Practice Education Council for Nursing and Midwifery.

83. While the allegations were being investigated through the adult safeguarding process, the Regional Lead Nurse Consultant for Mental Health and Learning Disability provided professional advice particularly on staffing focused on the provision of support such as funding to provide additional staffing.

Q6. Did you or your team make any recommendations about education and training of staff at MAH? If so, please provided details of your recommendations and describe whether those recommendations were implemented.

84. The identification of education and training needs within HSC Trusts is the responsibility of the Trust with the Executive Directors of Nursing working in partnership with service and other Directors to identify need and ensure that staff have access to education, training and development opportunities.

85. Executive Directors of Nursing access a significant level of education and training through the Clinical Education Centre, the HSC Leadership centre and through requests to the Education Commissioning Group (ECG) funded by the Department of Health.

86. Neither the PHA nor the nursing and midwifery team at the PHA had access to any regular resources or funding to support the education and training for staff in the health and social care system.

87. The Department of Health hold the budget for pre-registration nurse education and allocate a budget annually for post registration nursing and midwifery education. I or my deputy chaired the ECG on behalf of the CNO from 2010 until 2019. Some of these funds were used to support the Clinical Education Centre who provided a wide range of short programmes for nursing and midwifery staff including for example Adult Safeguarding.

88. The ECG budget was used to provide access to a wide range of post registration nursing and midwifery training. This budget was not designed to address all of the professional development needs of nurses and midwives, and as such other needs were funded through Trusts.

89. The ECG coordinated requests directly from Trusts and from CNO for post registration education. Departmental colleagues linked directly with education institutions through a series of contract negotiations to maximise the use of the

resources available. These requests were prioritised and opportunities used to maximise the efficiency of the funds available.

90. In addition to core post registration commissioning when specific priorities or initiatives were identified, CNO would request that the chair of ECG to action these, an example of which was the commissioning of Quality Improvement Training for nurses.

91. For example, as an outcome from the Professional Governance Report 2018, completed at the request of the Chief Nursing Officer, (discussed at paragraphs 44 to 52) there were a number of areas of professional development identified for the Chief Nursing Officer and Executive Directors of Nursing to consider. This included for example:

    a. Enhancing preparation and support for nursing staff moving into senior positions.
    b. Exploring a regional approach to the development and strengthening of the culture and value of nursing, with a suggestion that ' *Creating Caring Cultures*' programme delivered through the Foundation of Nursing Studies.
    c. Given the importance of the unregistered workforce that further work is progressed to ensure their contribution is maximised and they are appropriately supported.

92. This work was prioritised and progressed through the CNO Business meeting with Executive Directors of Nursing and the Chief Executive of the NI Practice and Education Council with some actions moving to the work plan of the Nursing and Midwifery Task Group.

93. In my role of chair of the ECG I commissioned the Foundation of Nursing Studies to compete two cohorts of a program entitled 'Creating Caring Cultures' on behalf of CNO. This programme commenced in 2018 with a first cohort of 30 nurses from Learning Disability Nursing.

94. In addition, in 2018/19 the PHA secured funding to enable staff, including nursing staff working in learning disability, to avail of the British Institute of Learning Disability (BILD) Positive Behaviour Coaches Support training (PBS). The training involved staff attending three consecutive days and a follow up day held six months later where participants had to present on a project they had implemented to imbed PBS within their area of practice and an action plan to take forward PBS within their workplace. The three day BILD training was delivered in two cohorts. Twelve of the staff who attended the three day coaches programme successfully completed this training and are now accredited British Institute of Learning Disability PBS coaches.

Q7. Were you or your team aware of serious adverse incidents relating to safeguarding for any persons resettled out of MAH from 2008 onwards? If so, please provide details, including the number of serious incidents and the PHA response.

95. I have reviewed the information available to me, facilitated by the PHA, from 2010 and can find no SAIs related to safeguarding for any persons resettled out of MAH from 2008 onwards. It is important to note that whilst there may have been SAI's notified which related to someone who had been resettled from Muckamore Abbey Hospital, if there was no reference to resettlement in the initial SAI notification, it would be difficult to determine if an SAI was related to this issue.

Q8. As an attendee at the HSCB, were you present at any Board discussion regarding concerns about MAH? If yes, please provide details, including details of the professional advice, if any.

96. My recollection is that discussions about the concerns raised about care in MAH in 2017-18 were raised in the confidential session of the HSCB.

97. Short reports were compiled by the Executive Director of Social Care and Children's services in consultation with myself and other relevant colleagues.

These reports were shared and focused on providing information on actions taken by the Trust in response to the SAIs.

98. My advice would have focused primarily on assurances provided by the Trust that appropriate actions taken by the Trust such as NMC referrals and other actions taken by the Trust to ensure the safety of patients.

Commissioning

Q9. What advice did PHA provide about the commissioning of learning disability services?

99. Commissioning is the process for securing the provision of health and social care from assessment of need, strategic planning, priority setting and resource acquisition, to addressing need by agreeing with providers the delivery of appropriate services, monitoring delivery and evaluating the impact and feeding back into a new baseline position.

100. The PHA role was the provision of professional nursing, midwifery and allied health professions and public health advice to the commissioning process.

101. The Department of Health set the strategic context for the commissioning of health and social care services through the Commissioning Plan Direction **[Exhibit 27]** and Indicators of Performance Directions. **[Exhibit 28]**.

102. This plan translated the strategic objectives, priorities and standards set by the Department into a range of plans and associated investments for the delivery of high quality and accessible health and social care services.

103. Under section 8(3) of the 2009 Act, the HSCB was required to develop the commissioning plan in consultation with, and having due regard to, advice or information provided by the PHA. The plan was also required to provide

details of health and social care services which it would commission regionally for each of the five Local Commissioning Group areas.

104. Local Commissioning Groups were multidisciplinary, multi-agency groups whose primary role was to ensure that local voices shaped the commissioning plan and the decisions made by the HSCB Board. The Department of Health stipulated the membership of the LCG, 17 members to include one nurse. See The Local Commissioning Groups (Membership) Regulations (Northern Ireland) 2009.

105. I have included a link to an example of a Commissioning Plan 2015/16. This plan is signed by Chairs and Chief Executives of both organisations.

106. Trusts in response to the commissioning plan produced Trust Delivery Plans, which outlined the detail of services including any new service developments within the funds available.

107. While two separate organisations, it is my experience that the PHA and HSCB worked together, to commission health and social care services for the population within the resources available.

108. The operational arrangements in place within the HSCB for commissioning focused on small multidisciplinary teams working in partnership with Trusts and others to identify need and agree what services would be commissioned. These teams were chaired or co-chaired by HSCB and PHA. The role of the PHA staff was the provision of professional public health advice and support. This included for example scrutiny of Investment Proposal Templates. This is a particularly important process as these templates detailed, for example, staffing levels of initiatives which the PHA nurse consultants had the opportunity to both challenge and support.

109. There was a well-established mental health and learning disability commissioning team. This group was chaired by an Assistant Director of Social Work HSCB, with membership drawn from HSCB, information, performance

management, and finance teams and from the PHA representation from nursing, medicine and allied health professions.

110. The PHA Nurse consultant was responsible for providing advice and guidance both professional and advice drawn from experience of working or commissioning in that specific area of practice. The advice given would encompass a wide range of issues, including opportunities or evidence to support service development, professional issues such as staffing, issues related to quality of services, allocation of resources and when required advice on support to Trusts in emerging or unexpected situations.

111. The Commissioning plan did not address all aspects of services nor the day to day operational management of the service which was the responsibility of the Trust.

Q10. Was that advice always incorporated into the commissioning plan?

112. The Commissioning plan was developed by multidisciplinary teams within the context of the funds available. IPTs were scrutinised prompting dialogue with Trusts and within the Commissioning team.

113. It is my experience that this commissioning team worked well at that time. There was a respectful professional relationship between members. Information such as IPTs were discussed and all contributions welcomed.

PHA and Ennis Investigation

Q11. Was PHA provided with Ennis report? If it was received?

(i) Who received it?

(ii) When was it received?

(iii)How did it come to be received?

114. It is my recollection, and from examination of the papers available to be, that the Ennis Report was not sent to the PHA. There is evidence **[Exhibit 29]**

email dated 26 November 2019 that a document entitled, *'Synopsis of Ennis Report'* was sent to the PHA through the Acting Director of Nursing. This was circulated as a paper for the Muckamore Departmental Assurance Group (MDAG). Actions in respect were taken forward by that group.

Q12. If PHA was provided with the report, what action, if any, did PHA take upon receipt?

115. It is my recollection, and from examination of the papers available to be, that the Ennis Report was not sent to the PHA, therefore no action was taken.

Q13. Was the report shared with the PHA Board or any of its subcommittees? If so please provide full details?

117. It is my recollection, and from examination of the papers available to be, that the Ennis Report was not sent to the PHA therefore there was no copy shared with the PHA Board or subcommittees.

Q14. In correspondence from RQIA to the Hospital Services Manager dated 03 December 2012 (concerning Ennis Ward), it is stated that a review of staffing levels at MAH had been requested by Molly Kane, Regional Lead nurse Consultant at the PHA. Was this review carried out? If so, Please provide details of and evidence relating to this exercise?

116. I have reviewed the information available to me, facilitated by the PHA, and cannot locate a copy of a review of staffing requested by the Regional Lead nurse consultant at the PHA.

117. I am aware that the Lead nurse consultant communicated frequently with the Trust in relation to staffing and through advice into the commissioning process helped ensure additional funding support was provided.

PHA And Leadership and Governance Report

Q15. At pages 163-165 of 'A Review of Leadership and Governance at Muckamore Abbey Hospital' dated 31st July 2020, the review team made a series of recommendations concerning PHA and other bodies (the Department of Health, the Belfast Trust and HSC Board) The Inquiry would invite any comments that you wish to make regarding those recommendations.

118. The recommendations of the 'A Review of Leadership and Governance at Muckamore Abbey Hospital' in relation to the HSCB/PHA were:

a) The HSCB/PHA should ensure that any breach of requirements brought to its attention has in the first instance been brought to the attention of the Trust Board.
b) Pending the Review of Delegated Statutory Functions reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there is risk of noncompliance.
c) Specific care sensitive indicators should be developed for inpatient learning disability and community care environments.

Q16. What action, if any, did the PHA take in relation to those recommendations? Please provide dates and details of any action taken.

119. The report and associated recommendations of the of 'A Review of Leadership and Governance at Muckamore Abbey Hospital' were published after I retired from my role as Executive Director of Nursing and Allied Health Professionals at the PHA It is my understanding that all of the recommendations outlined in this review were accepted and incorporated into the existing Muckamore Departmental Assurance Group HSC Action Plan which was overseen by the Muckamore Departmental Assurance Group (MDAG) at which the PHA is represented.

General

Q17. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions, that may assist in the Panels consideration of paragraphs 9, 10-13, 17 and 18-19 of the Terms of Reference?

120. I am content that the information I have provided in the sections above is a reflection of the assistance I am able to provide to the Inquiry in relation to the stated paragraphs of the Terms of Reference and, as such, do not wish to draw the Inquiry's attention to any additional issues at the present time.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: M. Hinds

Date: 17 April 2024

Table of Contents

Jim Livingstone
Director of Safety, Quality and Standards

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

POLICY CIRCULAR

Subject:

Phase 2 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services

For action by:

- Chief Executives, HSC Trusts
- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
- Chief Executive, NI Blood Transfusion Service
- Chief Executive, Business Services Organisation
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Executive, Patient and Client Council
- Director of Public Health, PHA
- Director of Performance Management, HSC Board
- Directors of Social Services in HSC Board and HSC Trusts
- Director of Dentistry in HSC Board
- Director of Pharmacy in HSC Board
- Directors of Nursing in HSC Board and HSC Trusts
- Director of Primary Care in HSC Board
- Medical Directors in HSC Trusts
- Chair, Regional Area Child Protection Committee
- Chair, Regional Adult Protection Forum
- Chief Executive, Regulation and Quality Improvement Authority
- CSCG/Risk management leads
- Unscheduled care improvement managers

Summary of Contents:

The purpose of this Circular is to advise HSC organisations of revised arrangements for adverse incident reporting which are being introduced following a review of the existing adverse Incident reporting and learning systems.
The Circular provides guidance on:
(i) the transitional reporting arrangements which will be put in place pending the full establishment of a new Regional Adverse Incident and Learning (RAIL) system, and
(ii) the revised reporting roles and responsibilities of stakeholder organisations.

Enquiries:

Any enquiries about the content of this Circular should be addressed initially to:
Safety & Quality Unit
DHSSPS
Room D 1
Castle Buildings
Stormont
BELFAST

Circular Reference: HSC (SQSD) 08/2010

Date of Issue: 30 April 2010

Related documents

DS 154/06 – Emergency Care Reform – Definition & Guidance Framework
HSS(MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports
HSS(MD) 06/2006: Memorandum of Understanding – Investigation Patient/Client Safety Incidents
HSC (SQSD) 22/2009: Phase 1 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

Superseded documents

HSS (PPM) 06/2004: Reporting and follow-up on SAIs: Interim guidance
HSS (PPM) 05/2005: Reporting of SAIs within the HPSS
Letter from Chief Inspector, Social Services Inspectorate 'Interface between Juvenile Justice Centre and Children in Residential Care', 1 November 2005
HSS (PPM) 02/2006: Reporting and follow-up on SAIs
HSS(MD) 12/2006: Guidance Document – "How to Classify Incidents and Risk"
Letter from the Chief Inspector, Social Services Inspectorate 'Interface between Juvenile Justice Centre and Children in Residential Care', 11 September 2006
HSC(SQSD) 19/2007: Reporting and follow-up on SAIs/Reporting on breaches of patients waiting in excess of 12 hours in Emergency Care Departments
Letter from Chief Social Services Officer 'Serious Adverse Incidents involving Looked After Children in Residential Care entering the Juvenile Justice Centre' , 15 May 2008

Status of Contents:

Action

Implementation:

From 1 May 2010

BT4 3SQ
Tel: 028 9052 8561
E-mail: sean.scullion@dhsspsni.gov.uk

Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance.htm

Dear Colleague

LEARNING FROM ADVERSE INCIDENTS AND NEAR MISSES REPORTED BY HSC ORGANISATIONS AND FAMILY PRACTITIONER SERVICES

Introduction

In March 2009, I wrote to you about the initial steps being taken to phase out the reporting of Serious Adverse Incidents (SAIs) to the Department and the implementation of the Regional Adverse Incident and Learning (RAIL) model.

The new RAIL model will reflect the statutory responsibilities of Health and Social Care organisations and will introduce a more coherent and comprehensive regional system for reporting incidents. This will ensure that safety messages and regional learning are identified and disseminated in a consistent and effective manner, and will provide a focus on driving improvements in the quality and safety of services through ensuring that important learning is used to inform and improve practice. It will also ensure that the Department and the Minister are informed of significant events in a timely fashion through the establishment of an Early Alert system, and the arrangements for this will be the subject of a separate circular.

The purpose of this circular is to provide specific guidance on:

a) the arrangements which will be in place following the transfer of the existing Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency, pending the establishment of RAIL, **Section 1**; and

b) the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department, **Section 2**.

This guidance will take effect from 1st May 2010. These arrangements will remain in place until the full implementation of the RAIL system, at which point they will be reviewed.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Yours sincerely

Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

Section 1: Reporting Serious Adverse Incidents

1.1 This section outlines the revised arrangements for reporting and management of serious adverse incidents, pending the full implementation of the new RAIL system.

Changes to the reporting of Serious Adverse Incidents

1.2 The requirement on HSC organisations to routinely report SAIs to the Department will cease with effect from the 1st May 2010. Those SAIs which have been reported to the Department up until this date will be reviewed by the Department, with a view to transferring responsibility for any follow-up action that may be required to the HSC Board, working with the PHA. However, it is likely that the Department will wish to retain oversight responsibility for a small number of incidents reported prior to 1st May 2010 where it considers there are particular or significant issues in relation to regional learning, and these will continue to be considered by the Department SAI Review Group, which will remain in operation for a limited period of time to facilitate this. Consequently the Department may continue to request appropriate follow-up information from reporting organisations in relation to these particular cases.

1.3 ***Reports to the HSC Board –*** In line with the operational guidance[1] issued by the HSC Board and PHA to HSC Trusts in parallel with this circular, all incidents which meet the criteria for SAIs as defined in this operational guidance should be reported to the HSC Board with effect from the 1st May 2010. Family Practitioner Services should maintain their existing arrangements for reporting SAIs to the HSC Board.

1.4 The HSC Board will acknowledge receipt of each SAI notified to it, and will obtain any necessary professional advice from the appropriate health and social care professional within the PHA or HSC Board. The PHA and the HSC Board will jointly determine whether any immediate action is required. The HSC Board will ensure that all relevant professional disciplines are involved as appropriate in the management of the incident. The HSC Board will request an incident investigation be carried out by the reporting organisation, to be forwarded to it within 12 weeks in line with current practice. In this regard, incident reviews should continue to be conducted and submitted in the format outlined in HSS (MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports, included at Appendix 3 of the HSC Board/PHA operational guidance. In addition, the National Patient Safety Agency's toolkit is available for investigations which require a full root cause analysis[2].

1.5 The HSC Board will establish a system to ensure that the reports of investigations are discussed by relevant multi-disciplinary staff from the HSC Board and the PHA to identify any learning recommendations arising, and the most appropriate methods of sharing and/or disseminating the lessons therein. The HSC Board will liaise with the Department as appropriate regarding the most effective mechanisms for disseminating any regional guidance which may be required.

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[1] http://www.hscboard.hscni.net/lnews/22%20April%202010%20-%20HSCB%20Procedure%20for%20the%20reporting%20and%20followup%20of%20SAI%20-%20April%202010.pdf

[2] http://www.nrls.npsa.nhs.uk/resources/?entryid45=59901

1.6 HSC organisations will retain their existing responsibility for reporting, managing, investigating, analysing and learning from adverse incidents/near misses occurring within their organisation in accordance with criterion 4 of the core Risk Management Controls Assurance Standard (CAS). The Risk Management CAS is being updated in line with this circular and will be available on the Department's website from June 2010. These responsibilities are described in more detail in **Section 2**. Similarly the HSC Board will retain existing responsibilities with regard to adverse incidents occurring in Family Practitioner Services.

1.7 ***Reports to the Regulation and Quality Improvement Authority (RQIA)*** - RQIA will continue to require incidents to be reported to it in accordance with the new statutory responsibilities it assumed associated with the transfer of functions from the Mental Health Commission, as detailed in the 2007 UTEC Committee guidance [3]. These include incidents involving ***suspected suicides*** and ***under 18s admitted to adult mental health and learning disability facilities*** as referred to in circular HSC(SQSD) 22/09.

1.8 The RQIA also has extended responsibilities under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Under the 'national preventative mechanism' (NPM), there is a statutory requirement to inform RQIA of the death of any patient or client not resulting from natural causes (including homicides), physical, sexual or other serious assaults and allegations/incidents of abuse in hospital or community services. This should involve, where appropriate, collaborative working with the HSC Board. Further details of RQIA responsibilities in respect of reporting and investigation of incidents are set out in Section 2.

1.9 ***Reporting of suspected suicides -*** From 1st May 2010, SAIs involving suspected suicides are to be reported to both the HSC Board and RQIA in the first instance. However, the management and follow-up of reported incidents with the reporting organisation will be undertaken by the HSC Board and PHA, who will liaise with RQIA in this process.

1.10 ***Reporting of incidents under Children Order Statutory Functions –*** Incidents/events relating to;

(a) the admission of under 18s to adult mental health and learning disability facilities;
(b) children from a looked after background who abscond from care settings, which includes trafficked children and unaccompanied/asylum seeking children;
(c) children from a looked after background who are admitted to the Juvenile Justice Centre or Young Offenders' Centre;
(d) placements outside of the regulated provision for 16-17 year olds; and
(e) serious incidents necessitating calling the police to a children's home

will no longer be reported through the SAI reporting system. With effect from 1st May 2010 such incidents/events should instead be reported directly to the Social Care and Children Directorate at the HSC Board. Details of the arrangements for such notifications are set out in the operational guidance issued by the Social Care and Children Directorate at the HSC Board.

[3] www.dhsspsni.gov.uk/utec_guidance_august_2007.pdf

1.11 ***Breach of 12 hours A&E standard*** – the Performance Management & Service Improvement Directorate within the HSC Board will continue to monitor breaches of this standard. The reporting of these should be emailed direct to hscbinformation@hscni.net using the existing proforma.

Section 2: Roles, Responsibilities and Accountability Arrangements for incident reporting pending the establishment of RAIL

Health and Social Care Trusts

2.1 HSC Trusts are responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide.

2.2 HSC Trusts are required to:

- Maintain a system to record and track adverse incidents/near misses in their organisation;
- Adhere to guidance issued by the HSC Board/PHA with regard to managing SAIs;
- Take any immediate steps necessary to prevent re-occurrence of harm;
- Investigate incidents using a method proportionate to the incident (and in compliance with the requirements set out in the joint Memorandum of Understanding between the HSC, Coroner's Service, PSNI and Health and Safety Executive on investigating patient or client safety incidents[4]) and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep the affected patient/client/their family informed at all stages of the incident, investigation and follow-up;
- Send recommendations that are relevant regionally to the HSC Board;
- Implement regional and local recommendations;
- Be able to provide evidence to the HSC Board and PHA that the requirements above are being met.

Family Practitioner Services

2.3 Family Practitioner Services are responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses within the context of the services that they provide. They will be required to produce evidence of learning as part of their clinical and social care governance arrangements which the HSC Board may use as part of its performance monitoring and service improvement or contractual monitoring arrangements.

2.4 Family Practitioner Services are required to:

- Maintain a system to record and track adverse incidents/near misses in their practice;
- Report to the RQIA and the HSC Board all actual or suspected suicides of patients registered with a GP practice and in receipt of secondary mental health care services in the last two years;

[4] http://www.dhsspsni.gov.uk/ph_hss(md)_6_-_2006.pdf
http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

- Investigate incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep the affected patient/client/their family informed at all stages of the incident, investigation and follow-up;
- Send recommendations that are relevant regionally, to the HSC Board;
- Implement regional and local recommendations;
- Be able to provide evidence to the HSC Board that the requirements above are being met.

Health and Social Care Board

2.5 In line with the HSC Board's performance management and accountability functions, it will hold Trusts and Family Practitioner Services to account for the effective discharge of their responsibilities in reporting and investigating adverse incidents and near misses, and will provide assurance to the Department that these responsibilities are being met and that learning is being implemented. In general terms, the HSC Board is responsible for maintaining those adverse incident reporting and monitoring mechanisms it considers necessary to enable it to carry out the full range of its commissioning, performance management and service improvement functions effectively, ensuring appropriate multidisciplinary involvement of HSC Board and PHA health and social care professionals.

2.6 The HSC Board, working with the PHA, will be responsible for the management of SAI reporting under the arrangements set out in its operational guidance, pending the full implementation of the RAIL system. In addition, the HSC Board is responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that it provides.

2.7 The HSC Board is required to:

- Maintain a system to manage SAI reporting, in partnership with the Agency, in line with the arrangements set out in the operational guidance issued in tandem with this circular, pending the implementation of the RAIL system;
- With input from the PHA, hold Trusts to account for the responsibilities outlined in paragraph 2.2 and provide assurance to the Department that these responsibilities are being met;
- Hold Family Practitioner Services to account for the responsibilities outlined in paragraph 2.4 and provide assurance to the Department that these responsibilities are being met;
- Maintain a system to record and track adverse incidents/near misses that occur within the HSC Board;
- Investigate such incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep relevant parties informed at all stages of the incident, investigation and follow-up;
- Send recommendations from such incidents that are relevant regionally, to adverse.incidents@dhsspsni.gov.uk;
- Implement regional and local recommendations;
- Be able to provide evidence to the Department that the requirements above are being met; and
- Participate as a member of the RAIL implementation project.

Public Health Agency

2.8 The PHA, through its integrated commissioning responsibilities with the HSC Board, will support the HSC Board in holding HSC Trusts and Family Practitioner Services to account for the discharge of their responsibilities and ensuring that regional learning is identified and disseminated, and will work with the Board to maintain a system for managing SAIs, pending the full establishment of the RAIL system.

2.9 The PHA will assume lead responsibility for implementing the RAIL system, including securing professional input as appropriate. In addition, the PHA will have responsibility for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that it provides.

2.10 The PHA is required to:

- Work with the HSC Board to maintain a system to manage SAI reporting, pending the establishment of the RAIL system;
- Maintain a system to record and track adverse incidents that occur within the PHA;
- Investigate such incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep relevant parties informed at all stages of the incident, investigation and follow-up;
- Send recommendations from such incidents that are relevant regionally, to adverse.incidents@dhsspsni.gov.uk;
- Implement regional and local recommendations;
- Be able to provide evidence to the Department that the requirements above are being met;
- Support the HSC Board in holding Trusts to account for the responsibilities outlined in paragraph 2.2 and provide assurance to the Department that these responsibilities are being met;
- Work collaboratively with the Department and the HSC Board to develop and progress the support structures and processes which will underpin the new RAIL system;
- Be responsible for the operational management of the RAIL system, once established; and
- Nominate the Project Director and provide administrative support for the RAIL implementation project.

Regulation and Quality Improvement Authority

2.11 From 1st April 2009, RQIA assumed responsibility for those incident reporting requirements which were previously the domain of the Mental Health Commission. This includes oversight of adverse incidents occurring within the mental health and learning disability programmes of care, establishing trend analysis and reporting on regional learning from such incidents or issues.

2.12 RQIA is also a named organisation under the UK's National Preventative Mechanism (NPM) established in accordance with the Optional Protocol to the Convention Against Torture (OPCAT). Under the NPM, RQIA is required to visit places of detention, regularly examine the treatment of persons deprived of their liberty, access all information referring to the treatment of those persons as well as their conditions of detention and make recommendations to the relevant authorities.

2.13 The RQIA will:

- Require HSC Trusts to continue to report adverse incidents to it where there are underlying statutory obligations to do so;
- Require HSC Trusts to share reports of adverse incidents occurring in a mental health and learning disability setting in accordance with discharging its new functions under the HSC (Reform) Act (NI) 2009[5]; and
- Require the HSC Board to share other relevant monitoring information in relation to mental health and learning disability programmes of care.

The Department

2.14 In line with its core functions and the revised accountability arrangements which came into effect from April 2009 following the re-organisation of services as part of the Review of Public Administration, the Department will:

- Continue to host the SAI Review Group for a limited period, and will progress a small number of existing SAIs, along with dissemination as appropriate of any regional learning arising from new incidents;
- Oversee the project management arrangements for the implementation of the RAIL system;
- Seek assurance from the HSC Board/PHA on the effectiveness of the interim incident reporting arrangements within HSC Trusts and Family Practitioner Services;
- Seek assurance from the PHA that it will be in a position to effectively operate the RAIL system, including securing professional input to identifying and cascading regional learning.

[5] 2009 c.1 (N.I.)

Timetable for Implementation of RAIL

3.1 It is planned that the RAIL system will be implemented, in partnership with key stakeholders in the process, on a phased basis over the next one to two years, subject to testing of the feasibility, cost and effectiveness of the system.

3.2 As part of the implementation process, a business case for the establishment of the administrative and IT support structures around the RAIL system will be developed, and a number of pilots will be rolled out and tested across the HSC.

Conclusion

3.3 This guidance circular covers the interim reporting arrangements for the initial phase of that implementation process, setting out the roles and responsibilities of all stakeholder bodies in this period, and will be reviewed when the RAIL system is established. Revised guidance will be issued when the new arrangements are in place.

Health and Social Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

October 2013

CONTENTS

FOREWORD

Commissioners and Providers of health and social care want to ensure that when a serious event or incident occurs, there is a systematic process in place for safeguarding services users, staff, and members of the public, as well as property, resources and reputation.

One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from serious adverse incidents (SAI). Working in conjunction with other Health and Social Care (HSC) organisations, this procedure has been developed to provide a system-wide perspective on serious incidents occurring within the HSC and Special Agencies and also takes account of the independent sector where it provides services on behalf of the HSC.

The procedure seeks to provide a consistent approach to:

- what constitutes a serious adverse incident;
- clarifying the roles, responsibilities and processes relating to the reporting, investigation, dissemination and implementation of learning
- fulfilling statutory and regulatory requirements
- tools and resources that support good practice.

Our aim is to work toward clearer, consistent governance arrangements for reporting and learning from the most serious incidents; supporting preventative measures and reducing the risk of serious harm to service users.

The implementation of this procedure will not only support governance at a local level within individual organisations but will also improve existing regional governance and risk management arrangements by facilitating openness, trust, continuous learning and ultimately service improvement.

John Compton
Chief Executive

SECTION ONE

1.0 BACKGROUND

Circular HSS (PPM) 06/04 introduced interim guidance on the reporting and follow-up on serious adverse incidents (SAIs). Its purpose was to provide guidance for HPSS organisations and special agencies on the reporting and management of SAIs and near misses.
www.dhsspsni.gov.uk/hss(ppm)06-04.pdf

Circular HSS (PPM) 05/05 provided an update on safety issues; to underline the need for HPSS organisations to report SAIs and near misses to DHSSPS in line with Circular HSS (PPM) 06/04
www.dhsspsni.gov.uk/hssppm05-05.pdf

Circular HSS (PPM) 02/2006 drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified respective organisations of changes in the way SAIs should be reported in the future and provided a revised report pro forma. It also clarified the processes DHSSPS had put in place to consider SAIs notified to it, outlining the feedback that would then be made to the wider HPSS.
www.dhsspsni.gov.uk/qpi_adverse_incidents_circular.pdf

In March 2006, DHSSPS introduced Safety First: A Framework for Sustainable Improvement in the HPSS. The aim of this document was to draw together key themes to promote service user safety in the HPSS. Its purpose was to build on existing systems and good practice so as to bring about a clear and consistent DHSSPS policy and action plan.
http://www.dhsspsni.gov.uk/safety_first_-_a_framework_for_sustainable_improvement_on_the_hpss-2.pdf

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care were issued by DHSSPS in March 2006.
www.dhsspsni.gov.uk/qpi_quality_standards_for_health___social_care.pdf

Circular HSC (SQS) 19/2007 advised of refinements to DHSSPS SAI system and of changes which would be put in place from April 2007, to promote learning from SAIs and reduce any unnecessary duplication of paperwork for organisations. It also clarified arrangements for the reporting of breaches of patients waiting in excess of 12 hours in emergency care departments.
http://www.dhsspsni.gov.uk/hss__sqsd__19-07.pdf

Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986, the Regulation & Quality Improvement Authority (RQIA) has a duty to make inquiry into any case where it appears to the Authority that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to reporting requirements under the above Order

previously issued in April 2000 was reviewed, updated and re-issued in August 2007. (Note: Functions of the previous Mental Health Commission transferred to RQIA on 1 April 2009)
www.dhsspsni.gov.uk/utec_guidance_august_2007.pdf

Circular HSC (SQSD) 22/2009 provided specific guidance on initial changes to the operation of the system of SAI reporting arrangements during 2009/10. The immediate changes were to lead to a reduction in the number of SAIs that were required to be reported to DHSSPS. It also advised organisations that a further circular would be issued giving details about the next stage in the phased implementation which would be put in place to manage the transition from the DHSSPS SAI reporting system, through its cessation and to the establishment of the RAIL system.
www.dhsspsni.gov.uk/hsc-sqsd-22-09.pdf

Circular HSC (SQSC) 08/2010, issued in April 2010, provided guidance on the transfer of SAI reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency. It also provided guidance on the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department,
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance.htm

Circular HSC (SQSD) 10/2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA).
http://www.dhsspsni.gov.uk/hsc__sqsd__10-10.pdf

In May 2010 responsibility for management of SAI reporting transferred from the DHSSPS (Department) to HSCB working in partnership with the Public Health Agency (PHA). Following consultation with key stakeholders, the HSCB issued the procedure for the 'Reporting and Follow up of Serious Adverse Incidents' to HSC Trusts, Family Practitioner Services (FPS) and Independent Service Providers.
http://www.hscboard.hscni.net/publications/Policies/101%20Serious%20Adverse%20Incident%20-%20Procedure%20for%20the%20reporting%20and%20followup%20of%20SAI%20-%20April%202010%20-%20PDF%20268KB%20.pdf

In May 2010 the Director of Social Care and Children HSCB issued guidance on 'Untoward Events relating to Children in Need and Looked After Children' to HSC Trusts. This guidance clarified the arrangements for the reporting of events, aligned to delegated statutory functions and Departmental Guidance,

which are more appropriately reported to the HSCB Social Care and Children's Directorate.

In 2005 the Regional Adult Protection Forum produced standardised, regional policies and procedures in the 'Safeguarding Vulnerable Adults' document, a framework based on best practice. This document represented a major new phase in improving adult protection arrangements across the region.
www.hscboard.hscni.net/publications/LegacyBoards/001%20Regional%20Adult%20Protection%20Policy%20and%20Procedural%20Guidance%202006%20-%20PDF%20249KB.pdf

In February 2011 the HSCB issued the 'Protocol for responding to SAIs involving an alleged homicide' perpetrated by a service user known to/referred to mental health and/or learning disability services, in the two years prior to the incident. The 2013 revised HSCB 'Protocol for responding to SAIs involving an alleged homicide' is contained in Appendix 13.

Circular HSS (MD) 8/2013 replaces HSS (MD) 06/2006 and advises of a revised Memorandum of Understanding (MOU) when investigating patient or client safety incidents. This revised MOU is designed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations are required when a serious incident occurs.
http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

DHSSPS Memo dated 17 July 2013 from Chief Medical Officer introduced the HSCB/PHA protocol on the dissemination of guidance/information to the HSC and the assurance arrangements where these are required. The protocol assists the HSCB/PHA in determining what actions would benefit from a regional approach rather than each provider taking action individually.

2.0 INTRODUCTION

The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Organisations, and Special Agencies (SA) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of their business or commissioned service.

The requirement on HSC organisations to routinely report SAIs to the Department of Health, Social Services and Public Safety (DHSSPS) ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA).

This process aims to:

- Provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users.

- Provide a coherent approach to what constitutes a SAI; to ensure consistency in reporting across the HSC and Special Agencies.

- Clarify the roles, responsibilities and processes relating to the reporting, investigation, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation / Special Agency or commissioned/funded service;

- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the investigation.

- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;

- Recognise the responsibilities of individual organisations and support them in ensuring compliance; by providing a culture of openness and transparency that encourages the reporting of SAIs

- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;

- Maintain a high quality of information and documentation within a time bound process.

SECTION TWO

3.0 APPLICATION OF PROCEDURE

3.1 Who does this procedure apply to?

This procedure applies to the reporting and follow up of SAIs arising during the course of the business in DHSSPS Arm's Length Bodies (ALBs) i.e.

- ***HSC organisations (HSC)***
  - Health and Social Care Board
  - Public Health Agency
  - Business Services Organisation
  - Belfast Health and Social Care Trust
  - Northern Health and Social Care Trust
  - Southern Health and Social Care Trust
  - South Eastern Health and Social Care Trust
  - Western Health and Social Care Trust
  - Northern Ireland Ambulance Service
  - Regulation & Quality Improvement Authority

- ***Special Agencies (SA)***
  - Northern Ireland Blood Transfusion Service
  - Patient Client Council
  - Northern Ireland Medical and Dental Training Agency
  - Northern Ireland Practice and Education Council

The principles for SAI management set out in this procedure are relevant to all the above organisations. Each organisation should therefore ensure that its incident policies are consistent with this guidance while being relevant to its own local arrangements.

3.2 Incidents reported by Family Practitioner Services (FPS)

Adverse incidents occurring within services provided by independent practitioners within: General Medical Services, Pharmacy, Dental or Optometry, are routinely forwarded to the HSCB Integrated Care Directorate in line with the HSCB FPS Adverse Incident Protocol. On receipt of reported adverse incidents the HSCB Integrated Care Directorate will decide if the incident meets the criteria of a SAI and if so will be the organisation responsible to report the SAI.

3.3 Incidents that occur within the Independent /Community & Voluntary Sectors (ICVS)

SAIs that occur within ICVS, where the service has been commissioned/funded by a HSC organisation must be reported. For example: service users placed/funded by HSC Trusts in independent sector accommodation, including private hospital, nursing or residential care homes, supported housing, day care facilities or availing of HSC funded voluntary/community services. These SAIs must be reported and investigated by the HSC organisation who has:

- referred the service user (this includes Extra Contractual Referrals) to the ICVS;

or, if this cannot be determined;

- the HSC organisation who holds the contract with the IVCS

HSC organisations that refer service users to ICVS should ensure all contracts, held with ICVS, include adequate arrangements for the reporting of adverse incidents in order to ensure SAIs are routinely identified.

All relevant events occurring within ICVS which fall within the relevant notification arrangements under legislation should continue to be notified to RQIA.

3.4 Reporting of HSC Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up investigation may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form (see Appendix 3). The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the investigation. In

these instances refer to Appendix 12 – Guidance on Joint Investigations.

3.5 Incidents reported and investigated by Organisations external to HSC and Special Agencies

The reporting of SAIs to the HSCB will work in conjunction with and in some circumstances inform the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure

3.5.1 Memorandum of Understanding (MOU)

In February 2006, the DHSSPS issued circular HSS (MD) 06/2006 − a Memorandum of Understanding − which was developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations are required into a serious incident.

Circular HSS (MD) 8/2013 replaces the above circular and advises of a revised MOU Investigating patient or client safety incidents which can be found on the Departmental website:

http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

The MOU has been agreed between the DHSSPS, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

It sets out the general principles for the HSCS, PSNI, Coroners Service for NI and HSENI to observe when liaising with one another.

The purpose of the MOU is to promote effective communication between the organisations. The MOU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for NI or HSENI separately or jointly. This may be the case when an

incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.

The MOU is intended to help:

- Identify which organisations should be involved and the lead investigating body.

- Prompt early decisions about the actions and investigations thought to be necessary by all organisations and a dialogue about the implications of these.

- Provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high level decisions are taken.

- Ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

HSC Organisations should note that the MOU does not preclude simultaneous investigations by the HSC and other organisations e.g. Root Cause Analysis by the HSC when the case is being investigated by the Coroner's Service and/or PSNI/HSENI.

In these situations, the Strategic Communication and Decision Group can be used to clarify any difficulties that may arise; particularly where an external organisation's investigation has the potential to impede a SAI investigation and subsequently delay the dissemination of regional learning.

3.6 Reporting of SAIs to RQIA

RQIA have a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and investigation, RQIA will work in conjunction with the HSCB/PHA with regard to the review of certain categories of SAI. In this regard the following SAIs should be notified to RQIA at the same time of notification to the HSCB:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.

*It is acknowledged these incidents should already have been reported to RQIA as a **'notifiable event'** by the statutory or independent organisation where the incident has occurred (in line with relevant reporting regulations). This notification will alert RQIA that the incident is also being investigated as a SAI by the HSC organisation who commissioned the service.*

- The HSCB/PHA Designated Review Officer (DRO) will lead and co-ordinate the SAI management, and follow up, with the reporting organisation; however for these SAIs this will be carried out in conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 14.

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'.[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service

The following criteria will determine whether or not an adverse incident constitutes a SAI.

4.2 SAI criteria

4.2.1. serious injury to, or the unexpected/unexplained death of:
- a service user (including those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2. any death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register;

4.2.3. unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.4. unexpected or significant threat to provide service and/or maintain business continuity;

4.2.5. serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.6. serious self-harm or serious assault *(including homicide and sexual assaults*)
- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old*

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

4.2.7. suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.8. serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

Note: The new HSC Regional Risk Matrix may assist organisations in determining the level of 'seriousness' refer to Appendix 15

5.0 SAI INVESTIGATIONS

SAI investigations should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of investigation focuses on the complexity of the incident and not solely on the significance of the event.

Whilst most SAIs will be subject to a Level 1 investigation, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 investigation immediately following the incident occurring. The level of investigation should be noted on the SAI notification form.

The HSC Regional Risk Matrix (refer to Appendix 15) may assist organisations in determining the level of 'seriousness' and subsequently the level of investigation to be undertaken. SAIs which meet the criteria in 4.2 above will be investigated by the reporting organisation using one or more of the following:

5.1 Level 1 Investigation – Significant Event Audit (SEA)

Most SAI notifications will enter the investigation process at this level and an SEA will immediately be undertaken to:

- assess why and what has happened
- agree follow up actions
- identify learning.

The possible outcomes from the investigation may include:

- closed – no new learning
- closed – with learning
- requires Level 2 or 3 investigation.

(refer to Appendix 5 guidance on SEA investigations)

If it is determined this level of investigation is sufficient, an SEA report will be completed (see Appendix 4) and sent to the HSCB within 4 weeks (6 weeks by exception) of the SAI being reported.

If the SEA determines the SAI is more complex and requires a more detailed investigation, the investigation will move to either a Level 2 or 3 investigation. In this instance the SEA report will still be forwarded to the HSCB within 4 weeks (6 weeks by exception) of the SAI being reported with additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 investigations.

5.2 Level 2 – Root Cause Analysis (RCA)

As stated above, some SAIs will enter at Level 2 investigation following a SEA.

When a Level 2 or 3 investigation is instigated immediately following notification of a SAI, the reporting organisation will inform the HSCB within 4 weeks, of the Terms of Reference (TOR) and Membership of the Investigation Team for consideration by the HSCB/PHA DRO. This will be achieved by submitting sections two and three of the investigation report to the HSCB. (Refer to Appendix 6 – template for Level 2 & 3 investigation reports).

The investigation must be conducted to a high level of detail (see Appendix 6 – template for Level 2 & 3 investigation reports). The investigation should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. (Refer to Appendix 10 Guidance notes on membership of review teams for Level 2 investigations).

Level 2 RCA investigations may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final investigation report (Refer to Appendix 12 Guidance on joint investigations).

On completion of Level 2 investigations, the final report must be submitted to the HSCB:

- within 12 weeks from the date the incident was discovered, or

- within 12 weeks from the date of the SEA.

5.3 Level 3 – Independent Investigation

Level 3 investigations will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice;
- are very high profile and attracting a high level of both public and media attention.

In some instances the whole team may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting, Chair and Membership of the investigation team will be agreed by the HSCB/PHA Designated Review Officer (DRO) at the outset (see Appendix 11 Guidance notes for Level 3 investigations).

The format for Level 3 investigation reports will be the same as for Level 2 investigations (see Appendix 7 – guidance notes on template for Level 2 and 3 investigations).

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident, the Protocol for Responding to a SAI in the Event of a Homicide, issued in 2010 and revised in 2013 should be followed (see Appendix 13).

5.4 Involvement of Service Users/Relatives/Carers in Investigations

It is important that teams involved in investigations in any of the above three levels ensure sensitivity to the needs of the service user/relatives/carers involved in the incident and agree appropriate communication arrangements, where appropriate.

The Investigation Team should provide an opportunity for the service user / relatives / carers to contribute to the investigation, as is felt necessary. The level of involvement clearly depends on the nature of the incident and the service users/relatives/carers wishes to be involved.

6.0 TIMESCALES

6.1 Notification

Any adverse incident that meets the criteria indicated in section 4.2 should be reported within **72 hours** of the incident being discovered using the SAI Notification Form (see Appendix 1).

6.2 Investigation Reports

LEVEL 1 – SEA

SEA reports must be completed using the SEA template and submitted to the HSCB within **4 weeks (6 weeks by exception)** of the SAI being notified.

LEVEL 2 – RCA

For those SAIs where a full RCA is instigated immediately, sections 2 & 3 of the RCA Report, outlining TOR and membership of the investigation team, must be submitted **no later** than **within 4 weeks** of the SAI being notified to the HSCB.

RCA investigation reports must be fully completed using the RCA report template and submitted to the HSCB **12 weeks** following the date the incident was discovered, or from the date of the SEA.

LEVEL 3 – INDEPENDENT INVESTIGATIONS

Timescales for completion of Level 3 investigations will be agreed between the reporting organisation and the HSCB/PHA DRO as soon as it is determined that the SAI requires a Level 3 investigation.

6.3 Investigation Report Extensions

LEVEL 1 INVESTIGATIONS – SEA

Extensions **will not** be granted for this level of investigation.

LEVEL 2 INVESTIGATIONS - RCA

In most circumstances, all timescales for submission of RCA investigation reports **must be** adhered to. However, it is acknowledged, by exception, there may be occasions where an investigation is particularly complex, perhaps involving two or more organisations or where other external organisation such as PSNI, HSCNI etc; are involved in the same investigation. In these instances the reporting organisation may request **one** extension to the normal timescale i.e. 12 weeks from timescale for submission of SEA report. This request **must be approved by the DRO** and should be requested when submitting the SEA report.

LEVEL 3 INVESTIGATIONS – INDEPENDENT

All timescales must be agreed with the DRO at the outset of the investigation. One extension may be granted, if agreed by the DRO.

6.4 Responding to additional information requests

Once the investigation report has been received, the DRO, with appropriate clinical or other support, will review the report to ensure that both the investigation and action plan are comprehensive.

If the DRO is not satisfied that the report reflects a robust investigation additional information may be requested. Responses to additional information requests must be provided in a timely manner:

- Level One investigation within **1 week**
- Level Two or Three investigation within **4 weeks.**

Progress in relation to timeliness of completed investigation reports will be monitored and reported to HSCB/PHA Regional SAI Group. Any variance from timescales and processes will be escalated, if necessary, to the HSCB's bi-monthly meetings with Trusts.

7.0 OTHER INVESTIGATIVE PROCESSES

The reporting of SAIs to the HSCB will work in conjunction with all other HSC investigation processes, statutory agencies and external bodies. In that regard, all existing reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

In that regard, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI.

7.1 Complaints in the HSC

Complaints in HSC' Standards and Guidelines for Resolution and Learning (The Guidance) outlines how HSC organisations should deal with complaints raised by persons who use/have used, or are waiting to use HSC services. While it is a separate process to the management and follow-up of SAIs, there will be occasions when an SAI has been reported by a HSC organisation, and subsequently a complaint is received relating to the same incident or issues, or alternatively, a complaint may generate the reporting of an SAI.

In these instances, the relevant HSC organisation must be clear as to how the issues of complaint will be investigated. For example, there may be elements of the complaint that will be solely reliant on the

outcome of the SAI investigation and there may be aspects of the complaint which will not be part of the SAI investigation and can only be investigated under the Complaints Procedure.

It is therefore important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to a SAI investigation. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner. Fundamental to this, will obviously be the need for the organisation investigating the complaint to communicate effectively with the complainant in respect of how their complaint will be investigated, and when and how they can expect to receive a response from the HSC organisation.

7.2 HSCB Social Care Untoward Events Procedure

The above procedure provides guidance on the reporting of incidents relating to statutory functions under the Children (NI) Order 1995.

If, during the investigation of an incident reported under the HSCB Untoward Events procedure, it becomes apparent the incident meets the criteria of a SAI, the incident should immediately be notified to the HSCB as a SAI. Board officers within the HSCB will close the Untoward Events incident and the incident will continue to be managed via the SAI process.

7.3 Child Protection and Adult Protection

Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to a child and adult protection.

If during the investigation of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the HSCB as an SAI.

It should be noted that, where possible, safeguarding investigations will run in **parallel** as separate investigations to the SAI process with the relevant findings from these investigations informing the SAI investigation and vice versa. However, all such investigations should be conducted in accordance with the processes set out in the Protocols for Joint Investigation of Cases of Alleged or Suspected Abuse of Children or Adults.

In these circumstances, the DRO should liaise closely with the HSC Trusts on the progress of the investigation and the likely timescales for completion of the SAI Report.

On occasion the incident under investigation may be considered so serious as to meet the criteria for a Case Management Review (CMR)

for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the HSCB as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

7.4 Transferring SAIs to other Investigation Processes

Following notification and initial investigation of a SAI, more information may emerge that determines the need for a specialist investigation.

This type of investigation includes:

- Case Management Reviews
- Serious Case Reviews
- Independent / Public Inquiry.

Once a DRO has been informed a SAI has transferred to one of the above investigation s/he will close the SAI and inform all relevant organisations.

7.5 De-escalating a SAI

It is recognised that organisations report SAIs based on limited information and the situation may change when more information has been gathered; which may result in the incident no longer meeting the SAI criteria.

Where a reporting organisation has determined the incident reported no longer meets the criteria of a SAI, a request to de-escalate the SAI should be submitted immediately to the HSCB by completing section 18 of the SAI notification form (Additional Information following initial Notification).

The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **5 working days** from the request was submitted.

If the DRO agrees, the SAI will be de-escalated and no further SAI investigation will be required. The reporting organisation may however continue to investigate as an adverse incident or in line with other HSC investigation processes (as highlighted above). If the DRO makes a decision that the SAI should not be de-escalated the investigation report should be submitted in line with previous timescales.

It is important to protect the integrity of the SAI investigation process from situations where there is the probability of disciplinary action, or criminal charges. The SAI investigation team must be are aware of the clear distinction between the aims and boundaries of SAI investigations, which are solely for the identification and reporting learning points, compared with disciplinary, regulatory or criminal processes.

HSC organisations have a duty to secure the safety and well-being of patients, the investigation to determine root causes and learning points should still be progressed ***in parallel*** *with other investigations, ensuring remedial actions are put in place as necessary and to reduce the likelihood of recurrence.*

8.0 LEARNING FROM SAIs

The key aim of this procedure is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided.

HSCB in conjunction with the PHA will:

- ensure that themes and learning from SAIs are identified and disseminated for implementation in a timely manner; this may be done via:
  - learning letters
  - learning newsletter
  - thematic reviews;

- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;

- review and consider learning from external/independent reports relating to quality/safety.

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations, which should run in parallel with the dissemination of any regional learning issued by HSCB/PHA.

9.0 REGIONAL ADVERSE INCIDENT LEARNING SYSTEM (RAIL)

Future introduction of any regional learning system, such as the Regional Adverse Incident Learning System (RAIL), will include establishing links with the procedure for learning from SAIs to contribute to a regional whole system approach to learning in health and social care.

10.0 TRAINING AND SUPPORT

10.1 Training

Training will be provided to ensure that those involved in SAI investigations have the correct knowledge and skills to carry out their role, i.e:

- Chair and/or member of an SAI investigation team
- HSCB/PHA DRO.

This will be achieved through an educational process in collaboration with all organisations involved, and will include training on investigation processes, policy distribution and communication updates.

10.2 Support

The HSCB/PHA will develop a panel of 'lay people' with professional areas of expertise in health and social care, which organisations can call upon to act as a chair and/or a member of a SAI investigation team (particularly when a degree of independence to the team is required).

The HSCB/PHA will ensure lay people are trained in investigation techniques for all three levels of investigation (similar to training as indicated above).

If a DRO wants a particular clinical view on the SAI investigation, the Governance Team will secure that input, under the direction of the DRO.

11.0 INFORMATION GOVERNANCE

The SAI process deals with a considerable amount of sensitive personal information. Appropriate measures must be put in place to ensure the safe and secure transfer of this information. As a minimum the HSCB would recommend the following measures be adopted when transferring patient/client identifiable information via e-mail or by standard hard copy mail:

- E-Mail – All e-mails containing patient identifiable information sent outside of the HSC e-mail network must be encrypted. E-mails sent within the secure HSC Network (e-mail addresses ending in [redacted], [redacted], [redacted] or [redacted]) are more secure however attachments/content that contains patient level information should still be protected. This can be done by password protecting Microsoft Word and Excel attachments. Passwords can then be relayed via the telephone to ensure the correct individual gains access.

- Standard Mail – It is recommended that any mail which is deemed valuable, confidential or sensitive in nature (such as patient level information) should be sent using 'Special Delivery' Mail.

Further guidance is available from the HSCB Information Governance Team on: Tel [redacted]

12.0 ROLE OF DESIGNATED REVIEW OFFICER (DRO)

A DRO is a senior professional/officer within the HSCB / PHA and has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations on any immediate action to be taken following notification of a SAI;

- agreeing the Terms of Reference for Level 2 and 3 investigations;

- reviewing completed SAI investigation reports and liaising with other professionals (where relevant);

- liaising with reporting organisations where there may be concerns regarding the robustness of the investigation or where there are any issues with proposed action plans;

- identification of regional learning, where relevant.

An internal HSCB/PHA protocol provides further guidance for DROs regarding the nomination and role of a DRO.

SECTION THREE

13.0 PROCESS

13.1 Reporting Serious Adverse Incidents

Any adverse incident that meets the criteria of a SAI as indicated in section 4.2 should be reported within 72 hours of the incident being discovered using the SAI Notification Form (Appendix 1) and forwarded to seriousincidents[redacted]

HSC Trusts to copy RQIA at seriousincidents@[redacted] in line with notifications relevant to the functions, powers and duties of RQIA as detailed in section 3.6 of this procedure.

Any SAI reported by FPS or ICVS must be reported in line with section 3 of this procedure

Reporting managers must comply with the principles of confidentiality when reporting SAIs and must not refer to service users or staff by name or by any other identifiable information. A unique Incident Reference/Number should be utilised on all forms/reports and associated correspondence submitted to the HSCB/PHA and this should NOT be the patients H &C Number or their initials. (See section 11 – Information Governance)

Note: Appendix 2 provides guidance notes to assist in the completion of the SAI Notification form

13.2 Reporting Interface Incidents

In line with section 3.4 of this procedure, any organisation alerted to an incident which it feels has the potential to be a SAI should report the incident to the HSCB using the Interface Incident Notification form (Appendix 3) to seriousincidents[redacted]

An organisation who has been contacted by the HSCB Governance Team re: an interface incident being reported; will consider the incident in line with section 4.2 of the procedure, and if deemed it meets the criteria of a SAI, will report to the HSCB in line with 13.1 of this procedure.

13.3 Acknowledging SAI Notification

On receipt of SAI notification HSCB Governance Team will record the SAI on the DATIX risk management system and electronically acknowledge receipt of SAI notification to reporting organisation; advising of the HSCB unique identification number, and requesting the completion of SEA Report within 4 week (6 weeks by exception) from

the date the incident is reported. Where relevant, RQIA will be copied into this receipt (Refer to Appendix 14 – Administrative Protocol between HSCB and RQIA)

13.4 Designated Review Officer (DRO)

Following receipt of a SAI the Governance Team will circulate the SAI Notification Form to the relevant Lead Officers within the HSCB/PHA to assign a DRO.

Once assigned the DRO will consider the SAI notification and if necessary, will contact the reporting organisation to confirm all immediate actions following the incident have been implemented.

13.5 Investigation Reports

Note: Appendices 5 and 7 provide guidance notes to assist in the completion of Level 1, 2 & 3 investigation reports.

Timescales for submission of investigation reports will be in line with section 6.0 of this procedure.

On receipt of an investigation report, the Governance Team will forward to the relevant DRO and where relevant RQIA.

The DRO will consider the adequacy of the investigation report and liaise with relevant professionals/officers including RQIA (*where relevant*) to ensure that the reporting organisation has taken reasonable action to reduce the risk of recurrence and determine if the SAI can be closed.

If the DRO is not satisfied that the report reflects a robust and timely investigation s/he will continue to liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received.

When the DRO (*in conjunction with relevant professionals/officers*) is satisfied (*based on the information provided*) that the investigation has been robust and recommendations are appropriate, he/she will complete an internal DRO Form validating their reason for closure.

13.6 Closure of SAI

On receipt of the internal DRO Form, the Governance Team will submit an email to the reporting organisation to advise the SAI has been closed, copied to RQIA (where relevant).

This will indicate that based on the investigation report received and any other information provided that the DRO is satisfied to close the SAI. It will acknowledge that any recommendations and further actions

required will be monitored through the reporting organisation's internal governance arrangements in order to reassure the public that lessons learned, where appropriate have been embedded in practice.

On some occasions and in particular when dealing with particularly complex SAIs, a DRO may close a SAI but request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring will be followed up via the Governance team.

13.7 Regional Learning from SAIs

If the DRO identifies any regional learning arising from the SAI investigation, this will be considered by the HSCB/PHA regional group and where relevant, will be disseminated as outlined in section 9.0.

13.8 Communication

All communication between HSCB/PHA and reporting organisation must be conveyed between the HSCB Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the HSCB DATIX risk management system.

14.0 EQUALITY

This procedure has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The procedure will therefore not be subject to equality impact assessment.

Similarly, this procedure has been considered under the terms of the Human Rights Act 1998 and was deemed compatible with the European Convention Rights contained in the Act.

SECTION FOUR APPENDICES

APPENDICES

APPENDIX 1

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION:	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE**
3. FACILTY / DEPARTMENT:	**4. DATE OF INCIDENT: DD / MMM / YYYY**
5. CONTACT PERSON:	**6. PROGRAMME OF CARE:** ***(refer to Guidance Notes)***

7. DESCRIPTION OF INCIDENT:

DOB: DD / MMM / YYYY **GENDER: M / F** **AGE: years**
(complete where relevant)

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: ***(refer to Guidance Notes)***	**DETAIL:** ***(refer to Guidance Notes)***	**ADVERSE EVENT:** ***(refer to Guidance Notes)***

8. <u>IMMEDIATE</u> ACTION TAKEN TO PREVENT RECURRANCE:

9. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*

10. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	**YES**	**NO**	**N/A**
11. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	**YES**	**NO**	**N/A**

12. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
any death of a child (up to eighteenth birthday) in a hospital setting or who is a Looked After Child or whose name is on the Child Protection Register	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide,homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident		
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner		
13. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED: ***(please select)***	**YES**	**NO**
if 'YES' (*full details should be submitted*):		
14. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? ***(refer to guidance notes*** *e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.)* ***please specify where relevant***	**YES**	**NO**
if 'YES' (*full details should be submitted including the date notified*):		

15. OTHER ORGANISATION/PERSONS INFORMED: ***(please select)***	**DATE INFORMED:**	**OTHERS:** ***(please specify where relevant, including date notified)***
DHSS&PS EARLY ALERT		
SERVICE USER / FAMILY		
HM CORONER		
INFORMATION COMMISSIONER OFFICE **(ICO)**		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE **(NIAIC)**		
NORTHERN IRELAND HEALTH AND SAFETY EXECUTIVE **(NIHSE)**		
POLICE SERVICE FOR NORTHERN IRELAND **(PSNI)**		
REGULATION QUALITY IMPROVEMENT AUTHORITY **(RQIA)**		
SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)**		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP **(NIASP)**		

16. LEVEL OF INVESTIGATION REQUIRED: ***(please select)***	**LEVEL 1**	**LEVEL 2***	**LEVEL 3***

*** FOR ALL LEVEL 2 OR LEVEL 3 INVESTIGATIONS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6**

17. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (***delete as appropriate***)

Report submitted by: _____ **Designation:** _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

18. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: ***(refer to Guidance Notes)***

Additional information submitted by: _____ **Designation:** _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

Completed proforma should be sent to: seriousincidents[redacted]
and (*where relevant*) seriousincidents[redacted]

APPENDIX 2

Guidance Notes

HSC SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

All Health and Social Care Organisations, Family Practitioner Services and Independent Service Providers are required to report serious adverse incidents to the HSCB within 72 hours of the incident being discovered It is acknowledged that not all the relevant information may be available within that timescale, however, there is a balance to be struck between minimal completion of the proforma and providing sufficient information to make an informed decision upon receipt by the HSCB/PHA.

The following guidance designed to help you to complete the Serious Adverse Incident Report Form effectively and to minimise the need for the HSCB/PHA to seek additional information about the circumstances surrounding the SAI. This guidance should be considered each time a report is submitted.

1. ORGANISATION: *Insert the details of the reporting organisation (HSC Organisation /Trust or Family Practitioner Service)*	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REF NO.** *Insert the unique incident number / reference generated by the reporting organisation.*
3. FACILTY / DEPARTMENT: *Insert the details of the hospital/facility/specialty/department/ directorate/place where the incident occurred*	**4. DATE OF INCIDENT: DD / MMM / YYYY** *Insert the date incident occurred*
5. CONTACT PERSON: *Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident*	**6. PROGRAMME OF CARE:** *Insert the Programme of Care from the following: Acute Services/ Maternity and Child Health / Family and Childcare / Elderly Services / Mental Health / Learning Disability / Physical Disability and Sensory Impairment / Primary Health and Adult Community (includes GP's) / Corporate Business(Other)*

7. DESCRIPTION OF INCIDENT:

*Provide a **brief factual description** of what has happened and a summary of the events leading up to the incident. **PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE.** Where relevant include D.O.B, Gender and Age. **All reports should be anonymised** – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

In addition include the following:

***Secondary Care** – recent service history; contributory factors to the incident; last point of contact (ward / specialty); early analysis of outcome.*

***Children** – when reporting a child death indicate if the Regional Safeguarding Board has been advised.*

***Mental Health** - when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide, attempted suicide in an in-patient setting or serious self-harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last year) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into the community arrangements;*
whether there was a history of DNAs, where applicable the details of how the death occurred, if known.

***Infection Control** - when reporting an outbreak which severely impacts on the ability to provide services, include the following: measures to cohort Service Users; IPC arrangements among all staff and visitors in contact with the infection source; Deep cleaning arrangements and restricted visiting/admissions.*

***Information Governance** –when reporting include the following details whether theft, loss, inappropriate disclosure, procedural failure etc.; the number of data subjects (service users/staff)involved, the number of records involved, the media of records (paper/electronic),whether encrypted or not and the type of record or data involved and sensitivity.*

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE:	**DETAIL:**	**ADVERSE EVENT:**
Insert CCS Stage of Care Code description	*Insert CCS Detail Code description*	*Insert CCS Adverse Event Code description*

8. IMMEDIATE ACTION TAKEN TO PREVENT RECURRANCE:

Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.

9. CURRENT CONDITION OF SERVICE USER:

***Where relevant** please provide details on the current condition of the service user the incident relates to.*

10. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	**YES**	**NO**	**N/A**
11. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please select and specify **where relevant**)*	**YES**	**NO**	**N/A**

12. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria from below)*	
serious injury to, or the unexpected/unexplained death of: - a service user - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
any death of a child (up to eighteenth birthday) in a hospital setting or who is a Looked After Child or whose name is on the Child Protection Register	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services)* and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

13. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED? *(please select)*	**YES**	**NO**
if 'YES' *(full details should be submitted):*		

14. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? ***where there appears to be a breach of professional code of conduct***	**YES**	**NO**
GENERAL MEDICAL COUNCIL **(GMC)** GENERAL DENTAL COUNCIL **(GDC)** PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)** NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)** LOCAL MEDICAL COMMITTEE **(LMC)** NURSING AND MIDWIFERY COUNCIL **(NMC**) HEALTH CARE PROFESSIONAL COUNCIL **(HCPC)** REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)** SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)** OTHER – PLEASE SPECIFY BELOW		
if 'YES' ***(full details should be submitted including date notified):***		

15. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	**DATE INFORMED:**	**OTHER:** *(please specify where relevant)*

DHSS&PS EARLY ALERT		Date informed:	
SERVICE USER / FAMILY			
HM CORONER			
INFORMATION COMMISSIONER OFFICE **(ICO)**			
NORTHERN IRELAND ADVERSE INCIDENT CENTRE **(NIAIC)**			
NORTHERN IRELAND HEALTH AND SAFETY EXECUTIVE **(NIHSE)**			
POLICE SERVICE FOR NORTHERN IRELAND **(PSNI)**			
REGULATION QUALITY IMPROVEMENT AUTHORITY **(RQIA)**			
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP **(NIASP)**			
16. LEVEL OF INVESTIGATION REQUIRED: ***(please select)***	**LEVEL 1**	**LEVEL 2***	**LEVEL 3***

*** FOR ALL LEVEL 2 OR LEVEL 3 INVESTIGATIONS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6**

17. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (***delete as appropriate***)

Report submitted by: _____ **Designation:** _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

18. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION

Use this section to provide updated information when the situation changes e.g. the situation deteriorates; the level of media interest changes

The HSCB and PHA recognises that organisations report SAIs based on limited information, which on further investigation may not meet the criteria of a SAI. Use this section to rrequest that a SAI be de-escalated and send to seriousincidents@h[redacted] with the unique incident identification number/reference in the subject line. When a request for de-escalation is made the reporting organisation must include information on why the incident does not warrant further investigation under the SAI process.

The HSCB/PHA will review the de-escalation request and inform the reporting organisation of its decision within 5 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than de-escalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full investigation report is required.

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED INVESTIGATION REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA REGIONALGROUP. THEY WILL BE MONITORED ACCORDING TO AGREED TIMESCALES. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREECHES ARE NOT REPORTED WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED.

Additional information submitted by: _____ **Designation:** _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

Completed proforma should be sent to: seriousincidents[redacted]
and (*where relevant*) seriousincidents[redacted]

APPENDIX 3

HSC INTERFACE INCIDENTS NOTIFICATION FORM

1. REPORTING ORGANISATION:	**2. DATE OF INCIDENT: DD / MMM / YYYY**
3. CONTACT PERSON AND TEL NO:	**4. UNIQUE REFERENCE NUMBER:**

5. DESCRIPTION OF INCIDENT:

DOB: DD / MMM / YYYY **GENDER: M / F** **AGE: years**
(complete where relevant)

6. ARE OTHER PROVIDERS INVOLVED? (e.g. *HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S*)	**YES**	**NO**
	if 'YES' (*full details should be submitted in section 7 below*)	

7. PROVIDE SUFFICIENT DETAILS TO ALLOW FOLLW UP:

8. <u>IMMEDIATE</u> ACTION TAKEN BY REPORTING ORGANISATION:

9. WHICH ORGANISATION/PROVIDER (*FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE*) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE INVESTIGATION AND FOLLOW UP OF THIS INCIDENT?

10. OTHER COMMENTS:

REPORT SUBMITTED BY: _____ DESIGNATION: _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

Completed proforma should be sent to: seriousincidents[redacted]

APPENDIX 4

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT

TITLE:	
DATE OF SIGNIFICANT EVENT:	
DATE OF SIGNIFICANT EVENT MEETING:	
SEA FACILITATOR/ LEAD OFFICER:	
TEAM MEMBERS PRESENT:	

WHAT HAPPENED?

WHY DID IT HAPPEN?

WHAT HAS BEEN LEARNED?

WHAT HAS BEEN CHANGED?

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

Where a Level two or three investigation is recommended please complete the sections below

THE INVESTIGATION TEAM :

INVESTIGATION TERMS OF REFERENCE:

APPENDIX 5

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT GUIDANCE

TITLE: *Insert unique identifier number*	*Self- explanatory*
DATE OF SIGNIFICANT EVENT:	*Self- explanatory*
DATE OF SIGNIFICANT EVENT MEETING:	*Self- explanatory*
SEA FACILITATOR/ LEAD OFFICER:	*Refer to guidance on Level one investigation team membership for significant event analysis –Appendix 9*
TEAM MEMBERS PRESENT:	*Self- explanatory*

WHAT HAPPENED?

(Describe in detailed chronological order what actually happened. Consider, for instance, how it happened, where it happened, who was involved and what the impact was on the patient/service user, the team, organisation and/or others).

WHY DID IT HAPPEN?

(Describe the main and underlying reasons contributing to why the event happened. Consider for instance, the professionalism of the team, the lack of a system or failing in a system, the lack of knowledge or the complexity and uncertainty associated with the event)

WHAT HAS BEEN LEARNED?

(Based on the reason established as to why the event happened, outline the learning identified. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education and training; the need to follow systems or procedures; the vital importance of team working or effective communication)

WHAT HAS BEEN CHANGED?

(Based on the understanding of why the event happened and the identification of learning, outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a new procedure or protocol.

Action plans should be developed and set out how learning will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan).

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

(Following the SEA it may become apparent that a more in depth investigation is required. Use this section to record if a Level two or three investigation is required).

APPENDIX 6

Insert organisation Logo

Root Cause Analysis Report on the investigation of a Serious Adverse Incident

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

Date submitted to HSCB:

1.0 EXECUTIVE SUMMARY

2.0 THE INVESTIGATION TEAM

3.0 INVESTIGATION TERMS OF REFERENCE

4.0 INVESTIGATION METHODOLOGY

5.0 DESCRIPTION OF INCIDENT/CASE

6.0 FINDINGS

7.0 CONCLUSIONS

8.0 LESSONS LEARNED

9.0 RECOMMENDATIONS AND ACTION PLANNING

10.0 DISTRIBUTION LIST

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APPENDIX 7

Health and Social Care Regional Guidance

for

Level 2 & 3 RCA Incident Investigation/Review Reports

INTRODUCTION

This document is a revision of the template developed by the DHSSPS Safety in Health and Social Care Steering Group in 2007 as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS.*"

The purpose of this template and guide is to provide practical help and support to those writing investigation reports and should be used, in as far as possible, for drafting all **HSC Level Two and Level Three** incident investigation/review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports.

The investigation report presents the work of the investigation team and provides all the necessary information about the incident, the investigation process and outcome of the investigation. The purpose of the report is to provide a formal record of the investigation process and a means of sharing the learning. The report should be clear and logical, and demonstrate that an open and fair approach has taken place.

This guide should assist in ensuring the completeness and readability of such reports. The headings and report content should follow, as far as possible, the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

This template was designed primarily for incident investigation/reviews however it may also be used to examine complaints and claims.

Insert organisation Logo

Report on the investigation of a Serious Adverse Incident

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

Date submitted to HSCB:

1.0 EXECUTIVE SUMMARY

Summarise the main report: provide a brief overview of the incident and consequences, background information, level of investigation, concise analysis and main conclusions, lessons learned, recommendations and arrangements for sharing and learning lessons.

2.0 THE INVESTIGATION TEAM

Refer to GUIDANCE ON INVESTIGATION TEAM MEMBERSHIP

The level of investigation undertaken will determine the degree of leadership, overview and strategic review required.

- *List names, designation and investigation team role of the members of the Investigation team. The Investigation team should be multidisciplinary and should have an Independent Chair.*
- *The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident and the level of investigation to be undertaken. However, best practice would indicate that investigation / review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice.*
- *In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered.*

3.0 INVESTIGATION TERMS OF REFERENCE

Describe the plan and scope for conducting the investigation. State the level of investigation, aims, objectives, outputs and who commissioned the investigation.

The following is a sample list of statements of purpose that should be included in the terms of reference:

- To undertake an investigation/review of the incident to identify specific problems or issues to be addressed;
- To consider any other relevant factors raised by the incident;
- To identify and engage appropriately with all relevant services or other agencies associated with the care of those involved in the incident;
- To determine actual or potential involvement of the Police, Health and Safety Executive, Regulation and Quality Improvement Authority and Coroners Service for Northern Ireland[2] [3]
- To agree the remit of the investigation/review - the scope and boundaries beyond which the investigation should not go (e.g. disciplinary process) – state how far back the investigation will go (what point does the investigation start and stop e.g. episode of care) and the level of investigation;
- To review the outcome of the investigation/review, agreeing recommendations,

[2] *Memorandum of understanding: Investigating patient or client safety incidents (Unexpected death or serious untoward harm)- http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf*

[3] *Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009*

3.0 INVESTIGATION TERMS OF REFERENCE

actions to be taken and lessons learned for the improvement of future services;

- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate. The level of involvement clearly depends on the nature of the incident and the service user's or family's wishes to be involved;
- To agree the timescales for completing and submitting the investigation report, distribution of the report and timescales for reviewing actions on the action plan;

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the investigation.

Clear documentation should be made of the time-line for completion of the work.

This list is not exhaustive

4.0 INVESTIGATION METHODOLOGY

This section should provide an outline of the type of investigation and the methods used to gather information within the investigation process. The NPSA's "Seven Steps to Patient Safety[4]" and "Root Cause Analysis Investigation Guidance[5]" provide useful guides for deciding on methodology.

- Review of patient/ service user records and compile a timeline (if relevant)
- Review of staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
  - Organisation-wide
  - Directorate Team
  - Ward/Team Managers and front line staff
  - Other staff involved
  - Other professionals (including Primary Care)
- Specific reports requested from and provided by staff
- Outline engagement with patients/service users / carers / family members / voluntary organisations/ private providers
- Review of local, regional and national policies and procedures, including professional codes of conduct in operation at the time of the incident
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), photographs, diagrams or drawings, training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

[4] http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787

[5] http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355

5.0 DESCRIPTION OF INCIDENT/CASE

Provide an account of the incident including consequences and detail what makes this incident a SAI. The following can provide a useful focus but please note this section is not solely a chronology of events

- Concise factual description of the serious adverse incident include the incident date and type, the healthcare specialty involved and the actual effect of the incident on the service user and/or service and others;
- People, equipment and circumstances involved;
- Any intervention / immediate action taken to reduce consequences;
- Chronology of events leading up to the incident;
- Relevant past history – a brief description of the care and/or treatment/service provided;
- Outcome / consequences / action taken;
- Relevance of local, regional or national policy / guidance / alerts including professional codes of conduct in place at the time of the incident

This list is not exhaustive

6.0 FINDINGS

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care/service provided. This section needs to clearly identify the care and service delivery problems and analysis to identify the causal factors.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

(ii) Contributory Factors

Record the influencing factors that have been identified as root causes or fundamental issues.

- Individual Factors (include employment status i.e. substantive, agency, locum voluntary etc.)
- Team and Social Factors
- Communication Factors

6.0 FINDINGS

- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors investigated and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful.
http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within this process.

7.0 CONCLUSIONS

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any on-going engagement / contact with family members or carers.

This section should summarise the key findings and should answer the questions posed in the terms of reference.

8.0 LESSONS LEARNED

Lessons learned from the incident and the investigation should be identified and addressed by the recommendations and relate to the findings. Indicate to whom learning should be communicated and this should be copied to the Committee with responsibility for governance.

9.0 RECOMMENDATIONS AND ACTION PLANNING

List the improvement strategies or recommendations for addressing the issues highlighted above (conclusions and lessons learned). Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions, and should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions:

- Recommendations for the investigating organisation
- Learning that is relevant to other organisations.

Action plans should be developed and should set out how each recommendation will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan.

10.0 DISTRIBUTION LIST

List the individuals, groups or organisations the final report has been shared with. This should have been agreed within the terms of reference.

APPENDIX 8

MINIMUM STANDARDS FOR ACTION PLANS

The action plan must define:

- Who has agreed the action plan
- Who will monitor the implementation of the action plan
- How often the action plan will be reviewed
- Who will sign off the action plan when all actions have been completed

The action plan **MUST** contain the following

1. Recommendations based on the contributing factors	The recommendations from the report - these should be the analysis and findings of the investigation
2. Action agreed	This should be the actions the organisation needs to take to resolve the contributory factors.
3. By who	Who in the organisation will ensure the action is completed
4. Action start date	Date particular action is to commence
5. Action end date	Target date for completion of action
6. Evidence of completion	Evidence available to demonstrate that action has been completed. This should include any intended action plan reviews or audits
7. Sign off	Responsible office and date sign off as completed

APPENDIX 9

LEVEL ONE INVESTIGATION - GUIDANCE ON INVESTIGATION TEAM MEMBERSHIP FOR SIGNIFICANT EVENT ANALYSIS

The level of investigation of an incident should be proportionate to its significance; this is a judgement to be made by the Investigation Team.

Membership of the team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved. Ultimately, for a level one investigation, it is for each team to decide who is invited, there has to be a balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited.

The investigating team should appoint an experienced facilitator or lead investigating officer from within the team to co-ordinate the review. The role of the facilitator is as follows:

- Co-ordinate the information gathering process
- Arrange the review meeting
- Explain the aims and process of the review
- Chair the review meeting
- Co-ordinate the write up of the Significant Event Analysis report
- Ensure learning is shared

APPENDIX 10

LEVEL TWO INVESTIGATION - GUIDANCE ON INVESTIGATION TEAM MEMBERSHIP

The level of investigation undertaken will determine the degree of leadership, overview and strategic review required. The level of investigation of an incident should therefore be proportionate to its significance. This is a judgement to be made by the Investigation Team.

The core investigation team should comprise a minimum of three people of appropriate seniority and objectivity. Investigation teams should be multidisciplinary, (or involve experts/expert opinion/independent advice or specialist investigators). The team shall have no conflicts of interest in the incident concerned and should have an Independent Chair. (*In the event of a suspected homicide HSC Trusts should follow the HSCB Protocol for responding to SAIs in the event of a Homicide - February 2012*)

The Chair of the team shall be independent of the service area where the incident occurred and should have relevant experience of the service area and/or chairing investigations/reviews. He/she shall not have been involved in the direct care or treatment of the individual, or be responsible for the service area under investigation. The Chair may be sourced from the HSCB Lay People Panel *(a panel of 'lay people' with clinical or social care professional areas of expertise in health and social care, who could act as the chair of an independent review panel, or a member of a Trust RCA review panel*).

Where multiple (*two or more*) HSC providers of care are involved, an increased level of independence shall be required. In such instances, the Chair shall be completely independent of the main organisations involved.

Where the service area is specialised, the Chair may have to be appointed from another HSC Trust or from outside NI.

Membership of the team should include all relevant professionals, but should be appropriate and proportionate to the type of incident and professional groups involved.

Membership shall include an experienced representative who shall support the review team in the application of the root cause analysis methodologies and techniques, human error and effective solutions based development.

Members of the team shall be separate from those who provide information to the investigation team.

It may be helpful to appoint an investigation officer from within the investigation team to co-ordinate the review.

APPENDIX 11

LEVEL THREE INVESTIGATION - GUIDANCE ON INVESTIGATION TEAM MEMBERSHIP

The level of investigation shall be proportionate to the significance of the incident. The same principles shall apply, as for level two investigations. The degree of independence of the investigation team will be dependent on the scale, complexity and type of the incident.

Team membership for level 3 investigations will be agreed between the reporting organisation and the HSCB/PHA DRO prior to the level 3 investigation commencing.

APPENDIX 12

GUIDANCE ON JOINT INVESTIGATIONS

Where a SAI involves multiple (*two or more*) HSC providers of care (e.g. a patient affected by system failures both in an acute hospital and in primary care), a decision must be taken regarding who will lead the investigation and reporting. This may not necessarily be the initial reporting organisation.

The general rule is for the provider organisation with greatest contact with the patient/service user to lead the investigation and action. There may, however, be good reason to vary this arrangement e.g. where a patient has died on another organisation's premises. The decision should be made jointly by the organisations concerned, if necessary referring to the HSCB Designated Review Officer for advice. **The lead organisation must be agreed by all organisations involved.**

It will be the responsibility of the lead organisation to engage all organisations in the investigation as appropriate. This involves collaboration in terms of identifying the appropriate links with the other organisations concerned and in practice, separate meetings in different organisations may take place, but a single investigation report and action plan should be produced by the lead organisation and submitted to the HSCB in the agreed format.

Points to consider:

- If more than one service is being provided , then all services are required to provide information / involvement reports to the investigation team
- All service areas should be represented in terms of professional makeup / expertise on the investigation team
- If more than one Trust/Agency is involved in the care of an individual, that the review is conducted jointly with all Trusts/Agencies involved.
- Relevant service providers, particularly those under contract with HSC to provide some specific services, should also be enjoined.
- There should be a clearly articulated expectation that the service user (where possible) and family carers, perspective should be canvassed, as should the perspective of staff directly providing the service, to be given consideration by the panel.
- The perspective of the GP and other relevant independent practitioners providing service to the individual should be sought.
- Service users and carer representatives should be invited / facilitated to participate in the panel discussions with appropriate safeguards to protect the confidentiality of anyone directly involved in the case.

This guidance should be read in conjunction with:

- Guidance on Investigation Team Membership (Refer to Appendix 9 to 11)
- Guidance on completing HSC Investigation Report Level 2 and 3 (Refer to Appendix 7)

APPENDIX 13

PROTOCOL FOR RESPONDING TO SERIOUS ADVERSE INCIDENTS IN THE EVENT OF A HOMICIDE - 2013

1. INTRODUCTION AND PURPOSE

1.1. INTRODUCTION

The Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs) was issued in April 2010 and revised October 2013. This procedure provides guidance to Health and Social Care (HSC) Trusts and HSCB Integrated Care staff in relation to the reporting and follow up of SAIs arising during the course of business of a HSC organisation, Special Agency or commissioned service.

This paper is a revised protocol, developed from the above procedure, for the specific SAIs which involves an alleged homicide perpetrated by a service user (*who will remain anonymous*) with a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and/or learning disability services, in the 12 months (1 year) prior to the incident.

This paper should be read in conjunction with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (Sept 2009 & May 2010).

1.2. PURPOSE

The purpose of this protocol is to provide HSC Trusts with a standardised approach in managing and coordinating the response to a SAI involving homicide.

2. THE PROCESS

2.1. REPORTING SERIOUS ADVERSE INCIDENTS

Refer to the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents revised in 2013.

2.2. MULTI-DISCIPLINARY REVIEW

As indicated in Promoting Quality Care (5.0) an internal multi-disciplinary review must be held as soon as practicable following an adverse incident. Where the SAI has resulted in homicide a more independent response is required.

An independent review team should be set up within twenty working days, of the notification of the incident, to the Trust.

2.3. ESTABLISHING AN INDEPENDENT REVIEW TEAM

2.3.1 CHAIR

The Chair of the Review Team should be independent from the HSC Trust, not a Trust employee or recently employed by the Trust. They should be at Assistant Director level or above with relevant professional expertise.

It is the role of the Chair to ensure engagement with families, that their views are sought, that support has been offered to them at an early stage and they have the opportunity to comment on the final draft of the report.

2.3.2 MEMBERSHIP

A review team should include all relevant professionals. The balance of the Team should include non-Trust staff and enable the review team to achieve impartiality, openness, independence, and thoroughness in the review of the incident. [ref: Case Management Review Chapter 10 Cooperating to Protect Children].

The individuals who become members of the Team must not have had any line management responsibility for the staff working with the service user under consideration. The review team must include members who are independent of HSC Trusts and other agencies concerned.

Members of the review team should be trained in the Procedure for the Reporting and Follow up of Serious Adverse Incidents 2013

3. TERMS OF REFERENCE

The terms of reference for the review team should be drafted at the first meeting of the review team and should be agreed by the HSCB before the second meeting.

The Terms of Reference should include, as a minimum, the following:

- establish the facts of the incident;
- analyse the antecedents to the incident;
- consider any other relevant factors raised by the incident;
- establish whether there are failings in the process and systems;
- establish whether there are failings in the performance of individuals;
- identify lessons to be learned from the incident; and
- identify clearly what those lessons are, how they will be acted upon, what is expected to change as a result, and specify timescales and responsibility for implementation.

4. TIME SCALES

The notification to the Trust of a SAI, resulting in homicide, to the Trust is the starting point of this process.

The Trust should notify the HSCB within 24hours and the Regulation and Quality Improvement Authority (RQIA) as appropriate.

An independent review team should be set up within twenty working days of the notification of the incident to the Trust.

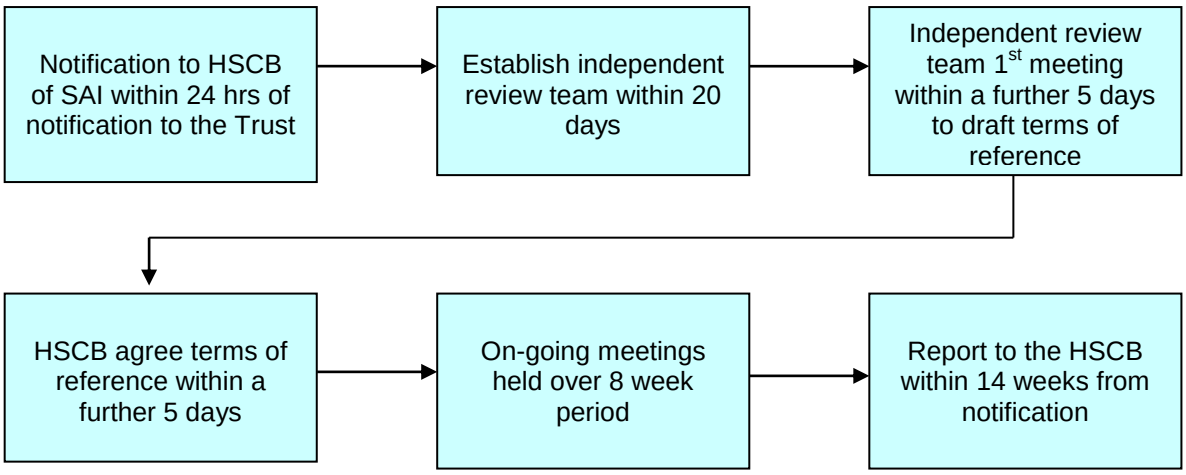
The team should meet to draft the terms of reference within a further five working days (i.e. twenty five days from notification of the incident to the Trust).

The HSCB should agree the terms of reference within a further five working days to enable work to begin at a second meeting.

The review team should complete their work and report to the HSCB within 14 weeks, this may be affected by PSNI investigations.

FLOWCHART OF PROCESS WITH TIMESCALES

NB Days refers to working days from the date of notification of the incident to the Trust



5. THE HEALTH AND SOCIAL CARE BOARD RESPONSIBILITY

On receipt of the completed Trust review report the HSCB will consider the findings and recommendations of the report and must form a view as to whether or not an Independent Inquiry is required.

The HSCB must advise the Department of Health, Social Services and Public Safety (DHSSPS) as to whether or not an Independent Inquiry is required in this particular SAI.

APPENDIX 14

REPORTING AND FOLLOW UP OF SAIs INVOLVING RQIA MENTAL HEALTH/LEARNING DISABILITY & INDEPENDENT/REGULATED SECTOR

ADMINISTRATIVE PROTOCOL

On receipt of a SAI notification and where a HSC Trust has also copied RQIA into the same notification, the following steps will be applied:

1. HSCB acknowledgement email to Trust advising on timescale for investigation report will also be copied to RQIA.

2. On receipt of the investigation report from Trust, the HSCB Governance Team will forward to the HSCB/PHA Designated Review Officer (DRO).

3. At the same time, the HSCB Governance Team will also forward the investigation report to RQIA, together with an email advising of a **3 week** timescale from receipt of investigation report, for RQIA to forward comments for consideration by the DRO.

4. The DRO will continue with his/her review liaising (where s/he feels relevant) with Trust, RQIA and other HSCB/PHA professionals until s/he is satisfied SAI can be closed.

5. If no comments are received from RQIA within the 3 week timescale, the DRO will assume RQIA have no comments.

6. When the SAI is closed by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

All communications to be sent or copied via:

HSCB Governance Team: ***seriousincidents*** [redacted]
and RQIA: **seriousincidents** [redacted]

APPENDIX 15

HSC Regional Impact Table – with effect from April 2013

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g., Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc.).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Risk Likelihood Scoring Table

Likelihood Scoring Descriptors	Score	Frequency (How often might it/does it happen?)	Time framed Descriptions of Frequency
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Health and Social Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

November 2016
Version 1.1

CONTENTS

SECTION TWO - APPENDICES

SECTION THREE - ADDENDUM

FOREWORD

Commissioners and Providers of health and social care want to ensure that when a serious event or incident occurs, there is a systematic process in place for safeguarding services users, staff, and members of the public, as well as property, resources and reputation.

One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from serious adverse incidents (SAIs). Working in conjunction with other Health and Social Care (HSC) organisations, this procedure was developed to provide a system-wide perspective on serious incidents occurring within the HSC and Special Agencies and also takes account of the independent sector where it provides services on behalf of the HSC.

The procedure seeks to provide a consistent approach to:

- what constitutes a serious adverse incident;
- clarifying the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning;
- fulfilling statutory and regulatory requirements;
- tools and resources that support good practice.

Our aim is to work toward clearer, consistent governance arrangements for reporting and learning from the most serious incidents; supporting preventative measures and reducing the risk of serious harm to service users.

The implementation of this procedure will support governance at a local level within individual organisations and will also improve existing regional governance and risk management arrangements by continuing to facilitate openness, trust, continuous learning and ultimately service improvement.

This procedure will remain under continuous review.

Valerie Watts
Chief Executive

SECTION ONE - PROCEDURE

1.0 BACKGROUND

Circular HSS (PPM) 06/04 introduced interim guidance on the reporting and follow-up on serious adverse incidents (SAIs). Its purpose was to provide guidance for HPSS organisations and special agencies on the reporting and management of SAIs and near misses.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss(ppm)06-04.pdf

Circular HSS (PPM) 05/05 provided an update on safety issues; to underline the need for HPSS organisations to report SAIs and near misses to the DHSSPS in line with Circular HSS (PPM) 06/04.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hssppm05-05.pdf

Circular HSS (PPM) 02/2006 drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified respective organisations of changes in the way SAIs should be reported in the future and provided a revised report pro forma. It also clarified the processes DHSSPS had put in place to consider SAIs notified to it, outlining the feedback that would then be made to the wider HPSS.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/qpi_adverse_incidents_circular.pdf

In March 2006, DHSSPS introduced Safety First: A Framework for Sustainable Improvement in the HPSS. The aim of this document was to draw together key themes to promote service user safety in the HPSS. Its purpose was to build on existing systems and good practice so as to bring about a clear and consistent DHSSPS policy and action plan.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/safety_first_-_a_framework_for_sustainable_improvement_on_the_hpss-2.pdf

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care were issued by DHSSPS in March 2006.

www.health-ni.gov.uk/publications/quality-standards-health-and-social-care-documents

Circular HSC (SQS) 19/2007 advised of refinements to DHSSPS SAI system and of changes which would be put in place from April 2007, to promote learning from SAIs and reduce any unnecessary duplication of paperwork for organisations. It also clarified arrangements for the reporting of breaches of patients waiting in excess of 12 hours in emergency care departments.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss__sqsd__19-07.pdf

Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986, the Regulation & Quality Improvement Authority (RQIA) has a duty to make inquiry into any

case where it appears to the Authority that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to reporting requirements under the above Order previously issued in April 2000 was reviewed, updated and re-issued in August 2007. (Note: Functions of the previous Mental Health Commission transferred to RQIA on 1 April 2009).

http://webarchive.proni.gov.uk/20101215075727/http://www.dhsspsni.gov.uk/print/utec_guidance_august_2007.pdf

Circular HSC (SQSD) 22/2009 provided specific guidance on initial changes to the operation of the system of SAI reporting arrangements during 2009/10. The immediate changes were to lead to a reduction in the number of SAIs that were required to be reported to DHSSPS. It also advised organisations that a further circular would be issued giving details about the next stage in the phased implementation which would be put in place to manage the transition from the DHSSPS SAI reporting system, through its cessation and to the establishment of the RAIL system.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2022-09.pdf

Circular HSC (SQSC) 08/2010, issued in April 2010, provided guidance on the transfer of SAI reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency. It also provided guidance on the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2008-10.pdf

Circular HSC (SQSD) 10/2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA).

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

In May 2010 the Director of Social Care and Children HSCB issued guidance on 'Untoward Events relating to Children in Need and Looked After Children' to HSC Trusts. This guidance clarified the arrangements for the reporting of events, aligned to delegated statutory functions and Departmental Guidance, which are more appropriately reported to the HSCB Social Care and Children's Directorate.

In 2012 the HSCB issued the 'Protocol for responding to SAIs involving an alleged homicide'. The 2013 revised HSCB 'Protocol for responding to SAIs involving an alleged homicide' is contained in Appendix 14.

Circular HSS (MD) 8/2013 replaces HSS (MD) 06/2006 and advises of a revised Memorandum of Understanding (MOU) when investigating patient or client safety incidents. This revised MOU is designed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required when a serious incident occurs.

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

DHSSPS Memo dated 17 July 2013 from Chief Medical Officer introduced the HSCB/PHA protocol on the dissemination of guidance/information to the HSC and the assurance arrangements where these are required. The protocol assists the HSCB/PHA in determining what actions would benefit from a regional approach rather than each provider taking action individually.

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/002%20%20HSCB-PHA%20Protocol%20for%20Safety%20Alerts.pdf

Circular HSC (SQSD) 56/16 (21 October 2016) from the Deputy Chief Medical Officer advises of the intention to introduce a Never Events process and that information relating to these events will be captured as part of the Serious Adverse Incident Process. The circular indicates the Never Events process will be based on the adoption of Never Event List with immediate effect.

https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-56-16.pdf

2.0 INTRODUCTION

The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Organisations, and Special Agencies (SA) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of their business or commissioned service.

The requirement on HSC organisations to routinely report SAIs to the Department of Health (DoH) {formerly known as the DHSSPS} ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA).

This process aims to:

- Provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users;

- Provide a coherent approach to what constitutes a SAI; to ensure consistency in reporting across the HSC and Special Agencies;

- Clarify the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation / Special Agency or commissioned/funded service;

- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the review;

- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;

- Recognise the responsibilities of individual organisations and support them in ensuring compliance; by providing a culture of openness and transparency that encourages the reporting of SAIs;

- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;

- Maintain a high quality of information and documentation within a time bound process.

3.0 APPLICATION OF PROCEDURE

3.1 Who does this procedure apply to?

This procedure applies to the reporting and follow up of SAIs arising during the course of the business in Department of Health (DoH) Arm's Length Bodies (ALBs) i.e.

- ***HSC organisations (HSC)***
  - Health and Social Care Board
  - Public Health Agency
  - Business Services Organisation
  - Belfast Health and Social Care Trust
  - Northern Health and Social Care Trust
  - Southern Health and Social Care Trust
  - South Eastern Health and Social Care Trust
  - Western Health and Social Care Trust
  - Northern Ireland Ambulance Service
  - Regulation and Quality Improvement Authority

- ***Special Agencies (SA)***
  - Northern Ireland Blood Transfusion Service
  - Patient Client Council
  - Northern Ireland Medical and Dental Training Agency
  - Northern Ireland Practice and Education Council

The principles for SAI management set out in this procedure are relevant to all the above organisations. Each organisation should therefore ensure that its incident policies are consistent with this guidance while being relevant to its own local arrangements.

3.2 Incidents reported by Family Practitioner Services (FPS)

Adverse incidents occurring within services provided by independent practitioners within: General Medical Services, Pharmacy, Dental or Optometry, are routinely forwarded to the HSCB Integrated Care Directorate in line with the HSCB Adverse Incident Process within the Directorate of Integrated Care (September 2016). On receipt of reported adverse incidents the HSCB Integrated Care Directorate will decide if the incident meets the criteria of a SAI and if so will be the organisation responsible to report the SAI.

3.3 Incidents that occur within the Independent /Community and Voluntary Sectors (ICVS)

SAIs that occur within ICVS, where the service has been commissioned/funded by a HSC organisation must be reported. For example: service users placed/funded by HSC Trusts in independent sector accommodation, including private hospital, nursing or residential care homes, supported housing, day care facilities or availing of HSC funded voluntary/community services. These SAIs must be reported and reviewed by the HSC organisation who has:

- referred the service user (this includes Extra Contractual Referrals) to the ICVS;

or, if this cannot be determined;

- the HSC organisation who holds the contract with the IVCS.

HSC organisations that refer service users to ICVS should ensure all contracts, held with ICVS, include adequate arrangements for the reporting of adverse incidents in order to ensure SAIs are routinely identified.

All relevant events occurring within ICVS which fall within the relevant notification arrangements under legislation should continue to be notified to RQIA.

3.4 Reporting of HSC Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up review may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form (see Appendix 3). The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the review. In these instances refer to Appendix 13 – Guidance on Joint Reviews.

3.5 Incidents reported and Investigated/ reviewed by Organisations external to HSC and Special Agencies

The reporting of SAIs to the HSCB will work in conjunction with and in some circumstances inform the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

3.5.1 Memorandum of Understanding (MOU)

In February 2006, the DoH issued circular HSS (MD) 06/2006 − a Memorandum of Understanding − which was developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident.

Circular HSS (MD) 8/2013 replaces the above circular and advises of a revised MOU Investigating patient or client safety incidents which can be found on the Departmental website:

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

The MOU has been agreed between the DoH, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

It sets out the general principles for the HSCS, PSNI, Coroners Service for NI and HSENI to observe when liaising with one another.

The purpose of the MOU is to promote effective communication between the organisations. The MOU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for NI or HSENI separately or jointly. This may be the case when an incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.

The MOU is intended to help:

- Identify which organisations should be involved and the lead investigating body.

- Prompt early decisions about the actions and investigations/reviews thought to be necessary by all organisations and a dialogue about the implications of these.

- Provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high level decisions are taken.

- Ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

HSC Organisations should note that the MOU does not preclude simultaneous investigations/reviews by the HSC and other organisations e.g. Root Cause Analysis by the HSC when the case is being reviewed by the Coroners Service and/or PSNI/HSENI.

In these situations, the Strategic Communication and Decision Group can be used to clarify any difficulties that may arise; particularly where an external organisation's investigation/review has the potential to impede a SAI review and subsequently delay the dissemination of regional learning.

3.6 Reporting of SAIs to RQIA

RQIA have a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA will work in conjunction with the HSCB/PHA with regard to the review of certain categories of SAI. In this regard the following SAIs should be notified to RQIA at the same time of notification to the HSCB:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.

  *It is acknowledged these incidents should already have been reported to RQIA as a **'notifiable event'** by the statutory or independent organisation where the incident has occurred (in line with relevant reporting regulations). This notification will alert RQIA that the incident is also being reviewed as a SAI by the HSC organisation who commissioned the service.*

- The HSCB/PHA Designated Review Officer (DRO) will lead and co-ordinate the SAI management, and follow up, with the reporting organisation; however for these SAIs this will be carried out in

conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 15.

3.7 Reporting of SAIs to the Safeguarding Board for Northern Ireland

There is a statutory duty for the HSC to notify the Safeguarding Board for Northern Ireland of child deaths where:

- a child has died or been significantly harmed (Regulation 17(2)(a)

AND

- abuse/neglect suspected **or** child or sibling on child protection register **or** child or sibling is/has been looked after Regulation (2)(b) (see Appendix 17)

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

4.2 SAI criteria

4.2.1 serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2 unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3 unexpected or significant threat to provide service and/or maintain business continuity;

[1] Source: DoH - How to classify adverse incidents and risk guidance 2006
http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

4.2.4 serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5 serious self-harm or serious assault *(including homicide and sexual assaults*)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.6 suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.7 serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

Note: The HSC Regional Risk Matrix may assist organisations in determining the level of 'seriousness' refer to Appendix 16.

5.0 SAI REVIEWS

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event.

Whilst most SAIs will be subject to a Level 1 review, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 review immediately following the incident occurring. The level of review should be noted on the SAI notification form.

The HSC Regional Risk Matrix (refer to Appendix 16) may assist organisations in determining the level of 'seriousness' and subsequently the level of review to be

undertaken. SAIs which meet the criteria in 4.2 above will be reviewed by the reporting organisation using one or more of the following:

5.1 Level 1 Review – Significant Event Audit (SEA)

Most SAI notifications will enter the review process at this level and a SEA will immediately be undertaken to:

- assess what has happened;
- assess why did it happened;
  - what went wrong and what went well;
- assess what has been changed or agree what will change;
- identify local and regional learning.

(refer to Appendix 5 – Guidance Notes for Level 1 – SEA & Learning Summary Report; Appendix 9 – Guidance on Incident Debrief); and Appendix 10 – Level 1 Review - Guidance on review team membership)

The possible outcomes from the review may include:

- closed – no new learning;
- closed – with learning;
- requires Level 2 or 3 review.

A SEA report will be completed **which should be retained by the reporting organisation** (see Appendices 4 and 5).

The reporting organisation will then complete a **SEA Learning Summary Report** (see Appendices 4 and 5 – Sections 1, 3-6), which should be signed off by the relevant professional or operational director and submitted to the HSCB within **8 weeks** of the SAI being notified.

The HSCB will not routinely receive SEA reports unless specifically requested by the DRO. This process assigns reporting organisations the responsibility for Quality Assuring Level 1 SEA Reviews. This will entail engaging directly with relevant staff within their organisation to ensure the robustness of the report and identification of learning prior to submission to the HSCB.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, the review will move to either a Level 2 or 3 RCA review. In this instance the SEA Learning Report Summary will be forwarded to the HSCB within the timescales outlined above, with additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 RCA review and proposed timescales.

5.2 Level 2 – Root Cause Analysis (RCA)

As stated above, some SAIs will enter at Level 2 review following a SEA.

When a Level 2 or 3 review is instigated immediately following notification of a SAI, the reporting organisation will inform the HSCB within 4 weeks, of the Terms of Reference (TOR) and Membership of the Review Team for

consideration by the HSCB/PHA DRO. This will be achieved by submitting sections two and three of the review report to the HSCB. (Refer to Appendix 6 – template for Level 2 and 3 review reports).

The review must be conducted to a high level of detail (see Appendix 7 – template for Level 2 and 3 review reports). The review should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. (Refer to Appendix 9 – Guidance on Incident Debrief); and Appendix 11 – Level 2 Review - Guidance on review team membership).

Level 2 RCA reviews may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final review report (Refer to Appendix 13 Guidance on joint reviews/investigations).

On completion of Level 2 reviews, the final report must be submitted to the HSCB within 12 weeks from the date the incident was notified.

5.3 Level 3 – Independent Reviews

Level 3 reviews will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice;
- are very high profile and attracting a high level of both public and media attention.

In some instances the whole team may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting Chair and Membership of the review team will be agreed by the HSCB/PHA Designated Review Officer (DRO) at the outset (see Appendix 9 – Guidance on Incident Debrief); and Appendix 12 – Level 3 Review - Guidance on Review Team Membership).

The format for Level 3 review reports will be the same as for Level 2 reviews (see Appendix 7 – guidance notes on template for Level 2 and 3 reviews).

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident, the Protocol for Responding to SAIs in the Event of a Homicide, issued in 2012 and revised in 2013 should be followed (see Appendix 14).

5.4 Involvement of Service Users/Family/Carers in Reviews

- Following a SAI it is important, in the spirit of honesty and openness to ensure a consistent approach is afforded to the level of service user / family engagement across the region. When engaging with Service Users/Family/Carers, organisations should refer to addendum 1 – *A Guide for Health and Social Care Staff Engagement/Communication with Service User/Family/Cares following a SAI.*

- In addition a 'Checklist for Engagement/Communication with the Service User/Family/Carers following a SAI' must be completed for each SAI regardless of the review level, and where relevant, if the SAI was also a Never Event (refer to section 12.2).

- The checklist also includes a section to indicate if the reporting organisation had a statutory requirement to report the death to the Coroners office and that this is also communicated to the Family/Carer.

6.0 TIMESCALES

6.1 Notification

Any adverse incident that meets the criteria indicated in section 4.2 should be reported within **72 hours** of the incident being discovered using the SAI Notification Form (see Appendix 1).

6.2 Review Reports

LEVEL 1 – SEA

SEA reports must be completed using the SEA template which will be retained by the reporting organisation (see Appendices 4 and 5). A SEA Learning Summary Report (see Appendices 4 and 5 – Sections 1, 3-6) must be completed and submitted to the HSCB within **8 weeks** of the SAI being reported for all Level 1 SAIs whether learning has been identified or not. The Checklist for Engagement/Communication with Service User/Family/Carer following a SAI' must also accompany the Learning Summary Report.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, timescales for completion of the RCA will be indicated by Trusts via the Learning Summary Report to the HSCB.

LEVEL 2 – RCA

For those SAIs where a full RCA is instigated immediately, sections 2 and 3 of the RCA Report, outlining TOR and membership of the review team, must be submitted **no later** than **within 4 weeks** of the SAI being notified to the HSCB.

RCA review reports must be fully completed using the RCA report template and submitted together with comprehensive action plans for each recommendation identified to the HSCB **12 weeks** following the date the incident was notified. (see Appendix 6 – Level 2 & 3 RCA Review Reports and Appendix 8 – Guidance on Minimum Standards for Action Plans).

LEVEL 3 – INDEPENDENT REVIEWS

Timescales for completion of Level 3 reviews and comprehensive action plans for each recommendation identified will be agreed between the reporting organisation and the HSCB/PHA DRO as soon as it is determined that the SAI requires a Level 3 review.

Note: Checklist for Engagement/Communication with Service User/Family/Carer following a SAI must accompany all SAI Review/Learning Summary Reports which are included within the report templates.

6.3 Exceptions to Timescales

In most circumstances, all timescales for submission of reports **must be** adhered to. However, it is acknowledged, by exception, there may be occasions where a review is particularly complex, perhaps involving two or more organisations or where other external organisations such as PSNI, HSENI etc.; are involved in the same review. In these instances the reporting organisation must provide the HSCB with regular updates.

6.4 Responding to additional information requests

Once the review / learning summary report has been received, the DRO, with appropriate clinical or other support, will review the report to ensure that the necessary documentation relevant to the level of review is adequate.

If the DRO is not satisfied with the information provided additional information may be requested and must be provided in a timely manner. Requests for additional information should be provided as follows:

- Level 1 review within **2 week**
- Level 2 or 3 review within **6 weeks**

7.0 OTHER INVESTIGATIVE/REVIEW PROCESSES

The reporting of SAIs to the HSCB will work in conjunction with all other HSC investigation/review processes, statutory agencies and external bodies. In that regard, all existing reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

In that regard, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI.

7.1 Complaints in the HSC

Complaints in HSC Standards and Guidelines for Resolution and Learning (The Guidance) outlines how HSC organisations should deal with complaints raised by persons who use/have used, or are waiting to use HSC services. While it is a separate process to the management and follow-up of SAIs, there will be occasions when an SAI has been reported by a HSC organisation, and subsequently a complaint is received relating to the same incident or issues, or alternatively, a complaint may generate the reporting of an SAI.

In these instances, the relevant HSC organisation must be clear as to how the issues of complaint will be investigated. For example, there may be elements of the complaint that will be solely reliant on the outcome of the SAI review and there may be aspects of the complaint which will not be part of the SAI review and can only be investigated under the Complaints Procedure.

It is therefore important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to a SAI review. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner. Fundamental to this, will obviously be the need for the organisation investigating the complaint to communicate effectively with the complainant in respect of how their complaint will be investigated, and when and how they can expect to receive a response from the HSC organisation.

7.2 HSCB Social Care Untoward Events Procedure

The above procedure provides guidance on the reporting of incidents relating to statutory functions under the Children (NI) Order 1995.

If, during the review of an incident reported under the HSCB Untoward Events procedure, it becomes apparent the incident meets the criteria of a SAI, the incident should immediately be notified to the HSCB as a SAI. Board officers within the HSCB will close the Untoward Events incident and the incident will continue to be managed via the SAI process.

7.3 Child and Adult Safeguarding

Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to a child and adult protection.

If during the review of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the HSCB as an SAI.

It should be noted that, where possible, safeguarding investigations will run in parallel as separate to the SAI process with the relevant findings from these investigations/reviews informing the SAI review (see appendix 17).

On occasion the incident under review may be considered so serious as to meet the criteria for a Case Management Review (CMR) for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the HSCB as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

7.4 Reporting of Falls

Reporting organisations will no longer be required to routinely report falls as SAIs which have resulted in harm in all Trust facilities, (as defined in the impact levels 3 – 5 of the regional risk matrix - see appendix 16). Instead a new process has been developed with phased implementation, which requires HSC Trusts to do a timely post fall review debrief to ensure local application of learning. See links below to Shared Learning Form and Minimum Data Set for Post Falls Review:

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/033%20Falls_Shared%20Learning%20Template_%20V2_June%202016.rtf

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/032%20Regional%20Falls%20Minimum%20Dataset%202016_V2_June%202016.pdf

Local learning will be shared with the Regional Falls Group where trends and themes will be identified to ensure regional learning.

Reporting organisations will therefore manage falls resulting in moderate to severe harm as adverse incidents, unless there are particular issues or the subsequent internal review identifies contributory issues/concerns in treatment and/or care or service issues, or any identified learning that needs to be reviewed through the serious adverse incident process.

7.5 Transferring SAIs to other Investigatory Processes

Following notification and initial review of a SAI, more information may emerge that determines the need for a specialist investigation.

This type of investigation includes:

- Case Management Reviews
- Serious Case Reviews

Once a DRO has been informed a SAI has transferred to one of the above investigation s/he will close the SAI.

7.6 De-escalating a SAI

It is recognised that organisations report SAIs based on limited information and the situation may change when more information has been gathered; which may result in the incident no longer meeting the SAI criteria.

Where a reporting organisation has determined the incident reported no longer meets the criteria of a SAI, a request to de-escalate the SAI should be submitted immediately to the HSCB by completing section 21 of the SAI notification form (Additional Information following initial Notification).

The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **10 working days** from the request was submitted.

If the DRO agrees, the SAI will be de-escalated and no further SAI review will be required. The reporting organisation may however continue to review as an adverse incident or in line with other HSC investigation/review processes (as highlighted above). If the DRO makes a decision that the SAI should not be de-escalated the review report should be submitted in line with previous timescales.

It is important to protect the integrity of the SAI review process from situations where there is the probability of disciplinary action, or criminal charges. The SAI review team must be aware of the clear distinction between the aims and boundaries of SAI reviews, which are solely for the identification and reporting learning points, compared with disciplinary, regulatory or criminal processes.

HSC organisations have a duty to secure the safety and well-being of patients/service users, the review to determine root causes and learning points should still be progressed **in parallel** with other reviews/investigations, ensuring remedial actions are put in place as necessary and to reduce the likelihood of recurrence.

8.0 LEARNING FROM SAIs

The key aim of this procedure is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided.

HSCB in conjunction with the PHA will:

- ensure that themes and learning from SAIs are identified and disseminated for implementation in a timely manner; this may be done via:
  - learning letters / reminder of best practice letters;
  - learning newsletter;
  - thematic reviews.

- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;

- review and consider learning from external/independent reports relating to quality/safety.

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. The management of dissemination and associated assurance of any regional learning is the responsibility of the HSCB/PHA.

9.0 TRAINING AND SUPPORT

9.1 Training

Training will be provided to ensure that those involved in SAI reviews have the correct knowledge and skills to carry out their role, i.e:

- Chair and/or member of an SAI review team
- HSCB/PHA DRO.

This will be achieved through an educational process in collaboration with all organisations involved, and will include training on review processes, policy distribution and communication updates.

9.2 Support

9.2.1 Laypersons

The panel of lay persons, (already involved in the HSC Complaints Procedure), have availed of relevant SAI training including Root Cause Analysis. They are now available to be called upon to be a member of a SAI review team; particularly when a degree of independence to the team is required.

Profiles and relevant contact details for all available laypersons can be obtained by contacting seriousincidents@hscni.net

9.2.2 Clinical/Professional Advice

If a DRO requires a particular clinical view on the SAI review, the HSCB Governance Team will secure that input, under the direction of the DRO.

10.0 INFORMATION GOVERNANCE

The SAI process deals with a considerable amount of sensitive personal information. Appropriate measures must be put in place to ensure the safe and secure transfer of this information. All reporting organisations should adhere to their own Information Governance Policies and Procedures. However, as a minimum the HSCB would recommend the following measures be adopted when

transferring patient/client identifiable information via e-mail or by standard hard copy mail:

- E-Mail - At present there is not a requirement to apply encryption to sensitive information transferred across the HSC network to other HSC organisations within Northern Ireland. Information transferred between the HSCB, Trusts and Northern Ireland Department of Health is not sent across the internet. If you are transferring information to any address that does not end in one of those listed below, it is essential that electronic measures to secure the data in transit, are employed, and it is advised that encryption is therefore applied at all times to transfers of sensitive / personal information.

  List of email addresses **within the Northern Ireland secure network:**
  '.hscni.net',
  'n-i.nhs.uk'
  'ni.gov.uk' or
  '.ni.gov.net'

  No sensitive or patient/service user data must be emailed to an address other than those listed above unless they have been protected by encryption mechanisms that have been approved by the BSO-ITS.

  Further advice on employing encryption software can be sought from the BSO ICT Security Team.

  Note: Although there is a degree of protection afforded to email traffic that contains sensitive information when transmitting within the Northern Ireland HSC network it is important that the information is sent to the correct recipient. With the amalgamation of many email systems, the chances of a name being the same or similar to the intended recipient has increased. It is therefore recommended that the following simple mechanism is employed when transmitting information to a new contact or to an officer you haven't emailed previously.

  Step 1 Contact the recipient and ask for their email address.
  Step 2 Send a test email to the address provided to ensure that you have inserted the correct email address.
  Step 3 Ask the recipient on receiving the test email to reply confirming receipt.
  Step 4 Attach the information to be sent with a subject line 'Private and Confidential, Addressee Only' to the confirmation receipt email and send.

- Standard Mail – It is recommended that any mail which is deemed valuable, confidential or sensitive in nature (such as patient/service user level information) should be sent using 'Special Delivery' Mail.

Further guidance is available from the HSCB Information Governance Team on: Tel 028 95 362912

11.0 ROLE OF DESIGNATED REVIEW OFFICER (DRO)

A DRO is a senior professional/officer within the HSCB / PHA and has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI
  - where a DRO believes the SAI review is not being undertaken at the appropriate level

- agreeing the Terms of Reference for Level 2 and 3 RCA reviews;

- reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for level 2 and 3 RCA Reviews; liaising with other professionals (where relevant);

- liaising with reporting organisations where there may be concerns regarding the robustness of the level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented;

- identification of regional learning, where relevant;

- surveillance of SAIs to identify patterns/clusters/trends.

Whilst the HSCB will not routinely receive Level 1 SEA reports these can be requested, on occasion, by a DRO.

An internal HSCB/PHA protocol provides further guidance for DROs regarding the nomination and role of a DRO.

12.0 PROCESS

12.1 Reporting Serious Adverse Incidents

Any adverse incident that meets the criteria of a SAI as indicated in section 4.2 should be reported within 72 hours of the incident being discovered using the SAI Notification Form (Appendix 1) and forwarded to seriousincidents@hscni.net

HSC Trusts to copy RQIA at seriousincidents@rqia.org.uk in line with notifications relevant to the functions, powers and duties of RQIA as detailed in section 3.6 of this procedure.

Any SAI reported by FPS or ICVS must be reported in line with 3.2 and 3.3 of this procedure.

Reporting managers must comply with the principles of confidentiality when reporting SAIs and must not refer to service users or staff by name or by any other identifiable information. A unique Incident Reference/Number should be utilised on all forms/reports and associated

correspondence submitted to the HSCB and this should NOT be the patients H &C Number or their initials. (See section 10 – Information Governance)

12.2 Never Events

Never Events are SAIs that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all health care providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

It is important, in the spirit of honesty and openness, that when staff are engaging with Service Users, Families, Carers as part of the SAI process, that in addition to advising an individual of the SAI, they should also be told if the SAI is a Never Event. However it will be for HSC organisations to determine when to communicate this information to Service Users, Families, Carers.

All categories included in the current NHS Never Events list (see associated DoH link below) should now be identified to the HSCB when notifying a SAI.

A separate section within the SAI notification form is to be completed to specify if the SAI is listed on the Never Events list. The SAI will continue to be reviewed in line with the current SAI procedure.

https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

12.3 Reporting Interface Incidents

In line with section 3.4 of this procedure, any organisation alerted to an incident which it feels has the potential to be a SAI should report the incident to the HSCB using the Interface Incident Notification form (Appendix 3) to seriousincidents@hscni.net.

An organisation who has been contacted by the HSCB Governance Team re: an interface incident being reported; will consider the incident in line with section 4.2 of the procedure, and if deemed it meets the criteria of a SAI, will report to the HSCB in line with 12.1 of this procedure.

12.4 Acknowledging SAI Notification

On receipt of the SAI notification the HSCB Governance Team will record the SAI on the DATIX risk management system and electronically acknowledge receipt of SAI notification to reporting organisation; advising

of the HSCB/PHA DRO, HSCB unique identification number, and requesting the completion of:

- SEA Learning Summary Report for Level 1 SAIs within 8 weeks from the date the incident is reported;
- RCA Report for Level 2 SAIs within 12 weeks from the date the incident is reported;
- RCA Report for Level 3 SAIs within the timescale as agreed at the outset by the DRO;

Where relevant, RQIA will be copied into this receipt.

12.5 Designated Review Officer (DRO)

Following receipt of a SAI the Governance Team will circulate the SAI Notification Form to the relevant Lead Officers within the HSCB/PHA to assign a DRO.

Once assigned the DRO will consider the SAI notification and if necessary, will contact the reporting organisation to confirm all immediate actions following the incident have been implemented.

12.6 Review/Learning Summary Reports

Note: Appendices 5 and 7 provide guidance notes to assist in the completion of Level 1, 2 & 3 review reports.

Timescales for submission of review/learning summary reports and associated engagement checklists will be in line with section 6.0 of this procedure.

On receipt of a review/learning summary report, the Governance Team will forward to the relevant DRO and where relevant RQIA.

The DRO will consider the adequacy of the review/learning summary report and liaise with relevant professionals/officers including RQIA (*where relevant*) to ensure that the reporting organisation has taken reasonable action to reduce the risk of recurrence and determine if the SAI can be closed. The DRO will also consider the referral of any learning identified for regional dissemination. In some instances the DRO may require further clarification and may also request sight of the full SEA review report.

If the DRO is not satisfied that a report reflects a robust and timely review s/he will continue to liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received. When the DRO has received all relevant and necessary information the timescale for closure of the SAI will be within 12 weeks, unless in exceptional circumstances which will have been agreed between the Reporting Organisation and the DRO.

12.7 Closure of SAI

Following agreement to close a SAI, the Governance Team will submit an email to the reporting organisation to advise the SAI has been closed, copied to RQIA (where relevant). The email will also indicate, if further information is made available to the reporting organisation (for example, Coroners Reports), which impacts on the outcome of the initial review, that it should be communicated to the HSCB/PHA DRO via the serious incidents mailbox.

This will indicate that based on the review / learning summary report received and any other information provided that the DRO is satisfied to close the SAI. It will acknowledge that any recommendations and further actions required will be monitored through the reporting organisation's internal governance arrangements in order to reassure the public that lessons learned, where appropriate have been embedded in practice.

On occasion and in particular when dealing with level 2 and 3 SAIs, a DRO may close a SAI but request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring will be followed up via the Governance team.

12.8 Regional Learning from SAIs

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. However, the management of regional learning and associated assurance is the responsibility of the HSCB/PHA.

Therefore, where regional learning is identified following the review of an SAI, the DRO will refer this for consideration via HSCB/PHA Quality and Safety Structures and where relevant, will be disseminated as outlined in section 8.0.

12.9 Communication

All communication between HSCB/PHA and reporting organisation must be conveyed between the HSCB Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the HSCB DATIX risk management system.

13 EQUALITY

This procedure has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The procedure will therefore not be subject to equality impact assessment.

Similarly, this procedure has been considered under the terms of the Human Rights Act 1998 and was deemed compatible with the European Convention Rights contained in the Act.

SECTION TWO APPENDICES

APPENDICES

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION:	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)*	**4.** DATE OF INCIDENT: DD / MM / YYYY
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON:	**7.** PROGRAMME OF CARE: *(refer to Guidance Notes)*

8. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY *(complete where relevant)* GENDER: M / F AGE: years

9. IS THIS INCIDENT A NEVER EVENT?				If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars
YES		NO		

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: *(refer to Guidance Notes)*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES	NO	N/A

14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the	

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO
if 'YES' (*full details should be submitted*):		

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: DD/MM/YY
	NO	*specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO
if 'YES' (*full details should be submitted including the date notified*):		

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 2

Revised November 2016 (Version 1.1)

Guidance Notes
SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

The following guidance designed to help you to complete the Serious Adverse Incident Report Form effectively and to minimise the need for the HSCB to seek additional information about the circumstances surrounding the SAI. This guidance should be considered each time a report is submitted.

1. ORGANISATION: *Insert the details of the reporting organisation (HSC Organisation /Trust or Family Practitioner Service)*	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE *Insert the unique incident number / reference generated by the reporting organisation.*
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)* *Insert the details of the hospital/facility/specialty/department/ directorate/place where the incident occurred*	**4.** DATE OF INCIDENT: DD / MM / YYYY *Insert the date incident occurred*
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON: *Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident*	**7.** PROGRAMME OF CARE: *Insert the Programme of Care from the following: Acute Services/ Maternity and Child Health / Family and Childcare / Elderly Services / Mental Health / Learning Disability / Physical Disability and Sensory Impairment / Primary Health and Adult Community (includes GP's) / Corporate Business(Other)*

8. DESCRIPTION OF INCIDENT:

*Provide a **brief factual description** of what has happened and a summary of the events leading up to the incident. **PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE.** Where relevant include D.O.B, Gender and Age. **All reports should be anonymised** – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

In addition include the following:

***Secondary Care** – recent service history; contributory factors to the incident; last point of contact (ward / specialty); early analysis of outcome.*

***Children** – when reporting a child death indicate if the Regional Safeguarding Board has been advised.*

***Mental Health** - when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide, attempted suicide in an in-patient setting or serious self-harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last year) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into the community arrangements;*
whether there was a history of DNAs, where applicable the details of how the death occurred, if known.

***Infection Control** - when reporting an outbreak which severely impacts on the ability to provide services, include the following: measures to cohort Service Users; IPC arrangements among all staff and visitors in contact with the infection source; Deep cleaning arrangements and restricted visiting/admissions.*

***Information Governance** –when reporting include the following details whether theft, loss, inappropriate disclosure, procedural failure etc.; the number of data subjects (service users/staff)involved, the number of records involved, the media of records (paper/electronic),whether encrypted or not and the type of record or data involved and sensitivity.*

DOB: DD / MM / YYYY GENDER: M / F AGE: years
(complete where relevant)

9. IS THIS INCIDENT A NEVER EVENT? Yes/No *(please select)*	If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: *(refer to Guidance Notes)* *Insert CCS Stage of Care Code description*	DETAIL: *(refer to Guidance Notes)* *Insert CCS Detail Code description*	ADVERSE EVENT: *(refer to Guidance Notes)* *Insert CCS Adverse Event Code description*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:
Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*
***Where relevant** please provide details on the current condition of the service user the incident relates to.*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED *(please select and specify **where relevant**)*	YES	NO	N/A

14. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria from below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO

if 'YES' *(full details should be submitted):*

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? *(please select)*	YES	DATE INFORMED: DD/MM/YY *Insert the date informed*
	NO	*Specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO

if 'YES' (*full details should be submitted including the date notified*):

GENERAL MEDICAL COUNCIL **(GMC)**
GENERAL DENTAL COUNCIL **(GDC)**
PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)**
NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)**
LOCAL MEDICAL COMMITTEE **(LMC)**
NURSING AND MIDWIFERY COUNCIL **(NMC**)
HEALTH CARE PROFESSIONAL COUNCIL **(HCPC)**
REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)**
SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)**

OTHER – PLEASE SPECIFY BELOW

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION:

Use this section to provide updated information when the situation changes e.g. the situation deteriorates; the level of media interest changes

The HSCB and PHA recognises that organisations report SAIs based on limited information, which on further review may not meet the criteria of a SAI. Use this section to rrequest that a SAI be de-escalated and send to seriousincidents@hscni.net with the unique incident identification number/reference in the subject line. When a request for de-escalation is made the reporting organisation must include information on why the incident does not warrant further review under the SAI process.

The HSCB/PHA DRO will review the de-escalation request and inform the reporting organisation of its decision within 5 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than de-escalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full review report is required.

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED REVIEW REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA REGIONALGROUP. THEY WILL BE MONITORED ACCORDING TO AGREED TIMESCALES. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREECHES ARE NOT REPORTED WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED.

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 3
Revised November 2016 (Version 1.1)

HSC INTERFACE INCIDENT NOTIFICATION FORM

1. REPORTING ORGANISATION:	**2. DATE OF INCIDENT: DD / MM / YYYY**
3. CONTACT PERSON AND TEL NO:	**4. UNIQUE REFERENCE NUMBER:**

5. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY **GENDER: M / F** **AGE: years**
(complete where relevant)

6. ARE OTHER PROVIDERS INVOLVED? (e.g. *HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S*)	**YES**	**NO**
	if 'YES' (*full details should be submitted in section 7 below*)	

7. PROVIDE DETAIL ON ISSUES/AREAS OF CONCERN:

8. <u>IMMEDIATE</u> ACTION TAKEN BY REPORTING ORGANISATION:

9. WHICH ORGANISATION/PROVIDER (*FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE*) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE REVIEW AND FOLLOW UP OF THIS INCIDENT?

10. OTHER COMMENTS:

REPORT SUBMITTED BY: _____ DESIGNATION: _____

Email: **Telephone:** **Date: DD / MM / YYYY**

Completed proforma should be sent to: seriousincidents@hscni.net

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION:	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY	
8. SUMMARY OF EVENT:	

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
11. SERVICE USER DETAILS: ***Complete where applicable***	
12. WHAT HAPPENED?	
13. WHY DID IT HAPPEN?	

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED:

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

16. RECOMMENDATIONS (please state by whom and timescale)

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

18. FURTHER REVIEW REQUIRED? YES / NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	20. PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

22. TERMS OF REFERENCE *(If known or submit asap)*:

SECTION 5

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME:	24. DATE APPROVED:

25. DESIGANTION:

SECTION 6

26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*								
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 5

Revised November 2016 (Version 1.1)

GUIDANCE NOTES
LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1 (To be submitted to the HSCB)

1. ORGANISATION: *Insert unique identifier number*	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: *Self- explanatory*
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: *Self- explanatory*	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY *Self- explanatory*
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS: *Self- explanatory*
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY *Self- explanatory*	
8. SUMMARY OF EVENT: ***As per notification form. (If the notification form does not fully reflect the incident please provide further detail.)***	

SECTION 2

9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
Refer to guidance on Level 1 review team membership for significant event analysis – Appendix 10	*NAMES AND DESIGNATIONS*

11. SERVICE USER DETAILS:
Complete where applicable

DOB / GENDER / AGE

12. WHAT HAPPENED?

(Describe in detailed chronological order what actually happened. Consider, for instance, how it happened, where it happened, who was involved and what the impact was on the patient/service user[1], the team, organisation and/or others).

13. WHY DID IT HAPPEN?

(Describe the main and underlying reasons contributing to why the event happened. Consider for instance, the professionalism of the team, the lack of a system or failing in a system, the lack of knowledge or the complexity and uncertainty associated with the event)

[1] *ensure sensitivity to the needs of the patient/ service user/ carer/ family member is in line with Regional Guidance on Engagement with Service Users, Families and Carers issued February 2015 (Revised November 2016)*

All sections below be submitted to the HSCB

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED: *(Based on the reason established as to why the event happened, outline the learning identified. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education and training; the need to follow systems or procedures; the vital importance of team working or effective communication)*

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE? *Based on the understanding of why the event happened and the identification of learning, outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a new procedure or protocol.*

NOTE: Action plans should also be developed and set out how learning will be implemented, with named leads responsible for each action point (Refer to Appendix 7 Minimum Standards for Action Plans).

Action plans for this level of review will be retained by the reporting organisation.

16. RECOMMENDATIONS (please state by whom and timescale) *It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.*

It is the responsibility of the reporting organisation to communicate to service users, families and carer's that learning identified relevant to other organisations (arising from the review of a SAI) and submitted to the HSCB/PHA, to consider and review, may not on every occasion result in regional learning.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

Self- explanatory

18. FURTHER REVIEW REQUIRED? YES / NO

Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW:
LEVEL 2 / LEVEL 3
Please select as appropriate

20. PROPOSED TIMESCALE FOR COMPLETION:
DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP(If known or submit ASAP):

Refer to section 2 of appendix 7.

22. TERMS OF REFERENCE(If known or submit ASAP):

Refer to section 3 of appendix 7.

SECTION 5 - (COMPLETE THIS SECTION FOR ALL LEVELS OF REVIEW)

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME: *Self- explanatory*

24. DATE APPROVED: *Self- explanatory*

25. DESIGANTION: *Self- explanatory*

SECTION 6

26. DISTRIBUTION LIST:

List of the individuals, groups or organisations the final report has been shared with.

APPENDIX 5

To be submitted to the HSCB

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

	a) Draft review report has been shared and further engagement planned to share final report	
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed (***if you select this option please also complete 'l' below***)	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**

Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONERS OFFICE
(under section 7 of the Coroners Act (Northern Ireland) 1959)

(complete this section for all death related SAIs)

1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**				**NO**			
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**				**NO**			
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 6

Revised November 2016 (Version 1.1)

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

2.0 THE REVIEW TEAM

3.0 SAI REVIEW TERMS OF REFERENCE

4.0 REVIEW METHODOLOGY

5.0 DESCRIPTION OF INCIDENT/CASE

6.0 FINDINGS

7.0 CONCLUSIONS

8.0 LESSONS LEARNED

9.0 RECOMMENDATIONS AND ACTION PLANNING

10.0 DISTRIBUTION LIST

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			
	c) Report not shared but contents discussed (***if you select this option please also complete 'l' below***)			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE** **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 7
Revised November 2016 (Version 1.1)

Health and Social Care Regional Guidance

for

Level 2 and 3 RCA Incident Review Reports

INTRODUCTION

This document is a revision of the template developed by the DoH Safety in Health and Social Care Steering Group in 2007 as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS.*"

The purpose of this template and guide is to provide practical help and support to those writing review reports and should be used, in as far as possible, for drafting all **HSC Level 2 and Level 3** incident review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports.

The review report presents the work of the review team and provides all the necessary information about the incident, the review process and outcome of the review. The purpose of the report is to provide a formal record of the review process and a means of sharing the learning. The report should be clear and logical, and demonstrate that an open and fair approach has taken place.

This guide should assist in ensuring the completeness and readability of such reports. The headings and report content should follow, as far as possible, the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

This template was designed primarily for incident reviews however it may also be used to examine complaints and claims.

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

Summarise the main report: provide a brief overview of the incident and consequences, background information, level of review, concise analysis and main conclusions, lessons learned, recommendations and arrangements for sharing and learning lessons.

2.0 THE REVIEW TEAM

Refer to Guidance on Review Team Membership

The level of review undertaken will determine the degree of leadership, overview and strategic review required.

- *List names, designation and review team role of the members of the Review Team. The Review Team should be multidisciplinary and should have an Independent Chair.*
- *The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident and the level of review to be undertaken. However, best practice would indicate that review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice.*
- *In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered.*

3.0 SAI REVIEW TERMS OF REFERENCE

Describe the plan and scope for conducting the review. State the level of review, aims, objectives, outputs and who commissioned the review.

The following is a sample list of statements of purpose that may be included in the terms of reference:

- To undertake a review of the incident to identify specific problems or issues to be addressed;
- To consider any other relevant factors raised by the incident;
- To identify and engage appropriately with all relevant services or other agencies associated with the care of those involved in the incident;
- To determine actual or potential involvement of the Police, Health and Safety Executive, Regulation and Quality Improvement Authority and Coroners Service for Northern Ireland[2] [3]
- To agree the remit of the review - the scope and boundaries beyond which the review should not go (e.g. disciplinary process) – state how far back the review will go (what point does the review start and stop e.g. episode of care) and the level of review;
- To consider the outcome of the review, agreeing recommendations, actions to be taken and lessons learned for the improvement of future services;
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate. The level of involvement clearly depends on the nature of the incident and the service user's or family's wishes or carer's wishes to be involved and must be in line with Regional Guidance on Engagement with Service Users, Families and Carers issued November 2016;

[2] *Memorandum of understanding: Investigating patient or client safety incidents (Unexpected death or serious untoward harm)- http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf*

[3] *Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009*

3.0 SAI REVIEW TERMS OF REFERENCE

- To agree the timescales for completing and submitting the review report, including the SAI engagement checklist, distribution of the report and timescales for reviewing actions on the action plan;

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the SAI review.

Clear documentation should be made of the time-line for completion of the work.

This list is not exhaustive

4.0 REVIEW METHODOLOGY

This section should provide an outline of the type of review and the methods used to gather information within the review process. The NPSA's "Seven Steps to Patient Safety[4]" and "Root Cause Analysis Review Guidance[5]" provide useful guides for deciding on methodology.

- Review of patient/ service user records and compile a timeline (if relevant)
- Review of staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
  - Organisation-wide
  - Directorate Team
  - Ward/Team Managers and front line staff
  - Other staff involved
  - Other professionals (including Primary Care)
- Specific reports requested from and provided by staff
- Outline engagement with patients/service users / carers / family members / voluntary organisations/ private providers
- Review of local, regional and national policies and procedures, including professional codes of conduct in operation at the time of the incident
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), photographs, diagrams or drawings, training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

Provide an account of the incident including consequences and detail what makes this incident a SAI. The following can provide a useful focus but please note this section is not solely a chronology of events

- Concise factual description of the serious adverse incident include the incident date and

[4] *http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787*

[5] *http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355*

5.0 DESCRIPTION OF INCIDENT/CASE

type, the healthcare specialty involved and the actual effect of the incident on the service user and/or service and others;

- People, equipment and circumstances involved;
- Any intervention / immediate action taken to reduce consequences;
- Chronology of events leading up to the incident;
- Relevant past history – a brief description of the care and/or treatment/service provided;
- Outcome / consequences / action taken;
- Relevance of local, regional or national policy / guidance / alerts including professional codes of conduct in place at the time of the incident

This list is not exhaustive

6.0 FINDINGS

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care/service provided. This section needs to clearly identify the care and service delivery problems and analysis to identify the causal factors.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

(ii) Contributory Factors

Record the influencing factors that have been identified as root causes or fundamental issues.

- Individual Factors (include employment status i.e. substantive, agency, locum voluntary etc.)
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors reviewed and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful. *http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/*

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within this process.

7.0 CONCLUSIONS

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any on-going engagement / contact with family members or carers.

This section should summarise the key findings and should answer the questions posed in the terms of reference.

8.0 LESSONS LEARNED

Lessons learned from the incident and the review should be identified and addressed by the recommendations and relate to the findings. Indicate to whom learning should be communicated and this should be copied to the Committee with responsibility for governance.

9.0 RECOMMENDATIONS AND ACTION PLANNING

List the improvement strategies or recommendations for addressing the issues highlighted above (conclusions and lessons learned). Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions, and should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions:

- Recommendations for the reviewing organisation
- Suggested /proposed learning that is relevant to other organisations

Action plans should be developed and should set out how each recommendation will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Guidance on Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan.

It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.

It is the responsibility of the reporting organisation to communicate to service users/families/carers that regional learning identified and submitted to the HSCB/PHA for consideration may not on every occasion result in regional learning.

10.0 DISTRIBUTION LIST

List the individuals, groups or organisations the final report has been shared with. This should have been agreed within the terms of reference.

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed (***if you select this option please also complete 'l' below***)	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate** (✓)				
Content with rationale?	**YES**		**NO**	

SECTION 2 INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate** (✓)	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate** (✓)	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate** (✓)	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 8

GUIDANCE ON MINIMUM STANDARDS FOR ACTION PLANS

The action plan must define:

- Who has agreed the action plan
- Who will monitor the implementation of the action plan
- How often the action plan will be reviewed
- Who will sign off the action plan when all actions have been completed

The action plan **MUST** contain the following

1. Recommendations based on the contributing factors	The recommendations from the report - these should be the analysis and findings of the review
2. Action agreed	This should be the actions the organisation needs to take to resolve the contributory factors.
3. By who	Who in the organisation will ensure the action is completed
4. Action start date	Date particular action is to commence
5. Action end date	Target date for completion of action
6. Evidence of completion	Evidence available to demonstrate that action has been completed. This should include any intended action plan reviews or audits
7. Sign off	Responsible office and date sign off as completed

APPENDIX 9

GUIDANCE ON INCIDENT DEBRIEF

• Level 1 - SEA Reviews

For level 1 reviews, the incident debrief can serve the purpose of the SEA review, (these can also be known as 'hot debriefs').

The review should:

- Collect and collate as much factual information on the event as possible, including all relevant records. Also gather the accounts of those directly and indirectly involved, including, where relevant, service user/relatives/carers or other health professionals.

- The incident debrief/significant event meeting should be held with all staff involved to provide an opportunity to:

    - support the staff involved[6]
    - assess what has happened;
    - assess why did it happened;
        - what went wrong and what went well;
    - assess what has been changed or agree what will change;
    - identify local and regional learning.

- The meeting/s should be conducted in an open, fair, honest, non-judgemental and supportive atmosphere and should be undertaken as soon as practical following the incident.

- Write it up – keep a written report of the analysis undertaken using the SEA Report template (see Appendix 4)

- Sharing SEA Report – SEA reports should be shared with all relevant staff, particularly those who have been involved in the incident.

• Level 2 and 3 RCA Reviews

An incident debrief can also be undertaken for level 2 and 3 reviews. This would be separate from the RCA review and should occur quickly after the incident to provide support to staff and to identify any immediate service actions.

[6] *Note: link to ongoing work in relation to Quality 2020 - Task 2 - Supporting Staff involved in SAIs and other Incidents*

APPENDIX 10

LEVEL 1 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review of an incident should be proportionate to its significance; this is a judgement to be made by the Review Team.

Membership of the team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved. Ultimately, for a Level 1 review, it is for each team to decide who is invited, there has to be a balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited.

The review team should appoint an experienced facilitator or lead reviewing officer from within the team to co-ordinate the review. The role of the facilitator is as follows:

- Co-ordinate the information gathering process
- Arrange the review meeting
- Explain the aims and process of the review
- Chair the review meeting
- Co-ordinate the production of the Significant Event Audit report
- Ensure learning is shared in line with the Learning Summary Report

APPENDIX 11

LEVEL 2 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review undertaken will determine the degree of leadership, overview and strategic review required. The level of review of an incident should therefore be proportionate to its significance. This is a judgement to be made by the Review Team.

The core review team should comprise a minimum of three people of appropriate seniority and objectivity. Review teams should be multidisciplinary, (or involve experts/expert opinion/independent advice or specialist reviewers). The team shall have no conflicts of interest in the incident concerned and should have an Independent Chair. (*In the event of a suspected homicide HSC Trusts should follow the HSCB Protocol for responding to SAIs in the event of a Homicide – revised 2013*)

The Chair of the team shall be independent of the service area where the incident occurred and should have relevant experience of the service area and/or chairing investigations/reviews. He/she shall not have been involved in the direct care or treatment of the individual, or be responsible for the service area under review. The Chair may be sourced from the HSCB Lay People Panel *(a panel of 'lay people' with clinical or social care professional areas of expertise in health and social care, who could act as the chair of an independent review panel, or a member of a Trust RCA review panel*).

Where multiple (*two or more*) HSC providers of care are involved, an increased level of independence shall be required. In such instances, the Chair shall be completely independent of the main organisations involved.

Where the service area is specialised, the Chair may have to be appointed from another HSC Trust or from outside NI.

Membership of the team should include all relevant professionals, but should be appropriate and proportionate to the type of incident and professional groups involved.

Membership shall include an experienced representative who shall support the review team in the application of the root cause analysis methodologies and techniques, human error and effective solutions based development.

Members of the team shall be separate from those who provide information to the review team.

It may be helpful to appoint a review officer from within the review team to co-ordinate the review.

APPENDIX 12

LEVEL 3 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review shall be proportionate to the significance of the incident. The same principles shall apply, as for Level 2 reviews. The degree of independence of the review team will be dependent on the scale, complexity and type of the incident.

Team membership for Level 3 reviews will be agreed between the reporting organisation and the HSCB/PHA DRO prior to the Level 3 review commencing.

APPENDIX 13

GUIDANCE ON JOINT REVIEWS/INVESTIGATIONS

Where a SAI involves multiple (*two or more*) HSC providers of care (e.g. a patient/service user affected by system failures both in an acute hospital and in primary care), a decision must be taken regarding who will lead the review and reporting. This may not necessarily be the initial reporting organisation.

The general rule is for the provider organisation with greatest contact with the patient/service user to lead the review and action. There may, however, be good reason to vary this arrangement e.g. where a patient/service user has died on another organisation's premises. The decision should be made jointly by the organisations concerned, if necessary referring to the HSCB Designated Review Officer for advice. **The lead organisation must be agreed by all organisations involved.**

It will be the responsibility of the lead organisation to engage all organisations in the review as appropriate. This involves collaboration in terms of identifying the appropriate links with the other organisations concerned and in practice, separate meetings in different organisations may take place, but a single review report and action plan should be produced by the lead organisation and submitted to the HSCB in the agreed format.

Points to consider:

- If more than one service is being provided, then all services are required to provide information / involvement reports to the review team;
- All service areas should be represented in terms of professional makeup / expertise on the review team;
- If more than one Trust/Agency is involved in the care of an individual, that the review is conducted jointly with all Trusts/Agencies involved;
- Relevant service providers, particularly those under contract with HSC to provide some specific services, should also be enjoined;
- There should be a clearly articulated expectation that the service user (where possible) and family carers, perspective should be canvassed, as should the perspective of staff directly providing the service, to be given consideration by the panel;
- The perspective of the GP and other relevant independent practitioners providing service to the individual should be sought;
- Service users and carer representatives should be invited / facilitated to participate in the panel discussions with appropriate safeguards to protect the confidentiality of anyone directly involved in the case.

This guidance should be read in conjunction with:

- Guidance on Incident Debrief (Refer to Appendix 9)
- Guidance on Review Team Membership (Refer to Appendix 11 & 12)
- Guidance on completing HSC Review Report Level 2 and 3 (Refer to Appendix 7)

APPENDIX 14

PROTOCOL FOR RESPONDING TO SERIOUS ADVERSE INCIDENTS IN THE EVENT OF A HOMICIDE – 2013 (updated November 2016 in line with the HSCB Procedure for the Reporting and Follow up of SAIs)

1. INTRODUCTION AND PURPOSE

1.1. INTRODUCTION

The Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs) was issued in April 2010 and revised November 2016. This procedure provides guidance to Health and Social Care (HSC) Trusts and HSCB Integrated Care staff in relation to the reporting and follow up of SAIs arising during the course of business of a HSC organisation, Special Agency or commissioned service.

This paper is a revised protocol, developed from the above procedure, for the specific SAIs which involves an alleged homicide perpetrated by a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident.

This paper should be read in conjunction with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (Sept 2009 & May 2010).

1.2. PURPOSE

The purpose of this protocol is to provide HSC Trusts with a standardised approach in managing and coordinating the response to a SAI involving homicide.

2. THE PROCESS

2.1. REPORTING SERIOUS ADVERSE INCIDENTS

Refer to the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents revised in 2016.

2.2. MULTI-DISCIPLINARY REVIEW

As indicated in Promoting Quality Care (5.0) an internal multi-disciplinary review must be held as soon as practicable following an adverse incident. Where the SAI has resulted in homicide a more independent response is required.

An independent review team should be set up within twenty working days, of the notification of the incident, to the Trust.

2.3. ESTABLISHING AN INDEPENDENT REVIEW TEAM

2.3.1 CHAIR

The Chair of the Review Team should be independent from the HSC Trust, not a Trust employee or recently employed by the Trust. They should be at Assistant Director level or above with relevant professional expertise.

It is the role of the Chair to ensure engagement with families, that their views are sought, that support has been offered to them at an early stage and they have the opportunity to comment on the final draft of the report.

2.3.2 MEMBERSHIP

A review team should include all relevant professionals. The balance of the Team should include non-Trust staff and enable the review team to achieve impartiality, openness, independence, and thoroughness in the review of the incident. [ref: Case Management Review Chapter 10 Cooperating to Protect Children].

The individuals who become members of the Team must not have had any line management responsibility for the staff working with the service user under consideration. The review team must include members who are independent of HSC Trusts and other agencies concerned.

Members of the review team should be trained in the Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016.

3. TERMS OF REFERENCE

The terms of reference for the review team should be drafted at the first meeting of the review team and should be agreed by the HSCB before the second meeting.

The Terms of Reference should include, as a minimum, the following:

- establish the facts of the incident;
- analyse the antecedents to the incident;
- consider any other relevant factors raised by the incident;
- establish whether there are failings in the process and systems;
- establish whether there are failings in the performance of individuals;
- identify lessons to be learned from the incident; and

- identify clearly what those lessons are, how they will be acted upon, what is expected to change as a result, and specify timescales and responsibility for implementation.

4. TIMESCALES

The notification to the Trust of a SAI, resulting in homicide, is the starting point of this process.

The Trust should notify the HSCB within 24hours and the Regulation and Quality Improvement Authority (RQIA) as appropriate.

An independent review team should be set up within twenty working days of the notification of the incident to the Trust.

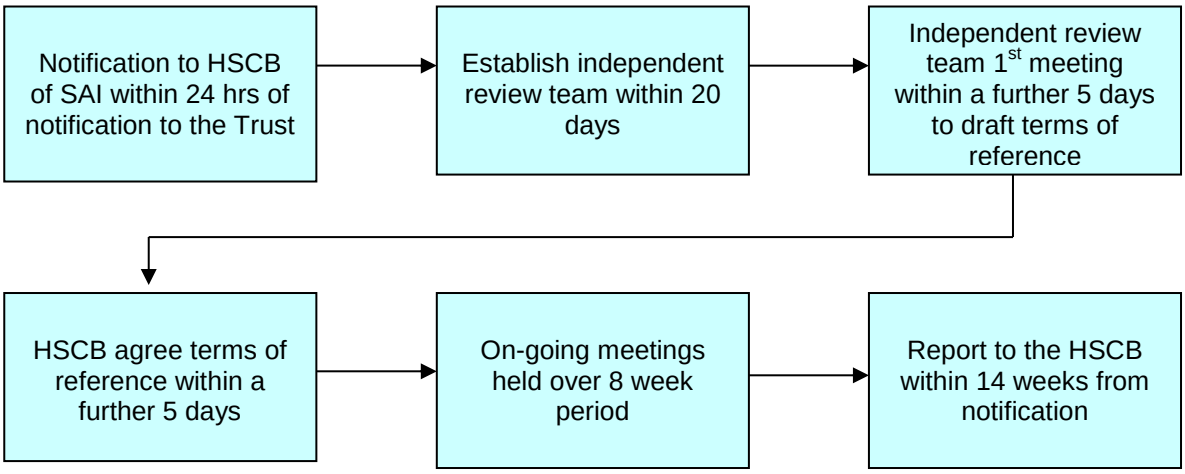
The team should meet to draft the terms of reference within a further five working days (i.e. twenty five days from notification of the incident to the Trust).

The HSCB should agree the terms of reference within a further five working days to enable work to begin at a second meeting.

The review team should complete their work and report to the HSCB within 14 weeks, this may be affected by PSNI investigations.

FLOWCHART OF PROCESS WITH TIMESCALES

NB Days refers to working days from the date of notification of the incident to the Trust



5. THE HEALTH AND SOCIAL CARE BOARD RESPONSIBILITY

On receipt of the completed Trust review report the HSCB will consider the findings and recommendations of the report and must form a view as to whether or not an Independent Inquiry is required.

The HSCB must advise the Department of Health, (DoH) as to whether or not an Independent Inquiry is required in this particular SAI.

APPENDIX 15

ADMINISTRATIVE PROTOCOL

REPORTING AND FOLLOW UP OF SAIs INVOLVING RQIA MENTAL HEALTH/LEARNING DISABILITY AND INDEPENDENT/REGULATED SECTOR

On receipt of a SAI notification and where a HSC Trust has also copied RQIA into the same notification, the following steps will be applied:

1. HSCB acknowledgement email to Trust advising on timescale for review report will also be copied to RQIA.

2. On receipt of the review/learning summary report from Trust, the HSCB Governance Team will forward to the HSCB/PHA Designated Review Officer (DRO).

3. At the same time, the HSCB Governance Team will also forward the review report/learning summary report[1] to RQIA, together with an email advising of a **3 week** timescale from receipt of review report/learning summary report, for RQIA to forward comments for consideration by the DRO.

4. The DRO will continue with his/her review liaising (where s/he feels relevant) with Trust, RQIA and other HSCB/PHA professionals until s/he is satisfied SAI can be closed.

5. If no comments are received from RQIA within the 3 week timescale, the DRO will assume RQIA have no comments.

6. When the SAI is closed by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

All communications to be sent or copied via:

HSCB Governance Team: ***seriousincidents@hscni.net***
and RQIA: **seriousincidents@rqia.org.uk**

[1] **For Level 1 SAIs the HSCB only routinely receive the Learning Summary Report. If RQIA also wish to consider the full SEA Report this should be requested directly by RQIA from the relevant Reporting Organisation.**

APPENDIX 16

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

APPENDIX 17

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES

The Procedure for the Reporting and Follow up of Serious Adverse Incidents (Revised November 2016) provides guidance to Health and Social Care organisations in relation to the reporting and follow up of Serious Adverse Incidents arising during the course of their business or commissioned service.

The guidance notes that the SAI review should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

The guidance notes that there are three possible levels of review of an SAI and specifies the expected timescale for reporting on a review report as follows:

Level 1 Review – Significant Event Audit (SEA). To be completed and a Learning Summary Report sent to the HSCB within 8 weeks of the SAI being reported.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review timescales for completion of the RCA will be determined following submission of the Learning Summary Report to the HSCB.

Level 2 Review – Root Cause Analysis (RCA). The final report to be submitted to the HSCB within 12 weeks from the date the incident was notified.

Level 3 Review – Independent Review. Timescales for completion to be agreed by the DRO.

It should be noted that not every referral to child or adult safeguarding processes will proceed to the completion of an SAI report. Within Children's Services, the most complex cases and those that involve death or serious injury to a child, where concerns about how services worked together exist, will be notified to the HSCB as an SAI and may be assessed as meeting the criteria for a Case Management Review (CMR) in which case they will be managed out of the SAI system. The CMR report will highlight the learning from the case.

However, the timescales for the completion of SAI reviews at Level 2 and 3 have proved to be challenging for the cases that do not reach the threshold for a CMR or which result from allegations of abuse of an adult. These are more likely to be some of the more complex cases, and generally involve inter- and multi- agency partnership working.

In responding to allegations of the abuse, neglect or exploitation of a child or vulnerable adult where it is suspected that criminal offence may have been committed, the Health and Social Care Trusts operate under the principles for joint working with the PSNI and other agencies as set out in

- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009);

- Sharing to Safeguard (DoH Revised HSCC 3/96 and currently being revised by DoH);
- Co-operating to Safeguard Children (DoH 2003); and
- Protocol for joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013)

The Memorandum of Understanding: Investigating patient or client safety incidents (2013) states that in cases where more than one organisation may/should have an involvement in investigating any particular incident, then:

"The HSC Organisation should continue to ensure patient or client safety, but not undertake any activity that might compromise any subsequent statutory investigations."

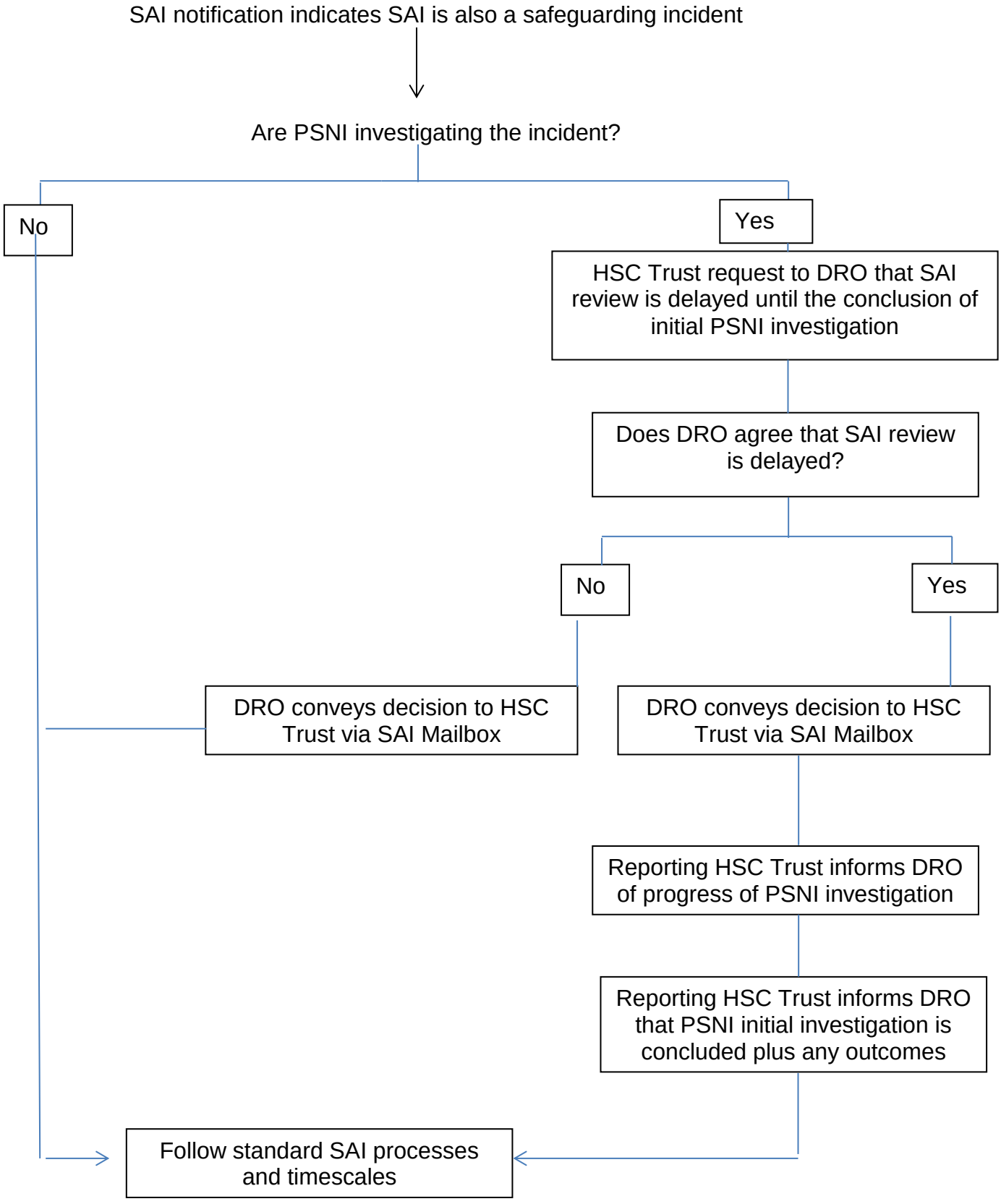
In addition "Achieving Best Evidence: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy" (revised in 2012), sets out clear protocols for interviewing vulnerable witnesses or victims, whether they are children or adults. This guidance ensures that interviews with vulnerable witnesses and victims are led by specially trained staff, conducted at the victims pace and take place in an environment that is conducive to the needs of the victim.

Clearly, there is an inter-dependency between PSNI and HSC investigations/reviews in complex cases involving multi-agency approaches and protocols. The identification and analysis of learning from these events is likely to be incomplete until both the PSNI and HSC have completed their separate and joint investigations/reviews using the protocols outlined above, and it is unlikely that this can be achieved within the timescales set out for both Level 1 and Level 2 reviews under the SAI procedure.

In such circumstances, the following process should be used:

- Trust report SAI to HSCB using the SAI Notification Form;
- The SAI Notification Form or section 22 of the notification form i.e. 'additional information following initial notification, should indicate the following:
  - The SAI is also a Safeguarding incident
  - PSNI are conducting an investigation of the circumstances surrounding the SAI
  - SAI evaluation will commence at the conclusion of the initial PSNI investigation;
  - Set out the arrangements for keeping the DRO informed of the progress of the PSNI initial investigation;
- If satisfied, the DRO will advise the Trust via the SAI Mailbox that he/she is in agreement with the proposal to delay the SAI review until the conclusion of the initial PSNI investigation;
- The reporting HSC Trust will inform the DRO as soon as the initial PSNI investigation has concluded, along with any outcomes and advise the SAI evaluation has commenced;
- The SAI will continue to be monitored by HSCB Governance team in line with timescales within the Procedure for the Reporting and Follow up of SAIs;
- If the DRO is **not** in agreement with the proposal to delay the SAI review, the reasons for this will be clearly conveyed to the Trust via the SAI Mailbox. Possible reasons for this may include, for example, situations where a criminal incident has occurred on HSC Trust premises but does not involve HSC Trust staff, or an incident involving a service user in their own home and a member of the public is reported to the PSNI by HSC Trust staff.

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES



SECTION THREE ADDENDUM

ADDENDUM

ADDENDUM 1

A Guide for Health and Social Care Staff

Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

November 2016
Version 1.1

Contents

Notes on the Development of this Guidance

This guidance has been compiled by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) working in collaboration with the Regulation and Quality Improvement Authority (RQIA), the Patient Client Council (PCC) and Health and Social Care (HSC) Trusts.

This guidance has been informed by:

- National Patient Safety Agency (NPSA) Being Open Framework (2009)
- Health Service Executive (HSE) – Open Disclosure National Guidelines (2013)

Please note the following points:

- *The term 'service user' as used throughout this guidance includes patients and clients availing of Health and Social Care Services from HSC organisations and Family Practitioner Services (FPS) and/or services commissioned from the Independent Sector by HSC organisations.*

- *The phrase 'the service user / family' is used throughout this document in order to take account of all types of engagement scenarios, and also includes a carer(s) or the legal guardian of the service user, where appropriate. However, when the service user has capacity, communication should always (in the first instance) be with them (see appendix 1 for further guidance).*

A review / re-evaluation of this guidance will be undertaken one year following implementation.

1.0 Introduction

When an adverse outcome occurs for a service user it is important that the service user / family (as appropriate) receive timely information and are fully aware of the processes followed to review the incident.

The purpose of a Serious Adverse Incident (SAI) review is to understand what occurred and where possible improve care by learning from incidents. Being open about what happened and discussing the SAI promptly, fully and compassionately can help the service user / family cope better with the after-effects and reduce the likelihood of them pursuing other routes such as the complaints process or litigation to get answers to their questions.

It is therefore essential that there is:

- full disclosure of a SAI to the service user / family,
- an acknowledgement of responsibility,
- an understanding of what happened and a discussion of what is being done to prevent recurrence.

Communicating effectively with the service user / family is a vital part of the SAI process. If done well, it promotes person-centred care and a fair and open culture, ultimately leading to continuous improvement in the delivery of HSC services. It is human to make mistakes, but rather than blame individuals, the aim is for all of us to identify and address the factors that contributed to the incident. The service user / family can add valuable information to help identify the contributing factors, and should be integral to the review process, unless they wish otherwise.

2.0 Purpose

This is a guide for HSC staff to ensure effective communication with the service user / family, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner.

It is important this guidance is read in conjunction with the regional Procedure for Reporting and Follow up of SAIs (November 2016) and any subsequent revisions relating to the SAI process that have or may be issued in the future. This will ensure the engagement process is closely aligned to the required timescales, documentation, review levels etc. *To view the SAI Procedure please follow the link below* http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf.

The HSCB Process works in conjunction with all other review processes, statutory agencies and external bodies. Consequently, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI. It is therefore important that all existing processes continue to operate in tandem with the SAI procedure and should not be an obstacle to the engagement of the service user / family; nor should an interaction through another process replace engagement through the SAI process.

In that regard, whilst this guidance is specific to 'being open' when engaging with the service user / family following a SAI, it is important HSC organisations are also mindful of communicating effectively with the service user / family when investigating adverse incidents. In these circumstances, organisations should refer to the NPSABeingOpenFramework www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726 which will provide assistance for organisations to determine the level of service user / family engagement when investigating those adverse incidents that do not meet SAI criteria.

The Being Open Framework may also assist organisations with other investigative processes e.g. complaints, litigation, lookback exercises, and any other relevant human resource and/or risk management related policies and procedures.

3.0 Principles of Being Open with the Service User / Family

Being open and honest with the service user / family involves:

- Acknowledging, apologising and explaining that the organisation wishes to review the care and treatment of the service user;
- Explaining that the incident has been categorised as a SAI, and describing the review process to them, including timescales;
- Advising them how they can contribute to the review process, seeking their views on how they wish to be involved and providing them with a leaflet explaining the SAI process (see appendix 2);
- Conducting the correct level of SAI review into the incident and reassuring the service user / family that lessons learned should help prevent the incident recurring;
- Providing / facilitating support for those involved, including staff, acknowledging that there may be physical and psychological consequences of what happened;

- Ensuring the service user / family have details for a single point of contact within the organisation.

It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

The following principles underpin being open with the service user / family following a SAI.

3.1 Acknowledgement

All SAIs should be acknowledged and reported as soon as they are identified. In cases where the service user / family inform HSC staff / family practitioner when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all professionals.

In certain circumstances e.g. cases of criminality, child protection, or SAIs involving theft, fraud, information breaches or data losses that do not directly affect service users; it may not be appropriate to communicate with the service user / family. When a lead professional / review team make a decision, based on a situation as outlined above, or based on a professional's opinion, not to disclose to the service user / family that a SAI has occurred, the rationale for this decision must be clearly documented in the SAI notification form / SAI review checklist that is submitted to the HSCB.

It is expected, the service user / family will be informed that a SAI has occurred, as soon as possible following the incident, for all levels of SAI reviews. In very exceptional circumstances, where a decision is made not to inform the service user / family, this decision must be reviewed and agreed by the review team, approved by an appropriate Director or relevant committee / group, and the decision kept under review as the review progresses. In these instances the HSCB must also be informed:

- **Level 1 reviews - on submission of Review Report and Checklist Proforma**
- **Level 2 and 3 reviews - on submission of the Terms of Reference and Membership of the review team.**

3.2 Truthfulness, timeliness and clarity of communication

Information about a SAI must be given to the service user / family in a truthful and open manner by an appropriately nominated person (see 4.2.2). The service user / family should be provided with an explanation of what happened in a way that considers their individual circumstances, and is delivered openly. Communication should also be timely, ensuring the service user / family is provided with information about what happened as soon as practicable without causing added distress. Note, where a number of service users are involved in one incident, they should all be informed at the same time where possible.

It is also essential that any information given is based solely on the facts known at the time. Staff should explain that new information may emerge as an incident review is undertaken, and that the service user / family will be kept informed, as the review progresses. The service user / family should receive clear information with a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of jargon, should be avoided.

3.3 Apology / Expression of Regret

When it is clear, that the organisation / family practitioner is responsible for the harm / distress to the service user, it is imperative that there is an acknowledgement of the incident and an apology provided as soon as possible. Delays are likely to increase the service user / family sense of anxiety, anger or frustration. Relevant to the context of a SAI, the service user / family should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm / distress that has occurred as a result of the SAI.

3.4 Recognising the expectations of the Service User / Family

The service user / family may reasonably expect to be fully informed of the facts, consequences and learning in relation to the SAI and to be treated with empathy and respect.

They should also be provided with support in a manner appropriate to their needs. Specific types of service users / families may require additional support (see appendix 1).

In circumstances where the service user / family request the presence of their legal advisor this request should be facilitated. However, HSC staff

should ensure that the legal advisor is aware that the purpose of the report / meeting is not to apportion liability or blame but to learn from the SAI. Further clarification in relation to this issue should be sought from Legal Services.

3.5 Professional Support

HSC organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report SAIs. Staff should feel supported throughout the incident review process because they too may have been traumatised by being involved. There should be a culture of support and openness with a focus on learning rather than blame.

HSC organisations should encourage staff to seek support where required form relevant professional bodies such as the General Medical Council (GMC), Royal Colleges, the Medical Defence Union (MDU), the Medical Protection Society (MPS), the Nursing and Midwifery Council, the Northern Ireland Association for Social Work (NIASW) and the Northern Ireland Social Care Council (NISCC).

3.6 Confidentiality

Details of a SAI should at all times be considered confidential. It is good practice to inform the service user / family about those involved in the review and who the review report will be shared with.

3.7 Continuity of Care

In exceptional circumstances, the service user / family may request transfer of their care to another facility; this should be facilitated if possible to do so. A member of staff should be identified to act as a contact person for the service user / family to keep them informed of their on-going treatment and care.

4.0 Process

Being open with the service user / family is a process rather than a one-off event. There are 5 stages in the engagement process:

- Stage 1 – Recognition
- Stage 2 - Communication
- Stage 3 – Initial Meeting
- Stage 4 – Follow up Discussions

- Stage 5 – Process Completion

The duration of this process depends on the level of SAI review being undertaken and the associated timescales as set out in the Procedure for the Reporting and Follow up of SAIs (2013).

4.1 Stage 1 - Recognition

As soon as the SAI is identified, the priority is to prevent further harm / distress. The service user / family should be notified that the incident is being reviewed as a SAI.

4.1.1 Preliminary Discussion with the Service User / Family

On many occasions it will be at this stage when the lead professional / family practitioner responsible for the care of the service user will have a discussion with the service user / family, advising of the need to review the care and treatment. This preliminary discussion (which could be a telephone call) will be in addition to the formal initial meeting with the service user / family (see 4.3).

A Level 1 review may not require the same level of engagement as Levels 2 and 3 therefore the preliminary discussion may be the only engagement with service user / family prior to communicating findings of the review, provided they are content they have been provided with all information.

There may be occasions when the service user / family indicate they do not wish to engage in the process. In these instances the rationale for not engaging further must be clearly documented.

4.2 Stage 2 – Communication

4.2.1 Timing of Initial Communication with the Service User / Family

The initial discussion with the service user / family should occur as soon as possible after recognition of the SAI. Factors to consider when timing this discussion include:

- service user's health and wellbeing;
- service user / family circumstances, preference (in terms of when and where the meeting takes place) and availability of key staff *(appendix 1 provides guidance on how to manage different categories of service user / family circumstances);*

4.2.2 Choosing the individual to communicate

The person[7] nominated to lead any communications should:

- Be a senior member of staff with a comprehensive understanding of the facts relevant to the incident;
- Have the necessary experience and expertise in relation to the type of incident;
- Have excellent interpersonal skills, including being able to effectively engage in an honest, open and transparent manner, avoiding excessive use of jargon;
- Be willing and able to offer a meaningful apology / expression of regret, reassurance and feedback.

If required, the lead person communicating information about the SAI should also be able to nominate a colleague who may assist them with the meeting and should be someone with experience or training in communicating with the service user / family.

The person/s nominated to engage could also be a member/s of the review team (if already set up).

[7] *FPS SAIs involving FPS this will involve senior professionals/staff from the HSCB Integrated Care Directorate.*

4.3 Stage 3 - Initial Meeting with the Service User / Family

The initial discussion is the first part of an on-going communication process. Many of the points raised here should be expanded on in subsequent meetings with the service user / family.

4.3.1 Preparation Prior to the Initial Meeting

- The service user / family should be given the leaflet - What I Need to Know About a SAI (see appendix 2);
- Share with the service user / family what is going to be discussed at the meeting and who will be in attendance.

4.3.2 During the Initial Meeting

The content of the initial meeting with the service user / family should cover the following:

- Welcome and introductions to all present;
- An expression of genuine sympathy or a meaningful apology for the event that has occurred;
- The facts that are known to the multidisciplinary team;
- Where a service user has died, advising the family that the coroner has been informed (where there is a requirement to do so) and any other relevant organisation/body;
- The service user / family are informed that a SAI review is being carried out;
- Listening to the service user's / families understanding of what happened;
- Consideration and formal noting of the service user's / family's views and concerns;
- An explanation about what will happen next in terms of the SAI review, findings, recommendations and learning and timescales;
- An offer of practical and emotional support for the service user / family. This may involve getting help from third parties such as charities and voluntary organisations, providing details of support from other organisations, as well as offering more direct assistance;
- Advising who will be involved in the review before it takes place and who the review report will be shared with;
- Advising that all SAI information will be treated as confidential.

If for any reason it becomes clear during the initial discussion that the service user / family would prefer to speak to a different health / social

care professional, these wishes should be respected, and the appropriate actions taken.

It is important during the initial meeting to try to avoid any of the following:

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different health and social care individuals.

It should be recognised that the service user / family may be anxious, angry and frustrated, even when the meeting is conducted appropriately. It may therefore be difficult for organisations to ascertain if the service user / family have understood fully everything that has been discussed at the meeting. It is essential however that, at the very least, organisations are assured that the service user / family leave the meeting fully aware that the incident is being reviewed as a SAI, and knowing the organisation will continue to engage with them as the review progresses, so long as the service user / family wish to engage.

Appendix 3 provides examples of words / language which can be used during the initial discussion with the service user / family.

4.4 Stage 4 – Follow-up Discussions

Follow-up discussions are dependent on the needs and wishes of the service user / family.

The following guidelines will assist in making the communication effective:

- The service user / family should be updated if there are any delays and the reasons for the delays explained;
- Advise the service user / family if the incident has been referred to any other relevant organisation / body;
- Consideration is given to the timing of the meetings, based on both the service users / families health, personal circumstances and preference on the location of the meeting, e.g. the service users / families home;
- Feedback on progress to date, including informing the service user / family of the Terms of Reference of the review and membership of the review panel (for level 2 and 3 SAI reviews);
- There should be no speculation or attribution of blame. Similarly, the health or social care professional / senior manager communicating the SAI must not criticise or comment on matters outside their own experience;
- A written record of the discussion is kept and shared with the service user / family;
- All queries are responded to appropriately and in a timely way.

4.5 Stage 5 – Process Completion

4.5.1 Communicating findings of review / sharing review report

Feedback should take the form most acceptable to the service user / family. Communication should include:

- a repeated apology / expression of regret for the harm / distress suffered;
- the chronology of clinical and other relevant factors that contributed to the incident;
- details of the service users / families concerns;
- information on learning and outcomes from the review
- Service user / family should be assured that lines of communication will be kept open should further questions arise at a later stage and a single point of contact is identified.

It is expected that in most cases there will be a complete discussion of the findings of the review and that the final review report will be shared with

the service user / family. In some cases however, information may be withheld or restricted, for example:

- Where communicating information will adversely affect the health of the service user / family;
- Where specific legal/coroner requirements preclude disclosure for specific purposes;
- If the deceased service users health record includes a note at their request that he/she did not wish access to be given to his/her family.

Clarification on the above issues should be sought form Legal Services.

There may also be instances where the service user / family does not agree with the information provided, in these instances Appendix 1 (section 1.8) will provide additional assistance.

In order to respond to the timescales as set out in the Procedure for the Reporting and Follow up of SAIs (November 2016) organisations may not have completed stage 5 of the engagement process prior to submission of the review report to HSCB. In these instances, organisations must indicate on the SAI review checklist, submitted with the final review report to the HSCB, the scheduled date to meet with the service user / family to communicate findings of review / share review report.

4.5.2 Communicating Changes to Staff

It is important that outcomes / learning is communicated to all staff involved and to the wider organisation as appropriate.

4.6 Documentation

Throughout the above stages it is important that discussions with the service user / family are documented and should be shared with the individuals involved.

Documenting the process is essential to ensure continuity and consistency in relation to the information that has been relayed to the service user / family.

Documentation which has been produced in response to a SAI may have to be disclosed later in legal proceedings or in response to a freedom of information application. It is important that care is taken in all communications and documents stating fact only.

Appendix 4 provides a checklist which organisations may find useful as an aide memoire to ensure a professional and standardised approach.

5.0 Supporting Information and Tools

In addition to this guidance, supporting tools have been developed to assist HSC organisations with implementing the actions of the NPSA's Being Open Patient Safety Alert.

Training on being open is freely available through an e-learning tool for all HSC organisations.

Information on all these supporting tools can be found at: www.**npsa**.nhs.uk/**beingopen** and www.nrls.**npsa**.nhs.uk/**beingopen**/.

Guidance on sudden death and the role of bereavement co-ordinators in Trusts can be found at:
http://webarchive.proni.gov.uk/20120830110704/http://www.dhsspsni.gov.uk/sudden-death-guidance.pdf

List of Acronyms and Abbreviations

FPS	-	Family Practitioner Services
GMC	-	General Medical Council
HSC	-	Health and Social Care
HSCB	-	Health and Social Care Board
HSE	-	Health Service Executive
MDU	-	Medical Defence Union
MPS	-	Medical Protection Society
NIASW	-	Northern Ireland Association for Social Work
NISCC	-	Northern Ireland Social Care Council
NMC	-	Nursing and Midwifery Council
NPSA	-	National Patient Safety Agency
PCC	-	Patient Client Council
PHA	-	Public Health Agency
RC	-	Royal colleges
RCA	-	Root Cause Analysis
RQIA	-	Regulation and Quality Improvement Authority
SAI	-	Serious Adverse Incident
SEA	-	Significant Event Audit

Appendix 1

Particular Service user Circumstances

The approach to how an organisation communicates with a service user / family may need to be modified according to the service user's personal circumstances.

The following gives guidance on how to manage different categories of service user circumstances.

1.1 When a service user dies

When a SAI has resulted in a service users death, the communication should be sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened.

1.2 Children

The legal age of maturity for giving consent to treatment is 16 years old. However, it is still considered good practice to encourage young people of this age to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the communication process after a SAI.

The opportunity for parents / guardians to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents / guardians alone or in the presence of the child. In these instances the parents' / guardians' views on the issue should be sought.

1.3 Service users with mental health issues

Communication with service users with mental health issues should follow normal procedures unless the service user also has cognitive impairment (see1.4 Service users with cognitive impairments).

The only circumstances in which it is appropriate to withhold SAI information from a service user with mental health issues is when advised to do so by a senior clinician who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion may be required to justify withholding information from the service user.

In most circumstances, it is not appropriate to discuss SAI information with a carer or relative without the permission of the service user, unless in the public interest and / or for the protection of third parties.

1.4 Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them.

In these cases communication would be conducted with the carer / family as appropriate. Where there is no such person, the clinicians may act in the service users best interest in deciding who the appropriate person is to discuss the SAI with.

1.5 Service users with learning disabilities

Where a service user / family has difficulties in expressing their opinion verbally, every effort should be made to ensure they can use or be facilitated to use a communication method of their choice. An advocate / supporter, agreed on in consultation with the service user, should also be identified. Appropriate advocates / supporters may include carer/s, family or friends of the service user or a representative from the Patient Client Council (PCC).

1.6 Service users with different language or cultural considerations

The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss SAI information. Avoid using 'unofficial translators' and / or the service users family or friends as they may distort information by editing what is communicated.

1.7 Service users with different communication needs

Service users who have communication needs such as hearing impaired, reduced vision may need additional support.

1.8 Service users who do not agree with the information provided

Sometimes, despite the best efforts the service user/family/carer may remain dissatisfied with the information provided. In these circumstances, the following strategies may assist:

- Facilitate discussion as soon as possible;
- Write a comprehensive list of the points that the service user / family disagree with and where appropriate reassure them you will follow up these issues.
- Ensure the service user / family has access to support services;
- Offer the service user / family another contact person with whom they may feel more comfortable.
- Use an acceptable service user advocate e.g. PCC or HSC layperson to help identify the issues between the HSC organisation and the service user / family and to achieve a mutually agreeable solution;

There may be occasions despite the above efforts the service user/family/carer remain dissatisfied with the HSC organisation's attempts to resolve their concerns. In these exceptional circumstances, the service user/family/carer through the agreed contact person, should be advised of their right to approach the Northern Ireland Public Services Ombudsman (NIPSO). In doing so, the service user/family requires to be advised by the HSC organisation that the internal procedure has concluded (within two weeks of this process having been concluded), and that the service user/family should approach the NIPSO within six months of this notification.

The contact details for the NIPSO are: Freephone 0800 34 34 34 or Progressive House, 33 Wellington Place, Belfast, BT1 6HN.

1.9 Service Users who do not wish to participate in the engagement process

It should be documented if the service user does not wish to participate in the engagement process.

Appendix 2

MAHI - STM - 307 - 190

Health and Social Care Board

Public Health Agency

What I need to know about a Serious Adverse Incident

Information for Service Users, Family Members and Carers

Insert Name of Organisation

This leaflet is written for people who use Health and Social Care (HSC) services and their families.

**The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

Introduction

Events which are reported as Serious Adverse Incidents (SAIs) help identify learning even when it is not clear something went wrong with treatment or care provided.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Health and Social Care Board (HSCB) by the organisation where the SAI has occurred. It may be:

- an incident resulting in serious harm;
- an unexpected or unexplained death;
- a suspected suicide of a service user who has a mental illness or disorder;
- an unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

A SAI may affect services users, members of the public or staff.

Never events are serious patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers. A small number of SAIs may be categorised as never events based on the Department of Health Never Events list.

SAIs, including never events, occurring within the HSC system are reported to the HSCB. You, as a service user / family member / carer, will be informed where a SAI and/or never event has occurred relating to treatment and care provided to you by the HSC.

Can a complaint become a SAI?

Yes, if during the follow up of a complaint the **(insert name of organisation)** identifies that a SAI has occurred it will be reported to the HSCB. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

How is a SAI reviewed?

Depending on the circumstance of the SAI a review will be undertaken. This will take between 8 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The (**insert name of organisation**) will discuss with you how the SAI will be reviewed and who will be involved. The (**insert name of organisation**) will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

How is the service user or their family/carer involved in the review?

An individual will be identified to act as your link person throughout the review process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the review;
- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;

- Are offered advice in the event that the media make contact.

What happens once the review is complete?

The findings of the review will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by **(insert name of organisation)** staff that is acceptable to you.

How will learning be used to improve safety?

By reviewing a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

We believe that this process will help to restore the confidence of those affected by a SAI.

For each completed review:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system. Therefore as part of our process to improve quality and share learning, we may share the anonymised content of the SAI report with other HSC organisations'

Do families get a copy of the report?

Yes, a copy of the review report will be shared with service users and/or families with the service user's consent.

If the service user has died, families/carers will be provided with a copy of the report and invited to meet with senior staff.

Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to review some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA work in conjunction with the HSCB / PHA with regard to the review of certain categories of SAI including the following:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the (**insert name of organisation)** to ensure that the recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the (**insert name of organisation**).

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the review will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

Further Information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below:

Your link person is ……..…….

Your link person's job title is……..…..

Contact number …….

Hours of work……..……

Prior to any meetings or telephone call you may wish to consider the following:

Think about what questions and fears/concerns you have in relation to:

(a) What has happened?
(b) Your condition / family member condition
(c) On-going care

You could also:

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

Contact details:
Free phone number: 0800 917 0222

Appendix 3

Examples of communication which enhances the effectiveness of being open	
Stage of Process	**Sample Phrases**
Acknowledgement	"We are here to discuss the harm that you have experienced/the complications with your surgery/treatment" "I realise that this has caused you great pain/distress/anxiety/worry" "I can only imagine how upset you must be" "I appreciate that you are anxious and upset about what happened during your surgery – this must have come as a big shock for you" "I understand that you are angry/disappointed about what has happened" "I think I would feel the same way too"
Sorry	"I am so sorry this has happened to you" "I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital an extra few days for observation" "I truly regret that you have suffered xxx which is a recognised complication associated with the x procedure/treatment." "I am so sorry about the anxiety this has caused you" "A review of your case has indicated that an error occurred – we are truly sorry about this"
Story	**Their Story** "Tell me about your understanding of your condition" "Can you tell me what has been happening to you" "What is your understanding of what has been happening to you" **Your understanding of their Story: (Summarising)** "I understand from what you said that" xxx "and you are very upset and angry about this"

	Is this correct? (i.e. summarise their story and acknowledge any emotions/concerns demonstrated.) "Am I right in saying that you……..." **Your Story** "Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned? "Do you mind if I tell you what we have been able to establish at this stage?" "We have been able/unable to determine at this stage that……." "We are not sure at this stage about exactly what happened but we have established that ……. We will remain in contact with you as information unfolds" "You may at a later stage experience xx if this happens you should ……."
Inquire	"Do you have any questions about what we just discussed?" "How do you feel about this?" "Is there anything we talked about that is not clear to you?"
Solutions	"What do you think should happen now?" "Do you mind if I tell you what I think we should do?" "I have reviewed your case and this is what I think we need to do next" "What do you think about that?" "These are your options now in relation to managing your condition, do you want to have a think about it and I will come back and see you later?" "I have discussed your condition with my colleague Dr x we both think that you would benefit from xx. What do you think about that?"
Progress	"Our service takes this very seriously and we have already started a review into the incident to see if we can find out what caused it to happen" "We will be taking steps to learn from this event so that we can

	try to prevent it happening again in the future” “I will be with you every step of the way as we get through this and this is what I think we need to do now” “We will keep you up to date in relation to our progress with the review and you will receive a report in relation to the findings and recommendations of the review team” “Would you like us to contact you to set up another meeting to discuss our progress with the review?” “I will be seeing you regularly and will see you next in….days/weeks. “You will see me at each appointment” “Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by……” “If you think of any questions write them down and bring them with you to your next appointment.” “Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services”

Appendix 4

Organisations may find this checklist useful an aide memoire to ensure a professional and standardised approach

Before, During and After Communication / Engagement Documentation Checklist

BEFORE	***Note taking***
Service users full name	
Healthcare record number	
Date of birth	
Date of admission	
Diagnosis	
Key HSC professional(s) involved in service user's care	
Date of discharge (if applicable)	
Date of SAI	
Description of SAI	
Outcome of SAI	
Agreed plan for management of SAI	
Agreed professional to act as contact person with the service user / family	

Service user / family informed incident is being reviewed as a SAI: • Date • By Whom • By what means (telephone call / letter / in person)	
Date of first meeting with the service user / family	
Location of first meeting (other details such as room booking, arrangements to ensure confidentiality if shared ward etc)	
Person to be responsible for note taking identified	
Person Nominated to lead communications identified	
Colleague/s to assist nominated lead	
Other staff identified to attend the disclosure meeting	
Anticipated service user / family concerns queries	
Meeting agenda agreed and circulated	
Additional support required by the service user / family, if any?	
The service user / family has been advised to bring a support person to the meeting?	
The service user consented to the sharing of information with others such as designated family members / support person?	

It has been established that the service user / family requires an interpreter? If yes, provide details of language and arrangements that have been or to be made.	

Signature: _____

***Date*:** _____

DURING ***Note taking***

There has been an acknowledgment of the SAI in relation to the service user / family experience.	
An apology / expression of regret provided	
The service user / family was provided with factual information regarding the adverse event	
The service user / family understanding of the SAI was established	
The service user / family was provided with the opportunity to: - Tell their story - Voice their concerns and - Ask questions	
The next steps in relation to the service user's on-going care were agreed and the service user was involved in the decisions made.	
The service user / family was provided with information in relation to the supports available to them.	
Reassurance was provided to the service user / family in relation to the on-going communication of facts when the information has been established and available – continuity provided.	
Next meeting date and location agreed	

Signature: _____

***Date*:** _____

AFTER

Circulate minutes of the meeting to all relevant parties for timely verification.
Follow through on action points agreed.
Continue with the incident review.
Keep the service user included and informed on any progress made – organise further meetings.
Draft report to be provided to the service user in advance of the final report (if agreed within review Terms of Reference that the draft report is to be shared with the service user prior to submission to HSCB/PHA).
Offer a meeting with the service user to discuss the review report and allow for amendments if required.
Follow through on any recommendations made by the incident review team.
Closure of the process is mutually agreed.
When closure / reconciliation was not reached the service user was advised of the alternative courses of action which are open to them i.e the complaints process.

Signature: _____

***Date*:** _____

Health and Social Care Board

Public Health Agency

Protocol for the Role of a HSCB/PHA Designated Review Officer (DRO) allocated to a Serious Adverse Incident (SAI)

Revised: March 2017

Version 1.0

Contents

1.0 Background

The requirement on HSC organisations to routinely report Serious Adverse Incidents (SAIs) to the Department of Health (DoH) ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA). During 2012/13 the HSCB, working with the PHA, undertook a review of the Procedure, issued in 2010, and issued revised guidance in September 2013.

A further review was undertaken in November 2016 and issued to all Arm's Length Bodies (ALBs) for full implementation on 1 January 2017. The procedure provides guidance to all Arms Length Bodies in relation to the reporting and follow-up of SAIs arising during the course of business of a HSC organisation/Special Agency or commissioned service.

2.0 Role of the HSCB/PHA in the SAI Process

- Responsible for the effective implementation of the procedure for the reporting and follow up of SAIs across the region;

- Ensuring there are mechanisms in place for SAIs to be reviewed by relevant professionals/senior officers;

- Ensuring there are adequate safety and quality structures within the HSCB/PHA so that trends, best practice and learning is identified, disseminated and implemented in a timely manner in order to prevent recurrence;

- Identify any immediate/medium/long term strategic issues which contributed to the incident and that need to be addressed, and communicate these to the relevant commissioning service;

- Maintain a high quality of information and documentation within a time bound process.

3.0 What are the HSCB/PHA Safety and Quality Structures relating to SAIs?

It is important that when a SAI occurs, that there is a systematic process for reviewing the incident and identify potential learning. The key aim being to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across health and social care as a whole.

The HSCB and PHA therefore have developed a safety and quality structure that provides an effective mechanism for identifying and disseminating regional learning across the province.

- **Quality Safety and Experience (QSE) Group**

QSE is a jointly chaired, group that provides an overarching, streamlined approach in relation to how the HSCB and PHA meet their statutory duty of quality. This multi-disciplinary group meet on a monthly basis to consider learning, patterns/trends, themes or areas of concern, and agree appropriate actions to be taken, from all sources of safety and quality information received by the HSCB and PHA.

A Regional SAI Review Subgroup reports to, and supports the work of the QSE Group.

- **Regional Serious Adverse Incident Review Sub-Group (RSAIRSG)**

The RSAIRSG is chaired by the HSCB Governance Manager and the PHA Senior Manager for Safety, Quality and Patient Experience. Membership comprises of professional representatives from the HSCB and PHA; RQIA are also in attendance.

The RSAIRSG has responsibility to ensure that trends, examples of best practice and learning in relation to SAIs are identified and disseminated in a timely manner.

- **SAI Professional Groups**

A number of professional groups from individual programmes of care have recently been established which allow DROs who share the same area of expertise to meet and discuss SAI reviews and where relevant identify regional learning prior to closure of the SAI. These professional groups also provide support to DROs when they may require advice in relation to specific SAIs.

The groups benefit from:

- Multi-professional input / wider circle of experience;
- Group sign off, decisions not focused on one individual;
- More complete understanding of the range of SAI issues within these service areas leading to the identification of regional trends.

- **Safety Quality and Alerts Team (SQAT)**

SQAT, which is closely aligned to the work of QSE, is responsible for performance managing the implementation and assurance of Regional Safety and Quality Alerts / Learning Letters / Guidance issued by HSCB/PHA in respect of SAIs.

SQAT is a multidisciplinary group with representatives from the HSCB and PHA and is chaired by the PHA Medical Director/ Director of Public Health. The Group meet fortnightly to co-ordinate the implementation of regional safety and quality alerts, letters and guidance issued by the DoH, HSCB, PHA and other organisations. This provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation.

An overview of the Safety and Quality Structures is outlined in Appendix 1.

- **HSCB Governance Team**

The HSCB Governance Team provides the co-ordination, administrative support to all of the above groups and to individual DROs in relation to the management of SAIs from notification to closure of a SAI.

4.0 What is a DRO?

A DRO is a senior professional/officer within the HSCB / PHA who has a degree of expertise in relation to the programme of care / service area where a SAI has occurred.

5.0 What is the role of a DRO?

The DRO has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI;
  - where a DRO believes the SAI review is not being undertaken at the appropriate level.

- Agreeing the Terms of Reference for Level 2 and 3 RCA reviews;

- Reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for Level 2 and 3 RCA Reviews, including service user/family/carer engagement and liaising with other professionals (where relevant);

- Liaising with reporting organisations via the Governance Team, where:

  - More information is required in relation to a Level 1 summary report. (Whilst the HSCB will not routinely receive the full Level 1 SEA report, these can be requested.)

  - There may be concerns regarding the robustness of the Level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented.

- Identification of regional learning, where relevant;

- Surveillance of SAIs to identify patterns/clusters/trends.

- Escalate concerns/issues as necessary to the Director and onwards to the respective Chief Executive as required.

6.0 Process

The following details the systematic approach in relation to the nomination of a DRO to a SAI and the process that follows until such time as the SAI can be closed. (A flowchart reflecting each step of the SAI process is detailed in Appendix 2.)

Step 1 - Notification of SAI

- SAI notified to Governance Team by Reporting Organisation;

- Governance Team.
  - Records SAI on the Datix Risk Management System;
  - Forward SAI Notification to DRO as per Regional DRO Listing or Allocation Flowchart and copy to relevant Directors/Senior Managers (current listing and flowcharts available via the following Link http://insight.hscb.hscni.net/resources/safety/);
  - Where the DRO is not automatically allocated from a Flowchart the Regional Lead/s will assign a DRO (this may be a Regional Lead or another member of staff from within their programme of care / area of specialism). Governance Team will forward SAI Notification to the assigned DRO;

- Acknowledge receipt of SAI Notification to reporting organisation and advise on date for submission of learning summary/review report.

Step 2 - Immediate Actions

- DRO will consider SAI and if they decide it to be of major concern they will liaise immediately with their Director with a view to bringing it to the attention of the Chief Executive;
- If required, the DRO will liaise with the Reporting Organisation regarding any immediate actions required. This will be carried out in conjunction with the Governance Team;
- Governance Team will update DATIX accordingly.

Step 3 - Submission of Learning Summary/Review Report/Additional Information

- Governance Team will liaise with Reporting Organisation with regard to review report deadlines i.e. reminders, DRO queries etc;
- Reporting Organisation submit learning summary/review report to serious.incidents@hscni.net (Governance Team);
- Governance Team forward learning summary/review report to DRO;
- DRO will liaise with other professional leads, including RQIA (where relevant) on receipt of learning summary/review report. For those SAIs that are medication related, the DRO may wish to liaise with the Secondary Care Medicines Governance Team (refer to appendix 2)
- If DRO and professional leads (where relevant) are not satisfied with learning summary/review report, DRO will request additional information from the Reporting Organisation until adequate assurance is provided.
- When a DRO has received all the information it is expected the reporting organisation will be informed within a period of 12 weeks that the SAI has been closed.

Step 4 - Closure of SAI

- When a DRO is satisfied with learning summary/review report, and where relevant any additional information that has been requested, he/she informs the HSCB Governance Team they are content to close the SAI in line with HSCB/PHA 'Criteria for Closing SAIs' (Appendix 3);

- The HSCB Governance Team refers the SAI to the relevant SAI Professional Group;

  - Acute;
  - Maternal and Child Health (Including Acute Paediatrics);
  - Elderly Services and Physical Disability and Sensory Impairment;
  - Mental Health and Learning Disability Services;
  - Prison Health;
  - Integrated Care;
  - Corporate Services;
  - Childrens Services – Social Care;
  - Adult Services – Social Care.

- SAI discussed at SAI Professional Group meeting and the following agreed:
  - SAI closed with regional learning and referred to RSAIRG and/or QSE Group either for noting or discussion;
  - SAI closed without regional learning.

- Governance Team closes SAI on DATIX and informs the Reporting Organisation (and RQIA where applicable) that SAI has been closed.

Step 5 – Regional Learning Identified

- Once regional learning has been identified by the Professional Group a DRO may be required to:
  - Refer learning to Network or Group that has already been established;
  - Draft an article for inclusion within a newsletter or draft a reminder or best practice or learning letter;
  - Attend a meeting of the RSAIRG or QSE group to discuss proposed learning;
  - Be involved in a Thematic Review or Task and Finish Group.

  A flowchart outlining the approval process and dissemination of regional learning can be accessed via the following link.

  http://insight.hscb.hscni.net/resources/safety/

7.0 Supporting the DRO Process

7.1 Datix

In order to ensure Statutory Information Governance requirements are adhered to, all communication for each stage in the process should be communicated by the DRO to the HSCB Governance Team. This ensures the Corporate Record for each SAI is fully documented on the Datix Risk Management System.

7.2 DROs Supporting Information

Appendix 4 provides DROs with some supporting information which they may wish to consider on receipt of SAI notifications and learning summary/review reports**.**

7.3 Escalation Process for DRO Requests

Throughout the process there may be occasions where the reporting organisation does not agree with a DRO request. Examples include:

- escalate a SAI to a higher level review;
- amend a review report;
- issues around family engagement;
- requests for additional information are withheld;
- request for a SAI following notification of an Early Alert;
- where a DRO/Professional has been made aware of an incident that they feel should be reported as a SAI.

On these occasions, DROs should follow the escalation process as detailed below:

Stage 1 – Reporting organisation notifies the DRO that they do not agree with their request

- DRO discusses the SAI at the next relevant SAI Professional Group and if agreed the reporting organisation is notified via the Chair of the Professional Group.

Stage 2 - If the reporting organisation does still not agree:

- The DRO informs the relevant HSCB/PHA Director;
- Relevant HSCB/PHA Director discusses this with the relevant Director within the Reporting Organisation.

Stage 3 – If the Reporting Organisation is still not in agreement:

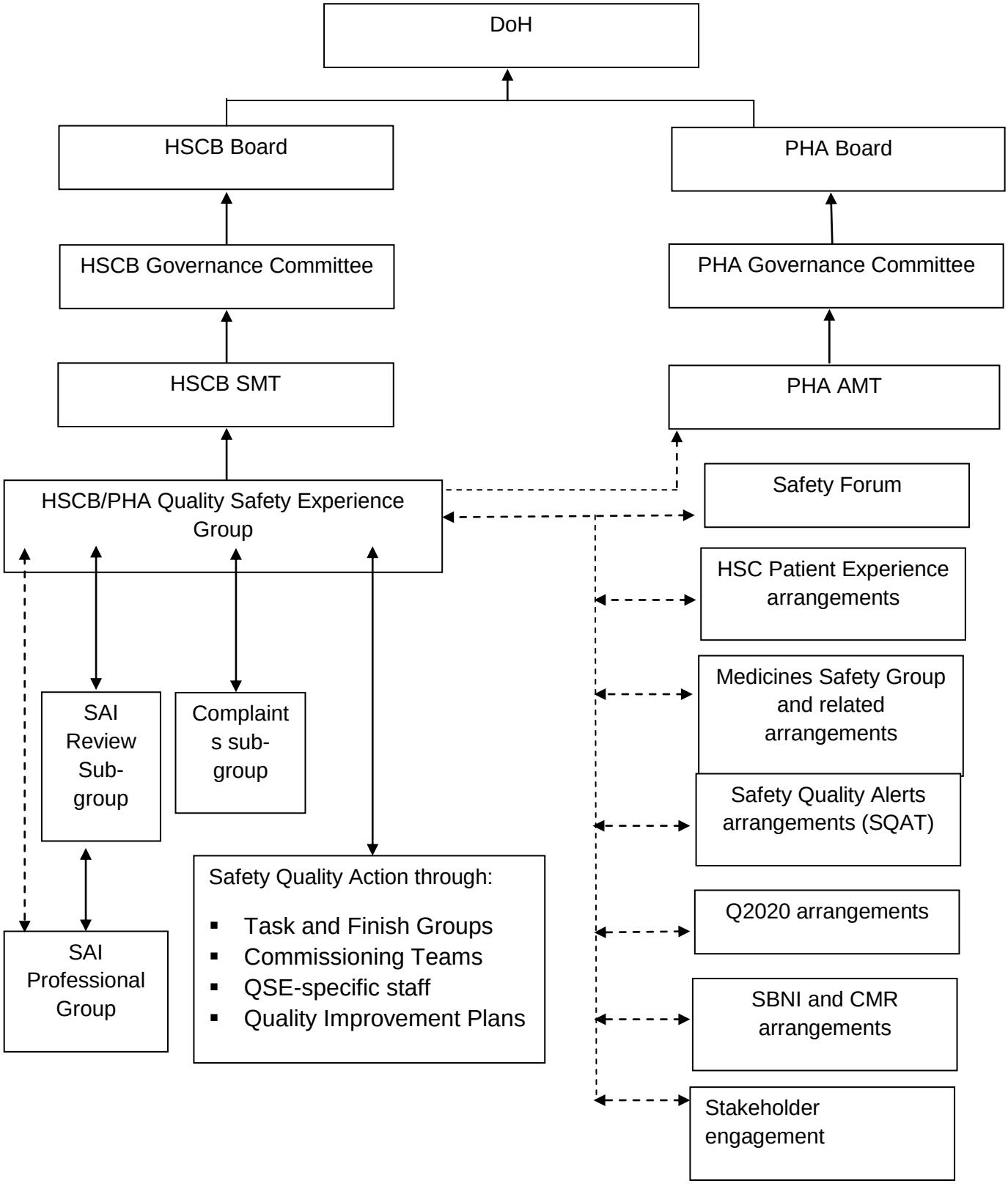
- This should be listed for consideration at QSE.

7.4 Interface Incidents Process

The HSCB/PHA process for the management of interface incidents notified to the HSCB can be accessed via the following link:
http://insight.hscb.hscni.net/resources/safety/

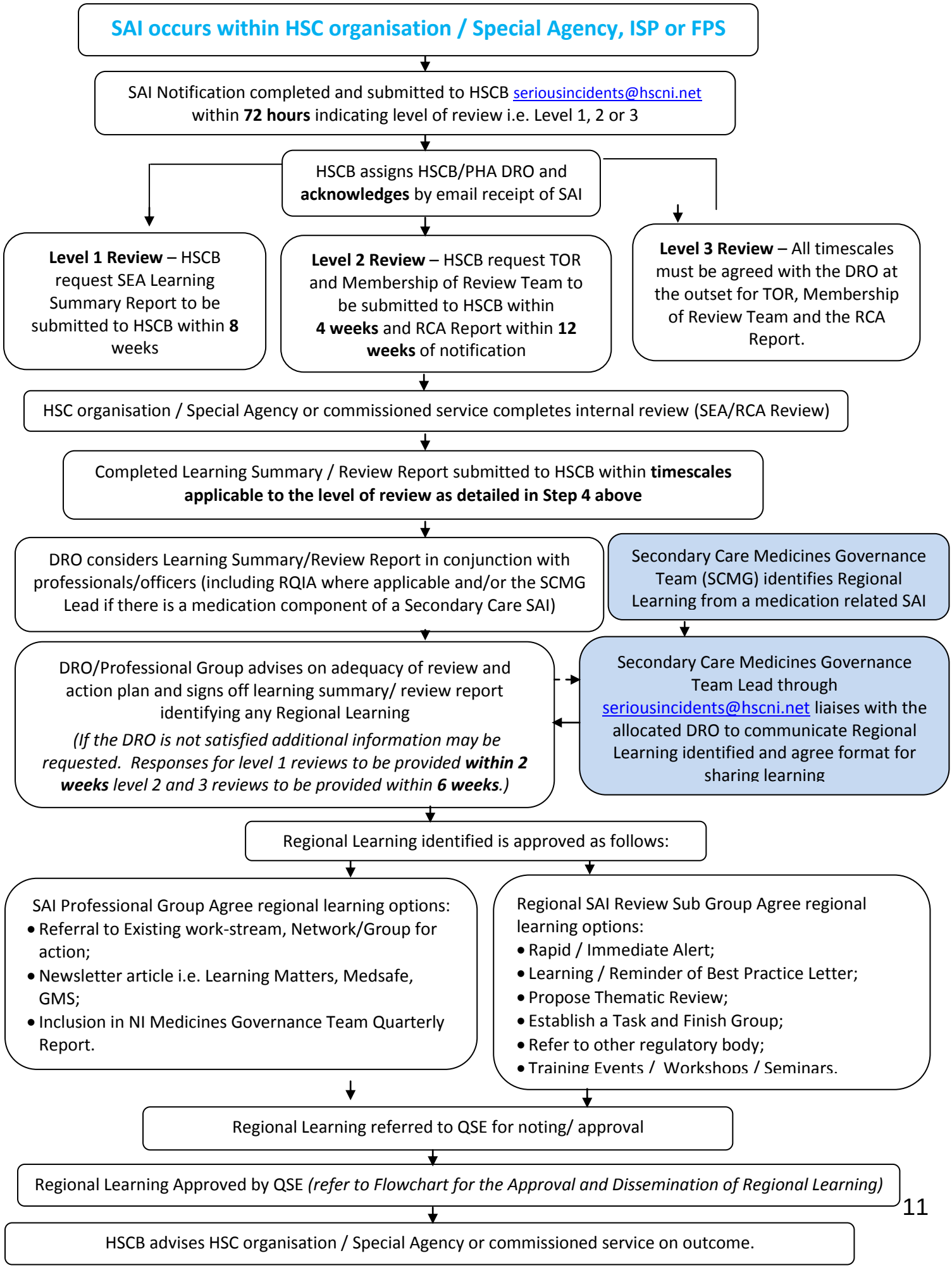
Appendix 1

HSCB/PHA SAFETY AND QUALITY STRUCTURES



Appendix 2

SAI PROCESS AND IDENTIFICATION OF REGIONAL LEARNING FLOW CHART – KEY STAGES



Appendix 3

CRITERIA FOR CLOSURE OF SAIs

A DRO can close an SAI when it meets one of the following three criteria:

1. An independent evaluation of the learning summary/review report received from the reporting organisation has been undertaken by a nominated HSCB/PHA Designated Review Officer (DRO) in conjunction with other officers/professionals (including RQIA) where relevant.

   Prior to closure the DRO must be satisfied that:

   - Format and content of the learning summary/review report is in line with regional templates for Level 1 and level 2/3 Reviews;

   - Review has been carried out appropriately by the reporting organisation (this is only applicable for level 2/3 reviews as the quality assurance of Level 1 reviews is the responsibility of the reporting organisation);

   - All reasonable steps have been taken to prevent recurrence;

   - Recommendations and actions are appropriate and where required there are performance mechanisms in place via the HSCB Governance Team to monitor these;

   - Any queries arising from the learning summary/review report have been resolved including confirmation of how local learning has been disseminated and regional learning identified;

   Other specifics of independent evaluation/review DRO may wish to consider are the Reporting Organisation:

   - has confirmed that it has discharged all statutory requirements;
   - has confirmed that all necessary safeguarding requirements associated with the incident are in place;
   - confirms details of any disciplinary action arising from the incident.

2. DRO has been informed the SAI has transferred to another relevant investigatory process i.e.

    - Case Management Review;
    - Public Inquiry;
    - Independent Expert Inquiry.

3. Following initial notification DRO is advised by reporting organisation that following preliminary reviews, incident is no longer considered a SAI. DRO will consider in conjunction with other officers/professionals, requesting additional information from reporting organisation if necessary; prior to de-escalating SAI and closure.

Appendix 4

Supporting Information for Designated Review Officers

1) At the time the SAI is notified

Immediate Actions

- Is the DRO satisfied that the Trust have taken reasonable actions to reduce the risk of recurrence pending the full review report. HSCB/PHA recognise that this cannot prejudge the outcome of the full review and that what appear to be the circumstances at the time of reporting, may not be substantiated through review;
  - The DRO should also consider if the HSCB/PHA have previously issued regional learning in relation to a similar type incident. In those circumstances, it may be appropriate to ask the Trust whether or not they have:
- Brought the incident to the attention of individual(s) staff involved to ensure that all are aware and to do an immediate review of the circumstances that led to the incident;
- Provided training/refresher training on relevant policies/procedures for the staff involved
- Informed other staff in the unit of the incident.

Level of Review

Do you agree with the level of review the Trust has proposed to undertake?

The nature, severity and complexity of serious incidents vary on a case-by-case basis and therefore the level of response should be dependent on and proportionate to the circumstances of each specific incident. The appropriate level of investigation will be proposed by the provider and agreed by the DRO upon notification, however the level of review may change as new information or evidence emerges as part of the review process.

- **Level 1 Review – Significant Event Audit (SEA)**

  Concise, internal review which is suited to less complex incidents which can be managed by individuals involved in the incident at local level.

- **Level 2 Review - Root Cause Analysis (RCA)**

  A comprehensive internal review which includes an independent element and is suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist advisors.

- **Level 3 Review - Root Cause Analysis (RCA)**

  This level of review is suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist advisors. It is required where the integrity of the review is likely to be challenged or where it will be difficult for an organisation to conduct an objective review internally.

  The HSC Regional Risk Matrix (Appendix 5) assist organisation to determine the level of seriousness and subsequently the level of review to be undertaken. DROs can similarly use this matrix to determine if they agree with the level of review being undertaken.

2) At the time the SAI Review Report is received

In your best professional judgment and from the information available to you:

- Has the family been involved appropriately?
- Where appropriate, has the Coroner been notified?
- Was membership of the Review Team appropriate for the level of review undertaken?
- From the information in the report, does it appear that the Review Team identified and reviewed the factors that led to the incident correctly and thoroughly?
- Do the conclusions reflect the facts of the incident?
- Do the recommendations address the underlying contributing factors?
- Is the Action Plan a reasonable set of actions to address the issues/recommendations identified by the review?
- Is there regional learning and if yes, what is that and how should it be handled
  - Learning Matters newsletter article
  - Learning Letter
  - Bespoke piece of work
  - Other?

- To the best of your knowledge, are you aware of other SAIs where the factors have been similar to this SAI?

- Can the SAI be closed – yes/no?

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Appendix 5

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

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HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

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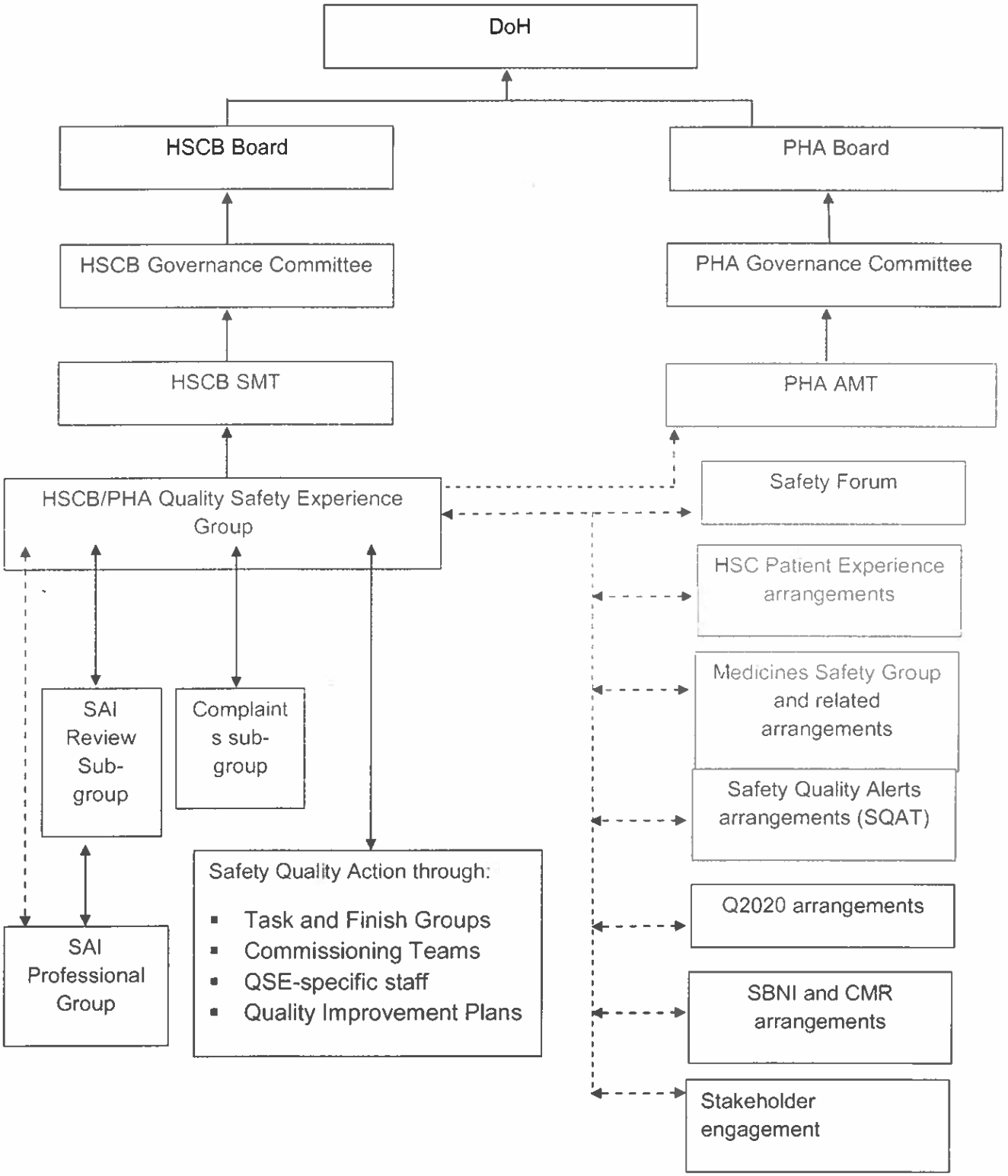
Appendix 1

HSCB/PHA SAFETY AND QUALITY STRUCTURES



7.0 Supporting the DRO Process

7.1 Datix

In order to ensure Statutory Information Governance requirements are adhered to, all communication for each stage in the process should be communicated by the DRO to the HSCB Governance Team. This ensures the Corporate Record for each SAI is fully documented on the Datix Risk Management System.

7.2 DROs Supporting Information

Appendix 4 provides DROs with some supporting information which they may wish to consider on receipt of SAI notifications and learning summary/review reports.

7.3 Escalation Process for DRO Requests

Throughout the process there may be occasions where the reporting organisation does not agree with a DRO request. Examples include:

- escalate a SAI to a higher level review;
- amend a review report;
- issues around family engagement;
- requests for additional information are withheld;
- request for a SAI following notification of an Early Alert;
- where a DRO/Professional has been made aware of an incident that they feel should be reported as a SAI.

On these occasions, DROs should follow the escalation process as detailed below:

Stage 1 – Reporting organisation notifies the DRO that they do not agree with their request

- DRO discusses the SAI at the next relevant SAI Professional Group and if agreed the reporting organisation is notified via the Chair of the Professional Group.

Stage 2 - If the reporting organisation does still not agree:

- The DRO informs the relevant HSCB/PHA Director;
- Relevant HSCB/PHA Director discusses this with the relevant Director within the Reporting Organisation.

Stage 3 – If the Reporting Organisation is still not in agreement:

- This should be listed for consideration at QSE.

7.4 Interface Incidents Process

The HSCB/PHA process for the management of interface incidents notified to the HSCB can be accessed via the following link:
http://insight.hscb.hscni.net/resources/safety/

Health and Social Care Board

Public Health Agency

HEALTH AND SOCIAL CARE BOARD / PUBLIC HEALTH AGENCY

SERIOUS ADVERSE INCIDENT REVIEW SUB-GROUP

TERMS OF REFERENCE

1. INTRODUCTION

The purpose of the Serious Adverse Incident Review Sub Group (SAIRSG) is to provide assurances that appropriate structures, systems and processes are in place within the Health and Social Care Board (HSCB) and Public Health Agency (PHA) for the management and follow up of serious adverse incidents arising during the course of the business of an HSC organisation/Special Agency or commissioned service.

The SAIRSG also has responsibility to ensure that trends, best practice and learning is identified and disseminated in a timely manner, in conjunction with the HSCB/PHA Quality and Safety Experience Group (QSE) and Safety and Quality Alert Team (SQAT).

2. ACCOUNTABILITY OF THE GROUP

The SAIRSG shall report to the HSCB/PHA QSE group.

3. OBJECTIVES OF THE GROUP

3.1 Review SAI Activity and Designated Review Officer (DRO) Learning summary reports, to identify learning and themes/trends arising from SAIs that require follow up / discussion / further action;

3.2 Ensure that themes/trends, best practice and regional learning from SAIs is identified to the QSE Group in a timely manner;

3.3 Make recommendations to the QSE Group on the commissioning of independent reviews in respect of specific SAIs;

3.4 Escalate, issues of concern and importance, in respect of SAIs to the QSE Group, as appropriate;

3.5 Provide a bi-annual SAI Learning Report to the Board of the HSCB and PHA and their respective Governance committees;

3.6 Provide assurances to SMT, AMT and the Boards of the HSCB and PHA and respective Governance Committees that SAIs are managed in an appropriate manner.

4. MEMBERSHIP OF THE GROUP

Core membership of the SAIRSG will consist of the following officers, or their nominated representative, from the HSCB and the PHA:

- Governance Manager, HSCB **(Chair)**
- Senior Manager: Safety, Quality and Patient Experience, PHA (Co-Chair)
- Consultant, Service Development & Screening, PHA (Medical Representative)
- Social Care Commissioner MH & LD, Social Services, HSCB (Social Care Representative)
- Pharmacy Lead - Medicines Governance and Public Health, HSCB (Integrated Care Representative)
- Patient Safety, Quality and Patient Experience Lead Nurse, PHA (Nursing & AHP Representative)
- Assistant Governance Manager, HSCB

In Attendance:

- RQIA representatives (for items of mutual interest to both RQIA and HSCB/PHA)

    - Director of Regulation and Nursing
    - Director of Mental Health and Learning Disability and Social Work

The SAIRSG may also invite, as appropriate, the relevant HSCB/PHA Officers from the service area in which a serious adverse incident has arisen, to attend meetings where that incident is being considered. Equally, where the SAIRSG considers that it requires other specialist knowledge it is at liberty to invite/co-opt any relevant specialist to provide advice.

5. QUORUM

The SAIRSG shall be quorate by the attendance of four members of the Group, to include the Chair and/or Co Chair.

6. ADMINISTRATION

The SAIRSG will be supported by the Governance Team who will ensure:

- agreement of the agenda with Chairperson;
- collate and circulate all associated papers at least 3 working days in advance of each meeting;
- keep a record of matters arising and log of actions;
- take forward the work of the SAIRSG, in conjunction with group members, to ensure actions, learning and outcomes from each meeting are progressed.

The action log from each meeting shall be approved and considered at the following meeting.

7. RELATIONSHIP / LINKS WITH OTHER GROUPS

There are a range of other quality and safety groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SAIRSG will work in conjunction with the following groups:

- HSCB / PHA Regional Complaints Sub Group
- Patient and Client Experience Steering Group
- Safety and Quality Alerts Group
- Promoting Good Nutrition Implementation Steering Group
- Regional Falls Prevention for Acute Services Group
- Regional Pressure Ulcer Prevention Advisory Group
- Regional Project Steering Group Evidencing Care through key nursing performance indicators
- Medicines Governance Advisors Groups
- Regional Child Protection Committee (RCPC)
- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board

8. FREQUENCY OF MEETING

The SAIRSG meetings will take place monthly (prior to QSE meeting).

9. REVISION OF TERMS OF REFERENCE

The SAIRSG will review its Terms of Reference on a biennial basis or earlier as required.

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY

TERMS OF REFERENCE

SAFETY AND QUALITY ALERTS TEAM (SQAT)

1.0 Introduction

The Health and Social Care Board (HSCB) and Public Health Agency (PHA) are responsible for the co-ordination and implementation of regional safety and quality alerts (SQAs), letters and guidance issued by the Department of Health (DoH), HSCB, PHA, Regulation and Quality Improvement Authority (RQIA) and other organisations.

The Safety and Quality Alerts Team (SQAT) was formed in April 2012 to co-ordinate the implementation of regional safety and quality alerts, letters and guidance. A subsequent protocol which outlines the management of the process was established and endorsed by the DoH in July 2013 and is reviewed on an annual basis. (See annex 1)

2.0 Accountability of the Group

The SQA Team shall report to the HSCB/PHA Quality and Safety Experience Group (QSE).

3.0 Objectives of the SQA Team

The SQA Team provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation. The Team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

4.0 Membership of the Group

Core membership of the SQA Team will consist of the following officers, or their nominated representative, from the HSCB and the PHA: (see annex 2 which details the current membership as at March 2017)

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services
- Assistant Director Nursing, Safety & Quality & Patient Experience
- Assistant Director Service Development & Screening
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Safety, Quality and Patient Experience Nurse, PHA

- Assistant Governance Manager, Safety and Quality, HSCB
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care, Head of GMS, HSCB when required
- Social Care and AHP input for Alerts relevant to those professions

5.0 Quorum

The SQA Team shall be quorate by the attendance of three members of the group; usually including representation of two professional areas. Where meetings proceed without relevant professionals present this can be endorsed at the next meeting.

6.0 Administration

- The Action log shall be taken by the Chair of the group (or nominated deputy)
- The agenda and papers will be developed by the Assistant Governance Manager and circulated by the PA to the Chair.
- The Assistant Governance Manager will oversee the process, maintain an up-to-date log, prepare for and support team meetings, and prepare an annual report. They will be supported by the Governance Support Manager and a Governance Support Officer.

7.0 Relationship/Links with Other Groups

There are a range of other quality and safety groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SQA Team will work in conjunction with various groups which include the following list of groups which is not definitive:

- HSCB / PHA Regional SAI Review Sub Group
- HSCB / PHA Regional Complaints Sub Group
- Patient and Client Experience Steering Group
- Promoting Good Nutrition Implementation Steering Group
- Regional Falls Prevention for Acute Services Group
- Regional Pressure Ulcer Prevention Advisory Group
- Regional Project Steering Group Evidencing Care through key nursing performance indicators
- Medicines Governance Advisors Groups
- Regional Child Protection Committee (RCPC)

- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board
- Medicines Safety Sub-Group (MSSG)
- PHA/HSCB SAI Professional Groups

8.0 Frequency of Meetings

Meetings of the Team will be fortnightly.

9.0 Review of Terms of Reference

The SQA Team will review its Terms of Reference on a biennial basis or earlier as required.

Annex 1

Health and Social Care Board

Public Health Agency

Health and Social Care Board / Public Health Agency

Protocol for Implementation of Safety and Quality Alerts

Reference SQAT-06.03.17	**Responsible Officer** Director of Corporate Services	**Review Frequency** Annual
Approved by SQAT	**Approval Date:** 6 March 2017	**Next review due** March 2018
Superseded documents (if applicable) HSCB/PHA Protocol for Implementation of SQAs (April 2012) HSCB/PHA Protocol for Implementation of SQAs (August 2013) HSCB/PHA Protocol for Implementation of SQAs (May 2015) HSCB/PHA Protocol for Implementation of SQAs (July 2016)		

I N D E X

Appendices

HSCB/PHA Protocol for Implementation of Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: March 2017

1.0 Introduction

Safety and Quality Alerts (SQAs) may arise from a variety of sources, including Serious Adverse Incidents (SAIs), reviews by the Regulation and Quality Improvement Authority (RQIA), safeguarding reports, legislative changes, medicines regulators, equipment or device failures, national safety systems, and independent reviews.

This protocol describes the process which the Health and Social Care Board (HSCB) and Public Health Agency (PHA) will use to oversee implementation of Safety and Quality Alerts (SQAs) by Health and Social Care (HSC) Trusts, including actions relevant to primary care providers. It applies to SQAs issued since 1 April 2012.

2.0 What are Safety Quality Alerts (SQAs)

This protocol covers SQAs and equivalent correspondence as outlined below. It applies to health and social care-related SQAs though the vast majority relate to health care. Specific arrangements for the independent sector and for SQAs that relate mainly to primary care are described later.

Category 1 SQAs include:

- Department of Health (DoH) Safety Quality & Standards (SQS) guidance and letters/circulars and Patient Safety Alerts (PSAs);
- Learning Letters or Reminder of Good Practice Letters arising from serious adverse incidents (SAIs) / Complaints;
- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports and equivalent robust other national enquiries/audits;
- Guidelines and Audit Implementation Network (GAIN) Reports.

Category 2 SQAs include:

- Medicines and Healthcare products Regulatory Agency (MHRA) notices;
- Safety Alert Broadcast System (SABS) notifications.

A separate process is in place for the following:

- NICE guidance. Appendix 1 gives a schematic overview of the interfaces between this process and the process for NICE guidance;
- Drug alerts and recalls;
- Professional In-Confidence alerts regarding individual practitioners.

3.0 Application of Protocol

3.1 Who does this procedure apply to?

This protocol applies to the process for ensuring that care is safe and that adverse events and harm are minimised, involves identifying risks, managing those risks by responding appropriately, disseminating information effectively, and applying the learning from safety or quality related adverse events. The protocol applies to the following HSC organisations:

HSC organisations (HSC)

- Health and Social Care Board
- Public Health Agency
- Business Services Organisation
- Belfast Health and Social Care Trust
- Northern Health and Social Care Trust
- Southern Health and Social Care Trust
- South Eastern Health and Social Care Trust
- Western Health and Social Care Trust
- Northern Ireland Ambulance Service
- Regulation & Quality Improvement Authority

4.0 Management Arrangements for SQAs

4.1 Role of HSCB/PHA Safety Quality Alerts Team

The HSCB and PHA will manage arrangements for the implementation and assurance of all Category 1 SQAs and some Category 2 SQAs (as required) through the Safety Quality Alerts Team (SQAT). Serious Adverse Incidents and Complaints are managed through their respective teams and reports to the Quality, Safety and Experience Group (QSE).

The SQA Team will include HSCB and PHA representatives from professional groups, and Corporate Services (Appendix 3). It will be sponsored, and chaired as necessary, by the Medical Director/Director of Public Health (DPH).

It will report through the Senior Management Team of HSCB to the HSCB Governance Committee and Board at the frequency outlined in the HSCB safety quality reporting framework.

To ensure timely co-ordination and implementation of regional safety and quality alerts, the Team will meet every 2 weeks. HSCB/PHA will put arrangements in place to ensure that any immediate issues that need to be addressed are processed immediately.

A Programme Manager will oversee the process, maintain an up-to-date log, prepare for and support SQA Team meetings. Appendix 4 gives a schematic overview of the HSCB/PHA Process for the Management of Safety and Quality Alerts.

4.2 Role of the HSCB Alerts Office

SQAs where Trusts or the independent sector have a primary role in implementation will be logged by the Alerts office managed by the Governance Team within HSCB Corporate Services.

All correspondence in relation to alerts will be channelled through the HSCB Alerts mailbox at Alerts.HSCB@hscni.net. The Alerts Office will maintain a system to track progress on implementation.

4.3 Trust Input

To ensure input from Trusts, the SQA Team will seek advice from relevant Trust professionals. Each Trust has identified a first point of contact for queries regarding SQAs (Appendix 3).

4.4 Interface with other Safety/Quality-related organisations

To ensure coordinated action across the wider system, the HSCB/PHA SQA Team will also seek input from the range of organisations and bodies that contribute to safety and quality of health and social care (Appendix 3), as required.

4.5 Alerts Relating to Independent Sector Providers

Independent providers are already required to respond to many of the types of Alerts covered by this protocol. In addition, the DoH or HSCB/PHA will send Alerts that they issue to RQIA for dissemination to relevant independent providers. The DoH also agree the annual work programme of RQIA which may include reviews of governance systems in independent providers, and/or assurance on implementation of specific SQAs.

4.6 Process for Sharing Regional Learning from NI with ROI and GB

A process for sharing regional learning from Northern Ireland with the Republic of Ireland and Great Britain is currently being considered. This protocol will be updated to detail the process once agreed.

5.0 Process

5.1 Process prior to dissemination of SQAs

The Department of Health (DoH) issues a variety of correspondence collectively referred to as Safety Alerts. These are issued to service providers to identify those actions which providers should undertake to assure patient and client safety and best practice. The following describes the process prior to finalisation and dissemination of SQAs.

The DoH, HSCB and PHA share certain SQAs between organisations for comment prior to dissemination to the HSC. These include:

- All Patient Safety Alerts (PSAs);
- Safety and Quality Alerts where assurance is required;
- Learning Letters.

For SQAs developed by the DoH these will be sent to the HSCB Alerts mailbox at Alerts.HSCB@hscni.net for issue to relevant health and social care professionals within HSCB and PHA, to seek comment prior to issue by the DoH to the HSC.

For SQAs developed by the PHA / HSCB these will be sent to the DoH Safety, Quality and Standards mailbox at qualityandsafety@health-ni.gov.uk for issue to relevant Policy Leads for review to ensure compatibility with DoH policy prior to issue by the HSCB/PHA.

At this stage the level of assurance may be also considered as outlined in section 5.3.

This approach is intended to ensure that the actions required of organisations are clear through a single communication.

5.2 Dissemination of SQAs

5.2.1 Dissemination of SQAs issued by DoH

SQAs from the DoH will be issued to the Chief Executive's office of relevant organisations, and copied to the HSCB/PHA Alerts Office, the Governance Leads in Trusts and other relevant Directors. A standard distribution list is given in Appendix 2.

5.2.2 Dissemination of Learning Letters/Reminder of Good Practice Letters issued by PHA/HSCB

When regional learning is identified following the review of an SAI, complaint or other incident a learning letter / reminder of good practice letter may be issued to the appropriate HSC organisations for wider circulation, application of learning and assurance that learning has been embedded.

A Learning letter/reminder of good Practice Letter will then be issued via the HSCB Alerts Office to the Chief Executive's office of relevant organisations, Governance Leads in Trusts and other relevant using the standard distribution list. (see Appendix 2)

5.3 Process Following Dissemination of SQAs

5.3.1 Process for Determining Assurances

Category 1 Alerts will be reviewed by the Safety Quality Alerts Team to make an initial determination on:

- Whether or not regional action is required to assist Trusts or primary care with implementation, and
- The nature of the assurance required regarding implementation.

If regional action is required, the proposed actions may be discussed where necessary with Trusts and/other relevant organisations to agree the precise task.

It is important to note that any regional actions do not in any way negate the responsibilities of Trusts or other organisations to take necessary actions to implement the Alert locally; immediate necessary action should not be delayed. However, it is recognised that some aspects of implementation may be more efficient, and may ensure a better outcome for patients, clients, staff and the public if they are developed in a standard way across the region.

To take forward work for the region, the principle of using existing systems as much as possible, will apply. However, if necessary, a Task and Finish Group may be established, including all relevant professionals and managers from relevant providers, and as appropriate, service users and/or the public.

Category 2 Alerts will be implemented primarily through existing systems. If on occasion explicit assurance or other action is required, it will be identified by the Safety Quality Alerts Team and described to Trusts and primary care providers as outlined for Category 1 Alerts.

5.3.2 Criteria for Identifying Regional Action and Assurance Levels

The PHA/HSCB SQA Team will determine the detail of the method of assuring implementation of an Alert. This will be proportionate to the assessed level of risk associated with the issue covered by the Alert. It will work on the principle of using existing systems of assurance as much as possible. Options for assurance methods include:

- Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements;

- Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA;
- Level 3 – completion of an audit specified by HSCB/PHA.

The following criteria will be used to assess whether or not regional action is required to assist implementation, and to determine the level of assurance required:

- The risk to an individual patient, client, staff member or member of the public, is high (impact);
- The number of patients, clients, staff or public who may be exposed to the risk is high (likelihood);
- Aspects of implementation are complex and outwith the control of Trusts or relevant organisations (complexity);
- A regional approach is achievable (deliverability & stakeholder agreement);
- Regional action will not introduce undue delay (timeliness);
- The Alert relates to an issue with a high public/political profile (public confidence);
- Other reasons (professional judgment).

In making its decisions, the HSCB/PHA SQA Team will take account of:

- Other Alerts relating to the service area in question;
- Common themes within a range of Alerts;
- Learning from Serious Adverse Incidents and Complaints;
- Existing safety and quality initiatives in health and social care.

5.3.3 Informing of Regional Action/Assurances Required

On completion of the processes outlined above, if regional action or assurance is required, the Chair of the Safety Quality Alerts Team will inform Trusts, primary care, and other relevant providers or stakeholders of the next steps or requirements. Communication will

be to the Trust Chief Executive's office, copied to the Trust Governance Lead.

5.3.4 Reviewing Compliance of SQAs

The Safety and Quality Alert Team will consider responses to SQAs and 'close' the Alert when it is assured that actions have been implemented, or there is an existing robust system in place to ensure implementation.

In addition bi-annual progress reports to Governance Committee will be prepared by the SQA Team for the following:

- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports and equivalent robust other national enquiries/audits;

These reports will detail the progress on implementation of report recommendations and provide the necessary appropriate assurance mechanism that all HSCB/PHA actions contained within reports are implemented.

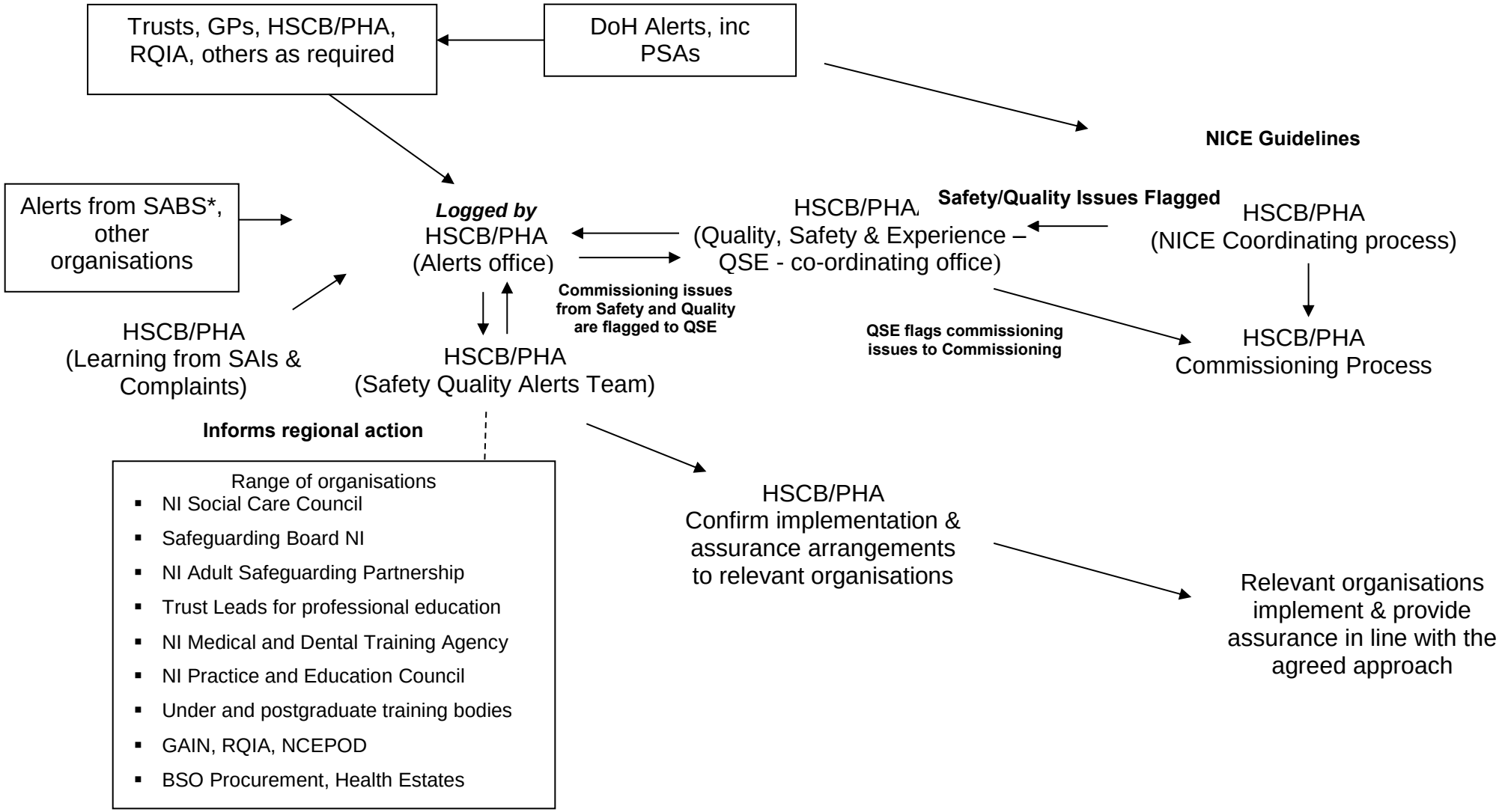
6.0 Reporting of SQAs

An annual report will also be prepared for the HSCB/PHA SQA Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board, DoH, Trusts and others as required.

7.0 Review of this protocol

This protocol will be refined on an on-going basis and not less than annually.

HSC System for Managing Safety and Quality Alerts – Structural Overview **Appendix 1**



MAHI - STM - 307 - 243

Template Distribution List **Appendix 2**

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs			CEX		
Medical Director			Medical Director/Director of Public Health		
Directors of Nursing			Director of Nursing/AHPs		
Directors of Social Services			PHA Duty Room		
Governance Leads			AD Health Protection		
Directors of Acute Services			AD Service Development/Screening		
Directors of Community/Elderly Services			AD Health Improvement		
Heads of Pharmacy			AD Nursing		
Allied Health Professional Leads			AD Allied Health Professionals		
NIAS			Clinical Director Safety Forum		
CEX			**HSCB**		
Medical Director			CEX		
RQIA			Director of Integrated Care		
CEX			Director of Social Services		
Medical Director			Director of Commissioning		
Director of Nursing			Alerts Office		
Director for Social Care			Dir PMSI & Corporate Services		
NIMDTA			**Primary Care (through Integrated Care)**		
CEX / PG Dean			GPs		
QUB			Community Pharmacists		
Dean of Medical School			Dentists		
Head of Nursing School			**Open University**		
Head of Social Work School			Head of Nursing Branch		
Head of Pharmacy School			**DoH**		
Head of Dentistry School			CMO office		
UU			CNO office		
Head of Nursing School			CPO office		
Head of Social Work School			CSSO office		
Head of Pharmacy School			CDO office		
Head of School of Health Sciences (AHP Lead)			Safety, Quality & Standards Office		
Clinical Education Centre			**NI Social Care Council**		
NIPEC			**Safeguarding Board NI**		
GAIN Office			**NICE Implementation Facilitator**		
NICPLD			**Coroners Service for Northern Ireland**		
NI Medicines Governance Team Leader for Secondary Care					

Membership **Appendix 3**

HSCB/PHA Safety Quality Alerts Team

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services, HSCB
- Assistant Director Nursing, Safety & Quality & Patient Experience, PHA
- Safety, Quality and Patient Experience Nurse, PHA
- Assistant Director Service Development & Screening, PHA
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care (Head of GMS) HSCB - when required
- Social Care and AHP input for Alerts relevant to those professions
- Assistant Governance Manager, Safety and Quality, HSCB

SQA Team Roles

- Chair – Dr Carolyn Harper
- Lead Performance & Corporate Services – Michael Bloomfield
- Lead Nurse – Lynne Charlton / Mary McElroy
- Lead Service Development & Screening – Dr Brid Farrell
- Lead Pharmacist – Matthew Dolan
- Lead Public Health Doctor – Dr Jackie McCall
- Lead Safety Forum – Dr Gavin Lavery
- Lead AHP – through Michelle Tennyson
- Lead GP – Dr Margaret O'Brien
- Lead Social Worker – through Fionnuala McAndrew
- Programme Manager – Margaret McNally
- Admin Support – Christine Thompson / Elaine Hyde

Trust Governance Lead Contacts

- Belfast – Dr Cathy Jack and Claire Cairns/Christine Murphy
- South East – Dr Charlie Martyn and Irene Low/Liz Campbell
- Southern – Dr Richard Wright and Margaret Marshall/ /Caroline Beattie Nicole Evans
- Northern – Mr Seamus O'Reilly and Sinead O'Kane /Ruth McDonald

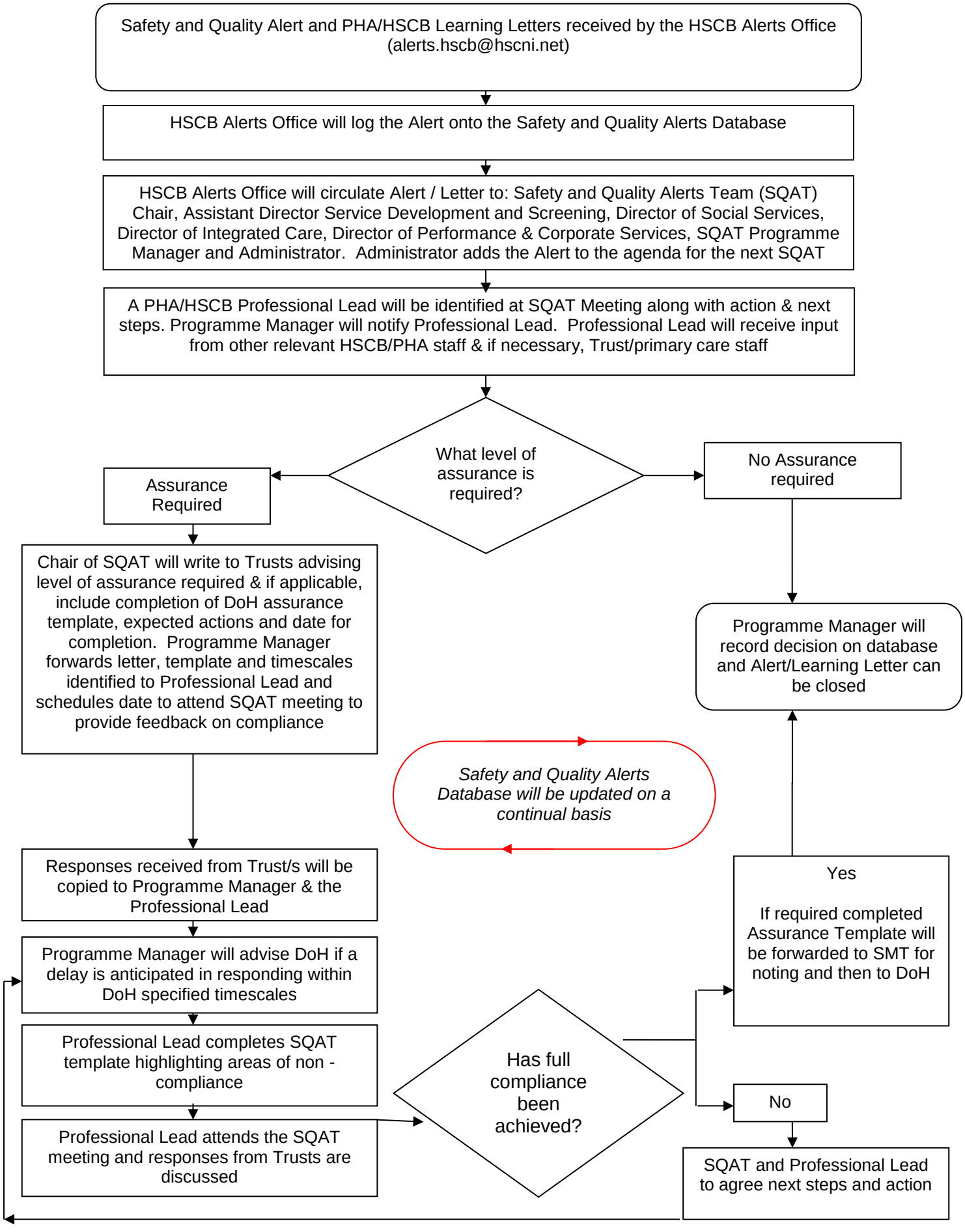
- Western – Dr Dermot Hughes and Therese Brown/Teresa Murray

Link as required with

- NI Social Care Council
- Safeguarding Board NI
- NI Adult Safeguarding Partnership
- Trust Leads for professional education
- NI Medical and Dental Training Agency
- NI Practice and Education Council
- Under and postgraduate training bodies
- GAIN
- RQIA
- BSO Procurement
- Health Estates, DoH

Appendix 4

HSCB/PHA Process for the Management of Safety and Quality Alerts



HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY

TERMS OF REFERENCE

SAFETY AND QUALITY ALERTS TEAM (SQAT)

1.0 Introduction

The Health and Social Care Board (HSCB) and Public Health Agency (PHA) are responsible for the co-ordination and implementation of regional safety and quality alerts (SQAs), letters and guidance issued by the Department of Health (DoH), HSCB, PHA, Regulation and Quality Improvement Authority (RQIA) and other organisations.

The Safety and Quality Alerts Team (SQAT) was formed in April 2012 to co-ordinate the implementation of regional safety and quality alerts, letters and guidance. A subsequent protocol which outlines the management of the process was established and endorsed by the DoH in July 2013 and is reviewed on an annual basis. (See annex 1)

2.0 Accountability of the Group

The SQA Team shall report to the HSCB/PHA Quality and Safety Experience Group (QSE).

3.0 Objectives of the SQA Team

The SQA Team provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation. The Team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

4.0 Membership of the Group

Core membership of the SQA Team will consist of the following officers, or their nominated representative, from the HSCB and the PHA: (see annex 2 which details the current membership as at March 2017)

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services
- Assistant Director Nursing, Safety & Quality & Patient Experience
- Assistant Director Service Development & Screening
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Safety, Quality and Patient Experience Nurse, PHA

- Assistant Governance Manager, Safety and Quality, HSCB
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- GP Input via Assistant Director of Integrated Care, Head of GMS, HSCB when required
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5.0 Quorum

The SQA Team shall be quorate by the attendance of three members of the group; usually including representation of two professional areas. Where meetings proceed without relevant professionals present this can be endorsed at the next meeting.

6.0 Administration

- The Action log shall be taken by the Chair of the group (or nominated deputy)
- The agenda and papers will be developed by the Assistant Governance Manager and circulated by the PA to the Chair.
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7.0 Relationship/Links with Other Groups

There are a range of other quality and safety groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SQA Team will work in conjunction with various groups which include the following list of groups which is not definitive:

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- Regional Child Protection Committee (RCPC)

- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board
- Medicines Safety Sub-Group (MSSG)
- PHA/HSCB SAI Professional Groups

8.0 Frequency of Meetings

Meetings of the Team will be fortnightly.

9.0 Review of Terms of Reference

The SQA Team will review its Terms of Reference on a biennial basis or earlier as required.

Annex 1

Health and Social Care Board

Public Health Agency

Health and Social Care Board / Public Health Agency

Protocol for Implementation of Safety and Quality Alerts

Reference SQAT-06.03.17	**Responsible Officer** Director of Corporate Services	**Review Frequency** Annual
Approved by SQAT	**Approval Date:** 6 March 2017	**Next review due** March 2018
Superseded documents (if applicable) HSCB/PHA Protocol for Implementation of SQAs (April 2012) HSCB/PHA Protocol for Implementation of SQAs (August 2013) HSCB/PHA Protocol for Implementation of SQAs (May 2015) HSCB/PHA Protocol for Implementation of SQAs (July 2016)		

I N D E X

Appendices

HSCB/PHA Protocol for Implementation of Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: March 2017

1.0 Introduction

Safety and Quality Alerts (SQAs) may arise from a variety of sources, including Serious Adverse Incidents (SAIs), reviews by the Regulation and Quality Improvement Authority (RQIA), safeguarding reports, legislative changes, medicines regulators, equipment or device failures, national safety systems, and independent reviews.

This protocol describes the process which the Health and Social Care Board (HSCB) and Public Health Agency (PHA) will use to oversee implementation of Safety and Quality Alerts (SQAs) by Health and Social Care (HSC) Trusts, including actions relevant to primary care providers. It applies to SQAs issued since 1 April 2012.

2.0 What are Safety Quality Alerts (SQAs)

This protocol covers SQAs and equivalent correspondence as outlined below. It applies to health and social care-related SQAs though the vast majority relate to health care. Specific arrangements for the independent sector and for SQAs that relate mainly to primary care are described later.

Category 1 SQAs include:

- Department of Health (DoH) Safety Quality & Standards (SQS) guidance and letters/circulars and Patient Safety Alerts (PSAs);
- Learning Letters or Reminder of Good Practice Letters arising from serious adverse incidents (SAIs) / Complaints;
- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports and equivalent robust other national enquiries/audits;
- Guidelines and Audit Implementation Network (GAIN) Reports.

Category 2 SQAs include:

- Medicines and Healthcare products Regulatory Agency (MHRA) notices;
- Safety Alert Broadcast System (SABS) notifications.

A separate process is in place for the following:

- NICE guidance. Appendix 1 gives a schematic overview of the interfaces between this process and the process for NICE guidance;
- Drug alerts and recalls;
- Professional In-Confidence alerts regarding individual practitioners.

3.0 Application of Protocol

3.1 Who does this procedure apply to?

This protocol applies to the process for ensuring that care is safe and that adverse events and harm are minimised, involves identifying risks, managing those risks by responding appropriately, disseminating information effectively, and applying the learning from safety or quality related adverse events. The protocol applies to the following HSC organisations:

HSC organisations (HSC)

- Health and Social Care Board
- Public Health Agency
- Business Services Organisation
- Belfast Health and Social Care Trust
- Northern Health and Social Care Trust
- Southern Health and Social Care Trust
- South Eastern Health and Social Care Trust
- Western Health and Social Care Trust
- Northern Ireland Ambulance Service
- Regulation & Quality Improvement Authority

4.0 Management Arrangements for SQAs

4.1 Role of HSCB/PHA Safety Quality Alerts Team

The HSCB and PHA will manage arrangements for the implementation and assurance of all Category 1 SQAs and some Category 2 SQAs (as required) through the Safety Quality Alerts Team (SQAT). Serious Adverse Incidents and Complaints are managed through their respective teams and reports to the Quality, Safety and Experience Group (QSE).

The SQA Team will include HSCB and PHA representatives from professional groups, and Corporate Services (Appendix 3). It will be sponsored, and chaired as necessary, by the Medical Director/Director of Public Health (DPH).

It will report through the Senior Management Team of HSCB to the HSCB Governance Committee and Board at the frequency outlined in the HSCB safety quality reporting framework.

To ensure timely co-ordination and implementation of regional safety and quality alerts, the Team will meet every 2 weeks. HSCB/PHA will put arrangements in place to ensure that any immediate issues that need to be addressed are processed immediately.

A Programme Manager will oversee the process, maintain an up-to-date log, prepare for and support SQA Team meetings. Appendix 4 gives a schematic overview of the HSCB/PHA Process for the Management of Safety and Quality Alerts.

4.2 Role of the HSCB Alerts Office

SQAs where Trusts or the independent sector have a primary role in implementation will be logged by the Alerts office managed by the Governance Team within HSCB Corporate Services.

All correspondence in relation to alerts will be channelled through the HSCB Alerts mailbox at Alerts.HSCB@hscni.net. The Alerts Office will maintain a system to track progress on implementation.

4.3 Trust Input

To ensure input from Trusts, the SQA Team will seek advice from relevant Trust professionals. Each Trust has identified a first point of contact for queries regarding SQAs (Appendix 3).

4.4 Interface with other Safety/Quality-related organisations

To ensure coordinated action across the wider system, the HSCB/PHA SQA Team will also seek input from the range of organisations and bodies that contribute to safety and quality of health and social care (Appendix 3), as required.

4.5 Alerts Relating to Independent Sector Providers

Independent providers are already required to respond to many of the types of Alerts covered by this protocol. In addition, the DoH or HSCB/PHA will send Alerts that they issue to RQIA for dissemination to relevant independent providers. The DoH also agree the annual work programme of RQIA which may include reviews of governance systems in independent providers, and/or assurance on implementation of specific SQAs.

4.6 Process for Sharing Regional Learning from NI with ROI and GB

A process for sharing regional learning from Northern Ireland with the Republic of Ireland and Great Britain is currently being considered. This protocol will be updated to detail the process once agreed.

5.0 Process

5.1 Process prior to dissemination of SQAs

The Department of Health (DoH) issues a variety of correspondence collectively referred to as Safety Alerts. These are issued to service providers to identify those actions which providers should undertake to assure patient and client safety and best practice. The following describes the process prior to finalisation and dissemination of SQAs.

The DoH, HSCB and PHA share certain SQAs between organisations for comment prior to dissemination to the HSC. These include:

- All Patient Safety Alerts (PSAs);
- Safety and Quality Alerts where assurance is required;
- Learning Letters.

For SQAs developed by the DoH these will be sent to the HSCB Alerts mailbox at Alerts.HSCB@hscni.net for issue to relevant health and social care professionals within HSCB and PHA, to seek comment prior to issue by the DoH to the HSC.

For SQAs developed by the PHA / HSCB these will be sent to the DoH Safety, Quality and Standards mailbox at qualityandsafety@health-ni.gov.uk for issue to relevant Policy Leads for review to ensure compatibility with DoH policy prior to issue by the HSCB/PHA.

At this stage the level of assurance may be also considered as outlined in section 5.3.

This approach is intended to ensure that the actions required of organisations are clear through a single communication.

5.2 Dissemination of SQAs

5.2.1 Dissemination of SQAs issued by DoH

SQAs from the DoH will be issued to the Chief Executive's office of relevant organisations, and copied to the HSCB/PHA Alerts Office, the Governance Leads in Trusts and other relevant Directors. A standard distribution list is given in Appendix 2.

5.2.2 Dissemination of Learning Letters/Reminder of Good Practice Letters issued by PHA/HSCB

When regional learning is identified following the review of an SAI, complaint or other incident a learning letter / reminder of good practice letter may be issued to the appropriate HSC organisations for wider circulation, application of learning and assurance that learning has been embedded.

A Learning letter/reminder of good Practice Letter will then be issued via the HSCB Alerts Office to the Chief Executive's office of relevant organisations, Governance Leads in Trusts and other relevant using the standard distribution list. (see Appendix 2)

5.3 Process Following Dissemination of SQAs

5.3.1 Process for Determining Assurances

Category 1 Alerts will be reviewed by the Safety Quality Alerts Team to make an initial determination on:

- Whether or not regional action is required to assist Trusts or primary care with implementation, and
- The nature of the assurance required regarding implementation.

If regional action is required, the proposed actions may be discussed where necessary with Trusts and/other relevant organisations to agree the precise task.

It is important to note that any regional actions do not in any way negate the responsibilities of Trusts or other organisations to take necessary actions to implement the Alert locally; immediate necessary action should not be delayed. However, it is recognised that some aspects of implementation may be more efficient, and may ensure a better outcome for patients, clients, staff and the public if they are developed in a standard way across the region.

To take forward work for the region, the principle of using existing systems as much as possible, will apply. However, if necessary, a Task and Finish Group may be established, including all relevant professionals and managers from relevant providers, and as appropriate, service users and/or the public.

Category 2 Alerts will be implemented primarily through existing systems. If on occasion explicit assurance or other action is required, it will be identified by the Safety Quality Alerts Team and described to Trusts and primary care providers as outlined for Category 1 Alerts.

5.3.2 Criteria for Identifying Regional Action and Assurance Levels

The PHA/HSCB SQA Team will determine the detail of the method of assuring implementation of an Alert. This will be proportionate to the assessed level of risk associated with the issue covered by the Alert. It will work on the principle of using existing systems of assurance as much as possible. Options for assurance methods include:

- Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements;

- Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA;
- Level 3 – completion of an audit specified by HSCB/PHA.

The following criteria will be used to assess whether or not regional action is required to assist implementation, and to determine the level of assurance required:

- The risk to an individual patient, client, staff member or member of the public, is high (impact);
- The number of patients, clients, staff or public who may be exposed to the risk is high (likelihood);
- Aspects of implementation are complex and outwith the control of Trusts or relevant organisations (complexity);
- A regional approach is achievable (deliverability & stakeholder agreement);
- Regional action will not introduce undue delay (timeliness);
- The Alert relates to an issue with a high public/political profile (public confidence);
- Other reasons (professional judgment).

In making its decisions, the HSCB/PHA SQA Team will take account of:

- Other Alerts relating to the service area in question;
- Common themes within a range of Alerts;
- Learning from Serious Adverse Incidents and Complaints;
- Existing safety and quality initiatives in health and social care.

5.3.3 Informing of Regional Action/Assurances Required

On completion of the processes outlined above, if regional action or assurance is required, the Chair of the Safety Quality Alerts Team will inform Trusts, primary care, and other relevant providers or stakeholders of the next steps or requirements. Communication will

be to the Trust Chief Executive's office, copied to the Trust Governance Lead.

5.3.4 Reviewing Compliance of SQAs

The Safety and Quality Alert Team will consider responses to SQAs and 'close' the Alert when it is assured that actions have been implemented, or there is an existing robust system in place to ensure implementation.

In addition bi-annual progress reports to Governance Committee will be prepared by the SQA Team for the following:

- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports and equivalent robust other national enquiries/audits;

These reports will detail the progress on implementation of report recommendations and provide the necessary appropriate assurance mechanism that all HSCB/PHA actions contained within reports are implemented.

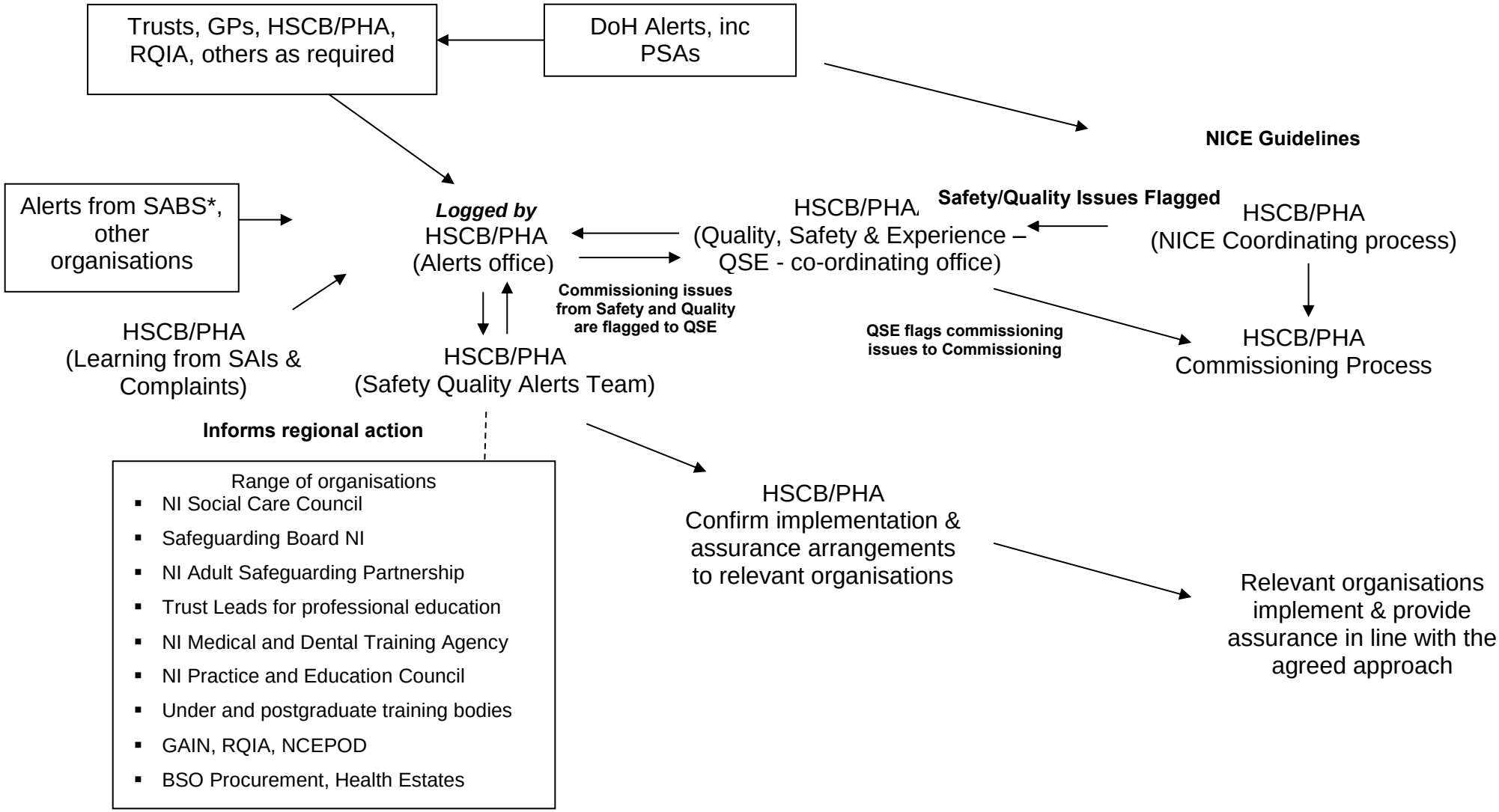
6.0 Reporting of SQAs

An annual report will also be prepared for the HSCB/PHA SQA Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board, DoH, Trusts and others as required.

7.0 Review of this protocol

This protocol will be refined on an on-going basis and not less than annually.

HSC System for Managing Safety and Quality Alerts – Structural Overview **Appendix 1**



MAHI - STM - 307 - 262

Template Distribution List **Appendix 2**

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs			CEX		
Medical Director			Medical Director/Director of Public Health		
Directors of Nursing			Director of Nursing/AHPs		
Directors of Social Services			PHA Duty Room		
Governance Leads			AD Health Protection		
Directors of Acute Services			AD Service Development/Screening		
Directors of Community/Elderly Services			AD Health Improvement		
Heads of Pharmacy			AD Nursing		
Allied Health Professional Leads			AD Allied Health Professionals		
NIAS			Clinical Director Safety Forum		
CEX			**HSCB**		
Medical Director			CEX		
RQIA			Director of Integrated Care		
CEX			Director of Social Services		
Medical Director			Director of Commissioning		
Director of Nursing			Alerts Office		
Director for Social Care			Dir PMSI & Corporate Services		
NIMDTA			**Primary Care (through Integrated Care)**		
CEX / PG Dean			GPs		
QUB			Community Pharmacists		
Dean of Medical School			Dentists		
Head of Nursing School			**Open University**		
Head of Social Work School			Head of Nursing Branch		
Head of Pharmacy School			**DoH**		
Head of Dentistry School			CMO office		
UU			CNO office		
Head of Nursing School			CPO office		
Head of Social Work School			CSSO office		
Head of Pharmacy School			CDO office		
Head of School of Health Sciences (AHP Lead)			Safety, Quality & Standards Office		
Clinical Education Centre			**NI Social Care Council**		
NIPEC			**Safeguarding Board NI**		
GAIN Office			**NICE Implementation Facilitator**		
NICPLD			**Coroners Service for Northern Ireland**		
NI Medicines Governance Team Leader for Secondary Care					

Membership **Appendix 3**

HSCB/PHA Safety Quality Alerts Team

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services, HSCB
- Assistant Director Nursing, Safety & Quality & Patient Experience, PHA
- Safety, Quality and Patient Experience Nurse, PHA
- Assistant Director Service Development & Screening, PHA
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care (Head of GMS) HSCB - when required
- Social Care and AHP input for Alerts relevant to those professions
- Assistant Governance Manager, Safety and Quality, HSCB

SQA Team Roles

- Chair – Dr Carolyn Harper
- Lead Performance & Corporate Services – Michael Bloomfield
- Lead Nurse – Lynne Charlton / Mary McElroy
- Lead Service Development & Screening – Dr Brid Farrell
- Lead Pharmacist – Matthew Dolan
- Lead Public Health Doctor – Dr Jackie McCall
- Lead Safety Forum – Dr Gavin Lavery
- Lead AHP – through Michelle Tennyson
- Lead GP – Dr Margaret O'Brien
- Lead Social Worker – through Fionnuala McAndrew
- Programme Manager – Margaret McNally
- Admin Support – Christine Thompson / Elaine Hyde

Trust Governance Lead Contacts

- Belfast – Dr Cathy Jack and Claire Cairns/Christine Murphy
- South East – Dr Charlie Martyn and Irene Low/Liz Campbell
- Southern – Dr Richard Wright and Margaret Marshall/ /Caroline Beattie Nicole Evans
- Northern – Mr Seamus O'Reilly and Sinead O'Kane /Ruth McDonald

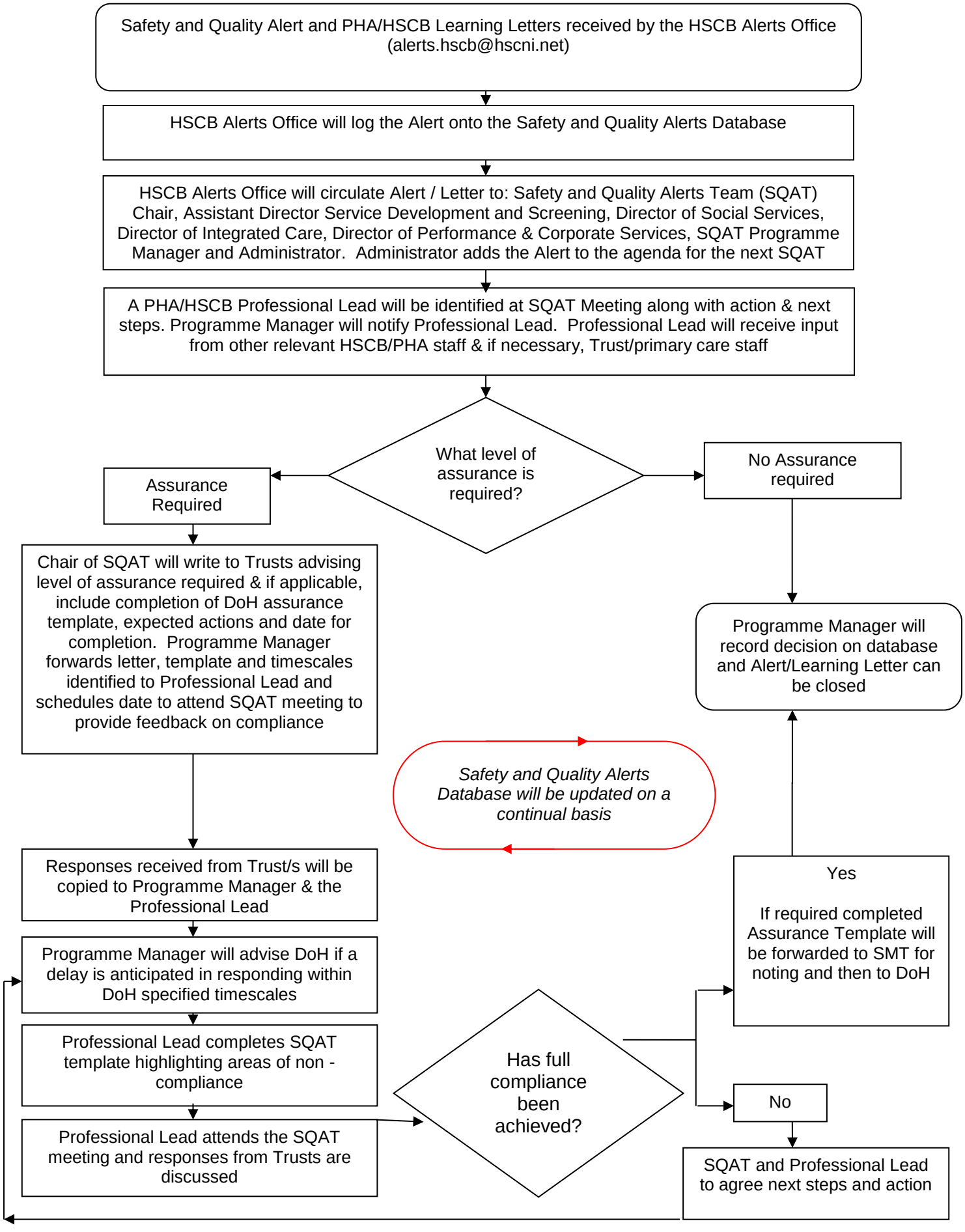
- Western – Dr Dermot Hughes and Therese Brown/Teresa Murray

Link as required with

- NI Social Care Council
- Safeguarding Board NI
- NI Adult Safeguarding Partnership
- Trust Leads for professional education
- NI Medical and Dental Training Agency
- NI Practice and Education Council
- Under and postgraduate training bodies
- GAIN
- RQIA
- BSO Procurement
- Health Estates, DoH

Appendix 4

HSCB/PHA Process for the Management of Safety and Quality Alerts



SAFETY AND QUALITY LEARNING LETTER

Subject	[Insert title]
HSCB reference number	**[For Alerts Office use only]**
Programme of care	
Assurances required	[Indicate if 1st, 2nd or 3rd line assurance is required]

LEARNING SOURCE			
SAI/Early Alert/Adverse incident		Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

TRANSFERABLE LEARNING

ACTION REQUIRED

Date issued		
Signed:		
Issued by		

RE: [Insert title] – Distribution List – [insert ✓ as appropriate]

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs			CEX		
First point of contact			Director of Public Health		
			Director of Nursing, Midwifery and AHPs		
NIAS			Director of HSCQI		
CEX			AD Service Development, Safety and Quality		
First point of contact			PHA Duty Room		
			AD Health Protection		
RQIA			AD Screening and Professional Standards		
CEX			AD Health Improvement		
Director of Statutory & Independent Hospitals, Audit & Review Services			ADs Nursing		
Director of Mental Health & Learning Disability, Children's Services and Prison Healthcare			AD Allied Health Professionals		
Director of Adult Care Services					
NIMDTA			**SPPG**		
CEX / PG Dean			Deputy Secretary		
QUB			Director of Primary Care		
Dean of Medical School			Director of Community Care		
Head of Nursing School			Director of Finance and Corporate Governance		
Head of Social Work School			Director of Hospital Care		
Head of Pharmacy School			Director of Performance, Safety and Service Improvement		
Head of Dentistry School			Alerts Office		
UU					
Head of Medical School					
Head of Nursing School			**Primary Care (through the Directorate of Primary Care, SPPG, DoH)**		
Head of Social Work School			GPs		
Head of Pharmacy School			Community Pharmacists		
Head of School of Health Sciences (AHP Lead)			Dentists		
			Dispensing GPs		
Open University			**BSO**		
Head of Nursing Branch			Chief Executive		
Clinical Education Centre					
NIPEC			**DoH**		
NICPLD			CMO office		
NI Medicines Governance Team Leader for Secondary Care			CNO office		

NI Social Care Council			CPO office		
Safeguarding Board NI			CSSO office		
NICE Implementation Facilitator			CDO office		
Coroners Service for Northern Ireland			Safety, Quality and Standards Office		

Health and Social Care Board

Public Health Agency

THEMATIC REVIEW

Report on the Regional Choking Review Analysis

February 2018

Contents

Executive Summary

Background

The Regional Serious Adverse Incident (SAI) group identified the need for a review of Adult SAIs and Adverse Incidents (AIs) relating to choking on food, to inform future regional safety work. The aim was to identify recurring themes, consider regional learning, highlight areas of good practice and to determine if regional actions are required to reduce/prevent reoccurrence of these incidents.

Methods

An inter professional review team was established with representation from the Public Health Agency (PHA), Health and Social Care Board (HSCB), HSC Trusts, the Regulation and Quality Improvement Authority (RQIA), a service user and other members of staff from HSC also contributed.

A review was undertaken of all SAIs reported between May 2010 and April 2016 where choking on food was associated with actual or potential harm. Qualitative analysis was carried out to identify the key themes. Themes identified by Trusts from reported AIs within the same period were also considered.

Findings

The review considered 17 SAIs; in 14 (82%) cases tragically the incident resulted in death. Key themes identified are outlined below:

- Aetiology of individuals who are at higher risk of choking;
- Behaviours which increase the risk of choking;
- Recognition of signs and symptoms of swallowing difficulties;
- Communication and understanding of Speech and Language Therapy (SLT) recommendations;
- Implementation of individual care plans;
- Physical environment & impact of changes in environment;
- Mealtimes and snacks;
- Dysphagia training & awareness.

Trust analyses of causal factors associated with 798 AIs related to choking on food were also considered, in addition to the themes outlined above Trusts had also identified the following themes:

- Posture of individuals when eating;
- Visitors, families, friends potentially unaware of SLT recommendations, giving individuals food which were not in keeping with the individuals care plan;
- Appropriate supervision when eating & drinking;
- Training in food preparation, CPR and first aid.

Throughout the review the team were made aware of a number of improvement initiatives underway or planned throughout the region which would have potential for scale and spread across the region.

Conclusion

The number and proportion of SAIs in this review that resulted in death emphasises the scale of the problem and the risks associated with dysphagia. The potential risk is also highlighted by the volume of regional related AIs.

The themes identified through analysis of SAIs and AIs, reinforce a need for co-ordinated efforts to facilitate learning and inform future quality improvement work with an aim of prevention or reduction of risk of choking in future.

A number of key messages relating to the areas below are identified within the report.

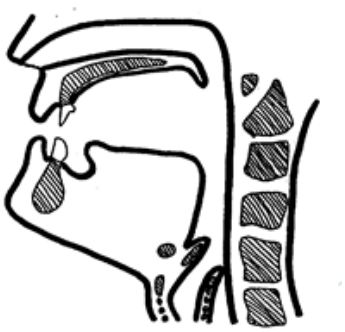
- Raising awareness
- Communication to staff delivering care directly
- Terminology
- Roles and responsibilities
- Education and Training
- Reporting
- Support to staff

The Regional Dysphagia Group, led by PHA has been asked to take forward the next steps outlined in the report.

1.0 Introduction

Swallowing is one of the body's most complex actions involving the movement of food and fluids from the mouth to the stomach and comprises of four stages shown below:

1. Pre Oral- What happens before you eat
2. Oral-What happens in the mouth
3. Pharyngeal-What happens in the Throat
4. Oesophageal- What happens in the food pipe from the throat to the stomach



1.1 Swallowing Difficulties

Impairment can occur at any of the four stages and result in an individual developing dysphagia, a condition where an individual has difficulty with some or all of the swallowing process; this can be either a long term or short term issue.

Dysphagia can affect an individual physically, psychologically and socially and consequently their quality of life. It can lead to malnutrition, dehydration, chest infections and choking, complications are significant and can be life threatening.

Common indicators of dysphagia are:

- Coughing or choking before/during/after swallowing
- Difficulty or pain on chewing or swallowing
- Food or saliva pooling in the mouth
- Drooling
- Repeated chest infections or deterioration in respiratory conditions
- Changes in breathing after swallowing such as shortness of breath or wheeze

- Changes to voice quality such as wet, strained sounding voice.
- Food refusal or difficulty placing food in the mouth.

Difficulties that may be observed in those with dysphagia can include:

- Physical problems which can affect chewing, controlling food in the mouth and swallowing ;
- Behavioural problems such as eating too quickly, overloading the mouth or pica (eating inappropriate and non-food items);
- Reduced awareness or insight into the risks associated with eating behaviours.

1.2 Prevalence of Dysphagia

The prevalence of dysphagia varies with the aetiology and age of the individual. It is difficult to ascertain the prevalence rate for some populations because of the way dysphagia is reported, often forming part of other health conditions for which the patient is being treated.

Older adults are at a greater risk of developing dysphagia due to the way the swallow function changes with age. As well as the effects of age on the body, the increased incidence of diseases in older age such as dementia and stroke are also factors which contribute to growing numbers of older people presenting with dysphagia.

Dysphagia can be the result of a wide range of conditions and illnesses which are considered below:

Acquired Neurological Conditions

Acquired Neurological problems are as a result of damage to the brain or the nervous system. The most common acquired neurological conditions which can cause dysphagia are;-

- *Stroke* which occurs when blood supply to part of the brain is cut off. It is estimated that between 51 and 78% of people who suffer a stroke will have

some degree of swallowing difficulty Studies[1]. The nature and severity of dysphagia will depend on the type and location of the stroke.

- *Parkinson's Disease* is caused by a loss of nerve cells within the brain. Recent studies indicate that 80 to 95% of those diagnosed develop dysphagia throughout the course of the disease[2].

- *Multiple Sclerosis (MS)* affects the brain and/or spinal cord, causing a wide range of potential symptoms, including dysphagia**.** Between 35 and 45 % of those with MS will present with dysphagia, whilst more common in the advanced stages of the condition it can occur at any time[3].

- *Motor Neurone Disease (MND*) is a progressive and terminal disease which results in degeneration of the motor neurones, or nerves, in the brain and spinal cord. It is estimated that between 30 and 100% of those diagnosed will experience swallowing difficulties. The degree of difficulty is dependent on the type of MND and also the stage of the condition with significant swallowing problems becoming very common in the later stages of the disease.[4]

- *Dementia* is a condition associated with an ongoing decline of brain functioning. Whilst there are a range of different types of dementia, dysphagia is very common among those diagnosed and is usually related to the aging process combined with changes within the brain caused by the dementia itself. Exact estimates of what percentage of those with dementia will develop dysphagia are difficult to find. Some studies indicate that between 13 and 57% of dementia sufferers will develop swallowing problems[5], when

[1] Martino, R et al; (2005) Dysphagia after stroke: incidence, diagnosis, and pulmonary complications. *Stroke,* Volume 36, Issue 12
Mann, G et al; (2000) Swallowing Disorders following Acute Stroke: Prevalence and Diagnostic Accuracy. *Cerebrovascular Diseases,* Volume.10, No. 5.
[2] Sultrup, I; Warnecke, T; (2016) Dysphagia in Parkinson's Disease. *Dysphagia*. Volume 31, Issue 1, pp 24–32
[3] Calcagno, P et al; (2002) Dysphagia in multiple sclerosis – prevalence and prognostic factors. *Acta Neurologocia Scandinavica,* Volume 105, Issue 1, Pages 40–43
[4] Walshe, M; (2014) Oropharyngeal Dysphagia in Neurodegenerative Disease. *Journal of gastroenterology and hepatology research* , volume 3, no 10.
[5] Alagiakrishnan, K et al; (2013) Evaluation and management of oropharyngeal dysphagia in different types of dementia: a systematic review. *Arch Gerontol Geriatr Volume 56,* Issue 1, Pages 1-9

individuals have needs that require them to reside in a care home environment this figure rises to 68%[6].

Congenital/developmental conditions

Dysphagia can also be caused by conditions a person is born with or problems which occur as an individual develops.

Learning disability

A learning disability is a lifelong condition which affects a person's ability to learn new skills. Learning disabilities, also known as intellectual disabilities, can be caused by a wide range of factors such as birth injury, an accident or illness in childhood or the presence of specific conditions such as Down Syndrome or Rett Syndrome.

Adults with a learning disability are at greater risk of eating, drinking and feeding difficulties than the general population. Whilst there is no reliable data on the numbers of people with learning disabilities who have swallowing problems, estimates range from 36% (based on speech and language therapy caseloads) to over 70% (based on inpatient populations). More recent studies have shown that approximatley15% of adults with learning disabilities require support with eating and drinking and 8% of those known to learning disability services will have dysphagia[7]. People with learning disabilities are more likely to present with behaviours which increase the risk of choking whilst eating and drinking, such as eating quickly or impulsively.

Cerebral palsy

Cerebral palsy is caused by a brain injury which occurs before, during or soon after birth. It **i**s a lifelong condition which affects normal movement and coordination. Typical swallowing problems in those with cerebral palsy include reduced oral skills, poor coordination of the swallow and difficulty coordinating swallowing with

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[6] Steele, C et al; (1997) Mealtime Difficulties in a Home for the Aged: Not Just Dysphagia. *Dysphagia*, Winter; **12**:43-50.

[7] Guidance, Swallowing difficulties (dysphagia), Updated 23 June 2017, Public Health England.

breathing. Dysphagia can range in severity depending on the nature and severity of the brain injury.

Mental health conditions

Individuals with mental health problems are reported to be at a higher risk of choking than the general population[8], this can be as a result of side effects of medication, movement disorders, seizures and eating/drinking behaviours which increase the risk of choking. In addition, those with mental health problems may be more likely to have a higher incidence of dental problems due to long term medication. It is also important to note that mental illness can co- exist with the conditions listed above which may further increase the risk and likelihood of significant swallowing problems occurring. Literature shows that 35% of people admitted to an acute mental health unit and 27% of patients attending a mental health day hospital can present with dysphagia[9].

Respiratory conditions

Any condition which causes difficulty in breathing can also cause swallowing problems. Studies have shown that 27% of those with chronic respiratory conditions such as COPD (Chronic Obstructive Pulmonary Disease) show signs of dysphagia when screened[10]. When breathing conditions deteriorate, the incidence of swallowing problems increases significantly, with recent studies showing 88% of those with acute respiratory conditions having significant dysphagia[11].

Cancer

Dysphagia is common among those presenting with cancers of the head and neck occurring in between 50-60%[12] of head and neck cancer survivors, this may be a

[8] Fioritti, A et al; (1997) Choking Incidents among Psychiatric Patients: Retrospective Analysis of Thirty-one Cases from the West Bologna Psychiatric Wards. *Canadian Journal Psychiatry*, Vol 42, Issue 5.
[9] Regan, J et al; (2006) Prevalence of Dysphagia in acute and community mental health settings. *Dysphagia* Volume 21, Issue 2, pp 95–101.
[10] McKinstry, A et al (2010) Outcomes of dysphagia intervention in a pulmonary rehabilitation program. *Dysphagia,* Volume 25, Issue 2, pp 104–111
[11] Kobayashi, S et al (2007) Impairment of the swallowing reflex in exacerbations of COPD; *Journal List Thorax,* volume .62 issue 11
[12] Shune, SE et al (2012) Association between severity of dysphagia and survival in patients with head and neck cancer. *Head and Neck,* Volume 36, pp 776-784

result of the location of the tumour, surgery or a side effect of treatment such as chemotherapy or radiotherapy.

Malnutrition

Dysphagia is strongly associated with malnutrition and vice versa. Literature shows that patients with Parkinson's disease who have dysphagia are four times more likely to lose 4.5 kg weight and require puree food and energy dense supplements[13]. For patients with Motor Neurone Disease, 70-80% can develop dysphagia and 20% develop malnutrition[14]. Patients with dementia who are malnourished are at higher risk of dysphagia (68.6%) and 41.7% of patients with dysphagia are at higher risk of malnutrition.[15] The practical issues include consuming too little of energy and protein releasing food due to eating smaller food portions and consuming less fluid despite eating more frequently throughout the day.

1.3 Choking

Choking is the introduction of a foreign object (edible or non-edible) into a person's airway which becomes lodged and reduces or completely obstructs the airflow to the lungs. It is an acute episode in which the person will cough incessantly or experience a colour change (with inability to cough or speak effectively) while ingesting food or drink. The solid or liquid has to be expelled to terminate the event.

Whilst it is recognised that anyone can experience a choking episode people with dysphagia have a higher risk of choking and the consequences can be fatal in all groups.

Whilst it is not possible to prevent all episodes of choking, reducing the risk of choking and improving the safety of individuals who have dysphagia, is essential. For the purpose of this review the focus is related to *choking on food*.

[13] Beyer PL et al (1995), Weight change and body composition in patients with Parkinson's Disease. *Journal of the American Dietetic Association,* Volume 95, Issue 9, Pp 979–983.
[14] Desport JC et al (1999), Nutritional Status is a prognostic factor for survival in ALS patients. *Neurology* Volume 22; 53(5):1059-63.
[15] Carrion, S et al; (2015) Oropharangeal dysphagia is a prevalent risk factor for malnutrition in a cohort of older patients admitted with an acute disease to a general hospital. *Clinical Nutrition,* Volume 34, Issue 3, Pp 436–442.

Higher risk food

Certain types of food can carry a higher risk of choking and may need to be modified or avoided for people with dysphagia, they include:

- round or long-shaped foods eg. sausages, grapes, sweets
- hard, tough, chewy, fibrous, stringy, dry, crispy, crunchy or crumbly foods
- floppy' foods eg. lettuce, cucumber, uncooked baby spinach leaves
- pips, seeds, pith/inside skin, skins or outer shells eg. on peas, grapes, husks
- hard chunks eg. pieces of apple
- sticky foods eg. cheese chunks, marshmallows
- juicy food where juice separates off in the mouth to a mixed texture eg. water melon
- foods of mixed consistency (eg. solids mixed with gravy, soup with lumps of vegetables)

National Patient Safety Agency's National Dysphagia Texture Descriptors provide standard terminology that be used by all health and social care professionals and food providers when communicating about an individual's requirements for a texture modified diet.

The food textures are:
B= Thin Puree
C= Thick Puree
D= Pre-mashed
E= Fork mashable
Normal Diet

The fluid texture are:
Normal fluid
Stage 1: Syrup thick
Stage 2: Custard thick
Stage 3: Pudding thick

2.0 Background

2.1 National context

Over the last 15 years there has been an increasing focus on choking as a significant safety issue. The National Safety Council highlight that choking is identified as the 4th leading cause of unintentional death.

The National Patient Safety Agency (NPSA)[16] in Great Britain reported that there were 605 reported incidents of choking related to adults with learning disabilities between April 2004 - 2007. Review of these incidents identified that they mainly happened at mealtimes with 41% occurring in residential care homes and 58% within inpatients and assessment services.

In 2007 NPSA developed specific guidance with an aim to ensure safer practice for adults with learning disabilities who have difficulty in swallowing. The guidance highlights best practice and provides resource materials to give practical help[17]. The National Reporting and Learning Service (NRLS) encourage healthcare organisations to foster a culture of patient safety and to consider human factors when designing and implementing systems and process.

In June 2011, the Department of Health England as part of the 'Improving Health and Lives Confidential Inquiry'[18] examined preventable deaths of people with learning disability and reported that a number of deaths were caused by solids or liquids going down the wrong way in the lung. The review included stories relating to people with learning disabilities who choked and died in care homes. Their findings showed that people died when carers were not looking after them, first aid was not used properly when the person was choking, staff were not following the care plans for eating and drinking and that people who were at risk of choking were not protected from that risk.

In September 2012, a multi-agency review carried out in Hampshire[19] following 5 cases of choking resulting in death, in learning disability clients, reported to Hampshire County Council between 2005 - 2010. The report sought to understand why people with a learning disability are at greater risk of choking and to determine how outcomes could be improved for individuals who are at risk of choking, in any care setting. There were a number of work stream areas identified during the review which were seen to influence the successful management of risk of choking, including:

[16] www.nrls.npsa.nhs.uk
[17] National Patient Safety Agency 'problems swallowing?' (July 2007) Resources for clients and carers: Ensuring Safer practice for Adults with learning disabilities who have dysphagia
[18] www.improvinghealthandlives.org.uk
[19] Hampshire Safeguarding Adult Board, Multi-Agency Partnership, September 2012, Reducing the risk of choking for people with a learning disability.

- Recognition of people who may be at risk of choking
- Appropriate referral to health professionals for advice and planning
- Care staff training around the recognition of risk, mental capacity assessments and best interests decision making, and First Aid to be given when someone chokes
- Effective commissioning and monitoring of placements for people who are at risk of choking
- Consistent reporting of choking incidents including application of safeguarding processes
- Information for the public.

Public Health England "making reasonable adjustments to dysphagia services for people with learning disabilities" – provides some excellent examples of training models for service providers, carers and families[20]

2.2 Local context

Minimum Care Standards for Regulated Services

The Department of Health NI has developed minimum standards for a range of regulated services. The standards outlined below, specify the arrangements, facilities and procedures that need to be in place in each setting to ensure the delivery of a quality service.

- Care standards for Nursing Home April 2015
- Minimum Care Standards for Independent Healthcare Establishments (2014)
- Residential Care Homes Minimum Standards Updated August 2011
- Domiciliary Care Agencies Minimum Standards Aug 2011
- Day Care Settings Minimum Standards Jan 2012

Within each of the standard documents there are specific standards and criteria related to nutrition and mealtimes which have direct relevance to providing care for individuals with dysphagia.

[20] Public Health England, Making reasonable adjustments to dysphagia services for people with learning disabilities (March 2016).

The minimum care standards for each setting also have specific standards related to staff training and development, with the following related criteria:

The training needs of individual staff for their roles and responsibilities are identified and arrangements are in place to meet them.

Trust Policies & Procedures

Each of the Trust organisations has policy or procedures/protocols in place relating to the management of dysphagia.

Promoting Good Nutrition Strategy

The overall vision of PGN strategy, is to improve the quality of nutritional care of adults in Northern Ireland in health and social care, whether delivered or commissioned, through the prevention, identification, and management of malnutrition in all health and social care settings including peoples own homes. The PGN strategy clearly demonstrates that malnutrition and swallowing difficulties are interlinked.

The 10 Key Characteristics within the strategy sets the scene for the development of a framework for action, by describing what good nutritional care looks like for each characteristic.

The two key actions related to dysphagia are:

- People with swallowing difficulties are screened
- All adults identified as having swallowing difficulties have a full swallow assessment by a Speech and Language therapist.

Evaluation of the implementation of the PGN strategy, within adult hospital settings, identified an opportunity for further regional engagement in order to understand current regional practice in relation to dysphagia screening and full swallow assessments. A scoping exercise which focused on 3 particular elements pertaining to dysphagia, namely dysphagia awareness, dysphagia screening and full swallow assessment of patients was carried out regionally. The findings of the scoping

exercise have been shared with the Regional Adult Dysphagia Group and will inform the regional dysphagia action plan going forward.

Incident Reporting

When a serious event or incident occurs, it is important to ensure that there is a systematic process in place for safeguarding services users, staff, and members of the public. One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from serious adverse incidents (SAIs). Working in conjunction with other Health and Social Care (HSC) organisations, the *HSCB/PHA Procedure for the Reporting and Follow up of Serious Adverse Incidents* was developed to provide a system-wide perspective on serious incidents occurring within the HSC and also takes account of the independent sector where it provides services on behalf of the HSC. The procedure defines an adverse incident and outlines the criteria for reporting of a serious adverse incident.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

In May 2014 the Health & Safety Executive (HSENI)[21] advised that if a death or major injury arises due to service user choking, in connection with the Trust's work activities, and it could have been prevented by the Trust through risk assessment, identifying and implementing control measures or if a failure to do any of these was identified, that this should be reported under RIDDOR[22].

RIDDOR requires employers and others to report deaths, certain types of injury, some occupational diseases and dangerous occurrences that **'arise out of or in connection with work'**. Generally, this covers incidents where the work activities, equipment or environment (including how work is carried out, organised or supervised) contributed in some way to the circumstances of the accident.

[21] https://www.hseni.gov.uk/publications/date/2014
[22] RIDDOR (Reporting of Injuries, diseases and Dangerous Occurrences Regulations (NI) 1997)

Dissemination of Regional Learning

Prior to this review being commenced and following regional recommendations arising from a SAI review, a reminder of best practice letter relating to management and advice for patients/clients with swallow/dysphagia problems, was issued in October 2015[23]. The learning focussed on the need to have robust systems in place, and working, to ensure that all staff involved in delivering care are fully aware, and reminded of, each resident's individual needs and care plans.

Dysphagia Awareness Training

Currently dysphagia awareness training is not considered mandatory across the region. There is a variation of training provided across HSC and independent sector organisations which is accessed from both statutory and private providers, including training offered by nutritional and pharmaceutical companies.

Improvement Initiatives

There are many examples of improvement initiatives related to the prevention of choking across the region, a small sample of which are highlighted below.

Stop Choking DVD link/song

A free help stop choking app which has been developed for people with learning disability is available at helpstopchoking.hscni.net. The app provides easy access to resources which include a choking awareness book, videos, leaflets and advice. Feedback has shown that people with learning disability have found the app easy to use and have loved being in control of their own learning.

Experiential Learning

A project using quality improvement methodology was undertaken in a care home in one Trust area. This project looked at the level of support required by care home staff to care for dysphagic clients safely. The model has suggested that experiential learning allows staff to have a concrete experience with clients they know, to reflect

[23] HSCB/PHA Reminder of Best Practice Letter, Management and advice for patients/clients with swallow/dysphagia problems, October 2015

on their experience and generate ideas on how to manage in the future, and to transfer this learning to new clients. This is done safely with a SLT clinician on hand through the early stages to support and guide.

Quality Improvement

A nationally recognized quality improvement project was undertaken by an independent provider organisation in partnership with a Trust. The project focused on choking, dysphagia and speech and language assessments with a key aim that all nurses, care assistants and support staff working within the group of care homes were aware of speech and language recommendations for each individual resident.

This drive in quality improvement resulted in the displaying of choking risk cards for visitors and visual cues for staff in dining rooms and tea trollies. This piece of work also helped improve written and verbal communication processes between the multidisciplinary team, the care teams and the catering staff through face-to-face learning and practice development. The outcomes of this initiative led to statistically significant reductions in episodes of choking and associated weight-loss.

Trust wide improvement initiative

One organisation has established a Trust wide cross- divisional group to fully implement and embed the Trust Dysphagia Management Policy for Adults. Training has been provided to over 800 staff community and hospital settings and ‘pop up’ ward based key facts information sessions have also been delivered. A Dysphagia page has been created on the staff intranet to allow all staff easy access to information to support their practice such as the SLT regional information leaflets re Textured Modified Diets. Additionally guidance is now available regarding the provision of snacks to service users who require a textured modified diet; snack lists are available which are appropriate to Acute and Community Hospital settings and for community and domiciliary settings. An information poster has been provided to all hospital wards, adult centres, short breaks and supported living settings along with a leaflet which has been produced and disseminated to all staff who work with adults who have dysphagia, including domiciliary care staff. A dysphagia champion was appointed on an interim basis in September 2016 and has audited practice in

Acute and community Hospitals and in Learning Disability facilities. The audit identified areas of excellent practice and areas for improvement. Excellent practice in Learning Disability facilities included the discrete use of service user photographs in serving areas to ensure that people who required texture modified foods were provided with the correct meals and snacks and having a dedicated member of staff responsible for ensuring that all SLT dysphagia care plan documentation is shared within the unit.

3.0 Aims and Objectives

The Regional SAI review group identified the need for a review of SAIs & AIs relating to choking on food, to inform future safety work. The aim of this review was to identify recurring themes, consider regional learning and determine actions required to reduce/prevent reoccurrence of choking on food as well highlighting areas of good practice.

It is important to note that the SAI reports included are unlikely to represent all of the near misses and harm that result from choking on food. In recognition, all HSC Trusts agreed to share adverse incident information (related to choking on food) from Trust Datix systems. This review therefore considers both SAIs and AIs to obtain an overall view of actual and potential harm associated with choking on food and related causal factors.

The SAIs and AIs included in this analysis have been individually reviewed at Trust level and resulting recommendations have been implemented locally or regionally where appropriate.

The objectives of this review were:

- Document the number of SAIs and AIs relating to choking on food
- Document key issues raised, in relation to care and treatment
- Identify themes arising from the SAIs
- Identify documented contributory or causal factors
- Give consideration to learning from AIs relating to choking on food
- Identify areas of good practice

- Make recommendations for further work or for specific improvements in the delivery of care and services, where appropriate; and
- Prepare a written report of the review, for learning and sharing with relevant parties. This report will be presented to Quality, Safety & Experience Group (QSE) prior to approval from SMT/AMT.

4.0 Methodology

4.1 Analysis of Serious Adverse Incidents

SAIs for consideration within this review were identified using the agreed search criteria below within the Regional DATIX database

- Choking
- Aspiration pneumonia
- Asphyxiation
- Difficulty swallowing

SAI notifications forms were screened for inclusion in the review by two reviewers. Full reports were requested where the SAI was related to choking on food. Using the above methodology, there were 17 cases which were identified and considered within the review.

Identification of the contexts and causal factors associated with choking on food was undertaken using qualitative methodology, predominantly the use of grounded theory[24], whereby the issues were identified while reviewing the data (instead of using preconceived hypotheses). Each SAI report included was assigned analytic theme(s), which formed the basis for the issues identified.

4.2 Findings of Serious Adverse Incidents

[24] Charmaz K. Grounded theory. Qualitative psychology: A practical guide to research methods. 2003 Mar 6:81-110.

Outcome

In 14 (82%) cases tragically the incident resulted in death.

Demographics

Reporting Organisation

There was variation in the number of SAIs reported by Trust organisations across all Adult Programmes of Care, ranging from 0 to 7.

Age and Gender

Of the 17 incidents, 10 occurred with males and 7 with females. 11 of the SAIs occurred in persons under 70 years, 6 occurred in those greater 70 years. Ages ranged from 42-80 years.

Care Setting

There was a variation in the settings in which the incidents occurred with most (58%) in nursing and residential care homes. Other settings included supported and independent living, and day centres.

5.0 Thematic Analysis of SAIs

From the SAIs reviewed the following themes were identified:

Causes

The SAIs reviewed show a prevalence of choking episodes among groups for whom the risk of choking is inherently higher, such as those with a mental health diagnosis (41%), learning disability (35%) and dementia.

Behaviours known to increase the risk of choking were identified as a strong theme. This was referenced in 9 (52%) of cases with the following terminology being used within reports:

- Eating quickly;
- Bolting food;
- Drinking fluids impulsively;

- Eating non-food items;
- Taking and eating other people's food;
- Tendency to gulp food/liquids;
- agitated behaviours;
- Holding food in mouth

Patients/Clients known to Speech and Language Therapy

In 13 (76%) of the 17 cases, individuals were known to Speech and Language Therapy (SLT) and there is evidence in the majority of the cases that recommendation for management and texture modification had been made.

Documentation of SLT recommendations

Of the 13 cases known to SLT, In 11 (87%) cases the investigation report considered that there was evidence of written documentation to support the swallow recommendations.

Communication of swallow recommendations to staff

From review of the incident reports it would appear that despite swallow recommendations being documented, availability of these recommendations to staff actually involved in meal provision and feeding was not always ensured. Some of the reasons detailed within the incident reports for this included:

- Nursing care plan relating to dysphagia needs was not in place;
- New staff member;
- Staff member was transferred from another unit;
- Swallow recommendations were not easily accessible in the dining area;
- Personal individual placemat was not in place in dining room;

Understanding of SLT terminology

The reports indicated that there are issues with the clarity and/or understanding of individual care plans and the SLT terminology used within care plans. On a review of the incidents there is evidence to suggest that even when recommendations were available to staff there was a lack of understanding in staff actually involved in the meal provision and feeding. There was recognition within a small number of the

review reports that food textures observed, as well as those recorded on food diaries and records of care were not in keeping with those recommended by SLT.

In 5 (41%) of the 12 cases where SLT assessment had resulted in modification to diet recommendations, texture descriptors had been used. It was recognised that in the remaining cases, a small number had occurred prior to 2012 when national texture descriptors had been published. It was noted that the Dysphagia Diet Food Texture Descriptors terminology was not used universally in all verbal and written communication and reference was made to training and awareness which had been delivered in advance of the introduction of texture descriptors.

Meal and snack times

Over half (58%) of the choking episodes reported as SAIs occurred at mealtimes, 5 occurred at snack time and in in a small number of cases it was unclear as to when the incident had occurred.

Food Type

In 5 (30%) of the cases sausages where identified as the food which caused the individual to choke. Other foods detailed within review reports included bread & butter, sandwich, cake, orange, scone, soup and braised steak.

In 9 (53%) of the 12 cases where SLT recommendations had been made for a modified diet, the food which resulted in choking was not of the texture recommended by the SLT, a small number of incidents occurred outside of mealtimes when individuals where given snacks, not by staff but by others who may not have been aware of their dietary requirements or by taking food not intended for them.

Change of environment

There does appear to be a theme relating to a move or change in environment or change to routine, this was referred to in 6 (35%) of the reports, with individuals recently resettled from long term care facilities, discharged from hospital to a nursing home and admitted to the acute hospital environment from home or another care environment.

Changing needs of individuals

Changing needs of the individual was noted in a number of the 17 cases reviewed. Signs of chest infection, recurrent chest infections, requirement for antibiotic therapy and pneumonia were referenced within reports along with recognition of chest infection as a possible sign of swallow difficulty and aspiration. Deterioration in clinical course in individuals with conditions known to increase the risk of swallowing difficulties, as having the potential to affect their ability to swallow is also noted.

Swallow awareness training for frontline staff

In less than 5 of the 17 reports reference was made to swallow awareness training. In a small number of reports reference was made to in house training provided both by Speech and Language Therapists and by catering staff within the care settings.

In 7 (41%) of the 17 reports, recommendations are made in relation to swallow awareness/dysphagia training, they are not explicit as to who should deliver the programmes or the content. A small number of the reports note that this training is not currently considered as mandatory.

Support to staff and others who witness choking incidents

The need for support to families, carers and other residents/clients who witness choking incidents is referenced within reports.

A small number of the reports make specific reference to the traumatic nature of these incidents and the need for support to staff. Within these reports there is reference to the support provided from senior staff in clinical areas along with occupational health input and care call helplines.

6.0 Good Practice Identified

It is important to note there were many examples of good practice highlighted throughout the SAI review reports these included:

- Prompt and effective management of choking episodes. The benefits of ensuring all staff are trained and updated in emergency first aid and CPR has been demonstrated throughout a number of these reported incidents. The procedure for summonsing emergency assistance worked extremely well in many instances;
- Comprehensive pre admission assessments and documentation completed in many cases;
- Early and appropriate involvement of SLT and dietetics teams within the care planning process;
- Clear evidence of written documentation from SLT to support the swallow recommendations and this had been communicated and shared by the SLT professional with the clinical areas;

7.0 Analysis of Adverse Incidents

In order to complement the findings of the thematic review of SAIs, Trusts agreed to share information held on DATIX relating to all AIs resulting from choking on food between May 2010 to end April 2016 (across all adult Programmes of Care). Datix was searched using the following key words:

- choking;
- aspiration pneumonia;
- asphyxiation;
- difficulty swallowing.

Following review by Trusts **798** AIs were considered as relevant.

7.1 Findings

Reporting Organisation

There was a variation in the number of AIs reported by Trust organisations ranging from 62 - 349.

Care Setting

There was a variation in the settings in which the incidents occurred with almost half (46%) occurring in Day Care settings, 28% in hospital settings and 15% in nursing and residential care homes. Remaining settings included supported living and individuals' own homes.

Day Care Settings

There was variation in the number of reported AIs in day care settings between Trusts, this ranged from 33 to 140 per Trust with 365 in total. The majority of day care settings in which incidents occurred where those who provided care for individuals with learning disabilities and mental health needs.

In-patient Hospital settings

Many of 222 incidents occurring in hospital where reported within mental health and learning disability settings along with clinical areas which provided care for the elderly and those with dementia. A small percentage of incidents where reported from acute inpatient hospital settings. The range of incidents reported by Trust was 16 to 109.

Nursing & Residential Care Settings

There were 116 (15%) incidents occurring in nursing and residential care home settings, reported incidents ranged by Trust from 7 to 66.

Supported Living

Adverse incidents in supported living settings accounted for 7% (57) of total reported incidents, which Trust reported numbers ranging from 6 to 19.

Own home

Incidents in this category were reported mostly by support workers providing care within the clients own home.

Other

The 23 incidents categorised in the other setting were mostly community settings including rehabilitation environments and also where exact location was not specified.

Food Types

Where the type of food which caused the individual to choke was detailed, similar to the review of SAIs, the majority of the food types are known to carry a higher risk of choking, these included:

- Sausage
- Chicken
- Biscuits
- Toast
- Lettuce
- Orange

7.2 Themes identified

Whist it was acknowledged that there would be less information available than that within an SAI review report, Trusts were asked if to identified key themes from AI analysis. The key themes identified below where similar to those identified in the analysis of SAIs:

- Known history of swallowing difficulty;
- Interpretation, understanding and documentation;
- Training: food preparation, dysphagia, CPR, first Aid;
- Recommendations which were present were not always adhered to;
- Behavioural issues;
- Posture of patient when eating;
- Visitors giving patients food they were not allowed;
- The importance of personalised care planning with regards to dietary requirements;
- Appropriate supervision in dining rooms.

Outcome

When reviewing the information provided in relation to adverse incidents it was also noted that in a number of incidents reference was made to the requirement of first aid measures including, back slaps, abdominal thrusts and suctioning measures by staff members present at the time of the incident along with doctors on call and paramedics. Prompt response and effective first aid measures clearly had a positive impact on the outcome for these individuals.

8.0 Learning

The SAIs reviewed show a prevalence of choking episodes among groups for whom the risk of choking is inherently higher, such as those with a mental health diagnosis, learning disability and dementia. Similarly, although the aetiology for all AIs was not available to the thematic review team in all cases, almost half of the incidents (365) occurred in day care settings, the majority in day care centres for those with learning disabilities and mental health needs. In addition, many of the incidents occurring in hospital (222) where reported within mental health and learning disability settings along with clinical areas which provided care for the elderly and those with dementia. Behaviours which are known to increase the risk of choking where described in many of the cases.

In the SAIs reviewed there is reference to level of access to SLT where it was requested. Interventions by SLT tend to be in response to a referral to the service. In order to obtain timely and appropriate referrals to SLT there continues to be a need for awareness training of frontline staff in the identification of signs and symptoms that indicate that there may be swallowing difficulties and how and when to refer appropriately for full swallow assessment.

Another causal factor highlighted was the changing needs of the individual and the timeliness of reassessment. Many people's ability to swallow safely will rapidly decline during periods of ill health and advice on how to respond in this urgent situation is often needed. Review of recommendations and consideration of clinical

condition allow patients/clients to follow the least restrictive diet, supporting a better quality of life, adherence to SLT recommendations and appetite. As the SAIs incidents have all occurred within client groups for whom swallowing difficulties are prevalent, swallow awareness training for frontline staff may result in increased safety for this population and rapid identification of those at increased choking risk so that timely referrals can be made to SLT.

Currently within Northern Ireland there is no regional consensus to which staff groups should access training & dysphagia awareness training is not recognised as mandatory. There is a variety of training programmes available in relation to dysphagia, swallow awareness and food preparation. However, there does not appear to be consistency across the Trusts and Independent Providers in relation to access to this training, length, content, whether they are mandatory or not or how competency is accessed. Those who access training do so from both statutory and private providers including nutritional and pharmaceutical companies. This ad-hoc approach has the potential to result in confusion. There is a need to ensure that the training for staff that is delivered is quality assured and standardised so that a common message is communicated in agreed language.

It is important to stress that simply accessing training is not enough and practice and learning from recent improvement initiatives would indicate that on-going monitoring of practices and support relating to dysphagia management within care facilities is essential to ensure that training is embedded.

In reviewing the SAI reports the importance of effective communication with the staff caring directly for individuals with swallowing difficulties was highlighted as an area for learning. Whilst the reports referred to written documentation of swallow recommendations in most cases detail relating to the availability of these recommendations to staff actually involved in meal provision and assistance with feeding was not always clear.

Although not referred to in all reports, a small number referred to the displaying of information relating to swallowing recommendations for example on a personal placemat at the clients table, whilst others displayed them on the walls of the

residents room. Sharing of the information contained within care plans including swallow recommendations can be misunderstood or misinterpreted by staff who are delivering care.

There is a need to consider the impact of environmental changes and changes to routine both on the individual and staff involved. The transfer of information from one facility to the next can be an issue but importantly there may be issues relating to the knowledge one team will have of a person from whom they have had caring responsibility for a long period of time. Some of the subtle caring practices may be difficult to capture and therefore to communicate effectively.

The precise sharing of information relating to all aspects of care and where possible, the careful and planned transfer of a client from one care setting to another so that those with the most knowledge of the individuals' care needs can be closely involved in the resettlement of the client into their new surroundings. The discharge care pathway needs to be clearly described with the "key" worker clearly identified. This individual is the central point through whom information relating to all care needs is disseminated.

When a patient safety incident occurs, a first priority is to care and support for the person, their family members and carers and indeed other service users who have witnessed the adverse/serious adverse event. The subsequent impact on front-line workers involved in or exposed to the event should also be acknowledged. These staff members need emotional and professional support from colleagues and supervisors, so that the occurrence of patient safety incidents results in learning and constructive changes in practice if indicated.

9.0 Conclusion

This review provides an analysis of SAIs relating to 'choking on food' reported across all programmes of care for the period of 6 years, 1 May 2010 to 31 March 2016. Themes identified from regional AIs associated with choking on food between 1 May 2010 to 30 April 2016, were also considered.

The reasons why patients choke are complex and can have numerous contributing factors such as physical illness, learning disability, mental health, medication and age.

The regional multi-disciplinary review group have identified recommendations to facilitate learning and inform future quality improvement work with an aim of prevention or reduction of risk of choking in the future. It is not usually possible to eliminate all risks but staff have a duty to protect individuals as far as 'reasonably practicable'[25]. This means the avoidance of any unnecessary risk. It is also clear that there were many examples of good practice highlighted throughout the reviews.

10.0 Key Messages

Regional

- Public awareness and awareness of staff should be raised regionally of the groups of people for whom there is a higher risk of choking.

- Terminology for food and fluid texture descriptors should be agreed regionally for use universally across all HSC facilities and by providers of modified meal contractors.

- A regional approach to agreeing roles, responsibilities along with tailored training & education to the level of competence and skills required by different groups of staff should be taken.

- Key safety messages from the thematic review and the dysphagia scoping exercise should be shared with relevant stakeholders, especially with those caring directly for individuals with swallowing difficulties.

[25] NPSA (March 2007) *'Healthcare risk assessment made easy'*

Individuals

- Care plans relating to individual dietary needs should be clear and unambiguous and should include swallowing recommendations, requirements for supervision, assistance with feeding and food and fluid consistency.

- Clear mechanisms for the communication of swallowing recommendations to those who are caring directly for individuals with swallowing difficulties should be developed including when transferring between locations.

- The needs of individuals with swallowing difficulties should be communicated effectively, particularly at pivotal times such as handover, meal and snack times, or if patients/clients move facilities, attend day centres or go out in the care of their relatives, carers or others. The development of a process for a safety pause before any meals and snack times are served to consider risks, based on one question such as *'what patient safety issues for meal and snack times do we need to be aware of today?*' should be considered.

- When planning menus consideration should be given to food that can carry a higher risk of choking and requirement for necessary modifications or in some cases avoidance.

- Individuals who have experienced a deterioration with their swallowing, dysphagia, or who have difficulty with chest infections or aspiration should be reviewed and their needs reassessed.

Family/ carer

- Families, carers and visitors (if appropriate) should be made aware if there is any risk of individuals choking and be kept up to date of relevant requirements regarding individual dietary needs.
- Information in an easy to understand format on dysphagia management should be made available for people with swallowing difficulties and their families and carers.

Staff

- The training and development needs of staff providing care and services for individuals with swallowing difficulties should be identified and arrangements put in place to meet them.

- Staff/witness support and counselling, should be available for any member of staff or witnesses involved either directly or indirectly in a choking incident.

- To help continuously improve safety in the future, systems should be put in place for the accurate reporting of patient safety incidents involving all patients with dysphagia**.**

11.0 Next Steps

A Regional Adult Dysphagia Group led by PHA has been recently established, comprised of Service Users, Carers, Statutory, Independent, Voluntary and Community Sectors and relevant staff groups.

The aim of the group is to improve identification and management of swallowing difficulties for adults with dysphagia and the following objectives have been set:

- Improve awareness of dysphagia;
- Standardise approach for identifying people with dysphagia;
- Standardise approach for managing people with dysphagia;
- Improved access to specialist intervention;
- Work towards a co production approach with service users and carers.

As a result of learning from this review the Regional Adult Dysphagia Group are asked to engage with relevant stakeholders to consider the following actions and subsequently develop an action plan with clear time frames for completion and implementation;

1. Develop a regional plan for communication of key safety messages arising from the thematic review, to include consideration of promotional materials and media aimed at raising awareness.

2. Develop proposals for consideration and approval by relevant stakeholders in relation to a regional approach to dysphagia awareness and training for all staff groups which would carefully consider the following areas:

    - Access to awareness and training;
    - Delivery options;
    - Theoretical content as required by staff group;
    - SLT care plan “language”/terminology including texture descriptors;
    - Appropriate supervision of patients whilst eating or drinking.
    - Assessment and compliance
    - Roles and responsibilities

3 Develop regional recommendations in relation to timeliness of SLT dysphagia assessment and intervention.

4 Seek regional consensus in relation to the use of Dysphagia Diet Texture Descriptors across the region. In reaching comprehensive consensus with all relevant stakeholders, agree a regional plan for dissemination and implementation using an agreed communication and assurance framework to ensure sharing with and awareness of relevant staff groups families and carers.

5 Seek and share outcomes of current improvement initiatives related to choking on food and give consideration to potential for spread to other areas.

6 Determine the value of a standardised format for swallow recommendations for use in all care settings. If agreed, engage with relevant stakeholders including professional groups to develop same.

7 Determine the value of regional guidance in relation to accurate reporting of patient safety incidents involving all patients with dysphagia. If agreed, engage with relevant stakeholders including professional groups to develop same.

Professor Charlotte McArdle
Chief Nursing Officer

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Our Ref:

Date: 24th November 2017

By Email:

Mary Hinds PHA

Mary.Hinds@hscni.net

Dear Mary

Due to a number of concerns in relation to learning disability and mental health nursing, I would appreciate if you could provide me with a scoping report on the systems, professional structures, policy and procedures that are in place to provide professional assurances to the Directors of Nursing in Trusts.

It is also important to explore to what extend learning disability and mental health nursing have been integrated into corporate nursing arrangements. I would also value if you can identify any challenges faced directly in this regard.

Within this report it would be helpful to have understanding of specific areas including:-

- Supervision, safeguarding and practice monitoring;
- The process in place to learn from incident reviews and events; and
- Mechanisms in place for learning disability and mental health nurses to access continuing professional development (excluding mandatory training).

I am hoping you can report your findings and recommendations to me by the end of January 2018.

Please feel free to contact me should you need to discuss further.

Yours Sincerely

Charlotte McArdle

Charlotte McArdle
Chief Nursing Officer

cc Directors of Nursing
Mental Health and Learning Disability Directors
Permanent Secretary

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Trust:_____ **Mental Health Nursing – Learning Disability**

Issue	Sources of Evidence
1.1 There are explicit and effective lines of accountability from the care setting to the HSC Trust Board through the Executive Director of Nursing.	
1.2 Detail the professional leadership structures within learning disability and mental health nursing.	
1.3 Detail the resources within the central/corporate nursing team to support the provision of professional assurance.	
1.4 Detail the resources within mental health and learning disability directorate teams that support the provision of professional assurance.	
1.5 Describe how a culture of shared values and person centred care is promoted in mental health and learning disabilities services.	
1.6 Describe any benchmarking activity in mental health and learning disability nursing.	

Prioritise People	
2.1 Indicate what structures, policies and procedures you have specifically in place in mental health and learning disability services, which ensure staff treat people with kindness, respect and compassion and effectively deliver the fundamentals of care.	
2.2 Describe the process for patient/users involvement including the collection of patient/client feedback and how it impacts on professional reflection and learning	
2.3 Illustrate what policies and procedures you have in place to ensure that staff, advocate for vulnerable patients and clients promoting, choice, inclusion, independence and rights	
2.4 A culture which ensures those with learning disabilities and mental health challenges are involved in decisions about their care.	
2.5 What structures are in place to take forward the agreed actions from *Strengthening the Commitment* and *Delivering Excellence: Supporting Recovery*	

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Preserve safety	
3.1 Recruitment of staff	
3.2 Confirm all NMC referrals are overseen by the Director of Nursing	
3.3 Describe the mechanisms in place to support staff working within their limits of competence including the ability to recognise and act on worsening physical and mental health in the person receiving care.	
3.4 Describe the mechanisms in place to escalate any concerns about public safety, patient care or professional practice.	
3.5 Indicate how the professional governance arrangements support nurses to understand their responsibility to take all reasonable steps to protect people who are vulnerable.	
3.6 Describe how the professional governance arrangements support the processes in the Trust to learn from incidents, reviews and events.	
3.7 Describe how you ensure appropriate delegation.	

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Practise effectively	
4.1 There is a process in place to measure and monitor nurse sensitive quality indicators in mental health and learning disability services.	
4.2 There is an appropriate learning environment for student nurses.	
4.3 Effective communications systems are in place which bring the voice of mental health and learning disability nursing to the attention of the Director of Nursing	
4.4 Ensure that nurses in mental health and learning disability services development needs are reflected proportionally in the Trusts education and training plan.	
4.5 Illustrate how practitioners are equipped to provide evidence based care through the maintenance and development of knowledge and skills.	
4.6 Indicate how nursing staff are supported to evaluate the quality of work and preserve the safety of those receiving care.	
4.7 Describe how nurses have access to supervision and are supported to meet regulatory requirements and professional guidance.	
4.8 Describe how nurses in mental health and learning disability are supported to work to their highest level of competence?	

4.9 Illustrate how appropriate workforce planning links with service development and professional standards.	

Promote professionalism and trust	
5.1 The Executive Director of Nursing and all nurse leaders are visible to the workforce and role model professional values and a positive person centred culture.	
5.2 The Executive Director of Nursing presents information at Board and/or standing committees concerning the level of performance of nursing services with specific reference to mental health and learning disability nursing.	
5.3 Ensure that nursing posts including senior nursing posts reflect professional leadership responsibilities in support of the professional governance framework.	
5.4 Support nurse leaders to develop a future focused motivational style of leadership which empowers staff and leads change.	
5.5 Provide advice to managers about reviewing circumstances where the competency or conduct of a nurse in mental health or learning disability falls below professional standards.	

Challenges / Opportunities	
6.1 Could you detail areas of good practice that you feel other colleagues would value learning from.	
6.2 Could you detail any challenges faced in providing professional assurances about nursing practice in mental health and learning disability services.	

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Professional Nursing Governance Report

Mental Health Nursing and Learning Disability Nursing.

January 2018

Introduction

This report has been compiled in response to a request from the Chief Nursing Officer (CNO) to provide a report on the systems, professional structures, policies and procedures that are in place to provide professional assurances to Directors of Nursing, specifically related to learning disability nursing and mental health nursing. Appendix A (CNO Letter)

Methodology

This report focuses on the processes, procedures and structures in place addressing areas such as:

- Professional governance framework.
- Adult safeguarding policy and procedures
- Mechanisms in place to learn from incident reviews and events
- Procedures in place for learning disability and mental health nurses to access continuing professional development.

In addition Trusts were asked to complete a template attached at Appendix B. (correspondence to HSC Trusts) This template is based primarily on the NMC Code of Conduct and identifies some of the key elements and features of a professional governance framework. The template asked Trusts to indicate the sources of evidence which are currently used to provide assurance along with areas of good practice or professional challenge.

As each area of nursing practice is different, with their own challenges and opportunities, Trusts were asked to complete one for mental health nursing and a separate one for learning disability nursing.

Response Structure

This response is sub divided into a number of sections based on the NMC Code of Conduct for Nurses and Midwives:

Section 1 Professionals Governance Frameworks – An overview. This includes reference to the overall structure, capacity and integration of professional governance arrangements including structures

Section 2 Prioritising People. This includes reference to patient/client involvement and engagement, use of a rights based approaches and the delivery of the fundamentals of care

Section 3 Preserving Safety This includes, safeguarding arrangements, escalation of concerns and learning from incidents and reviews

Section 4 Practise Effectively This refers to areas such as supervision, practice monitoring, support for continuing professional development and regulatory requirements

Section 5 Promotion of Professionalism and Trust. This includes reference to professional leadership, professional reports and maintenance of professional standards

Section 6 Challenges and opportunities.

Section 7 Conclusions and points for consideration

Section 8 Appendices

Introduction

Nurses and midwives in Northern Ireland perform their roles in a wide range of settings including hospital and community and in a wide range of teams both uni and multi-disciplinary, statutory and in partnership with the independent sectors. At the same time Trusts are large complex organisations which makes the process of professional assurance and accountability challenging.

Professional governance frameworks should reflect the mechanisms by which the Executive Director of Nursing can provide assurances to their Chief Executive and Trust Board about the quality of nursing care.

When implemented, a robust assurance framework provides clarity about professional responsibility and evidence that structures and processes are in place to provide the right level of scrutiny and assurance across nursing and midwifery services.

Health and Social Care Assurance Framework

The Health and Social Care (Reform) Act (Northern Ireland) 2009 provides the legislative framework within which the health and social care structures operates. The Health And Social Care Assurance Framework (2011) describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department.

They both set out the high level functions of the various health and social care bodies, providing the parameters within which each body must operate, and describes the necessary governance and accountability arrangements to support the effective delivery of health and social care in Northern Ireland.

Accountability for the exercise of proper control of financial, corporate and clinical and social care governance in the HSC system rests with the Department and the Minister. Assurance to the Department and the Minister about the safety and quality of services is provided from a number of different sources. Each health and social body has clearly defined roles and responsibilities in this regard.

The following sections of this report reflect a summary of the main findings from the information provided by Trusts. The emphasis is on learning from what works well and promoting discussion on areas where improvements could be made.

Section One - Professionals Governance Frameworks – An Overview

Each Trust has indicated that there are explicit and effective lines of accountability from the care setting to the Trust Board through the Executive Director of Nursing; however some of these reporting arrangements appear more straight forward than others, with a variety of groups and committees in place to support corporate governance arrangements. There some key similarities and notable differences in approaches.

The similarities focus on structures which focus on core groups of senior nurses reporting directly to the Executive Directors of Nursing.

Capacity

In all cases the Trust Executive Directors of Nursing are also supported by a number of other senior nurses/midwives who work within other Directorates including mental health and learning disability nurses. The nurses within the Directorates generally carry a professional assurance role alongside significant operational roles. In some cases these roles do not appear to currently require the post holder to be a nurse which makes the assurance structure vulnerable to changes in post holders.

The capacity within teams who provide professional assurance varies significantly both within central teams and within Directorates. The scale of central resource does not appear to be related to the size of the Trust either in population or geographical spread.

There is also a theme, although this does not apply in all Trusts, of a variance in the level of nursing posts identified to provide assurance, with learning disability services appearing to banded at a lower grade. While not making any assumptions about this observation it warrants further exploration.

Points for Consideration:

Further discussion on the capacity within the nursing and directorate teams in support of the Executive Director of Nursing is required. This is prompted by the variation in capacity and grade, the dual roles held by some post holders and the numbers of posts currently key to assurance but which do not require a nursing qualification.

Model of Governance

A number of Trusts describe the governance arrangements as an integrated model or corporate governance model with a focus on all Directors working corporately with professional governance reporting lines through other groups such as a Safety, Quality Improvement and Innovation Committee or Directorate Governance Groups. Others describe the structures linked to ‘collective leadership’ working alongside a professional structure.

The majority of Trusts, but not all, indicate a range of professional groups which address common areas such as:

- Workforce, education and learning
- Governance, regulation and revalidation
- Nurses in difficulty
- Research and development

Communication

Communication system vary in much the same way as structures but all rely on feedback from groups close to and including front line staff to alert the Executive Director of Nursing's teams to emerging issues.

As with any communication system its effectiveness is dependent on the skills and capacity of the practitioners involved and the supporting administrative infrastructure. In the case of mental health and learning disability nursing this effectiveness is further often complicated by geographical separation.

Points for Consideration

Given the reliance on the skills of a small number of senior nurses some of which hold dual roles, further work on preparation for and support in these roles is required along with the development of a supportive communications system. This could include reflecting on how this lead role has developed within other jurisdictions and the potential impact of the HSC leadership Strategy.

Culture and Values

A shared culture and value system is recognised to be one of the building blocks for effective professional governance arrangements and the delivery of effective services.

A number of Trusts have developed a Trust wide shared vision or strategy for nursing and midwifery that guides professional practice, development and innovation.

Many have indicated groups or activities such as Mental Health Safety Collaborative or Listening Groups sessions, team building events, adverse incident cultural survey, values clarification exercises and development of local professional networks as examples of how a culture of shared values is promoted.

The majority of Trusts reported that a clear expectation and focus on person centred care in all care environments enabled Trust staff to understand behaviours that were considered necessary and appropriate.

Many Trusts linked this work directly with the commissioning of nursing education and development opportunities.

Points for Consideration

The collaborative model should be explored further both at Trust and Regional level with the specific aim to ensure an improvement approach is taken to professional and service development building on the values of nursing.

Other mechanisms or sources of funding and development models should be explored to complement the post registration funding provided through the Department of Health.

Benchmarking Activities

To assist in organisations assessing their own performance it is helpful to participate in local and national benchmarking activity.

A number of accreditation and benchmarking actives were identified by some Trusts, for example;

- Royal College of Psychiatrists Quality Network for Learning Disability and Mental Health wards/ services.
- UK Benchmarking project for Mental health and Learning Disability
- European benchmarking linking with colleagues in Holland.

Trusts also identified a number of other mechanisms which contribute to an external assessment of service provision including:

- Patient experience feedback including 10,000 More Voices
- Adverse Incident and complaints monitoring
- Mortality and Morbidity meetings
- PPI Forums
- Suggestion boxes
- Safety Culture Survey
- Professional Peer support with neighbouring Trust working together.

Points for Consideration

A consistent regionally agreed ‘benchmarking’ or ‘peer review’ approach should be developed to embrace the views of patient/client, family and staff. This could potentially include the revisiting ‘Monitor’ focusing on the fundamentals of care, development of a cross Trust assurance process or a model which builds on the RQIA methodologies or building on the investment in improvement science education and support.

Section 2 - Prioritise People

The code of Conduct says that nurses, 'must put the interests of people using or needing nursing or midwifery services first. You must make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

Kindness, respect, compassion and the fundamentals of care.

The response from Trusts consistently addressed a number of core actions including policies and procedures in safeguarding vulnerable adults, breaking bad news policy alongside, continuing professional development, supervision and appraisals and comprehensive induction. There were a number of additional actions/initiatives including:

- Reference to the corporate values of the Trust including Integrity, compassion and excellence.
- Facilities 'statements of purpose.'
- Adherence to ISO procedures within Learning disability which are subject to biannual audit.
- Opportunities for staff to participate in practice development opportunities and service/quality improvement initiatives.
- Quality Improvement Forums to include *What matters to me initiative, Joy at work project.'*
- Education and support to staff in the management of actual and potential aggression accredited by the British Institute of Learning Disabilities (BILD)
- Use of the RQIA feedback to improve performance.
- Regular reviews of complaints, SAI and incidents.

While all of these elements contributed to a culture of care and compassion give the genesis of this work further decision is required.

Points for Consideration

Consideration should be given to exploring a regional approach to the development of, or strengthening of, the culture and values of nursing within a wider health and social care system. This could be supported for example by the Foundation of Nursing Studies, through Creating Caring Cultures Programme.

Involving and engaging service users

All Trusts provided examples of how service users views were collected, analysed and acted upon. Core to all Trusts responses are a wide range of service user forums and formal patient experience feedback.

Some areas which were highlighted but not common to all were:

- Recovery College programmes co designed and delivered with service users.(Mental Health)
- A service users consultant a full member of the mental health management team/ (Mental Health)
- Involvement of service users on recruitment panels. (Mental Health)
- Employment of Service Users Champions (Mental Health)
- Feedback from YIM YEM survey (You in Mind survey) and 10,000 Voices More survey

Care and support for vulnerable patients and clients.

All Trusts referenced policies and procedures such as vulnerable adults procedure, deprivation of liberty safeguarding and human rights policy, positive behaviours support and others already referenced in this paper. In addition the majority indicated the use of advocates and peer advocates in support of individuals, the establishment of groups to take forward the mental capacity act and education and support in human rights.

One Trust indicated that KPIS have been developed to promote daily 1:1 therapeutic contact with patients.

Strengthening the Commitment and Delivering Excellence: Supporting Recovery.

Professional leads in Trusts are identified as members of Strengthening the Commitment and Delivering Excellence Supporting Recovery Groups with an indication of chairman's roles in related sub groups, reporting back into the corporate professional structures generally three to four times a year.

Trusts have also cooperated in developing a Learning Together, Working Together framework which manages cross service and cross disciplinary training to equip the workforce with the skills to meet service users needs. Reference was also made to the reporting of linked KPIs into the corporate and other structures.

As part of the implementation of Strengthening the Commitment and Delivering Excellence: Supporting Recovery Trusts have identified a wide range of development opportunities for nurses including education and support initiatives, succession planning and new roles such as Acute Liaison Nurse posts.

Delivering Excellence Supporting Recovery, in the information received was reflected in all responses. This was also reflected in the significant developments in services within mental health such as Recovery Colleges.

In the formation related to Strengthening the Commitment was of a more general nature.

Points for Consideration

Consideration should be given to strengthening the Executive Nurse Director leadership role in delivering Strengthening the Commitment, to support the impact on front line services while strengthening links with core nursing teams.

Section 3 Preserve Safety

The Nursing and Midwifery Code of Conduct states, 'You must make sure that patients and public safety is protected. You work within the limits of your competence, exercising your professional duty of candour and raising concerns immediately whenever you come across situations that put patients of public safety at risk. You take necessary action to deal with any concerns where appropriate.

Recruitment and professional support.

The majority of Trusts report that appropriate high standards of nursing practice including the inclusion of a registered nurse on every recruitment panel for nursing posts is in place.

Some Trusts have indicated that they have escalation procedures in place to ensure recruitment process respond in a timely fashion to staff shortages, others indicate that they only recruit to mental health posts twice a year and learning disability one a year.

All Trusts have indicated they are involved in the Delivering Care Mental Health work to establish safe staffing levels. The Learning Disability nursing team believe this should be a priority for their area of practice.

One Trust has created an innovative career pathway for mental health nurses in the community.

Although not noted in the responses the NI Strengthening the Commitment Regional collaborative have commenced work on a Learning Disability Career Pathway in September 2017 facilitated by NIPEC It is anticipated the work will conclude within six months.

A number of Trusts have referenced the cumbersome nature of the electronic recruitment process.

Points for consideration

A sustainable mechanism should be found to share best practice recruitment and retention initiatives.

Consideration should be given to the inclusion of Learning Disability Services as part of Delivering Care.

Maintenance of the competence of staff

Maintaining and supporting staff to maintain their competence is important particularly given the increasing complexity of care and treatment and increasing acuity of patients and clients. Maintaining this level of competence is a shared responsibility between the employer and individual.

All Trusts referenced support systems and processes including allocation of preceptors, regular staff meeting, clinical supervision, reflective practice groups, safeguarding (children), multidisciplinary case discussions and processes for revalidation.

Post incidents reviews/debriefing was referenced in a number of returns along with audits of seclusion practice.

All Trusts indicate that all referrals to the Nursing and Midwifery Council are processed through the core nursing team under the direction of the Director of Nursing.

Points for consideration

A better understanding of the numerous groups and processes in place to support staff in mental health and learning disability nursing would help develop a consistency of approach. This review would also enable Trusts to review how these groups and processes link into the core nursing teams.

A number of Trusts indicate specific education and support mechanisms in place to support these two particular staff groups including:

- A development programme based on the SPIRIT Model
- Early warning signs of the deteriorating patients
- Life support training
- Person centred care plans
- MAPA
- Positive Behaviour Support

Some Trusts made specific reference to core nursing training including, Fallsafe Bundle, MUST bundle, Bedrail assessment, BRADEN Score and pain score.

Points for consideration

The challenge in both mental health and learning disability services is that they are less focused on clinical/physical interventions and more focused on establishing a positive therapeutic relationship with a patient/client. As a result it is more challenging to develop a system by which you can measure competence in the development and impact of a therapeutic relationship. Alongside ensuring that core nursing indicators are reflected, as appropriate, in these two areas of practice further consideration should be given as to how you measure a therapeutic relationship.

One Trust identified support to un-registered staff such as QCF vocational training.

Given the importance of the unregistered nursing support staff in the delivery of care and treatment further work needs to be completed to ensure the contribution of these staff is maximised and they are appropriately supported.

Escalation of concerns.

In a number of Trusts there is a statement that there is an open door policy within the profession with clear guidance to nurses on when to escalate emerging professional concerns.

In some, concerns are required to be raised with operational manager in the first instance. In these cases if local resolution cannot be reached then the advice of the professional leads should be sought.

A number of Trusts indicate explicitly that concerns can be raised both in writing and orally and that staff may involve a trade union or colleague to assist and advise them. A positive and constructive relationship between Trust and staff side organisations is seen as another mechanism by which staff can raise concerns.

In one case if staff believe that they cannot approach any of the above staff they ae encouraged to speak to the Chief executive, Chairman, Nominated Non Executive Director or Director of HR.

Points for consideration

Clarity is required to ensure that if a registrant cannot feel they can talk about professional issues to a manager they have a professional link to go to. Learning from the current project led by Director Nursing, WHSCT will contribute to this.

All Trusts noted a wide range of policies and procedures including:

- Whistleblowing
- Raising concerns procedures
- Disciplinary and other HR procedures

A number of Trusts indicated that lessons or issues raised through these processes are fed directly to the Director of Nursing and their core teams.

Learning from reviews, incidents and events

All Trust had similar processes by which incidents were reported, investigated and reviewed. How Trusts tried to ensure that there was learning from these varied. This is not unexpected nor unusual as this has been a challenge for all health care systems.

One Trust reports a review of their arrangements and a pilot of new mechanisms, the learning from may benefit others.

Mechanisms to ensure learning used currently include:

- Regular updates provided to staff through 'Dash boards'
- Multidisciplinary governance meetings
- Safety briefings. These seem to be embedded in some areas not explicitly or in the early stage of development in others.
- Display of a shared learning board in clinical areas
- Lessons learned committee
- Debriefing and reflective practice sessions conducted by senior nurses

Points for consideration

Sustainable mechanisms for sharing good practice and learning within the context of improvement should be further developed.

Section 4 Practise effectively

The NMC Code of Conduct states:

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice, You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

Measurement and monitoring nurse sensitive indicators

Trusts described a wide range of forums where quality indicators are discussed, monitored and action taken as a result. Some reference the general KPIs used in other care environments such as Fallsbundle and skin bundles.

Mental health teams appear to have more specific quality initiatives that can be referenced than learning disability teams.

Mental health nursing while having a clear focus on quality indicators also reflect an emphasis on multidisciplinary forums/ groups in taking this work forward. Participation in the Mental Health Collaborative is referenced by some a positive environment in which quality can be discussed and debated.

It is notable that learning disability nurses appear from the returns to have a less compressive approach professional indicators.

Maintenance of a learning environment

The provision of a learning environment for students and registered nurses can help support the delivery of high quality care and create an environment for continuous improvement.

All wards have current Educational audits in place carried out in conjunction with Approved Educational Institutes and Practice Education teams.

Students are encouraged to submit evaluation on completion of placements, these are then monitored by the Trust education teams and actions taken if required.

Mentors are in place appropriately educated, supported and monitored.

Points for consideration

In the context of the next stage of this work consideration should be given to receiving a report for the Educational Institutions about the quality of the learning environment.

Post registration education and support seems to rely heavily on access to the Post Registration Nursing and Midwifery Budget and the ability to release staff to access support which is becoming increasingly difficult.

Points for consideration

Given the reduction in this budget this is an area of significant concern and will require further discussion.

Supervision and support

Trusts reference the policies and procedures in place and the reporting arrangements to the Chief Nursing Officer. In addition Trusts describe actions which can be taken in support of nurses such as access to shadowing opportunities, improvement plans and support from specialist and other practitioners.

Consultant Nurses are used in some Trust to facilitate nurse forums to share good practice and discuss challenges.

Trusts reference supervision arrangements for nurses who are employed as registered nursing but also the arrangements in place for those who are on the register but do not require a professional nursing qualification for their current role.

Workforce planning, service development and professional standards.

Trusts identify in their governance structures how workforce planning and service development and professional standards link. All Trusts indicate that they are involved in the Delivering Care mental health project.

The role of the consultant nurse is referenced with regard to leading workforce reviews as required. Trusts also reference a Delivering Safe Care programme in mental health services.

Other initiatives which link workforce planning and service development include, effective support to new registrants, development of new roles in nursing, rotational systems to ensure nurses get a comprehensive experience of care environments and processes in place for succession planning.

Of note was the lack of reference to CAPA (Choice and Partnership Approach) despite investment within mental health teams since 2012.

Also of note was the lack of reference to Releasing Time to Care which was launched in 2009 in all mental health in patient wards in N Ireland. This assesses and monitors how time is released by making processes more efficient for patient care, with a subsequent improvement in the safety, quality and reliability of patient care and patient experience.

Points for consideration

Further work is required to ensure that improvement initiatives, such as collaboratives or those initiatives which maximise the use of improvement science are mainstreamed into both areas of practice is required.

Appropriate delegation

Appropriate delegation of care by the registered nurse is addressed specially in the Code of Conduct where it stages a nurse is, *'accountable for your decisions to delegate tasks and duties to other people'.* As such the nurse should only delegate task and duties within the other persons scope of competence, make sure they are adequately supervised and supported and confirm the outcome.

The majority of Trusts report piloting or testing the *Deciding to Delegate: A Decision Support Framework*. This is then linked to other processes such as clinical policies and procedures and Trust guidelines and protocols.

In one Trust in mental health services team leaders and ward sisters undertake developmental management training together to maximise consistency of approach.

Section 5 Promote Professionalism and Trust

The NMC Code of conduct states: You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other healthcare professionals and the public.

Visible nursing leadership and the promotion of shared values

Executive Directors of Nursing supported by their core teams ensure visibility and shared values in a number of ways:

- Leadership walk arounds
- Annual Trust professional conferences and events.
- Cascade of Directorate minutes

Leadership visibility has both importance and limitations.

Walk arounds and visits to ward/departments can give the Executive Director of Nursing a sense of a ward culture and an impression of care, however it requires further data and analysis of care to provide assurance.

Visible leadership however can also provide confidence and support and contribute to demonstrating to staff that they are valued, through the process of engagement and listening.

Achieving the right balance between visibility, assurance and the practical realities of large and complex organisations is challenging to resolve. In all areas therefore they rely on their supporting teams and network of professional leads to model professional standards.

Points for consideration

The contribution of professional leadership in strengthening an assurance process is crucial and warrants further discussion.

Provision of information to Trust Board

Trusts have identified a variety of reports which are produced and submitted to a range of groups and committees including:

- Annual Nursing Quality Report presented to a Trust Board
- Annual Supervision Report presented to a Trust Board
- Reporting to Trust Board on professional, quality and risk issues to both confidential and public sessions.
- Proactive questions to Executive Directors of Nursing and Trust to by Trust Chairman to ensure that any issues of concern are raised.
- Presentation of KPIs and nursing updates to Trust Governance Committees

In some cases it appears no profession specific reports are presented to the public Trust Board meeting.

The purpose of HSC Trust Boards is to govern effectively and in doing so build patient, public and stakeholder confidence that their health and healthcare is in safe hands. The board has an overarching responsibility, through its leadership and oversight, to ensure and be assured that the organisation operates with openness, transparency, and candour, particularly in relation to its dealings with patients and the public.[1]

Points for consideration

[1] The Healthy NHS Board, 2013: Principles for Good Governance. Leadership Academy

While the absence of a nursing/midwifery specific report to Public Trust Board does not suggest that assurance is less effective it may be interpreted as a lack of public transparency, therefore this area should be explored further.

Section 6 - Trust reported challenges and opportunities

As part of this process Trust identified are of challenge and opportunity. These are listed below and should form part of the next stage of this work to promote debate and discussion.

Challenges - Learning Disability

- The need to train learning disability nurse sensitive to the current age profile
- Need to stabilise and augment the skills of newly graduated nurses
- Recruitment processes can be cumbersome putting pressure on staff to cover vacancies
- There are some areas where nurses feel their roles within the MDT doesn't focus purely on nursing, particularly in care management roles.
- The capacity within core nursing roles to assure adequate challenge and support to operational teams on professional issues.

One Trust return included a statement, *'our current systems and processes are meeting the challenges faced in providing professional assurances about nursing practice in learning disability services.'*

Challenges - Mental Health

- As mental health nurses work in multidisciplinary teas it is important to ensure that all staff responsible for managing nurses understand the robust mechanisms for assurance. The role of nursing development lead is important in this.
- Recruitment difficulties particularly for community mental health nurses
- Gender profile of mental health nurses has changed, there is a need to encourage more men into the profession.
- Increasing acuity of service users need presenting to mental health services.
- Funded establishment falling short of assessed.

General

- General pressures on the ability to recruit nurses due to capacity issues.

Areas of best practice that should be shared

Best practice - Learning Disability

- QNIC Accreditation
- QNLD Accreditation
- RCN (NI) Nurse of the Year Awards
- Positive Behaviour Support Plans/Person Centred Care Plans
- Appreciative Inquiry Tool
- Co-production/co-design in community day services.
- Positive work undertaken by the Health Facilitators and the nurse led clinics are undertaken by the Epilepsy Nurse Specialist. The further development of epilepsy link nurses roles would strengthen this further.
- Review of deaths of people with learning disability
- Development of an initial assessment process for learning disability nurses has facilitated better information being available meaning that decisions can be made about nursing needs quickly.
- Learning Disability governance system.
- The development of an operational policy for community learning disability teams.

Best practice - Mental Health

- Service User involvement e.g. Peer Support workers
- Senior Nurse Practitioner post
- Mental Health pilot for entry to the Open University Undergraduate Mental Health Nursing Programme.
- Development of nurse led clinics.
- Development of new non pharmacological approaches for people living with dementia e.g. Montessori Activity Programming and the CLEAR model.
- Introduction of the Johns campaign, dementia navigators and dementia champions.
- Introduction of band three staff to community teams
- Initiatives which help maintain experienced staff in mental health including MHSOP
- Clinical microsystems coaching and quality improvement initiaves.

General

- The introduction of Always events

Section 7 – Conclusion and points for consideration

This report seeks to describe the systems, professional structures, policies and procedures that are in place to provide professional assurance to the Directors of Nursing specifically related to concerns raised about mental health and learning disability nursing.

While Trusts have provided a comprehensive report of the arrangements in place and mechanisms used to support the provision of assurance there are areas where further consideration and discussion may improve both the care and treatment of patients and clients, the support to staff and the assurance to the Executive Director of Nursing, Chief Executive and Chief Nursing Officer on the quality of nursing and midwifery care.

These issues have been drafted as points for consideration to enable the Chief Nursing Officer to lead the discussion about the next best steps in this work.

Points for consideration

1. Further discussion on the capacity within the nursing and directorate teams in support of the Executive Director of Nursing is required. This is prompted by the variation in capacity and grade, the dual roles held by some post holders and the numbers of posts currently key to assurance but which do not require a nursing qualification.

2. Given the reliance on the skills of a small number of senior nurses some of which hold dual roles, further work on preparation for and support in these roles is required along with the development of a supportive communications system. This could include reflecting on how this lead role has developed within other jurisdictions and the potential impact of the HSC leadership Strategy.

3. The collaborative model should be explored further both at Trust and Regional level with the specific aim to ensure an improvement approach is taken to professional and service development building on the values of nursing.

4. Other mechanisms or sources of funding and development models should be explored to complement the post registration funding provided through the Department of Health.

5. A consistent regionally agreed ‘benchmarking’ or ‘peer review’ approach should be developed to embrace the views of patient/client, family and staff. This could potentially include the revisiting ‘Monitor’ focusing on the fundamentals of care, development of a cross Trust assurance process or a

model which builds on the RQIA methodologies or building on the investment in improvement science education and support.

6. Consideration should be given to exploring a regional approach to the development of, or strengthening of, the culture and values of nursing within a wider health and social care system. This could be supported for example by the Foundation of Nursing Studies, through Creating Caring Cultures Programme.

7. Consideration should be given to strengthening the Executive Nurse Director leadership role in delivering Strengthening the Commitment, to support the impact on front line services while strengthening links with core nursing teams.

8. A sustainable mechanism should be found to share best practice recruitment and retention initiatives.

9. Consideration should be given to the inclusion of Learning Disability Services as part of Delivering Care.

10. A better understanding of the numerous groups and processes in place to support staff in mental health and learning disability nursing would help develop a consistency of approach. This review would also enable Trusts to review how these groups and processes link into the core nursing teams.

11. The challenge in both mental health and learning disability services is that they are less focused on clinical/physical interventions and more focused on establishing a positive therapeutic relationship with a patient/client. As a result it is more challenging to develop a system by which you can measure competence in the development and impact of a therapeutic relationship. Alongside ensuring that core nursing indicators are reflected, as appropriate, in these two areas of practice further consideration should be given as to how you measure a therapeutic relationship.

12. Given the importance of the unregistered nursing support staff in the delivery of care and treatment further work needs to be completed to ensure the contribution of these staff is maximised and they are appropriately supported.

13. Clarity is required to ensure that if a registrant cannot feel they can talk about professional issues to a manager they have a professional link to go to. Learning from the current project led by Director Nursing, WHSCT will contribute to this.

14. Sustainable mechanisms for sharing good practice and learning within the context of improvement should be further developed.

15. In the context of the next stage of this work consideration should be given to receiving a report for the Educational Institutions about the quality of the learning environment.

16. Given the reduction in this budget this is an area of significant concern and will require further discussion.

17. Further work is required to ensure that improvement initiatives, such as collaboratives or those initiatives which maximise the use of improvement science are mainstreamed into both areas of practice is required.

18. The contribution of professional leadership in strengthening an assurance process is crucial and warrants further discussion.

19. While the absence of a nursing/midwifery specific report to Public Trust Board does not suggest that assurance is less effective it may be interpreted as a lack of public transparency, therefore this area should be explored further.

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Tel: 028 95 363 429

Via Email
Professor Charlotte McArdle
Chief Nursing Officer
C5.14
Castle Buildings
Stormont Estate
BELFAST
BT4 3SJ

02 February 2018

Dear Charlotte

I have attached a report in response to your letter of the 24 November 2017. This has been compiled with the full cooperation and support of the Directors of Nursing in the Trusts.

In completing this scoping exercise it is apparent that the links between mental health nursing and learning disability nursing and the wider family of nursing and midwifery needs strengthened. This is not a criticism of the current arrangements but may reflect the history of the development of these areas of practice and the increasingly complex interface between professions and services.

I also believe that some of the learning from this coping exercise, while emanating from this work on mental health nursing and learning disability nursing, will I feel, have resonance for the nursing and midwifery family, particularly in the area of assuring nursing and midwifery practice.

I have in this report identified areas for further consideration which may help define the scope of further work. I would value a meeting with you to discuss the report and take a steer from you about how best my team and I can continue to support this important initiative.

Yours sincerely

Mary Hinds

Mary Hinds
Director of Nursing, Midwifery and AHPs
Public Health Agency

CC Rodney Morton
Valerie Watts

MAHI - STM - 307 - 337

Summary of Actions – Mental Health and Learning Disability Governance Report

Points for Consideration	Actions	Update	
1. Further discussion on the capacity within the nursing and directorate teams in support of the Executive Director of Nursing is required. This is prompted by the variation in capacity and grade, the dual roles held by some post holders and the numbers of posts currently key to assurance but which do not require a nursing qualification.	Each Trust Director Nursing to confirm that they have sufficient support/processes in place to enable them to provide assurances to their Board about the quality of nursing and midwifery care or that they have an agreed plan in place to support their role. The Assurance Framework group to describe the core principles and mechanism for assessing capacity to support the Executive Director in their role.		
2. Given the reliance on the skills of a small number of senior nurses some of which hold dual roles, further work on preparation for and support in these roles is required along with the development of a supportive communications system. This could include reflecting on how this lead role has developed within other jurisdictions and the potential impact of the HSC leadership	Education Commissioning Group to commission the RCN to develop a programme for middle tier managers. (8a or equivalent). This model to be evaluated March 2019.	Programme developed in 2018/19 Monitoring of the numbers of staff from Learning disability and mental health services to be completed.	

Strategy.			
3. The collaborative model should be explored further both at Trust and Regional level with the specific aim to ensure an improvement approach is taken to professional and service development building on the values of nursing.	Should we develop as part of the NMTG an improvement strategy for nurses and midwives? We could get one of the staff who have completed the training to develop this?		
4. Other mechanisms or sources of funding and development models should be explored to complement the post registration funding provided through the Department of Health.	The PHA in partnership with Trusts to explore alternate funding for bespoke education and development initiatives to include: • Person centred care • Cultural awareness • Quality improvement science		
5. A consistent regionally agreed 'benchmarking' or 'peer review' approach should be developed to embrace the views of patient/client, family and staff. This could potentially include the revisiting 'Monitor' focusing on the fundamentals of care, development of a cross Trust assurance process	This work will be progressed through the Assurance Framework Group or is it the KPI group?? Rodney, Sandra and I were thinking should we revisit / re-establish essence of care or something like it?	Professional Assurance Group established to report to CNO by XXX	

or a model which builds on the RQIA methodologies or building on the investment in improvement science education and support.			
6. Consideration should be given to exploring a regional approach to the development of, or strengthening of, the culture and values of nursing within a wider health and social care system. This could be supported for example by the Foundation of Nursing Studies, through Creating Caring Cultures Programme.	A programme to support nurses in all care areas to understand and promote caring cultures to be established.	Health Foundation was commissioned to provide the Caring Cultures programme prioritising Learning Disability Nursing followed by mental health nursing. Programme to run 2018/19 with evaluation completed by June 2019	
7. Consideration should be given to strengthening the Executive Nurse Director leadership role in delivering strengthening the Commitment, to support the impact on front line services while strengthening links with core nursing teams.	?		
8. A sustainable mechanism should be found to share best practice recruitment and retention initiatives.	XX to conduct a review of all regional groups/forums currently established for mental health and learning disability nursing.		

9. Consideration should be given to the inclusion of Learning Disability Services as part of Delivering Care.	Learning Disability nursing to be included in the Delivering Care schedule. Develop Mental Health Senior Nurse Decision Making Model (safety and therapeutic) Develop of Senior Nurse Infrastructure Model (Clinical Leadership and Supervision)	Delivering Care Mental Health phase 5a with DOH for approval.	
10. A better understanding of the numerous groups and processes in place to support staff in mental health and learning disability nursing would help develop a consistency of approach. This review would also enable Trusts to review how these groups and processes link into the core nursing teams.	Each Trust to conduct a review of all groups/forums currently established for mental health and learning disability nursing and their linkages with corporate nursing teams. These reports are to inform the Assurance Framework Group		
11. The challenge in both mental health and learning disability services is that they are less focused on clinical/physical interventions and more focused on establishing a positive therapeutic relationship with a patient/client. As a result it is more	Is this the KPI group??		

challenging to develop a system by which you can measure competence in the development and impact of a therapeutic relationship. Alongside ensuring that core nursing indicators are reflected, as appropriate, in these two areas of practice further consideration should be given as to how you measure a therapeutic relationship.			
12. Given the importance of the unregistered nursing support staff in the delivery of care and treatment further work needs to be completed to ensure the contribution of these staff is maximised and they are appropriately supported.	Should we talk to HRD for some funds to do this? Explore options for standards - credentialing -registering Competency Profiling Development of Educational Support Programme including mentoring.		
13. Clarity is required to ensure that if a registrant cannot feel they can talk about professional issues to a manager they have a professional link to go to. Learning from the current project led by Director Nursing, WHSCT will contribute to	Directors of Nursing to confirm that they have clear robust escalation procedures in place within their Trust.		

this.			
14. Sustainable mechanisms for sharing good practice and learning within the context of improvement should be further developed.	I think this is linked to point 10		
15. In the context of the next stage of this work consideration should be given to receiving a report for the Educational Institutions about the quality of the learning environment.	Has Charlotte already asked for this?		
16. Post registration education and support seems to rely heavily on access to the Post Registration Nursing and Midwifery Budget and the ability to release staff to access support which is becoming increasingly difficult. Given the reduction in this budget this is an area of significant concern and will require further discussion.	Chair of ECG to identify the post registration education and support need.		
17. Further work is required to ensure that improvement initiatives, such	Identify and invest in Quality Improvement Training for nurses working		

as collaboratives or those initiatives which maximise the use of improvement science are mainstreamed into both areas of practice is required.	in mental health and learning disability services.		
18. The contribution of professional leadership in strengthening an assurance process is crucial and warrants further discussion.	This work will be progressed through the Assurance Framework Group.		
19. While the absence of a nursing/midwifery specific report to Public Trust Board does not suggest that assurance is less effective it may be interpreted as a lack of public transparency, therefore this area should be explored further.	This work will be progressed through the Assurance Framework Group.		

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION:	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)*	**4.** DATE OF INCIDENT: DD / MM / YYYY
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON:	**7.** PROGRAMME OF CARE: *(refer to Guidance Notes)*

8. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY *(complete where relevant)* GENDER: M / F AGE: years

9. IS THIS INCIDENT A NEVER EVENT?				If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars
YES		NO		

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: *(refer to Guidance Notes)*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES	NO	N/A

14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults)* - on other service users, - on staff or - on members of the public	

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO
if 'YES' (*full details should be submitted*):		

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: DD/MM/YY
	NO	*specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO
if 'YES' (*full details should be submitted including the date notified*):		

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

October 2014 – March 2015

June 2015

CONTENTS

SECTION 1

1.0 BACKGROUND AND INTRODUCTION

From 1 May 2010 the responsibility for the management and follow up of Serious Adverse Incidents (SAIs) transferred from Department of Health, Social Services and Public Safety (DHSSPS) to the Health and Social Care Board (HSCB) working jointly with Public Health Agency (PHA) and collaboratively with Regulation Quality Improvement Authority (RQIA). In response, the HSCB issued the Procedure for the Reporting and Follow up of SAIs (the Procedure) to all HSC organisations and Special Agencies.

During 2012/3 the HSCB, working with the PHA, undertook a review of the Procedure, issued in 2010, and issued revised guidance in September 2013 for implementation on 1 October 2013 and with full operational implementation on 1 April 2014.

2.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

The current arrangements for managing SAIs reported to the HSCB/PHA are:

- Regional reporting system for all SAIs;
- SAIs are reviewed by senior professional officers; in addition, the HSCB senior management team receives and considers all SAIs on a weekly basis;
- SAIs are allocated to a nominated professional officer, who is the Designated Review Officer (DRO) responsible for reviewing and scrutinising reports;
- SAI Review Sub Group (SAIRSG) meetings to consider reports, identify themes and learning;
- Overarching HSCB-PHA Quality Safety and Experience (QSE) Group to consider the issues identified by the SAIRSG and agree actions and assurance arrangements;
- The Safety and Quality Alerts (SQA) Team provide an assurance mechanism for any actions to be taken forward as a result of regional learning;
- Escalation if required in respect of:
  - timescales for receipt of SAI and Investigation reports
  - assurances for action being taken forward by reporting organisations following the investigation.

3.0 WORK TAKEN FORWARD IN 2014- 2015

SERVICE USER AND FAMILY INVOLVEMENT IN SAIS

The HSCB and PHA SAI procedure makes clear the need for appropriate communication and involvement of service users, relatives and carers and from 1 April 2014, all SAI Investigation reports submitted to HSCB/PHA have a Service User/Family Carer Engagement Checklist attached.

APPENDIX C provides an analysis of service user/family/carer engagement for the period 1 April 2014 to 23 February 2015 for HSC Trusts. A further update to this information will be provided in the next edition.

In addition, and in line with DHSSPS communication, the HSCB and PHA have worked with the Patient Client Council, RQIA, and Trust Governance Leads to develop guidance for HSC organisations when involving service users/families throughout the relevant stages of the SAI process (issued in February 2015).

The purpose of the guidance is to ensure that communication with service users/families/carers, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner; thereby promoting a culture that effectively leads to improved service user and staff acceptance of the event. The guidance should be read in conjunction with the revised SAI Procedure in order ensure the engagement process is closely aligned to the required timescales, documentation, investigation levels etc. A leaflet has also developed to provide information for patients/families on the process.

DRO PROFESSIONAL GROUPS

During 2014/15 a pilot exercise was undertaken in relation to the process undertaken by DROs when reviewing SAI investigation reports. The pilot involved the following Programmes of Care (POC):

- Paediatrics and Child Health
- Maternity
- Mental Health (including Prison Health)
- Acute

A number of DROs from each of the above groups have met on a monthly basis to review SAI investigation reports, in order to close and/or identify any issue that requires consideration by the SAI Review Sub Group. The DRO professional groups benefit from:

- Multi-professional input / wider circle of experience,
- Group sign off , decisions not focused on one individual
- More complete understanding of the range of SAI issues within these service areas leading to the identification of regional trends

Consideration to extending this process to other POCs will be reviewed during 2015/16.

MEETINGS WITH HSC TRUSTS

During the reporting period the Chair and Co-chair of the RSAISG conducted a round of meetings with each of the HSC Trust Governance Leads to discuss issues relating to the Procedure for the Reporting and Follow up of SAIs and the more recent inclusion of the process for engaging with service user/ family and carers.

LAY PERSONS

In line with the current Complaints Procedure, the HSCB have established and continue to maintain of a list of lay persons for use by the HSC in the resolution of complaints. During the investigation of a complaint, a layperson can be used by an HSC organisation to provide an independent perspective and can, therefore, be adopted as one of the methods where HSC organisations could achieve 'enhanced' local resolution as part of the new single tier approach.

During 2014/15, and following consultation Trust Governance leads, it was agreed the current remit of lay persons could be extended to include their involvement in the SAI review process. This would provide support to HSC organisations who are routinely involved in the review of more complex SAIs, particularly when a degree of independence is required.

A number of lay persons expressed an interest in taking forward this role and attended a training event in March 2015 which provided an overview of the SAI process and included a session from a Trust Governance lead on the role of a Layperson in a Trust SAI Review.

Training on Root Cause Analysis for lay persons is scheduled for April and May 2015, after which, Trusts and HSCB Directorate of Integrated Care (HSCB) will be notified on the process to access lay persons to participate in SAI Reviews.

TRAINING

During the reporting period, a number of regional training programmes were undertaken to support staff in the implementation of the SAI procedure:

- Regional root cause analysis training (April and May 2014)
- Lay Persons training (March 2015)

4.0 SAIs REPORTED DURING PERIOD OCT 2014 – MAR 2015

During the period 1 October 2014 to 31 March 2015, the HSCB received 366 SAI notifications. This represents a decrease on the previous six months (April 2014 – September 2014) when 434 SAIs notifications were reported to HSCB.

A breakdown of these SAIs by reporting organisation and programme of care is detailed at Appendix B.

5.0 DE-ESCALATION OF SAIs

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAIs, however, it is recognised that SAI reports can be based on limited information at the time of reporting and further investigation may identify that the incident no longer meets the criteria of a SAI.

In such instances a request can be submitted, by the reporting organization, to de-escalate the SAI, however, the decision to approve the de-escalation will be made by the HSCB/PHA Designated Review Officer.

During the reporting period six (6) SAI notifications received were de-escalated.

6.0 DUPLICATE SAI REPORTING

On occasions a notification may be received from one or more organisations relating to the same incident. In such instances, a lead organisation will be identified to take forward the investigation and follow and the duplicate notification will be closed.

During the reporting period one duplicate SAI notification was received.

SECTION 2

1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

HSCB/PHA STRUCTURE FOR LEARNING FROM SAIS

It is important that when a serious event or incident occurs, that there is a systematic process for investigating and learning from incidents. The key aim from this process is to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC as a whole.

The HSCB, working closely with the PHA, is responsible for identifying and disseminating regional learning from its monitoring role in relation to SAIs, complaints and patient client and experience.

- **Quality Safety and Experience (QSE) Group**

  The HSCB and PHA recently established a jointly chaired QSE Group to provide an overarching, streamlined approach in relation to how the HSCB and PHA meet their statutory duty of Quality. This multi-disciplinary group meet on a monthly basis to consider learning, patterns/trends, themes or areas of concern, and agree appropriate actions to be taken, from all sources of safety and quality information received by the HSCB and PHA.

  A Regional SAI Review Subgroup reports to, and supports the work of the QSE Group.

- **Safety Quality and Alerts Team (SQAT)**

  The work of the QSE group is closely aligned to SQAT, which is responsible for overseeing the implementation and assurance of Regional Learning Letters/Guidance issued by HSCB/PHA in respect of SAIs

SAI LEARNING MECHANISMS

Learning opportunities from SAIs can be identified by the reporting organisation, DROs the Regional SAI Review and QSE Sub Groups and learning can take the form of:

- Local organisation actions;

- Formal learning letter;

- Thematic Reviews: Commissioned by the Regional SAI Sub Review Group and the QSE Group, to review trends, patterns and provide an in-depth analysis. Key learning points are disseminated across the HSC;

- Learning Matters Newsletter: HSCB-PHA have developed a newsletter to ensure that local incidents are shared regionally to drive improvements for patients and services across the HSC.

- The SAI Bi-annual Learning Report provides an overview on all learning letters / thematic reviews carried out and/or reported on during the period of reporting.

2.0 DISSEMINATION OF LEARNING INITIATIVES

Learning from SAIs is a significant element to improving practice. However the HSCB and PHA are cognisant that each and every SAI has an impact on individuals and families. Therefore, whilst for the purposes of this report patient identifiable information has been removed, this is not intended to diminish the personal impact that these incidents have had on the individuals involved.

The following initiatives were identified as part of the SAI review process and relate to learning from trends, reviews and individuals cases. Some of these initiatives may relate to learning identified and reported in the previous report as part of on-going work.

2.1. MONITORING FOR TWIN-TO-TWIN TRANSFUSION SYNDROME (TTTS) – (Update from previous report)

Review of the antenatal care of some twin pregnancies has shown that:

- The mothers of these babies were not monitored during pregnancy for TTTS in line with the schedule recommended by NICE Clinical Guideline 129 'Multiple Pregnancy: the management of twin and triplet pregnancies in the antenatal period'. The NICE guideline recommends that in monochorionic twin pregnancies diagnostic monitoring with ultrasound for feto-fetal transfusion syndrome (including to identify membrane folding) should start from 16 weeks and be repeated fortnightly until 24 weeks;

- There was a lack of clarity as to whether monitoring for TTTS was done at the same time as the ultrasonographer carried out the fetal anomaly ultrasound scan at 20 weeks; or whether a separate appointment with an obstetrician should have been arranged at that time to ensure that the mother was monitored for TTTS fortnightly between 16-24 weeks in addition to having a fetal anomaly ultrasound scan;

- The respective roles and responsibilities of obstetricians and ultrasonographers for monitoring TTTS were unclear;

- Obstetric staff of varying levels of seniority were involved in monitoring for TTTS.

A Safety and Quality Learning Letter LL/SAI/2014/027 was issued on 17 June 2014 setting out transferable learning and identified the following actions for HSC Trusts:

- Development of a clear policy that sets out the local arrangements for monitoring multiple pregnancies in line with the schedule recommended by

NICE (including a fetal anomaly scan). The NICE CG 129 is available at: http://publications.nice.org.uk/multiple-pregnancy-cg129);

- The Trust policy should be developed by a multidisciplinary team, including ultrasonographers, and must make it clear whose responsibility it is to monitor for TTTS fortnightly from 16-24 weeks in monochorionic multiple pregnancies, and remove all ambiguity regarding the respective roles of obstetricians and ultrasonographers;

- Trusts should ensure that those carrying out monitoring for TTTS are appropriately trained to do so. As far as possible, there should be continuity of staff who carry out the scans. Junior doctors should not be carrying out monitoring scans in multiple pregnancies unless directly supervised by an experienced consultant as part of their training;

- Trust policy should be reviewed and updated once the regional service model/care pathway is in place.

Trusts were asked to provide a response by the 30 September 2014 that the identified learning was actioned. They were asked to confirm the following:

1. The Learning Letter is shared with obstetricians, ultrasonographers, midwives, service managers, and other relevant staff;

2. A clear policy is developed that sets out the local arrangements for monitoring multiple pregnancies in line with the schedule recommended by NICE;

HSC Trust responses have been reviewed by the Safety and Quality Alerts team and all HSC Trusts have provided satisfactory responses indicating substantive action.

2.2. PRESCRIBING AND DISPENSING INCIDENTS INVOLVING BUCCAL MIDAZOLAM PRODUCTS – (Update from previous report)

Buccal midazolam may be considered as an alternative to rectal diazepam for the treatment of prolonged seizures. Several buccal midazolam products are available, as prefilled syringes (PFS) and a multi-dose bottle, with a range of strengths and volumes, which leads to increased risk. A number of adverse incidents have been reported where patients have received the incorrect buccal midazolam product. Whilst no harm has been reported in these cases, there was potential for serious harm to occur. HSCB previously issued a Medicines Safety Alert to GPs and Community Pharmacist in June 2012 highlighting 'Actions to Minimise the Risks with Buccal Midazolam Preparations'[1].

Contributory factors to the incidents included:

- Change in buccal midazolam product prescribed

[1] http://www.medicinesgovernance.hscni.net/primary-care/medicines-safety-alerts/

- Poor communication between GP, Community Pharmacist and Trust Specialist Epilepsy Nurse/Consultant
- Lack of knowledge of the range and strengths of products available and how these are administered
- Generic prescribing, which is contrary to HSCB generic exemptions list
- Insufficient patient/carer education and counselling.

A Safety and Quality Learning Letter LL/AI/2014/028 was issued on 20 June 2014 and identified the following actions that:

HSC Trusts should:

1. Share the Learning Letter with all staff involved in recommending, prescribing or dispensing buccal midazolam products;

2. Review and as necessary, update processes for managing patients who require buccal midazolam products, taking account of the suggestions in the Transferable Learning section of the letter.

3. Review all patients currently receiving buccal midazolam to ensure the recommendations included in the learning letter are implemented.

4. Confirm by 15 September 2014 to alerts.hscb@hscni.net that actions 1 and 2 have been completed and action 3 is underway.

GP practices should:

1. Share the Learning Letter with all staff involved in recommending, prescribing or dispensing (dispensing practices only) buccal midazolam products;

2. Review and as necessary, update your processes for managing patients who require buccal midazolam products, taking account of the suggestions in the Transferable Learning section of the letter.
3. Review all patients currently receiving buccal midazolam to ensure the recommendations included in the learning letter are implemented.

Community Pharmacies should:

1. Share the Learning Letter with all staff involved in recommending, prescribing or dispensing buccal midazolam products;

2. Review and as necessary, update your processes for managing patients who require buccal midazolam products, taking account of the suggestions in the Transferable Learning section of the letter.

All HSC Trusts have confirmed that they are implementing the actions required. Further work is being taken forward regionally in relation to a pathway for epilepsy and by the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) Regional work

2.3. SYSTEMS TO CHECK THE INTEGRITY AND STERILITY OF PACKS OR INSTRUMENTS PRIOR TO USE – (Update from previous report)

Several Serious Adverse Incidents across different HSC Trusts have highlighted process failures within Sterile Services, resulting in instruments / packs being available for clinical use when they had not completed the full sterilization process.

The instruments / packs were used even though the indicator tape, which changes colour to show sterilization is complete, had NOT changed colour. Adequate processes to check the sterility of the instruments / packs prior to leaving Sterile Services and at point of use had not been implemented**.**

A Safety and Quality Learning Letter LL/SAI/2014/029 was issued on 1 October 2014 and identified transferrable learning:

HSC Trusts were asked to:

- Discuss this Learning Letter with acute and community medical and nursing staff who use sterile instruments/packs, service managers for those areas, and other relevant staff;

- Review and update their systems for checking the integrity and sterility of instruments/packs prior to use to minimize the risk of individual error.

All HSC Trust have confirmed actions are complete or processes are underway to achieve actions.

THE FOLLOWING ITEMS ARE NEW LEARNING ISSUED SINCE LAST REPORT

2.4. EMERGENCY CALL ARRANGEMENTS IN OBSTETRIC UNITS

Two serious adverse incidents involving neonatal deaths have highlighted the need for Trusts to ensure that they have robust arrangements to summon the appropriate staff to be present at delivery in a timely way.

In one case, the Trust's investigation report highlighted that on-site staff were bleeped individually to attend the emergency incident at delivery. The investigating team recommended that to ensure there are no delays in accessing appropriate staff; consideration should be given to a baton bleep emergency system to include all team members necessary for the delivery and resuscitation of the mother and baby.

In the other case, there was a delay in calling the paediatric registrar to a preterm baby who required neonatal resuscitation after delivery. The bleep system was not used to contact the paediatric registrar, but rather, a verbal message was conveyed to the registrar who was working on a ward. The investigating team recommended that consideration is given to the grade of paediatric staff called in emergencies, particularly when there are known risk factors.

A Safety and Quality Learning Letter LL/SAI/2015/030 was issued on 12 January 2015 setting out the following transferrable learning for Trust Service Directors responsible for Maternity Services:

- In an emergency situation at delivery in an obstetric unit, all relevant members of staff should be called through the equivalent of the 'crash-call' system in cardiology services (sometimes referred to as a 'baton system'). A baton system simultaneously calls all team members necessary for the delivery and resuscitation of the baby/mother rather than bleeping or ringing individual members of staff to attend.

- In cases where it is anticipated in advance that neonatal resuscitation is likely to be required after delivery, an appropriately senior member of the neonatal/paediatric team should be called to attend as soon as it is apparent that delivery is imminent.

The reminder of best practice guidance letter identified the following actions for HSC Trusts:

- Share this Learning Letter with relevant staff;
- Take account of this Learning Letter and ensure that emergency-call arrangements in maternity units in your Trust are:
  - The functional equivalent of a crash-call system
  - Explained to new and existing staff
  - Tested/rehearsed regularly;

NIMDTA were asked to action the following:

- Disseminate this letter to doctors in training in relevant specialties.

HSC Trusts were asked to provide a response by 27 February 2015 to confirm actions have been completed. All HSC Trusts have confirmed actions are complete.

2.5. DISCHARGE PLANNING AND RECORDING LEGAL STATUS UNDER THE MENTAL HEALTH ORDER - Reminder of best practice

This incident related to the discharge of a patient detained under the Mental Health legislation. Trust findings emphasized the importance of discharge planning in respect of all young people admitted to mental health inpatient provision which should commence at the time of admission as required under Trusts' current Admission and Discharge Protocol & Procedures for mental health services (CAMHS & AMHS).

The incident also highlighted the need to ensure that care plans are documented fully, and reasons for decisions (including any revisions to the care plan and changes in legal status under the mental health legislation) recorded clearly in keeping with best practice and current protocol and procedures.

A Safety and Quality Best Practice Reminder letter SQR/SAI/2015/001, was issued on 14 January, highlighting the following requirements under current guidance:

For care professionals working in mental health services:

- You are responsible for documenting your assessment of a patient and the rationale for your care decisions including those relating to a patient's legal status under mental health legislation.

For HSC Trust Directors of Mental Health Services:

- Trusts are reminded to ensure that:
  - Current admission and discharge protocols and procedures are adhered to and any updates or revisions are highlighted and discussed at staff meetings, and circulated to all relevant staff
  - File records should be audited quarterly to ensure compliance with requirements to document mental health status and the reasons for any changes fully and clearly. The audit results should be communicated to all staff.

The reminder of best practice guidance letter identified the following actions for

HSC Trusts:

- Please share this reminder letter with all relevant staff, including discussing it in appropriate team meetings and professional forums;
- Please review and as necessary, update relevant training and procedures to incorporate requirements in this letter.
- Ensure file audits are conducted quarterly to quality assure practice against the issues highlighted in this letter.

NIMDTA was asked to action the following:

- Please disseminate this reminder letter to doctors in training in relevant specialties.

Director of Integrated Care, HSCB was asked to action the following:

- Please disseminate this reminder letter to all General Practitioners.

RQIA was asked to action the following:

- Please disseminate this reminder letter to all relevant Independent Sector providers.

HSC Trusts were asked to confirm by 28 February 2015, that actions 1-2 have been completed, and that the date of the last quarterly audit, or the date the next audit will begin. All HSC Trusts confirmed they have completed the required actions.

2.6. AVOIDANCE, RECGONITION AND MANAGEMENT OF ANAPHYLAXIS Reminder of best practice

A pregnant woman was prescribed intravenous co-amoxiclav even though the patient was known to have an allergy to penicillin and she was wearing an alert wristband. A midwife questioned the decision to prescribe co-amoxiclav in light of the known allergy, but was instructed to go ahead and administer the co-amoxiclav. The patient developed an anaphylactic reaction which was not immediately recognised. She eventually recovered after several days in ICU.
The Trust's investigation report also found that the Trust did not have a protocol for the management of anaphylaxis in the hospital setting.

A Safety and Quality Best Practice Reminder letter SQR/SAI/2015/002, was issued on 3 February 2015, highlighting the following requirements under current guidance:

For medical midwifery, nursing, pharmacy and equivalent staff in primary care:

- If you feel that a patient is being put at risk by another member of staff, and you remain concerned after speaking to that staff member, you should contact a more senior member of the team or organisation.

- Regarding this specific incident, you should not supply or administer medication to a patient who is known to be allergic to that medication.

- You should be prepared to listen to colleagues who question your treatment decisions, and reconsider them, as necessary – to err is human and it may protect you and your patients.

For Trust Service Directors responsible for any health care staff involved in prescribing, supplying or administering medication

- Trusts should have an open organisational culture which emphasizes the safety benefits of teamwork and encourages staff to give and accept respectful challenge, particularly of decisions of more senior staff. Staff should feel able to escalate concerns to a more senior member of staff when necessary.

- Trusts should have a protocol for the management of anaphylaxis in both hospital and community settings, and should ensure that staff have immediate access to the protocol. Suitable algorithms for the management of anaphylaxis are available from many bodies including the UK Resuscitation Council, Royal College of Physicians (London) and the Association of Anaesthetists of Great Britain &Ireland.

- Trusts should ensure that all staff have up-to-date training in the identification and management of anaphylaxis.

The reminder of best practice guidance letter identified the following actions that:

HSC Trusts should:

1. Share this letter with relevant staff, and discuss it at team meetings/safety briefings;

2. Ensure that you have a protocol for anaphylaxis in both hospital and community settings and that staff have immediate access to the protocol;

3. Ensure that all staff are provided with regular update training in the management and treatment of anaphylaxis.

HSC Trusts were asked to confirm by 13 April 2015, that actions 1-2 have been completed, and that training under action 3 is available. An update will be provided in the next report.

Director of Integrated Care, HSCB should:

- Disseminate this letter to GPs, dentists and community pharmacists.

NIMDTA should:

- Disseminate this letter to doctors in training in relevant specialties.

RQIA should:

- Disseminate this letter to relevant Independent Sector Providers.

2.7. RESIDUAL ANAESTHETIC DRUGS IN CANNULAE AND INTRAVENOUS LINES – Reminder of best practice

A woman who had an emergency caesarean section under general anaesthetic experienced a sudden respiratory arrest two hours later. The patient had 3 intravenous lines in place, two of which had 'octopus' (2 line) extensions. The respiratory arrest occurred minutes after intravenous fluids were started on one of the lines. The likely cause was that a residual amount of muscle relaxant drug, present in the line, had been administered inadvertently to the patient when intravenous fluids were run through on that line, causing muscle paralysis.
A neuromuscular blocking reversal agent was administered and the patient recovered quickly.

The staff, who were involved in this case, are to be commended for their prompt recognition of the cause of the respiratory arrest and taking the appropriate action.

A Safety and Quality Best Practice Reminder letter SQR/SAI/2015/003, was issued on 13 March 2015, highlighting the following requirements under current guidance:

On 24 July 2014, a Patient Safety Alert from NHS England (NHS/PSA/W/2014/008 attached) was issued to Trusts, RQIA and NIMDTA for dissemination to relevant staff.
This local case reinforces the need to implement the actions set out in the Patient Safety Alert.

For anaesthetists and all other theatre and recovery staff

- For each patient under your care, you need to ensure that all cannulae and extensions have been flushed through with saline, or another solution that does not contain anaesthetic drugs, before the patient leaves recovery or the department where the procedure/investigation was undertaken.

- You also need to ensure that any intravenous lines or extensions that are no longer required are removed before the patient leaves your care.

For Directors with responsibility for anaesthetic/theatre services

- You must have robust systems in your Trust that help staff to ensure that before the patient leaves recovery or the department where the procedure/investigation was undertaken:
    - All cannulae and extensions have been flushed through with saline, or another solution that does not contain anaesthetic drugs, and
    - Any intravenous lines or extensions that are no longer required are removed.

You should consider using the post-operative 'sign out' section of the WHO surgical safety checklist as part of your system.

The reminder of best practice guidance letter identified the following actions that:

HSC Trusts should:

- Share this Reminder of Best Practice Letter and attached Patient Safety Alert with all relevant staff;

- Review and as necessary, update your Trust's systems in light of the information in the Requirements under Current Guidance section;

Trusts were asked to confirm by 29 May 2015, that the actions above have been completed. An update will be provided in the next report.

NIMDTA should:

- Disseminate this letter to doctors in training in relevant specialties.

RQIA should:

- Disseminate this letter to relevant Independent Sector Providers.

2.8. REDUCED FETAL MOVEMENTS - Reminder of best practice

A woman who was 35 weeks pregnant attended a GP out-of-hours service as she was concerned she had not felt fetal movements for the previous 36 hours. The GP listened to the fetal heart with a sonicaid, reassured the mother, and she went home. The next day she contacted the maternity ward as she still felt no fetal movement. She was asked to attend the maternity unit immediately and an intrauterine death (stillbirth) was diagnosed.

In another case, a pregnant woman who was past her due date contacted the maternity assessment unit on two successive days with concern about reduced fetal movements. She was given telephone advice by a midwife on each occasion. There was no access to the patient's records during the telephone consultations, a full risk assessment was not performed and details of the advice given were not documented. During the first telephone contact the woman was asked to count fetal movements over a period of time, but despite having a lower than expected number of fetal movements, she was given inappropriate reassurance. On the second occasion the midwife was unaware that the mother had contacted the assessment unit the previous day, and the mother was again advised to count fetal movements over a period of time. The mother reported feeling no fetal movements and was asked to attend the hospital where an intrauterine death (stillbirth) was diagnosed.

A Safety and Quality Best Practice Reminder letter SQR/SAI/2015/004, was issued on 16 March 2015, highlighting the following requirements under current guidance:

The Royal College of Obstetricians & Gynaecologists has produced good practice guidance on reduced fetal movements. This is available at:

https://www.rcog.org.uk/en/guidelines-research services/guidelines/gtg57

Key points from the RCOG guidance will be incorporated to the Pregnancy Book and the next version of the Maternity Hand Held Record.

A patient information leaflet is also available at:

https://www.rcog.org.uk/en/patients/patient-leaflets/your-babys-movements-in-pregnancy

For general practitioners, community midwives, practice nurses and GP out of hours services

- If a pregnant woman contacts you with concern about fetal movements you should refer her to a maternity unit without delay.

For Emergency Department staff

- If a pregnant woman has concern about fetal movements you should contact the maternity team and arrange for them to assess her without delay.

For midwifery and obstetric staff

- In line with the RCOG guidance, you should advise women of the need to be aware of fetal movements up to and including the onset of labour, and you should tell them to contact their maternity unit without delay if they notice any decrease or cessation of fetal movements.

- You should follow the RCOG guideline on the risk assessment, investigation and management of women who have reduced fetal movements.

- You should ensure that you have sufficient information on the mother's history to make an informed judgment on the appropriate course of action.

- You should clearly document your assessment and management decisions.

For Trust Maternity Service Directors

- You should ensure that robust arrangements are in place in your Trust so that women with concerns about fetal movements are assessed appropriately.

The reminder of best practice guidance letter identified the following actions that:

HSC Trusts should:

1. Share this Reminder of Best Practice Letter with relevant staff.

2. Review and as necessary, revise your Trust's protocols to ensure that they are in line with the RCOG guideline on reduced fetal movements.

3. Send your local GPs and GP out of hours services details of how to refer women for assessment of reduced fetal movements, including the relevant contact telephone numbers.

4. Have in place an agreed referral pathway from ED to the maternity service. Ensure ED and maternity staff know that pathway, including how to access the relevant contact telephone numbers.

5. Review telephone triage protocols within maternity units to ensure that the relevant history is obtained from women who contact the unit with concern about fetal movements, and the appropriate advice is given, in line with the RCOG guideline.

6. Put in place a system for recording previous contacts/attendances at maternity assessment (day obstetric) units and ensure that this information is readily available to relevant staff.

Trusts were asked to confirm by 17 July 2015, that all actions above have been completed. An update will be provided in the next report.

OTHER LEARNING INITIATIVES TAKEN FORWARD

There are a range of other initiatives across the HSC where learning from SAIs changes practice to reduce the risk of recurrence. There has been a range of learning communications issued to family practitioner services relating to:

- Adverse incidents involving Rivaroxaban dosing
- Security of prescription pads
- Newer Oral Anticoagulant dosing
- Transdermal Fentanyl Patches

The following is a link to the Medicines Governance Website where these resources are available: http://www.medicinesgovernance.hscni.net/primary-care/medicines-safety-advice-letters/

Other examples of learning include:

Establishment of a Multi-agency Regional Practice Network - following Learning relating to a SAI involving a young female, with Portuguese citizenship, who came to the attention of Social Services following a referral from health professionals. The young person subsequently disappeared and was located in Wales.

Learning emerging from the SAI included the need for timely age assessment, active and robust information sharing between PSNI and other lead agencies throughout case management, escalation of any concerns about the effectiveness of multi-agency working and information sharing, analysis of the legal powers available to Trusts where a separated young person refuses a voluntary care arrangement and the inclusion of separated children within the revision of the Runaway and Missing from Home or Care Guidance.

To support the integration of learning to practice a regional practice learning network has been established comprising of representation from PSNI, Border Force, UKVI, VOYPIC, Trusts, RESWS, DHSSPS and HSCB to provide a vehicle for sharing learning and harnessing collaborative multi-agency working.

Regional Healthcare Associated Infection (HCAI) Forum - following learning from a SAI where a patient who had Carbapenemase Producing Organism (CPO) isolated, substantial regional work was carried out. The guidance, case summary and risk assessment relating to CPO was highlighted at a recent HCAI Learning Event.

In addition the Chief Medical Officer (CMO) issued a Carbapenemase Producing Enterobacteriaceae (CPE) Tool kit for Acute Trusts HSS(MD)11/2914. The PHA currently maintain a core dataset for CPE cases, reported through the Health Protection Duty Room, as part of routine case assessment and risk management.

SECTION 3

NEXT STEPS

1.0 REVIEW OF COMPLAINTS AND SAIs REPORTED IN RELATION TO CARE AND TREATMENT OF OLDER PEOPLE

Following a thematic review of SAIs and complaints relating to the care and treatment of older people, a workshop was held on 17 May 2013 to agree actions in response to regional learning identified. *(An Older Person is defined as someone 65 years and over).*

The workshop was attended by lead clinicians and managers of older people services across Northern Ireland. Expert speakers from across health and social care N.I., as well as other agencies interfacing with older peoples services, led the discussions and action planning.

An action plan was developed, to ensure that learning from this review and the workshop is used to inform the improvement of services for older people by identifying existing streams of work or establishing where a new focus of work is required. A report giving an overview of both pieces of work has been finalised and issued to relevant parties.

Five main themes were identified and as a result, the action plan outlines on-going work streams in which the themes will be addressed and will be taken account of in future work.

2.0 THEMATIC REVIEWS

Thematic Reviews are commissioned by the HSCB/PHA Quality Safety and Experience (QSE) Group, to review trends and patterns. These in-depth reviews ensure that local patterns are considered within the regional and national context and ensuing recommendations and key learning points are disseminated across the HSC.

Following an in-depth review of SAI reports, the following thematic reviews were undertaken:

- ***PATIENT MIS-IDENTIFICATION IN HOSPITALS***

‘Misidentification of Patients/ Clients’ in HSC services was identified as a theme through SAI analysis, following several reported incidents. The aim of this thematic review was to identify recurrent themes found within reported SAIs and to consider any regional actions that could be implemented to reduce the incidence of “Misidentification of Patients and Clients”.

This review has been finalised and will be issued in the coming weeks to the HSC along with the regional poster (designed in partnership with the five HSC Trusts) for display throughout Trust wards and departments to raise staff awareness of the importance of patient verification processes at every stage of care.

3.0 NEWSLETTER – "LEARNING MATTERS"

An essential element of improving services is the dissemination of information and a variety of methods are used to ensure learning is shared such as learning letters, alerts and reports. In addition the PHA/HSCB has developed a newsletter to compliment the other methods and to provide a forum where local learning from SAIs, reviews and complaints can be shared regionally.

Learning Matters Newsletter provides a new method of sharing learning relating to serious adverse incidents, complaints, reviews and patient experience across Northern Ireland. The **third edition was issued in December 2014** and covers the following topics:

- Avoiding Computer Confusion: Log In, Check And Log Out.
- National Patient Safety Alerts
- Masking Challenging Behaviours
- Share to Learn: Lesson of the Week
- Wrong Site/Wrong Procedure

This edition of the newsletter can be viewed at:

http://www.hscboard.hscni.net/publications/Learning%20Matters/08%20Learning_Matters_Issue_3-December_2014.pdf#search="learning matters"

http://www.publichealth.hscni.net/sites/default/files/Issue%203%20final.pdf

The Learning Matters Newsletter editorial team are currently developing a **'Special Maternity Edition'** of the Learning Matters Newsletter and will cover the following topics:

- Care of pregnant women who have had a previous caesarean section
- Antenatal fetal growth monitoring
- Maternity Early Warning Scores
- Operative vaginal delivery
- Human Factors

This special edition of the newsletter will be issued in the coming weeks.

4.0 SAI LEARNING EVENT

The HSC Safety Forum will be hosting a Regional SAI Learning Workshop on the 14 April 2015 at Mossley Mill, Newtownabbey.

The aim of the event is to provide an opportunity to share learning from Serious Adverse Incidents regionally. To facilitate this, HSC Trusts have agreed to present a number of case studies for discussion and a relative of a patient involved in a SAI will share their experience of the process and the impact it had on their family.

5.0 IMPACT OF DONALDSON REPORT RECOMMENDATIONS

A number of recommendations contained within the Donaldson Report 'The Right Time, The Right Place' refer to the current system of incident reporting and some that are specific to the current SAI process.

Following its publication, the Department launched a consultation on 24 February 2015. The HSCB/PHA are preparing a response to the consultation questionnaire which will be approved by HSCB Board prior to submission to DHSSPS on 22 May 2015.

SECTION 4

CONCLUSION

The HSCB and PHA want patients, carers and their families to feel confident about the quality and safety of health and social care services in Northern Ireland. There is a continued commitment to learn from SAIs, to improve services and to reduce the risks of recurrence, both within the reporting organisations and across the HSC as a whole. The dissemination of learning following SAIs and ensuring that quality improvements are embedded into practice remains a key priority for the HSCB/PHA.

To support this, the Safety Forum is hosting a workshop in April 2015 which will provide an opportunity to share the learning from SAIs and to gain the patient/family experience by listening to a relative of a patient involved in an SAI and the impact it had on their lives.

This report demonstrates actions planned and achieved in the period from October 2014 – March 2015. It also highlights the broad range of work that is routinely undertaken and reaffirms our commitment to safety, effectiveness and patient and client focus.

Since the last report, five learning letters/reminders of best practice have been disseminated to the relevant HSC organisations. Additionally the "Learning Matters" newsletter was published in December 2014, to compliment the other methods of learning and to provide a forum where local learning from SAIs, reviews and complaints can be shared regionally.

HSCB/PHA has continued to work with HSC Trust Colleagues in relation to enhancing service users/families involvement in the SAI process.

Quality, Safety and Patient Experience are a significant focus for the HSCB and PHA and both organisations will work in partnership with the HSC to improve the quality of care by learning from incidents and improving standards regionally.

APPENDIX A

REVISED CRITERIA FROM 1 OCTOBER 2013

DEFINITION OF AN ADVERSE INCIDENT AND SAI CRITERIA

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'.[2] arising during the course of the business of a HSC organisation / Special Agency or commissioned service

The following criteria will determine whether or not an adverse incident constitutes a SAI.

SAI criteria

- serious injury to, or the unexpected/unexplained death of:
  - a service user (including those events which should be reviewed through a significant event audit)
  - a staff member in the course of their work
  - a member of the public whilst visiting a HSC facility;

- any death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register;

- unexpected serious risk to a service user and/or staff member and/or member of the public;

- unexpected or significant threat to provide service and/or maintain business continuity;

- serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

- serious self-harm or serious assault *(including homicide and sexual assaults*)
  - on other service users,
  - on staff or
  - on members of the public

  by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS,*

[2] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

- suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

- serious incidents of public interest or concern relating to:
    - any of the criteria above
    - theft, fraud, information breaches or data losses
    - a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

APPENDIX B

ANALYSIS OF SAI ACTIVITY OCTOBER 2014 – MARCH 2015

The HSCB has **received 366 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[3] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Table 1 below provides an overview of all SAIs reported by organisation and includes **year on year comparison** of activity for the same **reporting period 1 October 2014 to 31 March 2015.**

Total Activity	Oct 13 - Mar 14	Oct 14 – Mar 15
BHSCT	70	84
BSO	0	2
HSCB	0	1
NHSCT	98	71
NIAS	1	2
NIBTS	1	0
PCARE	14	13
PHA	0	1
SEHSCT	38	59
SHSCT	47	86
WHSCT	31	47
Totals:	**300**	**366**

SAI DE-ESCALATION

SAI reports submitted can be based on limited information at the time of reporting. If on further investigation the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate.

In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation provides information on why the incident does not warrant further investigation under the SAI process. This information is considered by the HSCB/PHA Designated Review Officer prior to approving any de-escalation. During the reporting period **six (6) SAI notifications** received were subsequently **de-escalated**.

TOTAL DE-ESCALATED	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	4	0
NHSCT	3	3
PCARE	0	2
SEHSCT	2	0
SHSCT	1	0
WHSCT	0	1
Totals:	**10**	**6**

[3] Source- HSCB DATIX Information System

DUPLICATE SAI NOTIFICATIONS

A notification may be received from one or more organisation but relating to the same incident. During the reporting period there was one duplicate notification received.

TOTAL DUPLICATE	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	0	1
Totals:	0	1

SAI ANALYSIS BY PROGRAMME OF CARE

SAIs are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

De-escalated and duplicate SAI notifications have been **excluded** from the analysis in the remainder of this report.

ACUTE SERVICES

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	17	23
NHSCT	36	18
NIAS	1	2
NIBTS	1	0
SEHSCT	7	16
SHSCT	7	26
WHSCT	8	14
Totals:	**77**	**99**

Current period: Ninety nine (99) SAIs were reported. The top five groups related to the following classifications/categories. Twenty-two (22) incidents being the most reported in any one category.

Classification/category

- Diagnosis failed or delayed
- Treatment, procedure
- Accident that may result in personal injury
- Implementation of care or on-going monitoring/review
- Medication

Since the revised SAI criteria (see Appendix A) were introduced (October 2013), there has been an increase in the number of reported incidents relating to falls; within the above classification/ catergory: accident that may result in personal injury, 15% of the reported SAIs (n=15) for this programme of care relate to slip, trips, falls and collisions in an acute setting.

MATERNITY & CHILD HEALTH

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	37	40
HSCB	0	1
NHSCT	8	6
SEHSCT	8	10
SHSCT	12	14
WHSCT	7	16
Totals:	**72**	**87**

Current period: Eighty seven (87) SAIs relating to maternity and child health were reported. The revised criteria (Appendix A) included an additional requirement to report 'any death of a child in receipt of HSC services (up to eighteenth birthday)'. 84% of the reported SAIs (n=73) for this programme of care relate to HSC Child Death Notifications.

FAMILY & CHILD CARE

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	3	3
NHSCT	4	8
SEHSCT	5	5
SHSCT	1	1
WHSCT	0	2
Totals:	**13**	**19**

Current period: Nineteen (19) SAIs relating to family and childcare were reported. The largest classification/category group (n=14) related to 'Abusive, violent, disruptive or self-harming behaviour'.

OLDER PEOPLE SERVICES

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	0	0
NHSCT	22	18
SEHSCT	3	1
SHSCT	12	32
WHSCT	2	4
Totals:	**39**	**55**

Current period: Fifty five (55) SAIs reported related to older people services. The largest classification/category group (n=44) related to slips, trips, falls and collisions.

MENTAL HEALTH

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	8	11
NHSCT	17	13
PHA	0	1
SEHSCT	10	26
SHSCT	13	12
WHSCT	10	9
Totals:	**58**	**72**

Current period: Seventy two (72) SAIs relating to adult mental health services were reported. 63% (n=46) related to suspected / attempted suicides* or unexpected deaths.

**Suspected suicide – suicide (completed) whether suspected or proven. It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.*

LEARNING DISABILITY SERVICES

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	0	4
NHSCT	4	2
SEHSCT	2	0
SHSCT	0	0
WHSCT	1	0
Totals:	**7**	**6**

Current period: Six (6) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	0	0
NHSCT	1	0
SEHSCT	0	0
Totals:	**1**	**0**

Current period: No incidents relating to physical disability and sensory impairment services were reported.

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
PCARE	14	11
Totals:	**14**	**11**

Current period: Eleven (11) SAIs relating to Primary Health and Adult Community were reported. The largest classification/category group (n=7) was 'Medication'.

CORPORATE BUSINESS

ORGANISATION	Oct 13 - Mar 14	Oct 14 - Mar 15
BHSCT	1	2
BSO	0	2
NHSCT	3	3
SEHSCT	1	1
SHSCT	1	1
WHSCT	3	1
Totals:	**9**	**10**

Current period: Ten (10) SAIs were reported relating to corporate business. The largest classification/category group (n=3) related to 'Consent, Confidentiality or Communication'.

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents

APPENDIX C

Analysis of Checklist received 1 April 2014 to 23 February 2015

Table 1 a- Analysis of Engagement with patient /family/carer	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**61**	**100%**	**167**	**100%**	**80**	**100%**	**88**	**100%**	**78**	**100%**	**474**	**100%**
Patient / Service User / Family Notified not informed incident was being investigated as an SAI	6	9.8%	6	4%	10	12.5%	5	5.7%	13	16.7%	**40**	8.4%
Patient / Service User / Family informed incident was being investigated as an SAI	55	90.2%	161	96%	70	87.5%	83	94.3%	65	83.3%	**434**	91.6%

Table 1b - Analysis of Rationale for patient /family/carer not informed that incident was being investigated as an SAI	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		TOTAL	
Not Informed	**6**	**100%**	**6**	**100%**	**10**	**100%**	**5**	**100%**	**13**	**100%**	**40**	**100%**
No Contact details or NOK	1	16.7%	3	50.0%	3	30.0%	1	20.0%	1	7.7%	**9**	22.5%
Not applicable	3	50.0%	1	16.7%	1	10.0%	0	0.0%	1	7.7%	**6**	15.0%
Other rationale provided	2	33.3%	1	16.7%	6	60.0%	4	80.0%	11	84.6%	**24**	60.0%
Declined involvement	0	0.0%	1	16.7%	0	0.0%	0	0.0%	0	0.0%	**1**	2.5%

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Table 2 - Analysis of Investigation Reports shared/not shared	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		Total	
Checklists received	**61**	**100%**	**167**	**100%**	**80**	**100%**	**88**	**100%**	**78**	**100%**	**474**	100%
Investigation Report shared	32	52.5%	121	72.5%	33	41.3%	70	79.5%	32	41.0%	**288**	60.8%
Report not shared	29	47.5%	46	27.5%	47	58.8%	18	20.5%	46	59.0%	**186**	39.2%

Table 2b - Analysis of Investigation Reports not shared	BHSCT		NHSCT		SEHSCT		SHSCT		WHSCT		Total	
Report not shared	**29**	**100%**	**46**	**100%**	**47**	**100%**	**18**	**100%**	**46**	**100%**	**186**	**100%**
Plan to share report	4	13.8%	8	17.4%	9	19.1%	2	11.1%	9	19.6%	**32**	17.2%
Withdrew from process prior to finalisation of report	6	20.7%	10	21.7%	4	8.5%	0	0.0%	4	8.7%	**24**	12.9%
Declined report	3	10.3%	2	4.3%	14	29.8%	0	0.0%	3	6.5%	**22**	11.8%
No response to correspondence	3	10.3%	16	34.8%	5	10.6%	6	33.3%	13	28.3%	**43**	23.1%
Other rationale provided	11	37.9%	6	13.0%	10	21.3%	9	50.0%	15	32.6%	**51**	27.4%
No rationale provided	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	2.2%	**1**	0.5%
No contact details or NOK	2	6.9%	3	6.5%	5	10.6%	1	5.6%	1	2.2%	**12**	6.5%
Not applicable	0	0.0%	1	2.2%	0	0.0%	0	0.0%	0	0.0%	**1**	0.5%

Health and Social Care Board and Public Health Agency

Annual Quality Report 2017/18

HSC Health and Social Care Board

HSC Public Health Agency

QUALITY 2020

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Foreword

I am very pleased to present the fifth Annual Quality Report of the Health and Social Care Board (HSCB) and Public Health Agency (PHA).

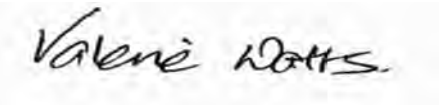
This report highlights a variety of work that has taken place over the last year, demonstrating our firm commitment to driving improvements in safety, outcomes, access, efficiency and patient satisfaction. While it is impossible to include information about every service the HSCB and PHA provide, nevertheless it is my hope that this report goes some way to reassure our patients, clients and the public of our commitment to continuous improvement and delivering high quality treatment and care.

During 2017/18 there was an important focus on quality improvement and improving outcomes for patients/clients within each of our directorates. I am particularly pleased to note the range of improvements which have been implemented as a result of, for example, the Dementia Together NI project. With the extensive public information campaign #STILL ME, the delivery of a range of training and education programmes and the recruitment of dementia champions and navigators across the HSC, the project has far exceeded all expectations.

Regionally, we have seen continuous progress in the management of clinical networks and I am delighted to share the work of the imaging services accreditation scheme, which, through the modernising radiology clinical network, has been commended as an exemplar model for collaborative working. Similarly, measuring improvement has remained an key area of focus and last year we continued to provide support to HSC Trusts and other HSC bodies on a range of key quality improvement priorities, which collectively resulted in, for example, a reduction in moderate to major/ catastrophic falls across the region.

Our commitment to the co-production of services has been evident through the various improvements implemented as a result of 10,000 More Voices and the continuous growth of recovery colleges across the region. Similarly, through the integration of care we have seen a range of transformed and enhanced services being delivered, +exhibiting strong inter-professional communication links between both primary and secondary care.

Finally, I would like to thank all the staff for their continuing efforts over the past year and I am particularly proud of what we have achieved together. As the HSC continues to face financial and operational pressures, the HSCB/PHA will focus on continually improving quality of care for people using their services and to put our patients, clients and staff at the heart of everything we do.



Transforming the culture

361

Serious Adverse Incident Reviews Completed

Regional learning methods approved:

- **12** reminder of best practice guidance letters
- **8** professional letters
- **42** newsletter articles
- **56** specialist group referrals
- **9** featured at the regional SAI learning event
- **2** thematic reviews commissioned

5 **Recovery Colleges fully operational**

Top 3 categories of complaints

1. Quality of treatment & care
2. Staff attitude & behaviour
3. Communication /information

10,000 TEN THOUSAND MORE VOICES

2,422 Stories Collected

Overall Total **12,720**

Strengthening the workforce

HSC staff...

32% trained at level 1 of the **Q2020 Attributes Framework**

2,826 trained in the use of the **Delirium Assessment & Management Tool**

Personal and Public Involvement (PPI)

23% completed the Engage & Involve PPI Training Programme

The Q Community in NI up to **123 members**

Q is an initiative which connects people who have quality improvement expertise across the United Kingdom

Roll out of Project ECHO®

in 30 clinical areas

Project ECHO is a tele-monitoring programme designed to address the growing demand for secondary care services

Measuring improvements

Regional Quality Improvement Plan priority areas focused on:

- **Pressure ulcer prevention**
- **Falls prevention**
- **National Early Warning Scores**
- **Mixed gender accommodation**

59 **Technology Appraisals issued**

Continued monitoring the implementation of

170 **Clinical Guidelines**

Raising the standards MAHI - STM - 307 - 383

Regional Clinical Networks implemented to achieve regional consistency in care & drive quality improvement, including:

- Critical Care Network
- Neonatal Network
- Cancer Network
- Pathology Network
- Diabetes Network
- Stroke Network
- Paediatric Network
- Trauma Network
- Radiology Network
- Pain Forum Network
- Lymphoedema Network

Development of 'Quality Improvement Collaboratives', including:

- Maternity collaborative
- Sepsis collaborative
- Mental Health collaborative
- Paediatric Collaborative

8 antenatal, newborn & adult screening programmes commissioned & quality assured:

1. Antenatal infection
2. Newborn blood spot
3. Newborn hearing
4. Abdominal Aortic Aneurysm
5. Bowel cancer
6. Breast cancer
7. Cervical cancer
8. Diabetic eye

1,407 downloads of the Learning Disability Hospital Passport from the PHA website

6,000 Learning Disability Hospital Passports & guidance notes distributed

69%

As a result of the **Developing Eyecare Partnership** 69% fewer patients were referred for suspect ocular hypertension

Mental Health 1+1 Project

Project launched with 3 bi-lingual staff - 4-year pilot programme supporting the **mental health & wellbeing needs of Black & Minority Ethnic communities**

Integrating the care

A-Z Health Conditions

The A-Z Health Conditions Platform was developed providing a suite of health information, supporting people to make decisions in relation to their personal illness & chronic conditions

3,464 key information summaries successfully completed by GPs enabling important accurate information to be quickly identified in an unscheduled care setting

26% increase

26% increase in Health Service patients receiving specialist oral surgery care within primary care compared to the previous year, as a direct result of the Oral Surgery Personal Dental Services Pilot

3,656 patients O_2

In April 2018, **3,656 patients** received a home oxygen concentrator via the home oxygen service

22% increase

22% increase in the number of children whose language development was age appropriate, as a direct result of the supporting speech, language & communication programme in Sure Start

Contents

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Theme one

Transforming the culture

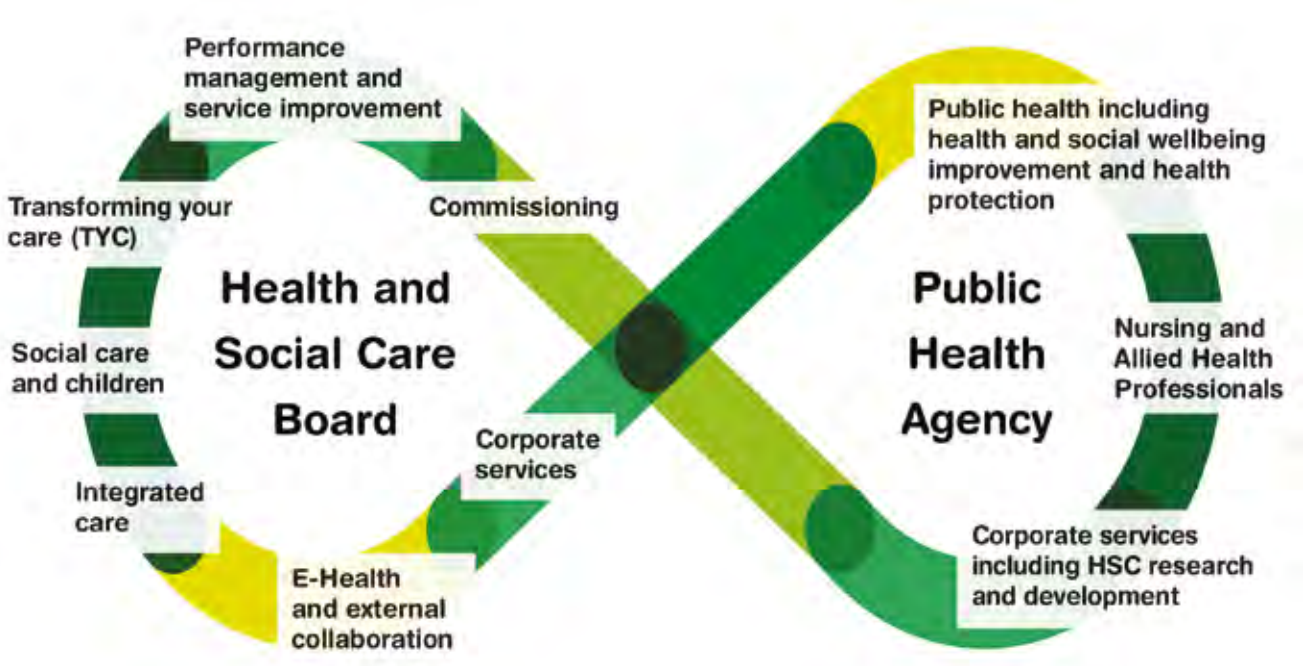
Transforming the culture

1.1 Introduction

The HSCB and PHA both recognise that for the quality of care and services to be of the highest standard, the culture of an organisation must be open, honest, transparent and, in particular, patient and client focused. Key to transforming organisational culture is the willingness of the senior team to lead from the front in motivating staff and, prioritising patient and client care, while embracing change in the rapid moving climate of Health and Social Care (HSC).

1.2 Who we are

The HSCB and PHA are considered arm's-lengths bodies within HSC. The organisations have a different range of roles and responsibilities, as reflected in their directorate structure. Ensuring that HSC services are safe, high quality, effective and meet people's needs is a core function of the HSCB and PHA. The two organisations work collaboratively to improve the quality of services delivered and work towards the Quality 2020 vision "to be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in Health and Social Care".

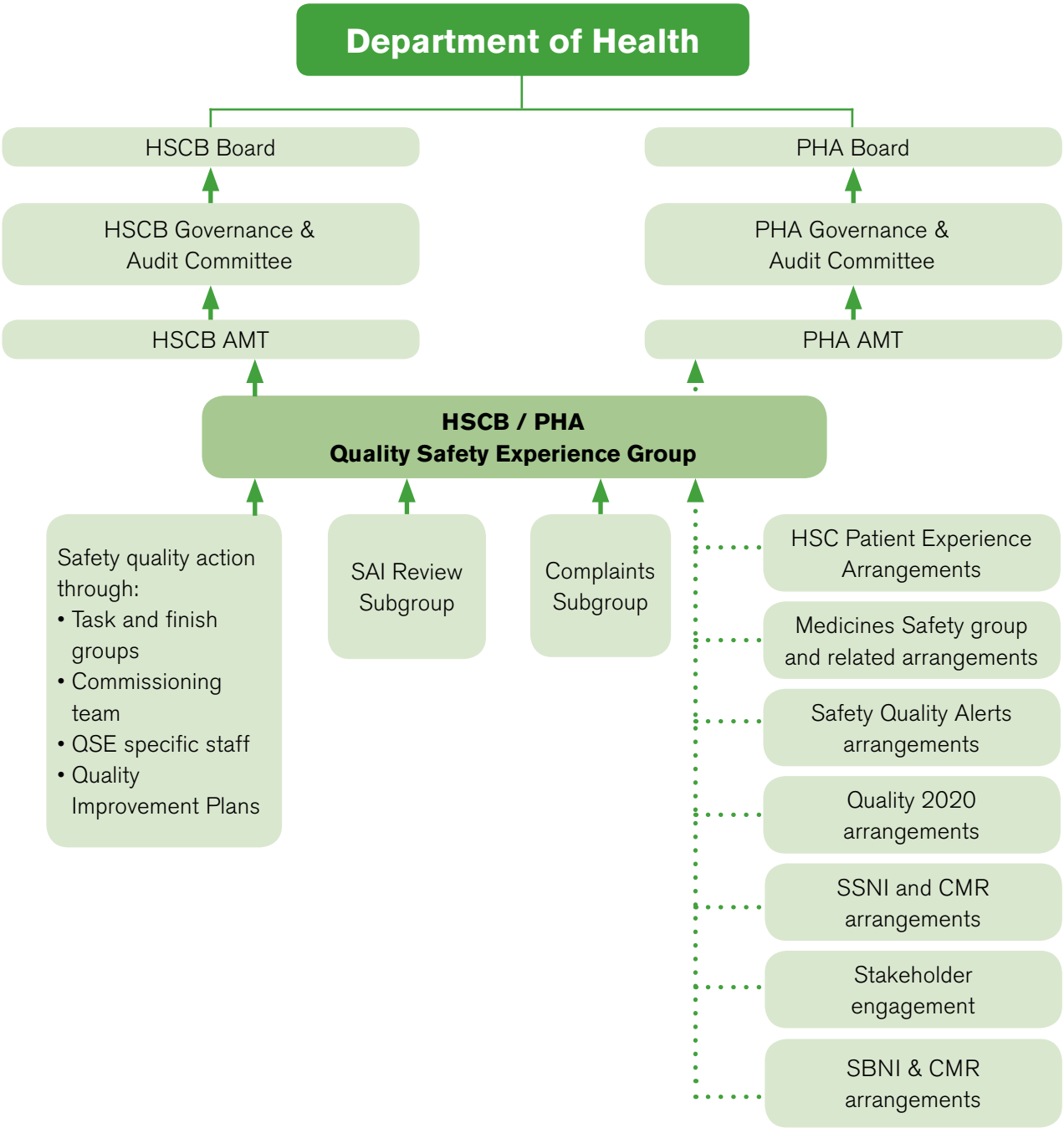


Transforming the culture

1.3 Leadership & governance

Within the HSCB and PHA, the **Quality, Safety and Experience (QSE) Group** monitors and reports on safety, effectiveness and the patient client experience. A number of other groups contribute to the work of improving the safety and quality of services as shown in the overview of the PHA/HSCB QSE governance and assurance structure.

The Safety Quality Alerts Team, Regional Complaints Group, Serious Adverse Incident Group, Designated Review Officer (DRO) professional groups, and the Safety Forum, report to, and support the work of QSE.



Transforming the culture

1.4 Learning

Regional learning from serious adverse incidents

The key aim of the Serious Adverse Incident (SAI) process is to improve patient and client safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC.

For the majority of SAIs reported, local learning will be identified and actioned by the reporting organisation. However, as the HSCB/PHA have a role in reviewing all SAIs they may also identify regional learning for dissemination across the HSC through a number of mechanisms.

During the reporting period 361 SAIs were closed by the HSCB/PHA following review. The following methods of regional learning were approved from SAIs closed in 2017/18:

12	**reminders of best practice guidance letters**
8	**professional letters**
42	**newsletter articles were identified**
56	**were referred to other specialist groups**
2	**thematic reviews were commissioned**
9	**were featured at learning events (SAI learning event)**

Listed below are four examples of regional learning identified last year:

- **Management of needlestick injuries in patients presenting to emergency departments**

This SAI related to a community pharmacy staff member who sustained a needlestick injury during the course of their duties. As a result, a reminder of best practice guidance letter was issued to the HSC and the HSCB and PHA worked with Trusts to ensure:

- Emergency departments within Trusts have a clear policy on managing people who present with needlestick injuries;
- All members of staff who may be involved in the management of patients presenting with a needlestick injury are aware of, and have received training in the Trust policy.

- **Acute management of diarrhoea related to cancer treatment**

A number of SAIs occurred in which people receiving systemic anti-cancer therapy were admitted to hospital with diarrhoea and subsequently died. A common feature in the incidents reported was that the seriousness of the patient's diarrhoea was not necessarily recognised and appropriate inpatient treatment was consequently delayed.

As a result, a reminder of best practice guidance letter was issued reminding Trusts of the requirements under current guidance and requesting this be brought to the attention of relevant staff.

Transforming the culture

• Choking on food

Last year a thematic review of choking on food led by the HSCB/PHA in conjunction with key stakeholders was distributed to the HSC. The themes identified through analysis reinforce a need for co-ordinated efforts to facilitate learning and inform future quality improvement work with an aim of prevention or reduction of risk of choking in future. A number of key messages relating to the areas below are identified within the report. These include:

- Raising awareness
- Communication to staff delivering care directly
- Terminology
- Roles and responsibilities
- Education and training
- Reporting
- Support to staff

In response to the choking on food thematic review, a multidisciplinary and multiagency Adult Swallowing Difficulties Regional Steering Group has been established. The group uses a co-production approach and has four workstreams including awareness, identification; assessment and management and International Dysphagia Diet Standardisation Initiative (IDDSI) implementation.

Funding has been agreed to support a number of specific actions within the work. Engagement activities have taken place to inform the work going forward. These include:

• Focus groups / workshops

Two focus groups & a regional workshop have been held to listen to issues from nursing/ residential homes, domiciliary care sector and Trust staff in relation to the identification and management of adults with dysphagia, including staff training needs.

• Public awareness raising

Information stands were held across the region in hospitals on European Swallow Awareness Day on 14th March 2018. Speech and language therapists (SLT) and SLT students provided information on swallowing difficulties and catering departments provided samples of a dysphagia diet. A short survey was also completed to gain information on the public's knowledge of dysphagia.

Transforming the culture

- **Fire risk associated with use of product to treat head lice**

This case involved a child treated for head lice who suffered severe burns following application of a treatment product and subsequent exposure to a source of ignition. Unfortunately due to the combustible nature of the treatment product the child's face and scalp. The child suffered 3rd degree burns to the face and neck. Although there are written warnings included with the product, these may not have been brought to the attention of the recipient by pharmacy staff.

As a result a Reminder of Best Practice Guidance letter was issued to the HSC with specific actions for Trusts, HSCB, GP practices, community pharmacies and the Regulation and Quality Improvement Authority (RQIA).

For further information on learning from SAIs please see following link **http://www.hscboard.hscni.net/publications/sai-learning-reports/**

Regional learning from complaints

The HSCB/PHA review complaints received from Trusts, family practitioner services (FPS), and those received directly by HSCB and PHA. For the majority of complaints, local learning will be identified and actioned by the reporting organisation. In some cases, the HSCB/PHA may also identify regional learning.

Areas of concern, patterns and trends from complaints are shared with relevant professional groups. This ensures that issues raised by complaints inform key areas of work on the quality of patient experience and safety, including thematic reviews and strategy and policy development.

Setting the context: during 2017/18
- **Trusts received 5814 complaints**
- **HSCB received 240 complaints regarding Family Practitioner Services**
- **HSCB acted as 'honest broker' in 54 complaints regarding Family Practitioner Services.**

Top 3 categories of complaints
1) **Quality of treatment and care**
2) **Staff attitude/behaviour**
3) **Communication/information**

During 2017/18, the HSCB hosted its fourth annual Learning From Complaints event, which focused on the themes of palliative care and the coordination of discharge packages. Both issues consistently feature in a significant number of complaints across primary and secondary care.

Transforming the culture

Palliative care is appropriate for people with a progressive or life limiting condition, regardless of age. Dame Cicely Saunder quote – *How people die remain in the memories of those who live on.* Therefore complaints regarding palliative care is appropriate for people with a progressive or life limiting condition. Timely communication of information between patients, families, carers and HSC providers is therefore paramount in improving patient and carer experience of palliative and end of life care. The timing of discharge also needs appropriate consideration, with referrals to district/palliative care made in a timely fashion.

Key messages from the day included; recommendations identified by the Patient Client Council (PCC) to improve interactions between clinicians, patients and their families; how complaints have influenced the discharge policies across the WHSCT emergency departments; how complaints have made a difference to the Regional Palliative Care Programme and consideration given to the theme of "moral distress" within intensive care and the associated impact this has on relatives, doctors and nurses.

To raise awareness of these issues and to highlight learning and good practice, feedback from this event was compiled and disseminated to the HSC.

For further information relating to complaints can be accessed at **http://www.hscboard.hscni.net/publications/complaints-publications/**

Learning from experience:

Learning from patient and client experience is a key indicator of quality of care and is integral to the implementation of Q2020 across the region. The HSCB/PHA lead the implementation of the 10,000 More Voices initiative for Northern Ireland. The rich source of information from the stories received through the 10,000 More Voices initiative continues to provide opportunities for learning , reflection and informing improvement work, for example:

- Stories from the individual 10,000 More Voices projects are reviewed on a weekly basis – this provides an opportunity for the relevant staff to highlight areas of good practice as well as considering any immediate learning or action that needs to be taken.

- Findings and results from 10,000 More Voices projects are presented at analysis and interpretation workshops at which key stakeholders, including service users work collaboratively to themes and trends. Following this, recommendations are developed, alongside local and regional action plans.

Transforming the culture

- Stories are used to inform education and training, including local induction programmes as well as pre and post registration education for medical, nursing and allied health professional students.

- 10,000 More Voices is now an integral part of quality improvement, informing 'Always Events' and quality improvement programmes within HSC Trusts.

To date over **12,000** stories have been collected, across a broad range of service areas, including: eye care services, hospital discharge, delirium and adult safeguarding.

Further information and completed project reports can be accessed at: **http://10000morevoices.hscni.net/**

10,000 More Voices Team at their celebration event in March 2018

> *"When I heard about 10,000 More Voices I felt it was important to tell our story, I hope that by doing so other families will be listened to or receive better explanations in these circumstances…… If as you say our story is used to shape future healthcare, improve services and educate staff then I am content that this opportunity is available."*
>
> *Thank you for taking time to listen to 10,000 Voices or even me."*

Transforming the culture

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

PPI is the active and effective involvement of service users, carers and the public in the commissioning, development and delivery of HSC services. Co-production is considered the pinnacle of such involvement. The PHA leads on the implementation of PPI in Health and Social Care. Recognising that core to quality improvement work is the involvement of service users and carers, a number of initiatives have been progressed in 2017/18. These include:

1.5 Involvement & co-production

Personal and public involvement (PPI)

- **Improving involvement in transformation -** Working closely with a number of the transformation workstreams, the PHA has provided guidance to ensure service users and carers are effectively and meaningfully involved in transforming HSC at all levels.

- **Improving access to information to improve involvement practices -** The PHA lead the co-production of the Engage website and e-learning resource for service users and carers. This has led to a significant improvement in the quality, availability and consistency of PPI information available. The PHA was also a partner in the quality improvement community of practice for PPI which has developed checklists for staff undertaking improvement work alongside service users and carers getting involved in this work.

- **Improving knowledge and skills –** The PHA continues to promote and deliver the Engage and Involve training programme, elements of which are now being delivered as part of quality improvement training in some HSC Trusts**.** In addition, innovative and high quality training for involvement, including an involvement leadership programme and specialist training for consultation has been commissioned.

- **Improving HSC performance for PPI -** The PHA continue to undertake performance monitoring for PPI across HSCT which focuses on what is working well and what can be improved. The HSCB / PHA were also subject to external PPI monitoring during this period.

- **Improving involvement standards – leading the way -** The PPI standards, developed by the PHA, have been used as the pathfinder for National Research Standards. The PHA has been working with the National Institute of Health Research (NIHR) and PPI leads from England, Scotland, Wales on this initiative.

Meaningful involvement across our services remains critical improvements in safety and quality. The PHA will continue to advance these core areas of responsibility in partnership with service users and carers.

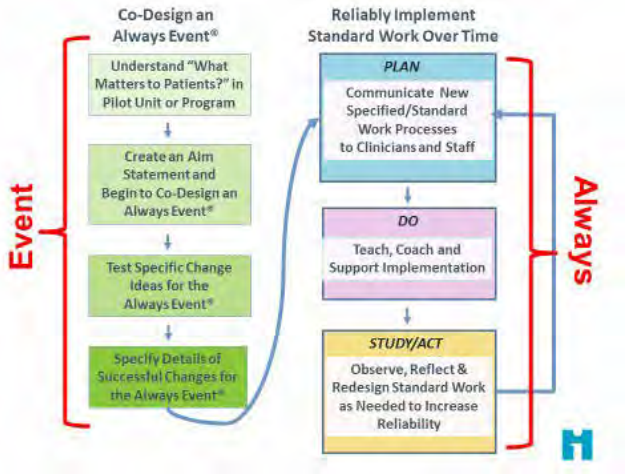
Further information on PPI is available at **http://engage.hscni.net/**

Transforming the culture

Implementation of Always Events in Northern Ireland

Always Events are defined as those aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health and social care delivery system.

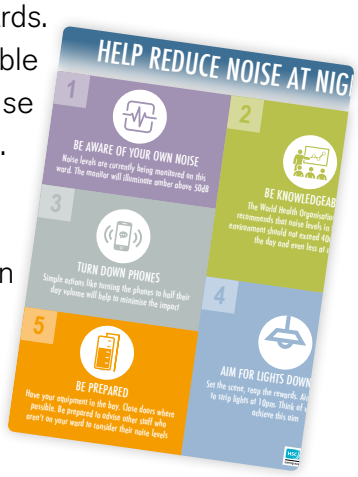
During 2017/18, the HSCB/PHA, through the regional Patient Client Experience Steering Group, have led the implementation of Always Events in each HSC Trust.



Using feedback from 10,000 More Voices, each Trusts identified a key area and pilot wards in which to test the methodology. A number of key improvements have been noted during the testing.

Belfast Health and Social Care Trust (BHSCT) will ALWAYS meet the World Health Organisation's Noise at Night recommendation

- Trust has linked with estates/labs department to review the use & frequency of the pneumatic chute system, replacing the foam padding on existing pods.
- Noise at night checklists have been introduced into the pilot wards.
- A traffic light noise monitor has been introduced into pilot wards.
- Apps were made available for staff to measure noise levels on ongoing basis.
- Posters & leaflets have been developed to remind people of human noise that can be reduced – building on the Trust animation "there is nothing like a good night sleep".



Northern Health and Social Care Trust (NHSCT) Mealtime matters: our pledge - we will ALWAYS protect patients mealtimes

- Core components of what should **always** happen at mealtimes have been established.
- A mealtimes bundle poster has been designed detailing the roles and responsibilities of nursing and catering staff at every mealtime.
- Electronic menu system has been introduced.
- A scale and spread plan was been developed with a view to total Trust-wide implementation by March 2019.

Transforming the culture

Southern Health and Social Care Trust (SHSCT) - I will ALWAYS be supported to communicate at the Outpatients Department Ramone Ward, Craigavon Area Hospital.

- Yellow with black writing signage introduced in outpatients department and at front entrance to Craigavon Area Hospital.
- Sensory awareness training for all staff has been co-produced by deaf service users and staff. This will also be co-delivered by the deaf service users.
- Yellow name badges introduced in the department and for eye care clinic staff.
- 'I am deaf' card has been introduced to increase awareness of a deaf patient awaiting appointment with details of interpreter services on the reverse.
- Sonido digital hearing system is now in place – posters and leaflets have been developed to raise awareness.

South Eastern Health and Social Care Trust (SEHSCT) - *To improve pain management satisfaction to 90% or greater throughout the inpatient setting.*

- ABCDE approach to pain assessment and management developed / pathway & logo 'Prioritise Pain' developed.
- Launch of project in pilot wards. Promotional posters, pens, balloons were used and information was shared using social media and staff newsletters etc.
- Pain score standardised in pilot wards.
- Successful pain study day for registered nurses hosted by Trust pain team. Some initial results indicate:
  - 76% increase compliance in recording of pain score on revised NEWS chart;
  - 93.4% of patients reported that they were always/frequently asked about their pain;
  - 18% increase in staff knowledge in relation to pain management in pilot wards following the project;
  - Increase in number of referrals to the hospital acute team.

Western Health and Social Care Trust (WHSCT) Family presence: promoting a shared person centred approach to visiting times and participation within the hospital.

- Standardisation of core information to promote family presence which includes information on how to best support patients and clients, information relating to illnesses, helping with food and drink, car parking, and visiting times.
- Personalised ward based posters & leaflets designed and distributed.
- The Trust has linked closely with the *John's Campaign: for the right to stay with people with dementia in hospital* and promotes dementia friendly wards.

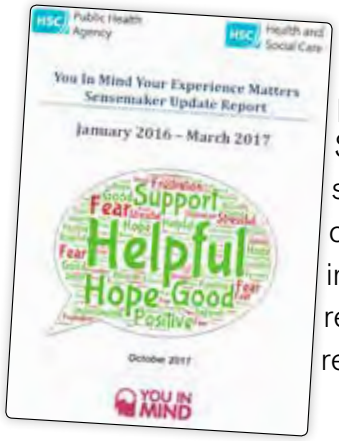
Transforming the culture

You in Mind 'Your Experience Matters' Sensemaker Re-Audit Report

In June 2017 the HSCB / PHA launched the 'You in Mind – Your Experience Matters' report on the re-audit of experience relating to mental health services. The survey, used to gather experience, was developed by service users and carers from each HSCT area using story telling methodology, enabling a more person centred / co-produced approach to improving experience.

Overall, the re-audit data suggests that there was a positive shift in how people perceive mental health care services. Approximately one third of all respondents said that they are hopeful for the future. For the majority of respondents, recovery focused practice was identified as an important part of their treatment.

Although it is recognised that there is still much to do, it is important to celebrate and acknowledge the positive work which has taken place across Northern Ireland. The launch event provided an opportunity to demonstrate the significant and valuable changes that have taken place in services across the region since the first report was published in 2012. Some examples of service/organisational change being implemented as a direct result of the Sensemaker re-audit findings include:



- SEHSCT - Developing an outcomes framework for the Recovery College.
- NHSCT - Maternal mental health and wellbeing workshop.
- BHSCT - Physical health care pathway in acute wards.
- WHSCT - Service user involvement in planning their care and treatment.
- SHSCT - Transforming the workforce & employment of peer support workers.

Regionally, Recovery services continue to improve within mental health with minimal financial investment. This is a result of the Trusts undertaking the journey together, initially with facilitation from Implementing Recovery Through Organisational Change (ImROC) and continues with a regional steering group lead by the PHA.

The full report is available here **http://www.publichealth.hscni.net/publications/you-mind-your-experience-matters%E2%80%99-sensemaker-re-audit-2015).**

Transforming the culture

Recovery newsletter

The PHA in collaboration with HSCB continues to work with Recovery Colleges and the ImROC Regional Group to co-produce a bi-annual newsletter. There have been five newsletters published providing a snapshot of peer support working, co-production, Recovery College activities and articles and poems from service users about their recovery journey.

The latest newsletter (Issue 5) was published at the end of March 2018 and highlights the establishment of the regional peer support workers into statutory mental health services. Also included in the newsletter is the launch of the European Union (EU) investment of €7.6 million in mental health recovery secured by the Co-operation and Working Together (CAWT) health and social care partnership.

Copies of the Recovery newsletters can be accessed on the following link: **http://www.publichealth.hscni.net/publications/recovery-newsletter**

Service framework for Mental Health and Wellbeing 2018-21 (public consultation stage)

The draft service framework for Mental Health and Wellbeing 2018-21 is the regionally agreed model for mental health care in Northern Ireland. It sets out the standards of care and treatment that individuals, their carers and wider family can expect to receive from HSC. The HSCB/PHA are leading the development of this service framework which reflects the principles and values of the 'You In Mind' Regional Mental Health Care Pathway, launched in 2014. The pathway recognises that all treatment and care needs to be highly personalised and recovery orientated.

The 'You In Mind' care pathway explains how people can access mental health care and details the quality of service they can expect from the point of referral to the point that services are no longer required. It describes how mental health professionals will work in partnership with people to access mental health services, though assessment, diagnosis, care and treatment, self-management, and recovery. It outlines how care decisions are made with and for people. It places people, families, partners and nominated friends at the heart of all decision-making.

Transforming the culture

#EndPJparalysis

PHA is leading, supported by the HSCB, Northern Ireland's participation in the nationwide 70 day, #EndPJparalysis challenge. The campaign has been endorsed by Professor Charlotte McArdle and aims to get people up, dressed and moving about, thus giving patients back one million days of their time that would otherwise be spent in a bed in hospital gowns or PJs. #EndPJparalysis is a means of valuing patients' time so they return sooner to loved ones staff may never meet, to homes staff will never visit, to spend more of their last 1000 days in a place that is not a hospital. The challenge is about embedding that into normal practice.

At the midway point of the campaign there are a variety of areas from all Trusts taking part in the campaign with almost 5000 patients up dressed and moving. PHA has secured repeat visits from #EndPJParalysis creator Professor Dolan in June 2018. Professor Dolan will deliver his TODAY programme which further highlights why we should focus on time being the most important currency in Healthcare. This follows on from five similar workshops held across Northern Ireland in January 2018 with very positive feedback.

Benefits of #endPJparalysis include:

- Reduced length of stay (< 1.5 days in Nottingham University Hospital Trauma and Orthopaedic Ward)
- Reduced loss of mobility, deconditioning and risk of falls (37% in same Nottingham University Hospital Trauma and Orthopaedic Ward)
- Reduced food wastage due to greater patient mobility and energy need
- Reduced risk of needing institutional care on discharge
- Enhanced wellbeing of patients and staff

Theme two

Strengthening the workforce

Strengthening the workforce

2.1 Introduction

The HSCB and PHA, who collectively employ over 800 staff, are determined to invest in the development of their staff and the creation of a working environment that enables everyone to make their best contribution. The organisations' diverse range of responsibilities, coupled with current demographic changes and economic climate, requires a sustained focus on improving quality. The HSCB/PHA recognise the importance of the workplace as a setting to promote health and wellbeing. Similarly, the process of working together across all divisions has been important in understanding complexities and developing a commitment from staff to embed improvement techniques in daily activities.

2.2 Supporting HSCB/PHA staff

Promoting health and wellbeing in the HSCB/PHA as a workplace

During 2017/18 the HSCB/PHA have led the implementation of a number of programmes to assist in promoting health and wellbeing for staff such as:

(a) Lesbian, Gay, Bisexual and Transgender (LGBT) Forum

A forum for lesbian, gay, bisexual and transgender staff continues to provide confidential support for LGBT staff and students in the HSC workplace. An e-learning module has been developed and widely promoted within HSC settings, The dedicated website to support LGBT staff in HSC now includes an online gallery of staff who are 'out at work'.

For more info - **http://www.lgbtstaff.hscni.net/**

Strengthening the workforce

(b) My Mood Matters/Living Life to the Full

Staff in the HSCB/PHA have been offered the opportunity to attend the My Mood Matters and Living Life to the Full programmes. Staff evaluation of both programmes has been very positive.

(c) Physical activity

Staff are encouraged to increase their physical activity during the working day by promoting the use of stairs, lunchtime walks and gym facilities. An upgrade to the gym facilities in Linenhall Street, Belfast and the introduction of the 'take the stairs' initiative also helped boost opportunities for physical activity. This was further rolled out to Tower Hill, Armagh and County Hall Ballymena sites HSCB/PHA sites. The 'take the stairs' initiative; saw an increase in upward journeys using the stairs by 81% and an increase in downward journeys by 86%. A toolkit has now been developed that can help other workplaces introduce this simple, effective and low cost measure. A short video was developed to raise awareness of the scheme.

(d) Staff wellness day

A wellness day for staff was held in February 2018. This event proved to be highly popular with a range of activities and advice available including: cookery demonstrations; Belfast City Council bike scheme; active travel; Tapestry Staff Disability Forum; trade unions; Pure Gym; Here NI and the Rainbow Project.

(e) HSC Healthier Workplaces Network

The PHA in conjunction with the HSCB has established a HSC Healthier Workplaces Network. This Network aims to develop improved and consistent workplace health programmes aligned to HR and other policies and which bring increased focus to valuing staff and the advantages that a diverse workforce can bring to organisations. The Network's four subgroups are now addressing the following areas: common measures and indicators; ageing workforce; a healthy workplaces charter; and on-line tools and apps.

For further information and access to the materials see **http://www.choosetolivebetter.com/content/getting-active**

2.3 Project ECHO – innovation & learning for the HSC

What is ECHO?

ECHO (Extension for Community Healthcare Outcomes) is a pioneering tele-monitoring programme designed to address growing demand for secondary care services. Using video-conferencing technology, participants benefit by sharing evidence-based best practice guidance and case-based learning. The model provides an affordable solution to addressing growing need in the UK for training and support. The approach is seen as an effective way of® improving access to specialist supported care and ultimately improving patient outcomes.

Project ECHO

Project ECHO seeks to develop clinician capacity to safely and effectively treat common, chronic, complex diseases. The HSCB/PHA in partnership with Hospice UK, are currently rolling out the ECHO model in 30 clinical areas to include **elective care, prison health, optometry/ophthalmology and dementia**. The model is a method to help improve the reach and availability of a wide range of under pressure health care services across Northern Ireland.

It is hoped that, through working with Integrated Care Partnerships (ICPs) and associated networks, new ways of delivering service which better fit the need for more chronic care irrespective of postcode will be developed, thus freeing up capacity for more complex issues in our acute centres.

Project ECHO

"Moving Knowledge not People"

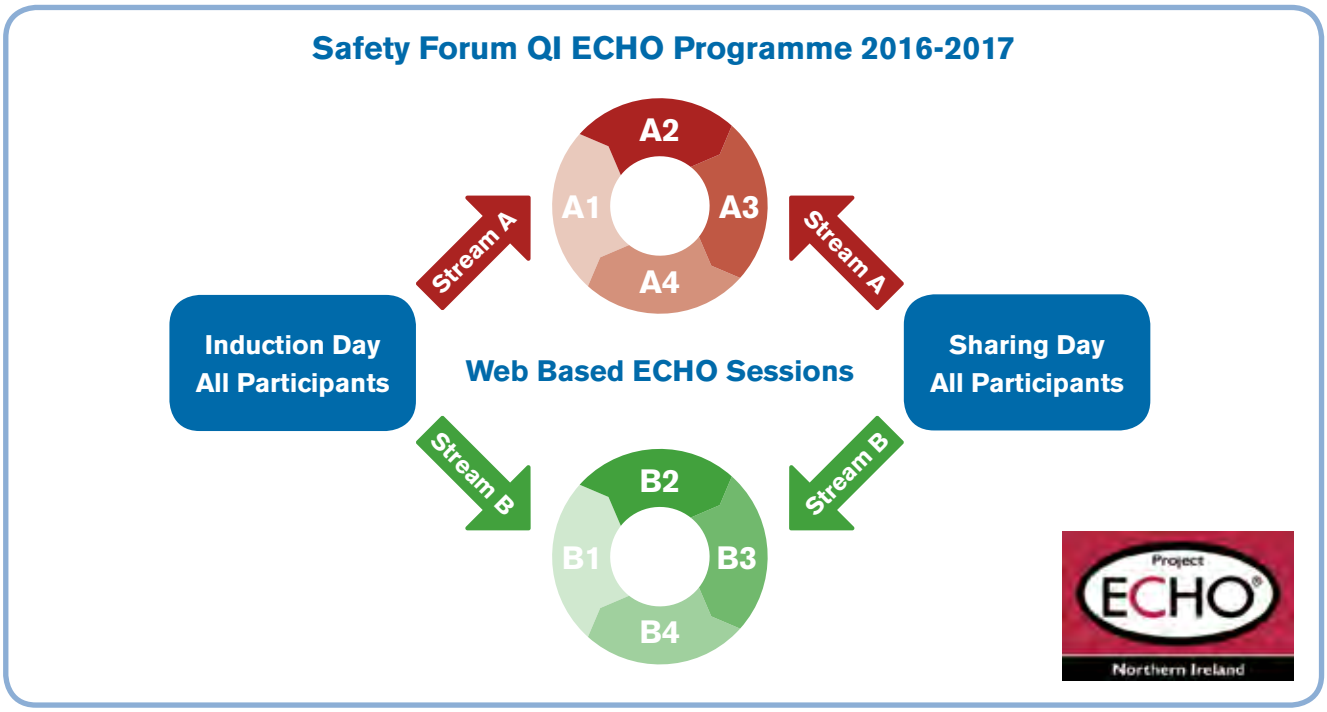
Strengthening the workforce

Quality improvement ECHO

Last year the HSC Safety Forum led its first quality improvement (QI) ECHO programme which provided Trusts with training in QI methodology, supporting the development and success of current or proposed Trust-based QI projects.

The range a range of quality improvement projects within the programme included:

- Learning disability project aimed to increase time spent on physical activity and fun opportunities to improve health and wellbeing. Activity levels increased from 48 minutes per child per week to 200 minutes.
- An outpatient team that aimed to reduce inappropriate urine sampling achieved a reduction in testing by 80%,
- A podiatry team exceeded their initial aim of increasing clinical capacity by increasing appropriate discharges from 5%-25%
- A mental health project aimed to increase the uptake and offer of carers' assessments in the community. The project demonstrated a 70% increase in carers' assessments completed



Strengthening the workforce

2.4 Sharing quality improvement

Q Community

Q is an initiative connecting people who have HSC improvement expertise across the United Kingdom. It is being led by the Health Foundation supported locally by the HSC Safety Forum based in the PHA.

The Q community is made of up a diverse range of people including those at the front line of health and social care, patient leaders, managers, commissioners, researchers, policymakers and others.

In 2017/18 a recruitment programme was undertaken in Northern Ireland. This programme was successful in attracting over 90 new members far exceeding initial expectations. New and existing members (123 in total) were invited to a welcome event in Titanic Belfast to learn from each other and from invited guests. This was followed up by a networking event in March 2018. In addition members have had access to a range of online resources, specialist training, networks and site visits across the United Kingdom. Members attended the national Q event in Liverpool, a site visit to explore artificial intelligence and problem solving and specialist patient experience training. Learning from these visits has been shared with the wider Q community through a series of reflective blogs.

PHA Safety Forum Awards 2017

The PHA, through the HSC Safety Forum invited organisations to nominate individuals or teams for the 3rd Northern Ireland Safety Forum Awards. The annual awards recognise and showcase the excellent work undertaken across the HSC system to drive improvement in quality of care and to strengthen patient safety

Four teams from across HSC were presented with their awards at a quality improvement event at the end of March. An award was made in each of four categories:

- Partnership working/co-production
- Innovation/transformation in care
- Integrated care
- Building reliable care

From the four categories, one overall winner was chosen. The winners covered a breadth of subjects, showed clear evidence of teamwork and tangible improvements to care.

Strengthening the workforce

2.5 Education and training for HSC

Primary care

Nursing: Last year the HSCB/PHA funded a bespoke foundation course, delivered by the HSC Clinical Education Centre (CEC), in line with the GP Nursing Framework, for general practice nurses (GPN) and healthcare assistants (HCA). The training was designed to meet the complex and changing service needs of patients in primary care settings. In total 141 GPN and HCAs accessed and positively evaluated the training. It is planned to roll out these regional training programmes in 2018.

Additional resources were secured to facilitate GPNs accessing post registration courses in local universities. In addition, courses were made available for general practice nurses via the Royal College of Nursing (RCN) and CEC. Additional courses included transformational leadership and cervical cytology.

In 2017/18, five Advanced Nurse Practitioners (ANP) have been working successfully in the Down GP Federation. Numbers are expected to increase over the next two years. This supports the career pathway of GPN to ANP level in primary care.

A regional network for GPNs has been established across Northern Ireland. A series of network events took place focusing on the management of long term conditions. Communication strategies for sharing correspondence, information on training and professional updates have been successfully re-established via the primary care intranet, the websites and social media.

Following a workforce review, a proposal has been developed that identifies the need for additional GPNs and HCAs to meet the increasing demands and pressures faced in general practice.

GP training numbers: The HSCB lead on the development of business cases to evidence the requirement to increase the GP training numbers. In response to workforce capacity concerns the number of GP training places has been increased from 65 (2015/16) to 95 (2017/18).

In a move to support retention of qualified GPs, there were 25 places on a two year retainer scheme covering 2016/17 and 2017/18. These GPs are attached to a practice and also commit to a number of out of hours sessions. In total 28 GPs took part in the scheme. Of the nine who left the scheme before their two year attachment was complete, five left to take up permanent GP jobs, either salaried or as a partner. A new cohort of retainer places will be available starting in 2018/19.

Strengthening the workforce

Dementia

As part of the implementation of the Dementia Together NI strategy a variety of training and education programmes have been delivered throughout Northern Ireland. These include:

- Development of the Dementia Learning and Development Framework has been used by local universities to inform course development / content for social workers and nurses
- A number of stand-alone training resources have been developed. in collaboration with the Northern Ireland Social Care Council (NISCC) including the development of a training app for domiciliary care staff and an online training resource for adult residential / nursing and day care staff on dementia, delirium and palliative care.
- In total 260 staff from across the statutory and independent sectors completed the dementia champion programme. This six month programme which included direct teaching and on-line learning required participants to complete a service improvement project within their area of work.
- One thousand copies of a training pack entitled 'Barbara's Story' were issued to HSC facilities, GPs, pharmacists, opticians, dentists, prison staff, PSNI and the Northern Ireland Ambulance Service (NIAS).
- More than 500 copies of a training pack entitled 'Supporting Derek' were issued to HSC staff working with people with learning disabilities.
- Development of a range of other bespoke training programmes for HSC staff including CLEAR (a model to assess and address unmet need) and the virtual dementia bus.
- HSC staff trained in the use of the delirium assessment and management tool totalled 2826. Forty staff have completed the relevant *train the trainer* programme.

Strengthening the workforce

Staff working with older people

• Regional multi-professional educational awareness programme for the identification and management of frailty

Frailty is a condition in which multiple body systems gradually lose their in-built reserves. Older people with frailty are at substantially increased risk of adverse outcomes including falls, disability, hospitalisation, nursing home admission and mortality. Early recognition of frailty and targeted interventions and management can significantly improve health outcomes for frail older adults. Staff knowledge and skills in relation to the identification and management of frailty is fundamental to achieving best outcomes. In order to improve HSC staff awareness in relation frailty the PHA commissioned the CEC to:

- Develop and pilot a face to face multi-disciplinary Frailty Educational Awareness Training programme.
- Develop an ELearning Frailty Educational Awareness Training programme.

This regional multi-professional educational awareness programme was designed to enhance health professional's knowledge and understanding of frailty with a view to improving prevention, identification, management and therefore outcomes for these older adults. Ninety three health professionals from across all disciplines attended this training with excellent feedback. The plan going forward is to roll this training out across the HSC.

• Loneliness aide-memoire for older people

It is recognised that loneliness in older people is a public health issue affecting their health and well-being. A recent Age NI survey highlighted that:

- One in three older people in Northern Ireland said that they are lonely
- 100,000 older people in Northern Ireland say that television is their main form of company
- 26,000 older people in Northern Ireland feel trapped in their own homes

As a result of these facts, Allied Health Professionals (AHPs) across Northern Ireland have worked with Age NI to develop an aide-memoire for HSC staff to raise awareness of older people and loneliness. The aim is to make a difference to an older person who is lonely by looking, listening and asking to see if they are lonely. In this way people can be directed towards agencies who can help. Some reasons for loneliness may include bereavement, retirement, living alone, lack of money, not having transport to get out and about. The aide memoire encourages staff to be aware of these factors in their daily interactions with older people.

Strengthening the workforce

Age NI engaged with older people to hear their views on the development of the aide memoire, through a workshop at which older people, AHPs, representatives from PHA, Age NI, HSCB and Translink had the opportunity to contribute to table and larger group discussions. The aide-memoire provides useful contact details including:

- Age NI the leading charity for older people in Northern Ireland;
- Silverline helpline for older people for information, friendship and advice; and
- Translink for practical advice on transport queries.

Staff are also advised to approach appropriate Trust contacts for local information.

"An older person in Northern Ireland described loneliness as "An ache in your heart so bad that it physically hurts. Longing for someone who cares."

• Rethinking Frailty Symposium

The PHA held a 'Rethinking Frailty' Symposium which provided an opportunity for the first time in Northern Ireland to bring together a wide range of stakeholders to look at and discuss all aspects of frailty and consider how best to take forward work in this area that would enable healthier and more fulfilling lives.

More than 100 people attended the event with representation from HSC, HSCB voluntary and community organisations, other statutory organisations and most importantly people with lived experience of frailty. Presentations addressed current regional and national perspectives in relation to the identification and management of frailty. This work captured the views of older people on frailty and what matters to them. This symposium has marked the beginning of significant work across Northern Ireland which aims to engage with all relevant stake holders to agree a common understanding of frailty and to improve the experience and health outcomes for all individuals who are frail or at risk of frailty.

Adult learning disability

In line with the Learning Disability Service Framework, the HSCB/PHA aim to ensure that services for adults with a learning disability provide the opportunity for people to enjoy personal and sexual relationships while protecting vulnerable adults from abuse. They have led the development of the operational protocol: 'Adults with Learning Disabilities: Personal and Sexual Relationships' which is being implemented by the Trusts. Last year, the HSCB/PHA commissioned the Family Planning Association (FPA) to provide training to support Trust staff with the implementation of the operational protocol. To date over 300 HSCT staff have received awareness raising (level 1) training from FPA. Approximately 30 Trust staff from across Northern Ireland have received Level 2 Peer Educator training to provide support and guidance to peers and colleagues on how to implement the protocols within their Trust. Year three of the training is currently been implemented by FPA.

Strengthening the workforce

Nursing

Following obtaining a grant award for 2017/18 from the Burdett Trust for Nursing, the PHA is leading a regional initiative that aims to improve nurse retention and recruitment in care of older people's settings in Northern Ireland. This innovative and collaborative approach is delivering a programme of development activities including team coaching, practice support, supervision and professional and personal effectiveness. The PHA leads for the project have successfully participated in national events associated with the Burdett Trust stipulations for the grant award. The evaluation of the project has seen very positive results to date.

Implementation groups are now established within each of the Trusts to provide support and guidance. In addition to quantitative information including staffing levels, vacancies, absence rates etc, qualitative baseline information has also been obtained including:

Values Clarification Exercise (VCE)- Understanding the values, beliefs and views that staff hold about working with older people including what staff think is important, and what staff feel should happen. This has been used to verify or inform local ward mission statements and develop training programmes.

- **Workplace Culture Critical Analysis Tool (WCCAT) -** The WCCAT has been developed to help people involved in the development of practice to undertake observational studies of work place settings in order to inform changes in practice. Examples of good and not so good practices have been observed and results shared with the ward managers and some of the other ward staff.

- **Nursing Workplace Satisfaction Questionnaire (NWSQ) -** used to evaluate nurse satisfaction with a new team model of nursing care delivery.

In addition, a bespoke training programme for staff in the 11 pilot wards commenced in January 2018. This programme has been tailored to meet the individual needs of staff. The programme includes: induction and preceptorship programmes, delivery of action learning sets by AGE NI peer facilitators, use of specialist nurses, training on resilience, assertiveness and coaching. The sustainability of this project will be further reviewed as part of the transformation agenda in nursing homes next year.

Strengthening the workforce

2.6 Delivering Care: A policy framework for nursing & midwifery workforce planning

Delivering Care is a policy framework aimed to support the provision of high quality care which is safe and effective in hospital and community settings. Initiated in 2012, it has used a phased approach to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities. The PHA and HSCB, in partnership with Trusts and other key stakeholders lead the implementation of the eight phases underway.

Workforce Phase	Staffing Model	Status
Phase 1: Acute medical and surgical wards	Staffing range	Funding for this phase has been secured and is in the process of phased implementation across designated wards in all HSCTs
Phase 1A: Elective care treatment care environments	Recommended range for 24/7 wards including day and short stay wards	Guidelines currently being scoped in HSCT 2018
Phase 2: Type 1 emergency departments	Nurse to annual attendance ratio	Recommendations endorsed by CNO. 1st phase of implementation due in 2018.
Phase 3: District nursing	Population based model	1st phase of implementation due in 2018 dependent on resources
Phase 4: Health visiting	Population based model – caseload weighting	1st phase of implementation due in 2018.
Phase 5: Mental health	Acute – nurse/bed ratio community – caseload and population based model	Phase 5A completed for acute inpatient mental health facilities. A number of workshops have been facilitated by the PHA and the expert reference group. The proposed recommendations around the staffing ranges for the category of inpatient environments have been shared for endorsement with the CNO. Phase 5b community staffing model to be progressed mid-2018
Phase 6: Neonatal nursing	Based on level of activity	Final proposals underway
Phase 7: Primary care nursing	Population based model from the GPN framework 2016	Finalised and with the CNO for endorsement 2018
Phase 8	Independent sector nursing homes	This phase is underway in 2018.

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Theme three

Measuring Improvement

Measuring Improvement

3.1 Introduction

The HSCB and PHA recognise that gathering information and examining data is important in assessing performance. They also recognise that it is vital that lessons from the information are learned, areas of high performance are duplicated and areas of lower performance are supported to improve. Last year the HSCB and PHA continued to promote the use of accredited improvement techniques to drive improvements and have worked with Trusts and other HSC bodies to provide support to improve outcome measurements in a range of quality indicators.

3.2 Quality improvement plans

The quality improvement plans (QIPs) focus on key priority areas to improve outcomes for patients and service users. The HSCB and PHA support Trusts on a range of initiatives to assist with the achievement of the QIP targets and facilitate a regional platform to enable good practice to be shared throughout Northern Ireland.

In 2017/18 QIP target areas were:

- **Pressure ulcer prevention;**
- **Falls prevention;**
- **National Early Warning Scores (NEWS);**
- **Mixed gender accommodation.**

Pressure ulcer prevention

The PHA along with HSCB supports Trusts through the Regional Pressure Ulcer Prevention Group to implement SKIN (an evidenced based collection of interventions proven to prevent pressure ulcers) in all hospitals in Northern Ireland. This group provides advice and support and shares regional learning across Northern Ireland. It focuses on strategies for pressure ulcer prevention and management across the Trusts.

Last year the focus was on the prevention of avoidable grade 3 & 4 pressure ulcers. These create deeper cavity wounds which can result in increased pain and suffering to patients.

Regionally a variation in the rate of avoidable grade 3 and 4 pressure ulcers was noted with a range of 0.01 to 0.33 between Trusts. For the purpose of quality improvement work, Trusts continually review their data to compare improvement over time and to learn from local variation.

In recognition of the need for continual evaluation and improvement, and to ensure that potential regional variation in recording and reporting of data across Northern Ireland is minimised, the PHA, in collaboration with the HSCB and Trusts are:

- Undertaking an improvement project in relation to measurement, display and interpretation of improvement data;
- Reviewing the current operational definitions including current regional application of same;

Measuring Improvement

- Reviewing the process for root cause analysis and process for obtaining bed day figures which reflect exactly the wards & clinical areas within which pressure ulcer data is collated and submitted to PHA;
- Developing a regionally agreed schedule for validation of data;
- Working with Trusts to ensure local and regional learning is identified and shared.

Falls prevention

During 2017/18 the PHA and HSCB through the Regional Falls Prevention Group have supported Trusts to implement and spread the Royal College of Physicians 'Fallsafe' bundle, an evidence based collection of interventions proven to reduce falls; in inpatient settings.

Trusts measure compliance against the Falls Safe Bundle and report to the PHA and HSCB on a quarterly basis. The Regional Falls Prevention Group provides advice, support and shares regional learning across Northern Ireland and focuses on strategies for falls prevention and management across the Trusts.

The Business Services Organisation (BSO) internal audit team carried out an audit of learning from serious adverse incidents (SAIs) and from falls across HSC organisations. This audit found that definitions were not consistent with the Trusts' classifications of falls and recommended that the current definitions should be brought into line with the regional incident grading matrix. There was regional agreement that this should commence from April 2017.

During 2017/18 the focus was on prevention of the number and rates of falls incidents classified as causing moderate to major/ catastrophic.

Regionally, for this period there has been a reduction in falls incidents resulting in moderate to major/catastrophic, the rate during 2017/18 is between **0.08** and **0.09** per 1,000 bed days.

NEWS (National Early Warning Scores)

As part of its leadership role, the HSC Safety Forum has led the regional implementation of NEWS in Trusts, including appropriate escalation arrangements to improve care of the deteriorating patient. This tool helps professional staff identify early deterioration in a patient's condition. Abnormal scores prompt specific actions and/or referral to greater expertise. Part of this work involved facilitating Trusts to clearly define their expectations regarding intervention when NEWS are abnormal. Trusts are committed to ensuring escalation of NEWS is a priority and have worked with the HSCB and PHA to measure compliance with accurately completed NEWS charts.

Measuring Improvement

Mixed gender accommodation (MGA)

HSC is committed to the delivery of person centred care. International and national evidence has highlighted that the provision of single gender accommodation has been identified by patients and relatives/carers as having significant impact on maintaining privacy and dignity whilst in hospital. There is therefore an expectation that men and women will not be required to sleep in the same area.

In line with the DoH Guiding Principles for Mixed Gender Accommodation, each Trust has developed a policy for the management of MGA in hospital. During 2017/18 the PHA has engaged with Trusts to review the current processes for recording MGA to agree operational definitions and develop a regional monitoring template for reporting occurrences. Trusts have been using the Institute for Healthcare Improvement (IHI) improvement methodology to test and evaluate the revised monitoring process. Initially on a small scale within a small number of wards per hospital site, with view to scale and spreading during 2018/19.

3.3 Key performance indicators (KPI)

A regional group has led the development of high level KPIs for nursing and midwifery to measure, monitor and evidence the impact and unique contribution the nursing has on the quality of patient and client care. There are three domains which many Trusts are currently presenting via dashboard systems, which allow data sets to be viewed collectively across all wards and departments.

Examples of indicators

Organisational: absence rates; normative staffing ranges and vacancy rates.

Safe and effective care: incidence of falls, pressure ulcers, omitted or delayed medications, absconding etc.

Patient experience: consistent delivery of care against identified need; involvement of the person receiving care in decisions made about their nursing care; time spent by nurses with the patient.

Measuring Improvement

Below are two examples of KPIs which are measured within mental health and learning disability services:

- **Anti-absconding KPI**

Research evidence has demonstrated that patients who abscond from inpatient mental health settings have increased risk of harm to self and others, suicide, self-harm, and self-neglect.

The anti-absconding intervention draws on empirical research into patient and staff experience of absconding and outlines effective practice based activities that can be employed by staff to reduce episodes of absconding.

In May 2014, the South Eastern Health and Social Care Trust (SEHSCT) initiated a pilot of the East London and City Mental Health Trust Anti-Absconding Work Book. The results from the pilot were extremely encouraging, showing a reduction in absconding rates of 70% as compared to the base line audit. Following the success of the pilot, the PHA/HSCB worked with all Trusts to develop the first regional mental health KPI, focused on the anti-absconding intervention.

Data is collated using an agreed audit tool and reported quarterly to the HSCB/PHA. Year two data is now complete and Trusts are working on increasing compliance with all elements of the KPI Intervention with evidence suggesting that compliance with the KPI is having an impact on reducing incidents of absconding.

The PHA working closely with the HSCB hosted a regional learning event in October 2017. The event facilitated the sharing of learning from year one of the implementation of the Anti-Absconding KPI intervention and reflection on the experiences of front line staff, service users and carers.

Following presentations from each Trust participants had an opportunity to take part in group activity designed to encourage staff to think about what it is like for patients, who are often admitted without having had the time to prepare for the admission, and the impact this can have on them. Participants were then asked to discuss how they could facilitate home and social contact for patients which might help reduce the risk of absconding. Feedback from those who attended the event was very positive and the regional learning identified has been used to inform the ongoing implementation of the KPI.

- **Review of Psychological Therapy Training in Nursing**

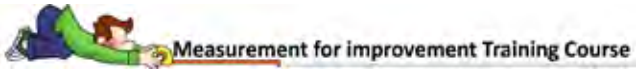
The provision of evidence based psychological therapies is fundamental in enabling psychological and personal recovery.

As set out in the 'You In Mind' Regional Mental Health Care Pathway, and other relevant guidance, mental health nurses are required to embed evidence based psychological therapies and recovery practice in the provision of all treatment and patient centred care.

In order to establish a baseline of psychological therapy practice across mental health nursing an audit tool was developed to test the psychological therapies KPI. Two cycles of data collection were completed as a pilot. This identified the need to establish the accredited training of registered in mental nursing across NI.

In October 2017, the PHA commissioned the HSC Clinical Education Centre (CEC) to carry out an audit which included training record audits and an online survey with staff working across all mental health settings and facilities in Northern Ireland. The findings of the audit have informed the next stages for the KPI.

3.4 Measurement for improvement masterclasses



During 2017/18 the HSC Safety Forum hosted a series of "Measurement for Improvement" masterclasses, facilitated by Paul Rafferty. These interactive sessions challenged participants to ask the following questions:

- Why measure?
- Is there an art to measurement?
- How can we illustrate and analyse variation?
- What are the steps for effective measurement?

Participants had the opportunity to explore the functionality of Excel and to bring along their own data to discuss and improve presentation. The technical skills were balanced with the clear message that data can win or lose hearts depending on how it is used to engage people. Feedback from the 50 participants, who were from a range of clinical and administrative positions, was extremely positive and further sessions are planned for 2018/19.

3.5 Implementation of National Institute for Health and Care Excellence (NICE) guidance

NICE is a non Departmental Public Body responsible for providing national guidance and advice to improve health and social care.

NICE produces different types of guidance, including:

- Technology Appraisals (new drugs, medical treatments and therapies);
- Clinical Guidelines (recommendations on the appropriate treatment and care of people with specific diseases and conditions); and
- Public Health Guidance (recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health).

The HSCB/PHA have put in place processes to take forward the implementation of Technology Appraisals, Clinical Guidelines and Public Health Guidance published by NICE and endorsed by the DoH.

During 2017/18, the HSCB/PHA issued 59 Technology Appraisals to the HSC and continues to monitor the implementation of 170 Clinical Guidelines which have been issued to the service.

The implementation of NICE guidance can often be the driver for change in a wide range of areas, as it provides commissioners, clinicians and other health care professionals with evidence based methodologies to improve and sustain higher quality outcomes for patients and clients.

More information about the Technology Appraisals and Clinical Guidelines that are being implemented can be found on the HSCB NICE webpage. **(http://www.hscboard.hscni.net/nice/)**

Measuring Improvement

Theme four

Raising the standards

Raising the standards

4.1 Introduction

The HSCB and PHA have established a framework of clear evidence-based standards and best practice guidance which is used in the planning, commissioning and delivery of services in Northern Ireland. The HSCB and PHA are continuously striving for excellence and raising the standards of care and the quality of services delivered. Below are examples of outcome quality improvement secured, through a number of interventions.

4.2 Managed clinical networks

The purpose of a managed clinical network is to provide a regional platform to achieve consistency in care and drive quality improvement within the network and beyond with a family centred approach. The HSCB/PHA lead the implementation of a number of clinical networks, some of which include:

- **Paediatric Network**
- **Critical Care Network**
- **Neonatal Network**
- **Pathology Network**
- **Stroke Network**
- **Cancer Network**
- **Trauma Network**
- **Diabetes Network**
- **Radiology Network**
- **Pain Forum Network**
- **Lymphoedema Network**

Below are two examples of how standards of health and social care have been improved through the work of the Northern Ireland Trauma Network.

Northern Ireland Major Trauma Network

The Northern Ireland Major Trauma Network supports the coordination of regional trauma services enabling patients with serious injury to receive timely, skilled, high quality hospital care, including rehabilitation and repatriation. In collaboration with all HSC, the Network is taking a whole system approach to developing processes and services to reduce mortality and morbidity rates for patients assessed as 'major trauma'.

In 2017/18 the Network Manager, Regional Clinical Lead and Local Clinical Leads (representing each HSCT) were appointed, as were a team of Trauma Audit Data Coordinators. Monthly meetings of the Network Board have provided strategic direction to the Network in line with its aims and objectives and the HSC Chief Executives' Forum supported the principle of a regional bypass and repatriation protocol.

A model for a designated Major Trauma Centre (MTC) has been agreed that includes a consultant-led trauma ward with additional intensive care beds that will support the introduction of a regional bypass protocol. This protocol has been developed in conjunction with the Belfast Health and Social Care Trust and HSCB/PHA and reflects NICE guidance for major trauma services and National Trauma Quality Indicators (TQUINS).

Raising the standards

Over 80 colleagues from trauma related specialties within the Trusts attended the Major Trauma Network's stakeholder engagement event in 2017. This provided an opportunity for people to learn about the Network and give feedback on suggested priorities to help develop the Network's first annual plan.

A Network Clinical Advisory Group (CAG) has agreed a Major Trauma Triage Tool and regional clinical protocols. This includes protocols for Whole Body Computed Tomography (CT), Traumatic Cardiac Arrest, Massive Blood Loss and a standardised Emergency Department Trauma document.

The Network's Nursing & AHP group provide multidisciplinary input and has undertaken a review of trauma training across Northern Ireland and developed a programme to support ward-based staff involved in providing care to patients following repatriation from the MTC's trauma ward.

In late 2017/18 service user representatives from the HSCB's Unscheduled Care Clinical Reference Group were engaged on the development of guidance and patient information relating to the Network's bypass and repatriation protocols.

A workshop on Supporting the Concept of Damage Control Surgery was held for surgical colleagues with expert speakers providing perspectives from various specialties on this subject. This supports regional preparedness for a mass casualty response as well as individual trauma cases. Future work on this will be to encourage clinical skills training for surgical colleagues.

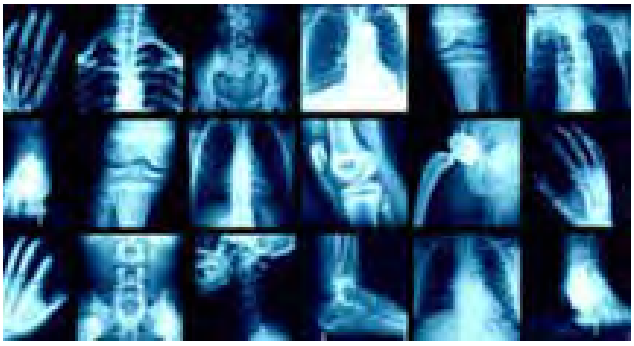
Important work commenced in 2017/18 to submit trauma data to the national database of the Trauma Audit Research Network (TARN). TARN monitors and measures standards of care and patient outcomes for trauma in the region and by hospital site. Two Northern Ireland TARN clinical reports were received providing core data on trauma, a focus on head and spinal injuries and abdominal and thoracic injuries. This information will be used for service improvement and to underpin the Network's programme of work to improve standards of care and reduce mortality and morbidity for seriously injured patients.

Raising the standards

Modernising Radiology Clinical Network (MRCN)

The HSCB/PHA established the MRCN in 2013 following the 2011 RQIA investigations into unreported plain film examinations. The Network's primary role was to oversee implementation of the recommendations outlined in the reports. The Network currently functions as a clinical advisory and implementation collaborative aimed at ensuring high quality, safe and sustainable diagnostic imaging services for the people of Northern Ireland. It is led by a Network Manager from the HSCB, supported by a Consultant in Public Health.

Diagnostic imaging is an integral part of modern healthcare and provides approximately 1.8million investigations in Northern Ireland each year. Imaging services play a role in diagnosing and screening for virtually all major illnesses and contribute to the planning of treatment. There is increasing recognition of the need to place imaging early in care pathways to reduce the time to diagnosis and treatment and to improve efficiency and effectiveness.



Some of the key achievements in 2017/18 include:

- Continued collaboration with the DoH in the recently published review of imaging services. The MRCN was represented at all of the public consultation events for the review.
- Detailed workforce review of radiologists, radiographers and assistant practitioners which will inform the regional workforce exercise being led by the DoH.
- Securing annual increases in the number of training places for consultant radiologists, which has seen the scheme recurrently expanded from 37 to 49.
- Development of a new regional pathway to expedite CT staging of new known cancers.
- Continued collaboration with other cancer / clinical reference groups.
- Appointment of the first consultant radiographer in Northern Ireland to the breast service in the Western Health and Social Care Trust.
- Continued investment in training radiographers to optimise the skills of advanced practice radiographers.
- Collaboration with colleagues from the University of Ulster to inform the undergraduate training requirements for advanced nurse practitioners in radiation protection for referring rights.
- Fully operational regional programme of Imaging Services Accreditation Scheme (ISAS) accreditation outlined below.

Raising the standards

Imaging Services Accreditation Scheme (ISAS)

The Society and College of Radiographers (SCoR) and Royal College of Radiologists (RCR) have worked together to develop ISAS to provide assurance that diagnostic imaging services offer patients consistently high quality services, delivered by competent staff, working in safe environments.

ISAS is based on current professional guidance updated annually and is independently assessed by the United Kingdom Accreditation Service (UKAS).

The ISAS scheme focuses primarily on the patient and their pathway through the imaging system. This includes how they access care, how they are cared for after their discharge and the quality of the services provided for them.

The Modernising Radiology Clinical Network (MRCN) considers ISAS to be fundamentally important for the future safe, effective provision of quality imaging services for the people of Northern Ireland.

A regional approach to deliver ISAS has been agreed in order to optimise opportunities for sharing learning across Trusts. A lead ISAS radiographer and lead ISAS radiologist have been appointed in each Trust and a regional lead from the HSCB oversees the programme.

A special interest group for diagnostic imaging has also been established which will consider relevant clinical guidance, audits and standards relating to diagnostic imaging as well as actively contribute to future revisions of the ISAS standard itself. This is a positive development for Northern Ireland and a real opportunity to participate and contribute to clinical development across the UK.

The regional ISAS programme has been commended as an exemplar model for collaborative working and a number of heath economies in England are now adopting the network approach to ISAS based on the Northern Ireland model.

4.3 Collaborative working

Mental Health Collaborative

The Mental Health Quality Improvement Collaborative, led by the HSC Safety Forum, continues to grow in strength. Since 2016 the work of the Collaborative has been focusing on the learning from the Thematic Review of Mental Health SAI Reports relating to Patient Suicides.

Templates have been developed by Trusts for safety briefings and the use of structured communication tools such as SBARD (Situation, background, assessment, recommendation, decision). These are now being tested, embedded and spread across mental health facilities in the Trusts.

The Collaborative also developed a core set of principles for reflective practice along with self-assessment questions and measures and Trusts are reporting success with these sessions.

To measure improvement in the overall culture, a Staff Safety Climate Survey was adopted. This was carried out in 2016 (baseline) and in 2017. In the 2017 survey more than 50% of the survey questions demonstrated positive increases in responses given.

Further developing the work of the Collaborative, the next topic will focus on communication with carers and, whilst in the early stages, there is already strong user and carer involvement.

Maternity Collaborative

PROMPT
Making Childbirth Safer, Together

In 2017/18 the Maternity Collaborative, led by the HSC Safety Forum has continued to support improvements in maternity services across Northern Ireland. The focus of the work has been safety in the intrapartum period of care. To support this work the HSC Safety Forum facilitated bringing the UK Practical Obstetric Multi-Professional Training (PROMPT) team to Northern Ireland to deliver the PROMPT programme in 2017. PROMPT is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working.

In total there were 52 participants from Northern Ireland joined by 24 colleagues from the Republic of Ireland.

To reduce variation and improve patient safety, the Collaborative have continued work on cardiotocography (CTG) evaluation and management of sepsis. The Collaborative has also agreed a regional dosing regimen for the administration of oxytocin, for use in the induction or augmentation of labour. This has now been incorporated into all Trust policies and guidelines.

Raising the standards

The work of the Collaborative has been recognised as an exemplar of good practice in an international publication entitled 'Healthcare Systems Improvement Across the Globe' (Braithwaite 2017). Additionally, the SAI process, which is administered by the HSCB, runs a regional group for maternity SAI's. The learning identified through this process is referred to the HSC Safety forum Maternity Quality Improvement Collaborative to ensure regional consistency when implementing learning.

Sepsis Collaborative

Improving sepsis care in Northern Ireland has been recognised as a strategic priority by the DoH. A regional quality improvement group has been established to take this forward.

In 2017/18 a new Sepsis Collaborative was established, led by the HSC Safety Forum, to scale and spread implementation of the Sepsis Six care bundle. Sepsis Six is the name given to a collection of medical therapies designed to reduce mortality of patients with sepsis. Sepsis is a life threatening condition that arises when organ failure occurs in the context of infection. The focus of the work is on early recognition and treatment of sepsis in emergency departments, acute medical and surgical, intensive care and high dependency settings. A workshop was held in March 2018 where a range of health professionals from all Trusts had an opportunity to listen to Dr Vida Hamilton, National Clinical Lead for Sepsis, Health Service Executive, discuss the work to improve sepsis care in the Republic of Ireland.

The sepsis work in Northern Ireland is being deliberatively linked to the regional antibiotic governance agenda given how important it is that these two strands of work coexist effectively.

Raising the standards

All Island Collaborative: Enhanced Care Guidelines

An All Island Collaborative Task Group has been set up by the Chief Nursing Officers in Northern Ireland and the Republic of Ireland, to take forward a piece of work to develop key principles for enhanced care that will be applied in both jurisdictions. The PHA has been involved in this collaborative initiative and has provided funding for the progression of the Northern Ireland pilot site. This work has been developed in line with the principles of Quadruple Aim. The Quadruple Aim model suggests that healthcare institutions simultaneously pursue four dimensions of performance. Namely:

- Improving the health of the population;
- Enhancing the patient experience;
- Reducing costs; and
- Improving the work life of healthcare providers, clinicians and staff

Enhanced care refers to the requirement of care outside of normal staffing levels. It is an activity where an allocated member of staff is constantly aware of the precise whereabouts of a patient through visual observation or hearing. Enhanced care should benefit both the patient and the staff involved. It is crucial that therapeutic activities appropriate to the patients' needs are undertaken as part of the enhanced care process.

Through collaborative working and aligning best practice guidance, the All Island Collaborative seeks to:

- Provide information through the development of a national all island guideline on shared key principles and outcome measures based on best practice;
- Provide guidance for the use of enhanced care observations that meets agreed patient needs, is cost effective and justifiable in each jurisdiction;
- Improve quality of care by ensuing that staffing and intervention reflect patient need;
- Support use of enhanced care in acute hospital and continuing care settings across the island of Ireland;
- Ensure decision making processes around assessment, alternative interventions, recording, and reassessment and monitoring of enhanced care are in place;
- Develop, test and implement local guidance to assess need and maintain safe patient care in each jurisdiction;
- Reduce the number of incidents relating to patient safety enhanced observations eg falls, complex behaviours etc.

Raising the standards

4.4 Strategy Implementation

Q2020

The PHA linking closely with HSCB, Trusts and Arm's Length Bodies lead the regional implementation of the Q2020 Strategy on behalf of the DoH. A number of taskgroups have been established to take forward work aligned to the Strategy. The focus for 2017/18 has been in the following areas:

- **Developing Professional Leadership** – this regional task group, chaired by Professor Charlotte McArdle, DoH, last year focused on standardising level 2 & level 3 training programmes aligned to the Q2020 Attributes framework.

- **Supporting staff involved in SAIs and other incidents** – this regional task group was chaired by Dr Cathy Jack, Belfast Health and Social Care Trust and Bob Brown, Western Health and Social Care Trust. Last year the group focused on understanding the level of support that was available to staff following an incident, and explored the concept of Schwartz rounds, in order to inform the development of a model of support for staff.
- **Strengthening our response to adverse incidents** – this task group, lead by Director of Nursing in Southern Health and Social Care Trust, focused on testing models to identify and implement learning following adverse incident within the Trust.
- **Developing a model for the development of Always Events in NI.** Last year the regional group, chaired by Mary McElroy, PHA focused on piloting an Always event in each Trust based on feedback from patient and client experience.
- **Improving patient safety through multi-disciplinary simulation & human factors training.** This regional group, chaired by Dr Mike Morrow, Northern Ireland Medical and Dental Training Agency and Caroline Lee, Clinical Education Centre focused on the development and testing of faculty relating to human factors and de-briefing last year. Additionally, the NI Simulation and Human Factors Network (NISHFN) continued to evolve, establishing specialist interest groups pertaining to human factors and paediatrics.

- Last year work began, led by Dr Mark Roberts, Safety Forum which aimed to ultimately **reduce the reoccurrence of the 3 main categories of Never Events**. This work will be progressed during 2018/19.

The PHA /HSCB hosted a regional Q2020 Event in November 2017 to coincide with world quality day. The aim of the event was share the work ongoing relating to Q2020 with the HSC. The event provided an opportunity to highlight the positive work which is on-going in relation to Quality 2020 and the wider quality agenda and provided a platform to share, learn and generate new ideas in relation to quality improvement.

Raising the standards

Dementia Together NI

The HSCB and PHA led the regional implementation of the Dementia Together NI (DTNI) project which ended in March 2018. This three year project far exceeded all expectations and targets.

The Dementia Together NI project received a number of prestigious awards and all four strands of the project have been independently evaluated by external evaluators and the findings were very positive.

Awareness raising, information and support

- Development of a public information website.
- Publication and distribution of 11 information booklets covering subjects as diverse as communicating effectively with a person with a dementia and choosing a care home to dental care, sight loss and planning ahead with dementia.
- Appointment of ten (Band 6) dementia navigators and development of operational guidance based on the findings of an external evaluation of the initiative.
- Appointment of 19 dementia companions in acute hospitals
- #STILLME, an extensive and effective public awareness campaign that included TV, radio outdoor, press, online and social advertising.
- Information developed for GPs and available on the GP intranet.

Short-breaks and support to carers

- Design (in collaboration with service users) and delivery of five short break pilot schemes. Schemes included extended domiciliary care services, befriending, night services and the provision of short vacations to 229 individuals.
- One hundred and eighty individual training courses provided information, training and support to 2463 informal carers.

Future of Dementia Together NI

Building on the success of the project, proposals have been submitted to the DoH in relation to the following, all of which are at various stages of development or implementation:]

- Publication (including promotional materials) and implementation of an agreed regional Dementia Care Pathway including the roll out of the Occupational Therapy Cognitive Rehabilitation Model which was initiated through the regional memory services collaborative. All Trusts have begun to look at how this pathway can be implemented and identifying the resources required.

- On-going work of the Delivering Social Change Phase 2 Dementia Project to develop improved e-health and social care systems and the collection and analysis of dementia care data. This project also includes a raft of research programmes over the next three years.

Raising the standards

- Improvements in dementia care in hospitals including implementation of recommendations from the audit of dementia care in acute hospitals and the roll out of John's Campaign.

- Improved locality planning processes to ensure meaningful engagement with local communities to build sustainable models for dementia care as new commissioning structures and processes are established.
- On-going work to embed the Learning and Development Framework and promote staff development within Dementia Care services.

- Promote research in three main areas - *cause*, *cure* and *care.*

Further information in relation to Dementia
http://www.hscboard.hscni.net/dementia/
www.NIDirect.gov.uk/dementia

Promoting Physical and Sensory Disability Strategy

The Physical and Sensory Disability (PSD) Strategy Implementation Group have operated on a co-production model. During 2017/18 a range of improvements which resulted in co-produced support for service users and staff have progressed including:

Regional communication support services

- Following extensive public consultation transition plans commenced in 2017/18 to transfer current communication support services for deaf and hard of hearing people to a regional shared service supplied by the Business Services Organisation

Sensory support service DVD

- Belfast Health and Social Care Trust Sensory Support Team produced a regional DVD on behalf of the PSD Strategy Implementation Group to provide information on sensory disability, possible causes and effects and supports. Service user's co- produced the DVD and shared their experiences of Sensory Support Team services.

Social networking services

- Social networking services were commissioned last year for people with physical and sensory disability. These services enable sustained community engagement for disabled people with the view to helping prevent disabled people needing care and support in the first place or from developing long-term dependencies on health and social care provision. All Trusts have implemented this initiative.

4.5 Improving partnerships

Developing eye-care partnerships

The Developing Eyecare Partnerships (DEP) strategy was launched in 2012 and led to a five year project to improve the commissioning and provision of eyecare services in Northern Ireland. The HSCB/PHA are jointly implementing the strategy. Below are some of the reported impacts of the work of the DEP project.

- **Patient**
  I thought I had to go to the hospital to have my red eye checked but now I can go to my local optometrist.

- **GP**
  Patients had come to me, then the optometrist, back to me, then to the hospital. Now they can go straight to their optometrist and onto the hospital for treatment.

- **The ophthalmologist**
  I can now offer care to more glaucoma patients due to the extension of the roles of allied health professionals.

- **Nurse specialist**
  I can now provide additional care to patients in the macular clinic as I have been trained in giving intravitreal injections.

- **Optometrist**
  I can now view the details of my patients eye problem, straight from their electronic care record so that, like their GP and hospital clinic staff I can involve the patient in their care more.

Raising the standards

- **The sensory support team**
  Patients in Northern Ireland are no longer 'registered blind' so it is easier for us to offer vital support without causing anxiety.

- **The eye casualty team**
  Optometrists now work alongside ophthalmologists in eye casualty which speeds things up for patients.

- **The HSC trust manager**
  Collective management of eye-care services has led to smarter use of resources.

For further information
http://www.hscboard.hscni.net/our-work/integrated-care/ophthalmic-services/developing-eye-care-partnerships/

Palliative Care in Partnership

Palliative Care in partnership

Palliative Care is about improving the quality of life for those with needs and improving the experience of those important to them. The Regional Palliative Care Programme – *Palliative Care in Partnership*, is led by the HSCB/PHA and brings together people with palliative care needs, those who care from them, clinicians and other professions, service providers, planners and DoH to ensure the delivery of a whole system, holistic approach to support and care. Ensuring that "what matters to me" is addressed for each person with palliative care needs, whether the need be physical, psychological, social or spiritual.

> *You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die.*
>
> *Dame Cecily Saunders*

Raising the standards

For some people, where they are cared for, matters to them. Given the choice most people would prefer to be cared for in their own home (which include residential and nursing home) at the end of life. In 2016, 47% of all deaths occurred in hospital, compared with 52% on 2010. The Programme aims to support a greater number of people who wish to be supported in their own home. In order to achieve this aim, Palliative Care in Partnership Programme is working to:

- **Raise awareness of palliative care which includes events during palliative care week in September.**
  Last year's theme was 'What have you heard? which aimed to clarify some myths about palliative care.

- **Implement processes to have proactive earlier identification of palliative care need.**
  Currently there are 46 GP practices engaged in an early identification prototype project with plans to expand to all practices in the coming year.

- **Allocate those with identified palliative care need a keyworker to help co-ordinate care across the system.**
  Typically the keyworker will be the persons District Nurse. Some resources have been allocated towards District Nursing. Districts Nurses have also undertaken additional training to enable them support people with palliative care needs and those important to them as part of their role.

- **Provide tools to enable the opportunity for the public to have advance care planning conversations and record them if they wish to do so.**
  In partnership with Macmillan Cancer Support the partnership has developed a free resource for the public to help them understand more about making plans for the future eg such as making a will, funeral plan or their wishes and preferences for care at end of life. In addition approximately 1000 staff have been trained in advance care planning.

- **Improved access to generalist and specialist palliative care services**.
  There has been additional specialist palliative care posts across the region to ensure those with complex palliative and end of life care needs can be supported. Tools and guidance have been developed to support specialist palliative care professions such as the management of symptoms in palliative care & the role of the specialist palliative care professional.

4.6 Population Screening in Northern Ireland

Early diagnosis through screening can lead to improved outcomes for a number of health conditions. The PHA is responsible for commissioning and quality assurance (QA) of eight antenatal, newborn and adult screening programmes:

Antenatal and newborn screening programmes:

- Antenatal infection
- Newborn blood spot
- Newborn hearing

Adult screening programmes:

- Abdominal Aortic Aneurysm
- Bowel cancer
- Breast cancer
- Cervical cancer
- Diabetic Eye

The key aim of population screening programmes in Northern Ireland is the early detection of disease as early detection often produces better outcomes for patients. The programmes demonstrate and reflect the highest levels of service quality as set out in national guidance and specifications. In addition, assuring the quality of screening is a fundamental objective embedded within all population screening programmes. This remained a key task of the PHA within 2017/18. Rigorous checks and measures have, and continue to be, in place. Where necessary, recommendations to improve practice have been provided to HSC providers.

• Cancer screening

Early detection of disease through population screening programmes often produces better outcomes. However, it is recognised that deprivation is associated with lower rates of participation in cancer screening. The PHA awarded a three year contract to the Women's Resource and Development Agency (WRDA) to raise awareness and promote informed choice in uptake of the cancer screening programmes. In 2017/18, peer facilitators delivered 127 educational awareness sessions to participants from disadvantaged, diverse and sometimes remote backgrounds. This included Africa House Women's Group, Kates Bridge Rural Support Group, Rathlin Development and Community Association, and Shankill Sure Start.

BE CANCER AWARE

Raising the standards

• Cervical screening

During 2017/18, the PHA worked with laboratories and primary care colleagues in the HSCB to take forward a number of initiatives to support the quality of the cervical screening service being delivered at primary care level. This included:

- Developing a process which enabled sample takers to record their own unique code against each sample. This improved the process for audit of individual performance, such as activity levels and inadequate rates and will allow audit reports to be generated for each primary care practice or clinic. The PHA also collaborated with primary care colleagues in the HSCB to develop an audit tool to support practices in undertaking audits and to help assure the quality of cervical samples being taken within practices.

- Developing a regional practice protocol for the provision of cervical screening services which was shared with all GP practices. The template may be adapted for use in each general practice and is aligned with current national and regional policy, standards and guidance for cervical screening. The intention is that this protocol will assist in standardising the service delivered at primary care level across Northern Ireland.

Cervical Screening

• Abdominal aortic aneurysm screening

Working with service users to explain individual programme aims and to increase uptake is clearly important. Within Abdominal Aortic Aneurysm (AAA) screening, service user engagement is facilitated through a range of recurring and targeted mechanisms. This includes the programme's annual service user event which brings together service users and programme providers to receive updates on programme performance, recent service developments suggested by service users and potential areas for improvement. Three patient representatives contribute to the programme's commissioning group to further support Personal and Public Involvement (PPI) and co-production initiatives related to the continued advancement of AAA screening in Northern Ireland.

AAA Screening

• Training and development for screening

A key element of work has been to support and facilitate the ongoing training and personal development of staff within population screening programmes. For example, within the Diabetic Eye Screening Programme staff have undertaken eye screener-specific training. Likewise, staff within the AAA and Breast Cancer Screening Programmes have benefited from peer review training (professional and clinical advisor training) alongside colleagues from similar English NHS Screening Programmes. This is integral to maintaining excellence and high standards of programme delivery. It also ensures staff are trained and equipped to both undertake and participate in external quality assurance visits - the key benchmark for population-based screening programmes.

For further information on screening programmes please see **http://www.publichealth.hscni.net/directorate-public-health/service-development-and-screening/screening**

4.7 Working with marginalised communities

Black and Minority Ethnic (BME) Groups

The health of migrants and Black and Minority Ethnic groups is an important area of focus, because of the poorer pattern of health experienced by these groups. Whilst many minority ethnic communities have close social networks and strong cultural beliefs and practices which can promote health and social wellbeing, it is also known that their experience has led to patterns of health inequality.

In April 2012, the PHA in collaboration with the HSCB, commissioned the BHSCT to provide the Northern Ireland New Entrant Service (NINES) by building on their existing Tuberculosis (TB) screening and BCG vaccination programme for 'at risk children'.

NINES offer a range of clinics which include:

- an holistic assessment of the health and well-being needs of new entrants
- continuing the TB screening and targeted BCG programmes
- increasing uptake of vaccinations (other than BCG)
- assisting with primary care registration
- supporting transition to mainstream services
- signposting to appropriate health services.

Raising the standards

It has been essential to work closely with BME communities to increase engagement and participation and develop appropriate health promotion and peer education programmes to improve equity of service and the quality of care provided. Housing, poverty, community relations and education have a significant impact upon health and wellbeing and, in order to assist in addressing these issues, the NINES team has developed multi-agency links with other statutory and voluntary organisations.

A new 4 year pilot programme funded by PHA, *'Mental Health 1+1 Project'*, supports the mental health and emotional wellbeing needs of BME communities. Three bi-lingual workers have been appointed to deliver support to local BME communities.

The project also aims to raise awareness within BME communities of wider services available beyond the project, and to make service providers aware of the need to adapt approaches to increase access from BME Communities. The project has highlighted that for European clients (clients predominantly Polish, Portuguese, Lithuanian) with little or no English, the main issue appears to be the language barrier, rather than a significant difference of cultural perspective on mental health. For African and East Timorean clients (predominantly Portuguese speaking) and for Chinese (both Cantonese & Mandarin speakers), a key cultural issue has been familiarising the client with the concept of mental health and emotional wellbeing, as something that they should and could enjoy.

Since 2012, the PHA has funded STEP (South Tyrone Empowerment Programme) to develop, manage and sustain an inclusive, collaborative, regional minority ethnic health and social wellbeing, good practice and information sharing network. A website has been developed which allows members to share good practice and keep up to date with BME activity. This, alongside regular e-alerts, seminars and an annual conference, focuses on members' needs and current issues which impact upon our BME population. This work builds on the strengths of members and has been an important mechanism for developing connections and improving outcomes.

For further information on STEP programme see **www.strongertogetherni.org**

Raising the standards

Travellers

It is difficult to accurately assess how many Travellers are currently living in Northern Ireland. The All Ireland Travellers Health Study (AITHS) carried out in 2010 estimate a population of 3,905 Travellers living in 1,562 families. The study also shows that the age profile of the Traveller community in Northern Ireland is markedly different from that of the general population, with 75% of people under the age of 30 years. Only 1% of Travellers are over 65 years compared to over 15% of non-Travellers. There are significant differences in life expectancy and other health and wellbeing outcomes for Travellers.

Consequently, addressing improvements in the circumstances in which Travellers live, learn and work, as well as improving access to services is essential. The Travelling community experience prejudice and racism in almost every aspect of life. This experience has a very detrimental effect on health and wellbeing.

The PHA and HSCB convened a Travellers Health and Wellbeing Forum in October 2010. The Forum, which includes Trusts, Education Authority, Traveller Support Groups, voluntary sector organisations and the HSCB/PHA, is committed to progress the recommendations outlined within the *All Ireland Travellers Health Study*, particularly with regard to health and wellbeing. This is achieved through the development of a yearly action plan with the Forum meeting four times a year to report on progress and agree new priorities. A particular emphasis has also been given to emotional health and wellbeing and PHA commission *Aware NI* to deliver regional mental health and emotional wellbeing programmes for Travellers. The Forum also works with other agencies and seeks to influence a more coordinated approach to meeting need alongside informing mainstream services so that access is improved.

In addition to the Forum, the PHA commission services from the Southern, Western and Belfast Trusts to deliver a range of programmes to address the needs of Travellers.

Services include:

- community development
- family support
- health programmes
- training and education
- signposting to services such as smoking cessation, cancer screening
- drug & alcohol services
- support to engage in local services e.g. Healthy Living Centres
- cultural awareness training
- support to engage in conflict resolution within families and communities

Raising the standards

Event speakers pictured at the Dementia Together NI celebratory event. Back row (from L-R): Eleanor Ross, PHA, Seamus McErlean, hscb, Chris Matthews, DoH, Tara Collins, Dementia NI, and Professor Assumpta Ryan, Ulster University. Front row (from L-R): Jerome Dawson, DoH, Andrew Dougal, PHA, Lorna Conn, HSCB and Sarah Penney, Ulster University.

Above pictured at the Q2020 Event in November 2017. L-R Dr Carolyn Harper, PHA, Dr Michael McBride, DoH, Carol McCullough, service user representative, Prof Charlotte McArdle, DoH, Mary Hinds, PHA.

Theme five

Integrating the care

Integrating the care

5.1 Introduction

The HSCB and PHA are committed to ensuring the integrated HSC system in Northern Ireland is effective and that there is seamless movement across all professional boundaries and sectors of care. A number of key improvements were led by the HSCB/PHA last year. This made a significant contribution to raising the quality of care and outcomes experienced by patients, clients and their families.

5.2 Centre for Connected Health and Social Care

The Centre for Connected Health and Social Care (CCHSC), located within the HSCB and PHA, promotes the use of technology and innovation in the HSC system in Northern Ireland. The primary purpose of CCHSC is to improve patient/client experience and to provide better quality and more effective care.

During the year the CCHSC continued to contribute to improving health and wellbeing through a number of partnership activities including:

encompass

e-Health and Care strategy

CCHSC has led the implementation of the eHealth and Care Strategy, ensuring that the strategic aims of the HSCB/PHA are fully reflected contributing to all of the workstreams, with a focus on supporting people, sharing information and fostering innovation projects. The CCHSC has also been supporting work on the 'encompass' programme, supporting various engagement activities and developing the Personal Public Involvement model to support involvement of patients, carers and the public.

HSC Online

A health conditions A-Z platform is being developed which will provide a comprehensive suite of health information, supporting people to make decisions in relation to their personal illness and chronic conditions. Hosted by *Nidirect*, the HSCB eHealth initiative developed in conjunction with the PHA will promote self-management where appropriate, and help people decide whether their condition has reached the threshold where advice or clinical assessment is required. It will link to signposting of appropriate services, assisting people in accessing services they require. Links will be provided to GP practices to book appointments online and order prescriptions, where these services have been made available by practices. In parallel, work will continue migrating content currently hosted on HSCB/PHA websites, to the N*idirect* platform.

Integrating the care

eHealth and Data Analytics Dementia Pathfinder Programme

CCHSC has been delivering the eHealth and Data Analytics Dementia Pathfinder Programme of work. The programme can be divided into two distinct areas:

- **eHealth projects** comprising of:
  - a **patient portal** and **app** for people with a diagnosis of dementia and their carers linked to the Northern Ireland Electronic Care Record (NIECR), as well as providing the IT infrastructure and security to support such portals and apps;
  - the development of a new patient care pathway, through the support of "**Project ECHO**" for dementia;
  - a local enhanced service for the completion of **key information summaries (KIS)** in the NIECR for the majority of dementia patients. This will mean that the patients will be recognised and flagged as having dementia across the electronic system.

- **Data analytics** projects comprising of:
  - **Setting up of data analytics platform and team** to undertake a scoping study to develop data analytics capability within health and social care;
  - **Commissioning Queen's University Belfast research** to develop a strong academic research base, ensuring clinical input and data analytics expertise is at the heart of the programme and can link, learn and disseminate information to the data analytics team from international and best practice approaches;
  - **Dementia analytics and research projects** - to commission ten dementia analytics projects exploring issues critical to patient outcomes and service planning and to assist in service development and design.

EU Engagement and projects

CCHSC is a member of DoH-led EU Engagement Forum set up to inform strategic directions and co-ordinate information about EU funding streams and networks. CCHSC led by HSCB / PHA works with Trusts, universities and industry to pursue both UK and EU funding opportunities to support HSCNI's contribution to the work of the European Innovation Partnership on Active and Healthy Ageing (EIP AHA).

5.3 Integrating care at home

24 hour District Nursing care

During 2018, *A District Nursing Framework 2018-2026 - 24 Hour District Nursing Care No Matter Where You Live* was launched. The Framework aims to provide the strategic direction for the provision of district nursing services in Northern Ireland. It paves the way for developing a service that is innovative, collaborative and transformed, available 24 hours a day, seven days a week, no matter where the patient lives. An outcomes based approach has been adopted for the four principles in the framework, which are

- Person centred;
- Efficient and effective;
- Expert;
- Integrated and population based around General Practice.

A number of improvement priorities, actions and indicators of success have been identified for each of the four principles. The PHA will be responsible for taking forward the implementation plan linking closely with HSCB and other stakeholders to progress the outcomes in this Framework, using a collective leadership approach.

Prof Charlotte McArdle, DOH Chief Nursing Officer:

"I believe this Framework sets the way forward for all of us to work together to deliver a world class district nursing service. I am confident that the implementation of the Framework will have a valuable impact on delivering safe and effective person centre care by district nurses and their teams in community settings."

Transformation of the home oxygen service

Oxygen therapy is vital in supporting adults and children with breathing difficulties, including those with long-term medical conditions such as cystic fibrosis and chronic obstructive pulmonary disease (COPD). Access to oxygen at home helps users to manage their symptoms so that they can live effectively in the community, rather than needing to be cared for in hospital.

The provision of oxygen therapy involves a range of health professionals in secondary and primary care settings who contribute to the patient's journey of care from initial clinical assessment to the supply of oxygen at home. Currently there are approximately 4,000 patients on oxygen therapy at home in Northern Ireland.

Integrating the care

Old service model

In Northern Ireland, oxygen therapy can be prescribed by GPs. The GPs assess the clinical needs of patients and determine the appropriate oxygen flow rate and hours of use per day. The service model required a large amount of communication between secondary care to advise GPs on prescribing. The service does not make any provision for the modern modalities to supply long term oxygen, nor does it make provision for a four hour response rate to allow discharge from hospital, offer a tapped install service to allow a safer installation of oxygen, or offer a 24/7 call-out service.

Transformed service model

Advances in oxygen technology, especially portable and transportable concentrators and liquid oxygen mean that patients with high oxygen demands can be supported to live at home, be active and have greater freedom and autonomy in managing their oxygen needs. In April 2017, 3752 patients received a home oxygen concentrator via the specialist oxygen contract. This may have been a standard, portable, transportable or self-fill concentrator. The average number of new patients per month is 210.

Community pharmacy hidden carers pilot

The Community Pharmacy Hidden Carers pilot began in the South Eastern Local Commissioning Group (LCG) area. Evidence shows that many carers become isolated through the demands of their caring role and are twice as likely as those who are not in a caring role to suffer from ill health. The aim of the pilot was to use community pharmacists to identify those carers who were not currently in touch with services and therefore unidentified. The role of the community pharmacist was to promote the Carers Support Service and thereby enable carers presenting at pharmacies to avail of the services.

Forty four pharmacies in the LCG area took part in the pilot and mandatory training sessions were held. An evaluation of the pilot was undertaken and the results showed that there were 61 referrals across the participating pharmacies. Thirteen of the carers were contacted for detailed feedback of the service. Ten of those contracted reported that they would not have known that the Carer Support Service was available if they had not been identified by the pharmacist. The evaluation recognised the value of community pharmacies in identifying hidden carers and recommended continuation of the pilot in the area and consideration of rollout across other areas. The service has been extended for a further six months across the South Eastern LCG. Both the Northern and the Western Trusts have identified funding to commence the project. The Southern Health and Social Care Trust hope to introduce the service and provisional discussions have also been held with Belfast Health and Social Care Trust.

5.4 Local enhanced services

Key Information Summaries

HSCB developed a Northern Ireland local enhanced service to introduce and train GPs in the use of key information summaries in 2017/18. The key information summary (KIS) is a summary of medical history and patient wishes. It allows GPs to record useful data about their patients which is then visible on the electronic care record (ECR) in unscheduled care settings such as GP out-of-hours and emergency departments. The information contained in the KIS helps to ensure improved patient safety and continuity of care. It allows accurate information to be quickly identified in an emergency and avoids key information having to be repeated several times.

Patients with dementia were identified as a group who would particularly benefit from use of the KIS therefore there was a particular focus on this group of patients.

A total of 152 GP practices were contracted to provide the KIS enhanced service in 2017/18 and have all completed the relevant training. The contracting GP practices are expected to have completed 5781 KIS assessments by the end of June 2018 with KIS assessments completed on 50% of their registered dementia patients. This will equate to 3374 assessments on dementia patients by the end of June 2018. By 31st March 2018 a total of 3464 KIS assessments had been successfully completed by GPs.

Oral Surgery - Personal Dental Services Pilot 2017/18

In 2017/18 an oral surgery Personal Dental Services (PDS) pilot was established to improve patient access to specialist oral surgery treatment within primary care and to reduce demand on secondary care. Within primary care in Northern Ireland there are six specialist high street oral surgery (HSOS) practices which treat health service patients on referral from general dental practitioners. However, in recent years HSOS activity under the health service has declined dramatically with providers citing economic reasons.

The oral surgery contractual arrangement being piloted offers HSOS practices a more viable business model but at the same time requires from them a greater commitment to health service provision. The pilot benefits the wider HSC through reduced pressure on secondary care, more effective use of Trust resources, increased value for money and greater financial control and predictability.

Integrating the care

Outcomes are positive for patients as well as overall waiting times are reduced.
Although in its infancy and still being evaluated, the pilot has clearly been successful in reversing the downward trend in the high street oral surgery service.

Additional key 2017/18 pilot outcomes include:

- Approximately 3000 more patients in 2017/18 received specialist oral surgery care within primary care than during 2016/17 (an increase of 26%).
- Equity in patient access has improved as service provision has increased across all five LCG areas.
- 1271 fewer oral surgery referrals were made to secondary care during the pilot period than in the same months of the previous year (a reduction of 12%).

A second phase of the oral surgery pilot is currently ongoing to allow for continued primary care oral surgery service provision, more extensive pilot evaluation and potential further refinements to the future service model.

Management of *Clostridium difficile* in the independent sector care and residential home setting

Laboratories in Northern Ireland notify the PHA of all *clostidium difficile* infections. On notification a reporting proforma is completed which contains information about the patient and associated risk factors, including antibiotic history in the last four weeks. Following completion of the proforma prompt Infection Prevention and Control (IPC) is given in relation to isolation of those infected, hand hygiene, appropriate use of personnel protective equipment, environmental and equipment cleaning and decontamination.
A guidance pack containing the advice is also emailed to the facility.

A twice weekly risk assessment review of all notifications is completed where they are risk assessed and decisions are made about the ongoing management. These meetings aim to provide assurance about IPC practice and can include;

- The provision of further expert advice and support via telephone or through the completion of support visits to the facility. The visit can also be used to gather information about IPC practice.

- Sharing of audit tools to help provide assurance of IPC and control practice such as hand hygiene and equipment audit.
- Support through teaching sessions for staff in relation to IPC – including the theory and practice.
- Providing a link between independent sector care home, GPs, Trusts and the Regulation Quality Improvement Authority (RQIA). These links ensure the direct dialogue of all stakeholders, continuity of approach will enhance resident safety.
- Encourage compliance with antimicrobial stewardship through awareness of Northern Ireland primary care guidance and through direct access to HSCB pharmacy colleagues.

A root cause analysis is carried out where appropriate, following a confirmed case of *clostridium difficile* infection. This analysis can identify factors that may have contributed to the person acquiring the infection. Learning is then shared with the relevant agencies.

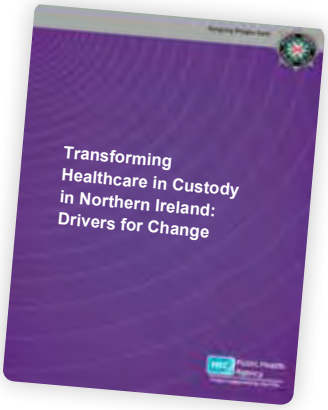
5.5 Criminal Justice Healthcare

The DoH and Department of Justice (DoJ) consulted on a draft joint healthcare/criminal justice strategy in 2017/18. The PHA and HSCB were instrumental in driving forward a number of recommendations for the regional action plan. Progress has included:

- An associated services multidisciplinary team for prison healthcare has been reconstituted; a mandate and work plan has been agreed.
- As part of commissioning team, work has been ongoing to formulate a plan to outline the requirements for the future service.
- As part of a ten point plan, proposals have been made to the DoH to take forward a number of transformation proposals to build on and progress the health needs assessment in prison environments.

During 2017/18 a multidisciplinary workforce review has been initiated and this will be evaluated in line with the service requirements, demand and supply of the recommended workforce for prison healthcare.

Joint PHA and PSNI Police Custody Pathfinder



A number of consultations and a regional workshop has taken place with key stakeholders to progress recommendations for the development of a Trust led model for healthcare in custody. The PHA in conjunction with DoH, DoJ and PSNI and the Belfast Health and Social Care Trust is leading work to develop a Trust led model for healthcare in custody. A joint funding envelope has been agreed to progress and test the model through a nurse led pathfinder in 2018.

The specification for the pathfinder has been successfully established with a plan to have this in place by September 2018. In parallel to this the regional roll out for nurse led services in custody suites is being progressed by a regional Task and Finish group co-chaired by PHA and PSNI.

5.6 Integrating the care for Learning disability services

Annual health check: patient pathway to support the development of a health and wellbeing plan

Health and wellbeing plans identify the personal health and wellbeing needs of individuals and describe the actions to empower individuals to make healthy choices to improve their health. Within the learning disability services a core quality indicator specifies that each person with a learning disability who receives an annual health check should have a health and wellbeing plan in place.

A patient pathway has been developed as well as detailed guidance in order to assist Trusts with the implementation of individual health and wellbeing plans for adults with a learning disability. The pathway and guidance will facilitate a consistent regional introduction to the development and implementation of health and wellbeing plans. A multi-disciplinary approach will describe roles and responsibilities and ensure the plans become integral and routine to existing assessment, care planning and review processes.

HSC Hospital passport for people with learning disability

The PHA has worked with HSCB and Trusts, education providers, people with a learning disability and their families and carers, to design the Hospital Passport and guidance notes for staff.

This involved consultations with a wide range of individuals with a learning disability, healthcare staff, voluntary organisations involved in the support and delivery of services to people with a learning disability, and family and carers.

The purpose of the Hospital Passport is to provide important information about the person with a learning disability. This information will help staff in general hospital settings make reasonable adjustments in order to support safe and effective care. This in turn will improve patient/client experience of care and treatment.

The Passport was launched in May 2017, with copies being distributed to each of the Trusts and to a number of the larger community and voluntary sector organisations working with people with learning disabilities across Northern Ireland.

In August 2017 following feedback received from healthcare professionals and carers the Passport was also made available in an accessible format. Individuals can type onto the document, print or save to a mobile device. The PHA has also provided a PPI award to an Association for Real Change (ARC) project called *Telling It Like It Is* (TILII). TILII is an organisation that works with individuals with a learning disability, who assisted with the evaluation of the Passport. TILII has engaged with peers to develop an easy read evaluation tool that can be used as part of the wider PHA evaluation.

Both the Passport and guidance notes are also available to download from the PHA website. **http://www.publichealth.hscni.net/publications/hsc-hospital-passport-and-guidance-notes**

5.7 Quality improvement: babies, children & families

Getting Ready for Baby

The Early Intervention Transformation Programme (EITP) aims to improve outcomes for children and young people across Northern Ireland through embedding early intervention approaches. There are a total of three workstreams within EITP. Workstream one is divided in to two areas

1. Getting Ready for Baby
2. Getting Ready for Toddler.

Getting Ready for Baby is a new way of delivering care and supporting first time parents through pregnancy, labour and birth and preparing for the early days of baby's life. It links antenatal appointments and parenting group support for the first time in Northern

Integrating the care

Ireland. This means that first time mothers will be part of an antenatal parenting group that meet at various points during pregnancy and will also receive antenatal care at this visit.

Getting Ready for Baby helps new parents get to know and develop a relationship with their baby using the Solihull Approach, an evidence based programme focused on emotional health and wellbeing. Getting Ready for Baby is currently only for first-time mothers with no major health issues.

Extensive data collection has been ongoing and the programme has received excellent feedback from a number of sources using questionnaires to evaluate. Feedback comments included:

> "The assurance of knowing others are experiencing the same ups and downs as you makes pregnancy much easier. You will leave armed with knowledge, confidence and a support group for life. The midwives are fantastic and will guide you through this wonderful time".

3+ Review

Work Stream One of EITP has designed an evidence informed approach to the 3+ Health Review using an integrated health and education review for children in their pre-school year. Whilst this is intended to be a holistic review, particular focus is on social, emotional and behavioural development.

As part of the programme the health visiting service will work together with nursery school principals and pre-school leaders to offer a 3+ Health Review for children attending pre-school education. The 3+ Health Review requires the parent/carer to complete a questionnaire and attend a short interview at the pre-school setting with the health visitor. The pre-school leader/nursery school teacher also has the opportunity to highlight any concerns or issues. It is designed to be easy to complete by parents at home or in the pre-school education setting with minimal support.

The 3+ Review has been well received by parents and this has been highlighted in the parent questionnaires.

Integrating the care

EITP Publications

The PHA worked with a number of key professionals across Northern Ireland to standardise child development public health information which was supported by the EITP.

A targeted consultation supported by Parenting NI, was conducted alingside the development of these messages to ensure they were appropriate to service user needs. This information has been distributed to Trusts, GP practices, Early Years settings and libraries to ensure messages are cascaded to help improve the health and well-being of children.

http://www.publichealth.hscni.net/publications/playing-parents-number-one-three-posters

http://www.publichealth.hscni.net/publications/helping-your-baby-learn-talk

http://www.publichealth.hscni.net/publications/helping-your-child-learn-talk

Safe sleeping

As a result of the findings of the Northern Ireland Infant Death Thematic Review (2015) we have a better understanding of sudden and unexpected infant death in Northern Ireland.

The PHA used the findings from the thematic review to highlight the key messages which aimed to prevent further deaths, and improve the health, safety and wellbeing of children. In consultation with practitioners from the key disciplines across the Trusts two new resources have been developed to assist practitioners to provide consistent messages about safe sleeping regularly both in the antenatal period and postnatally. The resources include a Parent Information Card and a Risk Assessment Tool.

Children with Special Educational Needs

The PHA hosted a number of regional workshops with staff from Trusts, the Education Authority and Department of Education to improve health input to the educational statutory assessment process. From these events a number of recommendations and actions have been put in place which will ensure regional standardisation of health advice in the statutory assessment process. This will ensure that children with Special Educational Needs (SEN) are identified and assessed in a timely manner, and advice provided within the statutory assessment process is provided within the specified timeframe. There was a high level of co-operation between health and education in ensuring this work meets the legislative requirements of the Children's Services Co-operation Act (Northern Ireland) 2015 to improve children's wellbeing.

Integrating the care

Supporting speech, language and communication (SLC) in Sure Start

There are 39 Sure Start projects delivering services in the 25% most deprived areas in Northern Ireland. The supporting speech, language and communication (SLC) programme in Sure Start aims to:

- support parents and staff to provide language rich environments;
- support early identification of SLC need; and
- ensure timely access to appropriate additional support.

To achieve the aims of the SLC programme, the PHA, working with key stakeholders, implemented *Wellcomm*, a speech and language screening tool in order to:

- help with the early identification of speech, language and communication needs
- help identify the appropriate type of SLC support
- monitor the SLC progress of the children

The Wellcomm Screening tool uses a red, amber, green scoring system to indicate if a child's language is age appropriate (green), has some difficulties (amber) or is delayed (red). It was administered in Sept/Oct 2016 prior to the SLC development programme being implemented and then re-administered in May/June 2017 following the SLC development programme.

SLC Programme Target	Achieved
100% of eligible children 2-3 year old will be screened using the Wellcomm Screening tool.	96%
Wellcomm Screening will be carried out by Early Years staff in 100% of 2-3 year old.	97%
To ensure consistency in the accuracy of screening, annual regionally agreed Wellcomm training will be delivered by SLTs in 100% of Sure Start projects.	100%
There is consultation with SLT regarding all children who score red on Sept/Oct screen and these children are signposted to appropriate services.	Achieved within each local area

Did the SLC programme improve the outcome for 2 3year old children?

For further information
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Health and Social Care (Reform) Act (Northern Ireland) 2009

CHAPTER 1

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Health and Social Care (Reform) Act (Northern Ireland) 2009

2009 CHAPTER 1

An Act to make changes to the administrative structures for health and social care; and for connected purposes. [21st January 2009]

BE IT ENACTED by being passed by the Northern Ireland Assembly and assented to by Her Majesty as follows:

Restructuring of administration of health and social care

Restructuring of administration of health and social care

1.—(1) The following bodies are dissolved—

(a) Health and Social Services Boards;

(b) the Mental Health Commission;

(c) the Central Services Agency; and

(d) Health and Social Services Councils.

(2) The Northern Ireland Health and Personal Social Services Regulation and Improvement Authority established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (NI 9)—

(a) is renamed the Health and Social Care Regulation and Quality Improvement Authority; and

(b) is referred to in this Act as "RQIA".

(3) Health and Social Services trusts established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 (NI 1)—

(a) are renamed Health and Social Care trusts; and

(b) are referred to in this Act as "HSC trusts".

(4) Special health and social services agencies established under Article 3 of the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 (NI 3)—

(a) are renamed special health and social care agencies; and

(b) are referred to in this Act as "special agencies".

(5) In this Act "the health and social care bodies" means—

(a) the Regional Health and Social Care Board, established under section 7 and referred to in this Act as "the Regional Board";

(b) the Regional Agency for Public Health and Social Well-being, established under section 12 and referred to in this Act as "the Regional Agency";

(c) the Regional Business Services Organisation, established under section 14 and referred to in this Act as "RBSO";

(d) HSC trusts;

(e) special agencies;

(f) the Patient and Client Council, established under section 16;

(g) RQIA.

Department's role in promoting and providing health and social care

Department's general duty

2.—(1) The Department shall promote in Northern Ireland an integrated system of—

(a) health care designed to secure improvement—

(i) in the physical and mental health of people in Northern Ireland, and

(ii) in the prevention, diagnosis and treatment of illness; and

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

(2) For the purposes of subsection (1) the Department shall provide, or secure the provision of, health and social care in accordance with this Act and any other statutory provision, whenever passed or made, which relates to health and social care.

(3) In particular, the Department must—

(a) develop policies to secure the improvement of the health and social well-being of, and to reduce health inequalities between, people in Northern Ireland;

(b) determine priorities and objectives in accordance with section 4;

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

(d) set standards for the provision of health and social care;

(e) prepare a framework document in accordance with section 5;

(f) formulate the general policy and principles by reference to which particular functions are to be exercised;

(g) secure the commissioning and development of programmes and initiatives conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland;

(h) monitor and hold to account the Regional Board, the Regional Agency, RBSO and HSC trusts in the discharge of their functions;

(i) make and maintain effective arrangements to secure the monitoring and holding to account of the other health and social care bodies in the discharge of their functions;

(j) facilitate the discharge by bodies to which Article 67 of the Order of 1972 applies of the duty to co-operate with one another for the purposes mentioned in that Article.

(4) The Department shall discharge its duty under this section so as to secure the effective co-ordination of health and social care.

(5) In this Act—

"health care" means any services designed to secure any of the objects of subsection (1)(a);

"health inequalities" means inequalities in respect of life expectancy or any other matter that is consequent on the state of a person's health;

"social care" means any services designed to secure any of the objects of subsection (1)(b).

Department's general power

3.—(1) The Department may—

(a) provide, or secure the provision of, such health and social care as it considers appropriate for the purpose of discharging its duty under section 2; and

(b) do anything else which is calculated to facilitate, or is conducive or incidental to, the discharge of that duty.

(2) Subsection (1) does not affect the Department's powers apart from this section.

Department's priorities and objectives

4.—(1) The Department shall determine, and may from time to time revise, its priorities and objectives for the provision of health and social care in Northern Ireland.

(2) Before determining or revising any priorities or objectives under this section, the Department must consult such bodies or persons as it thinks appropriate.

(3) Where the Department is of the opinion that because of the urgency of the matter it is necessary to act under subsection (1) without consultation—

(a) subsection (2) does not apply; but

(b) the Department must as soon as reasonably practicable give notice to such bodies as it thinks appropriate of the grounds on which the Department formed that opinion.

The framework document

5.—(1) The Department shall prepare a document (in this Act referred to as "the framework document") setting out in relation to each health and social care body—

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

(b) the matters for which the body is responsible;

(c) the manner in which the body is to discharge its functions and conduct its working relationship with—

(i) the Department, and

(ii) any other body specified in the document; and

(d) the arrangements for providing the Department with information to enable it to carry out its functions in relation to the body under section 2(3)(h) or (i).

(2) The framework document may contain—

(a) such guidance relating to the carrying out by each health and social care body of its functions, and

(b) such other material pertaining to the body or its functions,

as the Department considers appropriate.

(3) The Department—

(a) shall keep the framework document under review; and

(b) may from time to time revise it.

(4) The Department must carry out its duties under subsections (1) to (3) in the manner and to the extent that appear to it to be best calculated to promote—

(a) health and social care;

(b) the economy, efficiency and effectiveness of health and social care bodies; and

(c) economy, efficiency and effectiveness in connection with the matters in relation to which those bodies have functions.

(5) In preparing the framework document, or any revision of it which appears to the Department to be significant, the Department must consult—

(a) each health and social care body as respects its functions (or persons considered by the Department to represent that body); and

(b) any other bodies or persons the Department considers appropriate.

(6) Each health and social care body shall have regard to the framework document in carrying out its functions.

Power of Department to give directions to certain bodies

6.—(1) The Department may give directions of a general or specific nature to—

(a) the Regional Board,

(b) the Regional Agency, and

(c) RBSO,

as to the carrying out by that body of any of its functions.

(2) Before giving any directions to a body under subsection (1) the Department must consult that body.

(3) Where the Department is of the opinion that because of the urgency of the matter it is necessary to give directions under subsection (1) without consulting the body concerned—

(a) subsection (2) does not apply; but

(b) the Department must as soon as reasonably practicable give notice to that body of the grounds on which the Department formed that opinion.

(4) Where the Department is of the opinion that (for any reason other than the urgency of the matter) it is not reasonably practicable to comply with subsection (2)—

(a) that subsection does not apply; but

(b) the Department must as soon as reasonably practicable give notice to the body concerned of the grounds on which the Department formed that opinion.

(5) It is the duty of a body to comply with any directions given to it under subsection (1).

(6) Subsection (1) does not affect the Department's powers to give directions apart from this section.

The Regional Board

The Regional Health and Social Care Board

7.—(1) There shall be a body corporate to be known as the Regional Health and Social Care Board.

(2) Schedule 1 applies in relation to the Regional Board.

Functions of the Regional Board

8.—(1) The Regional Board shall exercise on behalf of the Department—

(a) such functions as are transferred to it by section 24; and

(b) such other functions of the Department (including functions imposed under an order of any court) with respect to the administration of health and social care as the Department may direct.

(2) The Regional Board must exercise its functions with the aim of—

(a) improving the performance of HSC trusts, by reference to such indicators of performance as the Department may direct; and

(b) establishing and maintaining effective systems—

(i) for managing the performance of HSC trusts;

(ii) for commissioning health and social care;

(iii) for ensuring that resources are used in the most economic, efficient and effective way in commissioning such care.

(3) The Regional Board must in respect of each financial year prepare and publish a document ("the commissioning plan") setting out such details as the Department may direct concerning—

(a) the health and social care which the Board is to commission in that year; and

(b) the costs to be incurred in that regard.

(4) The Regional Board—

(a) must, in drawing up the commissioning plan, consult the Regional Agency and have due regard to any advice or information provided by it; and

(b) must not publish a commissioning plan unless it has been approved by the Regional Agency.

(5) The functions mentioned in subsection (1)(a) and any function conferred on the Regional Board by any other statutory provision (whenever passed or made) are deemed to be functions which the Department has directed the Regional Board to exercise under subsection (1)(b).

(6) For the purposes of carrying out its functions the Regional Board may, on behalf of the Department, exercise the Department's general power under section 3.

(7) It is the duty of the Regional Board to carry out its functions in the manner which it considers is best calculated to discharge the Department's general duty under section 2(1).

(8) Subsections (6) and (7) apply subject to any directions given to the Regional Board by the Department under section 6.

Local Commissioning Groups

9.—(1) The Regional Board shall in accordance with paragraph 7 of Schedule 1 appoint a prescribed number of committees to be called "Local Commissioning Groups".

(2) Each Local Commissioning Group shall exercise its functions as regards such area of Northern Ireland as may be prescribed.

(3) Each Local Commissioning Group shall exercise—

(a) such functions with respect to the commissioning of health and social care as may be prescribed; and

(b) such other functions as the Regional Board may, with the agreement of the Department, determine.

(4) Each Local Commissioning Group must—

(a) exercise its functions in accordance with any scheme for the time being having effect under Article 18 of the Order of 1972; and

(b) in connection with the exercise of its functions—

(i) work in collaboration with the Regional Agency and have due regard to any advice or information provided by it; and

(ii) undertake such consultation as the Department may direct.

(5) Each Local Commissioning Group must exercise its functions with the aim of—

(a) improving the health and social well-being of people in the area as regards which the Local Commissioning Group exercises its functions;

(b) planning and commissioning health and social care to meet the needs of people in that area;

(c) securing the delivery to people in that area of health and social care that is efficient, co-ordinated and cost-effective;

(d) improving the availability and quality of health and social care in that area.

(6) Regulations may—

(a) make provision for the membership of Local Commissioning Groups;

(b) modify the application of paragraphs 7 to 11 of Schedule 1 in relation to those Groups;

(c) make such further provision in relation to those Groups as the Department considers appropriate.

(7) Before making regulations under subsection (6), the Department must consult the Regional Board.

Power of Regional Board to give directions and guidance to HSC trusts

10.—(1) The Regional Board may give directions of a general or specific nature to an HSC trust as to the carrying out by that trust of any of its functions.

(2) The Regional Board may give guidance to an HSC trust as to the carrying out by that trust of any of its functions.

(3) The Regional Board must—

(a) consult the HSC trust concerned, and

(b) obtain the approval of the Department,

before giving any directions under subsection (1).

(4) Where the Regional Board is of the opinion that because of the urgency of the matter it is necessary to give directions under subsection (1) without consulting the HSC trust concerned—

(a) subsection (3)(a) does not apply; but

(b) the Regional Board must as soon as reasonably practicable give notice to the HSC trust concerned of the grounds on which the Regional Board formed that opinion.

(5) The Regional Board must not give any direction under subsection (1) or any guidance under subsection (2) that would be inconsistent with—

(a) the framework document; or

(b) any direction given to the HSC trust by the Department under paragraph 6 of Schedule 3 to the Health and Personal Social Services (Northern Ireland) Order 1991 (NI 1).

(6) It is the duty of an HSC trust—

(a) to comply with any directions given to it under subsection (1);

(b) to have regard to any guidance given to it under subsection (2).

(7) The Department may by regulations provide that this section is to apply, subject to such modifications as may be prescribed, in relation to any prescribed body exercising on behalf of the Regional Board such functions as may be prescribed.

Provision of information, etc. to Regional Board by HSC trusts

11.—(1) Part 2 of Schedule 3 to the Health and Personal Social Services (Northern Ireland) Order 1991 (NI 1) (duties, powers and status of HSC trusts) is amended as follows.

(2) After paragraph 6 insert—

"6A.—(1) An HSC trust shall record such information with respect to the exercise of its functions as the Regional Board may direct.

(2) Information shall be recorded in such form, and retained for such period, as the Regional Board may direct.

(3) An HSC trust shall furnish to the Regional Board such reports, returns and other information as the Regional Board may require.

(4) In sub-paragraph (3) the reference to reports, returns and other information includes any report, return or other information that an HSC trust is required to provide to the Department under paragraph 7 or 8.".

The Regional Agency

The Regional Agency for Public Health and Social Well-being

12.—(1) There shall be a body corporate to be known as the Regional Agency for Public Health and Social Well-being.

(2) Schedule 2 applies in relation to the Regional Agency.

Functions of the Regional Agency

13.—(1) The Regional Agency shall exercise on behalf of the Department—

(a) the health improvement functions mentioned in subsection (2); and

(b) the health protection functions mentioned in subsection (3).

(2) The health improvement functions are—

(a) developing and providing, or securing the provision of, programmes and initiatives designed to secure the improvement of the health and social well-being of, and reduce health inequalities between, people in Northern Ireland; and

(b) health promotion, including in particular enabling people in Northern Ireland to increase control over and improve their health and social well-being.

(3) The health protection functions are the protection of the community (or any part of the community) against—

(a) communicable disease, in particular by the prevention or control of such disease;

(b) other dangers to health and social well-being, including dangers arising on environmental or public health grounds or arising out of emergencies.

(4) For the purpose of the exercise of the health improvement or health protection functions the Regional Agency may—

(a) engage in or commission research;

(b) obtain and analyse data and other information;

(c) provide laboratory and other technical and clinical services;

(d) provide training in relation to matters in respect of which the Regional Agency has functions;

(e) make available to any other body such persons, materials and facilities as it thinks appropriate;

(f) provide information, advice and assistance.

(5) The Department may by order amend subsections (1) to (4) for the purposes of altering the functions of the Regional Agency.

(6) In the exercise of its functions the Regional Agency must—

(a) co-operate with other bodies which exercise functions relating to health improvement or health protection; and

(b) in particular, provide the Department, the Regional Board and Local Commissioning Groups with such information, advice and assistance as they may reasonably require in connection with the exercise of their functions.

(7) A body mentioned in subsection (6)(a) must co-operate with the Regional Agency in the exercise by that body of any such functions as are mentioned there.

(8) The disclosure of information to or by the Regional Agency in pursuance of a duty of co-operation under subsection (6) or (7) does not breach any restriction on the disclosure of information (however imposed); but this subsection does not authorise a disclosure of information which contravenes the Data Protection Act 1998 (c. 29).

RBSO

The Regional Business Services Organisation

14.—(1) There shall be a body corporate to be known as the Regional Business Services Organisation.

(2) Schedule 3 applies in relation to RBSO.

Functions of RBSO

15.—(1) RBSO shall on behalf of the Department provide, or secure the provision of, support services to other health and social care bodies in accordance with directions under subsection (4).

(2) Support services are services which are required to be carried out by, or on behalf of, any of those health and social care bodies and include—

(a) administrative support, advice and assistance;

(b) financial services;

(c) human resource, personnel and corporate services;

(d) training;

(e) the management and maintenance of buildings, equipment and land;

(f) information technology and information management;

(g) the procurement of goods and services;

(h) legal, medical, scientific or other professional services;

(i) contractual compliance, internal audit and fraud prevention.

(3) It is the duty of RBSO to put in place arrangements for providing, or securing the provision, of support services under this section which—

(a) secure that those services are provided in the most economic, efficient and effective way; and

(b) are approved by the Department.

(4) After consultation with each of the health and social care bodies, the Department may direct that such support services as the Department may direct shall be provided by RBSO to such health and social care bodies as the Department may direct.

(5) RBSO may charge for support services provided by it.

(6) The Department may by order amend subsection (2).

Patient representation and public involvement

The Patient and Client Council

16.—(1) There shall be a body corporate to be known as the Patient and Client Council.

(2) Schedule 4 applies in relation to the Patient and Client Council.

Functions of the Patient and Client Council

17.—(1) The Patient and Client Council has the following functions as respects the provision of health and social care in Northern Ireland—

(a) representing the interests of the public;

(b) promoting involvement of the public;

(c) providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care for which a body to which this section applies is responsible;

(d) promoting the provision by bodies to which this section applies of advice and information to the public about the design, commissioning and delivery of health and social care;

(e) such other functions as may be prescribed.

(2) In exercising its functions under subsection (1)(a), the Patient and Client Council must—

(a) consult the public about matters relating to health and social care; and

(b) report the views of those consulted to the Department (where it appears to the Council appropriate to do so) and to any other body to which this section applies appearing to have an interest in the subject matter of the consultation.

(3) In exercising its functions under subsection (1)(b), the Patient and Client Council shall promote the involvement of the public in consultations or processes leading (or potentially leading) to decisions by a body to which this section applies which would or might affect (whether directly or not) the health and social well-being of the public.

(4) In exercising its functions under subsection (1)(c), the Patient and Client Council shall arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision (by way of representation or otherwise) of assistance to individuals making or intending to make a complaint of a prescribed description.

(5) The Patient and Client Council shall—

(a) undertake research and conduct investigations into the best methods and practices for consulting the public about, and involving them in, matters relating to health and social care; and

(b) provide advice regarding those methods and practices to bodies to which this section applies.

(6) The Patient and Client Council must publish any report under subsection (2)(b) in such manner as the Department may direct.

(7) In this section "the public" includes individuals, a group or community of people and a section of the public, however selected.

(8) This section and sections 18 and 19 apply to—

(a) the Department;

(b) the Regional Board;

(c) the Regional Agency;

(d) HSC trusts; and

(e) special agencies.

(9) For the purposes of this section and sections 18 to 20 a body is responsible for health and social care—

(a) if the body provides or will provide that care to individuals; or

(b) if another person provides, or will provide, that care to individuals—

(i) at that body's direction;

(ii) on its behalf; or

(iii) in accordance with an agreement or arrangements made by that body with that other person;

and references to the provision of care include references to the provision of care jointly with another person.

Duty to co-operate with the Patient and Client Council

18.—(1) A body to which this section applies must co-operate with the Patient and Client Council in the exercise by the Council of its functions.

(2) In particular, such a body must—

(a) consult the Patient and Client Council with respect to such matters, and on such occasions, as the body considers appropriate, having regard to the functions of the Council;

(b) furnish to the Council, subject to such conditions as the body may specify, such information as the Council considers necessary to enable it properly to exercise its functions; and

(c) have regard to advice provided by the Council under section 17(5)(b).

(3) Regulations may make provision authorising members of the Patient and Client Council to enter, for the purposes of any of the Council's functions, premises of a kind described in subsection (4).

(4) Those premises are—

(a) any premises controlled by a body to which this section applies or by a person providing primary medical services or general dental, pharmaceutical or ophthalmic services under Part 2 or 6 of the Order of 1972; and

(b) premises of such other description as may be prescribed.

(5) Any power of entry conferred by regulations under subsection (3) is exercisable only so far as is necessary for the purpose of enabling the Patient and Client Council to exercise its functions, and is subject to such conditions as may be prescribed.

(6) A body to which this section applies shall have due regard to any views expressed by the Patient and Client Council regarding health and social care for which that body is responsible.

Public involvement and consultation

19.—(1) Each body to which this section applies must take such steps as it considers appropriate—

(a) to promulgate information about the health and social care for which it is responsible;

(b) to obtain information about—

(i) the needs of persons to whom that care is being or may be provided; and

(ii) the efficacy of that care;

(c) to encourage and assist persons to whom that care is being or may be provided—

(i) to avail of that care in an appropriate manner, having regard to the need to use resources in the most economic, efficient and effective way; and

(ii) to maintain and improve their own health and social well-being.

(2) In particular, each body to which this section applies must, before the end of the period of 9 months beginning with the day appointed for the coming into operation of this section, or, if later, the establishment of the body concerned—

(a) prepare a consultation scheme in accordance with section 20; and

(b) in the case of a health and social care body, submit the scheme to the Department.

(3) The Department may direct any health and social care body to which this section applies to submit a revised scheme to it.

(4) The Department may, after consulting the Patient and Client Council, approve a consultation scheme submitted to it under this section with or without amendments.

Public involvement: consultation schemes

20.—(1) A consultation scheme must make it clear how the body to which the scheme is to apply will make arrangements with a view to securing, as respects health and social care for which it is responsible, that the following are (directly or through representatives) involved in and consulted on the matters mentioned in subsection (2), namely—

(a) the Patient and Client Council;

(b) persons to whom that care is being or may be provided; and

(c) the carers of such persons (that is to say the individuals who provide a substantial amount of care on a regular basis for such persons but who are not employed to do so by a health and social care body).

(2) Those matters are—

(a) the planning of the provision of that care;

(b) the development and consideration of proposals for changes in the way that care is provided; and

(c) decisions to be made by that body affecting the provision of that care.

(3) The consultation scheme must provide for the body to which it is to apply—

(a) to have due regard to any comments submitted to it in response to the consultation; and

(b) to prepare a written statement which—

(i) summarises the comments received; and

(ii) sets out the body's response to those comments.

(4) The consultation scheme must provide that the body to which it is to apply shall take such steps as in its opinion will give adequate publicity to the statement.

HSC trusts

Duty on HSC trusts in relation to improvement of health and social well-being

21. It is the duty of an HSC trust to exercise its functions with the aim of improving the health and social well-being of, and reducing health inequalities between, those for whom it provides, or may provide, health and social care.

Public-private partnerships

Public-private partnerships

22.—(1) A body to which this section applies may form, or participate in forming, companies to provide facilities or services for—

(a) HSC trusts; or

(b) any other persons or bodies exercising functions, or otherwise providing services, under any statutory provision relating to the promotion or provision of health and social care.

(2) A body to which this section applies may, with a view to securing or facilitating the provision by companies of facilities or services for persons or bodies falling within subsection (1)(a) or (b)—

(a) invest in the companies (whether by acquiring assets, securities or rights or otherwise), or

(b) provide loans and guarantees and make other kinds of financial provision to or in respect of them,

or both.

(3) For the purposes of subsections (1) and (2) it is immaterial that the facilities or services provided or to be provided by the companies in question are not provided or to be provided—

(a) only to persons or bodies falling within subsection (1)(a) or (b); or

(b) to persons or bodies falling within subsection (1)(b) only in their capacities as persons or bodies such as are mentioned in that provision.

(4) This section applies to—

(a) the Department; and

(b) a health and social care body, other than RQIA or the Patient and Client Council.

(5) In this section—

"companies" means companies within the meaning of the Companies Act 2006 (c. 46);

"facilities" includes the provision of (or of the use of) premises, goods, materials, vehicles, plant or apparatus.

(6) This section does not affect any powers of any body to which this section applies that are exercisable apart from this section.

Transfer of assets, liabilities and functions

Schemes for transfer of assets and liabilities

23.—(1) The power conferred by subsection (2) is exercisable in connection with the dissolution of the bodies mentioned in section 1(1).

(2) The Department shall make one or more schemes for the transfer of designated assets and liabilities of a dissolved body to—

(a) a health and social care body; or

(b) the Department.

(3) The power conferred by subsection (4) is exercisable in connection with—

(a) any change in the administrative structures for health and social care effected by or under this Act; or

(b) the efficient management of any assets or liabilities used for the purposes of health and social care.

(4) The Department may at any time make one or more schemes for the transfer—

(a) of designated assets or liabilities of the Department to a health and social care body;

(b) of designated assets or liabilities of a health and social care body to—

(i) the Department; or

(ii) any other health and social care body.

(5) On the transfer date the designated assets or liabilities are transferred and vest in accordance with the scheme.

(6) Schedule 5 has effect and in that Schedule—

(a) Part 1 contains provisions about schemes; and

(b) Part 2 contains provisions about the final accounts and reports of certain dissolved bodies.

(7) In this section and Schedule 5—

"designated", in relation to a scheme, means specified in or determined in accordance with the scheme;

"dissolved body" means a body dissolved by section 1(1);

"scheme" means a scheme under this section;

"the transfer date", in relation to a scheme, means the date specified by the scheme as the date on which it is to have effect.

Transfer of functions of Health and Social Services Boards

24.—(1) The functions exercisable immediately before the date on which section 1(1)(a) comes into operation by Health and Social Services Boards under any statutory provision or by virtue of a direction of the Department shall insofar as they consist of, or relate to—

(a) health improvement functions (within the meaning of section 13), or

(b) health protection functions (within the meaning of that section),

be exercisable as from that date by the Regional Agency.

(2) The other functions exercisable immediately before that date by Health and Social Services Boards under any statutory provision or by virtue of a direction of the Department shall as from that date be exercisable by the Regional Board in accordance with section 8.

(3) Subsections (1) and (2)—

(a) apply only to provisions or directions which have continuing effect; and

(b) are subject to any order under subsection (4).

(4) The Department may by order provide that subsections (1) and (2) are not to apply to any specified function.

(5) An order under subsection (4) may—

(a) provide for a specified function to be exercised by the Department or by a health and social care body; or

(b) provide that a specified function is to cease to be exercised.

(6) Where an order under subsection (4) provides for a specified function to be exercised by a health and social care body, the order may provide for that body to exercise that function on the Department's behalf.

(7) In this section "specified function" means any function of a Health and Social Services Board specified in an order made under subsection (4).

Transfer of functions of the Mental Health Commission

25.—(1) The functions exercisable immediately before the date on which section 1(1)(b) comes into operation by the Mental Health Commission under any statutory provision shall be exercisable as from that date by RQIA.

(2) Subsection (1) only applies to provisions which have continuing effect.

Transfer of functions of Central Services Agency

26.—(1) The functions exercisable immediately before the date on which section 1(1)(c) comes into operation by the Central Services Agency under any statutory provision or by virtue of any direction of the Department shall be exercisable as from that date by RBSO.

(2) Subsection (1)—

(a) applies only to provisions or directions which have continuing effect; and

(b) is subject to any order under subsection (3).

(3) The Department may by order provide that subsection (1) is not to apply to any specified function.

(4) An order under subsection (3) may—

(a) provide for a specified function to be exercised by the Department or by a health and social care body; or

(b) provide that a specified function is to cease to be exercised.

(5) Where an order under subsection (3) provides for a specified function to be exercised by a health and social care body, the order may provide for that body to exercise that function on the Department's behalf.

(6) In this section "specified function" means any function of the Central Services Agency specified in an order made under subsection (3).

Amendment of statutory and other references to dissolved bodies, etc.

27.—(1) This section applies for the purposes of a transfer of functions effected by section 24, 25 or 26; and in this section, in its application for the purposes of such a transfer—

"the transferor" means the body from which functions are transferred;

"the transferee" means the body to which functions are transferred;

"the transfer date" means the date on which functions are transferred.

(2) In relation to any time after the transfer date, any reference in any statutory provision or document to a Health and Social Services Board (whether general or particular) shall—

(a) in relation to any function transferred by section 24(1), be construed as a reference to the Regional Agency;

(b) in relation to any function transferred by section 24(2), be construed as a reference to the Regional Board;

and any reference which delimits functions of a Board by reference to its area shall, in relation to that time, be disregarded.

(3) In relation to any time after the transfer date, any reference in any statutory provision or document to the Mental Health Commission shall, in relation to any function transferred by section 25(1), be construed as a reference to RQIA.

(4) In relation to any time after the transfer date, any reference in any statutory provision or document to the Central Services Agency shall, in relation to any function transferred by section 26(1), be construed as a reference to RBSO.

(5) Subsections (2) to (4) apply unless contrary provision is made by or under this Act or the context otherwise requires.

(6) A transfer of functions to which this section applies does not affect the validity of anything done by, or in relation to, the transferor before the transfer date.

(7) Anything which before the transfer date was done by or in relation to the transferor in relation to any transferred function shall, if in effect immediately before that date, continue to have effect to the same extent and subject to the same provisions as if it had been done by, or in relation to, the transferee.

(8) Anything (including any legal proceedings) in the process of being done by or in relation to the transferor immediately before the transfer date may, so far as it relates to any transferred function, be continued by or in relation to the transferee.

Dissolution of special agencies

28.—(1) The Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 (NI 3) is amended as follows.

(2) In the Schedule, after paragraph 8 (execution of contracts and instruments not under seal) insert the following paragraph—

"Dissolution of special agencies

8A.—(1) The Department may by order dissolve a special agency.

(2) An order under this paragraph may be made—

(a) on the application of the special agency concerned; or

(b) if the Department considers it appropriate in the interests of health and social care.

(3) Except where it appears to the Department necessary to make an order under this paragraph as a matter of urgency, no such order shall be made until after the completion of such consultation as may be prescribed.

(4) An order under this paragraph may provide for the transfer to—

(a) the Department, or

(b) such other HSC body as the order may specify,

of such of the assets and liabilities of the special agency which is dissolved as the Department considers appropriate.

(5) The Department must exercise its powers under sub-paragraph (4) so as to ensure that all the liabilities of the special agency are transferred.

(6) An order under this paragraph may make provision in connection with the transfer of staff employed by or for the purposes of the special agency which is dissolved including provision for the making of a scheme by the special agency or such other body as may be specified in the order.

(7) An order under this paragraph—

(a) may include such incidental, supplemental or transitional provision as the Department considers appropriate; and

(b) shall be subject to negative resolution.

(8) Without prejudice to the generality of sub-paragraphs (4) to (7), if a special agency is dissolved under this paragraph, the Department, or such other HSC body as the Department may direct, shall undertake the responsibility for the continued payment of any such pension, allowances or gratuities as, by virtue of regulations made under paragraph 6, would otherwise have been the responsibility of the special agency which has been dissolved.

(9) A special agency may not be dissolved or wound up except in accordance with this paragraph.".

Supplementary

Orders, regulations, guidance and directions

29.—(1) No order shall be made under section 13(5), 15(6) or 30(1) unless a draft of the order has been laid before, and approved by resolution of, the Assembly.

(2) Regulations under this Act and orders under section 24(4) or 26(3) are subject to negative resolution.

(3) Any guidance issued or directions given by the Department or the Regional Board under this Act—

(a) shall be in writing; and

(b) may be varied or revoked by subsequent guidance or directions so issued or given.

(4) Regulations and orders under this Act may contain such incidental, supplementary, transitional and savings provisions as appear to the Department to be necessary or expedient.

Further provision

30.—(1) The Department may by order make such supplementary, incidental or consequential provision as it thinks necessary or expedient—

(a) for the general purposes, or any particular purpose, of this Act; or

(b) in consequence of any provision made by or under this Act, or for giving full effect to this Act or any such provision.

(2) An order under subsection (1) may apply (with or without modifications), amend or repeal any statutory provision passed or made before the passing of this Act.

(3) The Department may by order make such transitional or transitory provisions and savings as it considers appropriate in connection with—

(a) the coming into operation of any provision of this Act; or

(b) any provision made by an order under subsection (1).

(4) The powers conferred by this section are not restricted by any other power conferred by this Act.

Interpretation

31.—(1) In this Act—

"the Central Services Agency" means the Northern Ireland Central Services Agency for the Health and Social Services established under Article 26 of the Order of 1972;

"the Department" means the Department of Health, Social Services and Public Safety;

"the framework document" has the meaning given in section 5;

"the health and social care bodies" has the meaning given in section 1(5);

"Health and Social Services Board" means a body established under Article 16 of the Order of 1972;

"health care" has the meaning given in section 2(5);

"health inequalities" has the meaning given in section 2(5);

"HSC trust" means a Health and Social Care trust established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 (NI 1);

"the Mental Health Commission" means the Mental Health Commission for Northern Ireland established under Part 6 of the Mental Health (Northern Ireland) Order 1986 (NI 4);

"the Order of 1972" means the Health and Personal Social Services (Northern Ireland) Order 1972 (NI 14);

"prescribed" means prescribed by regulations;

"the Regional Agency" means the Regional Agency for Public Health and Social Well-being established under section 12;

"the Regional Board" means the Regional Health and Social Care Board established under section 7;

"RBSO" means the Regional Business Services Organisation established under section 14;

"RQIA" means the Health and Social Care Regulation and Quality Improvement Authority;

"regulations" means regulations made by the Department;

"social care" has the meaning given in section 2(5);

"special agency" means a special health and social care agency established under Article 3 of the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 (NI 3);

"statutory provision" has the meaning given in section 1(f) of the Interpretation Act (Northern Ireland) 1954 (c. 33).

(2) Other expressions used in this Act to which a meaning is given in Article 2(2), (3) or (4) of the Order of 1972 have the same meaning in this Act as in that Order.

Minor and consequential amendments

32. The statutory provisions mentioned in Schedule 6 have effect subject to the minor and consequential amendments specified there.

Repeals

33. The statutory provisions mentioned in the first column of Schedule 7 (which include provisions which are spent or no longer of any practical utility) are repealed to the extent specified in the second column of that Schedule.

Commencement

34.—(1) The following provisions come into operation on Royal Assent—

(a) section 23 and Schedule 5;

(b) section 24(4) to (7);

(c) section 26(3) to (6);

(d) section 28 to 31;

(e) this section; and

(f) section 35.

(2) The following provisions come into operation on Royal Assent insofar as they confer power to make regulations or orders—

(a) section 7(2) and Schedule 1;

(b) section 9;

(c) section 12(2) and Schedule 2;

(d) section 14(2) and Schedule 3;

(e) section 16(2) and Schedule 4;

(f) section 17; and

(g) section 18.

(3) The other provisions of this Act come into operation on such day or days as the Department may by order appoint.

Short title

35. This Act may be cited as the Health and Social Care (Reform) Act (Northern Ireland) 2009.

SCHEDULES

Sections 7 and 9.

SCHEDULE 1

THE REGIONAL HEALTH AND SOCIAL CARE BOARD

Status

1.—(1) The Regional Board shall not be regarded—

(a) as the servant or agent of the Crown; or

(b) as enjoying any status, immunity or privilege of the Crown.

(2) The property of the Regional Board shall not be regarded as property of, or held on behalf of, the Crown.

(3) Where land in which the Department has an interest is managed, used or occupied by the Regional Board, the interest of the Department shall be treated for the purposes of any statutory provision or rule of law relating to Crown land or interests as if it were an interest held otherwise than by, or on behalf of, the Crown.

(4) The Regional Board shall, notwithstanding that it is exercising any functions on behalf of the Department, be entitled to enforce any rights acquired and shall be liable in respect of any liabilities incurred (including liabilities in tort) in the exercise of those functions in all respects as if it were acting as a principal, and all proceedings for the enforcement of such rights or liabilities shall be brought by or against the Regional Board in its own name.

(5) Subject to the provisions of this Schedule, section 19 of the Interpretation Act (Northern Ireland) 1954 (c. 33) applies to the Regional Board.

General powers

2.—(1) Subject to any directions given by the Department, the Regional Board may do anything which appears to it to be necessary or expedient for the purpose of, or in connection with, the exercise of its functions.

(2) But the Regional Board may not borrow money.

Membership

3.—(1) The Regional Board shall consist of—

(a) a Chair appointed by the Department;

(b) a prescribed number of persons appointed by the Department;

(c) the chief officer of the Regional Board;

(d) such other officers of the Regional Board as may be prescribed; and

(e) not more than a prescribed number of other officers of the Regional Board appointed by the Chair and the members specified in heads (b) and (c).

(2) Except in so far as regulations otherwise provide, no person who is an officer of the Regional Board may be appointed under sub-paragraph (1)(a) or (b).

(3) Regulations may provide that all or any of the persons appointed under sub-paragraph (1)(b) must fulfil prescribed conditions or hold posts of a prescribed description.

Remuneration and allowances

4.—(1) The Regional Board shall pay to its members such remuneration and allowances as the Department may determine.

(2) A determination of the Department under this paragraph requires the approval of the Department of Finance and Personnel.

Term of office

5.—(1) The term of office of members of the Regional Board appointed under paragraph 3(1)(a), (b) or (e) shall be 4 years or such other period as may be determined by the Department at the time the appointments are made.

(2) A member of the Regional Board specified in paragraph 3(1)(c), (d) or (e)—

(a) who ceases to hold the qualifying office, shall cease to be a member of the Regional Board;

(b) who is suspended from the qualifying office, shall be suspended from membership of the Regional Board while suspended from that office.

(3) In sub-paragraph (2) "the qualifying office" in relation to a member of the Regional Board means the office under the Regional Board which the member held at the time of becoming a member of the Regional Board.

Resignation and removal

6.—(1) A member of the Regional Board appointed under paragraph 3(1)(a) or (b)—

(a) may resign membership by serving notice on the Department;

(b) may be removed from office by the Department.

(2) A member of the Regional Board appointed under paragraph 3(1)(e) may be removed from office by the Chair and the members specified in paragraph 3(1)(b) and (c).

(3) Where any member of the Regional Board—

(a) is absent from the meetings of the Regional Board for more than 6 months consecutively, except for an approved reason; or

(b) is convicted of an indictable offence;

the Regional Board shall forthwith, by resolution, declare the office to be vacant and shall notify that fact in such manner as it thinks fit, and thereupon the office shall become vacant.

(4) In sub-paragraph (3)(a) "approved reason" means a reason approved—

(a) in the case of members appointed under paragraph 3(1)(e), by the Chair and the members specified in paragraph 3(1)(b) and (c);

(b) in the case of any other member, by the Department.

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(5) Where the place of a member specified in paragraph 3(1)(a), (b) or (e) becomes vacant before the expiration of the member's term of office whether by death, resignation or otherwise, the vacancy shall be filled by appointment—

(a) in the case of a member specified in paragraph 3(1)(a) or (b), by the Department;

(b) in the case of a member specified in paragraph 3(1)(e), by the Chair and the members specified in paragraph 3(1)(b) and (c);

and any person so appointed shall hold office for the remainder of the term of office of the former member.

Committees

7.—(1) The Regional Board—

(a) shall appoint such committees as are required under section 9, and

(b) may appoint one or more other committees to which it may delegate such of its functions as it thinks fit.

(2) References in this Schedule to a committee are to a committee appointed under this paragraph.

(3) A person who is not a member of the Regional Board shall not, except with the approval of the Department, be appointed to a committee.

(4) The Regional Board may pay to members of its committees who are neither members nor employees of the Board such remuneration and allowances as the Board may, with the approval of the Department, determine.

(5) Every member of a committee who, at the time of appointment, was a member of the Regional Board shall, on ceasing to be a member of the Regional Board, also cease to be a member of the committee.

Sub-committees

8.—(1) The Regional Board or a committee may appoint a sub-committee to consider and report to the Regional Board or, as the case may be, the committee on any matter within the competence of the Regional Board or the committee.

(2) References in this Schedule to a sub-committee are to a sub-committee appointed under this paragraph.

(3) A sub-committee may include persons who are not members of the Regional Board or the committee which appoints the sub-committee.

Proceedings

9. Without prejudice to section 19(1)(a)(v) of the Interpretation Act (Northern Ireland) 1954 (c. 33), the Regional Board shall make standing orders regulating the procedure of the Board, its committees and sub-committees, including provision regulating—

(a) the convening of meetings;

(b) the fixing of the quorum; and

(c) the conduct of business at meetings.

Validity of proceedings

10. The proceedings of the Regional Board or of any committee or sub-committee are not invalidated—

(a) by any vacancy in the membership of the Regional Board or the committee or sub-committee;

(b) by any defect in the appointment of any of its members; or

(c) by any failure to comply with paragraph 9.

Disclosure of pecuniary, etc., interests and related provisions

11.—(1) Subject to sub-paragraph (2), sections 28 to 33 and 146 of the Local Government Act (Northern Ireland) 1972 (c. 9) and section 148 of that Act so far as it applies for the interpretation of those sections, shall apply to the Regional Board, a committee or sub-committee and to a member of the Regional Board, a committee or sub-committee as if—

(a) in those sections—

(i) any reference to a council were a reference to the Regional Board, a committee or sub-committee,

(ii) any reference to a councillor were a reference to a member of the Regional Board, a committee or sub-committee,

(iii) any reference to the clerk of the council were a reference to the chief officer of the Regional Board, and

(iv) any reference to that Act were a reference to this Act;

(b) in section 28(4) of that Act the words "or 46" were omitted and for the words from "by any local elector" onwards there were substituted the words "by any person.".

(2) Notwithstanding anything in sub-paragraph (1), an officer of the Regional Board who is a member of the Regional Board may vote upon any matter which affects the interests of officers of the Regional Board or such officers of any class (including a class to which the officer belongs), but must not vote upon any matter affecting only the officer's individual interest.

The chief officer and other staff

12.—(1) There shall be a chief officer of the Regional Board who shall be a member of the staff of the Regional Board and shall be responsible to the Regional Board for the general exercise of its functions.

(2) Subject to paragraph 13—

(a) the first chief officer shall be appointed by the Department; and

(b) any subsequent chief officer shall be appointed by the Regional Board.

13.—(1) The qualifications, remuneration and conditions of service of officers of the Regional Board may be determined by the Department.

(2) Regulations may make provision with respect to—

(a) the method of appointment of officers of the Regional Board;

(b) the qualifications, remuneration and conditions of service of such officers of the Regional Board as may be prescribed;

SCH. 1

and an officer such as is mentioned in head (b) shall not be employed otherwise than in accordance with the regulations.

(3) Determinations or regulations under sub-paragraph (1) or (2) may provide for approvals or determinations to have effect from a date specified in them.

(4) The date mentioned in sub-paragraph (3) may be before or after the date of giving the approvals or making the determinations but may not be before if it would be to the detriment of the officers to whom the approvals or determinations relate.

(5) The appointment and removal from office of such officers of the Regional Board as may be prescribed is subject to the approval of the Department.

Application of the seal

14. The application of the seal of the Regional Board shall be authenticated by the signatures of—

(a) at least one member of the Regional Board appointed under paragraph 3(1)(a) or (b); and

(b) the chief officer of the Regional Board.

Execution of documents

15.—(1) Any document which if executed by an individual would not require to be executed as a deed may be executed on behalf of the Regional Board by any person generally or specially authorised by the Regional Board for that purpose.

(2) In any legal proceedings any document purporting to have been so executed on behalf of the Regional Board shall be deemed to be so executed until the contrary is proved.

Finance

16.—(1) The Department may make payments to the Regional Board out of money appropriated for the purpose.

(2) Payments under this paragraph shall be made on such terms and conditions as the Department may determine.

(3) Subject to sub-paragraph (4), the Regional Board must pay to the Department all sums received by it in the course of, or in connection with, the carrying out of its functions.

(4) Sub-paragraph (3) does not apply to such sums, or sums of such description, as the Department may, with the approval of the Department of Finance and Personnel, direct.

(5) Any sums received by the Department under sub-paragraph (3) shall be paid into the Consolidated Fund.

Accounts

17.—(1) The Regional Board shall—

(a) keep proper accounts and proper records in relation to the accounts; and

(b) prepare a statement of accounts in respect of each financial year.

(2) The statement of accounts shall—

(a) be in such form; and

(b) contain such information,

as the Department may, with the approval of the Department of Finance and Personnel, direct.

(3) The Regional Board shall, within such period after the end of each financial year as the Department may direct, send copies of the statement of accounts relating to that year to—

(a) the Department; and

(b) the Comptroller and Auditor General.

(4) The Comptroller and Auditor General shall—

(a) examine, certify and report on every statement of accounts received from the Regional Board under this paragraph; and

(b) send a copy of any such report to the Department.

(5) The Department shall lay a copy of the statement of accounts and of the Comptroller and Auditor General's report before the Assembly.

Annual report

18.—(1) The Regional Board shall within such period after the end of each financial year as the Department may direct, prepare and send to the Department a report in such form, and containing such information, as may be prescribed.

(2) The Department shall lay a copy of the report before the Assembly.

Interpretation

19. In paragraphs 17 and 18—

"Comptroller and Auditor General" means the Comptroller and Auditor General for Northern Ireland;

"financial year" means—

(a) the period beginning with the day on which the Regional Board is established and ending on the next following 31st March; and

(b) each subsequent period of 12 months ending on 31st March.

Information

20.—(1) The Regional Board shall record such information with respect to the exercise of its functions as the Department may direct.

(2) Information shall be recorded in such form, and retained for such period, as the Department may determine.

(3) The Regional Board shall, in relation to its functions, furnish to the Department, such reports, returns and other information as the Department may require.

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Default powers of Department

21.—(1) The powers conferred by this paragraph are exercisable by the Department if it is satisfied that the Regional Board has without reasonable excuse failed to discharge any of its functions adequately or at all.

(2) The Department may—

(a) make an order declaring the Regional Board to be in default; and

(b) direct the Regional Board to discharge such of its functions, in such manner and within such period or periods, as may be specified in the direction.

(3) If the Regional Board fails to comply with the Department's direction under sub-paragraph (2), the Department may—

(a) discharge the functions to which the direction relates itself; or

(b) make arrangements for any other person to discharge those functions on its behalf.

Section 12.

SCHEDULE 2

THE REGIONAL AGENCY FOR PUBLIC HEALTH AND SOCIAL WELL-BEING

Status

1.—(1) The Regional Agency shall not be regarded—

(a) as the servant or agent of the Crown; or

(b) as enjoying any status, immunity or privilege of the Crown.

(2) The property of the Regional Agency shall not be regarded as property of, or held on behalf of, the Crown.

(3) Where land in which the Department has an interest is managed, used or occupied by the Regional Agency, the interest of the Department shall be treated for the purposes of any statutory provision or rule of law relating to Crown land or interests as if it were an interest held otherwise than by, or on behalf of, the Crown.

(4) The Regional Agency shall, notwithstanding that it is exercising any functions on behalf of the Department, be entitled to enforce any rights acquired and shall be liable in respect of any liabilities incurred (including liabilities in tort) in the exercise of those functions in all respects as if it were acting as a principal, and all proceedings for the enforcement of such rights or liabilities shall be brought by or against the Regional Agency in its own name.

(5) Subject to the provisions of this Schedule, section 19 of the Interpretation Act (Northern Ireland) 1954 (c. 33) applies to the Regional Agency.

General powers

2.—(1) Subject to any directions given by the Department, the Regional Agency may do anything which appears to it to be necessary or expedient for the purpose of, or in connection with, the exercise of its functions.

(2) But the Regional Agency may not borrow money.

Membership

3.—(1) The Regional Agency shall consist of—

(a) a Chair appointed by the Department;

(b) a prescribed number of persons appointed by the Department;

(c) the chief officer of the Regional Agency;

(d) such other officers of the Regional Agency as may be prescribed;

(e) not more than a prescribed number of other officers of the Regional Agency appointed by the Chair and the members specified in heads (b) and (c); and

(f) a prescribed number of members of district councils appointed by the Department in such manner as may be prescribed.

(2) Except in so far as regulations otherwise provide, no person who is an officer of the Regional Agency may be appointed under sub-paragraph (1)(a) or (b).

(3) Regulations may provide that all or any of the persons appointed under sub-paragraph (1)(b) must fulfil prescribed conditions or hold posts of a prescribed description.

Remuneration and allowances

4.—(1) The Regional Agency shall pay to its members such remuneration and allowances as the Department may determine.

(2) A determination of the Department under this paragraph requires the approval of the Department of Finance and Personnel.

Term of office

5.—(1) The term of office of members of the Regional Agency appointed under paragraph 3(1)(a), (b), (e) or (f) shall be 4 years or such other period as may be determined by the Department at the time the appointments are made.

(2) A member of the Regional Agency specified in paragraph 3(1)(c), (d) or (e)—

(a) who ceases to hold the qualifying office, shall cease to be a member of the Regional Agency;

(b) who is suspended from the qualifying office, shall be suspended from membership of the Regional Agency while suspended from that office.

(3) In sub-paragraph (2) "the qualifying office" in relation to a member of the Regional Agency means the office under the Regional Agency which the member held at the time of becoming a member of the Regional Agency.

(4) A member of the Regional Agency specified in paragraph 3(1)(f) who ceases to be a member of a district council shall cease to be a member of the Regional Agency.

SCH. 2

Resignation and removal

6.—(1) A member of the Regional Agency appointed under paragraph 3(1)(a), (b) or (f)—

(a) may resign membership by serving notice on the Department;

(b) may be removed from office by the Department.

(2) A member of the Regional Agency appointed under paragraph 3(1)(e) may be removed from office by the Chair and the members specified in paragraph 3(1)(b) and (c).

(3) Where any member of the Regional Agency—

(a) is absent from the meetings of the Regional Agency for more than 6 months consecutively, except for an approved reason; or

(b) is convicted of an indictable offence;

the Regional Agency shall forthwith, by resolution, declare the office to be vacant and shall notify that fact in such manner as it thinks fit, and thereupon the office shall become vacant.

(4) In sub-paragraph (3)(a) "approved reason" means a reason approved—

(a) in the case of members appointed under paragraph 3(1)(e), by the Chair and the members specified in paragraph 3(1)(b) and (c);

(b) in the case of any other member, by the Department.

(5) Where the place of a member specified in paragraph 3(1)(a), (b), (e) or (f) becomes vacant before the expiration of the member's term of office whether by death, resignation or otherwise, the vacancy shall be filled by appointment—

(a) in the case of a member specified in paragraph 3(1)(a) or (b), by the Department;

(b) in the case of a member specified in paragraph 3(1)(e), by the Chair and the members specified in paragraph 3(1)(b) and (c);

(c) in the case of a member specified in paragraph 3(1)(f), by the Department in such manner as may be prescribed;

and any person so appointed shall hold office for the remainder of the term of office of the former member.

Committees

7.—(1) The Regional Agency may appoint one or more committees to which it may delegate such of its functions as it thinks fit.

(2) References in this Schedule to a committee are to a committee appointed under this paragraph.

(3) A person who is not a member of the Regional Agency shall not, except with the approval of the Department, be appointed to a committee.

(4) The Regional Agency may pay to members of its committees who are neither members nor employees of the Regional Agency such remuneration and allowances as the Regional Agency may, with the approval of the Department, determine.

(5) Every member of a committee who, at the time of appointment, was a member of the Regional Agency shall, on ceasing to be a member of the Regional Agency, also cease to be a member of the committee.

Sub-committees

8.—(1) The Regional Agency or a committee may appoint a sub-committee to consider and report to the Regional Agency or, as the case may be, the committee on any matter within the competence of the Regional Agency or the committee.

(2) References in this Schedule to a sub-committee are to a sub-committee appointed under this paragraph.

(3) A sub-committee may include persons who are not members of the Regional Agency or the committee which appoints the sub-committee.

Proceedings

9. Without prejudice to section 19(1)(a)(v) of the Interpretation Act (Northern Ireland) 1954 (c. 33), the Regional Agency shall make standing orders regulating the procedure of the Regional Agency, its committees and sub-committees, including provision regulating—

(a) the convening of meetings;

(b) the fixing of the quorum; and

(c) the conduct of business at meetings.

Validity of proceedings

10. The proceedings of the Regional Agency or of any committee or sub-committee are not invalidated—

(a) by any vacancy in the membership of the Regional Agency or the committee or sub-committee;

(b) by any defect in the appointment of any of its members; or

(c) by any failure to comply with paragraph 9.

Disclosure of pecuniary, etc., interests and related provisions

11.—(1) Subject to sub-paragraph (2), sections 28 to 33 and 146 of the Local Government Act (Northern Ireland) 1972 (c. 9) and section 148 of that Act so far as it applies for the interpretation of those sections, shall apply to the Regional Agency, a committee or sub-committee and to a member of the Regional Agency, a committee or sub-committee as if—

(a) in those sections—

(i) any reference to a council were a reference to the Regional Agency, a committee or sub-committee,

(ii) any reference to a councillor were a reference to a member of the Regional Agency, a committee or sub-committee,

(iii) any reference to the clerk of the council were a reference to the chief officer of the Regional Agency, and

(iv) any reference to that Act were a reference to this Act;

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(b) in section 28(4) of that Act the words "or 46" were omitted and for the words from "by any local elector" onwards there were substituted the words "by any person.".

(2) Notwithstanding anything in sub-paragraph (1), an officer of the Regional Agency who is a member of the Regional Agency may vote upon any matter which affects the interests of officers of the Regional Agency or such officers of any class (including a class to which the officer belongs), but must not vote upon any matter affecting only the officer's individual interest.

The chief officer and other staff

12.—(1) There shall be a chief officer of the Regional Agency who shall be a member of the staff of the Regional Agency and shall be responsible to the Regional Agency for the general exercise of its functions.

(2) Subject to paragraph 13—

(a) the first chief officer shall be appointed by the Department; and

(b) any subsequent chief officer shall be appointed by the Regional Agency.

13.—(1) The qualifications, remuneration and conditions of service of officers of the Regional Agency may be determined by the Department.

(2) Regulations may make provision with respect to—

(a) the method of appointment of officers of the Regional Agency;

(b) the qualifications, remuneration and conditions of service of such officers of the Regional Agency as may be prescribed;

and an officer such as is mentioned in head (b) shall not be employed otherwise than in accordance with the regulations.

(3) Determinations or regulations under sub-paragraph (1) or (2) may provide for approvals or determinations to have effect from a date specified in them.

(4) The date mentioned in sub-paragraph (3) may be before or after the date of giving the approvals or making the determinations but may not be before if it would be to the detriment of the officers to whom the approvals or determinations relate.

(5) The appointment and removal from office of such officers of the Regional Agency as may be prescribed is subject to the approval of the Department.

Application of the seal

14. The application of the seal of the Regional Agency shall be authenticated by the signatures of—

(a) at least one member of the Regional Agency appointed under paragraph 3(1)(a) or (b); and

(b) the chief officer of the Regional Agency.

Execution of documents

15.—(1) Any document which if executed by an individual would not require to be executed as a deed may be executed on behalf of the Regional Agency by any person generally or specially authorised by the Regional Agency for that purpose.

(2) In any legal proceedings any document purporting to have been so executed on behalf of the Regional Agency shall be deemed to be so executed until the contrary is proved.

Finance

16.—(1) The Department may make payments to the Regional Agency out of money appropriated for the purpose.

(2) Payments under this paragraph shall be made on such terms and conditions as the Department may determine.

(3) Subject to sub-paragraph (4), the Regional Agency must pay to the Department all sums received by it in the course of, or in connection with, the carrying out of its functions.

(4) Sub-paragraph (3) does not apply to such sums, or sums of such description, as the Department may, with the approval of the Department of Finance and Personnel, direct.

(5) Any sums received by the Department under sub-paragraph (3) shall be paid into the Consolidated Fund.

Accounts

17.—(1) The Regional Agency shall—

(a) keep proper accounts and proper records in relation to the accounts; and

(b) prepare a statement of accounts in respect of each financial year.

(2) The statement of accounts shall—

(a) be in such form; and

(b) contain such information,

as the Department may, with the approval of the Department of Finance and Personnel, direct.

(3) The Regional Agency shall, within such period after the end of each financial year as the Department may direct, send copies of the statement of accounts relating to that year to—

(a) the Department; and

(b) the Comptroller and Auditor General.

(4) The Comptroller and Auditor General shall—

(a) examine, certify and report on every statement of accounts received from the Regional Agency under this paragraph; and

(b) send a copy of any such report to the Department.

(5) The Department shall lay a copy of the statement of accounts and of the Comptroller and Auditor General's report before the Assembly.

Annual report

18.—(1) The Regional Agency shall within such period after the end of each financial year as the Department may direct, prepare and send to the Department a report in such form, and containing such information, as may be prescribed.

SCH. 2

(2) The Department shall lay a copy of the report before the Assembly.

Interpretation

19. In paragraphs 17 and 18—

"Comptroller and Auditor General" means the Comptroller and Auditor General for Northern Ireland;

"financial year" means—

(a) the period beginning with the day on which the Regional Agency is established and ending on the next following 31st March; and

(b) each subsequent period of 12 months ending on 31st March.

Information

20.—(1) The Regional Agency shall record such information with respect to the exercise of its functions as the Department may direct.

(2) Information shall be recorded in such form, and retained for such period, as the Department may determine.

(3) The Regional Agency shall, in relation to its functions, furnish to the Department, such reports, returns and other information as the Department may require.

Default powers of Department

21.—(1) The powers conferred by this paragraph are exercisable by the Department if it is satisfied that the Regional Agency has without reasonable excuse failed to discharge any of its functions adequately or at all.

(2) The Department may—

(a) make an order declaring the Regional Agency to be in default; and

(b) direct the Regional Agency to discharge such of its functions, in such manner and within such period or periods, as may be specified in the direction.

(3) If the Regional Agency fails to comply with the Department's direction under sub-paragraph (2), the Department may—

(a) discharge the functions to which the direction relates itself; or

(b) make arrangements for any other person to discharge those functions on its behalf.

Section 14.

SCHEDULE 3

THE REGIONAL BUSINESS SERVICES ORGANISATION

Status

1.—(1) RBSO shall not be regarded—

(a) as the servant or agent of the Crown; or

(b) as enjoying any status, immunity or privilege of the Crown.

(2) The property of RBSO shall not be regarded as property of, or held on behalf of, the Crown.

(3) Where land in which the Department has an interest is managed, used or occupied by RBSO, the interest of the Department shall be treated for the purposes of any statutory provision or rule of law relating to Crown land or interests as if it were an interest held otherwise than by, or on behalf of, the Crown.

(4) RBSO shall, notwithstanding that it is exercising any functions on behalf of the Department, be entitled to enforce any rights acquired and shall be liable in respect of any liabilities incurred (including liabilities in tort) in the exercise of those functions in all respects as if it were acting as a principal, and all proceedings for the enforcement of such rights or liabilities shall be brought by or against RBSO in its own name.

(5) Subject to the provisions of this Schedule, section 19 of the Interpretation Act (Northern Ireland) 1954 (c. 33) applies to RBSO.

General powers

2.—(1) Subject to any directions given by the Department, RBSO may do anything which appears to it to be necessary or expedient for the purpose of, or in connection with, the exercise of its functions.

(2) But RBSO may not borrow money.

Membership

3.—(1) RBSO shall consist of—

(a) a Chair appointed by the Department;

(b) a prescribed number of members appointed by the Department;

(c) the chief officer of RBSO; and

(d) such other officers of RBSO as may be prescribed.

(2) Except in so far as regulations otherwise provide, no person who is an officer of RBSO may be appointed under sub-paragraph (1)(a) or (b).

(3) Regulations may provide that all or any of the persons appointed under sub-paragraph (1)(b) must fulfil prescribed conditions or hold posts of a prescribed description.

Remuneration and allowances

4.—(1) RBSO shall pay to its members such remuneration and allowances as the Department may determine.

(2) A determination of the Department under this paragraph requires the approval of the Department of Finance and Personnel.

Appointment, procedure etc.

5. Regulations may make provision as to—

(a) the appointment of members of RBSO under paragraph 3(1)(b) and (d) (including any conditions to be fulfilled for appointment);

SCH. 3

(b) the tenure of office of the Chair and other members (including the circumstances in which they cease to hold office or may be removed or suspended from office);

(c) the appointment of, constitution of, and exercise of functions by, committees and sub-committees (including committees and sub-committees which consist of or include persons who are not members of RBSO);

(d) the procedure of RBSO and any committees or sub-committees (including the validation of proceedings in the event of vacancies or defects in appointment);

(e) the staff, premises and expenses of RBSO;

(f) such other matters in connection with RBSO as the Department thinks fit.

The chief officer

6.—(1) There shall be a chief officer of RBSO who shall be a member of the staff of RBSO and shall be responsible to RBSO for the general exercise of its functions.

(2) Subject to regulations made under paragraph 5(e)—

(a) the first chief officer shall be appointed by the Department;

(b) any subsequent chief officer shall be appointed by RBSO.

Application of the seal

7. The application of the seal of RBSO shall be authenticated by the signature—

(a) of any member of RBSO; and

(b) of any other person who has been authorised by RBSO (whether generally or specifically) for that purpose.

Execution of documents

8.—(1) Any document which if executed by an individual would not require to be executed as a deed may be executed on behalf of RBSO by any person generally or specially authorised by RBSO for that purpose.

(2) In any legal proceedings any document purporting to have been so executed on behalf of RBSO shall be deemed to be so executed until the contrary is proved.

Finance

9.—(1) The Department may make payments to RBSO out of money appropriated for the purpose.

(2) Payments under this paragraph shall be made on such terms and conditions as the Department may determine.

Accounts

10.—(1) RBSO shall—

(a) keep proper accounts and proper records in relation to the accounts; and

(b) prepare a statement of accounts in respect of each financial year.

(2) The statement of accounts shall—

(a) be in such form; and

(b) contain such information,

as the Department may, with the approval of the Department of Finance and Personnel, direct.

(3) RBSO shall, within such period after the end of each financial year as the Department may direct, send copies of the statement of accounts relating to that year to—

(a) the Department; and

(b) the Comptroller and Auditor General.

(4) The Comptroller and Auditor General shall—

(a) examine, certify and report on every statement of accounts received from RBSO under this paragraph; and

(b) send a copy of any such report to the Department.

(5) The Department shall lay a copy of the statement of accounts and of the Comptroller and Auditor General's report before the Assembly.

Annual report

11.—(1) RBSO shall within such period after the end of each financial year as the Department may direct, prepare and send to the Department a report in such form, and containing such information, as may be prescribed.

(2) RBSO shall publish any report prepared under sub-paragraph (1) in such manner as the Department may direct.

(3) The Department shall lay a copy of the report before the Assembly.

Interpretation

12. In paragraphs 10 and 11—

"Comptroller and Auditor General" means the Comptroller and Auditor General for Northern Ireland;

"financial year" means—

(a) the period beginning with the day on which RBSO is established and ending on the next following 31st March; and

(b) each subsequent period of 12 months ending on 31st March.

Information

13.—(1) RBSO shall at such times as the Department may direct—

(a) provide the Department or a specified body with such information, and

(b) permit the Department or the specified body to inspect and take copies of such documents,

relating to RBSO's functions as the Department may direct.

(2) In sub-paragraph (1) "specified body" means a body specified in directions under that sub-paragraph.

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Default powers of Department

14.—(1) The powers conferred by this paragraph are exercisable by the Department if it is satisfied that RBSO has without reasonable excuse failed to discharge any of its functions adequately or at all.

(2) The Department may—

(a) make an order declaring RBSO to be in default; and

(b) direct RBSO to discharge such of its functions, in such manner and within such period or periods, as may be specified in the direction.

(3) If RBSO fails to comply with the Department's direction under sub-paragraph (2), the Department may—

(a) discharge the functions to which the direction relates itself; or

(b) make arrangements for any other person to discharge those functions on its behalf.

Section 16.

SCHEDULE 4

THE PATIENT AND CLIENT COUNCIL

Status

1.—(1) The Patient and Client Council (in this Schedule referred to as "the Council") shall not be regarded—

(a) as the servant or agent of the Crown; or

(b) as enjoying any status, immunity or privilege of the Crown.

(2) The property of the Council shall not be regarded as property of, or held on behalf of, the Crown.

(3) Subject to the provisions of this Schedule, section 19 of the Interpretation Act (Northern Ireland) 1954 (c. 33) applies to the Council.

General powers

2.—(1) The Council may do anything which appears to it to be necessary or expedient for the purpose of, or in connection with, the exercise of its functions.

(2) But the Council may not borrow money.

Membership

3. The Council shall consist of a Chair and other members appointed by the Department.

Remuneration and allowances

4.—(1) The Council shall pay to its members such remuneration and allowances as the Department may determine.

(2) A determination of the Department under this paragraph requires the approval of the Department of Finance and Personnel.

Appointment, procedure etc.

5. Regulations may make provision as to—

(a) the appointment of the Chair and other members of the Council (including the number, or limits on the number, of members who may be appointed and any conditions to be fulfilled for appointment);

(b) the tenure of office of the Chair and other members (including the circumstances in which they cease to hold office or may be removed or suspended from office);

(c) the appointment of, constitution of, and exercise of functions by, committees and sub-committees (including committees and sub-committees which consist of or include persons who are not members of the Council);

(d) the procedure of the Council and any committees or sub-committees (including the validation of proceedings in the event of vacancies or defects in appointment);

(e) the staff, premises and expenses of the Council;

(f) such other matters in connection with the Council as the Department thinks fit.

The chief officer

6.—(1) There shall be a chief officer of the Council who shall be a member of the staff of the Council and shall be responsible to the Council for the general exercise of its functions.

(2) Subject to regulations made under paragraph 5(e)—

(a) the first chief officer shall be appointed by the Department, and

(b) any subsequent chief officer shall be appointed by the Council.

Application of the seal

7. The application of the seal of the Council shall be authenticated by the signature—

(a) of any member of the Council; and

(b) of any other person who has been authorised by the Council (whether generally or specifically) for that purpose.

Execution of documents

8.—(1) Any document which if executed by an individual would not require to be executed as a deed may be executed on behalf of the Council by any person generally or specially authorised by the Council for that purpose.

(2) In any legal proceedings any document purporting to have been so executed on behalf of the Council shall be deemed to be so executed until the contrary is proved.

Finance

9.—(1) The Department may make payments to the Council out of money appropriated for the purpose.

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(2) Payments under this paragraph shall be made on such terms and conditions as the Department may determine.

(3) Subject to sub-paragraph (4), the Council must pay to the Department all sums received by it in the course of, or in connection with, the carrying out of its functions.

(4) Sub-paragraph (3) does not apply to such sums, or sums of such description, as the Department may, with the approval of the Department of Finance and Personnel, direct.

(5) Any sums received by the Department under sub-paragraph (3) shall be paid into the Consolidated Fund.

Accounts

10.—(1) The Council shall—

(a) keep proper accounts and proper records in relation to the accounts; and

(b) prepare a statement of accounts in respect of each financial year.

(2) The statement of accounts shall—

(a) be in such form; and

(b) contain such information,

as the Department may, with the approval of the Department of Finance and Personnel, direct.

(3) The Council shall, within such period after the end of each financial year as the Department may direct, send copies of the statement of accounts relating to that year to—

(a) the Department; and

(b) the Comptroller and Auditor General.

(4) The Comptroller and Auditor General shall—

(a) examine, certify and report on every statement of accounts received from the Council under this paragraph; and

(b) send a copy of any such report to the Department.

(5) The Department shall lay a copy of the statement of accounts and of the Comptroller and Auditor General's report before the Assembly.

Annual report

11.—(1) The Council shall within such period after the end of each financial year as the Department may direct, prepare and send to the Department a report in such form, and containing such information, as may be prescribed.

(2) The Council shall publish any report prepared under sub-paragraph (1) in such manner as the Department may direct.

(3) The Department shall lay a copy of the report before the Assembly.

Interpretation

12. In paragraphs 10 and 11—

"Comptroller and Auditor General" means the Comptroller and Auditor General for Northern Ireland;

"financial year" means—

(a) the period beginning with the day on which the Council is established and ending on the next following 31st March; and

(b) each subsequent period of 12 months ending on 31st March.

Information

13. The Council shall at such times as the Department may direct—

(a) provide the Department with such information, and

(b) permit the Department to inspect and take copies of such documents,

relating to the Council's functions as the Department may direct.

Default powers of Department

14.—(1) The powers conferred by this paragraph are exercisable by the Department if it is satisfied that the Council has without reasonable excuse failed to discharge any of its functions adequately or at all.

(2) The Department may—

(a) make an order declaring the Council to be in default; and

(b) direct the Council to discharge such of its functions, in such manner and within such period or periods, as may be specified in the direction.

(3) If the Council fails to comply with the Department's direction under sub-paragraph (2), the Department may—

(a) discharge the functions to which the direction relates itself; or

(b) make arrangements for any other person to discharge those functions on its behalf.

SCHEDULE 5

Section 23.

TRANSFER OF ASSETS, ETC.

PART 1

TRANSFER SCHEMES

Transfer of assets and liabilities

1.—(1) A scheme—

(a) may provide for the transfer of assets and liabilities which would not otherwise be capable of being transferred;

(b) shall, accordingly, have effect in relation to assets or liabilities to which it applies in spite of any provision (of whatever nature) which would otherwise prevent or restrict the transfer of those assets or liabilities;

(c) may contain supplementary, incidental, transitional and consequential provisions.

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(2) A scheme may define the assets and liabilities to be transferred by specifying or describing them (including describing them by reference to a specified part of the transferor's undertaking).

(3) A certificate issued by the Department that any assets or liabilities specified in the certificate have vested in any body by virtue of a scheme is conclusive evidence for all purposes of that fact.

(4) In this Schedule, in relation to any assets or liabilities transferred by a scheme—

"transferor" means the body from which those assets or liabilities are transferred; and

"transferee" means the body to which those assets or liabilities are transferred.

Transfer of employed staff

2.—(1) This paragraph applies if rights and liabilities under a contract of employment are transferred by virtue of a scheme.

(2) The Transfer of Undertakings (Protection of Employment) Regulations 2006 (S.I. 2006/246) apply to the transfer whether or not the transfer would, apart from this paragraph, be a relevant transfer for the purposes of the regulations.

(3) The scheme shall—

(a) in relation to each transferee, identify the transferring employees (whether by name or otherwise);

(b) include provision securing pension protection for such employees;

(c) include provision for procedures designed to resolve any grievances of such employees arising in relation to matters dealt with by the scheme; and

(d) include provision for the payment of compensation by the Department to any such employee who suffers loss or detriment in consequence of the scheme.

(4) Before making the scheme the Department must consult—

(a) in the case of a scheme which identifies transferring employees by name, those employees; and

(b) in the case of a scheme which identifies transferring employees in any other way, such persons as appear to the Department to be representative of transferring employees.

(5) For the purposes of this paragraph—

(a) "pension protection" is secured for a transferring employee if after the change of employer effected by the scheme the employee has, as an employee of the transferee, rights to acquire pension benefits and those rights are the same as or (taken as a whole) no less favourable than those that the transferring employee had as an employee of the transferor;

(b) "transferring employee" means an employee whose contract of employment becomes, by virtue of sub-paragraph (2), a contract of employment with a transferee; and

(c) employment in the Northern Ireland civil service for the purposes of the Department is to be treated as employment by the Department under a contract of employment (and the terms of that employment are to be regarded as constituting the terms of that contract).

(6) Procedures under sub-paragraph (3)(c) must involve consideration of grievances by a person other than—

(a) a member, or member of staff, of a transferor or transferee; or

(b) a member of staff of the Department.

Continuity

3.—(1) In any statutory provision or document—

(a) which relates to anything transferred by virtue of the scheme, and

(b) which is in effect immediately before the transfer date,

any reference to the transferor shall, in relation to any time after the transfer date, be construed as a reference to the transferee.

(2) Sub-paragraph (1) applies unless contrary provision is made by or under this Act or the context otherwise requires.

(3) A transfer by virtue of a scheme does not affect the validity of anything done by, or in relation to, the transferor before the transfer date.

(4) Anything which—

(a) before the transfer date was done by or in relation to the transferor for the purposes of or otherwise in connection with anything transferred by virtue of a scheme, and

(b) is in effect immediately before the transfer date,

shall continue to have effect to the same extent and subject to the same provisions as if it had been done by, or in relation to, the transferee.

(5) Anything (including any legal proceedings) which—

(a) relates to anything transferred by virtue of a scheme, and

(b) is in the process of being done by or in relation to the transferor immediately before the transfer date,

may be continued by or in relation to the transferee.

PART 2

ACCOUNTS AND REPORTS OF DISSOLVED BODIES

4.—(1) The appropriate body shall make arrangements for—

(a) a statement of accounts to be prepared in relation to—

(i) each Health and Social Services Board,

(ii) the Central Services Agency,

(iii) the Mental Health Commission, and

(b) a report to be prepared on the activities of each such body,

for the relevant period.

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(2) The statement of accounts and report shall—

(a) be in such form, and

(b) contain such information,

as the Department may determine.

(3) The appropriate body shall, within such time after the end of the relevant period as the Department may direct—

(a) send a copy of the statement of accounts and the report to the Department; and

(b) send a copy of the statement of accounts to the Comptroller and Auditor General.

(4) In this paragraph "the relevant period", in relation to a body, means the period—

(a) beginning on such day as the Department may determine; and

(b) ending immediately before the date on which the body is dissolved.

(5) The Comptroller and Auditor General shall—

(a) examine and report on any statement of accounts received under sub-paragraph (3); and

(b) send a copy of the report to the Department.

(6) The Department shall lay before the Assembly—

(a) a copy of the statement of accounts;

(b) the Comptroller and Auditor General's report;

(c) the report mentioned in sub-paragraph (1)(b).

(7) In this paragraph—

"the appropriate body" means—

(a) in relation to Health and Social Services Boards, the Regional Board;

(b) in relation to the Central Services Agency, RBSO;

(c) in relation to the Mental Health Commission, RQIA;

"the Comptroller and Auditor General" means the Comptroller and Auditor General for Northern Ireland.

Section 32.

SCHEDULE 6

MINOR AND CONSEQUENTIAL AMENDMENTS

General amendment of certain references to health and social services, etc.

1.—(1) In any provision of Northern Ireland legislation—

(a) for "personal social services" or "social services" substitute "social care";

(b) for "health services" substitute "health care";

(c) for "Health and Social Services trust" substitute "Health and Social Care trust";

(d) for "HSS trust" substitute "HSC trust";

(e) for "HSS contract" substitute "HSC contract";

(f) for "HSS employee" substitute "HSC employee".

(2) Sub-paragraph (1)(a) does not apply to any reference to the name of the Department.

(3) Sub-paragraph (1) does not apply—

(a) to any reference in the title of an Act, Order in Council or other statutory provision;

(b) to any reference in this Act or to any reference which is subject to amendment or repeal by or under any other provision of this Act; or

(c) where the context otherwise requires.

The Public Health Act (Northern Ireland) 1967 (c. 36)

2.—(1) For any reference to the Director of Public Health of a Health and Social Services Board substitute a reference to the Director of Public Health.

(2) For any other reference to a Health and Social Services Board substitute a reference to the Regional Agency.

(3) In section 32 (interpretation) at the appropriate places insert—

"Director of Public Health" means the Director of Public Health for Northern Ireland (see Article 32 of the Health and Personal Social Services (Northern Ireland) Order 1991);";

"the Regional Agency" means the Regional Agency for Public Health and Social Well-being;".

The Order of 1972

3.—(1) In Article 2(2) (interpretation)—

(a) omit the definitions of "the Agency", "Health and Social Services Board", "Health and Social Services trust", "health services", "the Ministry", "order", "personal social services", "regulations", "special agency" and "waters forming part of a port";

(b) in the definition of "directions" for the words from "and" to the end substitute "given by the Department";

(c) at the appropriate place, insert the following definition—

""the 2009 Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;";

(d) in the definition of "mental disorder" for "Act" substitute "Order".

(2) After Article 2(2) insert—

"(2A) In this Order the following expressions have the meanings given to them by section 31(1) of the 2009 Act—

"the Department";

"health care";

"health and social care bodies";

"health inequalities";

"HSC trust";

"the Regional Agency";

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"the Regional Board";

"RBSO";

"RQIA";

"regulations";

"social care"; and

"special agency".".

(3) Omit Article 4 (general duty of the Department).

(4) In Article 5 (provision of accommodation and medical services, etc.)—

(a) after "this Order" (wherever occurring) insert "or the 2009 Act", and

(b) in paragraph (2) for "Article 4(a)" substitute "section 2(1)(a) of the 2009 Act".

(5) In Articles 10(1)(a) (ancillary services) and 13 (education and research facilities) after "this Order" insert "or the 2009 Act".

(6) In Article 15(1) (general social welfare) for "Article 4(b)" substitute "section 2(1)(b) of the 2009 Act".

(7) Omit Article 16 (establishment of Health and Social Services Boards).

(8) In Article 17 (functions of Health and Social Services Boards) omit sub-paragraphs (1)(a) and (2).

(9) In Article 18 (schemes)—

(a) in paragraph (1) for "Health and Social Services Board" substitute "body to which this Article applies";

(b) in paragraph (3) for "Health and Social Services Board" substitute "body";

(c) in paragraphs (4) and (5) for "Health and Social Services Board" substitute "body to which this Article applies";

(d) at the end add—

"(6) This Article applies to—

(a) the Regional Board;

(b) a Local Commissioning Group;

(c) the Regional Agency.".

(9) Omit Article 19 (joint committees).

(10) In Article 21 (university liaison committees) for paragraph (1) substitute—

"(1) The Department may by order establish University Liaison Committees for the purpose of—

(a) advising the Regional Board and the Regional Agency on the administration of health care in relation to the provision of facilities for undergraduate or post-graduate clinical teaching or for research, and

(b) advising the Regional Board, the Regional Agency and the university or universities concerned on any matter of common interest to them.".

(11) In Article 21(2)(c) after "Order" insert "or the 2009 Act".

(12) In Article 24(1) (central advisory committees) after "this Order" (twice) insert "or the 2009 Act".

(13) In Article 25(1) (other advisory committees) for "Article 4" substitute "section 2 of the 2009 Act".

(14) Omit Articles 26 and 27 (the Northern Ireland Central Services Agency for Health and Social Services).

(15) In Article 31(1)(a) (accommodation and services for private patients) after "Order" insert "or the 2009 Act".

(16) In Article 38(1)(a) (protection of property of certain persons) after "Order" insert "or the 2009 Act".

(17) In Article 39(1) (burial, etc, of the dead) after "Order" insert "or the 2009 Act".

(18) In Article 41 (availability or provision of services, etc.) after "Order" (twice) insert "or the 2009 Act".

(19) In Article 42(1) (provision of services to persons not ordinarily resident in Northern Ireland) after "Order" insert "or the 2009 Act".

(20) In Article 45(1) (travelling expenses of patients, etc.)—

(a) in sub-paragraph (a) after "this Order" insert ", the 2009 Act"; and

(b) in sub-paragraph (c) after "Order" insert "or the 2009 Act".

(21) In Article 46 (provision of residential accommodation for officers) in sub-paragraphs (a) and (b) after "Order" insert "or the 2009 Act".

(22) In Article 48(1) and (1A) (land) for "any of the health or social services" substitute "health or social care".

(23) In Article 51 (powers of Department where services are inadequate) after "Order" (second time) insert "or the 2009 Act".

(24) In Article 52(2) (powers of Department in emergency) after sub-paragraph (g) insert—"and

(h) the 2009 Act.".

(25) In Article 53 (default powers) in paragraph (1) for the words from "any Health" to "Agency" substitute "any body to which this Article applies".

(26) After Article 53(1) insert—

"(1A) This Article applies to the following bodies—

(a) the Regional Board;

(b) the Regional Agency;

(c) RBSO;

(d) HSC trusts; and

(e) special agencies.".

(27) In Article 55 (recognition of local representative committees)—

(a) in paragraphs (2) and (3) for "its area" substitute "an area";

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(b) in paragraph (5)(c)—

(i) for "the area of a Health and Social Services Board" substitute "an area", and

(ii) omit "but is not himself on a list"; and

(c) in paragraph (5)(d) for "the area of a Health and Social Services Board" substitute "an area";

(d) in paragraph (6) for "its area" substitute "the area";

(e) in paragraph (7) omit sub-paragraph (b) and the word "and" preceding it.

(28) In Article 55A(5) (functions of local representative committees) for "its area" substitute "an area".

(29) In Article 55B(1) (local medical committees) for the words from "formed" to "Boards" substitute "formed for an area".

(30) In Article 56 (primary medical services)—

(a) in paragraph (1), omit "within its area" (twice), and

(b) in paragraph (2), omit "(whether within or outside its area)" (twice).

(31) In Article 57(4) (general medical services contracts: introductory) omit sub-paragraph (b).

(32) In Article 57G(3)(c) (persons performing primary medical services) omit the words from "as to" to "made, and".

(33) In Article 67 (co-operation) for the words from the beginning to "special agencies" substitute "In exercising their respective functions, health and social care bodies".

(34) In Article 68 (supply of goods and services to certain persons and bodies)—

(a) in paragraph (1) for "a body to which this Article applies" (twice) substitute "a health and social care body";

(b) omit paragraph (3).

(35) In Article 69 (supply of goods and services to district councils)—

(a) in paragraph (1) for "a body to which this Article applies" substitute "a health and social care body";

(b) omit paragraph (2).

(36) Omit Article 84 (powers of Department in cases of difficulty).

(37) In Article 87 (expenses of certain bodies)—

(a) for the heading substitute "Expenses of the special agencies";

(b) in paragraph (1), for the words from the beginning to "Agency" substitute "(1) The Department shall pay to the special agencies";

(c) omit paragraph (2).

(38) In Article 88(1) (regulation of financial matters of certain bodies) for the words from "Health" to "Agency" substitute "special agency".

(39) In Article 89(1)(a) (remuneration of members of bodies and certain other persons) omit head (iii).

(40) In Article 90(6) (accounts and audit) omit sub-paragraphs (a) and (b).

(41) In Article 91(6) (accounts of endowments and other property held on trust) for sub-paragraph (a) substitute—

"(a) the Regional Board;

(aa) the Regional Agency;".

(42) In Article 92B(3) (studies for improving economy, etc. in services) for sub-paragraphs (a) and (b) substitute—

"(a) the Regional Board;

(aa) the Regional Agency;

(b) RBSO;".

(43) In Article 94(1) after "Order" insert "or the 2009 Act".

(44) In Article 96 (preservation of associations of denominational hospitals) for "Health and Social Services Board" substitute "HSC trust".

(45) In Article 97(1) (protection for officer acting in execution of his duty) for the words from the beginning to the end of sub-paragraph (e) substitute "An officer of a health and social care body".

(46) In Article 98(1) (services free of charge) after "1997" insert "or the 2009 Act".

(47) In Article 107(1) (orders, regulations and directions) omit "16(1)" and "orders made under Article 76(1) to which paragraph 1(a) to (e) of Schedule 13 applies".

(48) Omit Schedule 1 (Health and Social Services Boards) and Schedule 3 (the Agency).

(49) In Schedule 6 (removal to suitable premises of persons in need of care and attention) in paragraph 12(a)(ii) for the words from "the Health" to "resides" substitute "the Regional Board".

(50) In Schedule 10 (prohibition on sale of medical practices)—

(a) in paragraph 1(1) omit "in that Board's area";

(b) in paragraph 2(2), for the words from "the Health" to "situated" substitute "the Regional Board".

The Northern Ireland Assembly Disqualification Act 1975 (c. 25)

4.—(1) Schedule 1 (offices disqualifying for membership of the Assembly) is amended as follows.

(2) In Part 2 of that Schedule omit the entry relating to the Mental Health Commission for Northern Ireland.

(3) In Part 3 of that Schedule—

(a) omit the entries relating to—

(i) the Chairman or any member, not also being an employee, of a Health and Social Services Board, and

(ii) the Chairman of the Northern Ireland Central Services Agency for the Health and Social Services; and

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(b) at the appropriate places insert—

"Chair or any member, not also being an employee, of the Patient and Client Council established under section 16 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.";

"Chair or any member, not also being an employee, of the Regional Health and Social Care Board established under section 7 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.";

"Chair or any member, not also being an employee, of the Regional Agency for Public Health and Social Well-being established under section 12 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.";

"Chair or any member, not also being an employee, of the Regional Business Services Organisation established under section 14 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.".

The Solicitors (Northern Ireland) Order 1976 (NI 12)

5. In Article 3(2) (interpretation) in the definition of "local authority" for the words from "or the" (first time) to "1972" substitute ", the Regional Health and Social Care Board, the Regional Business Services Organisation, the Regional Agency for Public Health and Social Well-being".

The Chronically Sick and Disabled Persons (Northern Ireland) Act 1978 (c. 53)

6.—(1) In section 1 (information as to need for and existence of social welfare services) in subsections (1) and (2) for "Articles 4(b) and" substitute "section 2(1)(b) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Article".

(2) In section 2 (provision of social welfare services)—

(a) for "Articles 4(b) and" substitute "section 2(1)(b) of the Health and Social Services (Reform) Act (Northern Ireland) 2009 and Article", and

(b) in paragraph (d) for "the said Articles 4(b) and 15" substitute "section 2(1)(b) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Article 15 of the Health and Personal Social Services (Northern Ireland) Order 1972".

The Magistrates' Courts (Northern Ireland) Order 1981 (NI 26)

7. In Article 51(2)(b) (remand for inquiry into physical or mental condition), for "the Mental Health Commission for Northern Ireland" substitute "the Health and Social Care Regulation and Quality Improvement Authority".

The Mental Health (Northern Ireland) Order 1986 (NI 4)

8.—(1) Subject to sub-paragraphs (2) to (4), in the Order for "the Commission" (meaning the Mental Health Commission) substitute "RQIA".

(2) In Article 2(2) (interpretation)—

(a) omit the definition of "the Commission";

(b) in the definition of "responsible authority" for sub-paragraph (ii) of paragraph (a) and sub-paragraph (ii) of paragraph (b) substitute—

"(ii) in any other case, the Regional Health and Social Care Board;";

(c) at the appropriate place in alphabetical order insert—

"RQIA" means the Health and Social Care Regulation and Quality Improvement Authority;".

(3) In Article 16(3)(d) (correspondence of detained patients) omit ", any Commissioner thereof".

(4) For Article 85 (establishment of Mental Health Commission for Northern Ireland) substitute—

"Duties of RQIA in relation to mental health

85. RQIA shall exercise—

(a) such functions under this Order as are transferred to it by section 25 of the Health and Social Care (Reform) Act (Northern Ireland) 2009, and

(b) such other functions relating to or connected with mental health as the Department may by order prescribe.".

(5) Omit Articles 88 and 89 and Schedule 4.

(6) In Article 112 for "A Board" substitute "The Regional Health and Social Care Board and the Regional Agency for Public Health and Social Well-being".

The AIDS (Control) (Northern Ireland) Order 1987 (NI 18)

9.—(1) In Article 2(2) (interpretation)—

(a) omit the definitions of "Board" and "HSS trust";

(b) at the end add—

""relevant body" means the Regional Health and Social Care Board, the Regional Agency for Public Health and Social Well-being and a health and social care trust.".

(2) In Article 3 (reports)—

(a) in paragraph (1) for "Board and by each HSS trust" substitute "relevant body".

(b) in paragraph (2) for "Board or HSS trust" substitute "relevant body".

(3) In the Schedule (contents of reports) for "Board or HSS trust" substitute "relevant body".

The Water (Fluoridation) (Northern Ireland) Order 1987 (NI 21)

10. In Article 3 (fluoridation of water supplies)—

(a) omit paragraph (3); and

(b) in paragraph (5), for the words from the beginning to "application" substitute "In making arrangements with the Department in pursuance of an application, the Regional Health and Social Care Board".

The Health and Medicines (Northern Ireland) Order 1988 (NI 24)

11.—(1) In Article 3 (powers for financing health services) in paragraph (3)(a) after "principal Order" insert "or the 2009 Act".

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(2) In Article 11 (transfer of staff) after "principal Order" insert "or the 2009 Act (within the meaning of the principal Order)".

The Disabled Persons (Northern Ireland) Act 1989 (c. 10)

12. In section 2(5)(b) (rights of authorised representatives of disabled persons) for "Articles 4(b) and" substitute "section 2(1)(b) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Article".

The Health and Personal Social Services (Northern Ireland) Order 1991 (NI 1)

13.—(1) In Article 2(2) (interpretation) at the appropriate place insert—

""the Regional Board" means the Regional Health and Social Care Board established under section 7 of the Health and Social Care (Reform) Act (Northern Ireland) 2009;".

(2) In Article 2(3) after "Article 2(2)" insert "and (2A)".

(3) Omit Article 3 (constitution of Health and Social Services Boards) and Article 4 (Health and Social Services Councils).

(4) In Article 7 (removal of Crown immunities)—

(a) omit paragraph (1);

(b) in paragraphs (2) to (4) for "health and social services body" substitute "health and social care body to which this Article applies";

(c) in paragraph (2), omit sub-paragraph (b) and the word "and" immediately before it;

(d) in paragraph (4) after "Order" insert "or the 2009 Act";

(e) for paragraph (6) substitute—

"(6) This Article applies to the following health and social care bodies—

(a) the Regional Board;

(b) the Regional Agency;

(c) RBSO;

(d) a special agency.".

(5) In Article 8(2) (health and social services contracts) for sub-paragraphs (a) and (b) substitute—

"(a) the Regional Board;

(aa) the Regional Agency;

(b) RBSO;".

(6) Omit Article 9 (primary and other functions of Health and Social Services Boards and special agencies).

(7) In Article 10 (health and social care trusts)—

(a) for paragraph (2) substitute—

"(2) Before making an order under paragraph (1), the Department shall consult—

(a) the Patient and Client Council, and

(b) such other persons and bodies as the Department considers appropriate.".

(b) in paragraph (3) for sub-paragraphs (a) and (b) substitute—

"(a) the Regional Board;

(aa) the Regional Agency;

(b) RBSO; or".

(8) In Article 21 (indicative amounts for doctors' practices)—

(a) in paragraph (1) omit the words "in relation to which it is the relevant Health and Social Services Board";

(b) in paragraph (4) for "the relevant Health and Social Services Board" substitute "the Regional Board";

(c) omit paragraphs (7) and (8A).

(9) In Article 23(1) (power to raise funds) for "Health and Social Services Boards" substitute "the Regional Board, the Regional Agency,".

(10) In Article 24(2) (schemes for meeting losses and liabilities, etc.) for sub-paragraphs (a) and (b) substitute—

"(a) the Regional Board;

(aa) the Regional Agency;

(b) RBSO;".

(11) In Article 32 (Director of Public Health) for paragraph (1) substitute—

"(1) The chief administrative medical officer of the Regional Agency shall be known as the Director of Public Health for Northern Ireland.

(1A) For any reference to the Director of Public Health of a Health and Social Services Board in—

(a) the statutory provisions mentioned in paragraph (2);

(b) any other statutory provision passed or made before the coming into operation of section 12 of the Health and Social Care (Reform) Act (Northern Ireland) 2009,

there shall be substituted a reference to the Director of Public Health for Northern Ireland.".

(12) Omit Schedule 1 (health and social services councils).

(13) In Schedule 3 (health and social care trusts)—

(a) in paragraph 3 omit sub-paragraphs (1)(d), (2) and (3);

(b) omit paragraph 19;

(c) in paragraph 24 after sub-paragraph (1) insert—

"(1A) The Department must exercise it powers under sub-paragraph (1) so as to ensure that all the liabilities of the HSC trust are transferred.".

The Children (Northern Ireland) Order 1995 (NI 2)

14.—(1) In Article 17A(3)(a) (assessments and services for children who are carers) for "(in the case of a Board)" substitute "or section 6 of the Health and Social Care (Reform) Act (Northern Ireland) 2009".

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(2) In Article 18A(4) (assessments: carers of disabled children) for "(in the case of a Board)" substitute "or section 6 of the Health and Social Care (Reform) Act (Northern Ireland) 2009".

(3) In Article 61(2) (right of guardian ad litem to have access to records) after "1972" insert "or section 6 of the Health and Social Care (Reform) Act (Northern Ireland) 2009".

The Commissioner for Complaints (Northern Ireland) Order 1996 (NI 7)

15.—(1) Schedule 2 (bodies subject to investigation) is amended as follows.

(2) Omit the entries relating to—

(a) a health and social services board,

(b) a health and social services council,

(c) the Mental Health Commission for Northern Ireland, and

(d) the Northern Ireland Central Services Agency for the Health and Social Services.

(3) At the appropriate places insert—

"The Patient and Client Council.";

"The Regional Health and Social Care Board.";

"The Regional Agency for Public Health and Social Well-being.";

"The Regional Business Services Organisation.".

The Criminal Justice (Northern Ireland) Order 1996 (NI 24)

16.—(1) In Article 22(5) (additional requirements in the case of mentally disordered offenders) for "the Mental Health Commission for Northern Ireland" substitute "the Health and Social Care Regulation and Quality Improvement Authority".

(2) In Schedule 1 (additional requirements in probation orders) in paragraph 4(1) for "the Mental Health Commission for Northern Ireland" substitute "the Health and Social Care Regulation and Quality Improvement Authority".

The Freedom of Information Act 2000 (c. 36)

17.—(1) Schedule 1 (bodies, etc. which are public authorities for the purposes of the Act) is amended as follows.

(2) In Part 3—

(a) omit paragraphs 46, 47 and 50;

(b) after paragraph 51 insert—

"51A. The Regional Business Services Organisation established under section 14 of the Health and Social Services (Reform) Act (Northern Ireland) 2009.

51B. The Patient and Client Council established under section 16 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

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51C. The Regional Health and Social Care Board established under section 7 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

51D. The Regional Agency for Public Health and Social Well-being established under section 12 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.".

(3) In Part 7 omit the entry relating to the Mental Health Commission for Northern Ireland.

The Health and Personal Social Services Act (Northern Ireland) 2001 (c. 3)

18.—(1) In section 51 (provision of information as to births and deaths)—

(a) in subsections (1) and (2) for "or the Agency" substitute ", RBSO";

(b) in subsection (4) for the words from "a Health" to "district" (first time) substitute "the Regional Board".

(2) In section 54(1) (public access to meetings of certain bodies)—

(a) for paragraphs (a) and (b) substitute—

"(a) the Regional Board;

(aa) the Regional Agency;

(b) RBSO;".

(b) for paragraph (e) substitute—

"(e) the Patient and Client Council, and".

(3) In section 59(2) after "Article 2(2)" insert "or (2A)".

The Audit and Accountability (Northern Ireland) Order 2003 (NI 5)

19.—(1) In Article 5(1) (additional bodies whose annual accounts are subject to audit by the Comptroller and Auditor General) omit sub-paragraph (l).

(2) In Schedule 1 (amendments with respect to accounts of certain bodies) omit paragraph 12.

SCHEDULE 7

Section 33.

REPEALS

Short Title	Extent of repeal
The Public Health Act (Northern Ireland) 1967 (c. 36)	In section 2(1) the words "for the area in which the examination took place". In section 2(3) the words "carrying on practice in their area". In section 3(1) the words "for any area" and "in that area". In section 7(3) the words "for the area". In section 14(2) the words "for the area". In section 18(1) the words "for the area in which the premises are situate".

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Short Title	Extent of repeal
	In section 32 the definition of "Health and Social Services Board".
The Health and Personal Social Services (Northern Ireland) Order 1972 (NI 14)	In Article 2(2) the definitions of "the Agency", "Health and Social Services Board", "Health and Social Services trust" "health services", "the Ministry", "order", "personal social services", "regulations", "special agency" and "waters forming part of a port". Article 4. In Article 15B(4) the words "under this Part". Article 16. Article 17(1)(a) and (2). Article 19. Articles 26 and 27. In Article 55— (a) in paragraph (5)(c) the words "but is not himself on a list"; (b) paragraph (7)(b) and the word "and" preceding it. In Article 56— (a) in paragraph (1) the words "within its area" (twice); and (b) in paragraph (2) the words "(whether within or outside its area)" (twice). Article 57(4)(b). In Article 57G(3)(c) the words from "as to" to "made, and". Article 68(3). Article 69(2). Articles 75 and 76. Article 84. Article 87(2). Article 89(1)(a)(iii). Article 90(6)(a) and (b). Article 91(6)(a). In Article 107(1) the words "16(1)" and "orders made under Article 76(1) to which paragraph 1 (a) to (e) of Schedule 13 applies". Schedules 1 and 3. In Schedule 10, in paragraph 1(1) the words "in that Board's area". Schedule 13.
The Northern Ireland Assembly Disqualification	In Part 2 of Schedule 1, the entry relating to the Mental Health Commission for Northern

Short Title	Extent of repeal
Act 1975 (c. 25)	Ireland. In Part 3 of Schedule 1, the entries relating to— (a) the Chairman or any member, not also being an employee, of a Health and Social Services Board; and (b) the Chairman of the Northern Ireland Central Services Agency for the Health and Social Services.
The Health and Personal Social Services (Northern Ireland) Order 1978 (NI 26)	Article 18.
The Mental Health (Northern Ireland) Order 1986 (NI 4)	In Article 2(2) the definition of "the Commission". In Article 16(3)(d) the words ", any Commissioner thereof". Articles 88 and 89. Schedule 4.
The Health and Personal Social Services and Public Health (Northern Ireland) Order 1986 (NI 24)	Article 3. Articles 11 and 12.
The Aids (Control) (Northern Ireland) Order 1987 (NI 18)	In Article 2(2) the definitions of "Board" and "HSS trust".
The Water (Fluoridation) (Northern Ireland) Order 1987 (NI 21)	Article 3(3).
The Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 (NI 3)	Article 5(2), (5), (9) and (10).
The Health and Personal Social Services (Northern Ireland) Order 1991 (NI 1)	Articles 3 and 4. Article 6. Article 7(1). In Article 7(2), sub-paragraph (b) and the word "and" immediately before it. Article 8(2)(b). Article 9. In Article 21— (a) in paragraph (1) the words "in relation

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Short Title	Extent of repeal
	to which it is the relevant Health and Social Services Board"; and (b) paragraphs (7) and (8A). Article 24(2)(b). In Article 32— (a) paragraph (2)(c) and (d); and (b) in paragraph (3) the words from "and" to "1989". Schedule 1. Part 2 of Schedule 2. In Schedule 3, paragraphs 3(1)(d), (2) and (3) and 19.
The Health and Personal Social Services (Northern Ireland) Order 1994 (NI 2)	In Schedule 1 the entry relating to Article 27 of the Health and Personal Social Services (Northern Ireland) Order 1972.
The Commissioner for Complaints (Northern Ireland) Order 1996 (NI 7)	In Schedule 2 the entries relating to a health and social services board, a health and social services council, the Mental Health Commission for Northern Ireland and the Northern Ireland Central Services Agency for the Health and Social Services.
The Health and Personal Social Services (Residual Liabilities) (Northern Ireland) Order 1996 (NI 13)	The whole Order.
The Health Services (Primary Care) (Northern Ireland) Order 1997 (NI 7)	In Article 13(2) the words "or by any other Board".
The Freedom of Information Act 2000 (c. 36)	In Part 3 of Schedule 1, paragraphs 46, 47 and 50. In Part 7 of Schedule 1, the entry relating to the Mental Health Commission for Northern Ireland.
The Health and Personal Social Services Act (Northern Ireland) 2001 (c. 3)	Section 54(3).
The Audit and Accountability (Northern Ireland) Order 2003 (NI 5)	Article 5(1)(1). In Schedule 1, paragraph 12.

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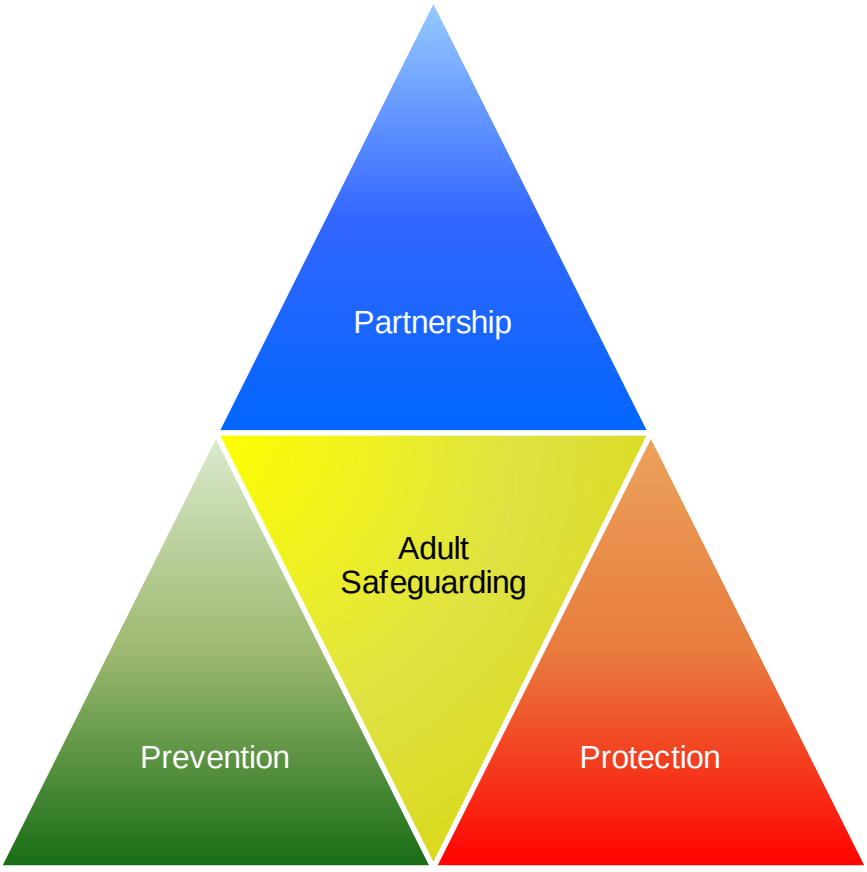
Adult Safeguarding

Prevention and Protection in Partnership



Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Department of Justice
www.dojni.gov.uk

July 2015

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This policy document replaces Part 1 of 'Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance' September 2006.

Foreword by the Minister for Health, Social Services and Public Safety

As each of us goes through life we encounter many challenges. For the most part we are able to overcome them, equipped with our experiences, knowledge and with support from friends or family.

The challenges of dealing with abuse, exploitation or neglect should never arise, but they can and they do. The harm caused can have a devastating and long-lasting impact on victims, their families and carers.

Unfortunately, some adults are more at risk of harm than others. Safeguarding adults at risk is a priority for the Northern Ireland Executive and a Programme for Government commitment.

As far as possible, the aim of the policy is to prevent harm from occurring in the first place, to offer effective protection to those who are harmed and to provide them access to justice.

This policy makes it clear that we must not tolerate harm to adults caused by abuse, exploitation or neglect. It promotes partnership working for the purpose of safeguarding and seeks to keep adults safe wherever they live and whenever they access services.

It is acknowledged that safeguarding adults is complex and challenging and requires the careful exercise of professional judgement.

I want to acknowledge the very positive contribution to safeguarding delivered by a wide range of organisations across the statutory, voluntary, community, independent and faith sectors. I believe this adult safeguarding policy sets the way forward for all of us to work together to improve adult safeguarding practice.

I am confident that the implementation of this policy will prevent and reduce the risk of harm and improve safeguarding outcomes and I commend it to you.

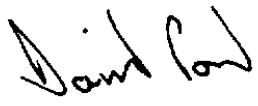
Simon Hamilton MLA
Minister for Health, Social Services and Public Safety

Foreword by the Minister of Justice

As Ministers we are committed to ensuring that steps are taken to identify those who may be at risk of harm and, working together with others, improve the safeguards that are in place to protect them. Along with other institutions and bodies, we can provide increased protections and ensure that where a crime has been committed support services and access to justice are available. There are many areas in which adult safeguarding issues are of interest to the criminal justice sector, including a range of crime types such as domestic and sexual violence, hate crime and human trafficking among others. The publication of this adult safeguarding policy improves the safeguards that are in place and, in conjunction with a range of changes to the criminal justice system in recent years, means that more support is available for those who are unfortunate enough to become a victim of crime.

Recent improvements to the criminal justice system mean that those that are at risk of harm and the victim of crime are provided with additional support and entitlements. A victim and witness care unit has been established, providing victims of crime with a single point of contact for as much of the criminal justice system as possible. Registered intermediaries schemes are enabling those with significant communication difficulties to give evidence to the police and at court. In addition, a range of special measures continue to be available to enable vulnerable and intimidated victims and witnesses give their best evidence to both the police and at court. A Victim Charter has also been published, setting out the services to be provided to, and entitlements of, victims of crime as they move through the criminal justice process. This will be placed on a statutory footing later this year.

While it will never be possible to remove the potential for harm to occur, what we can do is ensure that there is effective support and protection for those individuals who have been subject to harm as they move through the criminal justice process. We can also provide increased access to justice for victims and their families when harm does occur and a crime has been committed. We want to place a greater focus on early intervention, protection and enabling those who suffer harm to have a greater voice within the justice process. The publication of the new adult safeguarding policy is a key development in this area.



David Ford MLA
Minister of Justice

1. INTRODUCTION

Everyone has a fundamental right to be safe. Whatever the cause, and wherever it occurs, harm caused to adults by abuse, exploitation or neglect is not acceptable. This policy emphasises that safeguarding is everyone's business and that as good citizens we should all strive to prevent harm to adults from abuse, exploitation or neglect.

The aim of this policy is to improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect. It has been jointly developed and published by the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DOJ) on behalf of the Northern Ireland Executive. It sets out how the Northern Ireland Executive intends adult safeguarding to be taken forward across all Government Departments, their agencies and in partnership with voluntary, community, independent and faith organisations. A key objective is to reduce the incidence of harm from abuse, exploitation or neglect of adults who are at risk in Northern Ireland; to provide them with effective support and, where necessary, protective responses and access to justice for victims and their families. The policy contributes to fulfilment of a Northern Ireland Executive Programme for Government commitment to deliver a package of measures to safeguard children and adults who may be at risk of harm and to promote a culture where safeguarding is everyone's business.

The policy requires a cross-departmental approach within government because the delivery of improved safeguarding outcomes is the business of us all, as individuals, as members of communities, as providers of services, and as Government Departments responsible for the delivery of strategies and policies which directly or indirectly impact on the lives of all adults including those at risk. The policy requires us to put all individuals who may be at risk at the centre, to listen to and respect their views, and to work in partnership with them and on an inter-agency basis to create a society which has a zero-tolerance of harm to the most vulnerable adults living in Northern Ireland.

Within this policy the term 'safeguarding' is used in its widest sense, that is, to encompass both activity which **prevents** harm from occurring in the first place and activity which **protects** adults at risk where harm has occurred or is likely to occur without intervention.

By introducing this policy we aim to raise awareness of harm to adults at risk, define what harm is, how it manifests itself and importantly how we respond to it. The act of protecting against harm is principally the responsibility of Health and Social Care Trusts (HSC Trusts), and the Police Service of Northern Ireland (PSNI) where a crime is alleged or suspected. However the responsibility of preventing harm is shared more widely. It extends beyond statutory providers of services to the voluntary and community sector, financial institutions, the legal profession, faith-based organisations, independent health and social care providers, carers and all citizens.

2. WHAT DO WE MEAN BY SAFEGUARDING

The majority of adults live full, independent lives free from harm caused by abuse, exploitation or neglect. However, there is a growing recognition that some adults, for a wide variety of reasons, may have been harmed or may be at risk of harm. The full extent of the incidents of harm caused to adults in Northern Ireland is not known but it is suspected to be significantly under-reported.

The language of adult safeguarding previously focused on protection and used the term 'vulnerable adult.' This was widely misinterpreted, often used out of context and, for some, the term implied weakness on the part of the adult, which many found unacceptable. This policy moves away from the concept of 'vulnerability' and towards establishing the concept of 'risk of harm' in adulthood. It places the responsibility for harm caused with those who perpetrate it. Harm resulting from abuse, exploitation or neglect violates the basic human rights of a person to be treated with respect and dignity, to have control over their life and property, and to live a life free from fear. Harm can have a devastating and long lasting impact on victims, their families and carers. It is the impact of an act, or omission of actions, on the individual that determines whether harm has occurred. Any action which causes harm may constitute a criminal offence and/or professional misconduct on the part of an employee.

Adult safeguarding is based on fundamental human rights and on respecting the rights of adults as individuals, treating all adults with dignity and respecting their right to choose. It involves empowering and enabling all adults, including those at risk of harm, to manage their own health and well-being and to keep themselves safe. It extends to intervening to protect where harm has occurred or is likely to occur and promoting access to justice. All adults at risk should be central to any actions and decisions affecting their lives.

Safeguarding adults is complex and challenging. The focus of any intervention must be on promoting a proportionate, measured approach to balancing the risk of harm with respecting the adult's choices and preferred outcome for their own life circumstances. The right of a person with capacity to make decisions and remain in control of their life must be respected. Consideration of 'capacity' and 'consent' are central to adult safeguarding, for example, in determining the ability of an adult to make lifestyle choices, such as choosing to remain in a situation where they risk being harmed or where they choose to take risks. There should always be a presumption of capacity to make decisions unless there is evidence to suggest otherwise and current guidance for professionals in respect of determining capacity should be followed (see section 12). However there are also some circumstances when it may be necessary to consider the protection and rights of others, and overriding the withholding of consent may be necessary to ensure the protection of others.

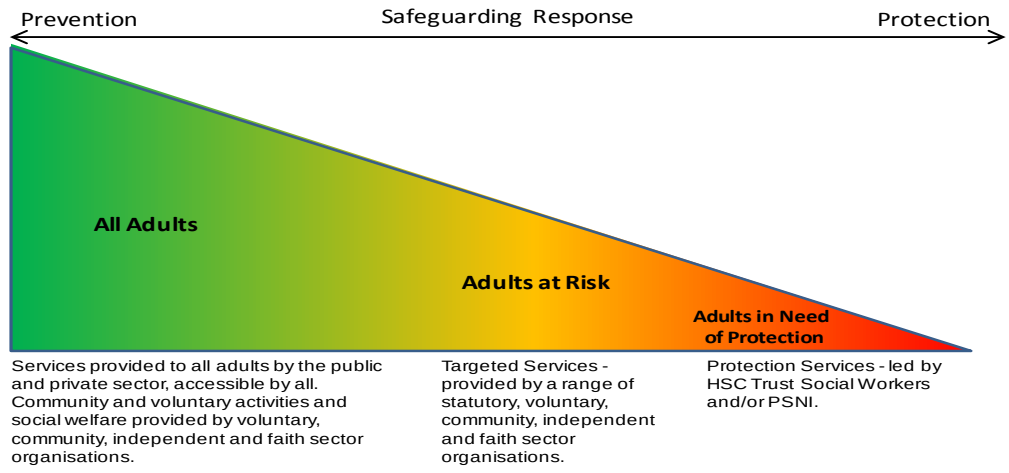
Preventative Safeguarding includes a range of actions and measures such as practical help, care, support and interventions designed to promote the safety, well-being and rights of adults which reduce the likelihood of, or opportunities for, harm to occur. Effective preventative safeguarding requires partnership working, that is, individuals, professionals and agencies working together to recognise the potential for, and to prevent, harm. Prevention is therefore the responsibility of a wide range of

agencies, organisations and groups; indeed it is the responsibility and concern of us all as good citizens and neighbours. All professionals and service providers across the public, private, statutory, voluntary, community, independent, and faith sectors that come into contact with adults, including those who may be at risk of harm, must be alert to the individual's needs and any risks of harm to which they may be exposed. Prevention will strive towards early intervention to provide additional supports at all levels for adults whose personal characteristics or life circumstances may increase their exposure to harm.

Protective Safeguarding will be targeted at adults who are in need of protection, that is, when harm from abuse, exploitation or neglect is suspected, has occurred, or is likely to occur. The protection service is led by HSC Trusts and the PSNI. The input of other individuals, disciplines or agencies may be required, either in the course of an investigation of an allegation of harm or in the formulation and delivery of a care and protection plan.

Figure 1 shows the continuum of adult safeguarding activity from prevention to protection.

Figure 1: **THE ADULT SAFEGUARDING CONTINUUM**



3. THE AIMS OF THIS POLICY

This policy aims to:

- promote zero-tolerance of harm to all adults from abuse, exploitation or neglect;
- influence the way society thinks about harm to adults resulting from abuse, exploitation or neglect by embedding a culture which recognises every adult's right to respect and dignity, honesty, humanity and compassion in every aspect of their life;
- prevent and reduce the risk of harm to adults, while supporting people's right to maintain control over their lives and make informed choices free from coercion;
- encourage organisations to work collaboratively across sectors and on an inter-agency and multi-disciplinary basis, to introduce a range of preventative measures to promote an individual's capacity to keep themselves safe and to prevent harm occurring;
- establish clear guidance for **reporting** concerns that an adult is, or may be, at risk of being harmed or in need of protection and how these will be **responded** to;
- promote access to justice for adults at risk who have been harmed as a result of abuse, exploitation or neglect;
- promote a continuous learning approach to adult safeguarding.

3.1. WHO IS THIS POLICY FOR?

The policy is intended to assist organisations, their staff and volunteers who are in contact with or providing services to adults across the statutory, voluntary, community, independent and faith sectors. While it is intended to be applied by managers, employees and volunteers in the course of the delivery of services and organisational activity, it can also be applied by individuals acting as responsible citizens at home and in local communities.

There is an expectation that all organisations and their staff will work in partnership as they apply this policy to their work with adults who may be at risk of harm or in need of protection. Appendix 1 lists some examples of organisations for whom this policy may have specific relevance, however this is not intended to be an exhaustive list.

4. UNDERPINNING PRINCIPLES

All Adult Safeguarding activity must be guided by five underpinning principles:

A Rights-Based Approach: To promote and respect an adult's right to be safe and secure; to freedom from harm and coercion; to equality of treatment; to the protection of the law; to privacy; to confidentiality; and freedom from discrimination.

Agencies and professionals who intervene in the lives of adults at risk should be guided by current best practice, the law and respect for rights set out in the European Convention on Human Rights[1] and enshrined in domestic law by the Human Rights Act 1998[2], acting in accordance with relevant UN and EU Conventions[3] on the Rights of Persons with Disabilities and the UN Principles for Older Person's 1991[4]. Any intervention to safeguard an adult at risk should be human rights compliant. It should be reasonable, justified, proportionate to the perceived level of risk and perceived impact of harm, carried out appropriately, and be the least restrictive of the individual's rights and freedoms. It cannot be arbitrary or unfair, and all adults should be offered the same services on an equal basis.

An Empowering Approach: To empower adults to make informed choices about their lives, to maximise their opportunities to participate in wider society, to keep themselves safe and free from harm and enabled to manage their own decisions in respect of exposure to risk.

For adults at risk of harm, empowerment is a process through which individuals are: enabled to recognise, avoid and stop harm; facilitated to make decisions based on informed choices including provision of support for those who lack capacity to make decisions; assisted to balance taking risks with quality of life decisions; supported and enabled to seek redress; and for adults who have been harmed, a process whereby they are enabled to recover their self-confidence and self-determination and make informed choices about how they wish to live their lives.

A Person-Centred Approach: To promote and facilitate full participation of adults in all decisions affecting their lives taking full account of their views, wishes and feelings and, where appropriate, the views of others who have an interest in his or her safety and well-being.

A person-centred approach is a way of working with an individual to identify how he or she wishes to live their life and what support they require. A person-centred approach to adult safeguarding demonstrates respect for the rights of the individual

[1] *The European Convention on Human Rights* can be accessed at: http://www.echr.coe.int/Documents/Convention_ENG.pdf

[2] The *Human Rights Act 1998* can be accessed at: http://www.legislation.gov.uk/ukpga/1998/42/contents

[3] Relevant Conventions include The *UN Convention on the Rights of Persons with Disabilities*, the *UN Convention on the Elimination of Discrimination Against Women* (CEDAW), and the *EU Istanbul Convention* on domestic and sexual violence against women

[4] The *UN Principles for Older Person's (1991)* can be accessed at: http://www.un.org/documents/ga/res/46/a46r091.htm

at its core, in particular, respect for the right of the individual to make their own informed choices and decisions. A person-centred approach should result in the individual making informed choices about how he or she wants to live and about what services and supports will best assist them, with cognitive and communication support being provided where necessary. Where the person lacks capacity to make a decision, best interest decisions should be made by professionals which take all available information into account, including information about previously expressed preferences or choices made by the person being safeguarded.

A Consent-Driven Approach: To make a presumption that the adult has the ability to give or withhold consent; to make informed choices; to help inform choice through the provision of information, and the identification of options and alternatives; to have particular regard to the needs of individuals who require support with communication, advocacy or who lack the capacity to consent; and intervening in the life of an adult against his or her wishes only in particular circumstances, for very specific purposes and always in accordance with the law.

Consideration of consent is central to adult safeguarding in determining the ability of an adult at risk to make lifestyle choices, including choosing to remain in a situation where they risk being harmed; determining whether a particular act or transaction is harmful or consensual; and determining to what extent the adult can and should be asked to take decisions about how best to deal with a given safeguarding situation. For consent to be valid, the decision needs to be informed, made by an individual with capacity to make decisions and made free from coercion, constraint or undue influence. Each decision must be considered on its own merits as an adult may possess capacity to make some decisions but not others and/or the adult's lack of capacity to make decisions may be temporary rather than permanent. A consent-driven approach to adult safeguarding will always involve making a presumption that the adult at the centre of a safeguarding decision or action has the capacity to give or withhold consent unless it is established otherwise (see section 12).

A Collaborative Approach: To acknowledge that adult safeguarding will be most effective when it has the full support of the wider public and of safeguarding partners across the statutory, voluntary, community, independent and faith sectors working together and is delivered in a way where roles, responsibilities and lines of accountability are clearly defined and understood. Working in partnership and a person-centred approach will work hand-in-hand.

Harm resulting from abuse, exploitation or neglect can be experienced by adults in a range of circumstances, regardless of gender, age, class or ethnicity. Adults who are at risk, suitably supported, must be central to the partnership, either as participants in preventative activities or protection intervention, or as contributors to decision-making in connection with the development of safeguarding policy, strategy and procedures. Where it is not possible for the adult at risk to contribute directly as participants or contributors, consideration must be given as to how they can be suitably supported to ensure that they are involved at an appropriate level. Successful adult safeguarding requires effective arrangements for all involved to work together. The strength of a collaborative approach will depend on the commitment and support from the highest level to safeguarding adults at the highest level.

5. KEY DEFINITIONS

The risk of harm occurs in all socio-economic, racial and ethnic groups, regardless of gender, age or sexual orientation. All adults at risk should be supported and empowered to minimise their own exposure to risk and to find their own balance between taking risks and making the most of the strengths in their own life circumstances.

The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.

An '**Adult at risk of harm'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain. **Life circumstances** may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

An '**Adult in need of protection'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

AND

c) who is **unable to protect** their own well-being, property, assets, rights or other interests;

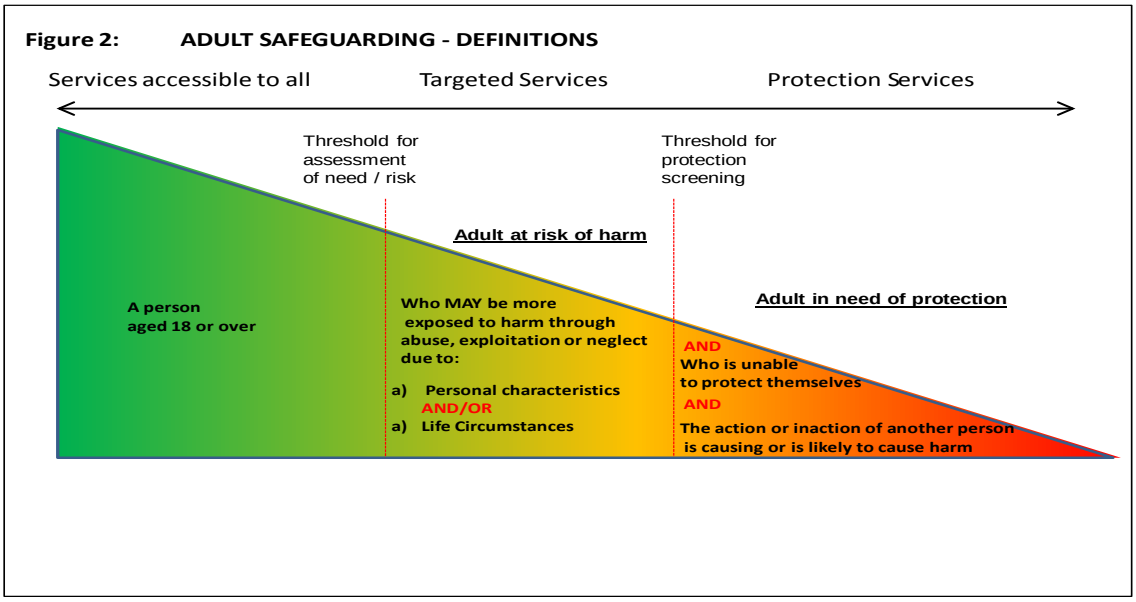
AND

d) where the **action or inaction of another person or persons** is causing, or is likely to cause, him/her to be harmed.

In order to meet the definition of an 'adult in need of protection' either (a) or (b) must be present, in addition to both elements (c), and (d).

The decision as to whether the definition of an 'adult in need of protection' is met will demand the careful exercise of professional judgement applied on a case by case basis. This will take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

Figure 2 below shows where the definitions sit on the continuum of adult safeguarding activity.



Harm is the impact on the victim of abuse, exploitation or neglect. It is the result of any action whether by commission or omission, deliberate, or as the result of a lack of knowledge or awareness which may result in the impairment of physical, intellectual, emotional, or mental health or well-being.

The full impact of harm is not always clear from the outset, or even at the time it is first reported. Consideration must be given not only to the immediate impact of harm and risk to the victim, but also the potential longer term impact and the risk of future harm.

Harmful conduct may constitute a criminal offence or professional misconduct.

A number of factors will influence the determination of the seriousness of harm. A single traumatic incident may cause harm or a number of 'small' incidents may accumulate into 'serious harm' against one individual, or reveal persistent or recurring harm perpetrated against many individuals.

The judgement of what constitutes '**serious harm'** is a complex one and demands careful application of professional judgement against a number of criteria.
Assessments conducted by or on behalf of statutory HSC professionals (see section 10) should include consideration of the following:

a) the impact on the adult at risk;
b) the reactions, perceptions, wishes and feelings of the adult at risk;
c) the frailty or vulnerability of the adult at risk;
d) the ability of the adult at risk to consent and participate in the decision making process;
e) the illegality of the act(s);
f) the nature, degree and extent of harm;
g) the pattern of the harm-causing behaviour;
h) previous incidents, including any previous HSC Trust involvement
i) the level of threat to the adult at risk's right to independence;
j) the apparent intent of the alleged perpetrator and extent of premeditation;
k) the relationship between the alleged perpetrator and the adult at risk;
l) the context in which the alleged harm takes place;
m) the risk of repetition or escalation of harm involving increasingly serious acts relating to this individual or other adults at risk; and
n) the factors which mitigate the risk through service provision or wider arrangements.

There are no absolute criteria for judging when harm has become 'serious harm'; however this decision should include consideration of the degree, severity, duration and frequency of harm. The seriousness of harm depends on the impact experienced by the individual. Particularly careful consideration must be given to cases where the adult is unable to understand the impact harm is having on them. This will demand the application of professional judgement to consider all of the available evidence, the concerns and the wishes of the individual and to determine the seriousness of harm and the most appropriate intervention.

Abuse is 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights'[5].

Abuse is the misuse of power and control that one person has over another. Abuse may be perpetrated by a wide range of people, including those who are usually physically and/or emotionally close to the individual and on whom the individual may depend and trust. This may include, but is not limited to, a partner, relative or other family member, a person entrusted to act on behalf of the adult in some aspect of their affairs, a service or care provider, a neighbour, a health or social care worker or professional, an employer, a volunteer or another service user. It may also be perpetrated by those who have no previous connection to the victim.

[5] Action on Elder Abuse: definition of abuse 1993 which can be accessed at: http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html. This was later adopted by the World Health Organisation - http://www.who.int/ageing/projects/elder_abuse/en/

The main forms of abuse are:

Physical abuse

Physical abuse is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This may include hitting, pushing, rough handling, exposure to heat or cold, force feeding, improper administration of medication, denial of treatment, misuse or illegal use of restraint and deprivation of liberty.

Sexual violence and abuse

Sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding[6]. Sexual violence and abuse can take many forms and may include non-contact sexual activities, such as indecent exposure, stalking, grooming, being made to look at or be involved in the production of sexually abusive material, or being made to watch sexual activities. It may involve physical contact, including but not limited to non-consensual penetrative sexual activities or non-penetrative sexual activities, such as intentional touching (known as groping). Sexual violence can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

Psychological / emotional abuse

Psychological / emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, humiliation or ridicule, provoking fear of violence, shouting, yelling and swearing, blaming, controlling, intimidation and coercion.

Financial abuse

Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not or could not consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property or inheritance.

Institutional abuse

Institutional abuse is the mistreatment or neglect of an adult by a regime or individuals in settings which adults who may be at risk reside in or use. This can occur in any organisation, within and outside the HSC sector. Institutional abuse may occur when the routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. Institutional abuse may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventative and/or protective measures are in place.

[6] The definitions of 'sexual violence and abuse' and 'domestic violence and abuse' will be amended to reflect those included within their revised strategies once published.

Neglect occurs when a person deliberately withholds, or fails to provide, appropriate and adequate care and support which is required by another adult. It may be through a lack of knowledge or awareness, or through a failure to take reasonable action given the information and facts available to them at the time. It may include physical neglect to the extent that health or well-being is impaired, administering too much or too little medication, failure to provide access to appropriate health or social care, withholding the necessities of life, such as adequate nutrition, heating or clothing, or failure to intervene in situations that are dangerous to the person concerned or to others particularly when the person lacks the capacity to assess risk.

This policy does not include self harm or self neglect within the definition of an 'adult in need of protection'. Each case will require a professional Health and Social Care (HSC) assessment to determine the appropriate response and consider if any underlying factors require a protection response. For example self harm may be the manifestation of harm which has been perpetrated by a third party and which the adult feels unable to disclose.

Exploitation is the deliberate maltreatment, manipulation or abuse of power and control over another person; to take advantage of another person or situation usually, but not always, for personal gain from using them as a commodity. It may manifest itself in many forms including slavery, servitude, forced or compulsory labour, domestic violence and abuse, sexual violence and abuse, or human trafficking.

This list of types of harmful conduct is not exhaustive, nor listed here in any order of priority. There are other indicators which should not be ignored. It is also possible that if a person is being harmed in one way, he/ she may very well be experiencing harm in other ways.

5.1. Related Definitions

There are related definitions which interface with Adult Safeguarding, each of which have their own associated adult protection processes in place.

Domestic violence and abuse

Domestic violence and abuse is threatening behaviour, violence or abuse (psychological, physical, verbal, sexual, financial or emotional) inflicted on one person by another where they are or have been intimate partners or family members, irrespective of gender or sexual orientation. Domestic violence and abuse is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person over another. It is usually frequent and persistent. It can include violence by a son, daughter, mother, father, husband, wife, life partner or any other person who has a close relationship with the victim. It occurs right across society, regardless of age, gender, race, ethnic or religious group, sexual orientation, wealth, disability or geography.

Human trafficking

Human trafficking involves the acquisition and movement of people by improper means, such as force, threat or deception, for the purposes of exploiting them. It can take many forms, such as domestic servitude, forced criminality, forced labour, sexual exploitation and organ harvesting. Victims of human trafficking can come from all walks of life; they can be male or female, children or adults, and they may come

from migrant or indigenous communities.

Hate crime

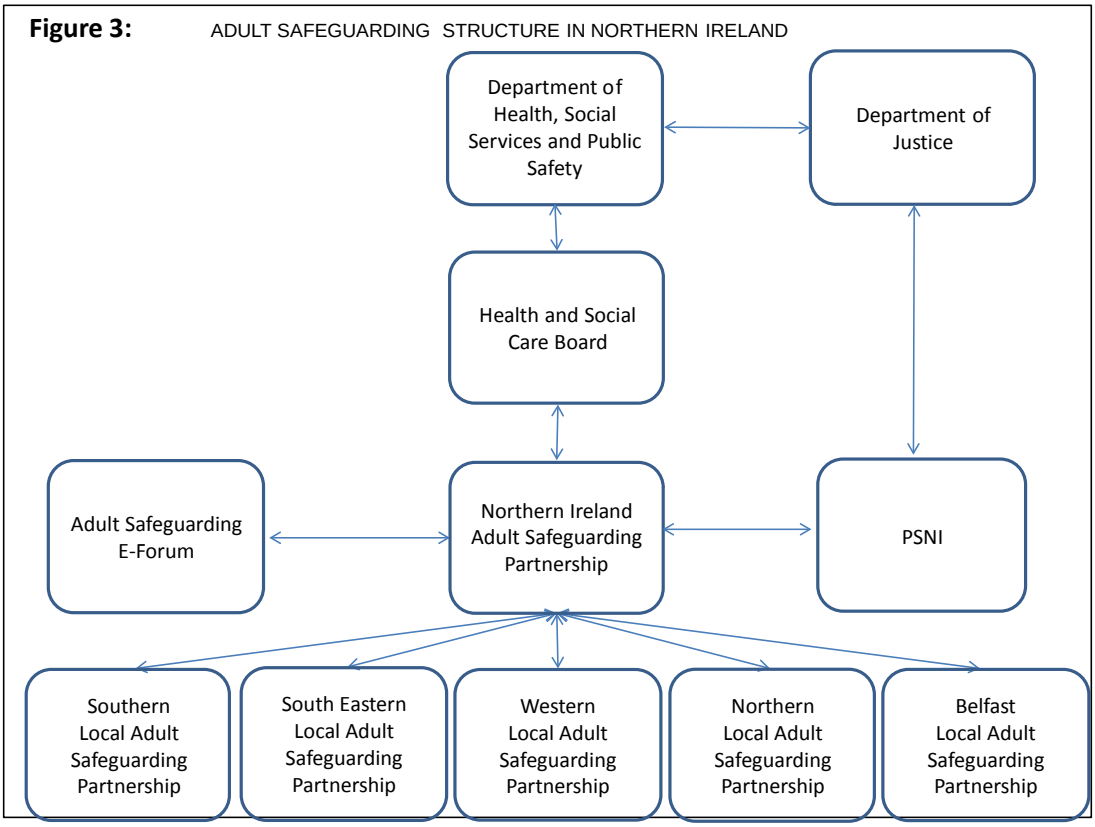
Hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity.

Victims of domestic violence and abuse, sexual violence and abuse, human trafficking and hate crime are regarded as adults in need of protection. There are specific strategies and mechanisms in place designed to meet the particular care and protection needs of these adults and to promote access to justice through the criminal justice system. It is essential that there is an interface between these existing justice led mechanisms and the HSC Trust adult protection arrangements described in this policy.

6. THE ADULT SAFEGUARDING INFRASTRUCTURE

The **Northern Ireland Adult Safeguarding Partnership (NIASP)** and five **Local Adult Safeguarding Partnerships (LASPs)** were established under the Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements (2010) [7]. They are collaborative partnerships with a responsibility for adult safeguarding in Northern Ireland. The partnerships are tasked by DHSSPS, with the support of the DOJ, with the delivery of improved adult safeguarding outcomes by way of a strategic plan[8], operational policies and procedures and effective practice, which will be developed and implemented in accordance with this policy. An outline of the structure is provided in Figure 3 below.

Figure 3: ADULT SAFEGUARDING STRUCTURE IN NORTHERN IRELAND



6.1. The Northern Ireland Adult Safeguarding Partnership (NIASP)

The NIASP is a regional collaborative body led by the Health and Social Care Board (HSCB). It is supported in its work by all its constituent members, who have made a commitment to adult safeguarding. The membership is drawn from the main statutory, voluntary, community, independent and faith organisations involved in adult safeguarding across the region and includes representation from service providers and users. The NIASP is responsible for promoting and supporting a co-ordinated

[7] *Adult Safeguarding in Northern Ireland – New Regional and Local Partnership Arrangements – March 2010* can be accessed at: http://www.dhsspsni.gov.uk/asva-_march_2010.pdf

[8] The *NIASP Strategic Plan* can be accessed at: http://www.hscboard.hscni.net/NIASP/Publications/NIASP%20-%20Strategic%20Plan%202013-2018.pdf

and multi-agency approach and for creating a culture of continuous improvement in adult safeguarding practice and service responses. The NIASP strategy promotes ownership of adult safeguarding issues within all partner organisations and across all professional groups and service areas.

The HSCB has lead responsibility for the effective working of the NIASP, which is chaired by the Director of Social Care and Children's Services, or a nominated deputy. The Chair ensures that safeguarding matters are brought to the attention of the appropriate Directors in the HSCB and the Public Health Agency (PHA). The Chair is accountable to the HSCB and is responsible for ensuring that there are robust governance arrangements in place and compliance with the HSCB's responsibility for Delegated Statutory Functions.

Each member representative is accountable to their employing organisation and should be of sufficient seniority to bring adult safeguarding issues to the attention of NIASP and to make decisions on behalf of their organisation. Each representative should ensure that any actions and decisions taken by the NIASP are shared and implemented as appropriate within their organisation.

6.2. Local Adult Safeguarding Partnerships (LASPs)

The five LASPs are located within, and accountable to, their respective HSC Trusts. Their role is to implement the NIASP Strategic Plan, policy and operational procedures locally. Each LASP has responsibility to promote all aspects of safeguarding activity in its area and to promote multi-disciplinary, multi-agency and interagency cooperation, including the sharing of learning and best practice. They will be visible within, and engage locally with, communities to raise the profile of adult safeguarding.

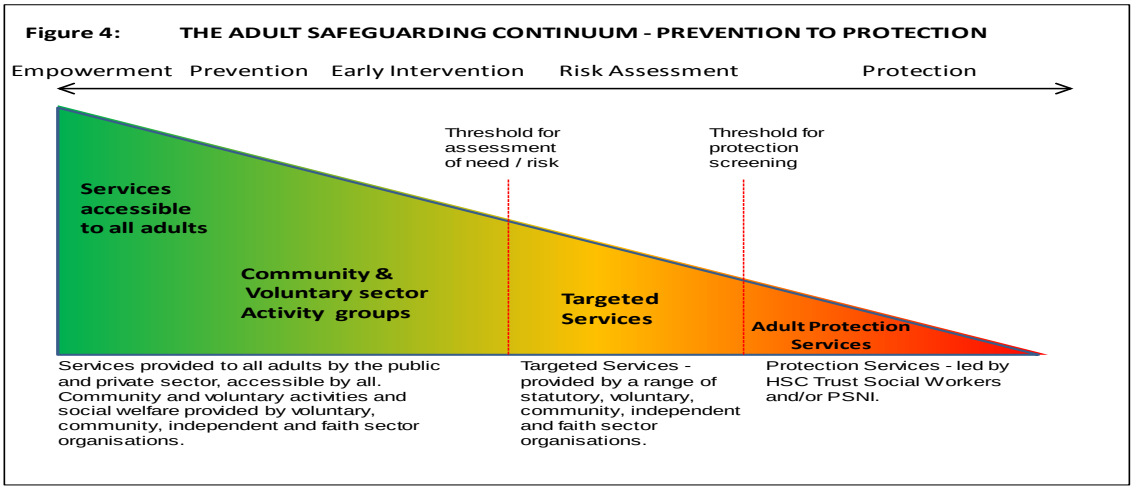
The LASP is chaired by the HSC Trust's Executive Director of Social Work or a senior designated nominee. It is responsible for ensuring that there are robust governance arrangements in place and ensuring compliance with the agreed statutory functions delegated by the HSCB.

Each partner organisation should be represented at a sufficiently senior level so that the LASP is effective in the implementation of guidance, policy and procedures at a local level, including engagement with service users, families, carers and the wider public. Each representative should be sufficiently senior to represent his/her organisation's views, to make decisions on its behalf and to ensure that safeguarding issues are dealt with in line with the organisation's established governance arrangements. Each representative should ensure that any actions and decisions taken by the LASP are shared and implemented as appropriate within their organisation.

7. THE CONTINUUM OF SAFEGUARDING – PREVENTION TO PROTECTION

Safeguarding is a broad continuum of activity. It ranges from the empowerment and strengthening of communities, through prevention and early intervention, to risk assessment and management, including investigation and protective intervention. At all stages along this continuum, safeguarding interventions will aim to provide appropriate information, supportive responses and services which become increasingly more targeted and specialist as the risk of harm increases. Presenting safeguarding activity in this way is intended to reflect the importance of prevention and early intervention, both as a means of improving the safety and quality of life and outcomes for all adults and reducing the risks of incidents of harm and need for more intrusive protection interventions. This is not intended to suggest that any stage or intervention along the continuum is mutually exclusive of the others. Throughout the continuum it is essential to recognise the importance of promoting empowerment and self-determination and the rights of all adults to make informed lifestyle choices.

Figure 4 below shows adult safeguarding interventions as a continuum of activity.



Local communities and services provided to the adult population are the starting point of the adult safeguarding continuum. Individuals will in the first instance be supported by their families and friends and by local community involvement and support. Using community development approaches, and working in partnership with local communities and organisations, we must build stronger, self-reliant communities and effective working relationships that promote people's rights, challenge inequalities and improve local support. Building safer communities involves helping adults to minimise their own exposure to the risk of harm from abuse, exploitation or neglect by empowering, equipping and enabling them to keep themselves safe, while at the same time enabling them to live their lives and pursue their interests to the fullest extent possible. Within communities there are a range of public and private services which will be available to and accessed by all adults.

This policy advocates that where there are potential interfaces with adults who may be at risk of harm, the organisations delivering such services should consider how adult safeguarding may be relevant to them and the actions they can take to prevent harm arising from abuse, exploitation or neglect to those using their services.

Within communities there are **recreational social, sporting or educational activities** available to all adults provided by a range of organisations across the statutory, voluntary, community, independent and faith sectors. Organisations providing these activities contribute to safeguarding adults by ensuring that these activities are delivered in a way which keeps adults safe. These organisations will need to assure themselves and everyone who comes in contact with them, that the organisation is committed to best safeguarding practice and to uphold the rights of all adults to live a life free from harm from abuse, exploitation and neglect. These organisations should have in place a culture of zero-tolerance of harm to adults which necessitates: the recognition of adults who may be at risk and the circumstances which may increase risk; knowing how adult abuse, exploitation or neglect manifests itself; and being willing to report safeguarding concerns. This extends to recognising and reporting harm experienced anywhere, including in the person's own home, in any care setting, in the community, and within organised community or voluntary activities (see section 8).

Voluntary, community, faith and independent service and/or activity providers are at the forefront of **preventative** safeguarding responses within the community. To be effective, preventative safeguarding requires everyone in society to work as partners, that is, individuals, families, carers, professionals and agencies working together to keep individuals safe and to prevent harm from abuse, exploitation or neglect.

One of the key ways of preventing escalation of the risk of harm is to intervene early. **Early intervention** is part of the safeguarding continuum and provides help and support to prevent problems reaching a point where a protection response becomes necessary.

In circumstances where community based activities can no longer meet the needs of an adult, or where there are emerging safeguarding concerns, contact should be made with the local HSC Trust for a professional **assessment of needs and/or risks**. All actions or interventions must be person centred and put the adult in need or at risk of harm at the centre of decision making.

If the concern relates to serious harm a referral may be made directly to the Adult Protection Gateway Service.

Very often it is the General Medical Practitioner (GP) who will be the first point of contact for adults and their families where an individual's needs are changing and they require further support. GPs and other allied health professionals, such as opticians, pharmacists, dentists or therapists, have a key role in the identification of risks of harm and ensuring appropriate referral to the HSC Trust for a further assessment of needs and/or risks.

Targeted services are services delivered specifically to 'adults who may be at risk' in order to meet assessed needs and/or address risks. The scale and intensity of service provision and intervention is likely to increase in proportion to the level of assessed need or risk. As the level of need or risk increases HSC Trusts may need to take action to prevent or manage any identified need or risk of harm, through provision of a service such as domiciliary based care, supported living, residential or nursing care. Targeted services will normally be delivered by, commissioned or contracted by, HSC Trusts. However voluntary, community, independent and faith

sector organisations may provide services targeted specifically at groups of adults at risk for recreational, social, sporting or educational purposes.

Targeted services include all services which fall under the definition of Regulated Activity contained within Schedule 2 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007[9]. This includes all health and social care services, whether delivered by statutory or independent providers, such as hospitals and GPs.

Many adults at risk will spend most of their time where they live, particularly those adults with restricted mobility and/or limited capacity to make decisions. These people may be more heavily dependent upon targeted services and the support of others, and their level of risk may increase as they spend much of their time in their home, often alone, or with the same people surrounding them, and with greater dependency on individuals or carers.

All targeted service providers, must be zero-tolerant of harm. There is an expectation that providers of targeted services will have robust governance and safeguarding procedures in place within their organisations to ensure that care is delivered in a way which instils confidence amongst those who use the service, staff, management, regulators and the public.

There is an expectation that commissioners of services will require, by way of service level agreements or contracts, the providers of targeted services to have robust governance and safeguarding regimes in place. There is an expectation that as employers, both service providers and commissioners must also ensure their organisations promote zero-tolerance of harm to adults within the workplace.

As the risk of harm increases, the safeguarding response required to mitigate it also increases. At the higher end of the safeguarding continuum is the **Adult Protection Gateway Service**. This service is provided for 'adults in need of protection', that is, those adults for who harm from abuse, exploitation or neglect, is a reality either because it has already occurred or, without intervention, is at serious risk of occurring. Protection interventions are led by social workers within the HSC Trusts and/or PSNI officers; the latter primarily where a crime or criminal act is alleged or suspected. These lead agencies will engage with the adult in need of protection in the first instance. They will also require information, action and support from other disciplines, agencies and organisations to assist with an adult protection or criminal investigation, or to contribute to the development and delivery of a care and protection plan for an adult in need of protection.

[9] The SVG Order can be accessed at: http://www.legislation.gov.uk/nisi/2007/1351/contents

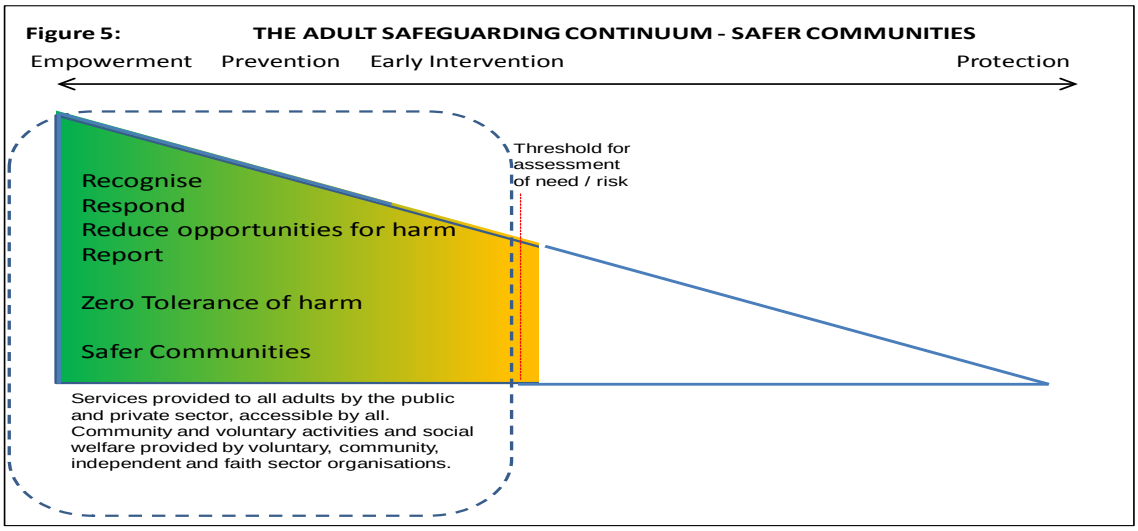
8. PREVENTION – PROMOTING SAFER COMMUNITIES AND SAFER ORGANISATIONS

The prevention of harm requires the promotion and creation of:

- **safer communities**, that is, safe places for all adults to live in, including those who may be at risk; and
- **safer organisations**, that is, safe places where all adults, including those who may be at risk, access and receive services or participate in organised activities.

Whether living in communities or working or volunteering in organisations, each of us needs to be zero-tolerant of potentially harmful behaviours against others, and when we suspect something is wrong, to report it (see section 10).

Figure 5 shows where safer communities sit on the Adult Safeguarding continuum.



8.1. Safer Communities

A key objective of this policy is to promote safer communities for adults to live in and safer organisations for them to be actively part of. The more socially isolated people are the greater the risk of harm arising from abuse, exploitation or neglect. The creation of safer communities for all adults is the responsibility of central and local government; of statutory sector service providers; and of voluntary, community, independent and faith sector providers. Local communities, neighbours and citizens also have a key role to play.

Empowerment is key to the promotion of safer communities and the prevention of harm. We should seek to connect people with the resources, activities and services that promote involvement and minimise opportunities for people to cause harm to others. Communities should aim to create opportunities to encourage and empower people to participate as fully as possible in their communities and broader society. Safer communities can play a vital signposting role in connecting people with local resources and supports that enable them to resolve their own problems and challenges.

There are a number of strands to the creation of safer communities that will greatly contribute to the prevention of harm.

Effective Health and Social Care Policies and Strategies

Being fit and well means people are better placed to ensure their personal safety. Initiatives which:

- aim to prevent slips, trips and falls;
- promote healthy eating, exercise and the sensible use of alcohol;
- ensure good dental and eye care;
- promote personal resilience, self awareness and independence;
- encourage and assist people where necessary to feel safe in their own home

all contribute to assisting people to be better able to address their personal well-being and safety. This requires effective health and social care planning and implementation, robust public health strategies and responses, and commissioning and delivery underpinned by standards frameworks[10] which set out the care that patients, clients, their carers and wider family can expect to receive.

Effective Community Safety Policies and Strategies

People who feel safe in their homes and community are more likely to feel in control of their lives and to take positive steps to ensure their personal safety. A number of types of crime – such as doorstep crime; distraction burglaries; bogus callers; rogue traders; cold callers and cyber crime are of particular concern with regard to adults at risk in our communities. The work of voluntary and community groups is critical to help adults who may be at risk to live safer lives and minimise their exposure to risk of harm through the promotion of local initiatives to provide information and support.

The 'Building Safer, Shared and Confident Communities – A Community Safety Strategy for Northern Ireland 2012-2017'[11] contains commitments to reduce fear of crime and help people to feel safer through regional and local programmes to increase trust and confidence. Through engagement with the voluntary and community sector, the strategy aims to:

- improve understanding of fear of crime and deliver tailored projects to reduce fear;
- promote intergenerational projects to bring old and young together to increase confidence;
- promote positive perceptions of young people; and
- engage with the media on reporting of crime and anti-social behaviour and its impact on fear and confidence.

The Policing and Community Safety Partnerships (PCSPs)[12] which operate in each council area are central to the delivery of safer communities. Each PCSP works with its local community to identify and address issues of concern in the local area and

[10] Frameworks for Mental Health and Wellbeing, Learning Disability and Older People's Health and Wellbeing can be accessed at: http://www.dhsspsni.gov.uk/mhsf_final_pdf.pdf
http://www.dhsspsni.gov.uk/learning_disability_service_framework_june_2013.pdf
http://www.dhsspsni.gov.uk/service_framework_for_older_people-2.pdf
[11] http://www.dojni.gov.uk/community-safety-strategy-2012-2017.htm
[12] Further information on PCSPs can be obtained from www.pcsps.org

PCSP Policing Committees work with local PSNI to develop local policing plans and monitor their performance in enhancing community safety in their area. They also work to secure the co-operation of the public to prevent crime and enhance community safety.

Effective Awareness of Adult Harm and Abuse and Responsibility to Report

Adult abuse is underreported. People may not report their concerns for a number of reasons, including not recognising it for what it is or fear of 'getting it wrong'. It is a reality that the adult who is at risk is often dependent on the person whose behaviour is, either intentionally or unintentionally, causing the harm.

Public awareness campaigns and education programmes can help the public to recognise that adult harm and abuse is unacceptable in a civilised society and encourages the reporting of concerns to the HSC Trust and the Adult Protection Gateway Service. Education programmes in schools and colleges encompassing 'good citizenship' principles and social responsibilities can help begin the shift towards a society which is zero-tolerant of adult harm.

Many public and private service providers within the community are well placed to identify early indications that an adult may be at risk, for example banks or legal services such as solicitors. Providers of services who are in a position of trust, in particular GPs and providers of primary care services, will have access to information regarding adults which may suggest they are at risk of harm. Service providers should be aware of the signs of harm to adults within their respective sectors, and should ensure organisational procedures are in place to guide staff when concerns are identified. All those working to provide services to the community generally have a responsibility to refer concerns to their local HSC Trust, and to cooperate and share information where necessary with any adult safeguarding investigations.

8.2. Safer Organisations

The continuum of adult safeguarding outlines the wide range of organisations involved in people's lives, from the small community activity groups through to larger organisations and statutory services. All organisations should ensure that any service they deliver is underpinned by the principles of respect and treating others with dignity (see section 4). This is the first and crucial step to ensuring that services are high quality, that the focus is on the individual receiving the service which may help to provide support and that harm is prevented. Increasing levels of need and risk are likely to lead to greater targeting of service provision, which, in turn, requires a heightened awareness of risk of harm and more robust measures will be required to prevent harm.

Robust governance arrangements are key to an organisation's ability to keep adults safe from harm. A range of governance arrangements exist, which should not and cannot operate in isolation. No single governance measure will ensure the safety of adults at risk. Both internal governance and external measures are vital to ensure that safeguarding concerns are identified early and escalated to enable appropriate action to be taken. Governance arrangements must be brought together to provide a level of assurance to managers and leaders that the organisation is doing all it can to keep adults in receipt of its services safe from harm.

Each organisation will have its own internal governance arrangements depending on the size of the organisation and the nature of its activities. The governance arrangements should be proportionately robust to enable managers at all levels, including the Chief Executive and Board members where applicable, to assure themselves that the organisation is delivering a safe, high quality service to all, and that it is effectively adhering to the adult safeguarding expectations appropriate to the organisation.

Senior managers should create a culture where staff and volunteers feel that their role and contribution is valued and that they are empowered, and supported in decision making by line managers. Senior management must ensure good governance is cascaded throughout the organisation. Line managers should ensure decisions taken by their staff which relate to adult safeguarding are consistent with organisational safeguarding policies.

Where an organisation permits, by way of contracts or otherwise, the use of its facilities or services by third parties to provide services or activities to adults, assurances should be sought from the third party that it is adhering to the appropriate level of governance as described below.

8.3. Minimum Safeguarding Expectations

At a minimum, any public service, voluntary, community, independent or faith organisation providing recreational social, sporting or educational activities or services will be expected to safeguard adults who may be at risk by:

- **recognising** that adult harm is wrong and that it should not be tolerated;
- **being aware** of the signs of harm from abuse, exploitation and neglect;
- **reducing opportunities for harm** from abuse, exploitation and neglect to occur; and
- **knowing how and when to report** safeguarding concerns to HSC Trusts or the PSNI.

8.4. Internal Governance – Policy and Procedures

The following policies and procedures are the building blocks of good governance that contribute to safe high quality care and they should be robustly implemented by any organisation.

These are essential for any organisation delivering, commissioned or contracted to deliver targeted services.

- Robust selection and recruitment procedures;
- Effective management, support, supervision and training of staff;
- Procedures for responding to, recording and reporting safeguarding concerns in a timely manner to the HSC Trusts;
- Procedures for cooperating within the organisation and with others as required to address safeguarding concerns;
- Procedures for assessing and managing risks;
- Management of reporting and escalating untoward/adverse incidents;

- Procedures for managing comments, complaints and suggestions;
- Procedures on the management of records, confidentiality, and the sharing of information, (see section 14);
- A written code of behaviour/conduct;
- A disciplinary policy, including referral to regulatory bodies where relevant; and
- A whistle-blowing policy.

Care and Service Standards

All providers of targeted services are required to have in place the above governance arrangements and, depending on the nature and level of the service delivered, providers may also be required to ensure compliance with care and/or service standards and regulations against which they will be inspected or audited. Where there are breaches in compliance with standards or regulations and the quality of care or the safety of service users is compromised, the role of inspection and that of the relevant regulator is critical in addressing the safeguarding concern and the prevention of harm.

All organisations providing targeted services to adults who may be at risk must have the above governance arrangements in place, supported by the implementation of an adult safeguarding policy.

Adult Safeguarding Policy

The **Adult Safeguarding Policy** will clearly demonstrate the organisation's commitment to a zero tolerance of adult harm. The policy must be owned and supported by senior management and be accessible to all within the organisation.

A key element of the adult safeguarding policy will be the nomination of **Adult Safeguarding Champions** (ASC)[13]. An ASC must be accessible to all service areas in the organisation as a source of advice and guidance. The nominated ASCs should be senior people within the organisation, suitably trained, experienced and skilled to carry out the role (see section 15).

The role of the **Adult Safeguarding Champion** is:

- to provide information and support for staff on adult safeguarding within the organisation;
- to ensure that the organisation's adult safeguarding policy is disseminated and support implementation throughout the organisation;
- to advise within the organisation regarding adult safeguarding training needs;
- to provide advice to staff or volunteers who have concerns about the signs of harm, and ensure reporting to HSC Trusts where there is a safeguarding concern (see section 10);
- to support staff to ensure that any actions take account of what the adult wishes to achieve – this should not prevent information about any risk of

[13] The term Adult Safeguarding Champion is intended to encompass the roles of the 'Nominated Manager' referred to in the Volunteer Now Standards and Guidance document 'Safeguarding Vulnerable Adults – a Shared Responsibility' and the role of the 'Alerting Manager' in the NIASP Adult Safeguarding Strategic Plan 2013-2018.

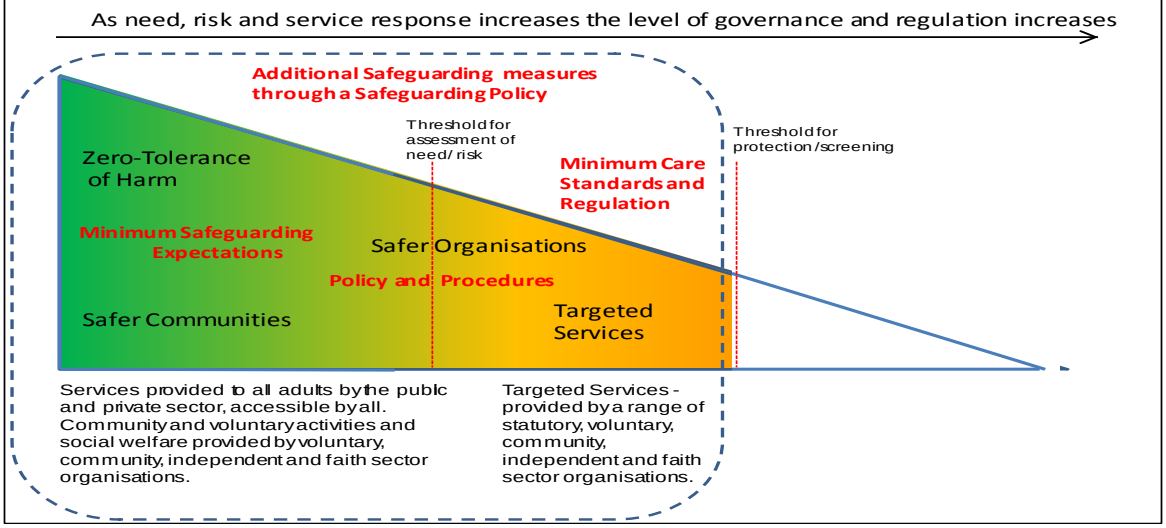
serious harm being passed to the relevant HSC Trust Adult Protection Gateway Service for assessment and decision-making;

- to establish contact with the HSC Trust Designated Adult Protection Officer (DAPO) (see section 11), PSNI and other agencies as appropriate;
- to ensure accurate and up to date records are maintained detailing all decisions made, the reasons for those decisions and any actions taken;
- to compile and analyse records of reported concerns to determine whether a number of low-level concerns are accumulating to become significant; and make records available for inspection.

Where the ASC is not immediately available, this should not prevent action being taken or a referral being made to the HSC Trust in respect of any safeguarding concern.

Figure 6 below shows the relationship between safer communities, safer organisations and the increasing governance arrangements.

Figure 6: SAFER COMMUNITIES AND SAFER ORGANISATIONS



As the level of need or risk and service intervention increases, more robust governance measures and requirements will apply.

9. EXTERNAL GOVERNANCE

9.1. Commissioning/ Subcontracting Arrangements

Services for adults at risk may be commissioned or sub-contracted by a range of organisations across the statutory, voluntary, community, independent or faith sectors. This may include, for example, commissioning by the NIHE, local councils, PSNI and other justice organisations, or the HSC sector. Any organisation which commissions or sub-contracts provision of a service for adults at risk to another third party organisation retains responsibility and accountability for the quality of the provision of that service.

The HSCB, HSC Trusts and the PHA may commission or purchase health and social care services from third party providers, whether from the voluntary, community, independent or faith sectors. This will include GP and other primary or health care services, such as private hospitals, nursing or residential care, supported housing, day care or domiciliary care services.

It is critical that all commissioning or subcontracting organisations ensure that it is a condition of all contracts or service level agreements with service providers that there are robust governance arrangements in place within those provider organisations to ensure that adults at risk are safe from harm and receive a high quality service.

HSC Trusts must provide advice and guidance to adults who may be at risk who are commissioning their own care, for example those in receipt of direct payments or self directed support, outlining what they should expect from their service provider in terms of governance arrangements and good safeguarding practice.

Those who have a role in the management and monitoring of **contracts** have a responsibility:

- to specify and issue contracts for the purchase of services commissioned to address identified needs;
- to acquire and maintain a sufficient level of knowledge about adult safeguarding relevant to their role;
- to require that all services meet their safeguarding requirements described in this policy and other standards of quality set by the DHSSPS;
- to work closely with service providers to assist them to address ongoing concerns that may relate to contractual/service level agreement requirements;
- to monitor the quality of the performance of service providers and identify any deterioration in standards of care and risks this may present;
- to regularly audit the third party service provider to ensure the service is being delivered in accordance with the contract and this policy;
- to escalate any concerns about the provision of care to the care manager / key worker or senior management; and
- where requirements are not being met, to use appropriate reporting mechanisms to ensure adults at risk are kept safe, and where necessary impose appropriate sanctions.

All professionals with responsibility for carrying out the **care management** process and function must:

- ensure that needs and risks to the adult at risk are identified and assessed, taking account of their views and preferences;
- ensure that there is a personalised care plan detailing the needs of the adult and specifying how the service provided will safely meet the needs and mitigate any risks identified;
- ensure the care plan is being implemented as agreed by the service provider;
- ensure that the care plan is reviewed regularly, as specified in the Care Management Guidance, or more frequently as required in order to respond to changing needs and/or risks;
- ensure a safe and high quality service is provided, noting any patterns emerging which suggest that there may be a cause for concern and acting upon any such concerns;
- ensure that they are informed of any incidents, accidents or "near misses" in respect of the individuals for whom they have commissioned care;
- ensure that they are informed of any changes in financial circumstances that come to the attention of the HSC Trust;
- ensure that they are informed of any complaints made and action taken to address them;
- analyse trends to identify patterns which may indicate low-level concerns or poor quality care issues which may accumulate to indicate that there is a risk of harm; and
- escalate concerns which may indicate serious harm or risk of serious harm to an adult at risk (see section 10).

9.2. Professional Regulation

Regulatory bodies are responsible for establishing and operating statutory schemes of regulation underpinned by professional standards and Codes of Conduct relating to the conduct and practice of their respective professions. They maintain registers of workers who meet those standards and this information is publicly available. Within the health and social care sector for example, doctors, nurses, social workers and allied health professionals must register with their respective regulatory body before being able to practice. Where risks of harm to a service user are identified, all professionals must act in accordance with any professional Code of Conduct agreed with their regulatory body.

A person who is the subject of an investigation by their regulatory body may also be under investigation in respect of an adult protection investigation. Where both investigations run in parallel, the adult protection investigation must take precedence to ensure that the rights and safeguarding needs of adults at risk are being protected and the integrity of any criminal investigation is maintained.

9.3. Legal Requirements

Where there are statutory requirements linked to safeguarding or quality of service provision, all organisations will need to be assured that they are fully compliant with the requirements of the law.

Of particular relevance to adult safeguarding is the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, which seeks to protect children and vulnerable adults from harm caused by those who work closely with them. Schedule 2 of this Order contains a definition of Regulated Activity, and anyone engaging in Regulated Activity should have their suitability checked through AccessNI prior to employment.

The **Disclosure and Barring Service**[14] (DBS) is responsible for maintaining the list of individuals barred from engaging in Regulated Activity with children and vulnerable adults across England, Wales and Northern Ireland. A regulated activity provider must refer anyone to the DBS who has harmed or poses a risk of harm to a child or a 'vulnerable adult' and who has been removed from working (paid or unpaid) in regulated activity, or would have been removed had they not left. The DBS will decide whether the person should be barred from working in regulated activity with children, or adults, or both.

It is an offence to knowingly engage a barred person in regulated activity and it is an offence to engage or offer to engage in regulated activity if you are barred.

Within the health and social care sector, HSC Trusts, voluntary, community, independent and faith sector providers must be assured that they are fully compliant with the duty of quality imposed on them by the Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003[15] and the Regulations made under that Order.

9.4. Regulation

There is a broad range of regulators, auditors and inspectorates which are relevant to adult safeguarding. Each has a specific role in measuring and ensuring that organisations comply with their own particular service or quality standards and the regulatory framework within which they operate.

Regulation, inspection and audit should make clear the expectation that service providers must meet the relevant quality standards, detect failings in provision of care or services early, and take appropriate action when sub-standard care is found.

Regulation needs to be responsive and proportionate, with the aim of ensuring public confidence in the services provided. This can only be achieved by a highly coordinated, integrated and expert regulatory system employing intelligent and thoughtful inspection. It will require the ability to apply both qualitative and quantitative judgement and to take effective enforcement action when necessary.

[14] Information on the Disclosure and Barring Service can be accessed at: http://www.nidirect.gov.uk/disclosure-and-barring-protecting-children-and-vulnerable-adults
[15] The 2003 Order can be accessed at: http://www.legislation.gov.uk/nisi/2003/431/contents

The Role of Regulation and Quality Improvement Authority (RQIA)

The RQIA is the independent regulator of the health and social care sector and has an important role in promoting continuous improvement in the quality and safety of care delivered across the range of health and personal social services. RQIA registers and inspects a range of services described in the Health and Person Social Services (Quality, Improvement and Regulation) Order (Northern Ireland) 2003. These services are subject to regulation and are provided by both the statutory and independent sectors. RQIA's regulatory function operates within a framework of regulations and standards produced by DHSSPS.

RQIA inspections and reviews are conducted across a range of HSC settings in the statutory, independent and voluntary sectors. RQIA has a specific role in inspecting mental health and learning disability hospital wards. RQIA, through its inspections and reviews, makes an independent assessment of the safety, quality and availability of health and social care services. Within the regulated care sector, inspections may be announced or unannounced, and examine compliance with regulations and minimum standards in the areas of care, medicines management, estates and finance. Other inspections or reviews can be commissioned and conducted across a range of health and personal social services. Where the service inspected is not meeting the required quality standards, or where compliance issues or concerns are identified, there are a range of robust sanctions and powers available to RQIA.

The RQIA has a key preventative role in adult safeguarding practice. As the independent regulator, RQIA has both a responsibility and the authority to ensure that safety and quality of care concerns which put service users at risk are addressed in the services which they inspect. The RQIA also has a key role in service improvement with the aim of encouraging improvement in the quality of the services they inspect and securing public confidence in the provision of those services by keeping the Department of Health, Social Services and Public Safety informed of their availability and their quality.

Governance information is essential to RQIA in the conduct of its inspections and reviews. It assists with the assessment of the service with specific regard to safeguarding performance. There are core governance elements which should be included in all inspections conducted within regulated services. These are the number, nature and outcome of:

- complaints made;
- safeguarding concerns raised with the Adult Safeguarding Champions;
- notifiable incidents or accidents which occurred as appropriate to that service setting; and
- any disciplinary procedures conducted.

Information collected during inspections and other information which may come to the attention of the RQIA, from a range of sources, including statutory notifications, must be collated and analysed to ensure trends are identified. In particular, information on complaints, notifiable incidents and accidents should be triangulated as these are key indicators of risk to service users. Inspectors should be aware that a number of low-level concerns could suggest patterns or trends which accumulate to a risk of serious harm to one or more adults.

Enforcement action is an essential element of the responsibilities of RQIA. There is a range of enforcement options which RQIA can use to ensure compliance with regulations and minimum standards, to effect improvements and to afford protection to service users. In most circumstances, and where appropriate, RQIA will make recommendations and requirements for quality improvement through regulation and inspection activity. Where a service is identified as being at risk of failing to meet minimum standards and/or comply with regulations, RQIA will consider the various options to enable the registered establishment or agency to make the necessary improvements. RQIA will normally adopt a stepped approach to enforcement. However, this would not rule out the option of moving directly to legal action, including prosecution, if the circumstances require. RQIA may increase inspection activity to monitor compliance and ensure that the necessary improvements are being made. RQIA may escalate enforcement actions at any time, proportionately and in relation to the level of risk to service users and the seriousness of any breach of regulation. RQIA will follow up enforcement action to ensure that quality improvements are achieved. In certain circumstances, where there is deemed to be a risk of serious harm to service users, RQIA may take urgent action. Such circumstances include, but are not exclusive to, those falling under the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009). This may involve, where necessary, using its powers to cancel registration and/or to seek the urgent closure of a registered service. RQIA publishes its enforcement policy and procedures online, along with copies of its inspection reports[16].

The RQIA will notify any serious concerns in relation to the quality of service provision or risk of harm to an individual/s to the relevant HSC Trust or the PSNI, and will be a key partner contributing to investigations with the other agencies to protect adults at risk who are in receipt of a regulated service.

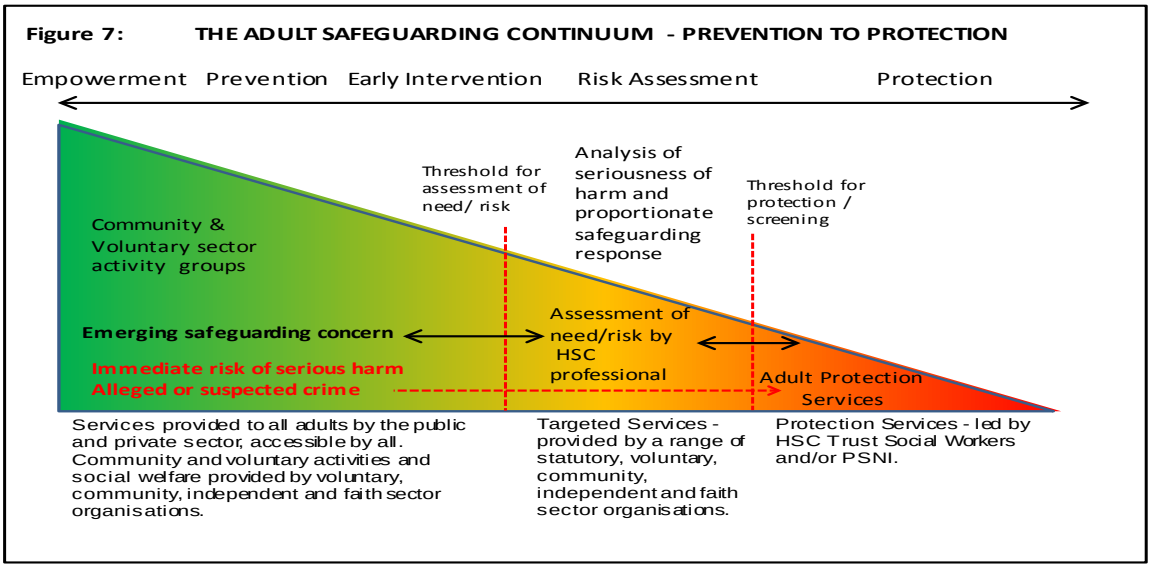
[16] RQIA publications are available on www.rqia.org.uk

10. REFERRAL PATHWAY FOR SAFEGUARDING CONCERNS

If there is a clear and immediate risk of harm or a crime is alleged or suspected, the matter should be referred directly to the PSNI or HSC Trust Adult Protection Gateway Service.

However in most circumstances there will be an emerging safeguarding concern which should normally be referred to the HSC Trust, for a professional assessment. It will be a matter for HSC professionals to judge whether the threshold for an adult protection intervention has been met, or whether alternative responses are more appropriate. Referrals can be made from any source.

Figure 7 shows the pathway for reporting emerging safeguarding concerns through targeted HSC services and if necessary to the HSC Trust adult protection service.



All HSC Trusts must have a single point of access for receipt of referrals regarding concerns about adults who may be at risk, and will promote and publicise contact arrangements within its area. HSC Trust arrangements must accommodate referrals which do not obviously fit existing Programme of Care structures, ensuring there are no safeguarding gaps.

10.1. Risk Assessment

When any risk of harm is identified, a risk assessment must be undertaken to establish the degree of risk of harm to that individual and to others. It is the responsibility of suitably qualified statutory HSC professionals to undertake such risk assessments once a concern has been raised. In certain circumstances HSC Trusts may ask another organisation to conduct risk assessments on its behalf.

HSC professionals are required to put the individual's needs and wishes at the heart of the risk assessment process, and to use their expert skills and professional judgement so that the most appropriate and preferred course of action or outcome is found for each individual.

Assessment is a process which focuses on the individual and their circumstances at the time, recognising that needs and risks can change over time. Assessment will analyse and be sensitive to the changing levels of need and risk faced by an individual. It may require specialist assessments or expert opinion to inform the evidence gathering. All information should be analysed to determine the nature and level of risk. The assessment will inform a proportionate response based on the views and wishes and the preferred outcomes of the individual.

In gathering information to inform the assessment, professionals should be aware that this may also be required as part of a criminal investigation. Therefore it is critical to ensure that any potential evidence that may be later required by the PSNI is not compromised.

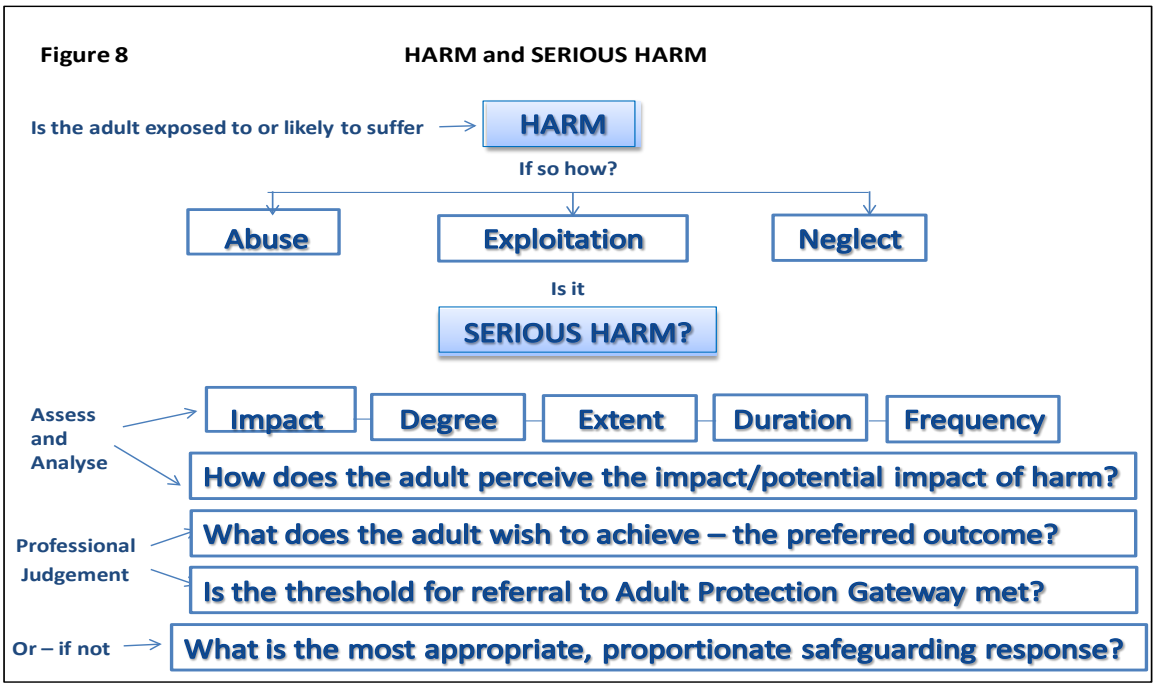
In making professional judgements, due regard should be given to the capacity of the adult to make informed choices, free from duress, pressure or undue influence and their capacity to make decisions to protect themselves from harm. All adults, including those at risk will always be assumed to have capacity to make decisions unless it has been determined otherwise (see section 12) and, ideally, a referral to the HSC Trust should be made with the adult's agreement and full participation. However, there may be circumstances in which the person concerned about an adult at risk may not be best placed to seek their consent to a referral being made, or the adult at risk is clearly stating that they do not want a referral to be made. Whilst the wishes of the adult should always be the paramount consideration, it is important to remember that there will be circumstances when other factors may be overriding, for example, where undue influence or coercion is suspected to have influenced the adult's decision or other people may be at risk. The inability to obtain an adult's consent in these circumstances should not prevent or delay concerns about that adult being reported to adult protection services. A balance must also be struck between an individual's human rights and the need to intervene to protect them from harming themselves or others.

Consideration should be given to the vulnerability of the alleged perpetrator. It is possible that a risk assessment may also be required for the perpetrator.

The analysis of risk will be central to decisions about future intervention. Any safeguarding intervention is not about being risk averse, nor simply about eliminating risk; adult safeguarding is about empowering and supporting people to make decisions that balance acceptable levels of risk in their lives. This may mean that individuals choose to live with risks or to take risks. The exercise of professional judgement in determining the level of risk of harm and whether a referral for an adult protection intervention is required is critical.

Where professionals have contact with an adult at risk they may have opportunities to identify risk of harm. Within the HSC sector this may be for example a GP, District Nurse, Social Worker or another Allied Health Professional, or may be within acute or hospital settings. Professionals must be alert to signs of harm and escalate their concerns to the Adult Protection Gateway Service with the local HSC Trust (see section 11).

Figure 8 illustrates the factors for consideration in determining whether harm has become 'serious harm'.



Where a risk assessment concludes that the adult is at risk of serious harm, or has experienced serious harm (see section 5), then consideration must be given to whether the threshold for referral to Adult Protection Gateway Service has been met.

10.2. Determining Whether the Thresholds for Referral to Adult Protection Gateway Service Are Met

In the majority of cases where serious harm has been identified, the thresholds for Adult Protection Gateway Service will be met. However it must be remembered that in some circumstances referral into the Adult Protection Gateway Service may not be the most appropriate response. This may include, for example, a peer on peer incident where capacity is an issue and alternative responses are more appropriate (see below). At all times the least intrusive and most effective response should guide the intervention. The following thresholds are intended as a guide.

Thresholds are not intended to be used as exclusion criteria, but should be used positively to assist professional judgements about making referrals into the HSC Trust Adult Protection Gateway Service, and, critically, to enable informed decisions in respect of the most appropriate or proportionate safeguarding response.

The threshold for referral to the HSC Trust Adult Protection Gateway Service is likely to be met if one or a number of the following characteristics are met:

- the perceptions of the adult(s) concerned and whether they perceive the impact of harm as serious;
- it has a clear and significant impact on the physical, sexual, psychological and/or financial health and well-being of the person affected;
- it has a clear and significant impact, or potential impact, on the health and

well-being of others;

- it involves serious or repeated acts of omission or neglect that compromise an adult's safety or well-being;
- it constitutes a potential criminal offence against the adult at risk;
- the action appears to have been committed with the deliberate and harmful intent of the perpetrator(s);
- it involves an abuse of trust by individuals in a position of power or authority; and
- it has previously been referred to a regulated service provider for action, and has not been sufficiently addressed.

If there is doubt about whether the threshold for Adult Protection has been reached, the concern should be discussed with the HSC Trust Adult Protection Gateway Service and a DAPO will advise whether the matter meets the threshold for referral into the Adult Protection Gateway Service.

Where a criminal act is either alleged or suspected, a report must be made to the PSNI.

10.3. A Determination that the Threshold for Referral to Adult Protection Gateway Service is Not Met – Alternative Safeguarding Responses

Where it is determined that the threshold for Adult Protection has not been met, other alternative courses of action should be explored with the adult. At all times the least intrusive and most effective response should be made. This is a matter for professional judgement, taking account of the individual circumstances and the wishes and views of the adult and may include:

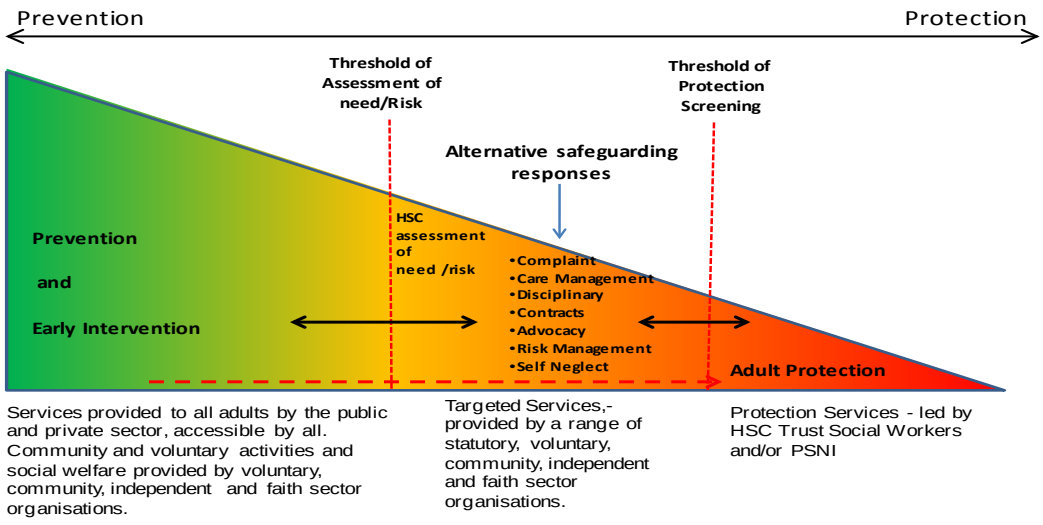
a) escalation to the service manager to address any issues about the quality of service provision;
b) referral to the RQIA for action as the regulator in respect of quality of care concerns or where concerns have been raised and there has been a lack of action by the service provider;
c) referral to a care manager/key worker for re-assessment and review of service user/carer's needs, views and care plan, or where appropriate a mental capacity assessment;
d) action taken under complaints procedures;
e) action taken under human resources/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;
f) referral to an advocacy service;
g) referral to another service;
h) a risk management intervention in relation to self neglect;
i) a strategy to manage risks within a complex group living environment and the management of challenging behaviour;
j) no further action required;

or a combination of two or more of the above.

Where an HSC Trust Adult Protection Gateway Service has agreed an alternative course of action, there must be mechanisms in place to ensure that those given lead responsibility to take certain actions report back to the DAPO on the outcome of the actions taken. All organisations involved in contributing to alternative courses of action will be expected to cooperate fully with HSC Trusts.

Figure 9 below shows where the thresholds sit in relation to the continuum of safeguarding activity.

Figure 9 **ADULT SAFEGUARDING THRESHOLDS**

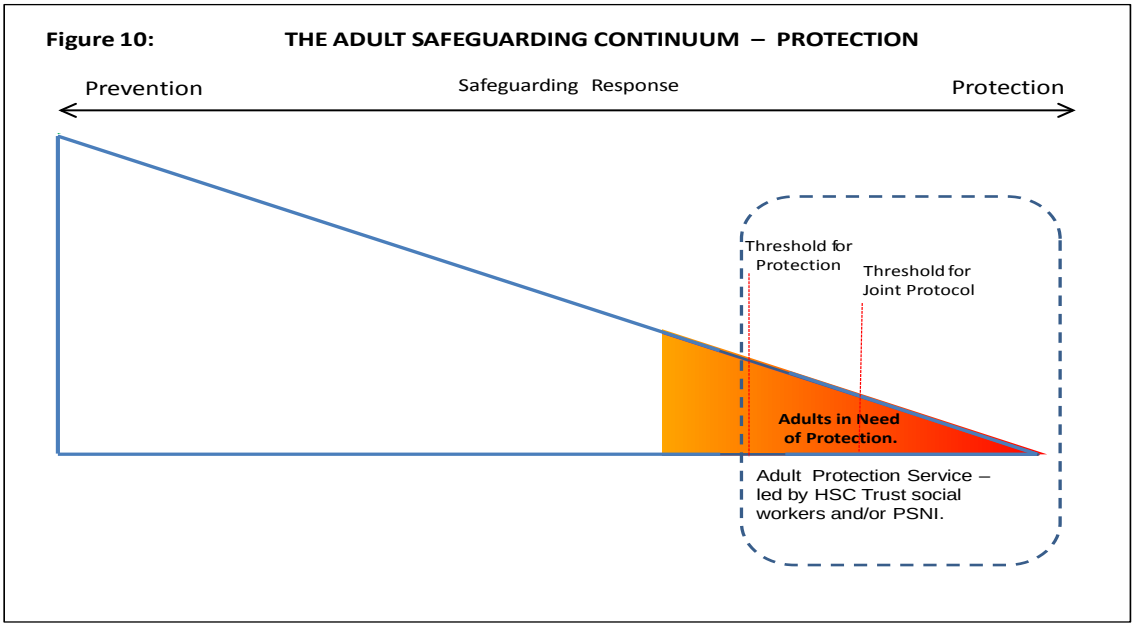


Any safeguarding concerns relating to breaches of regulations or non-compliance with care or service standards are matters for the regulator, regardless of whether the threshold of serious harm has been reached. The HSC Trust should raise such concerns with the RQIA and will then co-ordinate an interagency response. The role of RQIA in inspection and regulation is outlined in section 9 and will be critical in the identification and prevention of safeguarding concerns or incidents in a proportionate manner to prevent unnecessary engagement of the Adult Protection Gateway Service.

11. ADULT PROTECTION SERVICES

Figure 10 shows the Adult Protection Service on the safeguarding continuum.

Figure 10: THE ADULT SAFEGUARDING CONTINUUM – PROTECTION



HSC Trusts and the PSNI are the lead agencies with responsibility for adult protection.

Each **HSC Trust** will have an Adult Protection Gateway Service which will receive adult protection referrals. Referrals outside normal working hours should be made to the Regional Emergency Social Work Service (RESWS). Referrals will be accepted from any source, irrespective of Programme of Care boundaries.

HSC Trusts will be the lead agency in terms of the co-ordination of joint Adult Protection responses. Within each HSC Trust, responsibility for the Adult Protection rests with the Executive Director of Social Work, and the lead profession within HSC Trusts is social work.

In circumstances where a crime is alleged or suspected, a referral to the **PSNI** should be made by telephoning 101, or in an emergency, 999. Both numbers are accessible on a 24 hour, 7 days per week basis. The PSNI will be the lead criminal investigative agency and will progress a criminal investigation where required.

The **PSNI** will be the lead criminal investigation agency and a report should be made to the PSNI where a crime is alleged or suspected. Within PSNI, responsibility for Adult Protection rests with the Chief Superintendent who has responsibility for the Public Protection Branch[17].

A Joint Protocol will guide interagency referral, consultation and information exchange and working arrangements and will provide clarity in respect of the roles of

[17] Responsibility for Adult Safeguarding within PSNI is subject to organisational change. Changes will be reflected within the policy once completed.

the PSNI and HSC Trusts in the delivery of the adult protection response. The Joint Protocol will outline when and how other agencies will be engaged for the purpose of an adult protection investigation and protection planning.

Regional adult protection procedures for HSC Trusts will be developed by the HSCB, endorsed by the NIASP and LASPs and implemented across the region to ensure that adult protection responses and practice are consistent across all HSC Trust areas. HSC Trusts will be responsible for implementing these procedures on behalf of the HSCB.

PSNI is guided by current the Association of Chief Police Officers (ACPO) guidance 'Safeguarding and Investigating the Abuse of Vulnerable Adults 2012' as well as established protocols such as Safeguarding Vulnerable Adults (Regional Adult Protection Policy and Procedural Guidance) 2006 and 'Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' NIASP 2009. The Public Protection Branch (PPB) will be responsible for triaging reports under Joint Protocol arrangements. When a PPB passes the adult protection response to another branch of PSNI, the PPB will retain oversight and ensure ongoing engagement and communication with other partners under Joint Protocol.

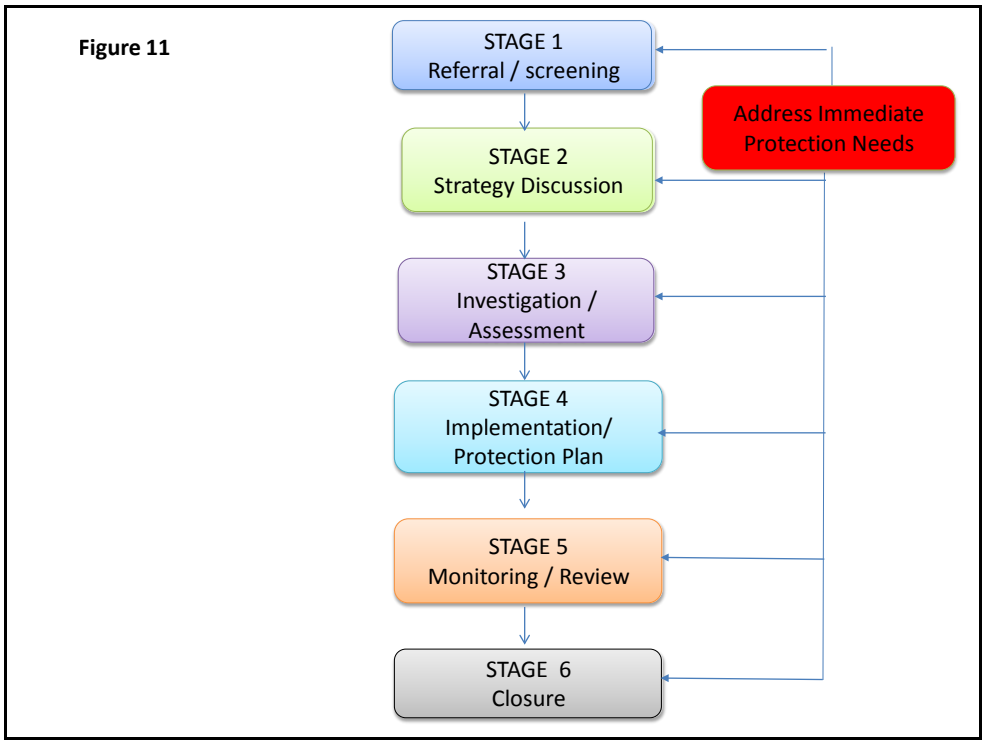
All operational adult safeguarding policies, procedures and protocols in support of this policy must be consistent with the underpinning principles contained in section 5 of this policy.

11.1. Adult Protection Process

Each adult protection intervention is likely to be unique and the response made must allow for flexibility and individualised decision-making. It is important that each adult protection intervention is conducted without undue delay, remains outcome focused, rather than process driven, and is subject to ongoing monitoring and review at an appropriately senior level. At all stages throughout the adult protection intervention, consideration should be given to whether the threshold for the Adult Protection Gateway Service continues to be met. Any action necessary to address immediate protection needs of the adult must be taken regardless of which stage of the process has been reached.

Each intervention will be made in accordance with an agreed process. A typical protection process is contained in figure 11 below encompassing 6 distinct stages. While presented in stages, the process is not intended to be linear in nature. It is possible that some stages will run in parallel and it may also require moving between stages in both directions. This policy does not advocate specific timescales for progressing through the stages of the protection process, because it is important that flexibility is maintained to allow for professional decision making. There can be complex issues to be managed such as fluctuating capacity to make decisions and complex investigations that may require interagency collaboration and consultation including cooperation with any PSNI investigations. Nonetheless, it is important that all adult protection interventions are progressed in a timely manner, and must not be allowed to drift unnecessarily.

Figure 11 shows the six stages of the Adult Protection Process.



At every stage the adult's human rights must be considered, and evidence of this recorded. The adult's rights, needs, views and wishes, should be central to the protection intervention to ensure that they receive the support needed to achieve an agreed outcome.

Processes and procedures in themselves will not protect, people and good practice will.

A **Designated Adult Protection Officer** (DAPO) will be responsible for the management of each referral received by a HSC Trust. DAPOs will be in place both within the Adult Protection Gateway Service, and within core services teams. Following initial screening by the Adult Protection Gateway Service, a DAPO in core services may be asked to manage the referral going forward.

Every DAPO must:

- be social work qualified;
- be working in a minimum of a band seven;
- have first line management responsibilities, or in a senior practitioner role;
- be suitably experienced; and
- have undertaken the necessary training (see section 15).

The role of the DAPO is to:

- make sure the needs, safety and wishes of the adult at risk are kept central to any actions and decisions taken;
- screen the referral;
- make contact with PSNI if a crime is alleged or suspected, or there is an

immediate risk of harm to an adult at risk;
- make key decisions including whether the threshold for protection intervention has been met;
- manage and coordinate the adult protection intervention;
- ensure that any risks to the adult(s) and others potentially at risk are assessed and agreed actions taken;
- analyse needs and risk assessments to determine the most appropriate course of action;
- inform and involve other agencies as necessary, and work with them to plan and carry out actions taken;
- be responsible for coordinating the sharing of information between agencies;
- ensure the support needs of the adult at risk and others affected are considered throughout;
- ensure appropriate documentation and records are fully completed, including records of all decisions taken;
- make sure the adult at risk and the referrer are given regular feedback, insofar as this is possible;
- analyse the adult safeguarding data within their service area and contribute to the governance arrangements as appropriate; and
- ensure that the connections are made with related interagency mechanisms such as:
    - Multi Agency Risk Assessment Conference (MARAC)
    - Domestic and sexual violence services
    - Public Protection Arrangements in Northern Ireland framework (PPANI)
    - Human trafficking procedures
    - Hate Crime Practical Action Scheme
    - The Office of Care and Protection (or equivalent)
    - Child Protection Gateway Service
    - Business Services Organisation Counter-Fraud Unit.

The DAPO may decide to close the adult protection process at any stage if:
- it is agreed that further investigation, assessment or intervention is not required to protect the adult at risk;
- the DAPO decides that an alternative safeguarding response is more appropriate, proportionate and effective to address the concern identified;
- a Protection Plan has been agreed and is in place and is effectively addressing the needs of and the risks to the adult; or
- the adult chooses to withdraw from the protection process.

Where the safeguarding concern relates to the quality of care provided to an adult in receipt of a regulated HSC service, the DAPO will engage the RQIA to ascertain whether the provider is in breach of regulation or minimum standards. The RQIA will act on all safeguarding concerns where there are breaches of standards or regulation and, where necessary, use their powers of improvement or sanction to ensure that the provider addresses any breach of the minimum standards to the satisfaction of RQIA.

The PSNI will be the lead agency when a criminal investigation is required, and any other related investigations or assessments must be coordinated with the PSNI.

Responsibility for coordinating, and communicating the outcome of, the criminal investigation lies with the Detective Inspector PPB. A criminal investigation will take precedence over any other adult safeguarding process. For example, a disciplinary process should not commence until after the conclusion of an adult protection criminal investigation by the PSNI, or following approval by PSNI.

11.2. Large Scale and/or Complex Investigations

A large-scale adult protection investigation may be initiated when a number of adults at risk have allegedly been abused or patterns or trends are emerging which suggest serious concerns about the quality of care, which put the safety of service users at risk.

This could include any of the following:

- multiple concerns within one service provider;
- one person is suspected of causing harm to multiple adults and/or in a number of settings;
- a group of individuals are alleged to be causing harm to one or more adults;
- where care arrangements are complicated by cross-boundary considerations.

A large-scale adult protection investigation is likely to involve a range of organisations, and potentially a number of individual adult protection interventions.

Complex (i.e. organised or multiple) abuse is defined as abuse involving one or more abusers and a number of related or non-related adults at risk. The abuser concerned may be acting with others to abuse adults at risk, may be acting in isolation, or may be using an institutional framework or position of authority to access adults at risk for abuse.

Such abuse can occur both as part of a network of abuse across a family or community and within institutions such as residential or nursing homes, supported living facilities, day support settings and in other provisions such as voluntary groups. There may also be cases of adults at risk being abused through the use of the internet. Such abuse is profoundly traumatic for the adults at risk who are involved. The investigation of large scale and/or complex abuse requires specialist skills from PSNI and HSC Trust staff.

Every investigation will require careful and thorough planning, effective inter-agency working and attention to the needs of the adult(s) involved. Some investigations become extremely complex because of the number of people or places involved and the timescale over which the abuse is alleged to have occurred.

On receipt of information which may indicate organised or multiple abuses, the HSC Trust Designated Officer should immediately consider whether a report to the PSNI is appropriate, initiate a joint strategy meeting and, where necessary, establish a Strategy Management Group (SMG) to oversee the process of investigation. Core representatives of SMG are:

- PSNI;
- HSC Trust nominated DAPO;
- a senior manager from the relevant adult programme of care; and

- RQIA (where the allegation relates to a regulated service).

Appropriate legal advice will be necessary and should be sought through PSNI and HSC Trust legal advisers.

The SMG will:

- establish the principles and practice of the investigation, draw up an investigation plan and ensure regular review of progress against that plan;
- establish and manage an Investigative Team within their respective agencies;
- ensure co-ordination between the key agencies and Investigative Team
- address the issue of resourcing individual investigations;
- act in a consultative capacity to those professionals who are involved in the investigation;
- draw up a media strategy that will address who will take responsibility for responding to the media;
- agree communication strategy/liaison with victims/families and carers involved in the investigation;
- agree level of information sharing, where appropriate to do so, with the proprietor and the staff of the facility/service under investigation;
- at the conclusion of the investigation, discuss salient features of the investigation with a view to making recommendations for improvements either in policy or in practice.

11.3. Operational Protection Policies and Procedures

The HSCB's regional operational adult protection procedures will underpin this policy and provide guidance to support good practice and sound professional decision making. Procedures will be subject to regular review.

Operational policies and procedures should:

a) clarify roles, responsibilities and expectations at all levels;
b) outline the importance of, and interface with, the Joint Protocol;
c) provide procedures for inter-agency working across the full range of organisations;
d) provide a consistent framework to guide adult protection interventions;
e) promote flexibility and a focus on outcome;
f) describe how the threshold of serious harm is applied at each stage of the process to enable the most proportionate response to be identified;
g) provide guidance on the management of adult protection referrals where more than one HSC Trust is involved;
h) encourage reflective professional practice;
i) support robust decision making;
j) strengthen professional line management and governance arrangements;
k) outline procedures for integration with the other investigations (see the role of the DAPO earlier in this section);
l) define information exchange procedures;
m) outline record keeping requirements; and
n) describe how large scale and/or complex investigations should be conducted.

12. CONSENT AND CAPACITY

12.1. Consent

Consideration of consent is central to adult safeguarding. Consent is a clear indication of a willingness to participate in an activity or to accept a service, including a protection service. It may be signalled verbally, by gesture, by willing participation or in writing. No one can give, or withhold, consent on behalf of another adult unless special legal provision for particular purposes has been made for this.

For consent to be valid, it must be given voluntarily by an appropriately informed person who is able to consent to the intervention being proposed. In cases where the individual lacks capacity, decisions will usually be made on behalf of the individual in accordance with current legal provisions.

A consent-driven approach to adult safeguarding will always involve:

- a presumption that the adult at the centre of a safeguarding decision or action is able to give or withhold consent unless it is established otherwise;
- acknowledging that an adult who lacks capacity to make a decision cannot give consent but that he or she should still be involved in decision-making as far as possible and given appropriate support;
- acknowledging that everyone who has capacity to make a certain decision has the right to pursue a course of action that others may judge to be unwise, but that sometimes a balance must be struck between an individual's human rights and the need to intervene to protect others;
- providing support to an adult where they have withheld consent and this has been overridden;
- ensuring consent/non-consent is informed through the provision of full and accurate information, making sure that the information is conveyed in a way which the adult fully understands and taking all practicable steps to help the person make and communicate the decision; and
- understanding that the choices and decisions made by the individual at any one time are not seen as irrevocable or non-negotiable.

Where there is a concern that an adult may be at risk of, or experiencing, harm and there are concerns about coercion or undue influence, this should be referred to the HSC Trust in accordance with section 11.

12.2. Capacity

An adult will always be assumed to have capacity to make a decision unless it is suspected otherwise. Capacity can fluctuate, and is both issue and time specific, therefore should be kept under regular review in connection with any safeguarding intervention, in particular a protection intervention.

Where there is a reasonable doubt regarding the capacity of an adult to make a specific decision or series of decisions, a referral must be made to the HSC Trust. The organisation or individual making the referral may need to consider any reasonable and proportionate interim steps necessary to protect the adult pending

further enquiries by the HSC Trust. An HSC professional within the HSC Trust will conduct a capacity assessment in accordance with existing legislation and guidance.

Lack of capacity

Tensions between an adult's autonomy and the need to intervene to keep an adult safe makes deciding whether or not to intervene when an adult lacks capacity to make a decision particularly difficult, and one that must always requires professional judgement in respect of the individual circumstances of the adult.

Where an adult lacks capacity to make a certain decision, they should be supported so they can be involved to the fullest extent in the decision that affects their life. Any interventions and actions taken by the HSC Trust must be in the best interests of the person being safeguarded, and in accordance with existing legislation and policy. HSC Trusts should, where appropriate, consult relevant family members or carers when considering action to be taken regarding an adult who lacks capacity to make a decision.

12.3. Lack of Consent

In some circumstances it may be necessary for the withholding of consent to be overridden. Where consent to intervene is not provided by the adult at risk, action to progress a case may still be taken in circumstances where there is a strong overriding public interest, or where a crime is alleged or suspected. This may happen when:

- the person causing the harm is a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service; or
- consent has been provided under undue influence, coercion or duress;
- other people are at risk from the person causing harm; or
- a crime is alleged or suspected.

In these circumstances, the adult should be informed of that decision, the reason for the decision, and reassured that as far as possible no actions will be taken which affect them personally without their involvement. Consideration should be given to any support the adult may need at this time, as they may be distressed by the prospect of their information being shared without their consent.

12.4. Advocacy

Advocacy involves enabling people to say what they want, to have their views heard, and empowering them to speak up for themselves. It informs the person about their options and helps them to take action when necessary to have their voice heard and secure their rights.

Whilst advocacy is a social work role, the use of independent advocacy services to support the adult at risk in making their choices may be appropriate, particularly for those who have difficulty being heard or expressing their views, or where there are conflicting interests. This is particularly the case where HSC staff, professionals or family are of the opinion that what the person wants is not in their best interests.

Advocacy can assist adults to be involved in, and influence, decisions taken about their care. It helps to ensure that the adult at risk remains central to the decision making process. Advocacy should not make decisions on behalf of the adult at risk, but always work in partnership with the adult they are supporting. People who are lack capacity to make a decision rely more heavily on others for many aspects of their care, treatment and support, and have the potential to benefit more from advocacy services to assist them exercise their rights.

13. ACCESS TO JUSTICE: SUPPORT FOR VICTIMS

Where a crime is alleged to have occurred there is a duty on PSNI to investigate. There are also a range of mechanisms in place to support a victim when giving a statement to the PSNI, evidence at court and in terms of emotional and practical support services more generally. The provision of these services requires effective cooperation across a range of organisations including the PSNI, HSC Trusts, the Public Prosecution Service and voluntary sector service and support providers.

Where a crime is reported to the PSNI a victim of crime information leaflet is available which provides contact details of general support services such as Victim Support NI and NSPCC Young Witness Service, as well as specialist support services, including for families bereaved through murder or manslaughter, victims of domestic and sexual violence, victims of trafficking and young victims of crime among others. The PSNI can refer victims of crime to Victim Support NI, where referral to specialist support services is also available dependent on the needs of the individual. Where an individual has concerns about their safety they should refer this to the police.

Victims of crime can have access to additional support to help them give evidence, as part of criminal proceedings where a person is under the age of 18, or where the quality of the evidence is likely to be affected because the person has mental health issues, learning or communication difficulties, a neurological disorder or a physical disability. Additional support is also available to those victims who are intimidated and the quality of whose evidence is likely to be affected because of fear or distress about testifying, for example, where the person is a victim of domestic violence, hate crime, trafficking, exploitation, bullying or abuse by professionals or carers or family members.

For these types of victims the PSNI will carry out interviews in accordance with 'Achieving Best Evidence in Criminal Proceedings' guidance. This sets out good practice in interviewing victims and witnesses and in preparing them to give their best possible evidence in court, so that they have an opportunity to access justice and provide their best evidence. Such interviews are normally video recorded.

Victims will have their needs assessed by the PSNI or Victim and Witness Care Unit (which provides a single point of contact from the point when the case file is transferred from the PSNI to the Public Prosecution Service).

Additional support at court, such as special measures[18], may be applied for by the Public Prosecution Service, with final decisions taken by the judge on their availability. More than one special measure may be granted in a particular case, with this again a decision for the judge. The special measures, as set out below, include:

- screens/curtains in the courtroom so the victim does not have to see the defendant;

[18] A leaflet on special measures is available at http://www.psni.police.uk/special_measures_leaflet.pdf. The legislation governing special measures can be found at: http://www.legislation.gov.uk/nisi/1999/2789/contents]

- a live video link allowing evidence to be given away from the courtroom, which also allows for a support to be present with the witness in the live link room;
- giving evidence in private, where the case involves a sexual offence, a slavery or human trafficking offence, or the person is deemed to be intimidated;
- video recorded statements – these allow the main evidence to be given using a pre-recorded video statement;
- using communication aids, such as alphabet boards (where the person's evidence is likely to be affected due to a learning or communication difficulty, mental health issue, physical disability etc.); and
- removal of wigs or gowns.

Another special measure is assistance from a communication specialist (a Registered Intermediary) when a person is telling the police what happened to them or is giving evidence in court. Registered Intermediaries are professionals with specialist skills in communication. The role of Registered Intermediaries is to facilitate the giving of evidence rather than provide a general support role. They assist a vulnerable person, who has a significant communication difficulty, during the criminal justice process if their communication difficulties would diminish the quality of their evidence. The Registered Intermediaries Schemes pilot is helping vulnerable people have access to justice where it may not have been possible before.

As well as help when giving evidence victims also have access to a range of general support services. Victim Support NI[19] helps people who have been a victim of, or a witness to, a crime. They provide emotional support, information and practical help to victims, witnesses and others affected by crime through compensation, community and witness services. Victim Support NI can also refer victims to specialist support services, where appropriate and available.

A Victim Charter provides victims of crime with relevant information, sets out what their entitlements are and the standards of service that they can expect to receive as they move through the criminal justice process. It will also make clear to service providers exactly what their duties are in ensuring victims receive the right level of service. The Charter provides information on the support services that are available to victims of crime, including specialist services.

[19] Further information on Victim Support NI can be found at: www.victimsupportni.co.uk/

14. INFORMATION MANAGEMENT AND INFORMATION SHARING

14.1. Information and Record Management

Information associated with adult safeguarding is likely to be of a personal and sensitive nature and its use is governed by the common law duty of confidentiality. At all times 'personal data' and 'sensitive personal data' [20] must be managed in accordance with the law, primarily the Data Protection Act 1998 (DPA) and the Human Rights Act 1998 which, among other things, gives individuals the right to respect for private and family life, home and correspondence.

The eight principles of the DPA state that personal data must be:

- processed fairly and lawfully and only for purposes compatible with the reason(s) for which the information was originally obtained;
- adequate, relevant and not excessive for the purposes for which it is processed;
- accurate and kept up to date;
- not kept for longer than is necessary;
- processed in line with the rights of the data subject;
- held securely; and
- not transferred to other countries outside the EEA without adequate protection.

All organisations providing targeted services to adults at risk must have an information management policy and associated governance arrangements in place which complies with the DPA and the Human Rights Act 1998. These policies must include the procedures to be followed by staff and volunteers in relation to:

- information management, including recording of information, its secure storage, and how this can be accessed and by whom;
- sharing information outside of the organisation for safeguarding purposes, and how requests for information will be considered and assessed (see Information Sharing for Safeguarding Purposes below);
- training to be provided to staff in relation to their duties under the DPA;
- subject access requests;
- complaints about information management; and
- identified breaches of data protection within the organisation.

Good records management standards and practices are required for the organisation to ensure confidentiality and that the security of service user information is respected. Many professionals are governed by a Code of Practice or Code of Conduct issued by the professional body with which they are registered, which will contain guidance on information management to support organisational policies. Guidance for voluntary, community, independent and faith sector organisations on the management of records, confidentiality and sharing of information is available in the Volunteer Now guidance document 'A Shared Responsibility'[21]. 'Good Management

[20] 'Sensitive Personal Data' is defined by Section 2 of the Data Protection Act 1998: http://www.legislation.gov.uk/ukpga/1998/29/section/2

[21] 'Safeguarding Vulnerable Adults: A Shared Responsibility' can be accessed at: http://www.volunteernow.co.uk/fs/doc/publications/vn-sva-web-full-colour.pdf

Good Records'[22] provides guidance for those who work within or under contract to Health and Social Care statutory organisations on the required standards of practice in the management of records.

14.2. Information Sharing for Safeguarding Purposes

In relation to adult safeguarding, the duty to share information about an individual can be as important as the duty to protect it. Effective safeguarding will depend on information being made available to those who need it at the right time. Proportionate information sharing may be required to prevent harm to the adult at risk or to others, and can facilitate preventative or early intervention approaches.

It is important that confidentiality is not confused with secrecy. Proportionality is the key in respect of the risks associated with deciding whether or not to share information.

Organisations and professionals should not give assurances of absolute confidentiality in adult safeguarding where there are concerns about risk of harm to one or more adults, nor should it be assumed that someone else will pass on information which may be critical to the prevention of harm to an adult.

Information sharing is one form of data processing, and as such is covered by principles and requirements of the DPA. The Information Commission's Office (ICO) has published a statutory Data Sharing Code of Practice[23] to assist organisations to comply with the DPA. The code is applicable to all organisations involved in sharing personal data, whether this is within different branches of the same organisation, or with a third party organisation. It contains guidance in factors to consider when deciding whether or not to share personal data, including checklists to assist organisations in their decision making.

Organisations that collect or hold personal data or sensitive personal data should explain in advance to the data subject how their information will be used, including under what circumstances the information might be shared. Guidance on how this can be undertaken is contained in the Privacy Notices Code of Practice[24] published by the ICO.

Targeted services providers must have procedures for staff and volunteers on how to share information in compliance with the DPA and the ICO Code of Practice. Decisions about what information should be shared and with whom should be taken on a case by case basis, and in accordance with organisational information management policies and the legal framework, and in line with this policy. The management interests of an organisation should not override the need to share information for safeguarding purposes.

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[22] 'Good Management Good Records' can be accessed at: http://www.dhsspsni.gov.uk/index/gmgr.htm

[23] The Data Sharing Code of Practice can be accessed at: https://ico.org.uk/media/for-organisations/documents/1068/data_sharing_code_of_practice.pdf

[24] The 'Privacy Notices Code of Practice' can be accessed at: https://ico.org.uk/media/for-organisations/documents/1610/privacy_notices_cop.pdf

If anyone has concerns about risk of harm to an adult, they should seek advice from the relevant HSC Trust or the PSNI.

Personal data may be shared when:

- the adult has given his or her valid consent (which in the case of sensitive personal data must be explicit); or
- where information sharing is necessary for matters of life or death or for the prevention of serious harm to the individual; or
- where sharing is necessary for the purposes of the administration of justice;
- where sharing information is for public or statutory duties.

Where the decision is made to share information without consent, the organisation must ensure that the adult is clearly informed of what information will be shared, why it will be shared, and who it will be shared with, providing this does not increase the risk to the adult. Organisations should avoid asking for consent to share information when it is likely that a decision will be taken to share the information regardless of whether consent is given. Any sharing of information must meet conditions under Schedules 2 and 3 of the Data Protection Act.

If there is reason to believe that sharing information due to a statutory duty to disclose may increase the risk of harm, or where there is doubt about whether the organisation can or should share information, the organisation may wish to obtain legal advice.

Good record keeping of decision making is essential in cases where information sharing is being considered. Staff should maintain records of the information gathered which explains and justifies their decisions.

14.3. Sharing Information Between Agencies

Effective safeguarding cannot be achieved without organisations working collaboratively to ensure the safety of the adult at risk is prioritised. Working together is dependent on there being a clear framework for doing so, and adult safeguarding should be based on good communication across sector and agency boundaries.

The effective and timely sharing of information between organisations is essential to deliver high quality adult safeguarding services focused on the needs of the adult.

Agencies and organisations which are required to share information on a regular basis to safeguard adults at risk must have Information Sharing Agreements (ISAs) in place which identify key members of staff and contact points within the organisation through which information can be channelled, including out of normal working hours. The agreements should be agreed at Board/Director level and subject to regular review.

Member organisations of NIASP have all signed an information sharing agreement. This agreement will stipulate when information may be shared without the subject's consent.

An ISA should outline how organisations have agreed to share information and ensure compliance with legal requirements. The purpose of an ISA is:

- to facilitate the secure exchange of information in an appropriate format, where necessary, to ensure the health, well-being and safeguarding of adults at risk;
- to provide a framework for the secure and confidential sharing of personal data between the partner organisations;
- to promote consistency of information sharing across partner organisations; and
- to support professional decision making in individual cases.

When an HSC Trust has a contract or commissioning arrangement with a third party organisation, the contract or commissioning agreement must state how the third party organisation must handle any personal data obtained through provision of the service. This must include how the information will be securely stored, managed, disposed of, and where appropriate shared, in compliance with the DPA and the Human Rights Act 1998.

15. SAFEGUARDING TRAINING

Effective adult safeguarding requires a specific level of knowledge, expertise and skill and understanding. Adult safeguarding is complex and must be delivered by a confident, competent and trained workforce, which includes those working in a voluntary or unpaid capacity.

NIASP has a responsibility to develop an inter-agency and inter-disciplinary approach to adult safeguarding training and practice development. NIASP will develop and agree a Regional Adult Safeguarding Training Framework which will specify learning outcomes and core content to meet a range of identified training needs within partner organisations.

The framework will provide a number of levels of training which reflect the varying levels of expertise required and the differing needs of organisations across the safeguarding continuum. The appropriate level of training will be determined by the roles and responsibilities of the individual.

Service providers should use the NIASP framework to identify and set out training and development pathways for their staff and volunteers, to ensure they have the appropriate skills and knowledge to engage in preventative activity and respond to safeguarding concerns commensurate with their role. This may involve a combination of formal training events, and time for staff to reflect on their own practice and the practice of others. Records should be maintained of all training and development undertaken by staff and volunteers.

16. A CONTINUOUS LEARNING APPROACH

All practitioners, agencies and organisations involved in work with adults at risk must ensure that the highest possible standards of care, support and protection are provided and maintained at all times, and improvements identified and put in place on a continuous basis. The NIASP will foster a culture of collaborative learning and continuous practice and service improvement in connection with adult safeguarding. This will require knowledge and understanding of the 'system' at the front-line, the identification of and exploration of learning from cases with different outcomes for adults at risk of harm, or adults who have been harmed and the implementation of learning from both. The emphasis should be on learning for the purpose of positive proactive change and improvement. It will require the support of staff who will be responsible for the implementation of change.

The NIASP will promote a culture of continuous improvement and collaborative learning to improve outcomes for adults who may be at risk and their experience of the adult protection responses.

This does not mean that those responsible for harming an adult at risk by an act of commission or omission should not be held to account. A range of accountability mechanisms already exist, including disciplinary mechanisms. These should be used where it is appropriate to do so.

The ultimate aim is to establish a system which promotes continuous learning and improvement to:

- establish whether there are lessons to be learned about the way in which local professionals, agencies and organisations work together to safeguard adults at risk;
- identify clearly what those lessons are, how they will be acted upon, by whom and by when, and what is expected to change as a results;
- improve multi-disciplinary and interagency working, and promote better approaches to prevention, protection and support of adults at risk.

The NIASP will seek the full support, cooperation and participation of its member organisations to identify opportunities for learning and to bring these to the attention of the NIASP.

APPENDIX 1

This policy is of specific relevance to:

- all NI Government Departments, their agencies and arm's length bodies;
- local councils;
- the Health and Social Care Board and Health and Social Care Trusts;
- Business Services Organisation;
- The Northern Ireland Ambulance Service HSC Trust;
- The Public Health Agency;
- The Northern Ireland Adult Safeguarding Partnership and the five Local Adult Safeguarding Partnerships;
- The Police Service of Northern Ireland;
- The Public Prosecution Service;
- The Probation Board for Northern Ireland;
- Policing and Community Safety Partnerships;
- The Northern Ireland Prison Service;
- The Northern Ireland Housing Executive;
- The Social Security Agency;
- regulatory and Inspection bodies across all sectors, including: Criminal Justice Inspection Northern Ireland, the Regulation and Quality Improvement Authority, The Education and Training Inspectorate, the General Teaching Council for Northern Ireland, the Northern Ireland Social Care Council, the General Medical Council, the Nursing and Midwifery Council and the Charities Commission;
- schools;
- Domestic and Sexual Violence Partnerships;
- voluntary and community organisations who work with, provide services to, or engage in, activities with adults;
- voluntary and community organisation umbrella bodies;
- Faith organisations and communities;
- care staff agencies;
- organisations and individuals who provide personal care funded through direct payments or through an individual's own funds;
- carers;
- Carers NI and other advocacy groups representing carers;
- housing associations;
- supported housing providers, the Northern Ireland Federation of Housing Associations Private landlords;
- accommodation providers;
- financial institutions, including: banks, Post Offices and building societies;
- credit unions;
- professions, including solicitors and barristers;
- The Office of Care and Protection;
- Northern Ireland Courts and Tribunal Service;
- independent Providers of health and social care service, including: General Medical Practitioners, pharmacists, dentists, private hospitals, private sector providers of domiciliary care, residential and nursing care homes, independent counsellors and independent therapist services;
- Allied Health Professionals and their regulatory bodies;

- opticians;
- further and higher education institutions;
- advice groups and helplines; for example, disability groups such as Disability Action and Action for Hearing Loss;
- Self help, user and advocacy groups;
- leisure facilities; and
- members of the public.

APPENDIX 2

Glossary

Access NI	AccessNI is a criminal history disclosure service in Northern Ireland. By law some employers must check your criminal history before they recruit. When asked by these employers, AccessNI supplies criminal history information about job applicants, volunteers and employees.
Adult Protection Gateway Service	The **Adult Protection Gateway Service** is the central referral point within the HSC Trust for all concerns about an adult who is, or may be, at risk.
Care Plan	A care plan sets out the assessed care and support needs of an individual and how those needs will be met to best achieve the individual's desired outcome. The individual should be fully involved in the development of the care plan.
Care Management	Care Management embraces the key functions of: case finding; case screening; undertaking proportionate, person-centred assessment of individual's needs; determining eligibility for service(s); developing a care plan and implementing a care package; monitoring and reassessing need and adjusting the care package as required.
Child Protection Gateway Service	The **Child Protection Gateway Service** is the central referral point within the HSC Trust for all concerns regarding the safety and welfare of children.
CJINI	Criminal Justice Inspection Northern Ireland is the independent statutory inspectorate with responsibility for inspecting all aspects of the criminal justice system in Northern Ireland apart from the judiciary. It also inspects a number of other agencies and organisations that link into the criminal justice system. CJI is funded by the Department of Justice and the Chief Inspector reports to the Minister for Justice.
Delegated Statutory Functions	Delegated Statutory Functions refer to all requirements of legislation with which statutory HSC organisations must comply. In successive legislation, the Health and Social Care Board (HSCB) is designated as 'The Authority' that is required to fulfill all relevant statutes. The HSCB delegates this responsibility to HSC Trusts under legally binding schemes referred to as 'Schemes for the Delegation of Statutory Functions'.
Designated Adult Protection Officer	A social worker within the HSC Trust with responsibility for managing and co-ordinating the adult protection process. The DAPO must: • be social work qualified; • be working in a minimum of a band seven; • have first line management responsibilities, or in a senior practitioner role;

	• be suitably experienced; and • have undertaken the necessary training.
DHSSPS	The Department of Health, Social Services and Public Safety.
DOJ	The Department of Justice.
Direct Payments	Direct payments are paid by an HSC Trust to people who have been assessed by an HSC Trust to meet the eligibility criteria for assistance from social services. A payment is made in lieu of the service so that the person can arrange and pay for their own care and support services instead of receiving them directly from the HSC Trust.
ETI	The Education and Training Inspectorate. The organisation which provides inspection services and information about the quality of education being offered including that within schools, further education and work-based learning, where adults at risk may be enrolled.
HSCB	The Health and Social Care Board. This is the body responsible for arranging or 'commissioning' a comprehensive range of modern, effective and safe health and social services for the people of Northern Ireland.
HSC Trust	Health and Social Care Trust. There are five Health and Social Care Trusts in Northern Ireland, providing local and regional health and social care services to the Northern Ireland public. The use of "HSC Trust" in the Policy document refers to the following five HSC Trusts: • The Belfast Trust • The South Eastern Trust • The Southern Trust • The Northern Trust • The Western Trust.
Joint Protocol	The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009. The Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.
LASP	Local Adult Safeguarding Partnerships. The five local multi-agency, multi-disciplinary partnerships located within their respective HSC Trusts.
MARAC	A MARAC is a Multi-Agency Risk Assessment Conference. It is a forum for local agencies to meet with the aim of sharing information about the highest risk

	cases of domestic violence and abuse and to agree a safety plan around victims.
National Referral Mechanism	A framework which exists to assist in the formal identification of victims of human trafficking and help to coordinate support to potential victims to appropriate service. The Department of Justice (DOJ) funds organisations to provide this support to adult potential victims of human trafficking. The PSNI are the lead agency in managing this response. However, consideration should be given to use of the Joint Protocol arrangements.
NIASP	The Northern Ireland Adult Safeguarding Partnership. The regional multi-agency, multi-disciplinary partnership that brings together representatives from organisations and communities of interest who have a significant contribution to make to adult safeguarding.
Office of Care and Protection	Office of Care and Protection is the department of the Court with responsibility for the administrative work associated with Part VIII of the Mental Health Order. This includes matters relating to enduring or lasting powers of attorney, and court-appointed deputies.
PBNI	Probation Board for Northern Ireland. PBNI works alongside statutory and other partners to minimise the risk of harm posed by offenders. PBNI is a Non Departmental Public Body of the Department of Justice (DOJ).
PCSP	Police and Community Safety Partnerships. Local bodies made up of Councillors and independent people in each Council area. PCSPs work with their community to identify issues of concern in the local area and potential solutions, and prepare plans to address these concerns.
Personal data	Personal data means data which relate to a living individual who can be identified – (a) from those data, or (b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller, and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual. It is important to note that, where the ability to identify an individual depends partly on the data held and partly on other information (not necessarily data), the data held will still be "personal data". The definition also specifically includes opinions about the individual, or what is intended for them.
PPANI	Public Protection Arrangements Northern Ireland. The

	purpose of the PPANI framework is to reduce the risks posed by sexual and violent offenders when they are released into the community in order to protect the public, including previous victims, from serious harm.
PPT	Public Protection Team. These are located in police stations throughout Northern Ireland.
Programme of Care	The structure in HSC Trusts within which social care is commissioned and delivered in Northern Ireland.
Protection Plan	A plan agreed with the adult at risk (or the person representing them or their best interests) detailing the actions to be taken, with timescales and responsibilities, to support and protect the person from harm.
PSNI	The Police Service of Northern Ireland.
RQIA	The Regulatory and Quality Improvement Authority. Northern Ireland's independent health and social care regulator, responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.
Sensitive Personal Data	Sensitive Personal Data means personal data consisting of information as to— (a) the racial or ethnic origin of the data subject, (b) his political opinions, (c) his religious beliefs or other beliefs of a similar nature, (d) whether he is a member of a trade union (within the meaning of the M1Trade Union and Labour Relations (Consolidation) Act 1992), (e) his physical or mental health or condition, (f) his sexual life, (g) the commission or alleged commission by him of any offence, or (h) any proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings. Sensitive Personal Data has a higher threshold when considering whether or not it can be shared, and carries higher requirements for secure management.

APPENDIX 3

Bibliography

The list below contains a list of sources used during the development of this policy. There may have been other documents which were reviewed during the course of the policy development which have been omitted, and where these are identified these will be included in future updates of this document.

Document Title	Author
Adult Support and Protection: Ensuring Rights and Preventing Harm	Edinburgh, Lothian and Borders Executive Group
Evidence Review – Adult Safeguarding	Institute of Public Care
Haringey Safeguarding Adults Multi Agency Information Sharing Protocol	Haringey Council
Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse.	Social Care Institute for Excellence with the Pan London Adult Safeguarding Editorial Board
Protecting our Older People in Northern Ireland: A Call for Adult Safeguarding Legislation	Commissioner for Older People for Northern Ireland
Safeguarding Adults: a National Framework of Standards for good practice and outcomes in adults protection work	The Association of Directors of Social Services
Safeguarding Vulnerable Adults Regional Adult Protection Policy and Procedural Guidance	Health and Social Care Board
Safeguarding Vulnerable Adults A Shared Responsibility	Volunteer Now

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Health and Social Care Board

NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP

Adult Safeguarding Operational Procedures

Adults at Risk of Harm and Adults in Need of Protection

September 2016

CONTENTS

SECTION A

INTRODUCTION

1. Introduction

1.1 Scope of the Operational Procedures

The responsibility for enacting the procedures to protect adults from harm caused by abuse, neglect or exploitation is principally the responsibility of Health and Social Care Trusts (HSC Trusts) and, where a crime is suspected or alleged, the Police Service of Northern Ireland (PSNI).

However, **safeguarding is everyone's business.**

These procedures are intended for use by all organisations working with, or providing services to, adults across the statutory, voluntary, community, independent and faith sectors. This includes paid staff and volunteers.

They describe what organisations need to do to provide a safe environment and how to respond appropriately to situations where an adult is at risk of being harmed or abused.

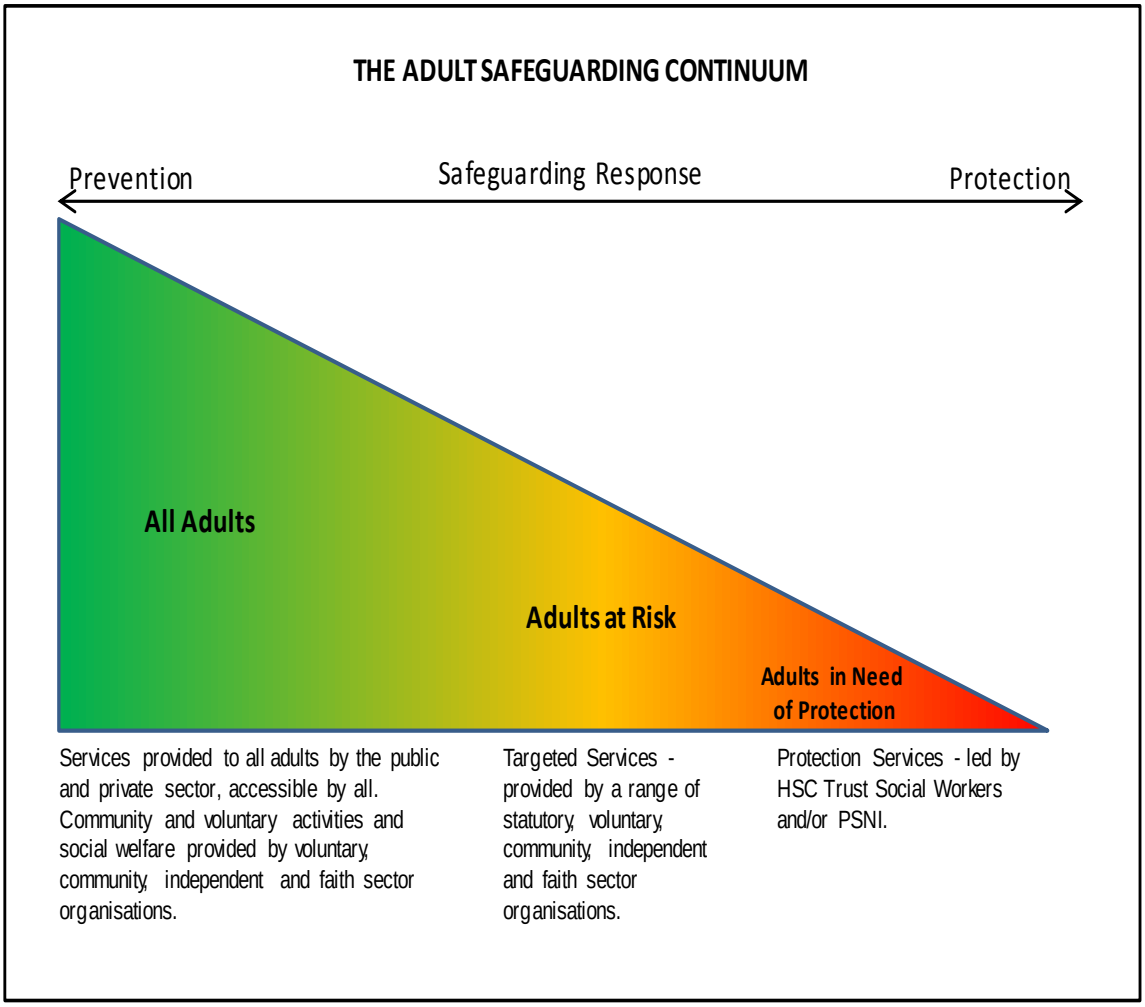
These procedures should be read in conjunction with all other relevant policies, such as:

- Adult Safeguarding: Prevention to Protection in Partnership Policy (DHSSPS 2015)
- Protocol for Joint Investigation of Adult Safeguarding Cases (NIASP 2016)

Safeguarding is a broad continuum of activity. It ranges from the empowerment and strengthening of communities, through prevention and early intervention, to risk assessment and management, including investigation and protective intervention. At all stages along this continuum, safeguarding interventions will aim to provide appropriate information, supportive responses and services which become increasingly more targeted and specialist as the risk of harm increases.

Safeguarding includes activity which **prevents** harm from occurring and activity which **protects** adults at risk where harm has occurred.

The diagram overleaf outlines this continuum



The continuum of adult safeguarding outlines the wide range of organisations involved in people's lives, from the small community activity groups through to larger organisations and statutory services. All organisations should ensure that any service they deliver is underpinned by the principles of respect and treating others with dignity. This is the first and crucial step to ensuring that services are high quality. The focus is on the individual receiving the service which may help to provide support and that harm is prevented. Increasing levels of need and risk are likely to lead to greater targeting of service provision, which, in turn, requires a heightened awareness of risk of harm and more robust measures will be required to prevent harm.

These procedures outline the actions needed to respond to adults at risk of abuse or harm.

1.2 How to Use the Operational Procedures.

These procedures set out broad principles of good practice when responding to situations where adults are at risk or in need of protection. They place the adult at the centre of the safeguarding process and provide some practical guidance on how specific roles such as the Adult Safeguarding Champion should be implemented.

The procedures support professional decision-making, placing a responsibility on practitioners to respond to each individual and their unique circumstances. Each response should be tailored to meet the needs of that individual, working towards the achievement of their preferred outcome.

The procedures do not describe every potential safeguarding scenario and some, such as those involving Domestic Violence or Modern Slavery, require more specialist responses. Guidance on these responses is available elsewhere and practitioners should refer to such detailed advice as necessary.

2. Definitions

2.1 What is Abuse?

Abuse is 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights'[1].

Abuse is the misuse of power and control that one person has over another. It can involve direct and indirect contact and can include online abuse.

The main forms of abuse are:

Physical abuse

[1] Action on Elder Abuse: definition of abuse 1993 which can be accessed at: http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html. This was later adopted by the World Health Organisation - http://www.who.int/ageing/projects/elder_abuse/en/

Physical abuse is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This may include hitting, pushing, rough handling, exposure to heat or cold, force feeding, improper administration of medication, denial of treatment, misuse or illegal use of restraint and deprivation of liberty. Female genital mutilation (FGM) is considered a form of physical **AND** sexual abuse.

Sexual violence and abuse

Sexual abuse is 'any behaviour (physical, psychological, verbal, virtual/online) perceived to be of a sexual nature which is controlling, coercive, exploitative, harmful, or unwanted that is inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability). [2] Sexual violence and abuse can take many forms and may include non-contact sexual activities, such as indecent exposure, stalking, grooming, being made to look at or be involved in the production of sexually abusive material, or being made to watch sexual activities. It may involve physical contact, including but not limited to non-consensual penetrative sexual activities or non-penetrative sexual activities, such as intentional touching (known as groping). Sexual violence can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

Psychological / Emotional Abuse

Psychological / emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, humiliation or ridicule, provoking fear of violence, shouting, yelling and swearing, blaming, controlling, intimidation and coercion.

Financial Abuse

Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not or could not consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation,

[2] The definitions of 'sexual violence and abuse' and 'domestic violence and abuse' are from "Stopping Domestic and Sexual Violence and Abuse in Northern Ireland, A seven year strategy. March 2016.

embezzlement, withholding pension or benefits or pressure exerted around wills, property or inheritance.

Institutional Abuse

Institutional abuse is the mistreatment or neglect of an adult by a regime or individuals in settings which adults who may be at risk reside in or use. This can occur in any organisation, within and outside Health and Social Care (HSC) provision. Institutional abuse may occur when the routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. Institutional abuse may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventative and/or protective measures are in place.

Neglect

Neglect occurs when a person deliberately withholds, or fails to provide, appropriate and adequate care and support which is required by another adult. It may be through a lack of knowledge or awareness, or through a failure to take reasonable action given the information and facts available to them at the time. It may include physical neglect to the extent that health or well-being is impaired, administering too much or too little medication, failure to provide access to appropriate health or social care, withholding the necessities of life, such as adequate nutrition, heating or clothing, or failure to intervene in situations that are dangerous to the person concerned or to others, particularly when the person lacks the capacity to assess risk.

The Safeguarding Adults: Prevention and Protection in Partnership Policy does not include self-harm or self-neglect within the definition of an 'adult in need of protection'. Each individual set of circumstances will require a professional HSC assessment to determine the appropriate response and consider if any underlying factors require a protection response. For example, self-harm may be the manifestation of harm which has been perpetrated by a third party and which the adult feels unable to disclose.

Exploitation

Exploitation is the deliberate maltreatment, manipulation or abuse of power and control over another person; to take advantage of another person or situation usually, but not always, for personal gain from using them as a commodity. It may manifest itself in many forms including slavery, servitude, forced or compulsory labour, domestic violence and abuse, sexual violence and abuse, or human trafficking.

This list of types of harmful conduct is neither exhaustive, nor listed here in any order of priority. There are other indicators which should not be ignored. It is also possible that if a person is being harmed in one way, he/she may very well be experiencing harm in other ways.

2.2 Related Definitions

There are related definitions which interface with Adult Safeguarding, each of which have their own associated adult protection processes in place.

Domestic violence and abuse

Domestic violence or abuse is 'threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a current or former intimate partner or family member'. Domestic violence and abuse is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person over another. It is usually frequent and persistent. It can include violence by a son, daughter, mother, father, husband, wife, life partner or any other person who has a close relationship with the victim. It occurs right across society, regardless of age, gender, race, ethnic or religious group, sexual orientation, wealth, disability or geography.

The response to any adult facing this situation will usually require a referral to specialist services such as Women's Aid or the Men's Advisory Project. In high risk cases a referral will also be made to the Multi- Agency Risk Assessment (MARAC) process. Specialist services will then decide if the case needs to be referred to a

HSC Trust for action under the safeguarding procedures. If in doubt, anyone with a concern can ring the Domestic and Sexual Violence helpline (0808 802 1414) to receive advice and guidance about how best to proceed.

Human Trafficking/Modern Slavery

Human trafficking/modern slavery involves the acquisition and movement of people by improper means, such as force, threat or deception, for the purposes of exploiting them. It can take many forms, such as domestic servitude, forced criminality, forced labour, sexual exploitation and organ harvesting. Victims of human trafficking/ modern slavery can come from all walks of life; they can be male or female, children or adults, and they may come from migrant or indigenous communities.

The response to adults at risk experiencing human trafficking/modern slavery will always be to report the incident to the Police Service.

Hate Crime

Hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity.

The response to adults at risk experiencing hate crime will usually be to report the incident to the Police Service.

2.3 Adult at Risk of Harm

An '**adult at risk of harm'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal characteristics and/or life circumstances.

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain. **Life circumstances** may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

2.4 Adult in Need of Protection

An **‘adult in need of protection’** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

A. personal characteristics

and/or

B. life circumstances

AND

C) who is unable to protect their own well-being, property, assets, rights or other interests;

AND

D) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed.

In order to meet the definition of an ‘adult in need of protection’ either (A) or (B) must be present, in addition to both elements (C), and (D).

In most situations HSC Trusts will make decisions regarding the degree of risk and level of harm an adult may be facing and decide on the most appropriate action to take. If there is a clear and immediate risk of harm, or a crime is alleged or suspected, the matter should be referred directly to the PSNI or HSC Trust Adult Protection Gateway Service.

If you think a crime has occurred where medical or forensic evidence might still be present consider the need for an urgent referral to the police service and be cautious not to touch or disturb possible evidential material.

SECTION B

ADULTS AT RISK OF HARM

3. The Adult Safeguarding Champion

3.1 Which Organisations Need an ASC?

Adult Safeguarding: Prevention and Protection in Partnership (2015) sets out the requirement for organisations to have an Adult Safeguarding Champion (ASC).
If the organisation or group does not have staff or volunteers who require to be vetted, then it is not required to have an ASC. However, having an ASC is identified as good practice for every group or organisation.

Targeted services include organisations that have staff or volunteers who are subject to **any** level of vetting under the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007.
All providers of targeted services are required to have an ASC and an adult safeguarding policy which demonstrates a zero tolerance of harm to adults.

Members of the public, voluntary and community groups NOT required to have an Adult Safeguarding Champion (ASC) should report all adult at risk or in need of protection safeguarding concerns directly to the HSC Trust Adult Protection Gateway Service. They can do so by phoning the Trust's single point of contact telephone number (see Appendix 2).

3.2 The Role of ASC

The ASC should be within a senior position within the organisation and should have the necessary training, skills and experience to carry out the role. The ASC provides strategic and operational leadership and oversight in relation to adult safeguarding for an organisation or group and is responsible for implementing its adult safeguarding policy.

The ASC is also the main point of contact with HSC Trusts and the PSNI for all adult safeguarding matters. Each organisation should, therefore, ensure that arrangements are in place to provide appropriate cover in the ASCs absence.

The ASC should ensure that, at a minimum, the organisation safeguards adults at risk by:

- Recognising that adult harm is wrong and should not be tolerated
- Being aware of the signs of harm from abuse, exploitation and neglect
- Reducing opportunities for harm, abuse, exploitation and neglect to occur
- Knowing how and when to report adult safeguarding concerns to HSC Trusts and / or the PSNI

3.3 Key Responsibilities of the ASC

1. To provide information, support and advice for staff and/or volunteers on adult safeguarding within the organisation.
2. To ensure that the organisation's adult safeguarding policy is disseminated and support implementation throughout the organisation.
3. To advise the organisation regarding adult safeguarding training needs.
4. To provide advice to staff or volunteers who have concerns about the signs of harm and ensure a report is made to HSC Trusts where there is a safeguarding concern.
5. To support staff to ensure that any actions take account of what the adult wishes to achieve – this should not prevent information about risks of serious harm being passed to the relevant HSC Trust Adult Protection Gateway Service for assessment and decision making.
6. To establish contact with the HSC Trust Designated Adult Protection Officer (DAPO), PSNI and other agencies as appropriate.
7. To ensure accurate and up to date records are maintained detailing all decisions made, the reasons for those decisions and any actions taken.
8. To compile and analyse records of reported concerns to determine whether a number of low level concerns are accumulating to become more significant. These records must be available on request for inspection or by way of service level agreements or contract review meetings.

In larger organisations the ASC may delegate the operational day to day responsibility for safeguarding to an appointed person(s) within their organisation. For example, a provider with a number of Nursing Homes throughout Northern Ireland may choose to delegate some of the tasks of an ASC to a member of staff in each facility. They will then report to the ASC on adult safeguarding matters on a regular basis and assist in the compilation of reports, training needs analyses and data analysis. Organisations who delegate operational tasks to appointed person(s)

must have sufficient numbers to ensure they are accessible to all service areas in the organisation as a source of advice and guidance.

In smaller organisations the ASC may be responsible for all actions relating to adult safeguarding situations, including working with the adult at risk and making referrals to PSNI and/or HSC Trusts.

Contact details for the HSC Trust Adult Safeguarding Gateway Services are contained in Appendix 2.

3.4 Information to be Monitored by an ASC

Most ASCs will already have daily access to a great deal of information that will assist the organisation or group improve the services it provides to adults at risk or in need of protection.

To meet the governance requirements set out in the Policy, the ASC will compile an annual Adult Safeguarding Position Report using the following core data:

- Number of referrals made to HSC Trusts involving both an adult at risk and an adult in need of protection;
- Number of adult safeguarding discussions where the decision taken was to **not** refer to HSC Trust;
- Any untoward event that triggered an adult protection investigation;
- Adult safeguarding training opportunities provided and uptake across staff groups; and
- Any action that your organisation plans to take to ensure it is compliant with Adult Safeguarding: Prevention and Protection in Partnership and to implement the organisation's own adult safeguarding policy.

3.5 The Adult Safeguarding Position Report

The Position Report is an important overview and governance tool for all organisations and groups supporting adults at risk or in need of protection. It will contain significant information for the organisation or group's Senior Management Team and/or Trustees. It should be scrutinised by them on an annual basis.

It would also be appropriate to provide core information from the Position Report in any organisational annual reports or updates.

The Position Reports should be made available for any external audit purposes, for example any audits undertaken by the Local Adult Safeguarding Partnership, and to demonstrate compliance with policies as specified within any contracts with HSC Trusts.

Services that are externally regulated, e.g. by RQIA or CJINI, may also be subject to inspection on adult safeguarding arrangements. The Position Report will be central in demonstrating that the organisation is complying with the requirements of the regional adult safeguarding policy.

If the service or group is contracted to provide services by the HSC normal contract monitoring processes should be used to provide confirmation to the relevant Trust(s) that the safeguarding Position Report is available for scrutiny.

4. Recognising and Responding to Adult Safeguarding Concerns

Staff or volunteers who are concerned about someone who may be experiencing harm or abuse must promptly report these to their line manager or person in charge.

There are a variety of ways that you could be alerted that an adult is suffering harm:

- They may disclose to you;
- Someone else may tell you of their concerns or something that causes you concern;
- They may show some signs of physical injury for which there does not appear to be a satisfactory or credible explanation;
- Their demeanour/behaviour may lead you to suspect abuse or neglect;
- The behaviour of a person close to them makes you feel uncomfortable (this may include another staff member, volunteer, peer or family member); or
- Through general good neighbourliness and social guardianship.

Being alert to potential abuse plays a major role in ensuring that adults are safeguarded and it is important that all concerns about possible abuse are taken seriously and appropriate action is taken.

4.1 When an Adult at Risk Discloses Abuse

In cases where an adult discloses abuse to a staff member or volunteer, it is vital that staff/volunteers know how to react appropriately.

All staff/volunteers should be made aware of to the following guidelines:

Do

- Stay calm;
- Listen attentively;
- Express concern and acknowledge what is being said;
- Reassure the person – tell the person that s/he did the right thing in telling you;
- Let the person know that the information will be taken seriously and provide details about what will happen next, including the limits and boundaries of confidentiality (see leaflet);
- If urgent medical/police help is required, call the emergency services;
- Ensure the immediate safety of the person;
- If you think a crime has occurred be aware that medical and forensic evidence might be needed. Consider the need for a timely referral to the police service and make sure nothing you do will contaminate it;
- Let the person know that they will be kept involved at every stage;
- Record in writing (date and sign your report) and report to the Line Manager/person in charge/Adult Safeguarding Champion at the earliest possible time;
- Act without delay.

Do not

- Stop someone disclosing to you;
- Promise to keep secrets;
- Press the person for more details or make them repeat the story;

- Gossip about the disclosure or pass on the information to anyone who does not have a legitimate need to know;
- Contact the alleged person to have caused the harm;
- Attempt to investigate yourself;
- Leave details of your concerns on a voicemail or by email;
- Delay.

The line manager or person in charge will take any immediate action required to ensure the adult at risk of harm is safe and make a decision as to when it is appropriate to speak with the adult at risk of harm about the concerns and any proposed actions. They must then report the concerns and any action taken to the services appointed person or Adult Safeguarding Champion.

5. Responding to an Adult Safeguarding Concern – the Role of the ASC

When an alert is raised within an organisation in relation to an adult safeguarding concern or disclosure, the ASC or appropriate appointed person, where these tasks have been delegated, will ensure the following actions occur:

- Consider whether the concern is a safeguarding issue or not. This may involve some 'checking out' of information provided whilst being careful not to stray into the realm of investigation.
- **Where immediate danger exists or the situation warrants immediate action** ensure any necessary medical assistance has been sought and refer to HSC Adult Protection Gateway or PSNI.
- Support staff to ensure any actions take account of the adult's wishes.
- Where it has been deemed that it is not a safeguarding issue, other alternative responses should be considered such as monitoring, support or advice to staff or volunteers.
- If it is decided that it is a safeguarding issue, the situation should be reported to the HSC Key Worker where known. If unaware of HSC Key Worker contact details, a referral will be made to HSC Trust Adult Protection Gateway service. The HSC Trust will then conduct a risk assessment and decide what response is appropriate.

- If a crime is suspected or alleged, contact the HSC Adult Protection Gateway Service directly.
- If the concern involves a regulated service, inform RQIA.
- Act as the liaison point for any investigative activity which is required and will ensure easy access to relevant case records or staff.
- Ensure accurate and timely records and any adult safeguarding forms required have been completed.

If an adult at risk does not want a referral made to the HSC Trust or PSNI, the ASC or appropriate person must consider the following:

- Do they have capacity to make this decision?
- Have they been given full and accurate information in a way which they understand?
- Are they experiencing undue influence or coercion?
- Is the person causing harm a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service?
- Is anyone else at risk from the person causing harm?
- Is a crime suspected or alleged?

These factors will influence whether or not a referral without consent needs to be made. If in doubt contact the HSCTrust Gateway service for advice and guidance.

If it is determined that the concern(s) do not meet the definition of an adult at risk or an adult in need of protection, the concerns raised must be recorded; including any action taken; and the reasons for not referring to HSC Trust.

The ASC will ensure that records of reported concerns are compiled and analysed to determine whether a number of low-level concerns are accumulating to become significant. If the organisation is regulated by RQIA or other bodies, then the ASC will make records available to them for inspection.

Where the ASC or appointed person is not immediately available, this should not prevent action being taken or a referral being made to the HSC Trust in respect of any safeguarding concern.

In most circumstances there will be an emerging safeguarding concern which should be referred to the relevant HSC Trust for assessment. HSC professionals will determine whether the threshold for an adult protection intervention has been met, or whether alternative safeguarding responses are more appropriate.

6. Responding to an Adult Safeguarding Concern – the Role of the HSC Trust

6.1 Determining if an adult is at risk

On receipt of the adult at risk referral the HSC Trust keyworker will discuss the concern with their line manager to establish the facts of concern and determine if the threshold for an adult at risk is met. Where this is not met they will inform the referrer of the outcome of their decision and make any necessary recommendations for alternative responses.

The line manager must ensure that the adult's immediate needs are met, eg they are in no immediate danger and that any medical assistance required has been sought.

Line managers must refer all cases where there is a clear and immediate risk of harm to the adult or a crime is alleged or suspected, to the PSNI using the emergency police 999 number and the Designated Adult Protection Officer (DAPO) in the HSC Trust Adult Safeguarding Gateway Team. The appropriate documentation should be used (see Appendix 7).

Where the decision is that the adult is potentially at risk of harm the line manager and the keyworker will discuss the appropriate response. This will include an assessment of the risk identified in the referral and review of the care and support needs which will minimise the risk of harm (See Appendix 7). The consent of the adult at risk will be sought (see Section 7:0 below for advice on capacity and consent) and the assessment will include the wishes and views of the adult at risk and where appropriate their family and carers. The keyworker will inform the referrer of the outcome of the assessment and care plan.

6.2 Determining if the Threshold for Referral to the Adult Protection Gateway Service is met

Where a risk assessment concludes that the adult is at risk of or has experienced serious harm, the next step is to consider whether the threshold for referral to the HSC Trust Adult Protection Gateway Service has been met.

Where the line manager determines that the threshold for an adult in need of protection is met, the keyworker refers the concern to the HSC Trust Adult Protection Gateway service (See Section C). The keyworker will advise the adult in need in protection of the decision to refer.

The following thresholds are intended as a guide only. It should be noted that thresholds are not intended to be used as exclusion criteria, but should be used positively to assist professional judgements about making referrals into the HSC Trust Adult Protection Gateway Service, and, critically, to enable informed decisions in respect of the most appropriate or proportionate safeguarding response.

The threshold for referral to the HSC Trust Adult Protection Gateway Service is likely to be met if one or a number of the following characteristics are met:

- the perceptions of the adult(s) concerned and whether they perceive the impact of harm as serious;
- it has a clear and significant impact on the physical, sexual, psychological and/or financial health and well-being of the person affected;
- it has a clear and significant impact, or potential impact, on the health and well-being of others;
- it involves serious or repeated acts of omission or neglect that compromise an adult's safety or well-being;
- it constitutes a potential criminal offence against the adult at risk;
- the action appears to have been committed with the deliberate and harmful intent of the perpetrator(s);
- it involves an abuse of trust by individuals in a position of power or authority; and
- it has previously been referred to a regulated service provider for action, and has not been sufficiently addressed.

If there is doubt about whether the threshold for Adult Protection has been reached, the concern should be discussed with the HSC Trust Adult Protection Gateway Service and a DAPO will advise whether the matter meets the threshold.

Where a criminal act is either alleged or suspected, a report must be made to the PSNI.

NB: In the majority of cases where serious harm has been identified, the threshold for referral to the HSCTrust Adult Protection Gateway Service will have been met. However, in a limited number of circumstances referral to this service may not be the most appropriate response. This may include, for example, a peer on peer incident where capacity is a concern. In such circumstances, an alternative response may be more appropriate (see below)

6.3 Alternative Safeguarding Responses

Where it is determined that the threshold for Adult Protection has **not** been met, other alternative courses of action should be explored with the adult. At all times the least intrusive and most effective response should be made. This is a matter for professional judgement, taking account of the individual circumstances and the wishes and views of the adult and may include:

a) escalation to the service manager to address any issues about the quality of service provision;
b) referral to the RQIA for action as the regulator in respect of quality of care concerns or where concerns have been raised and there has been a lack of action by the service provider;
c) referral to a care manager/key worker for re-assessment and review of service user/carer‘s needs, views and care plan, or where appropriate a mental capacity assessment;
d) action taken under complaints procedures;
e) action taken under human resources/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;
f) referral to an advocacy service;

g) referral to another service;
h) a risk management intervention in relation to self-neglect;
i) a strategy to manage risks within a complex group living environment and the management of challenging behaviour;
j) no further action required;

or a combination of two or more of the above.

Any safeguarding concerns relating to breaches of regulations or non-compliance with care or service standards are matters for the regulator, regardless of whether the threshold of serious harm has been reached. The HSC Trust should raise such concerns with the RQIA and will then co-ordinate an interagency response. The role of RQIA in inspection and regulation will be critical in the identification and prevention of safeguarding concerns or incidents in a proportionate manner to prevent unnecessary engagement of the Adult Protection Gateway Service.

7. Human Rights, Consent and Capacity

Adults at risk of harm should be central to decisions regarding any actions to prevent or protect them from harm. The adult's reasons for refusal to consent to a referral to the HSC Trust for assessment and support should be explored with them. Consent may be over-ridden in some cases, for example, where the individual lacks the capacity to appreciate the nature of the concerns and the potential consequences to them of not addressing those concerns; where there is a potential risk to others or in the public interest.

If you have any concerns that the adult at risk may not have capacity to consent or may be coming under pressure to refuse consent you should refer to the HSC Trust key worker or HSC Trust Adult Protection Gateway team.

Human Rights, Consent and Capacity, the European Convention for the Protection of Human Rights and Fundamental Freedoms (Human Rights Act 1998)

The Human Rights Act 1998 has been fully effective from 2nd October 2000. It incorporates the European Convention for the Protection of Human Rights and

Fundamental Freedoms into United Kingdom Domestic Law. This makes it unlawful for public authorities to act in a manner which is incompatible with the rights and freedoms guaranteed by the Convention sets out the main Convention Rights enshrined in the 1998 Act.

Decisions taken not to comply with the wishes of the adult in need of protection/adult at risk may constitute a breach of Human Rights legislation. Where consideration is being given not to comply with the wishes of the adults in need of protection adult/adult at risk, the decision taken must be lawful, proportionate and in keeping with what is in the public interest.

Public authorities can interfere with an individual's rights providing it is lawful, proportionate and necessary in a democratic society.

Lawful means 'prescribed by law' and the legal basis for any restriction on rights and freedoms must be established and identified. Reporting a relevant offence, as defined in the Criminal Law Northern Ireland Order (1967), is not only lawful but a legal requirement on public authorities.

Proportionate means the proposed action is viewed by any reasonable person as fair, necessary and the least restrictive in order to benefit the individual.

Necessary in a democratic society means

(1) Does it fulfil a pressing social need?
(2) Does it pursue a legitimate aim? And
(3) Is the proposed action in the public interest taking into consideration whether other Adults at risk or children may be at risk of harm?

7.1 The Decision Making Process

In applying the key principles of lawfulness, proportionality and whether it is necessary in a democratic society, a public authority representative must ask the following questions:

- Is there a legal basis for my actions?
- Is it proportionate and necessary in a democratic society?

- Is the procedure involved in the decision-making process fair and does it contain safeguards against abuse?
- Was there an alternative and less restrictive course of action available? (The Intervention should be strictly limited to what is required to achieve the objective).
- Is the restriction required for legitimate purposes?
- If I fail to interfere with this individual's rights could there be a more serious outcome in not affording the individual adequate protection in fulfilment of their human rights?

Decisions to interfere with an individual's rights may be subject to scrutiny by the Courts. However, if public authorities can show that they applied the relevant Human Rights principles when making their decision, they are less likely to be over-ruled. It is very important to keep notes and decisions should be recorded in full.

7.2 Consent

The wishes of the adult in need of protection are of paramount importance in all cases of alleged or suspected abuse. Where a crime is suspected the issue of possible PSNI involvement should be discussed with the adult in need of protection.

The consent of the adult in need of protection for contact with the PSNI should be sought as a first step.

The adult in need of protection should be provided with as much information as possible to assist them in making an informed decision regarding how they wish the situation to be handled. They should be fully advised by the Trust key worker and/or Designated Adult Protection Officer (DAPO) of the Protocol for Joint Working process and of their right to have a referral made to the PSNI. The adult in need of protection should also be informed if this is a referral to PSNI for action, or whether consultation on the need for a Joint Agency approach is required.

The adult in need of protection should be advised that agreeing to a Joint Agency consultation does not in itself constitute agreement to a full PSNI investigation. The benefits of a Joint Agency consultation in terms of information gathering should be explained. Their entitlement to full consultation and involvement at each stage in the

Joint Protocol process should also be emphasised. All staff involved must ensure that this person centred approach is strictly adhered to.

Details of all supports available to an adult in need of protection as outlined in 'Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy' (2012) should also be provided.

In the majority of cases where the adult in need of protection is deemed to have capacity, the PSNI will only proceed to a full investigation with the consent of the adult in need of protection. In practice this will mean that the adult in need of protection should be willing to make a complaint to the PSNI. However, there are some exceptions to this.

7.3 Dispensing with Consent

In exceptional circumstances, the DAPO may need to consider over riding the wishes of an adult in need of protection if they do not consent to a joint agency consultation with the PSNI. These include situations where:

1. There is reasonable evidence or information to indicate that a possible relevant offence has been committed and the Trust have a legal obligation to report to the PSNI.
2. There is a significant query regarding the individual's capacity to make an informed decision and therefore their ability to give or withhold consent is in question. Actions taken must be proportionate to the level of concern and the views of substitute decision makers.
3. Information available clearly demonstrates that the individual is subject to substantial undue influence or coercion.
4. There is a significant risk to other adults at risk and/or children.
5. The likelihood of further harm is high and there is a substantial opportunity to prevent further crime.

The PSNI also have the authority to investigate alleged or suspected criminal abuse where this is agreed to be in the best interests of the adult in need of protection and or others.

The above list indicates possible situations where the DAPO may need to consider overriding the wishes of an adult in need of protection adult. The list is not exhaustive. Cases will need to be assessed on a case by case basis and requirements in relation to making decisions which are lawful, proportionate and necessary in the public interests are applicable.

7.4 Acting without Consent in Emergency Situation

In situations where the adult in need of protection is in imminent danger it may not be possible to discuss with them their wishes and obtaining a valid consent may not be achievable. Trust staff, under these circumstances, should take whatever action they feel is appropriate to protect the adult in need of protection, including seeking medical and/or PSNI intervention.

Where there is no information and/or clarity regarding the wishes of the adult in need of protection and it is safe to do so, consideration should be given to deferring a decision re a joint agency consultation until such time as the adult in need of protection's views and permission can be sought. The DAPO will need to consider this on a case by case basis, mindful that a number of factors will need to be taken into account. Where a decision is taken to consult with the PSNI and the adult in need of protection has not consented to this, a detailed rationale for this decision should be recorded.

7.5 Capacity

There should be no assumptions made regarding an individual's capacity or incapacity and in the first instance unless there is contrary information, every individual should be viewed as having the capacity to make decisions about their own situation. However, if an issue is raised in relation to any individual's cognitive ability to make an informed decision about their safety, the DAPO should ensure a capacity assessment is completed.

Capacity assessments/reassessment should determine:

a. the extent to which the adults in need of protection/adult at risk is able to make informed decisions about their safety and protection.

b. whether the adults in need of protection adult/adult at risk is able to make a complaint to the PSNI and/or give legal instruction.
c. whether the adults in need of protection adult/adult at risk has the capacity to be interviewed by the PSNI.

Capacity assessments will also inform the assessment of the needs of the adult at risk or in need of protection.

Formal capacity assessments should be carried out by an appropriately trained professional. In cases where the adult in need of protection is already known to specialist services the professional involved may be able to provide an informed opinion in relation to the individual's capacity.

It is important to remember that an individual's capacity to consent to any course of action, decision or intervention may fluctuate. A capacity assessment should not, therefore, be considered as a one-off event. DAPOs should ensure that issues of capacity are constantly borne in mind throughout any safeguarding or protection interventions.

The onus is on professionals such as nurses and social workers to ensure that any intervention where the individual is considered to lack capacity is respectful of the person's human rights and that actions are both proportionate and lawful.

It is important to note that any and all information provided by an adult in need of protection is relevant and should be considered in a safeguarding context.

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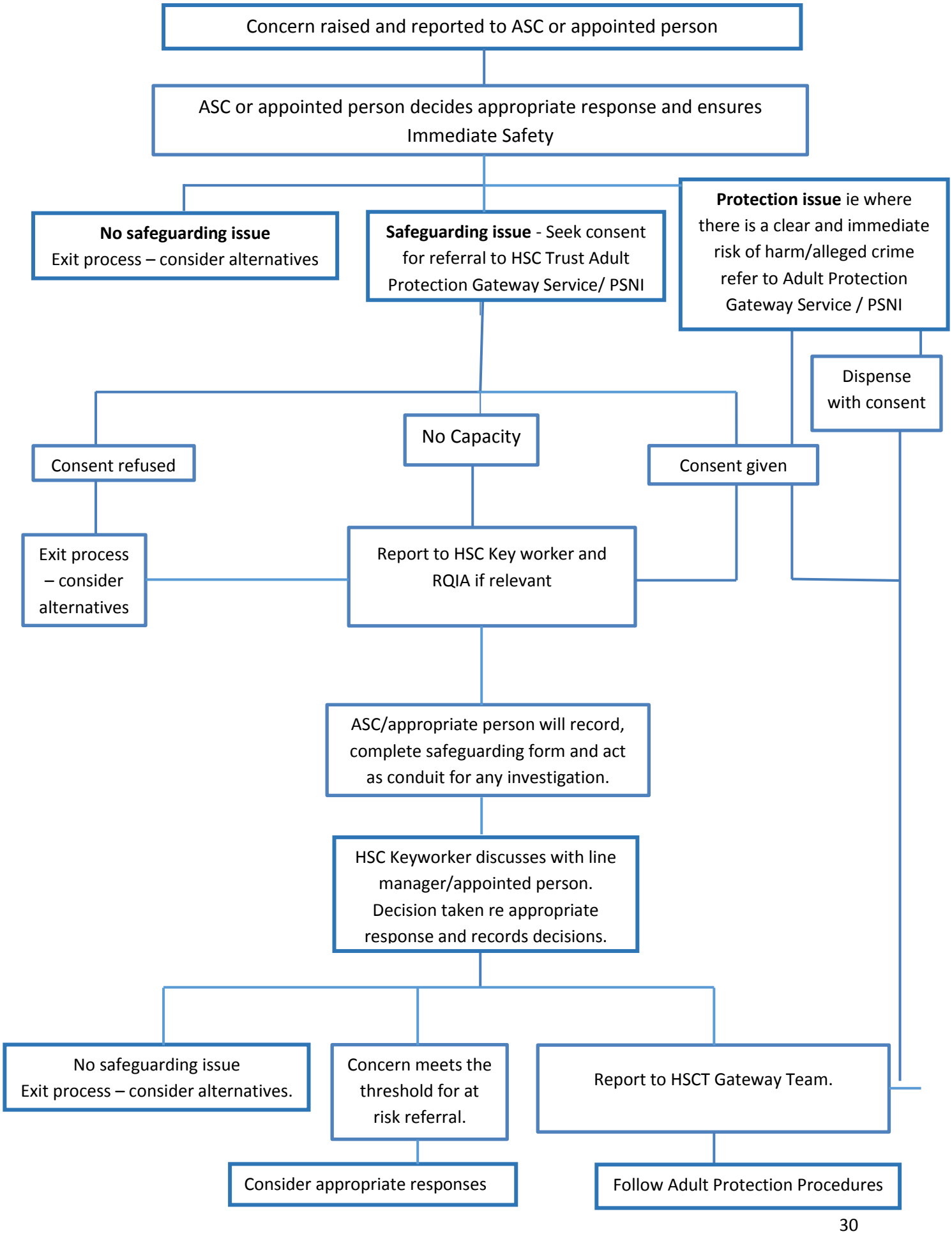
PATHWAY FOR DEALING WITH CONCERNS



SECTION C

SAFEGUARDING ADULTS IN NEED OF PROTECTION

Introduction:

These procedures set out the process to be followed in reporting and responding to concerns that an adult is at risk of harm and may be in need of protection (see Appendix 3, Six Stages of the Adult Protection Process).

8. Roles and Responsibilities

Safeguarding is everyone's business and includes the decision to make a referral when there is a concern relating to an adult in need of protection. There will however be more specific roles and responsibilities within the process and these will be discussed in more detail in the relevant section of the protection process (see below).

8.1 Designated Adult Protection Officer

A Designated Adult Protection Officer (DAPO) will be responsible for the management of each referral received by a HSC Trust. DAPOs will be in place both within the Adult Protection Gateway Service, and within core service teams.

Every DAPO must:

- Be a qualified social worker at Band 7 seniority or above;
- Have first line management responsibilities, or in a senior practitioner role;
- Be suitably experienced; and
- Have undertaken the required training as outlined in the Northern Ireland Adult Safeguarding Partnership Training Framework (2016).

The role of the DAPO is to

- ✓ Complete an initial screening against the thresholds for serious harm. Where this threshold has not been met, the DAPO should consider all alternative safeguarding responses
- ✓ Manage and coordinate the adult protection intervention;
- ✓ Provide formal/informal support and debriefing to the Investigating Officer/ABE interviewer;
- ✓ Analyse the adult safeguarding data within their service area and contribute to governance arrangements as appropriate; and

- ✓ Ensure that the connections are made with related interagency mechanisms such as:
  - Multi Agency Risk Assessment Conference (MARAC)
  - Domestic and sexual violence services
  - Public Protection Arrangements in Northern Ireland framework (PPANI)
  - Human trafficking and modern slavery procedures
  - Hate Crime Practical Action Scheme
  - The Office of Care and Protection (or equivalent)
  - Child Protection Gateway Service
  - Business Services Organisation Counter-Fraud Unit.

The DAPO may decide to close the adult protection process at any stage if

- ✓ It is agreed that further investigation, assessment or intervention is not required to protect the adult;
- ✓ The DAPO decides that an alternative safeguarding response is more appropriate, proportionate and effective to address the concern identified;
- ✓ A Protection Plan has been agreed and is in place and is effectively addressing the needs of and the risks to the adult and there is no need to conduct an investigation; or
- ✓ The adult chooses to withdraw from the protection process.

Where the safeguarding concern relates to the quality of care provided to an adult in receipt of a regulated HSC service, the DAPO will engage the Regulation and Quality Improvement Authority (RQIA) to ascertain whether the provider is in breach of regulation or minimum standards. The RQIA will act on all safeguarding concerns where there are breaches of standards or regulation and, where necessary; use their powers of improvement or sanction to ensure that the provider addresses any breach of the minimum standards to the satisfaction of RQIA.

Where there are multiple adults in need of protection the DAPO will also

- ✓ Liaise and agree with other potential DAPOs who will take lead responsibility.
- ✓ Agree joint working and feedback arrangements as necessary.

This is critical:

a) In cases where there is more than one programme of care involved in delivering a service.
b) If the adult in need of protection is in a care environment outside their home e.g. Acute Care.
c) Where there is more than one Trust involved in the provision of care (Ref Section 10 on Large Scale and Complex Investigations).

8.2 The HSC Investigating Officer

The Investigating Officer must be a HSC Trust professionally qualified practitioner (Band 6 and above). Investigating Officers **must** receive specific training as set out in the NIASP Training Framework prior to undertaking the role.

Their role is to carry out an assessment of risk, collate and analyse all available information, determine how best to protect the adult in need of protection and/or others, to explore alternatives available and to provide advice and support.
The Investigating Officer, alongside relevant professionals, will be responsible for direct contact with the adult in need of protection, their carers and relevant others.

While carrying out these duties, the Investigating Officer will be guided and supported by the DAPO. The Investigating Officer will:-

- ✓ Meet with the adult in need of protection and carer/relative separately to establish the preliminary information.
- ✓ Investigate allegations and concerns as directed by the DAPO. The investigation should take the form of an assessment of risk, needs and, where appropriate, a carer's assessment. This will inform the review and updating of the interim protection plan.
- ✓ Inform the adult in need of protection of expressed concerns and the Adult Protection investigation process. The investigation process should ensure that the wishes/choices of the adult are paramount.
- ✓ Inform the adult in need of protection of his/her rights to protection under law.
- ✓ Support the adult in need of protection through the assessment process.

- ✓ Keep the adult in need of protection informed and updated throughout the investigation process to ensure informed decision making.
- ✓ Identify needs and supports which may be required by the person alleged to have caused the harm and, where appropriate, refer on for professional input and support.
- ✓ Commission medical or other specialist assessments, where appropriate.
- ✓ Inform and liaise with relevant professionals and significant others as appropriate.
- ✓ Make a clear record of the investigation process.
- ✓ Keep the DAPO informed of the investigation process and outcome of the assessment, risks and ongoing concerns.
- ✓ Provide an investigation report for a case conference/review. This report must include an analysis of the findings with a conclusion and, where appropriate, make recommendations.
- ✓ Ensure the implementation of any care and protection plan as agreed with the DAPO.

8.3 The HSC Achieving Best Evidence Interviewer

The specialist Achieving Best Evidence (ABE) Interviewer must be a professionally qualified Social Worker. Specialist Interviewers must have completed Investigating Officer training, Joint Protocol training and ABE training prior to undertaking the role.

The Specialist Interviewer will be responsible for planning and conducting interviews with service users who may have been the victim of a crime. These interviews will be undertaken jointly with the PSNI and in accordance with the guidance laid out in “Protocol for Joint Investigation of Adult Safeguarding Cases (2016)” and “Achieving Best Evidence in Criminal Proceedings” (2012).

The Pre Interview Assessment, where possible, will be conducted by the same person conducting the ABE Interview. (See also Protocol for Joint Investigation of Adult Safeguarding Cases (2016) and Achieving Best Evidence in Criminal Proceedings (2012)).

8.4 Line Manager

On receiving an allegation or concern of abuse the line manager must ensure that the adult's immediate needs are being met; i.e. that they are in no immediate danger and that medical assistance if required is sought. The line manager must consider the need for emergency PSNI intervention. For example, where there remains immediate risk of harm to the adult in need of protection or others the line manager must contact the emergency PSNI number, 999.

Line managers must refer all cases where there is a clear and immediate risk of harm or a crime is alleged or suspected regarding an adult at risk to the PSNI or the DAPO in the HSC Trust Gateway Service using the relevant regional referral and recording systems, including where there are concerns that physical harm has occurred, a body map or diagram completed by an appropriately trained person.

In most circumstances there will be an emerging safeguarding concern which should normally be referred to the HSC Trust for a professional assessment of risk. It will be a matter for the HSC professional to judge whether the threshold for an adult protection intervention has been met, or whether alternative responses are more appropriate.

In circumstances where the care manager for the service user is from another HSC Trust, the referral should be made to the Adult Safeguarding Gateway Service in the placing HSC Trust. The line manager must also notify the host Trust for information purposes as this may be relevant to other current concerns (refer to section 15.2). In instances where the person who has allegedly caused the harm is also an adult at risk the line manager should ensure necessary arrangements are in place to support them.

In instances where the allegations are made against a member of staff, the line manager will be responsible for the instigation of appropriate protection measures which may involve staff such as redeployment, being placed on restricted duties or precautionary suspension and any subsequent disciplinary procedures. The line manager must consult with the responsible DAPO to ensure that Disciplinary Procedures run parallel to the adult protection investigation. It is essential in these circumstances that close communication and sharing of information is maintained

between the line manager, DAPO and Human Resources. (See section on Guidance on the Co-ordination of Adult Protection Investigations with Human Resource and/or PSNI Investigations)

8.5 HSC Regional Emergency Social Work Service

The Regional Emergency Social Work Service (RESWS) provides an emergency social work service outside normal office hours including weekends and public holidays. These are 5pm to 9am Monday to Thursday and 5pm on Friday to 9am on Monday. There is 24 hour cover over public holidays.

The RESWS responds to a wide range of people in crisis and deals with situations which cannot be left until the next working day. People in crisis can include older people, people with mental health issues, learning disabilities, physical disabilities, potential victims of human trafficking and children and young people.

There are a number of situations in which the RESWS will become involved or work with other agencies to ensure the safety of an individual and others who may be at risk. Examples of emergency situations are where:

- There are immediate significant protection and welfare concerns in relation to an adult at risk and/or an adult in need of protection;
- There are immediate significant protection and welfare concerns in relation to children and young people;
- Urgent advice and/or support is required by families or carers;
- Older people are at risk;
- There is consideration that compulsory admission to hospital under the Mental Health Order (NI) 1986 is required.

Staff within RESWS will provide an adult safeguarding and adult protection service where required and Managers within the RESW will fulfil the role of Designated Adult Protection Officers (DAPOs) when required RESWS will respond to all elements of the role in emergency situations which require an urgent response.

8.6 Role of Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) has a key preventative role in adult safeguarding practice. As the independent regulator, RQIA has both a

responsibility and the authority to ensure that safety and quality of care concerns which put service users at risk are addressed in the services which they inspect. The RQIA also has a key role in service improvement with the aim of encouraging improvement in the quality of the services they inspect and securing public confidence in the provision of those services by keeping the Department of Health, Social Services and Public Safety informed of their availability and their quality.

Governance information is essential to RQIA in the conduct of its inspections and reviews. It assists with the assessment of the service with specific regard to safeguarding performance. There are core governance elements which should be included in all inspections conducted within regulated services. These are the number, nature and outcome of:

- complaints made;
- safeguarding concerns raised with the Adult Safeguarding Champions;
- notifiable incidents or accidents which occurred as appropriate to that service setting; and
- any disciplinary procedures conducted.

Enforcement action is an essential element of the responsibilities of RQIA. There is a range of enforcement options which RQIA can use to ensure compliance with regulations and minimum standards, to effect improvements and to afford protection to service users. In most circumstances, and where appropriate, RQIA will make recommendations and requirements for quality improvement through regulation and inspection activity. Where a service is identified as being at risk of failing to meet minimum standards and/or comply with regulations, RQIA will consider the various options to enable the registered establishment or agency to make the necessary improvements. RQIA will normally adopt a stepped approach to enforcement. However, this would not rule out the option of moving directly to legal action, including prosecution, if the circumstances require. RQIA may increase inspection activity to monitor compliance and ensure that the necessary improvements are being made. RQIA may escalate enforcement actions at any time, proportionately and in relation to the level of risk to service users and the seriousness of any breach of regulation. RQIA will follow up enforcement action to ensure that quality improvements are achieved. In certain circumstances, where there is deemed to be

a risk of serious harm to service users, RQIA may take urgent action. Such circumstances include, but are not exclusive to, those falling under the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009). This may involve, where necessary, using its powers to cancel registration and/or to seek the urgent closure of a registered service. RQIA publishes its enforcement policy and procedures online, along with copies of its inspection reports[3].

The RQIA will notify any serious concerns in relation to the quality of service provision or risk of harm to an individual/s to the relevant HSC Trust or the PSNI, and will be a key partner contributing to investigations with the other agencies to protect adults at risk who are in receipt of a regulated service

9. Adult Protection Procedures

Each adult protection intervention is likely to be unique and the response made must allow for flexibility and individualised decision-making. It is important that each adult protection intervention is conducted without undue delay, remains outcome focused, rather than process driven, and is subject to ongoing monitoring and review at an appropriately senior level. At all stages throughout the adult protection intervention, consideration should be given to whether the threshold for the Adult Protection Gateway Service continues to be met. Any action necessary to address immediate protection needs of the adult must be taken regardless of which stage of the process has been reached.

10. Stage 1 Screening the Adult Protection Referral

On receipt of a referral the DAPO will take the following actions:

- Consider immediate safeguards for the adult and take appropriate action to meet identified safety needs.
- Ensure that a face to face contact with the adult in need of protection is completed without undue delay.
- Clarify basic facts and determine if the adult meets the definition of an adult in need of protection.

[3] RQIA publications are available on www.rqia.org.uk

- Determine whether the threshold for serious harm (Appendix4) and the threshold for referral to the HSC Trust Adult Protection Gateway Service are met. This is likely to be met if one or a number of the following characteristics are met:
    - ✓ The perceptions of the adult(s) concerned and whether they consider the impact of harm as serious;
    - ✓ It has a clear and significant impact on the physical, sexual, psychological and/or financial health and well-being of the person affected;
    - ✓ It has a clear and significant impact, or potential impact, on the health and well-being of others;
    - ✓ It involves serious or repeated acts of omission or neglect that compromise an adult's safety or well-being;
    - ✓ It constitutes a potential criminal offence against the adult in need of protection;
    - ✓ The action appears to have been committed with the deliberate and harmful intent of the perpetrator(s);
    - ✓ It involves an abuse of trust by individuals in a position of power or authority; and
    - ✓ It has previously been referred to a regulated service provider for action and has not been adequately addressed.
- If referral does not meet the above protection thresholds, the DAPO will advise referrer and agree appropriate alternative safeguarding responses. At all times the least intrusive and most effective response should be made.
- Where the HSC Trust Adult Protection Gateway Service DAPO determines that an alternative course of action is appropriate, there must be mechanisms in place to ensure that the outcomes of this action is reported back to the DAPO;
- Consideration of consent is central to adult safeguarding. Consent is a clear indication of a willingness to participate in an activity or to accept a service, including a protection service. It may be signalled verbally, by gesture, by willing participation or in writing. No one can give, or withhold, consent on behalf of another adult unless special legal provision for particular purposes has been made for this. For consent to be valid it

must be given voluntarily by an appropriately informed person who is able to consent to the intervention being proposed. In cases where the individual lacks capacity, decisions will usually be made on behalf of the individual in accordance with current legal provisions. If the person has no suitable family or friend who can be consulted with regarding their best interests, an advocate may be appointed.

- Where there is a query regarding the capacity of the adult to consent to the referral, the DAPO should screen the referral into the adult protection process pending the completion of a capacity assessment. The absence of a capacity assessment must not delay the protection of an adult in need. It is important that a capacity assessment is undertaken as soon as possible. It may be established that with the appropriate support, the adult in need of protection is able to make their own decisions.
- In some circumstances it may be necessary for the withholding of consent to be overridden. Where consent to intervene is not provided by the adult at risk, the DAPO may decide to progress a case in circumstances where there is a strong overriding public interest, or where a crime is alleged or suspected. This may happen when:
    - The person causing the harm is a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service; or
    - Consent has been provided under undue influence, coercion or duress;
    - Other people are at risk from the person causing harm; **or** a relevant and reportable crime is alleged or suspected In these circumstances, the adult should be informed of that decision, the reason for the decision, and reassured that as far as possible no actions will be taken which affect them personally without their involvement. Consideration should be given to any support the adult may need at this time, as they may be distressed by the prospect of their information being shared without their consent.

- The DAPO must ensure that the HSC staff member communicating with the adult in need of protection has sufficient knowledge of the Protocol for Joint Investigation of Adult Safeguarding Cases to provide relevant

information in order that the adult in need of protection can make an informed decision in relation to PSNI involvement.

- If the allegation is a potential crime there must be consideration of the application of the Protocol and immediate liaison with the PSNI to avoid contamination of evidence.
- Consider if there are other adults or children in need of protection.
- Consider any indicators of potential human trafficking or modern slavery and, if relevant, refer to regional guidance.
- Inform other relevant organisations of the nature of the allegation and the actions being taken.
- Complete the relevant electronic information system.
- Complete the relevant documentation advising the referrer of outcomes of the screening decision. The referrer, if appropriate, notifies service user / family with due regard to maintaining the safety of the service user in need of protection.
- Where appropriate, the Gateway DAPO will forward the screened referral to the most appropriate DAPO within core operational services to take the lead role in initiating, convening and chairing a strategy planning meeting/discussion. Feedback should be given to the person who made the referral, taking into account confidentiality and data protection issues.

10.1 Supporting an Adult at Risk Who Makes Repeated Allegations

An adult at risk who makes repeated allegations that have been investigated and are unfounded should be treated without prejudice. Each allegation must be responded to and recorded under these procedures. A risk assessment must be undertaken respecting the rights of the individual and measures taken to protect staff and others and a case conference convened, where appropriate.

10.2 Responding to Family Members, Others Who Make Repeated Allegations

Allegations of abuse made by family members or others should be investigated without prejudice. However, where repeated allegations are made and there is no foundation to the allegations and further investigation is not in the best interests of the adult in need of protection, then the appropriate HSC Trust Director should make a determination in consultation with relevant others about an appropriate response.

10.3 If a Referral is Received after an Adult in need of protection has Died:

The referral or complaint may contain an allegation or suspicion that abuse or neglect could have been a contributory factor in the person's death. The allegation may be made by a family member or friend, a concerned member of staff who is 'whistleblowing', or as a result of a report from the Coroner. Such information should immediately be passed to the relevant DAPO who will consider whether a referral to the PSNI is required. If the deceased was in receipt of services at the time of their death, such a referral will give rise to action under the regional Serious Adverse Incident (SAI) reporting procedures. As part of the SAI process, the HSC Trust will consider whether there are potential risks to other adults and, if necessary, will initiate a protection investigation to address these specific concerns.

10.4 Outcome of Screening:

There is Insufficient Information to Determine if an Investigation is Required

Additional information is to be sought to inform the type of investigation needed or to provide a rationale for a decision not to investigate under Adult Protection.

The Threshold of Adult in Need of Protection IS NOT MET

Where it is determined that the threshold for Adult Protection has not been met, other alternative courses of action should be explored with the adult. At all times the least intrusive and most effective response should be made.

At every stage the adult's human rights must be considered, and evidence of the impact of any decision on those rights recorded. The adult's rights, needs, views and wishes, should be central to the protection intervention to ensure that they receive the support needed to achieve an agreed outcome.

A decision to close the Adult Protection process must be agreed by all relevant organisations and signed off by the DAPO. The reasons for closing the Adult Safeguarding process should be recorded and a copy sent to strategy meeting attendees. The adult at risk should have a copy of the decisions that takes into account issues of confidentiality and the need for protection of personally identifiable information.

The Threshold for Referral to Adult Protection Gateway Service is Met: -

The DAPO will proceed with the management of the protection process.

11. Stage Two: Strategy Discussion

11.1 Purpose of the Strategy Discussion

Strategy meetings provide a forum for professionals and agencies to work together to ensure a coordinated investigation and protection response. They are an opportunity to address any potential conflicts between agencies at an early stage. They also provide the opportunity for clarification of roles and responsibilities in relation to HSC Trust, PSNI, RQIA and where applicable an employing organisation.

In complex situations the strategy discussion is normally a meeting of key people to decide the process to be followed after considering the initial available facts. However, there may be occasions when a telephone discussion would be more appropriate and proportionate, eg emergency situations. There must be careful consideration about the most appropriate way to ensure the wishes of the adult in need of protection are at the centre of the decision making at a strategy discussion.

Every effort should be made prior to the meeting to explain its purpose to the adult in need of protection to find out their concerns, what they want to happen and how they want to be involved in what is decided. This can be done either by the keyworker or the Investigating Officer, or both if this is deemed most appropriate.

11.2 Supporting the Adult in Need of Protection:

The wishes of the adult in need of protection are central to the process and will, as far as possible, direct any decision-making. However, there may be circumstances in which the person concerned about the adult in need of protection may not be best placed to seek their consent to a referral being made, or the person clearly states that they do not want a referral to be made.

Whilst the wishes of the adult should always be the paramount consideration, it is important to remember that there will be circumstances when other factors mean this may not be possible, for example, where there appears to be undue influence or

coercion or another person is suspected to have influenced the adult's decision or other people may be at risk or it constitutes a relevant offence.

The strategy meeting will consider the wishes of the adult in need of protection as to who will support them throughout the adult protection process if this is required. During this process those involved must:

- Ensure that the adult in need of protection is given every opportunity to speak in private regarding their concerns, taking care not to place the adult in need of protection at greater risk.
- Inform the person of advice, support, assistance or services available.
- Offer the use of an advocate if this would be beneficial.
- Decide what information legally can be shared with next of kin. This may vary in differing circumstances either due to consent and capacity issues or through the choices of the adult in need of protection. The principles of best interests and information sharing apply. Good practice will evidence the rationale for the decision to share such information.
- Promote the human rights of the adult in need of protection.

11.3 Role of DAPO at the Strategy Discussion

The DAPO must ensure that an adult protection strategy discussion is convened and chaired, and minutes taken and circulated. The DAPO will invite those who will provide critical or relevant information that will inform decision making to attend and/or provide a written report. This may include, for example, the PSNI or RQIA. The DAPO will also invite those who will be required to implement the various elements of any protection plan. In respect of regulated services this will include the Regulator. If the allegation involves a member of staff or paid carer, the strategy discussion will be attended, where appropriate, by:

- PSNI
- RQIA
- The authorised officer for contracts
- The HSC Trust commissioning manager/Contracts Manager
- The Human Resources officer
- The line manager of the member of staff

- A senior manager of the employing organisation

Where a formal strategy meeting is convened of any individual requested to attend should treat the request as a priority. In exceptional circumstances, iIf no one from the organisation is able to attend, they should provide written information as requested and ensure it is available at the meeting.

In most cases it would be deemed to be good practice for a strategy discussion to take place as soon as possible. It is important that each adult protection intervention is conducted without undue delay, and remains outcome focused, rather than process driven. There can be complex issues to be managed such as fluctuating capacity to make decisions and complex investigations that may require interagency collaboration and consultation including cooperation with any PSNI investigations.

Nonetheless, it is important that all adult protection interventions are progressed in a timely manner, and must not be allowed to drift unnecessarily. HSC Trusts must ensure that the timeliness of interventions will be monitored and reviewed at an appropriately senior level.

11.4 Role of Line Managers in Strategy Planning

Line Managers may be required to take part in a strategy discussion in relation to service delivery and /or in relation to a member of staff. The Line Manager will be asked to contribute information about potential risk to inform the protection plan.

Line managers will implement any actions agreed and, in conjunction with the DAPO, they will agree what information will be shared with the person raising the concern and the adult in need of protection. Line managers may also be responsible for taking protective actions in relation to the person who has allegedly caused the harm. They will record all conversations, meetings with the person who allegedly has caused the harm, feedback to the DAPO, refer to HR for advice and notify appropriate professional and regulatory bodies as required.

NB where a PSNI investigation has commenced, it will be necessary to seek PSNI permission prior to interviewing a member of staff under disciplinary procedures, in case this interferes with PSNI procedures.

11.5 Adult Protection Strategy Discussion

The strategy discussion must demonstrate the following actions have been undertaken.

- Review the screening decision, including any requirement to refer to PSNI
- Consider the wishes of the adult in need of protection
- Clarify the mental capacity of the adult in need of protection to make decisions about their own safety. Arrange for an assessment by the most appropriate person, if required
- If the person does not have mental capacity, decide how they will be supported to be involved as much as they are able, and/or who is a suitable person to act in the person's best interests.
- Consider the use of advocacy if appropriate
- Identify any communication needs of the adult in need of protection
- Discuss the nature of the concerns and review preliminary risk assessment and interim protection plan
- Consideration should be given to the safety and wellbeing of other adults or children. Where appropriate, refer to children's Gateway Service and/or Adult Gateway service.
- Consider the human rights for both the adult in need of protection and the person alleged to have caused the harm who may also be an adult at risk.
- Review and record available, relevant information and determine any further information required. Discussions should include decisions about sharing of information.
- Agree the most appropriate way of responding to the concerns identified, e.g. Single agency PSNI investigation; Single agency HSC Trust investigation; Joint Protocol investigation; disciplinary investigation; family group conference; care planning; risk management meeting; or formal complaint in order to create and implement a protection plan. The detailed rationale for this decision must be recorded and will be subject to audit.

- Where a decision has been made that an investigation will take place, agree an investigation plan to include timescales for same and how it should be conducted and by whom.
- Agree a clear rationale for the actions to be undertaken and by whom.
- Agree a communication strategy including who should inform service user/carer/advocate of outcome of strategy discussion.
- Consider the need to inform other regulatory/professional bodies.
- Circulate minutes to all invitees within ten working days using the appropriate regional pro forma (Appendix 6).
- If the investigation is likely to be prolonged, other strategy meeting(s) must be held to ensure that actions are progressed and the interim protection plan is providing adequate safeguards for the adult at risk (and other individuals at risk if necessary).
- Full cooperation will be afforded to police investigations and in such cases the DAPO must ensure appropriate care and protection plans are in place to protect and safeguard the adult in need of protection. It will be necessary to consult with PSNI before proceeding with any internal organisational investigations such as disciplinary proceedings
- Regular contact should be maintained between the DAPO and the PSNI representative during the PSNI investigation process, and the position communicated to the staff member's manager and HR representative (particularly as the suspension/transfer decision must be reviewed every 4 weeks).

11.6 Coordination of Adult Protection and Disciplinary Investigations:

The focus of a Disciplinary Investigation is to determine if a staff member has breached disciplinary rules, which may require disciplinary action to be taken. The threshold for decision-making is whether there is a case to answer 'on the balance of probabilities'.

The different focus of protection and disciplinary investigations will require separate reports to be prepared. However, coordinating the process by which each investigation gathers information will make the best use of the Trust's skills and expertise, avoid duplication, and avoid undue delay.

11.7 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is Also an Adult at Risk

The primary focus of the strategy meeting or discussion is the adult in need of protection. However, it may be necessary to hold a separate multi-agency meeting to address the needs and behaviour of the person causing the harm. Decisions that will need to be taken at the strategy meeting in relation to the person causing the harm will include:

- How to co-ordinate action in relation to the adult at risk causing the harm.
- Identification and allocation, of a separate care manager/keyworker in order to ensure that the needs of the adult at risk causing the harm are met and that a care plan is devised to ensure that other adults at risk are not also put at further risk from that person's actions.
- Whether there is likely to be a criminal prosecution (if known at this point).
- What information needs to be shared and with whom.

The DAPO will maintain communication with those concerned with the care of the adult at risk who is also alleged to be the person causing harm.

In all situations, the care manager/key worker representing the adult at risk and the relevant staff working with the person causing the harm must be informed of any risk management issues immediately and be closely involved at all stages of the investigation

Where the person alleged to have caused the harm is under 18 years of age, a referral should be made to the relevant HSC Trust Children's Services

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The strategy discussion should demonstrate how the needs of the person who has allegedly caused the harm have been supported during the adult protection investigation.

Throughout the Adult Protection process, people alleged to have caused harm must be treated and spoken to without prejudice.

The person allegedly causing harm has a right to information about any allegations made. However, their right to information must be balanced with the rights of the adult in need of protection and/or any other safety concerns.

Where a decision is taken not to inform the person alleged to have caused harm of an allegation there must be a clear rationale for this decision which must be recorded and kept under review. Where a crime is alleged or suspected, advice should be sought from PSNI before information is shared.

11.8 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is a Member of Staff/Volunteer

If the person alleged to have caused the harm is a member of staff or a volunteer and an immediate decision is needed, the line manager should notify those with responsibility for Human Resource functions in the relevant organisation of the concern and liaise with the relevant manager for a decision on whether precautionary suspension/transfer/restricted duties of the staff or volunteer is necessary and appropriate. The employer should inform the person in broad terms of the nature of the allegations in line with HR Procedures.

There is a requirement in these circumstances to ensure that the rights of the adult in need of protection and the rights of a member of staff/ volunteer are fully considered and all actions taken at this stage are without prejudice in order to facilitate the investigation/s taking place.

11.9 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is a Family Member, Friend or Carer.

Cases where the person alleged to have caused harm is a family member, friend or carer need to be treated with particular sensitivity. For example, information may need to be given to the person alleged to have caused harm to ensure they understand how poor care practices can become abusive. A carer may also require a carer's assessment.

In cases where a crime is alleged or suspected, advice on what can or should be shared should be sought from the PSNI.

11.12 Outcomes of Strategy Discussion

The strategy meeting/discussion must decide who will inform the adult in need of protection of the decisions and outcomes reached at the meeting. There are a number of outcomes that may be determined at the strategy (see Appendix 5). The relevant outcome should be recorded in the minutes of the meeting.

i. Insufficient Information to Determine if an Investigation is Required

It is agreed that additional information is to be sought to inform the type of investigation needed or to provide a rationale for a decision not to investigate under Adult Protection.

ii. Threshold of Adult in Need of Protection is not met

Where the threshold of "an adult in need of protection" is not met other alternative courses of action should be explored with the adult. At all times the least intrusive and most effective response should be made. This is a matter for professional judgement, taking account of the individual circumstances and the wishes and views of the adult and may include:

- ✓ Escalation to the service manager to address any issues about the quality of service provision;
- ✓ Referral to the RQIA for action as the regulator in respect of quality of care concerns or where concerns have been raised and there has been a lack of action by the service provider;
- ✓ Referral to a care manager/key worker for re-assessment and review of service user/carer's needs, views and care plan, or where appropriate a mental capacity assessment;
- ✓ Action taken under complaints procedures;
- ✓ Action taken under HR/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;
- ✓ Referral to an advocacy service;
- ✓ Referral to another service or agency;
- ✓ A risk management intervention in relation to self -neglect;
- ✓ A strategy to manage risks within a complex group living environment

and the management of challenging behaviour;

- ✓ No further action required; **or**

a combination of any of the above.

At every stage the adult's human rights must be considered, and evidence of the impact of any decision on those rights recorded. The adult's rights, needs, views and wishes, should be central to the protection intervention to ensure that they receive the support needed to achieve an agreed outcome.

A decision to discontinue the Adult Safeguarding process must be agreed by all relevant organisations and signed off by the DAPO. The reasons for closing the Adult Safeguarding process should be recorded and a copy sent to strategy meeting attendees. The adult at risk should have a copy of the decisions that takes into account issues of confidentiality and the need for protection of personally identifiable information.

iii. The Threshold for an Adult in Need of Protection is Met

If the threshold is met and it is determined that investigation is required then consideration should be given as to the most appropriate type of investigation. This may be either a single agency (HSC Trust or PSNI) or alternatively a Joint Protocol Investigation.

Where the threshold is met and the adult in need of protection has capacity to withhold consent for an adult protection investigation, the expressed wishes of the adult will be respected and the investigation will not proceed provided there are no other adults at risk or concerns which may constitute a relevant and reportable offence.

In such circumstances, practitioners must be confident that the adult at risk is making this decision without undue influence, threats and intimidation. If there are no other people at risk from the person causing the harm, there will be no further action under the procedures at this time. In this situation there should be a written record, confirming their decision not to proceed with an investigation.

The adult at risk should be given information about abuse and neglect, possible sources of help and support and who to contact if they should change their mind or the situation changes and they no longer feel able to protect themselves.
If protection concerns persist the strategy meeting must consider other types of intervention to be offered, including a risk management plan, care plan or Family Group Conference or legal powers available to intervene with the person(s) causing the harm. This must be shared and agreed in writing with the adult in need of protection.

11.13 Single Agency PSNI Investigation

Where a single agency PSNI investigation is considered to be the appropriate response, PSNI officers should refer to Police Service Procedures. During a single agency PSNI investigation the HSC Trust will ensure, where appropriate, any adult safeguarding or protection issues are addressed.

HSC Trusts will give full co-operation to police investigations and in such cases the DAPO must ensure appropriate risk and protection plans are in place to protect and safeguard the adult in need of protection.

The PSNI and HSC Trust should continue to liaise throughout the investigation in relation to any protection issues. The HSC DAPO will continue to hold strategy discussions throughout the PSNI single agency investigation to ensure that the protection plan is reviewed and those involved are updated on the progress of the PSNI investigation.

11.14 Joint Agency Investigations

Refer to Protocol for Joint Investigation of Adult Safeguarding Cases (2016).

In cases where an investigation is proceeding under the Protocol, clarity should be sought at the strategy meeting as to whether any element of a Trust protection investigation can commence (to include review of documentary evidence; meeting with adult in need of protection; meetings with witnesses; meetings with the person alleged to have caused the harm) in parallel with the PSNI investigation. Criminal investigations by the PSNI will take priority over all other investigations. Any internal investigation should not proceed without the knowledge and agreement of the

PSNI. This will ensure that the criminal investigation is not jeopardised or prejudiced by internal enquiries.

11.15 HSC Trust Single Agency Investigation

Where the decision is taken to continue with a single agency HSC Trust investigation under the protection procedures, the DAPO will be responsible for the management of the protection investigation, including the following::

- The appointment of a HSC Investigating Officer(s).
- Ensure the adult in need of protection is aware of the allegation of abuse;
- Ensure the wishes of the adult in need of protection are recorded;
- Agree methodology and terms of reference for the investigation. This should reflect agreed management of other possible forms of harm which may become apparent during the investigation.
- Is the response proportionate?
- Agree documentation to be reviewed.
- Consider needs of other adults at risk/children.
- Consider HR/other investigatory processes. If there are going to be a number of investigations, running alongside adult protection, the meeting or discussion will decide in what order the various investigations, assessments and enquiries should take place.
- Identify an indicative timeframe in which the investigation should take place. The investigation should begin as soon as possible after the strategy meeting or discussion without undue delay.
- Is there any medical evidence or record of the impact of the abuse?
- Has there been a disclosure? Is it signed and dated?
- Have the human rights of both the adult in need of protection and the person alleged to have caused the harm been considered?
- Is there any documentary evidence available? E.g. bank statements, accident reports.
- Has the adult in need of protection been contacted about the alleged abuse?
- Have the holistic ‘best interests’ of the adult in need of protection remained paramount in the decision making process?
- Have the wishes of the adult in need of protection been recorded?

- Has the adult in need of protection's capacity to consent been considered and is there any report regarding capacity where appropriate?
- Are there risks to other adult in need of protection or children? If so, agree a referral to the children's services and who will make the referral.
- Have appropriate regulatory and professional bodies been informed, e.g. RQIA, NISCC?
- Has consideration been given to notifying other relevant agencies, e.g. other departments, trusts, providers?
- If the alleged offender is an employee Human Resources should be consulted.
- Has consideration been given to ensuring appropriate supports are available for the adult in need of protection accounting for cognitive ability, comprehension and communication needs?
- Has consideration been given to appropriate supports for carers during the investigation?
- Identify any possible personal safety issues for the person who will conduct the investigation and plan to address these.
- Action that may lead to legal proceedings should take precedence over other proceedings and there should be discussion and co-ordination of those processes to avoid prejudicing such investigations.
- Agree how communication will be maintained during the investigation.
- Identify who will be the responsible person within each participating organisation for any agreed actions.
- If the situation indicates that the adult in need of protection is being subjected to domestic violence and the risks are high, agree a referral to MARAC. Designate the organisation and the person who will complete the DASH risk assessment and make the referral (NB The MARAC process does not replace the Adult Protection process, but adds benefit to any risk assessment).
- If the alert was made by a service user or a member of the public about abuse or neglect within an organisation, the organisation's complaints procedure may form part of the investigation and risk assessment. A decision will be made on a case-by-case basis as to whether the

complaints process is suspended pending the outcome of protection investigation.

- Agree the need for further strategy reviews during the investigation and agree dates.

12. Stage Three: Investigation/Assessment

12.0 Purpose of the Investigation

A single agency adult protection investigation is a professional assessment which analyses the risk of harm and serious harm, the impact of that harm on the adult in need and determines if this may have led to abuse. Such assessment requires experienced professional judgement to ensure outcomes are proportionate, necessary and lawful.

The purpose of the investigation is to:

- ✓ Establish the facts and contributing factors leading to the referral. Determine and manage the level of risk to an adult in need of protection and or others and update the care and protection plan as required.

The investigation must:

- ✓ Be open to the possibility of the presence of other forms of harm.
- ✓ Reflect the wishes of the adult in need of protection
- ✓ Produce an investigation report.

12.1 The Investigating Officer Role

The Investigating Officer will:-

- ✓ Meet with the adult in need of protection and carer/relative separately where appropriate to establish the preliminary information.
- ✓ Investigate allegations and concerns when appointed by DAPO. The investigation should take the form of an assessment of risk and needs. This will inform the review and updating of the interim protection plan.
- ✓ Inform the adult in need of protection of expressed concerns and the adult protection investigation process. The investigation process should ensure that the wishes/choices of the adult are paramount.

- ✓ Inform the adult in need of protection of his/her rights to protection under law.
- ✓ Support the adult in need of protection through the assessment process.
- ✓ Keep the adult in need of protection, or their representative, informed and updated throughout the investigation process to ensure informed decision making.
- ✓ Consider whether there is a need to refer the person alleged to have caused the harm on for professional input and support.
- ✓ Commission medical or other specialist assessments, where appropriate.
- ✓ Inform and liaise with relevant professionals and significant others.
- ✓ Investigating officer may require other information, action and support from other disciplines, agencies and organisations to assist with and adult protection or criminal investigation.
- ✓ Make a clear record of the investigation process.
- ✓ Keep the DAPO informed of the investigation process and outcome of the assessment, risks and ongoing concerns.
- ✓ Provide an investigation report for a case conference/review. This report must include an analysis of the findings and a conclusion and recommendations.
- ✓ Keep personally identifiable information concerning the adult in need of protection, the person causing the harm and any third parties to a minimum.
- ✓ Ensure the implementation of any care and protection plan as agreed with the DAPO.

12.2 The Investigation Report

The investigation report must clearly set out the following:

- ✓ Context of the referral and detail of the alleged concerns;
- ✓ A pen picture of the adult in need of protection and his/her circumstances, including formal and informal networks of support.
- ✓ An assessment of the adult in need of protection's capacity to consent.
- ✓ Information about the person alleged to have caused the harm.
- ✓ A brief account of the methodology for the investigation.
- ✓ The investigation findings, including:

- a professional assessment of the impact of the harm on the adult in need of protection **AND**
- analysis of the evidence giving consideration of the impact of decisions on the person's rights and the need to balance competing rights as positively as possible

✓ The report must reach conclusions on the balance of probability, determining whether harm occurred.

✓ Make recommendations where appropriate.

12.3 Undertaking the Investigation

Timescales

The Investigating Officer will make contact with the adult in need of protection and begin the investigation immediately following receipt of the referral and an initial discussion with the DAPO. The investigation should be conducted without undue delay. The Investigating Officer must keep the DAPO informed of the progress of the investigation and any change to the investigation plan. If for any reason the investigation plan cannot be completed within the agreed timescales, a revised agreement about timescales and any necessary action(s) to be taken must be reached between the DAPO and other relevant organisations and clearly recorded.

The DAPO can take a professional decision to close the investigation process where additional information identified throughout the investigation demonstrates that there is no requirement to proceed with a protection investigation. The DAPO must communicate the rationale for closing the investigation in writing to the strategy planning group. Any disagreements should be recorded on the regional adult protection closure documentation.

12.4 If the Adult in Need of Protection Moves During the Adult Protection Process

The DAPO must:

- Contact and reach agreement with a senior manager or DAPO in the new host Trust about future action, roles and responsibilities.
- Send fully documented and relevant information and summaries as appropriate.

Other organisations that have been involved in the investigation must also be advised if the adult need of protection has moved to another area.

In some cases family, friends or carers may remove an adult from the UK before a full investigation can be carried out and protective measures put in place. If there is any indication that such a removal is being planned, legal advice must be sought urgently.

12.5 If the Person Alleged to Have Caused the Harm Moves During the Adult Protection Process

If the person allegedly causing the harm is an informal carer or member of the public, any information on a change of address or location should be shared with the PSNI. If the person allegedly causing the harm is a paid worker or a volunteer, the line manager should also follow appropriate Human Resources advice.

12.6 If a Referral or Complaint is Received After an Adult in Need of Protection Has Died

The referral or complaint may contain an allegation or suspicion that abuse or neglect could have been a contributory factor in the person's death. The allegation may be made by a family member or friend, a concerned member of staff who is 'whistleblowing', or as a result of a report from the Coroner. Such information should immediately be passed to the relevant DAPO who will consider whether a referral to the PSNI is required.

If the deceased was in receipt of services at the time of their death, such a referral will give rise to action under the regional Serious Adverse Incident (SAI) reporting procedures. As part of the SAI process, the HSC Trust will consider whether there are potential risks to other adults and, if necessary, will initiate a protection investigation to address these specific concerns.

12.7 Resolution of disagreements

Where there are disagreements at any stage in the process that cannot be resolved by discussions between those responsible for decision making, these should be escalated to senior managers within the HSC Trust and/or PSNI, who will make a determination. At all times participating agencies should avoid delay resulting from

inter-agency disagreement and ensure that the wellbeing of the person in need is prioritised.

13. Stage 4 Implementation / Protection planning

Following the completion of the final draft investigation report consideration must be given by the DAPO to the most appropriate method for sharing and agreeing the final outcomes of the investigation and the process for managing the next steps or recommendations with the adult in need of protection.
The forum for decision-making and managing any outstanding risks must be carefully considered and fully person-centred. It might involve, for example, a risk management meeting, a Family Group Conference, a family meeting held in the person's own home a case discussion or a case conference.

When the adult in need of protection lacks capacity, the DAPO must take the complexity of the case and interagency involvement into consideration when deciding on the most appropriate forum for sharing information and agreeing the protection plan.

13.1 Planning the Meeting

The case conference meeting should take place after the completion of the protection investigation. Some parallel investigations may not be completed, for example, a criminal prosecution or Human Resources process but this should not be considered grounds to delay the meeting. The DAPO should ensure that a suitable meeting is convened without undue delay. The DAPO will Chair and ensure arrangements are in place to have the meeting minuted. The Investigating Officer should submit their investigation report to the Chair of the case conference prior to the meeting. Copies will also be made available to all attendees. Representatives invited to and attending the meeting should have the delegated authority to agree to provide services to contribute to the reviewed protection plan if their organisation has a role to play.

13.2 Purpose of the Case Conference

The purpose of the case conference is to evaluate the available evidence and to determine an outcome based on balance of probability (see above).

The aim of this meeting is to:

- Consider the information contained in the investigating officer's report.
- Consider the evidence and, if the allegation of abuse/serious harm is substantiated, plan what action is indicated.
- Agree and plan further action(s) if required.
- Consider whether there are legal or statutory actions indicated.
- Make a decision about the levels of current risks to the adult in need of protection or others and a judgement about any likely future risks.
- Analyse and evaluate the findings of the investigation report and agree a consensus decision as to the conclusions reached; i.e. substantiated; unsubstantiated; partially substantiated; inconclusive. Record any disagreements/amendments within the minutes of the meeting.
- Agree an ongoing protection plan if required including how this will be reviewed and monitored.

These aims must be met irrespective of whether the meeting is a formal case conference or a meeting with the adult in need of protection within their family home.

13.3 Sharing the report

The content of the draft report and care and protection plan should be shared with the adult in need of protection and their family where appropriate prior to the case conference in order to ascertain their views on the findings and reflect these at the case conference.

A copy of the draft report should also be shared with the person who was alleged to have caused the harm and the relevant employer where the person is a member of staff. This provides an opportunity for a right to reply and the report may either be amended to reflect comments, correct inaccuracies, or to register disagreements. Any decision not to share this draft report must be recorded including the rationale for this decision.

When deciding to share the draft report, the DAPO should carefully consider any possibility of escalating risk to the adult in need of protection or others inclusive of

staff whistleblowing requirements. The rationale for all decisions must be recorded by the DAPO.

All parties, where appropriate, have a right to a copy of the **final** written investigation report except where to do so would place the adult in need of protection or others at greater risk of harm. The adult in need of protection and provider organisations should be advised of the confidential nature of the report.

13.4 Outcomes of the Case Conference

The meeting must reach a decision, based on the balance of probabilities, as to whether the harm occurred. The meeting must agree whether there is a need for an ongoing protection plan with associated roles and responsibilities for implementation t agree any recommendations that should be taken forward. The meeting must make a decision as to whether the case should be closed under Adult Protection Procedures.

The protection plan will focus on the adult in need of protection. Actions arising in relation to the person causing the harm should be taken forward by the keyworker under normal care planning arrangements.

Possible recommendations of the case conference may include the following:

- The case conference should consider requirements to refer to other regulatory or professional bodies.
- Consider any systemic, contractual or practice issues that must be referred to the relevant organisation for action.
- Consider the need for further or additional information to be shared with Human Resources.

13.5 Minutes

The minutes record the decisions of the meeting and evidence how these decisions were made. The minutes will be shared with those present and those contributing to the protection plan. The protection plan will be attached to the minutes of the meeting.

Where the adult in need of protection has not been in attendance at the meeting the outcome should be shared with them as soon as possible and the protection plan discussed and agreed. If the person does not have capacity, a decision should be made in their best interests and shared appropriately.

Where there is information that cannot be shared outside the case conference meeting, it should be redacted from versions of documents sent out. It is imperative that Data Protection Act 1998 principles are adhered to. Whether or not minutes of the meeting are shared with the adult in need of protection, the DAPO will decide the best person to feed back to them on the outcome of the meeting. This should take place as soon as possible afterwards. The adult in need of protection should be enabled to raise any issues they may have about the decisions taken and the protection plan that has been developed/agreed.

13.6 Feedback to the Person Alleged to Have Caused the Harm

A decision must be made in the meeting about what feedback should be provided to the person alleged to have caused harm and the organisation that employs that person (if relevant), as well as who should provide it. Due consideration must be given to any potential risk this might pose to the adult in need of protection. The rationale for any decision not to feedback to the person alleged to have caused the harm must be clearly recorded and agreed by the case conference. If the person alleged to have caused the harm does not have mental capacity (and is also an adult at risk), feedback will be given to the person acting in their best interests.

14. Stage Five: Monitoring/Review of the Protection plan

14.1 Purpose of the Review

The purpose of the review is to ensure that the actions agreed in the protection plan have been implemented and to decide whether further action is needed. Additional concerns of abuse or neglect would be considered as a new alert/referral.

The review should

- Review the risk assessment
- Decide about ongoing responsibility for the protection plan

- Decide, in consultation with the adult need of protection or their personal representative, what changes, if any, need to be made to the protection plan to decrease or manage the level of risk
- Decide whether there is need for a further review and, if so, set a date
- Decide whether to close the Adult Protection Plan.

14.2 Recording and Feedback

- Record any decisions, agreed actions and those responsible for contributing to the implementation of the protection plan.
- Ensure that all involved in the review of the protection plan have a copy of the review notes, including the adult in need of protection or their personal representative (with the permission of the adult in need of protection and where it is safe and appropriate to do so).
- Reach agreement about feedback arrangements, in accordance with the adult in need of protections best interests, if they do not have mental capacity and do not attend the review. This feedback should be provided as soon as possible after the review meeting.

15. Stage Six: Closing the Adult Protection Process

The Adult Protection process may be closed at any stage if it is agreed that further investigation is not needed or if the investigation has been completed and a protection plan is agreed and put in place. In most cases a decision to close the Adult Protection process is taken at the case conference or case conference review where the protection plan is reviewed.

The DAPO must reach agreement to close the process with all organisations that have been involved in the investigation and protection plan. Where there is disagreement this should be escalated to the senior managers within the relevant organisations for resolution. The closing process must be signed off by the DAPO and/or a Senior Manager in the case of a serious/complex Adult Protection situation.

15.1 Actions on Closing

The DAPO should ensure that, on conclusion of the process:

- All necessary and agreed actions are completed or are in progress.

- Case records contain all relevant information and forms are satisfactorily completed.
- The person in need of protection knows that the process is concluded and where/who to contact if they have any future concerns about abuse.
- Responsibility for the review of the protection plan transfers to the operational team.
- All those involved with the person are informed about the closure and know how to re-refer if there are renewed or additional concerns.
- Referral is made to appropriate professional and regulatory bodies and/or notifiable occupation schemes where necessary.
- The referrer is notified of completion.
- The necessary monitoring forms and all data monitoring systems are completed.

16. Investigation of Large Scale, Organised or Multiple Abuse Cases

A large-scale adult protection investigation is likely to involve a range of organisations and potentially a number of individual adult protection interventions. Organised or multiple abuse is defined as abuse involving one or more abusers and a number of related or non-related adults at risk. The person alleged to have caused the abuse may be acting with others to abuse adults at risk, may be acting in isolation, or may be using an institutional framework or position of authority to access adults at risk of abuse.

Such abuse occurs both as part of a network of abuse across a family or community and within institutions such as residential or nursing homes, supported living facilities, day support settings and in other provisions such as voluntary or community groups. There may also be cases of adults at risk being abused through the use of the internet. Such abuse is profoundly traumatic for the adults at risk who become involved; its investigation is time-consuming and demanding work which requires specialist skills from PSNI and HSC Trust staff.

Each investigation of organised or multiple abuse will be different, according to the

characteristics of each situation and the scale and complexity of the investigation. Some investigations become extremely complex because of the number of people or places involved and the timescale over which the abuse is alleged to have occurred. However, every investigation will require careful and thorough planning, effective inter-agency working and attention to the needs of the adult(s) in need of protection and the adult(s) at risk involved.

On receipt of information which may indicate organised or multiple abuses, the HSC Trust Gateway Service DAPO must immediately consider whether a report to the PSNI is appropriate, initiate a joint strategy meeting and, **if it is considered necessary,** establish a Strategy Management Group (SMG) to oversee the process of investigation. Core members of an SMG are:

- PSNI;
- HSC Trust DAPO;
- a senior manager from the relevant HSC Trust adult Programme of Care; and
- RQIA (where the allegation relates to a regulated service).

Appropriate legal advice will be necessary and should be sought through PSNI and HSC Trust legal advisers.

16.1 Functions of the Strategic Management Group

The SMG will:

- Establish the principles and practice of the investigation and ensure regular review of progress against that plan;
- Prioritise and allocate expedient resources to establish an Investigative Team within their respective agencies;
- Ensure co-ordination between the key agencies and the Investigative Team within the HSC Trusts and PSNI. This includes resolving any interagency operational interface challenges between various established processes;
- Ensure decisions of the strategy planning group are actioned in a timely manner;

- Act in a consultative capacity to those professionals who are involved in the investigation;
- Draw up a media strategy to respond to public interest issues and agree who will take responsibility for responding to media enquiries;
- Have oversight of the agreed communication strategy/liaison with adults in need of protection/families and carers involved in the investigation;
- At the conclusion of the investigation, discuss salient features of the investigation with a view to making recommendations for improvements either in policy or in practice;
- The closing process must be signed off by the SMG in the case of a serious/complex Adult Protection situation.

16.2 Working Across Trust Boundaries

It should be recognised that there may be an increased risk to the adult in need of protection whose care arrangements are complicated by cross boundary considerations. These situations may arise in residential, nursing or hospital placements where funding or commissioning responsibility lies with one HSC Trust (Placing), but the concerns about potential harm or exploitation subsequently arise in another Trust area (Host).

The scenarios most likely to arise in cross boundary adult protection investigations are:

Scenario A: where allegations relate to one individual only, in which case the responsible Placing HSC Trust undertakes the investigation and informs the Host HSC Trust of the concerns and outcomes for information and any necessary relevant contractual actions.

Scenario B: If, during the course of the investigation, there are emerging concerns about systemic practice potentially leading to harm for other residents, the Placing Trust must notify the Host Trust. The Host Trust must assume responsibility by convening a strategy meeting with a view to extending the investigation.

Scenario C: If an incident arises within an acute hospital it is the responsibility of the DAPO within that acute setting to respond by taking any necessary immediate actions and referring to the Trust of residence as appropriate. If the disclosure

relates to an incident prior to admission, the DAPO will link with the resident Trust to respond as appropriate.

16.3 Responsibilities of the Host Trust

The Host Trust will always take the initial lead on responding to a referral. This will include taking any necessary immediate action to protect the adult/s in need of protection, and where appropriate, making initial contact with the PSNI. Where there are concerns regarding more than one adult in need of protection the HSC Trust where the harm occurs will have overall responsibility for co-ordinating the adult protection investigation.

In all cases, it is vital that, when a referral is received, there is open communication between Host and Placing Trusts to ensure that:-

- Any immediate risks are identified and acted upon;
- There is a single, timely response to the referrer;
- Strategy discussions to co-ordinate the investigation are commenced without delay; and
- The individual's on-going case management needs are addressed.

The Host Trust will also co-ordinate initial information gathering, including systems checks to determine services that have been or are involved and ensures prompt notification to any other relevant agencies.

It is the responsibility of the Host Trust to identify all adults at risk within a regulated facility or service who may have been victims of the person alleged to have caused the abuse and to notify the Placing Trusts, or where the adult at risk's usual place of residence is outside Northern Ireland, the relevant Local Authority in Great Britain or the Health Service Executive in the Republic of Ireland. This includes those adults at risk not known to any HSC Trust.

In those instances where Joint Protocol/ABE social work interviewers are required these will be provided by the Placing Trust or by agreement with the Host Trust.

16.4 Responsibilities of the Placing Trust

- Attend any Strategy Meeting(s).
- Identify the Investigating Officer who will be part of the wider investigation team.
- Provide any necessary support and information to the Host Trust in order for a prompt and thorough investigation to take place.
- Exercise a continuing duty of care to the adult at risk/in need of protection.
- Inform families of investigation and ensure ongoing communication as agreed throughout.
- Devise and implement an Individual Protection plan.
- Act on the case conference recommendations.

Appendices

Appendix 1

References

Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy.
Department of Justice (2012)

Adult Safeguarding: Prevention and Protection in Partnership
Department of Health Social Services and Public Safety and Department of Justice (2015)

Northern Ireland Adult Safeguarding Partnership Training Framework
NIASP (2016)

Stopping Domestic and Sexual Violence and Abuse in Northern Ireland: A Seven Year Strategy
Department of Health and Department of Justice (2016)

Protocol for Joint Investigation of Adult Safeguarding Cases
NIASP (2016)

Appendix 2

Glossary of Terms

Abuse is 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights'. Abuse is the misuse of power and control that one person has over another. It can involve direct and indirect contact and can include online abuse.

ABE (Achieving Best Evidence) Interviewer – The Specialist Achieving Best Evidence Interviewer must be a professionally qualified Social Worker. The Specialist Interviewer will be responsible for planning and conducting interviews with service users who may have been the victim of a crime. These interviews will be undertaken jointly with the PSNI and in accordance with the guidance laid out in "Protocol for Joint Investigation of Adult Safeguarding cases" and "Achieving Best Evidence in Criminal Proceedings."

Adult Protection Gateway Service – is the central referral point within the HSC Trust for all concerns about an adult who is, or may be, at risk.

Adult Safeguarding - encompasses both activity which **prevents** harm from occurring in the first place and activity which **protects** adults at risk where harm has occurred or is likely to occur without intervention.

Adult at risk of harm – A person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

i) **personal characteristics** (*may include but are not limited to age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain*);

and/or

ii) **life circumstances** *(may include, but are not limited to, isolation, socio-economic factors and environmental living conditions).*

Adult in need of protection - An adult at risk of harm (above):

i) who is **unable to protect** their own well-being, property, assets, rights or other interests;

and

ii) where the **action or inaction of another person or persons** is causing, or is likely to cause, him/her to be harmed.

ASC (Adult Safeguarding Champion) - The ASC should be within a senior position within the organisation and should be suitably skilled and experienced to carry out the role. The ASC provides strategic and operational leadership and oversight in relation to adult safeguarding for an organisation or group and is responsible for implementing its adult safeguarding policy statement. The ASC is also the main point of contact with HSC Trusts and the PSNI for all adult safeguarding matters.

Case Conference - The purpose of the case conference is to evaluate the available evidence and to determine an outcome based on balance of probability.

CRU (Central Referral Unit) – The central point of referral to PSNI in relation to adult protection is based in Belfast.

CJINI (Criminal Justice Inspection Northern Ireland) - an independent legal inspectorate with responsibility for inspecting all aspects of the criminal justice system in Northern Ireland apart from the judiciary. It also inspects a number of other agencies and organisations that link into the criminal justice system.

Domestic Abuse - Domestic violence and abuse is threatening behaviour, violence or abuse (psychological, physical, verbal, sexual, financial or emotional) inflicted on one person by another where they are or have been intimate partners or family members, irrespective of gender or sexual orientation. Domestic violence and abuse is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person over another. It is usually frequent and persistent. It can include violence by a son, daughter, mother, father, husband, wife, life partner or any other person who has a close relationship with the victim. It occurs right across society, regardless of age, gender, race, ethnic or religious group, sexual orientation, wealth, disability or geography.

Designated Adult Protection Officer (DAPO) – the person responsible for the management of each referral received by a HSC Trust. DAPOs will be in place both within the Adult Protection Gateway Service and within core service teams. The DAPO will provide formal/informal support and debriefing to the Investigating Officer/ABE interviewer; analyse the adult safeguarding data within their service area and contribute to the governance arrangements as appropriate; and ensure that the connections are made with related interagency mechanisms.

DBS (Disclosure and Barring Service) - helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

Exploitation - the deliberate maltreatment, manipulation or abuse of power and control over another person; to take advantage of another person or situation usually, but not always, for personal gain from using them as a commodity . It may manifest itself in many forms including slavery, servitude, forced or compulsory labour, domestic violence and abuse, sexual violence and abuse, or human trafficking.

FGC (Family Group Conferencing) - A family group conference is a process led by family members to plan and make decisions for a person who is at risk. People are normally involved in their own family group conference, although often with support from an advocate. It is a voluntary process and families cannot be forced to have a family group conference.

Hate Crime - hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity.

Harm - the impact on the victim of abuse, exploitation or neglect. It is the result of any action whether by commission or omission, deliberate, or as the result of a lack of knowledge or awareness which may result in the impairment of physical, intellectual, emotional, or mental health or well-being.

Investigation Officer (IO) - is a HSC Trust professionally qualified practitioner. Their role is to establish matters of fact, how best to protect the adult in need of protection and/or others, to explore alternatives available and to provide advice and support. The Investigating Officer alongside relevant professionals will be responsible for direct contact with the adult in need of protection, their carers and relevant others.

The Protocol – (Protocol for Joint Investigation of Adult Safeguarding Cases) - - the Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.

LASP (Local Adult Safeguarding Partnerships) - the five local multi-agency, multi-disciplinary partnerships located within their respective HSC Trusts.

MARAC (Multi Agency risk Assessment Conference) - it is a forum for local agencies to meet with the aim of sharing information about the highest risk cases of domestic violence and abuse and to agree a safety plan around victims.

Modern Slavery - human trafficking involves the acquisition and movement of people by improper means, such as force, threat or deception, for the purposes of exploiting them. It can take many forms, such as domestic servitude, forced criminality, forced labour, sexual exploitation and organ harvesting. Victims of human trafficking can come from all walks of life; they can be male or female, children or adults, and they may come from migrant or indigenous communities.

NIASP (Northern Ireland Adult Safeguarding Partnership) – the regional multi-agency, multi-disciplinary partnership that brings together representatives from organisations and communities of interest who have a significant contribution to make to adult safeguarding.

NISCC (Northern Ireland Social Care Council) – is the independent regulatory body for the NISC workforce, established to increase public protection by improving and regulating standards of training and practice for social care workers.

NMC (Nursing and Midwifery Council) – is the independent regulator for nurses and midwives in England, Wales, Scotland and Northern Ireland. NMC sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers.

Protection Plan – a plan agreed with the adult at risk (or the person representing them or their best interests) detailing the actions to be taken, with timescales and responsibilities, to support and protect the person from harm.

Registered Intermediary - RIs have a range of responsibilities intended to help adult witnesses who are in need of protection, defendants and criminal justice practitioners at every stage of the criminal process, from investigation to trial.

RQIA (Regulation and Quality Improvement Authority) - Northern Ireland's independent health and social care regulator, responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

SAI (Serious Adverse Incident) - an adverse incident is an event which causes, or has the potential to cause, unexpected or unwanted effects that will involve the safety of patients, staff, users and other people.

Serious Harm – is a professional decision considering the impact, extent, degree, duration and frequency of harm; the perception of the person and their preferred outcome.

Single Agency Investigation – a single agency adult protection investigation is a **professional assessment** which analyses the risk of harm and serious harm, the impact of that harm on the adult in need and determines if this may have led to abuse. Such assessment requires experienced professional judgement to ensure outcomes are proportionate, necessary and lawful.

Special Measures - the measures specified in the Criminal Evidence (NI) Order 1999, as amended, which may be ordered in respect of some or all categories of eligible witnesses by means of a special measures direction. The special measures are the use of screens; the giving of evidence by live link; the giving of evidence in private; the removal of wigs and gowns; the showing of video recorded evidence in chief, and aids to communication.

SMG (Strategic Management Group) – has responsibility to oversee the process of investigation. Core representatives of SMG are: PSNI; HSC Trust nominated Adult protection Gateway DAPO; a senior manager from the relevant adult programme of care; and RQIA (where the allegation relates to a regulated service).

Strategy Meeting - In complex situations the strategy discussion is normally a meeting of key people to decide the process to be followed after considering the initial available facts.

Appendix 3

HSC Trust Adult Safeguarding Contact Details

HSC Trust	Adult Safeguarding Number
Belfast	028 9504 1744
Northern	028 2563 5512
Western	028 7161 1366
South Eastern	028 9250 1227
Southern	028 3741 2015/2354

Regional Emergency Social Work Service (RESWS)

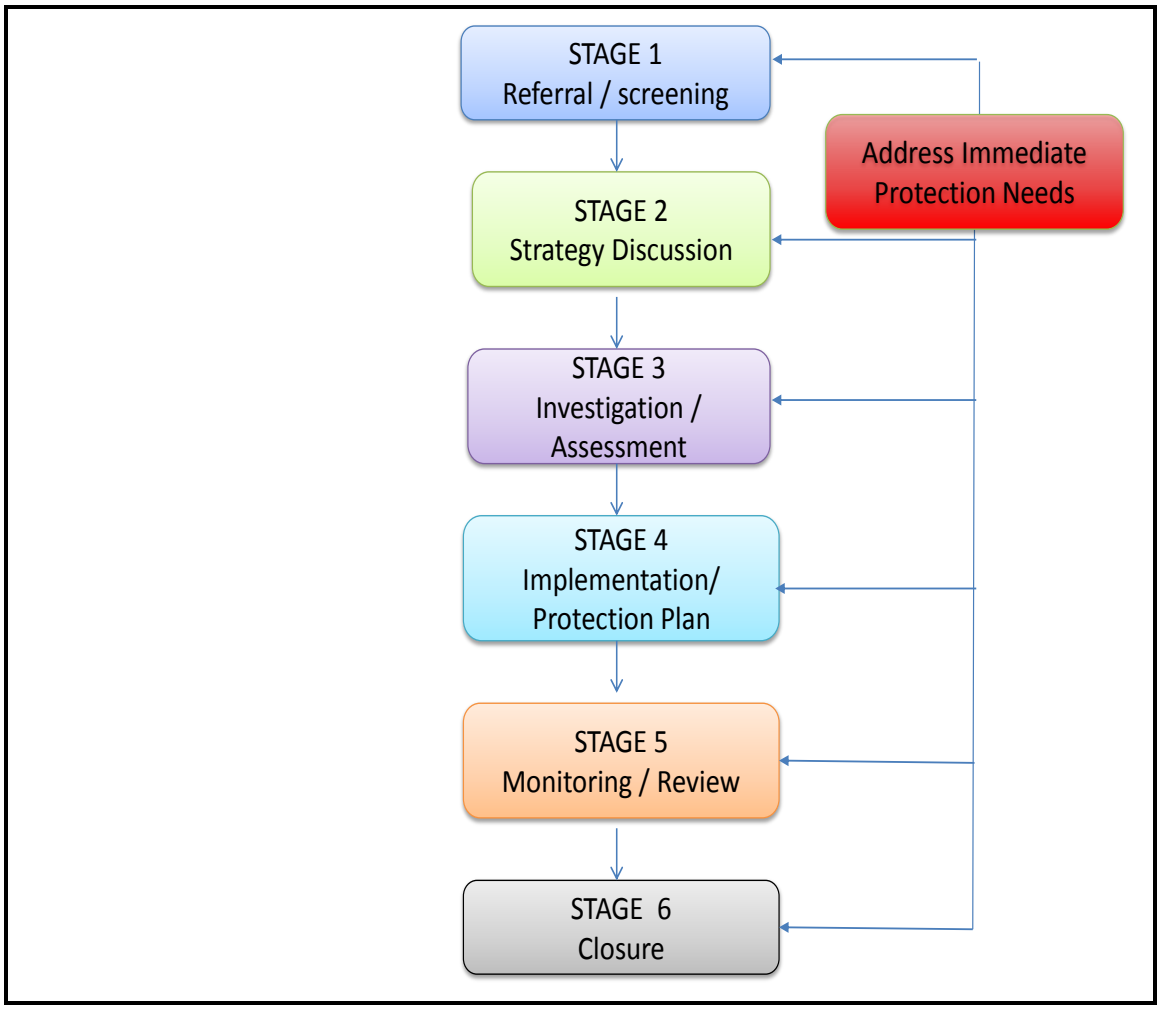
Tel: 028 9504 9999 (Mon-Fri 5pm-9am; Saturday & Sunday)

HSC Trust Child Protection Contact Details

HSC Trust	Child Protection Gateway Number
Belfast	028 9050 7000
Northern	0300 1234 333
Western	028 7131 4090
South Eastern	0300 1000 300
Southern	0800 7837 745

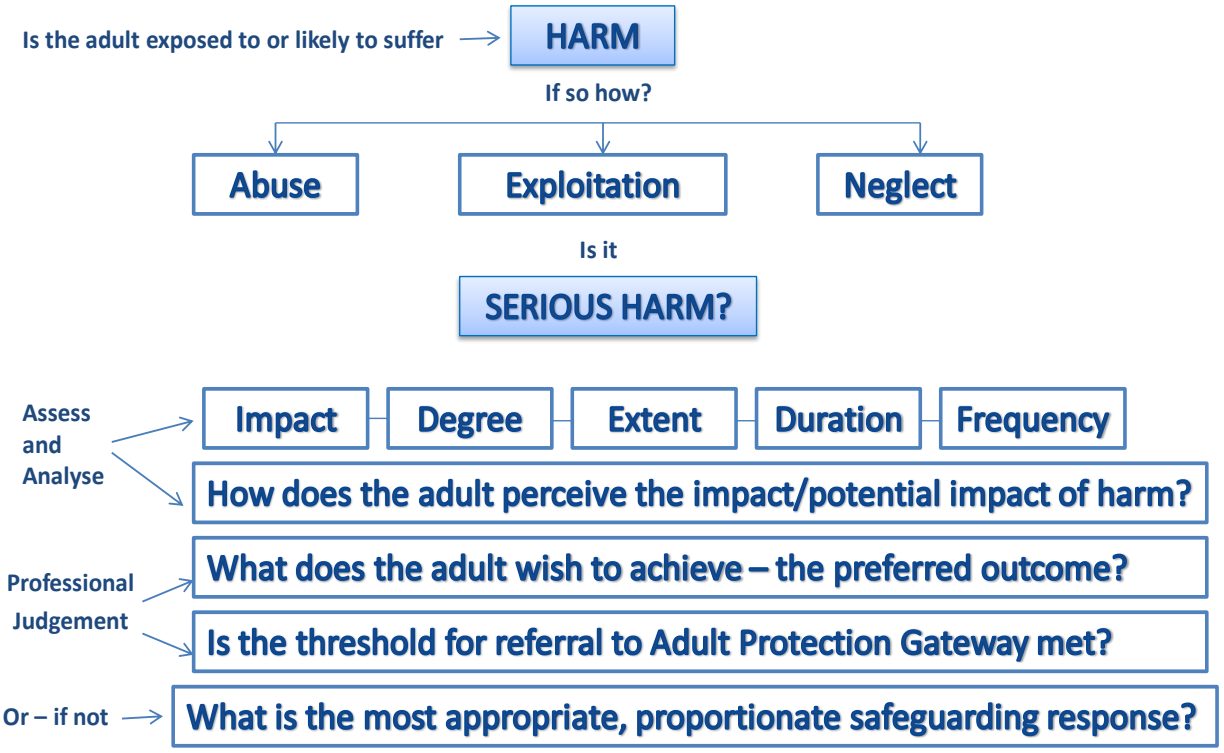
Appendix 4

Six Stages of Adult Protection Process



Appendix 5

Factors for Consideration in Determining whether Harm has become Serious Harm



Appendix 6

Possible Outcomes

Possible Outcomes for the adult in need of protection	
Protection Plan	**Actions**
Increased monitoring	Referral to advocacy service
Removal from property	Referral to counselling services
Application to the Office of Care and Protection	Assessment/support/advice/services
Application to change Appointee-ship	Referral to MARAC
Referral under the "Family Homes and Domestic Violence (Northern Ireland) Order 1998" re use of non-molestation or Occupancy Order	Seek legal advice regarding use of "The Mental Health (Northern Ireland) Order 1986" Guardianship; or application to the High Court for a Declaration of Best Interests
Review of Self-directed Support/Direct Payments	

Possible outcomes for the person alleged to have caused the harm	
Protection Plan	**Actions**
Referral under Joint Protocol Procedures	Assessment/support, advice, services
Removal from property	Continued monitoring
Management of access to adult in need of protection	Counselling/training
Action by RQIA	Disciplinary action
Action by contract compliance	Referral to a regulatory/Professional body/ISA
	Referral to court-mandated treatment
	Referral to PPANI
	Action under “The Mental Health (Northern Ireland) Order 1986”

Appendix 7

HSC Trust Risk Assessment

When any risk of harm is identified, a risk assessment must be undertaken to establish the degree of risk of harm to that individual and to others. It is the responsibility of suitably qualified statutory HSC professionals to undertake such risk assessments once a concern has been raised. In certain circumstances HSC Trusts may ask another organisation to conduct risk assessments on its behalf. The decision regarding the most appropriate professional to undertake the assessment will be determined by the nature of the need/risk identified, for example where the concern relates to pressure ulcers the most appropriate professional to assess and respond is likely to be from nursing and/or tissue viability.

HSC professionals are required to put the individual's needs and wishes at the heart of the risk assessment process, and to use their expert skills and professional judgement so that the most appropriate and preferred course of action or outcome is found for each individual.

Assessment is a process which focuses on the individual and their circumstances at the time, recognising that needs and risks can change over time. Assessment will analyse and be sensitive to the changing levels of need and risk faced by an individual. It may require specialist assessments or expert opinion to inform the evidence gathering. All information should be analysed to determine the nature and level of risk. The assessment will inform a proportionate response based on the views and wishes and the preferred outcomes of the individual.

In gathering information to inform the assessment, professionals should be aware that this may also be required as part of a criminal investigation. Therefore it is critical to ensure that any potential evidence that may be later required by the PSNI is not compromised.

In making professional judgements, due regard should be given to the capacity of the adult to make informed choices, free from duress, pressure or undue influence and their capacity to make decisions to protect themselves from harm. All adults, including those at risk will always be assumed to have capacity to make decisions unless it has been determined otherwise and, ideally, a referral to the HSC Trust

should be made with the adult's agreement and full participation. However, there may be circumstances in which the person concerned about an adult at risk may not be best placed to seek their consent to a referral being made, or the adult at risk is clearly stating that they do not want a referral to be made. Whilst the wishes of the adult should always be the paramount consideration, it is important to remember that there will be circumstances when other factors may be overriding, for example, where undue influence or coercion is suspected to have influenced the adult's decision or other people may be at risk. The inability to obtain an adult's consent in these circumstances should not prevent or delay concerns about that adult being reported to adult protection services. A balance must also be struck between an individual's human rights and the need to intervene to protect them from harming themselves or others.

The analysis of risk will be central to decisions about future intervention. Any safeguarding intervention is not about being risk averse, nor simply about eliminating risk; adult safeguarding is about empowering and supporting people to make decisions that balance acceptable levels of risk in their lives. This may mean that individuals choose to live with risks or to take risks. The exercise of professional judgement in determining the level of risk of harm and whether a referral for an adult protection intervention is required is critical.

Where professionals have contact with an adult at risk they may have opportunities to identify risk of harm. Within the HSC sector this may be for example a GP, District Nurse, Social Worker or another Allied Health Professional, or may be within acute or hospital settings. Professionals must be alert to signs of harm and having carried out a professional assessment they should escalate their concerns to the Adult Protection Gateway Service with the local HSC Trust.

Consideration must also be given to the vulnerability of the person who is alleged to have caused harm. It is possible that a risk assessment may also be required for the person who is alleged to have caused harm.

Appendix8

Adult Protection Regional Documentation

APP1 FORM

REGIONAL ADULT PROTECTION PROCEDURES

APP1(a) REFERRAL / SCREENING INFORMATION

For completion by HSC staff and contracted providers

PLEASE ENSURE SECTIONS 1 & 2 ARE FULLY COMPLETED BEFORE REFERRAL TO TRUST DAPO

Name:	Date of Birth: *(if not known, please give approximate age)*	Date of Referral:
Address: Postcode:	Gender: M ☐ F ☐	Service/Client Group:
Telephone No:	Is the person known to the Trust? Yes ☐ No ☐	Reference No:

SECTION ONE

Section 1 – completed by Referrer

Source Of Referral			
☐ Carer	☐ Other Trust	☐ RQIA	☐ Regulated Care Home
☐ GP	☐ Other Health Professional	☐ Adult Mental Health Unit	☐ Other Regulated Facility *Specify*
☐ Hospital Staff	☐ Anonymous	☐ Self	☐ Learning Disability Hospital
☐ PSNI	☐ Social Worker	☐ MARAC	☐ Other *Specify*
☐ DHSS	☐ Care Manager/Care or Homecare Worker	☐ Adult Safeguarding Champion	
☐ Vol. Organisation	☐ Housing Association	☐ Acute General Hospital	

Details Of Referrer (*the person who brings the concerns to the attention of your agency*)	
Name:	Relationship to adult at risk of harm:
Job title and agency:	Contact number:

Who Was The First Person To Note Concern		
Name:	Relationship to adult at risk of harm:	Contact number:

APP1 FORM

Key Contacts			
	Name	Address	Contact number:
Key Worker			
Care Manager			
G.P			
Family/Carer			
Significant other			
Other			

What Is The Main Form Of Suspected, Admitted Or Known Abuse?			
☐ Physical	☐ Sexual	☐ Institutional Abuse	☐ Human Trafficking
☐ Financial	☐ Neglect	☐ Psychological	☐ Domestic Violence
☐ Discrimination	☐ Exploitation		

Incident Report

Background Information: *(To include factors precipitating referral, home circumstances, support available, including issues of capacity)*

Incident Report – Location / Date / Time of Incident *(Please give exact details of what has been reported and if appropriate include names of any witnesses and note injuries on the attached body chart)*

Details Of Any Witnesses

Name: **Name:**

Address: **Address:**

Contact No: **Contact No:**

APP1 FORM

Describe The Impact Of The Incident On the Adult At Risk of Harm

The Adult At Risk of Harm Usual Living Arrangements

Does the adult at risk of harm live alone? ☐ Yes ☐ No

Does the person who is suspected to have caused harm live with the adult at risk of harm? ☐ Yes ☐ No

Is the adult at risk of harm present location different from home address? ☐ Yes ☐ No *If Yes give present location*

Have You Taken Any Action Due To Emergency Situation To Avoid Immediate Serious Risk?

Was immediate protection needed for adult at risk of harm? ☐ Yes ☐ No

If Yes give details:

Are there any children or other adults at risk? ☐ Yes ☐ No

If Yes give details:

Was immediate protection required? ☐ Yes ☐ No

If Yes give details:

Adult At Risk of Harm's Knowledge Of Referral

Does the adult at risk of harm know that a referral may be made? ☐ Yes ☐ No

Is the adult at risk of harm able to give informed consent? ☐ Yes ☐ No ☐ N/K

Has the adult at risk of harm consented to a referral? ☐ Yes ☐ No

APP1 FORM

Details of Person/Persons Suspected of Causing Harm		
Name:	Date of Birth:	☐M ☐F
Address:		

Does the person/persons suspected of causing harm know that an allegation has been made against them? ☐ Yes ☐ No ☐ N/K

Is the person/persons suspected of causing harm known to the adult at risk of harm? ☐ Yes ☐ No ☐ N/K

If yes please specify below:

☐ Family member ☐ Another service user ☐ Paid carer ☐ Trust employee

☐ Other *(specify)*

Any Additional Information Relevant To The Referral
(Please note the views of others you have consulted and note any difference of opinion)

Signature:	Date:

APP1 FORM

SECTION TWO

Completed by Appointed Person

Have 'Alerts' been checked to establish if previous APP1s are recorded? ☐ Yes ☐ No ☐ N/K

Have previous APP1 alerts been recorded? ☐ Yes ☐ No ☐ N/K

If yes give summary of previous APP1s

Actions Agreed By Appointed Other

Further information required prior to a decision being made and If yes, What information is required and who will action ☐ Yes ☐ No

Answer EITHER

(a. HSC Trust Line managers)

Consultation with core team DAPO re adult at risk of harm ☐ Yes ☐ No

OR

(a. Adult Safeguarding Champion managers)

Consultation with key worker if known / or Adult Protection Gateway service re adult at risk of harm ☐ Yes ☐ No

Referral of Adult in need of protection to Trust Adult Protection Gateway Services ☐ Yes ☐ No

No further action under Adult Protection Procedures ☐ Yes ☐ No

Is there a need to refer to or notify?

☐ Professional Community Assessment ☐ Quality Assurance Team ☐ Care Management

☐ Contracts ☐ Human Resources ☐ Adverse incident reporting ☐ RQIA ☐ PSNI

Is there a need to consider any immediate Human Rights issues? ☐ Yes ☐ No

(Please refer to drop down of Convention Human Rights or manual form)

Details of Decision Making

This should prioritise issues of Risk/ Harm/ Possible Criminal Offence

Signature:	**Date:**

APP1(b) - Initial Screening by Trust Adult Protection Service

SECTION THREE

- *Section 3 – completed by Trust DAPO*

Outcome of Initial Screening and Actions Agreed by DAPO under Adult Protection Procedures	Date:

Details of Decision Making

☐ Referral does not meet criteria for Trust Adult Protection Procedures
☐ Decision pending further information
☐ Referral forwarded to Trust core team for investigation as Adult at Risk of Harm
☐ Referral accepted for Investigation under Adult Protection Procedures
☐ Referral being considered under Joint Protocol

Are there any considerations for allocation of referral?

Has the adult in need of protection any preferences relating to who should carry out the investigation? *(e.g. gender)* ☐ Yes ☐ No ☐ N/K
If Yes, please specify

Has the adult in need of protection any special requirements? ☐ Yes ☐ No ☐ N/K
If Yes, please specify

Are there issues of safety for the worker? ☐ Yes ☐ No ☐ N/K
If Yes, state what safeguards are in place

Will the service user (adult in need of protection) be visited on the same day as referral received? ☐ Yes ☐ No
If no, state reasons

APP1 FORM

Details of Decision Making

Is immediate action required to protect the adult in need of protection?

Urgent medical attention required?	☐ Yes	☐ No
Additional care resources or staff required?	☐ Yes	☐ No
Protection or respite admission required?	☐ Yes	☐ No
Any other action required	☐ Yes	☐ No

Details of decision making:

Is there a possible criminal offence? ☐ Yes ☐ No ☐ N/K

Is there a need to preserve possible forensic evidence? ☐ Yes ☐ No

Is there a need for immediate report to the PSNI? ☐ Yes ☐ No

Is Joint Agency Consultation required? ☐ Yes ☐ No ☐ Pending more information

If Yes, please complete AJP1

Outcome of Report to PSNI / Joint Agency Consultation: *(Lead agency to record all decisions on AJP documentation)*

PSNI lead Investigation	☐ Yes	☐ No
Trust Lead Investigation	☐ Yes	☐ No
Joint Protocol Investigation	☐ Yes	☐ No
PIA required	☐ Yes	☐ No
ABE interview required	☐ Yes	☐ No ☐ N/K

APP1 FORM

Are the criteria met for Not-Reporting to PSNI? ☐ Yes ☐ No

If criteria are met for Not-Reporting complete section below:

In making the decision NOT to report to the PSNI please ensure that all criteria have been met. (ALL boxes must be ticked):

☐ The victim has capacity to make an informed decision and does not want to make a complaint to PSNI / or the victim does not have sufficient capacity and the next of kin does not wish to make a complaint on their behalf
(Refer to Joint Protocol Appendix 7 Consent/Capacity/Human Rights)

and

☐ The Trust is not required by law to make a referral to PSNI
If the incident does not meet the threshold of relevant offence under section 5 of the Criminal Law Act (NI) 1967
(Refer to Joint Protocol Appendix 2 Definition of Relevant Offence)

and

☐ It is a minor incident
A comprehensive assessment of all the factors must be taken into consideration
(Refer to Joint Protocol Appendix 8 Factors to be considered in the assessment of the seriousness of Harm and Risk of Harm)

and

☐ The situation is being managed through an Adult Protection process and/or there are other protective measures in place

Are there any Human Rights issues? ☐ Yes ☐ No
(Please refer to drop down of Convention Human Rights or manual form)

Do the RQIA need to be informed? ☐ Yes ☐ No ☐ N/K
If yes:-

Name of Inspector: **Date:**

Does the Trust need legal advice? ☐ Yes ☐ No ☐ N/K

Date of Contact:

APP1 FORM

Are there any other potential DAPOs to be consulted? ☐ Yes ☐ No ☐ N/K
If Yes give details:

Details Of DAPOS:

Name:	**Name:**	**Name:**
Trust:	**Trust**	**Trust:**
Service Area:	**Service Area :**	**Service Area:**
Contact No:	**Contact No:**	**Contact No:**

Has a discussion taken place? ☐ Yes ☐ No

If Yes record any joint working and feedback arrangements agreed between Managers/DAPOs (NB: This is critical when there is more than one Service area or one Trust involved).
Details of discussion:

Signature of DAPO:	**Date:**

HSC

APP1 FORM

Trust Adult Protection Investigation Commenced	Date:

Referral allocated to:

DAPO: Contact No:

Investigating Officer: Contact No:

Allocated By: Date:

SOSCARE ADMIN BOX: SCREENING DECISION	DO DECISION AS PER CODES
MULTIPLE INCIDENT	
NO OF CLIENTS INVOLVED	
ALLEGED ABUSE	
STAFF INVOLVED	
ADULT PROTECTION PLAN INITIATED	
DATE AP PLAN INITIATED	
LEGAL STATUS OF CLIENT	
DATE OF JOINT AGENCY CONSULTATION	
OUTCOME OF JA CONSULTATION	
DATE SCREENING COMPLETED	
REASON SCREENING COMPLETED	

ADULT PROTECTION PROCEDURES

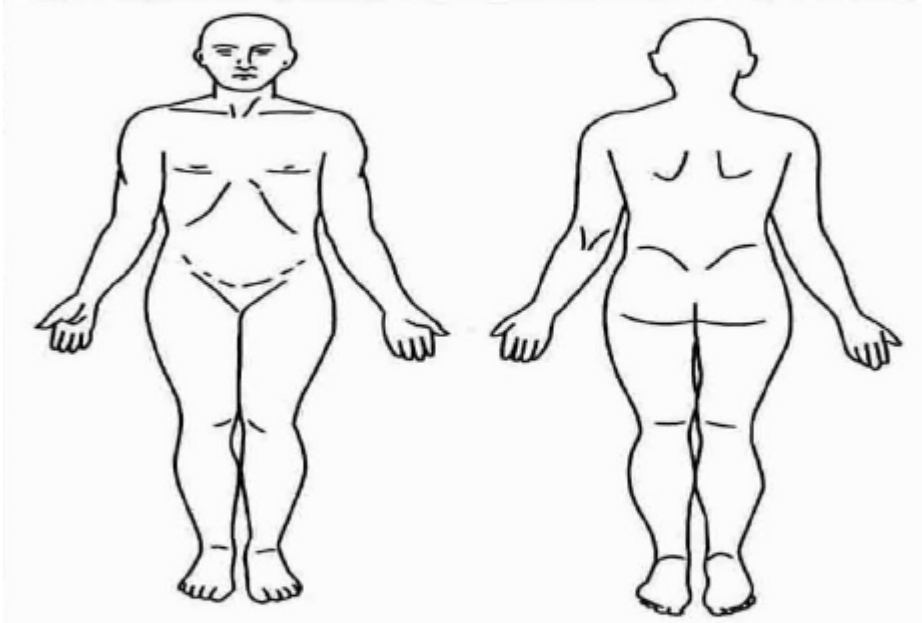
REFERRAL FORM – BODY MAP

Name: _____ **Date of birth:** _____

Health & Social Care Number *(if known)* _____

APP1(a) Body Map is to be used in conjunction with the APP1Referral form by practitioners to record the location, size and number of injuries which may have been caused as a result of abuse or inappropriate care. Where used, the completed APP1(a) Body Map should be submitted with the APP1 Referral form.

Please mark with numbers drawn on the body map in black ink to indicate the different injuries, and provide brief details for each injury, e.g. measurements of wound, colour of bruise, etc using arrows (a ruler is provided to assist with measurement):



No	Site	Size	Bruise/cut/burn/ pressure ulcer/other	Colour	Comments
1					
2					
3					
4					
5					
6					

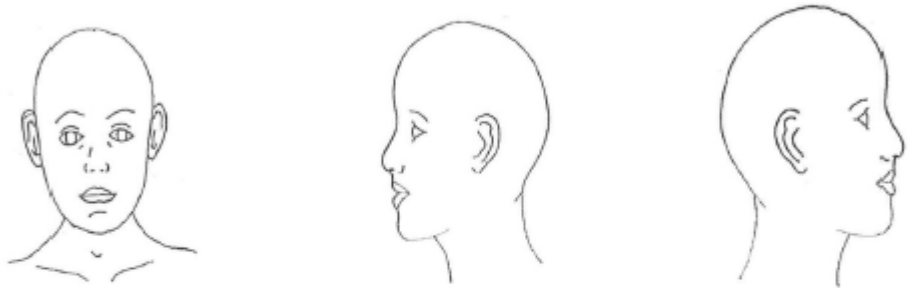
HSC

APP1 BODY MAP

Body Map notes:

Note any other details, such as anything the vulnerable adult discloses on examination (verbatim), or information received from any other source regarding injuries.

Front & Side Views – Head



Number	Site	Size	Bruise/cut/burn/ pressure ulcer/other	Colour	Comments

Timing of Injury:	
Date when the Injury happened (*if Known*)	
Date Injuries above were first observed (*if this is different to the original date*)	

Completed By:	
Printed Name/designation of person completing Body Map form	
Signature of personal completing Body Map form	
Contact details of person completing Body Map Form	
Date/time of completion	

(NB. When used, completed APP1 Body Map form should be attached to completed APP1 Referral form)

APP2

REGIONAL ADULT PROTECTION PROCEDURES

ACKNOWLEDGEMENT OF REFERRAL

To be completed by the DAPO and returned to Referrer within 2 days

NAME:	ADDRESS:	DATE OF BIRTH:
	TELEPHONE NO:	DATE OF REFERRAL:

OUTCOME OF REFERRAL RECEIVED

Referral not appropriate for Adult Protection Investigation ☐

Adult Protection Investigation commenced ☐

Name of Designated Adult Protection Officer

Contact telephone number

Contact email address

Name of Investigating Officer (if appointed at this stage)

Address

Contact telephone number

SIGNATURE OF DAPO

DATE ☐

APP3

REGIONAL ADULT PROTECTION PROCEDURES

RISK ASSESSMENT AND MANAGEMENT

Introduction

This risk assessment and management tool should be used when a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal characteristics and/or life circumstances **AND** who is unable to protect their own wellbeing, property, assets, rights or other interest **AND** where the action or inaction of another person or persons is causing or is likely to cause him/her to be harmed. The assessment should be used to inform and support but not replace professional decision making.

Risk assessment and management planning should include key individuals that can contribute to the assessment of risk and/or the management response. This may necessitate the investigating officer commissioning specific risk assessments from relevant others which will be included in the overall risk assessment. Wherever possible this should always include the person who is at risk and in need of protection. If they decline to be involved or it is not appropriate for them to contribute, their views, as far as possible, should be included and feedback provided. If for reasons of mental capacity the person is unable to make decisions about their safety and welfare, it may be necessary to consider opinions from others who can represent them such as family, friends or an independent advocate.

List all risks that require to be considered. These are the risks that are or may leave the person open to harm through abuse, exploitation or neglect. There may be other risks that are managed effectively and therefore do not need to be included in this assessment. Sometimes the concerns emerge because of the persons at risk not accepting or engaging about the risks they are facing. If this is the case, seek to understand the reasons for this and how support can be offered in a manner acceptable to them.

The nature and degree of risk may change, over time, for a variety of reasons. It should not be assumed that the risk management plan will always remain necessary but it should at all times be proportionate, tailored and mindful of the Human rights of the person at risk and others as appropriate.

APP3

REGIONAL ADULT PROTECTION PROCEDURES

RISK ASSESSMENT AND MANAGEMENT

(To be completed by INVESTIGATING OFFICER)

SECTION 1

NAME:	**ADDRESS:** **POSTCODE:**	**DATE OF BIRTH:**
REFERENCE NUMBER:	**TEL NO.**	**GENDER:** M ☐ F ☐

NAME OF WORKER (S) AND JOB TITLE COMPLETING THE RISK TOOL & THOSE CONTRIBUTING TO THE ASSESSMENT

Background: *(are there factors that may mean the person is more at risk of harm from others due to personal characteristics and / or life circumstances and is unable to protect themselves. Include existing strengths and protection factors precipitating referral, home circumstances, support available, high levels of carer stress or summary / outcome of previous investigations)*

Wishes of adult in need of protection: *(is the person aware of alleged abuse? If so what is their perception of the impact/potential impact of harm? Do they understand the risks around the situation they are in? What do they see as the benefits for them in taking the risk? What protective steps do they wish to consider? Do they want to remain in their current environment? Do they wish to involve police?)*

Capacity / consent to issues under investigation: *(Please include statement as to consent of adult in need of protection for information about risks to be shared; relevant reports / opinions and bear in mind how client's capacity might be enhanced, are the views of others required?)*

HSC

APP3

Section 2. Please complete separately for each risk identified	
Current Risk of abuse / harm identified.	**Specific evidence of risk of abuse / harm**
What has been the impact of the harm on the adult's independence, health, general wellbeing?	**Specific evidence demonstrating impact**
Assess evidence demonstrating Pattern / frequency of risk of abuse / harm for each identified risk. ***(consider repeated acts of omission / neglect that compromise safety)***	**Outcome** Isolated ☐ Occasional occurrence ☐ Repeated occurrence ☐ Established pattern ☐
Evidence demonstrating probability of reoccurrence or escalation for each identified risk	**Outcome** Unlikely ☐ Likely ☐ Highly probably ☐ Certainty ☐
Assess the Severity of degree, extent and duration of risk of abuse / harm for each identified risk	**Outcome** Serious ☐ Moderately Serious ☐ Very Serious ☐ Extremely serious / Death ☐
Detail evidence which suggests the risk may constitute a potential criminal offence? (include relevant reference to coercion; threatening behaviour; abuse of trust / position)	Specific evidence demonstrating risk
Has there been an impact on other adults at risk / in need of protection or children?	☐ Yes ☐ No (If yes record what appropriate action has been taken to protect?)
Positive factors that minimise each identified risk of abuse / harm	

APP3

Section 3

Human Rights Considerations:

Identify which Human Rights have been considered:
(see attached European Convention guidance and please give details)

Risk analysis summary:

View of Professional

View of adult in need of protection / carer

Explain reasons for any disagreements to the risk assessment and by whom

Completed by: Date:

Adult in need of protection signature Date:

Carer signature Date:

Review Date:

APP4

REGIONAL ADULT PROTECTION PROCEDURES

PROTECTION PLAN

PRIVATE AND STRICTLY CONFIDENTIAL

NOTE:
The contents of these reports are not to be reproduced, copied or divulged.

Information obtained at a case discussion is not to be discussed with or revealed to others without first obtaining written permission from the source of the information.

Any important omissions or inaccuracies in these reports should Be notified to the Chairperson within 7 days: otherwise it Will be assumed that the reports are agreed.

NAME:	DATE CREATED:	DATE OF COMMENCEMENT:	DATE OF REVIEW:

RISK	ASSESSED NEED	INTERVENTION	BY WHOM	REASON FOR NOT TAKING ANY ACTION
1.				
2.				
3.				
4.				
5.				
6.				

APP4

UNMET NEED AND UNRESOLVED ISSUES: *(If there are unmet needs or unresolved issues, identify the alternative services that have been provided)*

ARE ANY OF THE FOLLOWING ACTIONS REQUIRED (tick all appropriate boxes)

- ☐ *REFERRAL TO THE OFFICE OF CARE AND PROTECTION*
- ☐ *ADMISSION TO A CARE FACILITY*
- ☐ *NON-MOLESTATION ORDER*
- ☐ *DASH FORM*
- ☐ *APPLICATION FOR GUARDIANSHIP M.H.O.*
- ☐ *ADMISSION FOR ASSESSMENT M.H.O.*
- ☐ *REFERRAL TO MARAC*
- ☐ *CARER'S ASSESSMENT*

ADULT IN NEED OF PROTECTION / CARER COMMENTS:

WILL THIS CASE BE MONITORED UNDER THE ADULT PROTECTION PROCEDURES ☐ **YES** ☐ **NO**

IF YES, BY WHOM:

WHAT IS THE FREQUENCY OF MONITORING:

WILL THE MONITORING BE MANAGED VIA:

☐ **PROFESSIONAL SUPERVISION** **DATE**

☐ **CASE DISCUSSION/CONFERENCE DATE**

IF NO,

☐ **THE INVESTIGATING OFFICER WILL CONTINUE IN A KEY WORKER ROLE**

☐ **CASE TRANSFERRED TO OTHER KEY WORKER / SERVICE**

(please specify)

☐ **CLOSE CASE UNDER ADULT PROTECTION**

☐ **OTHER (please specify)**

ADULT IN NEED OF PROTECTION'S

SIGNATURE:

DATE:

AND/OR CARER / ADVOCATE /

REPRESENTATIVE'S SIGNATURE:

DATE:

KEY WORKER SIGNATURE:

DATE:

DESIGNATED ADULT PROTECTION OFFICER

SIGNATURE:

DATE:

APP5

REGIONAL ADULT PROTECTION PROCEDURES

STRATEGY / CASE DISCUSSION MINUTES

PRIVATE AND STRICTLY CONFIDENTIAL

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This provides a template to record who attended the meeting, reports submitted and future review arrangements. The DAPO will also include a minute of the essential facts, discussion and decisions taken at the meeting.

NAME:	**ADDRESS:**	**DATE OF BIRTH:**
REFERENCE NO:	**POSTCODE:**	**GENDER:** M ☐ F ☐
VENUE:	**DATE**	
DAPO CHAIR:		

WAS THE SERVICE USER INVITED? YES ☐ NO ☐
WAS THE SERVICE USER IN ATTENDANCE? YES ☐ NO ☐
(if not give details)

OTHERS INVITED (ADVOCATE OR CARER)

NAME IN ATTENDANCE YES ☐ NO ☐
NAME IN ATTENDANCE YES ☐ NO ☐

IF NOT INVITED OR DID NOT ATTEND SPECIFY REASON

APP5

NAME OF THOSE PRESENT	TITLE

LIST OF APOLOGIES RECEIVED

WRITTEN REPORTS SUBMITTED BY:

Free-text Minutes

Prompt: *please evidence due consideration of Human Rights issues through completion of risk assessment.*

INTRODUCTIONS / PURPOSE OF MEETING

- *Synopsis of referral and immediate actions taken to safeguard the individual(s)*

PROFESSIONAL REPORTS

- *Key worker*
- *PSNI*
- *RQIA*
- *Human Resources(if applicable)*
- *Professional*
- *Other reports*

DISCUSSION – *Record of concerns raised and consideration given to the following as appropriate in making multiagency decisions: -*

- *Consent / capacity*
- *Undue influence / coercion*
- *Crime prevention*
- *Human Rights Considerations*
- *Best interests Concept*
- *Proportionate Response*
- *Wishes of the Adult in Need of Protection*
- *Safeguarding of other adults at risk of harm and children*
- *Supports for adult in need of protection and family through investigation process*
- *Employee Relations issues / Contracts Dept. External Providers*

APP5

INVESTIGATION STRATEGY

- *Process of Investigation – single/joint (include detail of methodology – Medical / structured meetings / documentary evidence to be reviewed / Joint Interview)*
- *Appointment of Investigating Officer*
- *Who will conduct interviews / structured meetings / when / with whom*
- *Requirement for ABE Joint Protocol interview*
- *Arrangements for special needs, race, culture, gender, language, communication etc.*

REVISED CARE PLAN *including Actions to be taken / when / by whom*

- *Services, treatment or therapy to be accessed*
- *Modifications in services*

REVIEW OF PROTECTION PLAN (record on ***APP4***)

- *Steps to be taken to ensure future safety, incl. When and by whom.*
- *Support services through the legal process*
- *Updated risk assessment and management including actions to be taken*

OTHER ACTIONS

- *Reporting to other bodies. I.e. RQIA, Professional Regulators, DBS*
- *Reporting back arrangements and communication strategy.*
- *Record of reasons for not proceeding where there is no significant indicator of risk or insufficient evidence to substantiate concern(s)*
- *Decision to terminate protection plan and close involvement on SOSCARE module.*
- *Date for next meeting following completion of the investigation or earlier if required.*

SOSCARE ADMIN BOX: UPDATE VA STRATEGY PLANNING		
1	Date of Meet/Discussion	
2	Type of Contact (Select from coded list)	
3	Location of incident	
4	Alleged Abuse (Select from coded List)	
5	DAPO	
6	Method of Discussion (Select from coded list)	
7	Location of Meeting	
8	Other Staff involved (Soscare number)	
9	Other Agencies (select from coded list)	
10	Initiate/Review APP	(Y ☐ or N ☐)
11	Outcome	
12	Date Next meet/Discussion	
13	Clarification Meeting	
14	Date	
15	Date of Investigation	

APP5

SOSCARE ADMIN BOX: VA CASE DISCUSSION STAGE (Complete for every Discussion/Review)		
4	Other agencies involved (select from coded list)	
5	Category of abuse	
6	Outcome of case discussion (select from coded list)	
7	Has APP been updated?	
8	Date of Next Discussion/Review	
9	Termination date	
10	Reason for termination	

Signed:

Dated:

APP6

ADULT PROTECTION PROCEDURES

SIGNIFICANT SAFEGUARDING MEETING / EVENT REPORT

PRIVATE AND STRICTLY CONFIDENTIAL

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NAME OF ATTENDEE:	**ADDRESS:**
(IF APPLICABLE) **NAME AND POSITION OF PERSON ACCOMPANYING:**	**TEL. NO:**
ALLEGED VICTIM REFERNCE NO:	
NAMES OF INVESTIGATION STAFF:	
DATE:	**TIME:** / **VENUE:**

PURPOSE OF THE MEETING:

(Include Boundaries of Confidentiality; whistleblowing policy & potential use of safeguarding report and information for HR processes as appropriate.)

GENERAL BACKGROUND QUESTIONS:

APP6

SPECIFIC QUESTIONS PERTAINING TO INDIVIDUAL CONTEXT:
(Open ended questions should be relevant to the aspect of care / support being provided and investigated in order to gather the individual's knowledge of the circumstances)

REPORT OF ALLEGED INCIDENT AND COMMENTS FROM THOSE PRESENT:

Summary of Action required:

- To safeguard adults; children or others:
- Is dash form required?
- To forward information to identified and agreed persons.

Signature of investigators **Date**

APP7

ADULT PROTECTION REPORT ON THE INVESTIGATION IN RESPECT OF

DATE:

Designated Adult Protection Officer:

Designation:

Report Authors:

Date report signed off:

PRIVATE AND STRICTLY CONFIDENTIAL

NOTE:
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APP7

EXECUTIVE SUMMARY

LIST THE MEMBERSHIP OF THE INVESTIGATION TEAM. *(IO (s) and DAPO)*

INVESTIGATION TERMS OF REFERENCE (*What have you been asked to do?)*

INVESTIGATION METHODOLOGY *(How were the concerns investigated. Include details of any capacity/consent issues, interviews conducted, documentation reviewed, outcome of JP/PSNI investigations etc.)*

PROVIDE A DESCRIPTION OF INCIDENT/CASE. *(Outline the details of the adult safeguarding concerns including any previous concerns. Include a pen picture of the adult/s in need of protection.)*

APP7

FINDINGS *(This section must include the detail and analysis of the factual evidence identified in the investigation including the source and dates of any meetings where information came to light. Detail must include the weight attributed by the IO to the seriousness of the harm /abuse and the rationale for same. Attach a copy of the risk assessment completed by the IO.)*

CONCLUSIONS *(Were the adult safeguarding allegations substantiated on the balance of probability/not substantiated etc. Include the views of the Adult in Need of Protection and/or their representative.)*

LESSONS LEARNED

RECOMMENDATIONS AND ACTION PLANNING

APP7

DISTRIBUTION LIST

APP8

REGIONAL ADULT PROTECTION PROCEDURES

CLOSURE / TRANSFER SUMMARY MEETING

PRIVATE AND STRICTLY CONFIDENTIAL

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Any important omissions or inaccuracies in these reports should Be notified to the Chairperson within 7 days: otherwise it Will be assumed that the reports are agreed.

NAME:	**ADDRESS:**	**DATE OF BIRTH:**
REFERENCE NO:		**GENDER: M☐ F☐**
DATE OF REFERRAL:	**POSTCODE:**	

Adult Safeguarding investigation completed ☐Yes ☐No

Summary of Investigation outcomes discussed at case discussion:

AGREED ACTION

Case to be transferred ☐Yes ☐No
(if yes complete Sections One and Two)

Case closed ☐Yes *(if yes complete Section One)* ☐No

SECTION ONE (CASE TO BE CLOSED TO ADULT PROTECTION SERVICE)

Reason for Closure?	Investigation complete ☐	Client unwilling to proceed ☐
	Refer other agency ☐	Refer other process ☐

Has anyone expressed a contrary view to transfer/closure? ☐Yes ☐No

(if yes specify)

Has the service user been informed in writing? ☐Yes ☐No

Has the referrer been notified of outcome? ☐Yes ☐No

Have relevant others been informed in writing? ☐Yes ☐No

(if yes specify) (include contracts; HR; RQIA; other professionals)

APP8

SECTION TWO (ONGOING SAFEGUARDING ACTIVITY WITH ADULT AT RISK)

☐ Investigating officer will continue with a key worker role in core team

☐ Transfer to other services
(specify) _____ Date of Transfer _____

☐ Transfer to Investigating Officer in different team
(specify) _____ Date of Transfer _____

☐ Transfer to other Trust
(specify) _____ Date of Transfer _____

☐ Other
(specify) _____ Date of Transfer _____

☐ Date SOSCARE completed _____

SIGNED INVESTIGATING OFFICER	**DATE**
SIGNED DAPO	**DATE**

Form forwarded to: Care Manager ☐ GP ☐ PSNI ☐ Care Provider ☐

RQIA ☐ Client/Carer ☐ Relevant other ☐

APP9

REGIONAL ADULT PROTECTION PROCEDURES
CASE RECORD / CONTACT SHEET

Worksheet No:

Reference No:

Client Name: Address: DOB:

DATE	NATURE OF CONTACT	CONTENT / INFORMATION	OUTCOME/ACTION (SIGNATURE)

APP9

REGIONAL ADULT PROTECTION PROCEDURES
CASE RECORD / CONTACT SHEET

Worksheet No:

Reference No:

Client Name: Address: DOB:

DATE	NATURE OF CONTACT	CONTENT / INFORMATION	OUTCOME/ACTION (SIGNATURE)

Belfast Health and Social Care Trust

BHSCT Annex A

Initial call made to: Ms Kathy Fodey **(DHSSPS) on** 09/11/12 **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name: Dr David Robinson

Organisation: Belfast HSC Trust

Position: Co-Director Nursing: Governance, Standards and Performance

Phone: RO1

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest*** √
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty*** √

Brief summary of event being communicated: ****If this relates to a child please specify BOD, legal status, placement address if in RRC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child – Looked After or on CPR – please confirm report has been forwarded to Chair of Regional CPC.***

On 7 November 2012, a member of staff reported that 2 staff (one Staff Nurse, and one Health Care Support Worker) and one Student Nurse had physically abused 4 patients in Ennis Ward in Muckamore Abbey Hospital. These staff have been suspended pending outcome of investigations. The PSNI have been informed. The Trust is in the process of referring the staff to the Independent Safeguarding Authority. The Nursing and Midwifery Council has been notified of the precautionary suspension of the Registered Nurse involved in this incident.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Dr David Robinson on behalf of Miss Brenda Creaney

Contact details:

Telephone (work or home) RO1

Mobile (work or home)

Email address (work or home) david robinson@belfasttrust.hscni.net

Forward proforma to Patient/Client Safety Services, Risk & Governance Department using the 'EarlyAlertNotificationMedDir' mailbox.

FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable) .....

Angie McPoland

From: Molly Kane
Sent: 13 November 2012 17:26
To: Angie McPoland
Subject: Fw: Early Alert Notification: EA/BHSCT/09/11/12 HSCB Ref: EA1658
Attachments: Early Alert Proforma EA1658.doc

Importance: High
Sensitivity: Confidential

From: serious incidents
Sent: Friday, November 09, 2012 05:10 PM GMT Standard Time
To: Aidan Murray; Gerry Waldron; Molly Kane
Cc: Anne Madill; Carolyn Harper; Dean Sullivan; Eddie Rooney; Edmond McClean; Elaine Hamilton; Fionnuala McAndrew; Jacqui Burns; John Compton; Mary Hinds; Michael Bloomfield; Pamela McCreedy; Paul Cummings; Philip Moore; Sloan Harper
Subject: FW: Early Alert Notification: EA/BHSCT/09/11/12 HSCB Ref: EA1658

You have been identified as Lead Officers for this Early Alert and you should therefore liaise with other relevant professionals within the HSCB/PHA and contact the reporting organisation if appropriate, to determine whether further action is required or if the Early Alert can be closed.

Please confirm by **7 December 2012** of whether further action is required or if the Early Alert can be closed.

***Please note**: If an SAI is subsequently received before the above date, the SAI will be circulated to you as Lead Officer and the Early Alert closed*

Mareth Campbell
Governance Office
Health and Social Care Board Southern Office
Tower Hill
ARMAGH BT61 9DR
Tel: 028 37 414410
E mail mareth.campbell@hscni.net

From: McCaul, Shane [mailto:shane.mccaul@belfasttrust.hscni.net]
Sent: 09 November 2012 16:40
To: early alert; 'earlyalert@dhsspsni.gov.uk'; cx office
Cc: brenda.creaney@belfasttrust.hscni.net; Robinson, David; McNicholl, Catherine; Tony Stevens; Champion, June; Cairns, Claire; EarlyAlertNotificationMedDir
Subject: Early Alert Notification
Importance: High
Sensitivity: Confidential

Sent on behalf of Claire Cairns Corporate Governance Manager

Dear Colleagues

Please find attached Early Alert Notification for the Belfast Health & Social Care Trust.

If you have any queries or require further assistance please do not hesitate to contact Claire Cairns, Corporate Governance Manager by email: claire.cairns@belfasttrust.hscni.net or Telephone 028 950 48359 mob: RO1 [redacted]

Regards,

Shane

Shane McCaul
Risk & Governance
Belfast Health & Social Care Trust
6th Floor McKinney House
Musgrave Park Hospital
Stockmans Lane
Belfast BT9 7JB
Contact Number: 028 95048098
Email Address: earlyalertnotificationmeddir@belfasttrust.hscni.net

Jim Livingstone
Director of Safety, Quality and Standards

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

POLICY CIRCULAR

Subject:

Early Alert system

Circular Reference: HSC (SQSD) 10/2010

Date of Issue: **28 May 2010**

For action by:

- Chief Executives, HSC Trusts
- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
- Chief Executive, NIBTS
- Chief Executive, Business Services Organisation
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Executive, Patient and Client Council
- Director of Public Health, PHA
- Director of Performance Management and Service Improvement, HSC Board
- Directors of Social Care and Children in HSC Board and HSC Trusts
- Directors of Nursing and AHP in PHA and HSC Trusts
- Director of Integrated Care in HSC Board
- Medical Directors in HSC Trusts
- Chair, Regional Area Child Protection Committee
- Chair, Regional Adult Protection Forum
- Chief Executive, Regulation & Quality Improvement Authority
- CSCG/Risk management leads
- Unscheduled care improvement managers

Summary of Contents:

The Circular provides guidance on the operation of an Early Alert System, designed to ensure that the Department is made aware in a timely fashion of significant events occurring within HSC organisations.

Related documents

HSC (SQSD) 22/2009: Phase 1 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

HSC (SQSD) 08/2010: Phase 2 – Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

Superseded documents

Status of Contents:

Action

Implementation:

From 1 June 2010

Enquiries:
Any enquiries about the content of this Circular should be addressed initially to:
Safety & Quality Unit
DHSSPS
Room D1
Castle Buildings
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BELFAST
BT4 3SQ
Tel: 028 9052 8561
E-mail: sean.scullion@dhsspsni.gov.uk

Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance.htm

Dear Colleague

ESTABLISHMENT OF AN EARLY ALERT SYSTEM

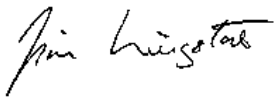
In March 2009, I wrote to you about the initial steps being taken to phase out the reporting of Serious Adverse Incidents (SAIs) to the Department, and the implementation of the Regional Adverse Incident and Learning (RAIL) system (Circular HSC (SQSD) 22/2009).

Circular HSC (SQSD) 08/2010, which issued on 30 April 2010, advised of the transfer of responsibility for managing SAIs from the Department to the HSC Board and Public Health Agency with effect from 1st May 2010, and the revised reporting arrangements which will be in place until the new RAIL system is fully implemented.

The purpose of this circular is to provide specific guidance on the arrangements which should be followed with effect from 1st June to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Yours sincerely



Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

Introduction of an Early Alert System

Purpose of the Early Alert System

1.1 The Early Alert System will provide a channel which will enable Chief Executives and their senior staff (Director level or higher) in Health and Social Care (HSC) organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

It is important to note that this reporting system is intended to complement, not replace, existing channels of communication, both formal and informal.

1.2 While it is likely that some of the notifications reported as Early Alerts will also require to be managed as adverse incidents by HSC organisations**, many adverse incidents will NOT need to be reported through this channel.**

Criteria for using the Early Alert System

1.3 The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. ***Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;***

2. ***The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;***

3. ***The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;***

4. ***The media have inquired about the event;***

5. ***The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless;***
    - ***i. there has been an event which has caused harm to a patient or client and which has given rise to a Coroner's investigation; or***
    - ***ii. evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received, or***
    - ***iii. the Coroner's inquest is likely to attract media interest.***

6. ***The following should always be notified:***
    i. ***the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;***
    ii. ***the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;***
    iii. ***allegations that a child accommodated in a children's home has committed a serious offence; and***
    iv. ***any serious complaint about a children's home or persons working there.***

7. ***There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.***

1.4 Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

1.5 It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

1.6 It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice speaks in person to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

1.7 The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within 24 hours of notification of the event, to the Department at earlyalert@dhsspsni.gov.uk and the HSC Board at earlyalert@hscni.net

ANNEX A

☒ **Initial call made to** _____ **(DHSSPS) on** _____ **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: **If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - please confirm report has been forwarded to Chair of Regional CPC.*

……

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……

……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact _____

Contact details: Telephone (work or home) ……

Mobile (work or home) ……..

Email address (work or home) …….

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: …….. Office: ……..

Forwarded for consideration and appropriate action to: …… Date: ….....

Detail of follow-up action (if applicable) ……

Angie McPoland

From: Angie McPoland
Sent: 15 November 2012 16:19
To: Mary Hinds
Cc: Molly Kane
Attachments: Molly Kane.docx

Importance: High

Mary,

Please find brief from Molly regarding Muckamore Abbey Hospital.

Angie McPoland
Personal Secretary to
Pat Cullen
Assistant Director of Nursing, Safety Quality & Patient Experience
Public Health
Agency
12-22 Linenhall Street
BELFAST
BT2 8BS
Telephone 02890 321313 ext 2413
Direct Line 02890 553946

Molly Kane

15th Nov 12

Briefing Notes regarding Allegations of Abuse Muckamore Abbey Hospital

On 9/11/12 HSCB/PHA received an early alert notification from Belfast Trust stating that on 7 November 2012 the Trust had received a report that 3 staff (1staff nurse, 1 Healthcare support worker and 1 student Nurse, (student nurse is also employed in the hospital as a H.C. Support worker)) had physically abused four patients in Ennis Ward in Muckamore Abbey Hospital. The 3 staff have been suspended and PSNI informed. Safeguarding procedures have been instigated.

Ennis is a 17 bedded, female, re-settlement ward for individuals with challenging behaviour.

Senior Nurse, Ms Esther Rafferty, Muckamore Abbey Hospital was contacted per telephone on Tues 13th Nov and arrangements made for Mrs Molly Kane, Regional Lead Nurse Consultant, Mental Health and Learning Disability and Mr Aidan Murray, Assistant Director for Mental Health & Learning Disability to meet with Mrs Rafferty to discuss the allegations. During the course of the telephone call Mrs Rafferty advised Mrs Kane that RQIA were presently undertaking an unannounced inspection of the ward.

Mrs Kane and Mr Murray met with Esther Rafferty on 14 November 2012.

Issues discussed

- Allegations and Action taken
- Consideration as to whether this is a broader matter

- Staffing issues/levels.

Esther provided paper detailing the allegations raised and action taken to date. The allegations were made by a Health Care Assistant who was working on the word from Bohill Care Home, managed by Priory Group. A safeguarding strategy meeting had been held on Friday 9th November 20 12 and protection plan put in place. A review of the protection plan is to take place on Thursday 15 November 2012. A single agency investigation is ongoing with PSNI in the lead. Belfast Trust Safeguarding designated officer is Aine Morrison. Body charts have been completed on the 4 patients involved, this has indicated numerous marks on individuals but may be related to individuals challenging behaviour. Body charts are also being completed for all patients in the ward during the course of normal personal care activities in order to minimise any distress. The ward manager was on leave when the alleged incidents had occurred.

Action Taken

- 3 staff whom allegations have been made are suspended
- Other staff on ward on day of incident have be re-deployed
- Staffing levels have been increased from 5 to 6 staff on duty daily and an additional Band 7 has been re-deployed. There is also proposal to provide an additional Band 6 Nurse to the ward during the day (this will be discussed at safeguarding meeting tomorrow).
- An additional Band 6 is also on duty each night
- The relatives of the 4 individuals involved have been informed of the allegations, and the other relatives have been made aware that allegations have been made

Senior hospital staff have been providing a monitoring roll into the ward since the Trust became aware of the allegations

The Society of Parents and friends of Muckamore are also aware that the allegations and were meeting with Trust management directly following our meeting.

Other Issues

During the course of the meeting Mrs Rafferty advised that –

Vulnerable adults training is available and has been offered to all staff on site

Whistle blowing policy has previously been made available to all staff

Staff involved are not aware of the actual allegations made against them

Mrs Rafferty advised that in the 10 months she has been in post she has suspended 8 members of H.C. staff. 3 incidents were in regard to allegations of staff assault on patients. She stated that 1 staff member had been dismissed and received caution by the PSNI. Another had received a discretionary caution by PSNI.

Additionally we were informed that 6 months ago a support worker from Ennis had been suspended due to allegation. Police had investigated – no charges brought staff member resigned and no further action was taken.

Mrs Rafferty was asked if she had informed the Board of these suspensions and she advised that she had not as there were numerous allegations made against staff and may come to nothing. She advised that these matters are reported through the vulnerable adults' protocols.

She further advised that there were 500 incidents regarding assaults on staff last year.

As Ms Rafferty had an appointment with the Parents and Friends meeting was brought to an end and agreement made that we would contact her again when we had time to consider the information received.

MAHI - STM - 307 - 710

MEETING	**Meeting with Directors of Nursing to discuss Learning Disability Nursing issues**
DATE, TIME & VENUE	**Wednesday 30 January 2013 at 2.30 pm in Mary Hinds Office, Linenhall Street, Belfast**
Present	**Chair – Pat Cullen (PHA), Molly Kane (PHA,notes), Charlotte McArdle (SET), Olive McLeod (NHSCT), Wendy Crossan (representing Anne Witherow, WHSCT), Moira Mannion (representing Brenda Creaney, BHSCT), Esther Rafferty (BHSCT), Bryce McMurray (representing Francis Rice, SHSCT), Professor Owen Barr (University of Ulster)**
Apologies	**None**
In attendance	**Joyce McKee for 1 item**

Issue	Key Information	Recommended Actions
1) Welcome and introductions	Pat welcomed everyone to meeting and introductions made.	
2) Purpose of the meeting	Pat outlined that the purpose of meeting was to discuss the LD Nurses role in light of the changes in service provision with increasing emphasis on care in the community. Pat indicated that there are genuine concerns about the quality of care afforded to adults with learning disabilities in both hospital and community places. There are ialso ssues around the availability of	

Issue	Key Information	Recommended Actions
	mentoring/support for staff due to care being provided in smaller community facilities isolated from major centres. It was recognised that these factors along with the complexity of needs of some of the individuals being supported present particular challenges to providing quality care.	
3) Vulnerable Adults Reporting (Joyce McKee)	Joyce attended the meeting to present on adult safeguarding activity. Joyce outlined the role of the NI Adult Safeguarding Partnership Board and provided information on adult safeguarding activity for the first and second quarters of 2012/13. Joyce informed the meeting that the Programme for Government has a number of commitments in relation to safeguarding and it is anticipated that there will be a 5% increase in activity over the next three years. Joyce stated that in the first two quarters there had been a total number of 2,595 new referrals under the vulnerable adults reporting policy and from these 1,552 care and protection plans had been implemented. From this total it was noted that 421 care and protections plans related to people with Learning Disability. Discussion ensued regarding the reasons for the apparent high level figure reported in Learning Disability. It was also recognised that there could be under reporting in other areas. Esther advised that there is approximately 60 – 65 a month on average reported from Muckamore and some of this is peer on peer abuse. The information collated is such that details of the nature of the alleged	

Issue	Key Information	Recommended Actions
	abuse eg physical, sexual, neglect, psychological, emotional, financial or institutional and the location where the abuse occurs can be provided. Again it was noted that there was significant numbers occurring in Learning Disability hospital facilities. Joyce advised that it is intended that this information will be shared quarterly at the Local Adult Safeguarding Partnership (LASP), all of which have Trust representation. Those present thanked Joyce for attending the meeting and recognised that the information raised numerous issues and questions and would need further consideration. It was noted by the meeting that the process of reporting and attending to the Vulnerable Adults process was much improved within mental health and learning disability, which is a factor that may be contributing to the higher referral figures but will need to be explored. One hypothesis may be that the increase of referral and recording reflected an improvement of knowledge and adherence to the vulnerable adult legislation and not accepting of potential abuse. However it was noted that one abuse was one too many and wouldn't be acceptable.	
4) RQIA Inspection	Pat outlined a number of issues which had come to HSCB/PHA attention in recent times via RQIA inspections and investigations. Pat stated that there was numerous commonalities in the various investigations that had been undertaken, these included:- a) Lack of good nursing care b) Lack of care planning, in many instances care planning was poor and not reflecting patient's need	

Issue	Key Information	Recommended Actions
	c) Deprivation of Liberty, no rational for restrictive practices d) Lack of personal belongings e) Lack of training for staff on vulnerable adults f) Poor communication with relatives g) Levels of observations not identified in care plan h) Inadequate staffing levels, in regards to numbers and ratios of staff i) Low staff morale j) Allegations of physical abuse and the toleration of poor standards Pat also highlighted that in many instances it was noted that whilst patients and staff had both moved from the hospital to community there was no change in the care provided and that the hospital model was not always suitable for the care that was required in the community. All present recognised that these were significant issues of concern. Professor Barr also raised the issue of non-Learning Disability Nurses working in Learning Disability and expressed reservations regarding their competence and skills to deal with the complex range of some individuals with a Learning Disability. Additionally Professor Barr highlighted that he had some concerns regarding the new Regional Assessment Tool (RAT) that was being developed to assist with care planning. He indicated that it may not be suitable to identify some of the particular issues experienced by people with Learning Disabilities. For example, in regard to ability to communicate.	

Issue	Key Information	Recommended Actions
	Charlotte agreed to raise Professor Barr's concerns regarding the RAT with regional steering group. Discussion also indicated that various models of care planning are being used across the province with Roper, Logan & Tierney Activities of Daily Living being the most common. However, the Southern Trust is using the Northern Ireland Single Assessment Tool. Learning Disability Nurses employed as support staff in community facilities was discussed. Bryce stated that RQIA are in some instances looking for nursing duties to be provided in the homes by community nursing services as the nurses working in the home are no longer employed as nurses. Concern was raised by those present regarding the regulations not being conducive to innovation and the changing climate and environment that staff are working in with Transforming Your Care. The literatal interruption of regulations in some instances can prevent staff adapting and progressing. Consideration was also given to whether Learning Disability Nursing governance issues are reaching Trust Board tables and whether concerns raised by Learning Disability Nurses to Trust Governance departments are acted upon. All agreed that action was needed to address the issues discussed. Charlotte indicated that there were some practical issues that needed to be taken forward. This included improvements in record keeping and consideration to the introduction of KPIs into Learning Disability	**Charlotte**

Issue	Key Information	Recommended Actions
	Nursing services along with an examination of the workforce. The number of nurses on precautionary suspension and lengthy investigation processes was also raised as an issue requiring action. All present agreed that to address the numerous issues outlined action was required at a regional level to co-ordinate the work and prevent fragmentation in the different Trusts. Moira shared with the meeting the use of the 15 step productive ward fresh eyes tool and the indicators of early signs of abuse developed by Hull University for cultural and practice assessments. Moira acknowledged that the material from Hull University had been shared with her by Professor Barr. Professor Barr also suggested that the indicators from the early signs project undertaken by the University of Hull may be useful to support this work and there was also consideration given to the 15 step programme. Professor Barr agreed to circulate information to the group.	**Professor Barr**
5) Learning Disability Nurse Strategy (Strengthening the Commitment)	Molly made reference to the Learning Disability Nursing Strategy, Strengthening the Commitment which has been produced across the four countries. Currently NIPEC is leading on the development of an action plan. It was felt that this document required to be considered in the light of the information discussed at todays' meeting to ensure that these issues were possible are incorporated within the action plan and addressed by service. As such it was agreed that a meeting would be arranged with Glynis Henry, Frances Cannon, five Directors of Nursing, Pat and Molly to discuss how best we take this matter forward. Pat agreed to set up this meeting as soon as possible.	**Pat**
DATE OF NEXT MEETING	20TH February 13 @ 10am, 4th Floor Meeting room, Linenhall St,	

Issue	Key Information	Recommended Actions
	Belfast	

MEETING	**Meeting with Directors of Nursing to discuss Learning Disability Nursing issues**
DATE, TIME & VENUE	**Wednesday 20th February 2013 at 10.00am PHA, Linenhall Street, Belfast**
Present	**Chair – Molly Kane, Anne Witherow (by teleconference), Bryce McMurray, Frances Cannon Francis Rice, Glynis Henry and Moira Mannion.**
Apologies	**Charlotte McArdle, Esther Rafferty, Olive McLeod, Pat Cullen and Professor Owen Barr**

Issue	Key Information	Recommended Actions
1) Welcome and introductions	Molly welcomed everyone to meeting and apologies were noted.	
2) Note of the meeting of 30th January 2013	Moira noted that amendments were required. These included the use of the word 'alleged'. The amendments were agreed and when available the amended note of the 30th January meeting will be reissued.	**Note of 30th Jan 2013 meeting to be amended in line with Moira's comments and reissued via Molly's office by 6th March**
3) Vulnerable Adults Reporting	Francis noted that a framework for risk assessment is in place in Trusts via 'Promoting Quality Care' and that every effort should be made to avoid duplication particularly when assessing for the risk in respect of vulnerable adults. Molly is to raise matter with Joyce McKee and ask her to contact Bryce McMurray for further info	**Molly to liaise with Joyce**

Issue	Key Information	Recommended Actions
4) RQIA Inspection	Francis noted that DHSSPS have established a group to consider if the current legislation associated with regulation is capable of appropriately supporting current and future community based models of service delivery. Following discussion it was agreed that the work of the DHSSPS led group would be enriched by the contribution of if those charged with the management of community based services and other agencies involved. Francis advised that Colin McQuillan from DSD recognises the need to review how individuals with greater and more complex needs can be supported in the community and this may include nursing care provision.	
5) Indicators from the early signs project undertaken by the University of Hull.	Professor Barr had circulated this information. Following discussion it was agreed that these indicators could be useful to the future work of the group. This item to be discussed further at the next meeting.	**For discussion at next meeting.**
6) Supporting the movement of LD nurses to community based services	All present agreed that those LD nurses who are transferring to work in community based services required support to do so. Such support should include, for example • Induction • Supervision. • Training which would facilitate them working with primary and other community health and social care professionals, cross agency and inter-sectoral working, social inclusion etc. Glynis and Bryce noted that SHSCT had developed a proposal to support the modernisation of the LD nursing workforce with the aim of preparing hospital based nurses to work in community based services..	**Bryce and Glynis by 6th March 2013.**

Issue	Key Information	Recommended Actions
	This proposal had been submitted to the ECG possibly in 2009/2010 but had not at that time received funding. It was agreed that Bryce and Glynis would try to locate this proposal. Thereafter it would be shared with the group with the aim of testing it for 'fit' with members. Francis stated that he is aware that in certain circumstances supporting people provides funding to assist staff to be trained in new ways of working. Tansition from hospital to working in community would fall into the area Glynis and Frances also referenced the recent TYC Education Commissioning work-shop for Children's' nursing which had been hosted in NIPEC and included the contribution of Pamela Mc Creedy, Feedback on the day from attendees had been positive. All present supported a suggestion for NIPEC to host a similar event for LD nursing. This was agreed. Pauline Mc Mullan (ECG Business Contracts Manager) will be updated and arrangements for the workshop will be put in place by NIPEC in order to make the most of the timely opportunity which is presenting itself. Pamela McCreedy will be invited to the workshop. It was also felt it would be useful to look at the ECG plan for learning disability nursing and identify the specific programmes that have been commissioned and numbers of LD nurses on courses. Following discussion on workforce capacity it was thought that consideration should be given to pre registration recruitment and number of places available. Glynis advised that this is broadly reflected	**Frances and Glynis to arrange workshop for as soon as practical.** **Frances, Moira, Pauline (McMullan) by 30th March 2013.**

Issue	Key Information	Recommended Actions
	in the Draft Action Plan for Strengthening the Commitment.	
7) Learning Disability Nurse Strategy (Strengthening the Commitment)	Glynis advised that DHSSPS had asked NIPEC to progress work to develop a draft action plan to address the recommendations of this UK wide strategy. Having completed this piece, it had been submitted to CNO for consideration. Glynis summarised the draft action plan and members agreed that it seemed to meet needs. Glynis noted that Maurice (Devine) plans to work in NMAG DHSSPS 1 day/week and that in a recent conversation with CNO it had been agreed that Maurice , CNO, Francis and Glynis would meet to discuss next steps. That will also present an opportunity to review the draft action plan to ensure that 'safeguarding' is sufficiently included in the draft action plan. Glynis agreed to seek the afore-noted meeting with CNO, Maurice and Frances asap.	**Glynis by 6th March 2013.**
8) Date of next meeting	It was agreed that a further meeting will be arranged when the above actions have been addressed	**Molly to agree a suitable date.**

DIRECTION

2015 No. 1

The Health and Social Care Commissioning Plan Direction (Northern Ireland) 2015

The Department of Health, Social Services and Public Safety makes the following Direction in exercise of the powers conferred by sections 6 and 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009(1):

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care Commissioning Plan Direction (Northern Ireland) 2015 and shall come into operation on 6 March 2015.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission regionally and for each of the five LCG areas, for the period 1st April 2015 to 31st March 2016, for consideration and approval by the Minister. In doing so, it shall detail the values and volumes of services to be commissioned to meet the needs of local populations and meet the standards and targets set out in the Schedule to this Direction. The Commissioning Plan must also include the underpinning financial plan, and set out how commissioning will serve to deliver the planned transformation of services, including *Transforming Your Care*. It should set out clear timescales and milestones for the delivery of commissioning intentions and the agreed service changes arising from the implementation of TYC.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board and the underpinning financial plan align with and support the delivery of the Executive's Programme for Government (PfG) commitments and associated milestones, its Economic Strategy and its Investment Strategy; the Minister's vision and priorities for health and social care; extant statutory obligations, including equality duties under the Northern Ireland Act 1998(2), the discharge of delegated statutory functions and requirements under Personal and Public Involvement (PPI); and Departmental standards, policies, strategies and guidelines.

3.—(1) The Commissioning Plan must demonstrate that services being commissioned by the Regional Board will deliver the following three overarching strategic themes:

(a) *To improve and protect population health and wellbeing, and reduce health inequalities.*

(1) 2009 c.1 (N.I.) as amended by 2014 c.5
(2) 1998 c.47

The Commissioning Plan must demonstrate how the services to be commissioned will improve and promote the health and wellbeing of local populations, contribute to the prevention of ill health and reduce health inequalities, in accordance with Section 2(3) (g) of the Act. It should outline how commissioning will support the aims and outcomes of the Public Health Strategic Framework 2013-23 and related population health strategies, and indicate how the Regional Board and Regional Agency are working collaboratively with communities and partner organisations to address the determinants of health.

(b) *To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.*

The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board will deliver high quality, safe and effective care in the most appropriate setting. The Plan must demonstrate how services will be commissioned to improve access to treatment, care and support closer to home, and facilitate people to live as independently as possible in the community. This should include preventing people unnecessarily entering hospital, enabling them to return home safely as soon as they are fit to do so, and supporting people with health and care needs living in the community, as well as their families and carers. The Plan should set out how progress will be made towards implementing the Delivering Care Framework, including Delivering Care for Health Visiting, Delivering Care for Emergency Departments and Delivering Care for District Nursing. The Plan should also detail how commissioning will be used to promote innovation and appropriate use of technology in the delivery of health and social care services – on the basis of single solutions for the region.

The Commissioning Plan must demonstrate how the services to be commissioned will fulfil the statutory duty on the Regional Board under Article 34(1)(a) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003(3); reflect the principles, values and standards set out in the Quality 2020 Strategy; improve the safety and effectiveness of services to deliver safe, high quality care that meets recognised standards, including those set out in Service Frameworks; and improve the patient and client experience. The Plan must explain the outcomes which will be delivered for patients, clients and carers and outline how the Regional Board will take account of their views in the commissioning of services, including through reference to reports produced and priorities highlighted by the Patient and Client Council, the outcomes of the 10,000 voices project and the audit of the five standards of patient experience.

The Commissioning Plan must demonstrate that the services being commissioned ensure that the most vulnerable in society, including children and adults at risk of harm, are looked after effectively across all our services, and detail how statutory responsibilities to assess needs, safeguard, protect and support vulnerable groups, including through the discharge of delegated statutory functions, will be met. There should be an emphasis on prevention and early intervention, in particular in connection with those families whose children are on the edge of care. The Plan will demonstrate how all HSC Trusts, as corporate parents, will be expected to meet the specific needs of looked-after children by providing high quality, enduring placements for them and supporting their transition out of care and into adult life.

(c) *To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.*

The Commissioning Plan must act as a driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes. It must demonstrate how the Regional Board and Regional Agency intend to incur expenditure within their budgets, how the Regional Board intends to ensure that HSC Trusts do not exceed budget allocations, and how proposed expenditure makes best use of the resources available to meet its statutory obligations under section 8(2)(b)(iii) of the Act. The Plan should incorporate plans for each of the five LCGs, and should reflect the use of an evidence-based methodology, including the Capitation Formula (subject to approval by the Department), to assess the relative needs of the populations of the LCG areas and hence each LCG's target fair share, and the actual resources deployed for the respective populations.

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(3) S.I. 2003/431 (N.I. 9)

It must also demonstrate how the Regional Board will commission services in a cost effective manner, including commissioning across provider boundaries and utilising alternative providers where appropriate, and by ensuring that performance and costs are benchmarked and that best practice is shared and implemented across all HSC Trusts. The Plan should also explain how the Regional Board, in consultation with the Regional Agency as appropriate, will address significant under-performance against requirements by providers.

Commissioning and the use of financial allocations

4.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from 1st April 2015 to 31st March 2016, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

(3) This information shall be provided separately for each of the five LCGs, for provider organisations and for services commissioned regionally by the Regional Board in the manner specified by the Department in its budget allocation letters.

(4) This information shall include an analysis of how the Regional Board plans to shift the proportion of spend from hospital services to primary and community services in accordance with the planned transformation of health and social care services.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 6 March 2015.

Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

SCHEDULE

Standards and Targets for 2015/16

Theme	*Standard/ Target*
To improve and protect population health and wellbeing, and reduce health inequalities.	**Bowel cancer screening** 1. By March 2016, complete the rollout of the Bowel Cancer Screening Programme to the 60-74 age group, by inviting 50% of all eligible men and women, with an uptake of at least 55% of those invited. **Tackling obesity** 2. From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited. **Substance misuse** 3. During 2015/16, the HSC should build on existing service developments to work towards the provision of seven day integrated and co-ordinated substance misuse liaison services in appropriate acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention Programmes. **Family Nurse Partnership** 4. By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme.
To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.	**Unplanned admissions** 5. By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas. 6. During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.

Carers' assessments

7. By March 2016, secure a 10% increase in the number of carers' assessments offered.

Direct payments

8. By March 2016, secure a 10% increase in the number of direct payments across all programmes of care.

Allied Health Professionals (AHP)

9. From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.

Hip fractures

10. From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

Cancer services

11. From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Unscheduled care

12. From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.

13. By March 2016, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area.

Emergency readmissions

14. By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days.

	Elective care – outpatients / diagnostics/ inpatients 15. From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks. 16. From April 2015, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken. 17. From April 2015, at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks. **Organ transplants** 18. By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors. **Stroke patients** 19. From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis. **Healthcare acquired infections** 20. By March 2016 secure a reduction of x% in MRSA and *Clostridium difficile* infections compared to 2014/15. **[x to be available in April/May 2015 following analysis of 2014/15 performance and benchmarking process.]** **Patient discharge** 21. From April 2015, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours. **Mental health services** 22. From April 2015, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to

	access psychological therapies (any age). **Children in care** 23. From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%. 24. By March 2016, ensure a three year time frame for 90% of children who are adopted from care. **Patient safety** 25. From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points. **Normative staffing** 26. By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.
To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.	**Excess bed days** 27. By March 2016, reduce the number of excess bed days for the acute programme of care by 10%. **Cancelled appointments** 28. By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment. **Delivering transformation** 29. By March 2016, complete the safe transfer of £83m from hospital/ institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model. **Pharmaceutical Clinical Effectiveness Programme** 30. By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE COMMISSIONING PLAN DIRECTION (NORTHERN IRELAND) 2015

1. This direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the Minister's vision and priorities during the year 1st April 2015 to 31st March 2016.

2. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2015/16 financial year are resourced through the underpinning financial plan and will serve to deliver on the agreed planned transformation of services, including TYC.

3. The targets and standards included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year.

4. Effective performance management of the health and social care system requires availability of a range of indicators to help track trends. An Indicators of Performance Direction will be produced alongside the Commissioning Plan Direction to ensure that the HSC has a core set of indicators in place, with common definitions applied across the sector. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

DIRECTION

2015 No. 4

The Health and Social Care Indicators of Performance Direction (Northern Ireland) 2015

The Department of Health, Social Services and Public Safety makes the following direction in exercise of the powers conferred by sections 6 and 8(2)(a) of, and paragraph 20 of Schedule 1 to the Health and Social Care (Reform) Act (Northern Ireland) 2009(**1**):

Citation, commencement and interpretation

1.—(1) This direction may be cited as the Indicators of Performance Direction (Northern Ireland) 2014 and shall come into operation on 15 May 2015.

(2) In this direction–

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act.

Performance indicators

2.In exercise of its functions under section 8(2) of the Act, with the aim of improving the performance of the HSC Trusts, the Regional Board shall refer to the indicators of performance set out in the Schedule for the period 1st April 2015 to 31st March 2016.

3.The Regional Board shall record the information against the indicators of performance set out in the Schedule for the period 1st April 2015 to 31st March 2016.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 15 May 2015.

Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

(**1**) 2009 c.1 (N.I.) as amended by 2014 c.5

SCHEDULE

Priority	*Indicators*
To improve and protect population health and wellbeing, and reduce health inequalities.	**Life expectancy** A1. Average life expectancy for women and men. A2. Life expectancy differential between Northern Ireland average and most disadvantaged areas for women and men. A3. Healthy life expectancy. A4. Potential years of life lost from causes considered amenable to healthcare. A5. Infant mortality. A6. Age standardised death rate for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas. **Suicide and self-harm** A7. Suicide rates across Northern Ireland and the differential in suicide rates between the 20% most deprived areas and the NI average. A8. Number of A&E presentations due to deliberate self-harm. **Diabetes** A9. Prevalence of diabetes. **Tackling obesity** A10. Level of overweight and obesity across the life course (2-10 year olds and 16+). A11. Proportion of adults meeting the Chief Medical Officer's recommended guidelines on physical activity. A12. Proportion of adults (aged 16+) consuming the recommended five

	portions of fruit and vegetables each day. **Alcohol and substance misuse** A13. Proportion of adults who report having reached or exceeded the recommended weekly alcohol limit. A14. Standardised rate of alcohol-related admissions to hospital within the acute programme of care. A15. Standardised rate of drug-related admissions to hospital within the acute programme of care. **Smoking** A16. Proportion of adults who smoke. A17. Number of pregnant women, children and young people, and adults from deprived areas (lower quintile) who set a quit date through cessation services. **Wellbeing** A18. Self-reported wellbeing. **Sexual health** A19. Number of new episodes of selected sexually transmitted infections diagnoses made by genito-urinary medicine clinics. A20. Number of new HIV diagnoses. **Pregnancy and young children** A21. Rate of births to mothers under 17 years of age (with breakdown against most deprived areas). A22. Breastfeeding rate at discharge from hospital. A23. Rate of each core contact within the pre-school child health promotion programme offered and recorded by health visitors.

To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.	**Care closer to home** B1. Number of pathways for each of the Integrated Care Partnership (ICP) initial priority areas being implemented by each ICP. B2. Percentage of risk stratified patients within the ICP initial priority areas, designated as high risk of hospital admission, who are actively managed on a care pathway. B3. Number of (i) patient education and self-management support programmes and (ii) participants in patient education and self-management support programmes. B4. (a) Number of patients benefiting from remote telemonitoring; (b) number of patients benefiting from the provision of telecare services; and (c) number of (i) telehealth and (ii) telecare monitored patient days. B5. (a) Number of client referrals passed to reablement and (b) number of clients who started on a reablement scheme. B6. Number of adults in receipt of day opportunities, by programme of care. B7. Number of older persons living in supported living facilities. B8. (a) Number of people with continuing care needs waiting longer than five weeks for an assessment of need to be completed and (b) number of people with continuing care needs waiting longer than eight weeks, from their assessment of need, for the main components of their care needs to be met. B9. Number of hearing aids fitted within 13 weeks as a percentage of completed waits. B10. Percentage of patients waiting over 13 weeks for any wheelchair (basic and specialised). B11. Percentage of patients who have lifts and ceiling track hoists installed within 16

	weeks of the OT assessment and options appraisal. **Mental health and learning disability** B12. Number of long-stay patients in learning disability and psychiatric hospitals resettled to appropriate places in the community. B13. Number of referrals for ASD (under 18). B14. Number diagnosed with ASD (under 18). **Safeguarding vulnerable adults** B15. Number of adult protection referrals received by HSC Trusts. **Looked after children** B16. Number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type. B17. Proportion of school-aged children who have been in care for 12 months or longer, who have a personal education plan. B18. Number of new specialist/ professional foster care households and the number of children they are approved for, in line with TYC proposal 50. B19. Length of time for best interest decision to be reached in the adoption process. B20. Percentage of children with an adoption best-interests decision that are notified to the Adoption Regional Information Service within 4 weeks of the HSC Trust approving the adoption panel's decision that adoption is in the best interest of the child. B21. Percentage of care leavers in education, training and employment by placement type. B22. Percentage of care leavers at age 18, 19 and 20 years in education, training or employment.

	Patient safety B23. Summary hospital-level mortality indicator rates by LCG. B24. Percentage of all adult inpatient wards in which the Fall Safe bundle has been implemented. B25. Percentage compliance with the malnutrition universal screening tool in acute adult inpatient wards. B26. Number of incidents of hospital-acquired pressure-ulcers (grade 3 and 4) occurring in all adult inpatient wards, and the number of those which were unavoidable. **Flu vaccine** B27. Uptake of seasonal flu vaccine by front-line health and social care workers. **Maternity** B28. Activity in maternity and child health programme of care. B29. Percentage reduction in intervention rates (including caesarean sections) benchmarked against comparable units in UK and Ireland. B30. Percentage of babies born by caesarean section and number of babies born in midwife-led units either freestanding or alongside. **Unscheduled care** B31. (i) Total out of hours GP attendance and (ii) out of hours GP attendance by timeband 12am to 8.30am; 8.30am to 6pm; and 6pm to 12am. B32. Number of GP referrals to emergency departments. B33. Percentage of new and unplanned review attendances at emergency care departments waiting: less than 30 minutes, 30 minutes to 1 hour, 1 to 2 hours, 2 to 3 hours, 3 to 4 hours, 4 to 6 hours, 6 to 8 hours, 8 to 10 hours, 10 to

	12 hours and 12 hours or more, before being treated and discharged or admitted.
	B34. (a) Number and percentage of attendances at emergency departments triaged within 15 minutes; (b) time from arrival to triage (initial assessment) for (i) ambulance arrivals and (ii) all arrivals; and (c) time from triage (initial assessment) to start of treatment in emergency departments.
	B35. Percentage of patients triaged at levels 1, 2, 3, 4 and 5 of the Manchester Triage Scale at Type 1 or 2 emergency departments.
	B36. (a) Patient handover times and (b) ambulance turnaround times by length of time (less than 15 minutes; 15 – 30 minutes; 31 – 60 minutes; 61 – 120 minutes; and more than 120 minutes).
	B37. Percentage of cardiac arrest patients who suffered an out of hospital cardiac arrest who have return of spontaneous circulation on arrival at hospital.
	B38. Total time spent in emergency departments including the median, 95th percentile and single longest time spent by patients in the A&E department, for admitted and non-admitted patients.
	B39. Percentage of people who leave the emergency department before their treatment is complete.
	B40. Percentage of unplanned reattendances at emergency departments within seven days of original attendance.
	Fracture
	B41. Percentage of patients, where clinically appropriate, waiting less than seven days for inpatient fracture treatment.
	Cancer services
	B42. Number of red flag cancer referrals.
	Elective care
	B43. Number of GP referrals to consultant-led

	outpatient services. B44. Number of outpatient appointments with procedures within the specialities of pain management, ophthalmology, gynaecology, general surgery, plastic surgery and dermatology. B45. Number of barium enema, computerised tomography, magnetic resonance imaging, non-obstetric ultra sound, positron emission tomography and plain film x-ray tests undertaken. B46. Percentage of routine diagnostic tests reported on within two weeks of the test being undertaken. B47. Percentage of routine diagnostic tests reported on within four weeks of the test being undertaken. B48. Total number of attendances at consultant-led outpatient services in the independent sector, by HSC Trust. B49. Total number of patients admitted for inpatient treatment in the independent sector, by HSC Trust. **Emergency admissions/ readmissions** B50. Number of 30 day emergency readmissions by days after discharge, by HSC Trust. B51. Percentage of emergency admissions returning within seven days and within 8-30 days, by HSC Trust. B52. Clinical causes of emergency readmissions (as a percentage of all readmissions) by Trust for (i) infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF). B53. Number of emergency readmissions with a diagnosis of venous thromboembolism. B54. Number and proportion of emergency admissions and readmissions for people aged 0-64 years and 65 years and over:

	(i) with and (ii) without a recorded long-term condition, in which medicines were considered to have been the primary or contributing factor, by HSC Trust.
	Organ transplants
	B55. Percentage change in overall transplants.
	B56. Total number of deceased organ donors by type.
	B57. Number of organs declined.
	Cardiac catheterisation
	B58. Percentage increase in access to cardiac catheterisation.
	Stroke services
	B59. (a) Percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hospital providing 24/7 stroke lysis within 60 minutes of call; and (b) percentage of patients with suspected stroke or unresolved transient ischaemic attack (assessed face to face) who receive an appropriate care bundle.
	B60. Number of patients admitted with stroke.
	B61. Average length of stay for stroke patients.
	Specialist drug therapies
	B62. Number of patients waiting longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis.
	B63. Number of patients waiting longer than 13 weeks to commence NICE-recommended therapies for multiple sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS.
	B64. Number of patients waiting longer than six weeks to commence specialist drug treatment for wet AMD for the first eye,

	and six weeks for the second eye. **Pharmacy, prescribing and medicines optimisation** B65. (a) Prescribing activity, and the level of compliance of GP practices, by LCG for each chapter of NI Medicines Formulary; (b) prescribing activity by LCG for generic prescribing and dispensing rates. B66. Level of prescribing compliance with the NI Formulary by HSC Trust. B67. Evidence of shared learning outcomes and communications issued arising from medication incidents reported in primary and secondary care. B68. The number and proportion of patients admitted to hospital receiving the integrated medicines management service, by HSC Trust. B69. The number of medicines management and public health pharmaceutical services delivered in the community reported by LCG area. B70. Proportion of people accessing the "Building the Community Pharmacy Partnership" programme residing in the bottom three quintiles of wards / Super Output Areas by deprivation.
To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.	**Expenditure** C1. Balance of expenditure between community and hospital based services. C2. Percentage of funding spent on primary and community care. C3. Total investment in tackling obesity. **Hospital efficiency indicators** C4. Elective average pre-operative stay. C5. Elective average length of stay in acute programme of care.

	C6. Day surgery rate for each of a basket of 24 elective procedures. C7. Percentage of operations cancelled for non-clinical reasons. C8. Percentage of patients admitted electively who have their surgery on the same day as admission. C9. Ratio of new to review outpatient appointments attended, by HSC Trust. C10. Rate of new and review outpatient appointments where the patient did not attend, by HSC Trust. C11. (a) Number of new and review outpatient appointments cancelled by the hospital, by HSC Trust and by specialty; (b) rate of new and review outpatient appointments cancelled by the hospital, by HSC Trust; and (c) ratio of new to review outpatient appointments cancelled by the hospital, by HSC Trust. C12. Number and percentage of hospital cancelled appointments in the acute programme of care with an impact on the patient, by HSC Trust and by (i) impact and (ii) reason of cancellation.

Denise Boulter

From: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>
Sent: 26 November 2019 18:29
To: 'Brenda Aaroy'; Brenda Creaney (BHSCT); Briege Quinn; P90's Sister McLaughlin Christine; P77 Mother don.bradley@setrust.hscni.net; 'Doreen Ward'; Eileen Mceneaney (NHSCT); Young, Eileen; 'Francis Rice'; 'Gavin Davidson'; Hazel McClenaghan; Holland, Sean; McMenamin Jennifer; Karen Obrien (WHSCT); 'Laura Dickson'; Mark Lee (HSCB GDS Contact); Lourda Geoghegan; Margaret Blakley; Mencap Northern Ireland; Marieb Heaney (BHSCT); Marie Roulston; marion.moffett@belfasttrust.hscni.net; Charlotte McArdle (Health NI); McCaffrey, Alison; McMaster, Ian; McNeany, Barney; Miskelly, Gwyneth; 'Moira McMurray'; Morrison, Aine; Rodney morton (Health NI); Oscar Donnelly; Paulina Spychalska; Corr, Petra; Redmond, Maire; Siobhan Rogan (DoH); Ruth Lockhart; Cedar Foundation; Tracy Griffin; Helen Tweedie (doh); Walsh, Tracey; Jackie McIlroy; Bernie.owens@belfasttrust.hscni.net; Maria Finnegan (BHSCT); Dunn, Alyson
Cc: Jerome Dawson
Subject: RE: Muckamore Departmental Assurance Group (MDAG) 27 November 2019 - Additional paper
Attachments: Synopsis of Ennis Report - redacted version.docx

All
Further to my e-mail below, please see attached amended paper – please disregard previous version.
Apologies for any inconvenience.
Thanks
Sean

From: Scullion, Sean
Sent: 26 November 2019 16:55
To: 'Brenda Aaroy' <brenda.aaroy@belfasttrust.hscni.net>; 'Brenda Creaney' <brenda.creaney@belfasttrust.hscni.net>; 'Briege Quinn' <briege.quinn@hscni.net>; 'P90's Sister [redacted]>; 'Christine McLaughlin' <christine.mclaughlin@westerntrust.hscni.net>; 'P77 Mother [redacted]; 'Don Bradley' <don.bradley@setrust.hscni.net>; 'Doreen Ward' <D.Ward@cedar-foundation.org>; 'Eileen McEneaney' <eileen.mceneaney@northerntrust.hscni.net>; 'Eileen Young' <eileen.young@setrust.hscni.net>; 'Francis Rice' <francis.rice@belfasttrust.hscni.net>; 'Gavin Davidson' <g.davidson@qub.ac.uk>; 'Hazel McClenaghan' <hazel.mcclenaghan@northerntrust.hscni.net>; Holland, Sean <Sean.Holland@health-ni.gov.uk>; 'Jennifer McMenamin' <jennifer.mcmenamin@westerntrust.hscni.net>; 'Karen O'Brien' <karen.obrien@westerntrust.hscni.net>; 'Laura Dickson' <laura.dickson@belfasttrust.hscni.net>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; 'Lourda Geoghegan' <lourda.geoghegan@rqia.org.uk>; 'Margaret Blakley' <margaret.blakley@hscni.net>; Mencap Northern Ireland <margaret.kelly@mencap.org.uk>; 'Marie Heaney' <marieb.heaney@belfasttrust.hscni.net>; 'Marie Roulston' <marie.roulston@hscni.net>; 'Marion Moffatt' <marion.moffett@belfasttrust.hscni.net>; McArdle, Charlotte <Charlotte.McArdle@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; McMaster, Ian <Ian.McMaster@health-ni.gov.uk>; 'McNeany, Barney' <Barney.McNeany@southerntrust.hscni.net>; Miskelly, Gwyneth <Gwyneth.Miskelly@health-ni.gov.uk>; 'Moira McMurray' <moira.mcmurray@northerntrust.hscni.net>; Morrison, Aine <Aine.Morrison@health-ni.gov.uk>; Morton, Rodney <Rodney.Morton@health-ni.gov.uk>; 'Oscar Donnelly' <oscar.donnelly@northerntrust.hscni.net>; 'Paulina Spychalska' <paulina.spychalska@rqia.org.uk>; 'Petra Corr' <petra.corr@northerntrust.hscni.net>; Redmond, Maire <Maire.Redmond@health-ni.gov.uk>; Rogan, Siobhan <Siobhan.Rogan@health-ni.gov.uk>; 'Ruth Lockhart' <ruth.lockhart@hscni.net>; Cedar Foundation <s.mathews@cedar-foundation.org>; 'Tracy Griffin' <tracy.griffin@southerntrust.hscni.net>; Tweedie, Helen (DoH) <Helen.Tweedie@health-ni.gov.uk>; Walsh, Tracey <Tracey.Walsh@health-ni.gov.uk>; McIlroy, Jackie <Jackie.McIlroy@health-ni.gov.uk>; 'Bernie.owens@belfasttrust.hscni.net' <Bernie.owens@belfasttrust.hscni.net>; 'maria.finnegan@belfasttrust.hscni.net' <maria.finnegan@belfasttrust.hscni.net>; 'Dunn, Alyson' <Alyson.Dunn@northerntrust.hscni.net>

Cc: Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>
Subject: RE: Muckamore Departmental Assurance Group (MDAG) 27 November 2019 - Additional paper

MDAG members

Further to below, please see attached an additional paper for tomorrow's meeting.

Thanks
Sean

From: Scullion, Sean
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Subject: Muckamore Departmental Assurance Group (MDAG) 27 November 2019 - Agenda and Papers

To MDAG members

Please find attached the agenda and papers for Wednesday's MDAG meeting at 10am in Training Room 3, Portmore, Muckamore.

If you have not already done so, I would appreciate it if you could please confirm your attendance or apologies asap in order to finalise numbers.

Papers attached:

- Agenda
- Minutes of 30 October MDAG meeting (MDAG/13/19)
- Highlight Report and Dashboard (MDAG/14/19)
- HSC Action Plan – progress update (MDAG/15/19)
- Process map of Adult Safeguarding arrangements in MAH (MDAG/16/19)(note this contains embedded documents, and also consideration of capacity, consent, best interests, service users' wishes and views and

carers' wishes and views are not mapped alongside the more procedural elements of the process but are part of every step).

- Leadership and Governance Review Terms of Reference (MDAG/17/19)

Thanks

Sean

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Synopsis of Ennis Report

This is a synopsis of the Adult Safeguarding Investigation Report regarding Ennis Ward completed by Aine Morrison, Collette Ireland and Carmel Drysdale on 23.10.13. The report provided did not have appendices attached.

Background:

The investigation was initiated because of a complaint by a staff member from Bohill Care Home who had been working into the ward in preparation for patients to be resettled into the community. The complaint related to allegations of a physical and verbal nature in respect of 4 patients.

7 initial allegations were made on 8.11.12 relating to 4 patients (although other parts of the report state 8.10.13). The allegations against 2 staff related to physical abuse and verbal abuse. A complaint was also made against a student nurse in respect of verbal abuse.

Investigation:

The investigation consisted of the following:-

1. **Interviews with staff from Bohill**

Nine staff were interviewed by the Trust and a number of interviews were also conducted by the PSNI. A number of themes emerged from the interviews with Bohill staff:-

- 22 incidents of Physical abuse of patients were identified. These included: pulling a patient from sofa onto floor; patient was witnessed screaming and accusing a staff member of hitting her and there was evidence of blood coming from her mouth; pushing a patient so hard into a chair that she hit her head off back of chair; not intervening when patients hit other patients; pushing/pulling backwards or grabbing clothes and wrists of a patient.
- 10 incidents of Verbal nature e.g. shouting into patient face, condescending, shouting 'get out of my way', threatening a patient she would not get sweets /lemonade unless she put her clothes on, encouraging a patient to hit a fellow patient back.
- 16 concerns raised about the management of behaviour of patients e.g. threats to not provide meals in order to manage behaviour; encouraging a patient to hit another who had assaulted her; not to give patients too much attention as they would want it all the time; making a patient sit in a chair with her legs up and restricting her ability to get out of it; belt tightening and; patient placed outside in rain.
- Lack of supervision of patients e.g. patients left unsupervised, patient left sitting outside in rain.
- Poor induction of Bohill staff e.g. care plan was inadequate and did not inform staff how to manage patients behaviour.
- Other issues e.g. management of meal times; patient had sore head and staff refused to give her a tablet as she hadn't eaten her dinner; putting two pads on patients; lack of stimulation and warmth on ward; lack of staff engagement and interaction with patients.

2. Patient interviews

There was limitations to the interviews conducted. Only 3 patients deemed to have capacity to participate in interviews. The first patient interviewed was in relation to an incident she had reported to her brother that staff member had grabbed her 'by the scruff of her neck and took to her bedroom. She said it was a 'jokey comment.' The second patient interviewed 'recalled her dinner scraped into the bin as she didn't like it and being refused a sandwich as an alternative' but could not identify the staff member. One other patient reported no concerns.

Other capacious patients were not interviewed because their family objected.

3. Contact with Relatives

7 families were contacted and on the whole raised no concerns. The following issues however, were raised-

The relative who had been advised by his sister that staff member had 'grabbed her by scruff of neck' felt his sister would not 'tell lies...and may not say anything that would get her into trouble'.

Another relative raised concerns regarding: low staff levels: lack of supervision of patients including an incident when 3 staff sat at a dining table chatting and not supervising a patient; patient was shabby in appearance- holes in cardigan; and one patient not allowed to go to Mass because of her behaviour.

Another relative was concerned about the number of times a patient had been assaulted by fellow patients.

4. PSNI Interviews

All staff interviewed denied the allegations however; the PSNI referred two staff to the PPS with a recommendation for prosecution.

In relation to first staff member:

1. Two counts of common assault and ill treatment, one relating to fastening a belt tightly and putting a patient outside a fire door and the other pulling a patient from the sofa onto the floor.

2. One count of ill treatment - leaving a patient to sit outside without appropriate protective clothing on.

3. One count of assault occasioning actual bodily harm and ill treatment- Hitting a patient and blood was seen coming from her mouth.

In relation to the second staff member:

1. Five counts of common assault and ill treatment relating to: fastening a belt tightly and putting a patient outside a fire door; grabbing a patient by the jumper and told to "Get the F* out of my face" and then pulling the patient across the room and pushed on to a

sofa; pushing a patient into a chair causing her to hit her head of the back of the chair; unknown patient pushed onto a chair, blood wiped roughly from her mouth using a personal hygiene mitt.

2. Two counts of ill treatment: Patient left to sit outside without appropriate clothing on and; failure to intervene when a fellow patient was being assaulted.

5. Social services interviews of the involved staff

Four of the staff alleged to have been involved in some incidents where interviewed by the investigating team. They all denied the allegations made.

a. Bohill staff reported that 2 staff members were involved in pushing a patient, and 'yanked at her belt forcefully.' The investigating team concluded that the allegations could not be confirmed 'as there were no witnesses and MAH deny belt tightening practices.'
b. Another staff member was reported to have witnessed another staff member pushing a patient onto a sofa. The staff member denied any recollection of the incident.
c. Allegations regarding staff member: grabbing a patient by scruff of neck- this was explained as 'a joke'; leaving patient unsupervised resulting in Bohill staff being assaulted – this was explained as staff shortages and; shouting at patients– this was unconfirmed as there were no witnesses.

6. Interviews with ward staff

8a, Band 7, Band 6, Band 5, Band 3, Band 2, Speciality Doctor and a Consultant Psychiatrist were all interviewed. All those interviewed raised no concerns about staff attitudes towards patients or of the quality of interaction with patients; or the quality of care provided to patients; however, they raised a number of concerns regarding staffing levels, removal of the ward transport and the physical environment of the ward.

7. Review of previous concerns

There was one previous incident reported in May 2012 by a Day care member that a Band 2 Nursing assistant from Ennis handled a patient roughly and was threatening towards them. This was investigated by the PSNI who took no further action and the Trust referred the matter to ISA but the staff member left the Trust before any disciplinary action took place.

8. Review of care plans

RQIA found that in the case of one patient the support plan was not detailed to her specific requirements.

Conclusions:

1. The investigating team acknowledged that 12 Bohill staff were consistent in their accounts but accepted that no concerns regarding care had been raised by MAH staff. The investigating team 'acknowledged that Bohill staff where working in a new

environment were the context of some actions may not have been clear to them.. they were coming from a newly built.. environment in contrast to an older style hospital'. The investigating team "recognises...it can be difficult for (Ennis) staff team... to come forward with concerns about their own practice. However, the investigating teams experience is that this has happened in other investigations and therefore gives some weight to the fact that no MAH staff reported any care concerns. The investigating team also noted the apparent genuineness and caring attitude shown by MAH staff in their interviews".

2. 'Investigating team believe that of the named staff (apart from the two referred by the police) that there is not enough evidence to warrant disciplinary action against any of them..... (they) also believe that there is no way of knowing who, if any, of the other staff were involved'.

3. 'The investigating team .. in Ennis has changed substantially since the investigation began with approximately have the staff being new to the ward. While the investigating team is unable to draw definitive conclusions on many of the allegations, if there had been wider issues about practice on the wards the team believe that this would now be an important protective factor'.

4. As a result of positive comments made by monitoring staff about the care provided since the allegations were made the investigating team concluded that the 'current ward staff have the skills and abilities necessary to provide good quality care'.

5. 'The reports of staffing difficulties may have meant that it was difficult to manage the patients waiting outside the dining room.. (they) felt it was possible that visiting staff may not have known the rationale behind this routine'.

Recommendations:

1. MAH should pursue a disciplinary investigation in relation to the conduct of two staff.

2. The team recommended that all wards in the hospital are reviewed by staff external to the ward to see if any environmental changes are needed.

3. The investigating team recognise that there was an action plan in relation to the overall staffing crisis in MAH at the time which included Ennis, but recommend that hospital senior management review their response to these two specific incident reports to see if this was appropriate.

4. Staff from other facilities working into MAH should have a proper induction.

5. Two patient specific recommendations were made in respect of what criteria staff use for considering a referral to specialist behavioural support services and to review practice that could be deemed restrictive.

6. The staff team would be provided with some information in relation to the nature of the current investigation including the outcomes, conclusions and recommendations.

7. Staff at all grades including medical staff should receive appropriate adult safeguarding training.

8. Resettlement patients should have access to a full range of professionals.