Exhibit 1

From the Permanent Secretary and HSC Chief Executive

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

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Tel: 028 90 520559
Fax: 028 90 520573
Email: Richard.pengelly@dhsspsni.gov.uk

Our Ref: RP185

Date: 22 December 2014

Michael McBride
Interim Chief Executive
Belfast HSC Trust
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH

Dear Dr McBride

1. Your appointment as Interim Chief Executive of the Belfast Health and Social Care Trust carries with it the responsibility of accounting officer of that body. I am therefore writing to formally designate you as accounting officer, for the funds (including grant-in-aid) of that body, with effect from 8 December 2014 and to define the relationship between your responsibilities in that capacity and mine as principal accounting officer for the Department.

2. Within the context of your appointment as accounting officer I would also like to acknowledge your continuing role as Chief Medical Officer and that consequentially it is possible that situations may arise where complexity and/or potential conflicts emerge. I recognise that these arrangements, while necessary and important, are not perfect and I would therefore wish to reinforce my commitment to working with you, and the Trust, to resolve any challenges which may arise quickly and constructively.

3. Chapter 3 of Managing Public Money Northern Ireland (MPMNI) sets out the responsibilities of accounting officers and can be accessed using the link: Accounting Officer Memorandum but I have attached this document for ease of reference. This sets out your duties as accounting officer in which capacity you will be responsible for safeguarding public funds in your charge and ensuring that they are applied only to the purposes for which they were voted and, more generally, for efficient and economical administration. In particular, can I draw your attention to sections 3.7 and 3.8 which address conflicts of interest and the responsibilities of the accounting officer of an arm's length body.

4. In order to carry out your responsibilities as accounting officer, you need a thorough understanding of propriety and accountability issues – these are set out in the HM Treasury Handbook: Regularity and Propriety which can be obtained by accessing the link: HM Treasury Handbook: Regularity and Propriety. Comprehensive training is available through a course run by the Chief Executives' Forum which is specifically tailored for your needs in a Northern Ireland context. I am copying your appointment letter to the Head of the Chief Executives' Forum so that they can notify you of when the next relevant course is planned.

5. I should also explain that your designation as accounting officer may be withdrawn if I conclude that you are no longer a fit person to carry out the responsibilities of an accounting officer or that it is otherwise in the public interest that your designation be withdrawn. I would not take such a decision without full and careful examination of the facts which you would have a suitable opportunity to contribute to and to add your viewpoint. Nor would I take such a decision without giving your Board a full account of my reasons as well as a chance to make representations. Withdrawal of accounting officer status would obviously bring into question your fitness for the position of Chief Executive generally.

6. As principal accounting officer of the Department I have a duty to satisfy myself that the body has adequate financial systems and procedures in place to promote the efficient and economical conduct of its business and to safeguard financial propriety and regularity. In addition, I am responsible among other things for advising the Minister on the allocation of departmental resources, and, after consultation with you, the setting of appropriate financial and non-financial performance targets for the Belfast Health and Social Care Trust.

7. As accounting officer for the Belfast Health and Social Care Trust you are responsible to the Board and accountable to the Assembly for the body's use of resources in carrying out its functions as set out in the Financial Memorandum. Subject to my responsibilities as described in paragraph 5 above, you are responsible for all the matters in the Memorandum in respect of the body.

8. In relation to your role, there are several areas, in particular, where the Assembly expects accounting officers to take personal responsibility:

- *regularity and propriety,* including seeking DFP approval for any expenditure outside the normal delegations or outside the subheads of Estimates, and carried through with appropriate disclosures in the resource accounts;

- selection and *appraisal* of programmes and projects: using the *Green Book* (supported by additional DFP guidance*)* to evaluate alternatives, and good quality project and programme management techniques, such as Office of Government Commerce (OGC) Gateways™, to track and where necessary adjust progress;

- *value for money:* ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed to provide confidence about suitability, effectiveness, prudence, quality, good value and avoidance of error and other waste, judged for the public sector as a whole, not just for the Accounting Officer's organisation;

- management of *opportunity and risk* to achieve the right balance commensurate with the institution's business and risk appetite;

- *learning from experience,* both using internal feedback, and from right across the public sector; and

- accounting accurately for the organisation's *financial position* and *transactions*: to ensure that the government published financial information is transparent

and up to date, and that the organisation's efficiency in the use of resources is tracked and recorded.

9. Your judgement as accounting officer on matters for which you are responsible may only be overridden by the Board, in which case I should be informed as soon as possible. Advice to the Board is covered in the Accounting Officer Memorandum but in general terms you are responsible, inter alia, for advising the Board on matters of financial propriety, regularity or of prudent and economical administration, efficiency and effectiveness. You are also responsible for taking formal action if the Board is contemplating a course that would infringe these requirements.

10. You are liable to be summoned to appear before the Public Accounts Committee (PAC) to give evidence on the discharge of your responsibilities as accounting officer for Belfast Health and Social Care Trust. In such circumstances the PAC would probably wish to take evidence from both the Principal accounting officer and yourself. It will be for me to answer on those matters affecting the Belfast Health and Social Care Trust, which fall within my responsibility as Principal accounting officer. In giving evidence to the Committee you should be guided as appropriate by the Accounting Officer Memorandum.

11. I am sending copies of this letter to the Head of the Northern Ireland Civil Service, the Comptroller and Auditor General, the Clerk to the Northern Ireland Public Accounts Committee, the Treasury Officer of Accounts, the Chief Executives' Forum and to Ian Fleming in DFP Supply.

12. I would be grateful if you would acknowledge receipt of this letter and its enclosures.

Yours sincerely

RICHARD PENGELLY

Copies have been sent to (w/o enclosures):

Head of the Northern Ireland Civil Service
Comptroller and Auditor General
Clerk to the Northern Ireland Public Accounts Committee
Treasury Officer of Accounts
Chief Executives' Forum
Ian Fleming DFP Supply
Craig Morrow (NIAO)

Exhibit 2

Independent Review of the Learning Disability Resettlement Programme In Northern Ireland

Bria Mongan & Ian Sutherland

July 2022

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Acknowledgements

The review team completed significant engagement and received considerable documentary evidence from a wide range of stakeholders and wish to acknowledge and thank those who so kindly shared their expertise.

The review team would like to thank all those who gave so generously of their time to meet with them and contribute to the review most especially the individuals and family carers who have lived experience of resettlement. The richness of their advice and experience has informed our findings and recommendations.

Learning disability care providers from across the voluntary and independent sectors shared their knowledge as system experts with the review team.

The review team benefited from a site visit to MAH and valued the opportunity to meet with patients and ward staff

The directors in each of the HSC Trusts and their senior management teams actively engaged and supported the work of the review team providing documentary evidence and assisted in the identification of the barriers and challenges that need to be addressed to expedite resettlement.

Staff from DoH, SPPG /HSCB also provided considerable documentary evidence, advice and support.

The HSCB/SPPG provided technical and secretarial support and the review team would particularly wish to thank Patricia Elliott for her technical expertise in the production of the report and Caroline McGonigle for her support throughout the fact finding process of the review.

1. Executive Summary

1.1 In October 2021 the Health and Social Care Board (HSCB) commissioned two experienced senior leaders in health and social care to undertake an independent review of the learning disability resettlement programme in Northern Ireland, with a particular focus on the resettlement from Muckamore Abbey Hospital (MAH), which is a specialist learning disability hospital managed by the Belfast Health and Social Care Trust (BHSCT) but located outside Antrim.

1.2 The purpose of the review built on a stated intention from Department of Health and HSCB to strengthen the existing oversight arrangements for the resettlement of patients from MAH and other learning disability hospitals whose discharge plans have been delayed. The review team were required to work with stakeholders to identify both good practice and overarching vision, as well as barriers, and to develop an action plan to ensure that the needs of the patients are being considered and are met. The review was to include consideration of the effectiveness of planning and delivery for the proposed supported living and alternative accommodation schemes which were in development to support the resettlement plans for these individuals.

1.3 There is a strong legislative base and policy framework, although the policy and strategy relating to services for people with learning disabilities/ASD and their families is in urgent need of updating, and this is currently being reviewed. An overarching vision for learning disability services in the 2020's would allow stakeholders to agree a Learning Disability Service Model, which would guide commissioners and providers towards the development of better integrated, community orientated services which will deliver stronger outcomes for people with learning disability and their families. This policy will need to consolidate the outstanding ambition that no-one will live in a specialist learning disability hospital and that hospital will focus on its primary function of offering assessment and treatment only for those people for whom this cannot be made available within a community setting.

1.4 Leadership and governance with regard to the resettlement programme in Northern Ireland has been less than adequate. Progress and momentum to deliver homes outside of hospital for the remaining cohort has been slow. There were a number of confounding factors that impacted directly on progress. The global pandemic had a massive impact on the capacity and capability of leadership teams to maintain momentum on 'business as usual' priorities, as a determined focus to tackle ovid was required. Similarly during the same period the impact of MAH being identified at a national level as a hospital where patients had not been well safeguarded meant that the operational day to day logistics of maintaining safe practice in relation to sufficient and stable staffing was a significant challenge in itself. Additionally, there has been an extended period of

significant organisational change as the regional commissioning functions previously undertaken by the Regional HSCB were 'transitioned' back within the DoH under the Strategic Planning and Performance Group, with the new arrangements coming in to effect from the 1.4.22. in order to strengthen the focus on system wide performance management. Whilst these and other factors impacted directly on the progress of resettlement and offers something in way of mitigation for the poor progress of resettlement plans, it does not satisfactorily explain why some Trusts made negligible progress, but for others consistent stepped change was achieved.

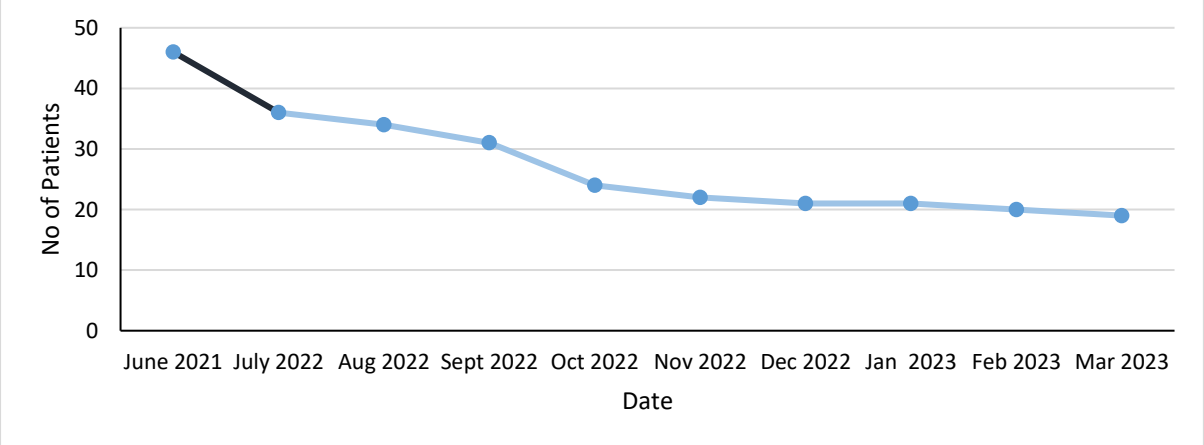
1.5 The BHSCT which managed MAH, had a significant challenge to balance the dual responsibility of rapidly improving quality and safety within the hospital, whilst maintaining progress on resettlement for those patients. This balance was not achieved, and the focus shifted away from resettlement to crisis management of MAH. The Trust Board were reassured by the executives that there were plans in place to support the resettlement of these individuals, whereas better scrutiny of the assurances provided would have shown this not to be the case, and that the plans were not robust. Arrangements in BHSCT were further hampered by significant changes in the leadership team for LD services. Other Trusts responsible for resettlement of patients from MAH had made more progress in the development of new services, although the delivery had been slower than hoped with delays relating to building over-runs and recruitment difficulties. The HSCB had made efforts to support regional co-ordination of the resettlement programme, but these were not effective in delivery of a well-co-ordinated programme plan. In particular the HSCB was not good enough in terms of performance management of the resettlement programme which amounted to little more than performance monitoring. We saw some strong leadership by individuals both in the statutory and non-statutory sectors, and whilst the rhetoric was of a robust commitment to collaboration there was little evidence of strong partnership working. In terms of leadership around the delivery of schemes in most cases management grip was weak and this contributed significantly to drift and delay. The voices of people who required resettlement and their families were not well heard within this process and they did not feel that they were empowered or engaged in the process at all levels. Opportunities to learn from their expertise by experience were missed.

1.6 Strategic commissioning and inter-agency working were supported by a clear and explicit strategic priority being identified around resettlement and workforce development in the 2019/20 commissioning plan. The Northern HSC Trust and South Eastern HSC Trust had response plans that were proactive and generally well progressed, but the BHSCT plans failed to progress beyond the preliminary stages. The lack of either effective programme or project management meant there was no over-arching, costed plan. Trusts were planning in relative isolation and communication of joint arrangements was inadequate. Generally there was

a tendency by Trusts to initiate new developments without fully exploring whether there was some existing provision within the market that could meet some of the identified need, even if this required some re-design or re-purposing of provision. The new build options, whilst being bespoke, were generally costly in terms of capital and revenue, and resulted in long lead in time to delivery. There was limited evidence of senior engagement with the independent social care sector as strategic partners as well as providers, and therefore market shaping was not evident.

1.7 The review team looked at the approach being taken to individualised care planning. There was a lack of consistency in the documentation used to support care planning for transition from hospital to community, and nor was there an agreed regional pathway for resettlement, which should map out roles and responsibilities within the process. Families and providers both commented that they felt only involved in a limited way in developing assessments and care plans. Of the remaining patients awaiting discharge almost a quarter had been in MAH for more than 20 years and one person for more than 40 years. About a third of this group had also had one or two previous trials in community placements, although there was little evidence of how lessons were learnt from these unsuccessful moves. However, in the 12 months from June 2021 to June 2022 the population in MAH awaiting resettlement had reduced by 20%, and the trajectory of future resettlements by NHSCT and SEHSCT should mean that between September 2022 and March 2023 the population will reduce by a further approximately 50%, leaving around 19 people in MAH awaiting resettlement.

1.8 Whilst progress at the beginning of the review had been slow HSC Trusts have recently reviewed their approach to consider alternative options that have potential for more timely discharge. The review team were pleased to see that this has improved the resettlement trajectory which anticipates that the population will reduce to between 15 and 19 by the end of March, 2023.



1.9 A key element of the review was the operational delivery of provision to meet the needs of this cohort and the wider LD population. There is an impressive range of provision across registered care and supported living settings providing approximately 2,500 places for people with LD in the community. There was a tendency of commissioners and resettlement teams to not engage with providers to consider potential existing opportunities, although this has changed in recent months. The overall trend within supported living schemes is to smaller size provision, with the largest number of schemes offering 3 places. The biggest single issue and risk facing the range and quality of the provision was workforce, and the DoH are now sponsoring work regionally to try to address this challenge which will report in 2023. The quality of care within the independent sector is regulated and inspected by RQIA, and the overall quality is good. There is some very innovative practice emerging within the independent sector, with a strong commitment to the use of Positive Behaviour Support (PBS) models, with some examples of transformational care being provided to individuals in their own new homes. Where provision was strongest there was a strong partnership between providers and local HSC Trust commissioning/care management and clinical services, so that individuals had access to a wide range of highly responsive services.

1.10 The Trust's commissioning of schemes of registered care provision to meet their respective resettlement cohorts was variable. The NHSCT and SEHSCT demonstrated a more proactive and consistent approach to planning of this provision, and consequently have reached a stage where 2 substantial new care settings, along with some smaller scale provision will over the next 6 months provide new homes to approx. 80% of their remaining MAH residents. The BHSCT have over the last 3 years been scoping 3 potential new schemes, but these have never got beyond the most preliminary stages of planning. The review team are more encouraged that the new leadership group responsible for LD within that Trust are now considering other options, including some existing provision which could have the potential to be rapidly re-purposed. In general, and at variance with statements that the Trusts have a learning culture, there has been little rigorous evaluation of the successes and failures within the resettlement programme. The review team heard a rich tapestry of stories from families about their lived experience, and this should form the basis of some qualitative work, but in addition there should be some review of the clinical and social benefits derived by people who have gone through resettlement.

1.11 For families, safeguarding continues to be an abiding concern, which is overshadowed by a loss of trust and confidence in MAH and health and social care systems more generally. The oversight of adult safeguarding will be strengthened when the new adult safeguarding arrangements come in to place, and it is encouraging that an Interim Adult Protection Board (IAPB) was established in 2021. There continue to be issues of concern in relation to the use of physical intervention, and surveillance by CCTV, and for the families the review team met, how these are addressed in community settings is central to the success of placements. There is a need for further consultation with

individuals, families and providers to inform regional policies on these important areas moving forward. Family members were clear with the review team that after community placement they would continue to play a key role in assuring and ensuring the safety of their relative, and therefore wanted to see open and flexible access to care environments. Care providers were clear about safeguarding responsibilities but expressed a concern that they experienced considerable variation in the application of thresholds in relation to investigation of safeguarding concerns, and families expressed concern that in some situations investigations were not progressed in a timely fashion.

1.12 Families were an incredibly rich source of evidence to the review team, and their lived experience tells a tale of both success and failure. The full report includes aspects of these accounts. The review team strongly believe that individual families need to be at the centre of these processes and fully engaged within all aspects of the resettlement, but they also need to be able to influence policy and strategy so that their expertise by experience can inform best practice. The review team were struck by the extent to which trauma and distress featured within the experience that was shared, and that all of the professionals working with these individuals and families need a good understanding of trauma informed practice. Trusts were all considering and developing their advocacy and other supports for individuals and families, and they need to further consider how they can put in place opportunities to ensure better communication and engagement and opportunities to organise carer support events such as group gatherings.

2. Terms of Reference

2.1 Terms of Reference: The terms of reference for the review were agreed with the HSCB and DoH, after consultation with senior leaders in learning disability services from the 5 HSC Trusts.

2.2 Purpose of Review: The purpose of the review built on a stated intention from DoH and HSCB to strengthen the existing oversight arrangements for the resettlement of patients from MAH (MAH) and other learning disability hospitals whose discharge plans have been delayed. The review team were required to work with stakeholders to identify both good practice and barriers and develop an action plan to ensure that the needs of the patients are being considered and are met. The review was to include consideration of the effectiveness of planning and delivery for the proposed supported living and alternative accommodation schemes which were in development to support the resettlement plans for these individuals.

2.3 The review team were to work collaboratively with stakeholders, with the commitment of the Chief Executives and the Directors, engaging appropriately with relevant staff, agencies, families and service users.

2.4 Timescale: The timetable for the work was to take place over a 6 month period which began in effect in November 2021.

2.5 The Review Team were required to give particular consideration of the current care plans for all the service users in MAH and critically analyse the actions taken to identify and commission suitable community placements. In addition they were asked to look specifically at the following areas:-

- Length of time patient has been in MAH and where they were admitted from
- Ascertain if resettlement has already been trialled
- Summarise the policy and practice evidence base in relation to resettlement programmes.
- Identify those individuals where plans are absent or weak in relation to their resettlement
- Work with leaders in the appropriate Trusts to ensure that suitable resettlement plans are developed.
- Critically evaluate the progress of resettlement plans as devised by the responsible Trust for the identified individuals.
- Business cases which have been completed or are still in process identifying any positive outcomes and any strategic or operational barriers. Make recommendations for actions that would strengthen or accelerate the delivery of proposed pipeline schemes.

- Review to what extent the engagement strategies employed individually by Trusts, and collectively by the system as a whole have been effective in supporting the delivery of the MAH resettlement programme.

2.6 Inter-Agency Working : The review team were asked to consider whether/how the agencies and professionals involved in resettlement of patients, have worked effectively with each other at each and every stage of the process.

2.7 Parental/Carer Engagement/Advocacy: The review team were also asked to consider as a critical factor whether and to what extent the families of the patients were engaged in decision making around resettlement. In this context the review team were also asked to explore whether and to what extent, independent advocacy and support was provided.

2.8 Outside of Scope: Whilst there are Issues relating to children and young people with learning disability/Autism who may be subject to delayed discharge in other settings, this population were not included within the terms of reference for this review.

3. Methodology

3.1 The HSCB in appointing the review team intended to ensure that an objective, critical appraisal was undertaken of the existing programme of resettlement for individuals with learning disability/autistic spectrum disorder with a primary focus on the remaining population of people who were awaiting discharge from MAH to new homes.

3.2 The review team decided to adopt an approach for the review based on 'appreciative inquiry' (1) this is a strengths-based positive approach to leadership development and organisational change. This approach seeks to engage stakeholders in self-determined change, and incorporates the principle of co-production.

3.3 By adopting this approach the review team were both 'observers' of the system and how it was delivering the required outcomes for people identified for resettlement, but also as 'agents' by helping to seek solutions that would assist key stakeholders to improve the resettlement programme in Northern Ireland.

3.4 The review team adopted the following methods to progress the key lines of inquiry:

- Direct observation and participation in key processes
- Direct interviews with a wide range of stakeholders
- Gathering and analysing data relevant to the resettlement process
- Focus groups – both face and face and digital engagement.

3.5 The initial engagement with the statutory health and social care agencies was through the leadership meetings established by the HSCB to develop and oversee the delivery of effective services for people with a learning disability/ASD. This included the Learning Disability Leadership Group comprising the senior social care leaders from the HSCB, the 5 Trust Directors of Mental Health and Learning Disability Services, along with representation from the DoH and RQIA. Additionally the review team participated in a range of operational and strategic meetings with programme leads for learning disability services within the HSCB and HSC Trusts. Some of these processes were inter-agency and included NIHE representation.

3.6 The review team sought data and documentary evidence from a wide range of organisations including the DoH, HSCB, the 5 HSC Trusts, NIHE, RQIA and other agencies. Information was sought through direct requests and through questionnaire response.

3.7 The review team held an extensive range of engagement sessions with a range of external stakeholders. This included the following:

- Northern Ireland Housing Executive - NIHE
- Regulation and Quality Improvement Authority – RQIA
- Northern Ireland Social Care Council – NISCC
- Patient and Client Council – PCC
- Royal College of Psychiatrists – NI/Learning Disability Division - RCPsych
- ARC Northern Ireland
- Independent Health Care Providers [NI) – IHCP

3.8 The review team felt it was of primary importance that the lived experience of individuals with learning disability/ASD and their carers/families who had been engaged in resettlement had to be well represented within the review. They met with individuals and groups of carers who had either been through or were still going through the resettlement process. This provided some of the richest detail of how the system was working, or not working, for people who wanted to have the opportunity to live in a setting outside of hospital with as much independence as possible.

4. Legislative, Strategic and Policy Context.

In this section we will critically evaluate the legislation and strategic policy across England, Scotland, Wales and the Republic of Ireland to identify models of good practice in reducing delayed discharge patients and preventing hospital admission.

4.1 MAH opened as a regional learning disability hospital in 1949 and by 1984 the in-patient population had grown to 1,428.

4.2 The scale of resettlement between 2007 and 2020 was significant, with reduction in the population at MAH to 46 patients by June 2021. During the period of this review, the Muckamore Abbey population has reduced further to 36 in-patients by July 2022. It is encouraging that further discharges have been achieved however, 10 of the delayed discharge population are from the original Priority Target List (PTL), which relates to patients living in a long stay learning disability hospital for more than a year at 1st of April, 2007, and have been discharge delayed between 16 and 45 years. The impact of institutionalisation for a small number of long-stay patients has been a barrier in transitioning to the community. The complexity of need and range of co-morbidities of recent admissions many of whom have been impacted by previous community placement breakdown, has made discharge particularly challenging. However, the review team visited community resettlement schemes successfully supporting individuals with very complex needs equivalent to the needs of those people delayed in discharge. These examples of good practice highlight that the models of care and support required to build sustainable community placements for individuals with complex needs are already operational in Northern Ireland and the success factors need to be scaled up and embedded in commissioning and procurement processes.

4.3 The pace of progress in relation to finding new homes in recent years has been disappointing, with an increasing number of judicial reviews progressed by patients or their family carers in regards to the failure of HSC Trusts to commission an appropriate community placement for people delayed in hospital. Legal judgements have highlighted that delayed discharge breaches are incompatible with obligations pursuant to section 6 of the Human Rights Act 1998. (Ctrl Click) and Article 8 of the European Convention on Human Rights (Ctrl Click)There is therefore an ethical, strategic and legal imperative to complete resettlement.

4.4 The policy direction in Northern Ireland and Great Britain changed in the 1980's and from that time there have been a series of targets set to reduce the number of in-patients in Learning Disability hospitals and develop resettlement options.

However, targets and deadlines for achieving this have been missed, ignored and repeatedly reset.

4.5 The 1992/97 Department of Health and Social Services (DHSS) Regional Strategy,' Health and Wellbeing into the New Millennium'[1] established a commitment to reduce the number of people admitted to traditional specialist hospitals and a commitment that care should be provided in the community and not in specialist hospital environments. In 1995, a decision was taken by the Department of Health and Social Services to resettle all long-stay patients from the 3 learning disability hospitals in Northern Ireland. The target set by the Regional Strategy for the resettlement of all long-stay patients from learning disability hospitals by 2002 was not met.

4.6 The 2002 Bamford Review of Mental Health and Learning Disabilities represents the key strategic driver shaping delivery of services for individuals with learning disabilities and or Autistic Spectrum Disorder (ASD) over the past 25 years.

4.7 The second report from the Bamford review 'Equal Lives' published in 2005 sets out a compelling vision for developing services and support for adults and children with a learning disability. Equal Lives concluded that progress needs to be accelerated on establishing a new service model, which draws a line under outdated notions of grouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of the future needs to be based on integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else. This will involve developing responses that are person centred and individually tailored; ensuring that people have greater choice and more control over their life; that services become more focused on the achievement of personal outcomes, i.e., the outcomes that the individuals themselves think are important; increased flexibility in how resources are used; balancing reasonable risk taking and individuals having greater control over their lives with an agency's accountability for health and safety concerns and protection from abuse.

4.8 The Bamford review 'Equal Lives' published in 2005 (ctrl click) included a target that all people with a learning disability living in a hospital should be resettled in the community by June 2011. A priority target list (PTL) of those patients living in a long stay learning disability hospital for more than a year at 1st April 2007 was established to enable monitoring of progress on the commitment to resettlement of long-stay patients. In 2005, the Hospital had 318 patients and a target was set to reduce to 87 patients by 2011.

[1] *Health and personal social services: a regional strategy for Northern Ireland 1992-1997.*

4.9 'Transforming Your Care' was published by the Minister for Health in 2011(ctrl click) which further strengthened the commitment to close long stay institutions and complete resettlement by 2015. A draft Strategic Implementation Plan was developed to drive forward the recommendations in terms of learning disabilities with a focus on resettlement, delayed discharge, access to respite for carers, individualised budgets, day opportunities , advocacy and Directly Enhanced Services (DES) Whilst this resulted in the development of additional community services the resettlement target was again missed.

4.10 DHSSPS Service Frameworks aimed to set out clear standards of health and social care that service users and their carers can expect. They are evidence based, measurable and are to be used by health and social care organisations to drive performance improvement, through the commissioning process. The Service Framework for Learning Disability was initially launched in 2013 and revised in January 2015 (ctrl click). It sets out 34 standards in relation to the following key thematic areas; safeguarding and communication; involvement in the planning and delivery of services; children and young people; entering adulthood; inclusion in community life; meeting physical and mental health needs; meeting complex physical and mental health needs; a home in the community; ageing well and palliative and end of life care. The standards provide guidance to the sector on how to: improve the health and wellbeing of people with a learning disability, their carers and families, promote social inclusion, reduce inequalities in health and social wellbeing and improve the quality of health and social care services, by supporting those most vulnerable in our society.

4.11 RQIA Review of Adult Learning Disability Community Services Phase II October 2016 (ctrl click) reviewed progress made by the 5 Health and Social Care (HSC) Trusts, in the implementation of 34 standards, relating to Adults with a Learning Disability in the Department of Health (DoH) Service Framework. The review found that none of the 5 community learning disability teams in HSC Trusts demonstrated an evidence base for the model of service configuration they have put in place. The RQIA review concluded that community services have developed more as a result of historic custom and practice in each Trust area, with little sharing of practice noted regionally regarding models of care used by each team. It was difficult for the review team, therefore, to effectively compare and contrast the models of service provision across Northern Ireland. The RQIA review found that there is no agreed uniform model for behavioural support services across the 5 Trusts.

4.12 This review team noted that these findings still apply. Community services are at different stages of development in each of the 5 HSC Trusts and the terminology used to describe similar services varied across HSC Trusts which makes it

difficult to compare and contrast services. It is still of concern that there is no agreed model for behavioural support services. Each Trust and care provider organisation have adopted differing accredited programmes with training programmes available only on licence which limits the portability of staff working flexibly across HSC Trusts and the independent sectors. It is of note that consideration was given by a HSC Trust to deploy Trust staff to supplement the care provider workforce to expedite a resettlement however, the barrier to this innovation was that the staff in the Trust and staff in the provider organisation had been trained in different therapeutic interventions and could not work in the same team unless re-trained. It is critical that standardisation of positive behaviour approaches and therapeutic intervention methodologies is considered to maximise collaboration and enable mutual aid at times of crisis.

4.13 'Systems, Not Structures – Changing Health and Social Care' (The Bengoa Report) (DoH, 2016) (ctrl click) Guided by 'The Triple Aim': to improve the patient experience of care (including quality and satisfaction); improve the health of populations and achieve better value by reducing the per capita cost of health care. The report provides a succinct transformation model relevant and useful in the development of the learning disability service model and driving the system towards Accountable Care Systems with the provider sector taking collective responsibility for all health and social care for a given population.

4.14 Health and Wellbeing 2026 – Delivering Together (DoH, 2017) (ctrl click) is the policy response to the Bengoa Report and aligns to Draft Programme for Government with increasing focus on outcomes.

4.15 The emergence in 2017 of allegations of abuse at MAH, resulted in an independent Serious Adverse Incident (SAI) review of safeguarding practices between 2012 and 2017 at MAH. The SAI report exposed not only significant failings in the care provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities.

4.16 The final 'Way to Go' report (ctrl click) was shared with key stakeholders in December 2018 and a summary of the report was published in February 2019. This resulted in a further public commitment to the families of MAH patients by the DoH Permanent Secretary in 2018 that patients delayed in discharge would be resettled by December 2019. This commitment has not been met.

4.17 The DoH established a Muckamore Departmental Assurance Group (MDAG) to provide assurance in respect of the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH and the Permanent Secretary's subsequent commitment on resettlement made in December 2018. The DoH

recognised the need for the HSC system to work together in a co-ordinated way to deliver a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs. Some of the MDAG actions have not yet been achieved.

4.18 The 'Review of Leadership and Governance at MAH' (ctrl click) was established to build upon the SAI review and the report published in July 2020 highlighted system-wide issues and a failure in the care provided to some of the most vulnerable members of our society. The findings highlighted the need to provide a clear and coordinated regional learning disability pathway similar to that in place for mental health services. HSC Trusts were remitted to carry out a full re-assessment of the needs of their patients in MAH and prepare discharge plans for all those delayed in discharge. The review found that HSC Trusts had not yet completed a full reassessment of all patients and that discharge plans had not been prepared for all patients.

4.19 Many of the findings and recommendations from both the 'Way to Go' report and the 'Review of Leadership and Governance at MAH' (ctrl click) remain relevant and outstanding and will be reiterated in this review. The' Way to Go' report made 2 overarching recommendations; a renewed commitment to enabling people with learning disabilities to have full lives in their families and communities and the development of a Learning Disability strategic framework focused on contraction and closure of the long-stay hospital and a vision for a full lifecycle pathway across children's and adult services. The Leadership and Governance review findings highlight that Discharge of Statutory Function (DSF) reports provided annually by the Trust to the HSC Board, were largely repetitive and did not provide the necessary assurance with insufficient challenge from Trust Board and the HSC Board. This review found that this remains an area of concern and that limited progress has been made in regard to the strengthening of governance to ensure a greater challenge in regard to reporting and accountability arrangements.

4.20 The review team reviewed the strategic policy for Learning Disability services across England, Scotland, Wales and the Republic of Ireland to identify best practice and the learning from actions taken by other regions in regard to learning disability resettlement and avoidance of hospital admission. The review team identified common themes in the strategic direction for Learning Disability services across England and Scotland with focus on hospital avoidance through development of intensive care and support in the community. The following sections provide a high level summary of the key policy and practice evidence which should inform the strategic direction for learning disability services and the resettlement programme in Northern Ireland.

4.21 Despite the evidence base on concern about safety and quality in institutional settings, there has been a lack of progress in the closure of long-stay beds. This issue has been addressed across all jurisdictions over many years and it is important to learn from these experiences and actions. Our review found a striking alignment across all nations in regards to strategic direction with a focus on a Human Rights and person-centred approach. The 2007 Bamford Review of Mental Health and Learning Disabilities has been the key strategic driver shaping the delivery of services for individuals with learning disabilities and/or autism in Northern Ireland. The principles and values underpinning the Bamford review, remain relevant to current policy direction and are in keeping with the strategic direction of other UK nations. Feedback to the review team from a range of stakeholders however, highlighted the effectiveness of the Mental Health strategy in building upon Bamford and the need for refreshed strategic policy for learning disability services.

4.22 The Bamford Review of Mental Health & Learning Disability in 2002 (ctrl click) recommended a comprehensive legislative framework for new mental capacity legislation and reformed mental health legislation for Northern Ireland. The Mental Capacity Act (Northern Ireland) 2016 (ctrl click) has been partially commenced and currently provides a new statutory framework in relation to deprivation of liberty. Part 10 of the MCA will set out the provisions for people in the criminal justice system when enacted. Mental health legislation is complex most especially relating to patients with a forensic history. The review team noted a lack of clarity across the HSC system in regards to patients who have been stepped down from detention in hospital under Art 15 leave. The review team recommends a review of the needs and resettlement plans for all forensic patients.

4.23 There have been a series of high profile scandals following investigations identifying abuse to residents in HSC facilities over the past decade. MAH is the largest adult safeguarding investigation across the UK. On 8th September 2020, the Health Minister announced his intention to establish a Public Inquiry into the allegations of abuse at MAH. The MAH Public Inquiry commenced the hearing sessions of the Inquiry in June 2022 which will run until December 2022

4.24 The Care Quality Commission report (2011) (ctrl click) after inspection of Winterbourne View found a “systemic failure to protect people” Evidence of maltreatment of patients in specialist hospitals in England continued to emerge and eight years later, The Care Quality Commission report on Whorlton Hall (2019) (ctrl click) found people in learning disability hospital being failed and the Care Quality Commission (2019) found evidence of unsafe patient care and abusive treatment by staff at Eldertree Lodge, an in-patient facility for adults with learning disabilities and autism. These scandals have prompted development in strategic policy and a renewed focus on implementation plans to address the

long-standing issue of over-reliance on admission to hospital resulting in delayed discharge and institutionalisation.

4.25 Strategic Policy in England- Building the Right Support: A National Plan NHS England et al (2015) (ctrl click) placed emphasis on the "highly heterogeneous" or diverse characteristics of the population referred to as 'people with a learning disability and/or autism' This challenge has not been sufficiently addressed in learning disability policy in Northern Ireland to date. The majority of people with learning disability live with their families supported if required by a range of community services. The smaller percentage of those with a range of very complex needs requiring coordinated care and support across justice, housing, mental health, and the range of learning disability provider organisations need to be integrated into future strategic policy and commissioning direction.

4.26 There have been a range of reports on the issue of delayed discharge however, there has been a lack of robust and independent evaluation of what has worked well. England, Scotland and Wales are further developed than Northern Ireland in refreshing the approach needed. This review has identified a number of key themes across the revised strategic policy in England and Scotland that should inform revised strategic direction and short and medium term actions required for Northern Ireland.

4.27 'Transforming Care England' – Oct.2015 (ctrl click) - Good practice guidance covers strategic, operational and micro- commissioning and describes what 'Good looks like' with nine Golden threads-core principles. Key actions include;

- Provide enhanced vigilance and service coordination for people displaying behaviours which may result in harm or placement breakdown.
- Establish a Dynamic Support Database to provide focus on individuals at risk of placement breakdown and development of proactive rather than reactive crisis driven response- Target those escalating in need/ at risk of admission- risk stratification.
- Important that experts by experience have been involved in all of the panels. One of the issues has been language – such as database rather than risk register
- Establish a 'Change Fund' from the centre for development of admission avoidance 24/7 intensive support teams
- Positive Behaviour Service framework and provider engagement
- Housing Needs Assessment
- Effective Assessment tools/ Discharge planning meetings- Complex care co-ordinators to focus on transition plans
- More detailed tracker tool to support analysis and performance management to create a master database-history of discharges, re-admissions and trends.

- Fortnightly meetings on each individual patient with clear projections about the trajectory for discharge and progress over time.
- Specialist LD beds should be increasingly co-located within mainstream hospital settings rather than in isolated stand-alone units.
- The success lies not within systems and processes but within sustainable human relationships and collaboration highlighting the need for system leadership, collaborative working to build a one team approach.

4.28 The NHS 10 Year Plan was published in England in January 2019, and made specific commitments to the improvements to be progressed for people with learning disability and ASD. These included:

- Improve community-based support so that people can lead lives of their choosing in homes not hospitals; further reducing our reliance on specialist hospitals, and strengthening our focus on children and young people
- Develop a clearer and more widespread focus on the needs of autistic people and their families, starting with autistic children with the most complex needs
- Make sure that all NHS commissioned services are providing good quality health, care and treatment to people with a learning disability and autistic people and their families. NHS staff will be supported to make the changes needed (reasonable adjustments) to make sure people with a learning disability and autistic people get equal access to, experience of and outcomes from care and treatment
- Reduce health inequalities, improving uptake of annual health checks, reducing over-medication through the Stopping The Over-Medication of children and young people with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) programmes and taking action to prevent avoidable deaths through learning from deaths reviews (LeDeR)
- Continue to champion the insight and strengths of people with lived experience and their families in all of our work and become a model employer of people with a learning disability and of autistic people
- Make sure that the whole NHS has an awareness of the needs of people with a learning disability and autistic people, working together to improve the way it cares, supports, listens to, works with and improves the health and wellbeing of them and their families.

4.29 'Same as You' (2000) (ctrl click) was the catalyst for Scotland's long-stay closure programme. 'Keys to Life' 10-year Learning Disability Strategy **(**2014) (ctrl click) acknowledged wider system failure in the challenge of expediting discharges and developed a National framework agreement for procurement for specialist residential based care with a focus on the outcomes and rates that will apply. The 'Coming Home' report (2018) commissioned by the Scottish Government (ctrl click) highlighted that a significant number of people remained delayed discharge.

A short life working group was set up to undertake a focused piece of work in relation to complex needs and delayed discharge and published their 'Coming Home Implementation report in February 2022 (Gov.Scot) (ctrl click) . The findings and recommendations are broadly similar to the actions arising from Transforming Care England.

- Engagement with experts by experience and wider stakeholders is critical
- First step is accurate data on Needs Assessment at both population and individual level. Quality of assessments were found to be too generic and quality variable and not sufficiently co-produced with families
- Establish a community living change fund over the next 3 years to be used to design community based solutions running concurrently with disinvestment planning.
- Develop a National Dynamic Support Register to create greater visibility in terms of strategic planning and to allow performance management of admissions to hospital supported by a National panel that can troubleshoot individual cases
- Develop a Positive Behaviour framework-
- Produce a guide to support commissioning and procurement of complex care packages and establish detailed understanding of revenue costs of different care packages. The report highlighted a lack of effective scrutiny of data.

4.30 The Welsh Government published a Learning Disability Action Plan 2022- 2026 in May 2022. The plan builds on and incorporates the Improving Lives Programme (2018) (ctrl click) actions with a focus on reducing admissions through increased community based crisis prevention, access to specialised care and highlights the need to promote Positive Behavioural Support and Trauma Informed care.

4.31 The Irish Government published a national policy 'Time to Move On' 2011 (ctrl click)which sets out the way forward for a new model of support in the community The report highlighted that the model is simple in approach but noted significant challenges to delivery. Integral to the strategy was the 'We Moved On' stories of successful transition and promoting the voice to include advocacy, self-advocacy and family advocacy. The review team met with the HSE National lead who advised that bridging funding through a multi-annual investment plan for 5 year period has been established alongside a value for money and policy review of high cost placements to establish the level of funding per person. Robust Needs assessment was also identified as a priority.

The review team found significant learning from engagement with policy leads in England and ROI which have informed this review and findings.

4.32 Tackling the closure of long-stay beds has been a long standing problem for many decades across all UK nations. Recent strategic policy has recognised that the focus should now be on what is achievable rather than being paralysed by the challenges. There has been growing consensus nationally on solutions and next steps. It is critical that a one system approach is developed in Northern Ireland to address the silo working and duplication that remains across the 5 HSC Trusts. Adopting an accountable care approach will drive collaboration between HSC Trusts and the range of organisations involved in supporting individuals who are currently 'stranded' in learning disability hospitals.

4.4 Recommendations

- DoH should develop the strategic policy for learning disability services, updating the recommendations arising from the Bamford review to reflect the needs of the highly heterogeneous Learning Disability population and inter-connectedness with the Mental Health and Autism strategies.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better and a regional programme to tell the positive stories of those who have moved on.

5. Leadership & Governance

In the last chapter we consider the policy and strategic context for the delivery of the resettlement programme in Northern Ireland, and in this chapter we want to explore how the leaders within Northern Ireland engaged with this challenge.

5.1.1 Within the chapter we will look at how we gathered evidence of leadership and impact, and then go on to consider it under the following areas: strategic leadership and governance; leadership for the operational delivery of resettlement outcomes for individuals awaiting discharge following lengthy periods in hospital; and finally how people who use services and their representatives were engaged in this complex arena.

5.1.2 Evidence Gathered: The review team were pleased that in addition to having access to a raft of documentary evidence that we also had direct access to meet with many of the leaders within the system at all levels, and to observe or participate in key meetings within the leadership framework.

5.1.3 Amongst the documentary evidence that we accessed included strategic and policy documents, Trust Board minutes and Trust Corporate Risk Registers. We also attended the Muckamore Departmental Assurance Group (MDAG) and had access to their more recent action plans and minutes. We also had sight of material related to the Delegated Statutory Functions Reports including the composite reports and action plans.

5.1.4 A very rich area of evidence related to engagement with leaders through direct meetings. This included the Mental Health & Learning Disability Strategic Leadership Group (Directors and other senior officers from HSCB/SPPG & Trust Directors); Regional Learning Disability Operational Group (Trust Assistant Directors and Commissioning & Finance Leads in HSCB/SPPG, along with representation from NIHE and RQIA. We had 'challenge and support sessions with Trust LD Leadership Teams We have tried to represent the statutory leadership framework diagrammatically – *see below*

5.1.5 The review team were particularly grateful for the extensive and generous sharing of views and experiences from a broad range of stakeholders. Importantly this included parents and carers of people who had direct experience of the resettlement process along with charities that represent them such as Mencap. We also met with leaders from other agencies including housing, provider organisations in the independent sector, regulators for services and the social care workforce, and clinical leadership through the RCPsych. (NI) – Learning Disability Faculty.

5.1.6 An important factor needs to be acknowledged from the outset in considering the leadership challenge in relation to the resettlement programme during recent years, and relates to the context from 2019 to 2022. The global pandemic had a massive impact on the capacity and capability of leadership teams to maintain momentum on 'business as usual' priorities, as a determined focus to tackle Covid was required. Similarly during the same period the impact of MAH being identified at a national level as a hospital where patients had not been well safeguarded meant that the operational day to day logistics of maintaining safe practice in relation to sufficient and stable staffing was a significant challenge in itself. Additionally, during this period there has been an extended period of significant organisational change as the regional commissioning functions previously undertaken by the Regional HSCB were 'transitioned' back within the DoH under the Strategic Planning and Performance Group, with the new arrangements coming in to effect from the 1.4.22. Whilst these and other factors impacted directly on the progress of resettlement and offers something in way of mitigation for the poor progress of resettlement plans, it cannot entirely explain leaders' failure to deliver timely alternatives to residence in MAH in the context of the long term planning in this area. The individuals in MAH didn't

'suddenly' need new homes; there had been a lengthy 'gestation' to this situation, and many opportunities for earlier action.

5.1.7 The review considered leadership in three separate contexts. The first was strategic leadership at the most senior level of the organisations involved, including senior leaders in public service, both executive and non-executive. Strategic leadership focuses on establishing the vision and strategic direction, and ensures effective governance, oversight and scrutiny of delivery of strategic objectives. The second is senior operational leadership to ensure that plans for delivery are robust and achieved, and requires effective partnership working between commissioners, providers – both statutory and non-statutory. The third area that we wanted to consider in relation to effective leadership and governance was the extent to which people at the centre of resettlement, particularly those who were being moved to their new homes and their family members, were engaged and involved in the process, and how effectively they could shape and influence leadership. Central to this is the need to understand leadership at all levels, and how this intersects. What the review team were looking for is sometimes referred to as 'the golden thread, that should weave through all the layers of leadership to ensure that there is a seamless route from strategic vision to effective delivery, and that the best outcomes are delivered in the most efficient and cost effective way, with transformational impact on the lived experience of the people who are being resettled from institutional care to new homes within the community.

5.2 Strategic Leadership & Governance

5.2.1 Strategic leadership and governance has been central to the successes and failures within delivery of the learning disability resettlement programme in Northern Ireland. The policy context since the Bamford Review and before was clear that long stay specialist learning disability hospitals should never be someone's permanent home. Whilst the ambition was clear, and some progress was made, the goal was slow to achieve and by July 2021 46 people remained living in MAH, and more than 5 of these had been in the hospital for between 30 and 45 years. The emerging picture of extensive institutional abuse in MAH in 2018 re-focused attention on the lives of people living in MAH both in terms of the day to day safety of people who were living there, and the need to push harder to find new homes for those remaining individuals within high quality community settings. Whilst this was a significant challenge, it wasn't a new one, and had been a stated health and social policy objective in Northern Ireland since 2005, so it had to be asked why it hadn't yet been achieved.

5.2.2 In order to achieve the significant change required in improving the lives of all people with learning disability and ASD, there was a consistent acknowledgement for the need to update the strategic policy. This was a priority recommendation from the previous Independent Review Panel, which required "an updated strategic framework for Northern Ireland's citizens with learning disability and neuro-developmental challenges which is co-produced with self-

advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the hospital and must be accompanied by the development of local services."

5.2.3 The response to this recommendation was that there should be a co-produced model for Learning Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time in the right place; along with a costed implementation plan, which will provide the framework for a regionally consistent, whole system approach. This significant task was to be progressed by the HSCB/PHA, and they commissioned a consultation with a wide range of stakeholders which led to the production of a consultation response entitled "We Matter". The final draft of the "We Matter" Learning Disability Service Model was formally presented by the HSCB to officials at the DoH in early October 2021, but to date this has not resulted in the issuing of the long awaited updated strategic framework. It remains important that this work is brought to completion but equally its delay should not have been a reason for a failure on the part of the HSCB and individual HSC Trusts to expedite the resettlement process.

5.2.4 In the next chapter we will explain how in 2019/20, further to a direction from the Permanent Secretary, the regional commissioning framework clearly stated that the resettlement of people from MAH and other LD specialist hospitals remained a strategic priority.

5.2.5 In the context of the significant concerns about MAH the DoH established a Muckamore Departmental Assurance Group (MDAG). The Muckamore Departmental Assurance Group was established to monitor the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff, and the Permanent Secretary's subsequent commitment on resettlement made in December 2018. The Group is jointly chaired by the Chief Social Services Officer and the Chief Nursing Officer, and is made up of representatives from HSC organisations and other key stakeholders, and representatives from families of Muckamore Abbey Hospital patients. It was good to see such a broad constituency, including the families of people living in MAH being brought together. The group undertook considerable work which was organised and monitored through a comprehensive action plan; this was updated and monitored regularly. The plan covered areas such as leadership and governance, safeguarding, resettlement and workforce. In relation to resettlement, after three years of the MDAG operating, all of the actions relating to resettlement continued to be rated as 'red' in relation to delivery. So whilst there was a robust mechanism for holding the system to account and monitoring what had been achieved, in relation to resettlement there was an inertia which represented slow or negligible progress. This led to some considerable frustration across the system, which was evidenced through a number of families launching judicial reviews against health and care organisations to challenge a failure to deliver resettlement

outcomes for their loved ones. Despite a well-articulated call to action there was an absolute lack of urgency and focus in the delivery of the resettlement programme.

5.2.6 Within the MDAG action plan the Director of Social Care and Children (DCSC) was the identified lead for all actions in relation to the delivery of the resettlement programme. In order to deliver this the (DCSC) worked with the Trust Directors through a Mental Health and Learning Disability Strategic Leadership Group. The commissioning plan for 2019/20 was clear about the HSCB/PHA strategic priorities and intentions for resettlement and the required Provider Response (set out in Chapter 6; 6.4.6, 6.4.7, 6.4.8). In order to deliver the required action a number of groups were established to progress at pace the resettlement programme, and further explore this under the next section. However, the DSC & C/HSCB also held a responsibility for ensuring that the individual Trusts were held to account in relation to the delivery of their delegated statutory functions (DSF's), and a specific responsibility for performance management in relation to the delivery of the key strategic targets. Whilst there were fully formalised processes for accountability meetings, with remedial action proposed where performance was weak in relation to the delivery of DSF's, this rarely achieved the significant improvement required. In particular in relation to the resettlement programme, the actions taken by senior officers of the HSCB often represented at best performance monitoring, rather than effective performance management.

5.2.7 Effective performance management relies on the provision of valid data, analysis of performance measures, responsible challenge in relation to under-performance, and effective support to address broader barriers that stand in the face of objective achievement. The absence of fully effective performance management allowed for significant drift in the delivery of strategic priorities which directly impacted on the broader issues relating to the continued concerns around the safety of MAH. There has been significant organisational change since the Minister announced the closure of the HSCB, and the transfer of many of the strategic commissioning and performance management functions have reverted to the Strategic Planning and Performance Group within the Department of Health. We have seen a change in tone and approach in relation in the execution of performance management responsibilities both immediately prior to the transfer to SPPG on the 1.4.22 and subsequently. A number of additional senior appointments have been made within the social care team which should strengthen capacity. In light of these changes the review team are hopeful that the challenge and support function essential to effective performance management will continue to improve.

5.2.8 Belfast Health and Social Care Trust are central to the strategic leadership and governance in relation to the care and treatment of people in MAH, as well as to the resettlement process from the hospital. Their leadership responsibility needs to be set in the context of two important reports commissioned by the

Trust. The first of these was “A Way To Go” (2018) which undertook a review of safeguarding within MAH between 2012 and 2017, which identified extensive evidence of catastrophic failings and found that there was a culture of tolerating harm within MAH. The authors went on to express grave concern that it was “shattering that no-one intervened to halt the harm and take charge”. The CCTV evidence which supported the findings within this report also became central to the subsequent PSNI investigation of allegations against significant numbers of staff within the hospital. The second important report was the Review of Leadership and Governance at Muckamore Abbey Hospital completed in July 2020. This report described the leadership team at MAH as dysfunctional, with a lack of clarity about leadership, and a sense of dis-connectedness with the BHSCT as a whole. The report concluded that the changes in senior management resulted in confusion for front line staff; there was little evidence of practice development and quality improvement in MAH; that there was insufficient challenge from the Trust Board and HSCB in relation to the DSF reporting, and that feedback provided to the Trust from the HSCB related to failings in meeting resettlement targets. The report also reported on limited escalation of key events or concerns to the Trust Board, and also that “The resettlement agenda at the hospital meant that focus on the hospital as a whole was lost: - relatives/carers of patients and hospital staff’s anxieties about closure were not addressed in a proactive way to reinforce the positives associated with patients’ transition to care in the community. There was insufficient focus on the infrastructural supports required to maintain discharged patients safely in the community” In the final section of the report its’ final recommendation is that, “The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.”

5.2.9 In relation to this recommendation the review team undertook some desk top review of the Trust Board minutes over the preceding year. It was clear that update reports were being brought by the responsible Director in relation to all aspects of the services at MAH. However, we had some concerns about how effective the overview and scrutiny of Trust Board was in relation to certain key elements. In particular there was an acceptance of assurances given that the 16 remaining patients awaiting resettlement from MAH who were the responsibility of the BHSCT had robust plans in place for resettlement. However this was contingent on the proposed service developments which would deliver new homes, and as we will detail in later sections of the report there was no confidence that robust plans were in place for the delivery of such schemes, and that even if in train the earliest date for delivery would have been 2025/2026. In light of this the review team would consider that the Trust Board accepted reassurance from senior leaders, rather than driving for solid assurances which would underpin effective delivery.

5.2.10 One year on from the publication of the Leadership and Governance Review, which recommended that BHSCT consider sustaining the significant number of managerial arrangements instigated following events of 2017 pending the

wider Departmental review of MAH services. The current review team looking at the situation through the lens of resettlement find that there appears to have been only limited progress in relation to the changes that were called for. There continues to be some instability in relation to the leadership arrangements, in that during the last 6 months there have been changes of Director, Co-Director, Lead Social Worker and Lead Nurse; and some of these posts are appointed only on an 'interim basis' implying that they may only be temporary appointments, and with none of the incumbents bringing recent senior operational leadership experience in the field of learning disability. Whilst the review team accept the principle of the transferability of skills and that this is particularly important within senior roles, there is also a need to have a sound understanding of the 'business' particularly in the context of risks and opportunities. However the review team also acknowledge the clear commitment that these newly appointed leaders bring to their responsibilities, which could bring significant opportunity to move on at greater speed.

5.2.11 The review team could see that within BHSCT there had been a real vigour, both by Trust Board and the Executive Team, to address the issues that had emerged as the full extent of the institutional abuse at MAH became clear. This posed them with the linked challenges of rapidly improving the quality and safety of care for the patients within MAH whilst ensuring that there was progress at pace to achieve more resettlement. The review team could see that to some extent the former was contingent on the latter, i.e. that the more quickly the population reduced in the hospital through resettlement the sooner that the issues related to safe staffing levels could be addressed as assuming the staffing establishment was retained and the patient population reduced then the nurse:patient ratio improved accordingly. The review team felt that this balance wasn't maintained and that the importance of getting the hospital back to a safe and stable position diverted attention away from the importance of steady and consistent progress in relation to moving patients who were deemed medically and multi-disciplinary 'fit for discharge' to new homes. Therefore as will be laid out in subsequent sections the progress of the proposed schemes to be led by BHSCT effectively slowed almost to a standstill, and so other than for a small number of individuals who were able to move to existing provision there were very few people moved. This is in contrast with the NHSCT and SET who have secured new provision which will shortly become fully operational in the next 6 months and consequently a much higher proportion of their clients have plans where there is confidence that they will move in the near future.

5.2.12 BHSCT had a wider responsibility than the other Trusts as they were managing MAH, and had responsibility for the dedicated resettlement teams located at the hospital who had a pivotal role in being the link and liaison with the local teams within the MAH resettlement team had a pivotal role with all 3 Trust community teams including for the BHSCT, NHSCT, and SEHSCT who ultimately would assume responsibility for the clients upon transition to their new homes. However all three of these Trusts had a shared responsibility for the overall

delivery of the resettlement programme. Given the high profile concerns about the safety of MAH, and the linked urgency to find alternative homes for the remaining patients as soon as possible, the review team were concerned that not all Trusts had included resettlement of people with LD/ASD on their Corporate Risk Registers, although in some cases they were on Directorate Risk Registers. Again this may have hampered the ability of Trust Boards to assure themselves that all of the appropriate actions were being progressed to ensure swift actions were being delivered to address the significant risks.

5.3 Leadership in Operational Delivery of the Resettlement Programme

5.3.1 Within the system delivery relies on having senior executive and operational leaders who can take policy and strategy, and ensure that the linked objectives are delivered in practice, and that the outcomes that follow improve the lives of the people with learning disabilities and their families.

5.3.2 Within the HSC system in Northern Ireland this covers a broad range of leaders in senior roles in commissioning, and within statutory and non-statutory provider organisations. We have already mentioned the role of the Mental Health and Learning Disability Leadership Group which comprised Directors across the HSCB and HSC Trusts with input from other key agencies such as PHA and RQIA. It should be noted that some of these Directors had strong clinical and professional backgrounds, and had been well established within an executive role, whilst others were relatively new to role and may have come from other service domains. There was certainly a positive set of working relationships within the group, and whilst there was a well-articulated commitment to work collectively and collaboratively this was not always then evident in the subsequent partnership working. Below this group sat the RLDOG which was chaired by the HSCB, but comprised primarily Assistant Directors/Co-Director from the 5 Trusts. At times it was unclear what role the HSCB held within the RLDOG – whether their role was as convenor and facilitator, or to lead the co-ordination process and take a performance management role within the group. This contributed to a lack of clarity about leadership within RLDOG, and this meant that the commitment and engagement of senior staff from the HSC Trusts could be variable. More clarity about leadership within the RLDOG, with a clearer focus on achieving progress and delivering improved outcomes would have been more helpful. Whilst RLDOG was expected to work on a broader range of service developments and priorities across the learning disability domain, during the 6 months that the review team were involved it primarily focused on resettlement and access to assessment and treatment services within specialist LD hospitals.

5.3.3. The learning disability resettlement programme in Northern Ireland did not have an over-arching programme or project plan. Whilst it was in the commissioning plan as a strategic priority for 2019/20, and Trusts were expected to respond

accordingly, this meant that individual Trusts developed their own approaches to addressing the needs of their cohort of patients within the remaining MAH population. Some Trusts addressed this positively and developed fairly robust plans over time, but overall there was a sense that the programme was fragmented. There was certainly some evidence that HSC Trusts were planning in relative isolation. There were examples of Trusts entering discussions with providers about developing services in other Trust areas, without the 'host' Trust being informed or consulted. The HSCB convened another group called Community Integration Programme (CIP) which had a sole focus on the resettlement but it was unclear how this group's role differed from that of RLDOG, particularly given the significant overlap of membership. The HSCB had developed what they called the MAH template which HSC Trusts were asked to complete in relation to their MAH populations and plans for individuals. The review team supported the social care officer responsible for CIP to make some improvements to this so that it could be used more effectively as a 'tracker tool' and then this could support a performance management approach.

5.3.4 In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia. The system seemed more pre-occupied with process and there was insufficient focus on solution finding and achieving positive outcomes quickly. The system was also prone to adopting 'crisis-management' approaches linked to pressures escalated from BHSCT in relation to difficulties within staffing or access to admission at MAH. This meant that the system was primarily reactive rather than proactive. We give further examples of how poor leadership hampered progress in delivery in later sections.

5.3.5 Overall the review team felt that the learning disability resettlement programme would have benefitted from an effective project managed approach, which we have seen used to good effect in other similar situations. This would have more effectively co-ordinated the efforts of the system as a whole, and ensured less variation in the overall delivery of agreed outcomes. It also would have facilitated more effective opportunities to engage with providers within the social care market in order to streamline the service developments required to support the resettlement process in a timelier way, and would have brought provider-informed solutions forward for consideration.

5.4 Leadership Engagement with People who Use Services and their Carers.

5.4.1 The review team met with the Chief Executive and Patient Client Council (PCC) senior leadership team who are undertaking the role of Advocate to the Public Inquiry and supported families during feedback on the findings of the Leadership and Governance review team. PPC advised that in their engagement, families talked about the invisibility of learning disability and expressed anger and a lack of trust in the HSC system. PCC also found in their

engagement with families that safeguarding was foremost in their concerns. PCC advised the review team that the pain and trauma for families was palpable and that a trauma informed approach would be needed to engage and support families who had been let down so badly.

5.4.2 The feedback from PCC concurs with the feedback the review team received in our own engagement with families in the BHSCT, NHSCT and SEHSCT and sets the context for consideration of leadership engagement with people who use services and their carers across the HSC system. The review team will address the issue of carer engagement in more detail in a chapter 10.

5.4.3 Families reported that they felt learning disability was invisible at government and policy level and comparison was made by some families to the profile of mental health services resultant from the Mental Health strategy and appointment of a Mental Health Champion. Many families reported their fatigue, the emotional toll of life long caring and battling for resources and services over many years.

5.4.4 The Welsh Government 'Improving Lives Programme (2018) placed particular emphasis on communication and effective working relationships at all levels across the system, what they referred to as the softer skills required to drive transformation and improve lives. The importance of and necessity to build trusted relationships was evident at strategic and operational leadership levels but more so in relation to building effective partnership working with individuals and families with lived experience of using services.

5.4.5 It is clear that across the HSC system there is recognition of the need for engagement and involvement of people with lived experience in both the planning and delivery of services however this is easier said than done. Two MAH carer representatives are members of MDAG and the review team observed both carers influencing and holding senior leadership to account through constructive challenge. However, the review team did not see evidence of effective engagement of people who use learning disability services or their family carers influencing the numerous other learning disability work streams established by HSCB/SPPG to contribute to and influence the resettlement agenda. The review team acknowledge that HSCB and the 5 Trusts had significant engagement with individuals with a learning disability and family carers in the development of the draft service model' We Matter'. However this level of contribution was issue specific and has not been sustained.

5.4.6 The review team noted some tensions in the relationships between Trust Directors due to the pressures associated with the challenge of accessing an acute learning disability bed when required. The establishment of a regional bed manager as agreed at MDAG would have significantly mitigated the tension however, there was significant delay by HSCB/SPPG in the actions required to establish this post. The review team were pleased to see and wish to

acknowledge that the three Directors co-dependent on MAH have recently committed to working collaboratively with a focus on the mutual aid required to respond to challenges at MAH but also to expedite the remaining resettlement challenge. The Directors have held solution focused workshops establishing time and space for reflection and the development of the trusted relationships that will be required to further enhance a one team approach.

5.4.7 Engagement events with family carers highlighted the importance of continuity of key workers in building effective working relationships at case work level but families also referred to a trusted key worker as their go to person when they had to navigate through different parts of the HSC system or when they were facing challenge or difficult decisions. The turnover of staff at both key worker and managerial level was reported by carers to directly impact on their trust in the HSC system. Relationship based HSC practice and continuity of key worker would significantly improve the experience of people at the centre of resettlement and their family members.

5.4.8 The impact of the turnover at HSC senior management level was raised by external agencies, both external statutory and independent sector provider organisations that generally have experienced stability in senior leadership teams. NIHE Supporting People leaders advised that there has been a loss of memory for HSC Trusts due to the turnover in senior leadership. Voluntary sector leaders also advised the review team that the turnover in Trust HSC leadership is challenging and highlighted variation across Trusts regarding being respected as valued partners with significant expertise. The voluntary and independent sectors are key stakeholders in the delivery of community-based services and will be central to the accountable care approach needed to meet growing demand and challenge. The review team acknowledged that each Trust has held engagement events with provider organisations but the review team saw it as a missed opportunity not to have collaborated given that many care providers deliver across all 5 Trusts.

5.4.9 At operational level, all Trusts have made significant efforts to establish effective engagement strategies as detailed in chapter 10 however, these are at an early stage of development. BHSCT has established a robust infrastructure mapping engagement from Trust Board level with a Non-Executive Director undertaking the role of learning disability lead at Board level, through dedicated forums in MAH and community learning disability services. It is significant that only a very small number of MAH families are in attendance at the MAH Forum meeting. This would suggest a level of disengagement of MAH families. Some MAH families told the review team that they are not willing to attend meetings as they have been led up the hill too many times and only now wish to engage if there is a concrete and viable plan for their loved one's discharge.

5.4.10 Effective engagement requires trust and openness and this has been seriously impacted due to the allegations of abuse at MAH which has made engagement more challenging. Some families have such a level of distrust that they are not willing to engage with the Trust. It is important that Trusts give this matter consideration. The review team saw missed opportunities for Directors to reach out to families who had raised specific concerns relying instead on delegating to other managers.

5.4.11 The review team had the opportunity to spend time with individual families actively listening to their experiences with some families advising that this made them feel respected and their experience valued. Families also advised that at case planning level they are not always respected as experts by experience.

5.5 Conclusions and Recommendations.

The voice of people with a learning disability and their family carers was not sufficiently evident within leadership processes addressing resettlement. The review team did not see evidence of effective co-production in strategic or operational service planning and delivery.

- Consideration should be given to the development of a Provider Collaborative to bring together the range of organisations delivering specialist learning disability care with statutory HSC leaders.
- HSC system should establish an effective programme and project managed approach for the learning disability resettlement programme
- People with a learning disability and their family carers should be respected as experts by experience with Trusts building co-production into all levels across the HSC system HSC Trust

6. Strategic Commissioning, Planning and Inter-Agency Working

In this chapter we will consider the models and approaches to commissioning and how this can support effective inter-agency working.

6.1 Prevalence of Learning Disability.

6.1.1 At the foundation of good commissioning is understanding the target population and their needs both collectively and individually. Whilst the review was primarily focussed on the population of people experiencing delayed discharge within MAH, this group of individuals with very specific needs based on their experience of living with a disability and in addition their experience of living in institutional care for an extended period of time, it is important to consider them in the context of the wider population of people with learning disability or intellectual disability in Northern Ireland.

6.1.2 The 2021 Northern Ireland (NI) Census data will include data on health and disability, but this element of the data will not be published before September 2022. However the University of Ulster and others undertook data analysis funded by the ESRC (Economic and Social Research Council), which was supported by health and social care organisations, both statutory and non-statutory in Northern Ireland. The research focussed on access and analysis of existing administrative data relating to learning disability in Northern Ireland between 2007 and 2011. Their key findings included prevalence data and demonstrated that within the overall Census Population the prevalence of learning disability was 2.2%; the prevalence rate amongst those aged 15 or younger was 3.8%, whilst the prevalence rate amongst those over 16 was 1.7%. Overall prevalence of learning disability ranged from 1.9% in the NHSCT to 2.5% in BHSCT. From the Census data they found that learning disability was also associated with greater deprivation. Within their conclusions the researchers comment that there is burgeoning international research which continues to detail the extreme disadvantages that are disproportionately faced by those in society living with a learning disability. Additionally they comment that learning disability specifically, at a population level, has either remained unrecorded and undetected or has been camouflaged/hidden/buried within general health data, that have referred to limitations in day-to-day activities or inability to work as a result of health problems or disability. Learning Disability Data & Northern Ireland, Ulster University, *'Enhancing the visibility of learning disability in NI via administrative data research'* Ctrl Click

6.1.3 Mencap is a charity which works across the UK with and for people with learning disabilities and their families. They have published figures calculated using learning disability prevalence rates from Public Health England (2016) and from the Office for National Statistics [2020). They estimate there are approximately 1.5 million people with a learning disability in the UK, indicating that approximately 2.16% of the UK adult population have a learning disability. They indicate that there are 31,000 adults with a learning disability in Northern Ireland, and 11,000 children with a learning disability (0-17).

6.1.4 In simple terms what we know about the 31,000 adults is that the vast majority live in their local communities either independently or semi-independently with support from their families, friends, and support services. Less than 10% of them live in registered care or supported accommodation schemes, and in most circumstances, these are still either within or close to their local communities. At the time of writing there were only around 60 people with learning disabilities in specialist hospital in Northern Ireland which equates to approximately 0.2 % of the total LD population, and of this small group about three quarters were awaiting resettlement or discharge to new permanent homes. In considering the needs of this last group of people we have needed to look at how the system works to meet the needs of the larger population, and to look at how those commissioning services and those providing services ensure positive outcomes for this important group of individuals in our society.

6.1.5 We have commented in a previous section about the importance of developing a regional strategy and service model for services for people with learning disabilities in Northern Ireland. This strategy will need to describe this community and their diverse and varied needs so that regionally work can be completed to develop a strategic commissioning plan which can support the service delivery for this group of people. You will see later in this section that work was commenced by the HSCB and PHA on the development of a Learning Disability Service Model in 2019/20, which resulted in the co-production of a report called " We Matter " which is currently being considered by the DoH and will contribute to the production of the final strategy.

6.2 Commissioning Models

6.2.1 Whilst there are numerous models of commissioning the one that we have chosen to identify primarily is "Integrated Commissioning for Better Outcomes" which (ctrl click) was developed by NHSE, the LGA and ADASS as a practical tool for local authorities and NHS commissioners to support improving outcomes through integrated commissioning. It was published in 2018 to support health and social care economies to transform their services through a person centred approach to commissioning which is focussed on the needs of the local area. It

emphasises that effective commissioning relies on a strong focus on people, place and population.

The framework identifies what matters most to people:

- *Being the person at the centre, rather than the person being fitted into services.*
- *Citizens, people who use services, patients and carers are treated as individuals.*
- *Empowering choice and control for those people.*
- *Setting goals for care and support with people.*
- *Having up-to-date, accessible information about services.*
- *Emphasising the importance of the relationship between citizens, people who use services, carers, patients, providers and staff.*
- *Listening to those people and acting upon what they say.*
- *A positive approach, highlighting what people can do and might be able to do with appropriate support, not what they cannot do.*

6.2.2 The framework draws on a definition of commissioning developed by the Cabinet Office and Commissioning Academy in its statement about public sector commissioning.

"*We commission in order to achieve outcomes for our citizens, communities and society as a whole; based on knowing their needs, wants, aspirations and experience.*"

6.2.3 The second example is designed to help the voluntary sector work with the statutory sector and is based on the well-known commissioning cycle model. It describes the 4 stages of commissioning within the commissioning cycle as:

Analysis: this stage aims to define the change that is needed by defining the need – the problem that needs solving – and the desired outcome.

Planning: involves designing a range of options that will work to address the issues identified against the desired outcome.

Securing services: is the process of funding the option or range of options agreed to deliver the defined outcome via an agreed funding method – grant funding, contracting, etc.

Reviewing: entails evaluating the chosen option(s) to see what has worked well and what can be improved further.

Model of Commissioning

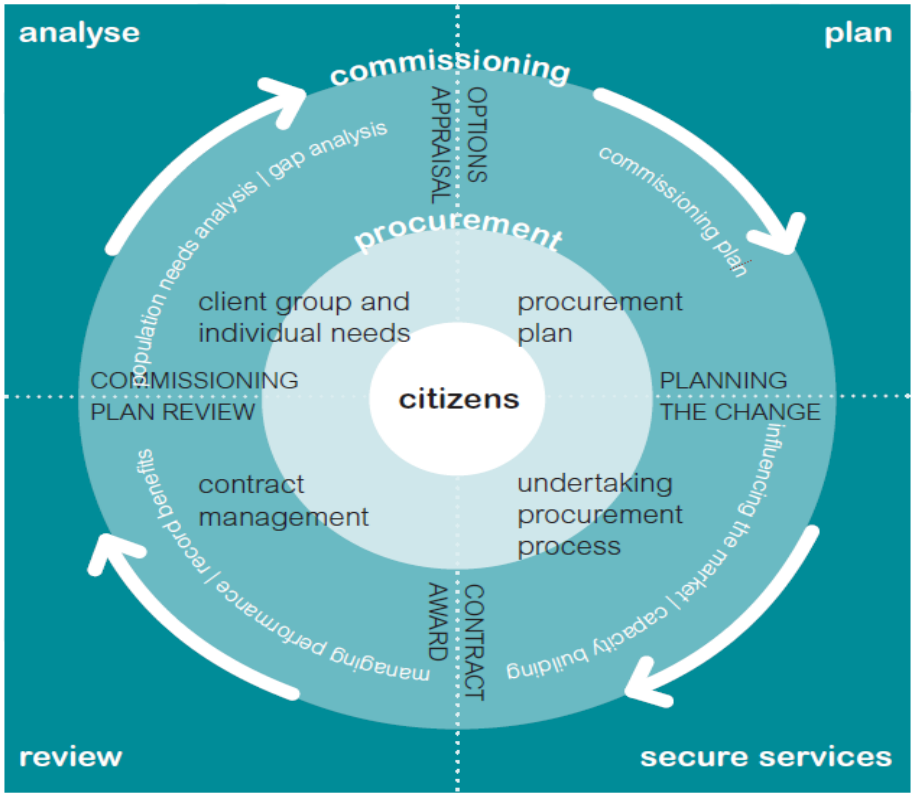


Fig 1

6.2.4 It is important to understand that commissioning activity will be essential at all levels within the health and care system. Strategic commissioning needs to support a population based approach underpinned by a strong assessment of needs, which is delivered by senior strategic leaders in partnership with other parts of the system. Locality based commissioning requires HSCT's to ensure that at a local level these strategic ambitions are delivered through the effective purchase and supply of a broad range of directly delivered and commissioned services from providers across the independent providers, both private and charitable/" not for profit". This locality-based commissioning should ensure a sufficient supply of key services including access to registered care in nursing and residential homes, and access to accommodation providing care and support for people with significant needs. Both of the above need to relate closely to 'micro-commissioning' which is where care and support is commissioned in a bespoke way for the needs of an individual through a detailed understanding of their specific needs and requirements, resulting in a personalised care solution. Micro commissioning is directly aligned to the individualised care planning which is described in a later session, and must be underpinned by a commitment to co-production with the individual and as appropriate with the involvement of family.

6.2.5 The review team needed to look at how this broad approach to commissioning had been applied to the needs of the cohort population of people who remained in MAH and who required to be discharged to appropriate community-based accommodation with access to ongoing care and support appropriate to their needs. The approach we took was to review the programme that had been developed in England to address the needs of a similar population; to consider the framework for commissioning both health & care and housing services; and to review how these arrangements had been applied in practice to support the resettlement of the group of people who had been prioritised through direction from the Permanent Secretary.

6.3 Transforming Care in England.

6.3.1 "Transforming Care for People with Learning Disabilities - Next Steps" was published in January 2015 by NHS England, Local Government Association, and Association of Directors of Adult Social Services (ADASS). The report identified a significant change in direction in the policy and practice in relation to gatekeeping admission to specialist learning disability settings, alongside dedicated strategies for admission avoidance and more effective discharge planning. The report relied heavily on a report commissioned by NHS England from Sir Stephen Bubb which reviewed how to accelerate the transformation of key services that people with learning disabilities and their families were looking for. The catalyst for this reform came after the shocking expose by Panorama/BBC in 2011 of institutional abuse of people with learning disabilities and/or autism at Winterbourne View, an independent private hospital at Hambrook in South Gloucestershire. The key organisations committed to strengthen the Transforming Care delivery programme by creating a new delivery board, bringing together the senior responsible owners from all organisations.

6.3.2 Central to the approach within Transforming Care was **a commitment to empower people with learning disability and their families**, and to strengthen people's rights within the health and care system. A key recommendation from Sir Bubb was for NHS England to introduce a "right to challenge "by providing a Care and Treatment Review (CTR) to any inpatient or inpatient's family which requested one. CTR's were to be embedded as "business as usual". Early evidence showed that the use of CTR's was effective in speeding up and strengthening discharge planning for those individuals in specialist learning disability hospitals.

6.3.3 A guiding principle in the approach was to ensure that people get the right care in the right place, and to ensure that people with learning disabilities and/or autism were discharged into a community setting as soon as possible. In

parallel there would be the development of robust admission gateway processes so that where an admission to hospital was considered from someone with a learning disability and/or autism, that a challenge process would be in place to check that there is no suitable alternative. The ambition was to reduce the number of people in inpatient settings, reduce their length of stay, and ensure that there was better quality of care both in hospital and community settings. Critically the process also required that where an individual is identified as requiring admission to a specialist learning disability inpatient facility that they have an agreed discharge plan from the point of admission. Work was undertaken in parallel to ensure that services for people with learning disability and/or autism who also have a mental illness or behaviour that challenges were improved both within inpatient and community support provision.

6.3.4 The above approach was supported through strategic commissioning by NHS and local authorities who had a shared responsibility to fund care and support throughout the pathway. This required the health and care system to develop quality standards and outcome metrics which were reflected within the NHS Standard Contract and were then applied with assurance processes undertaken by clinical commissioning groups at a local level to ensure that there were robust arrangements to monitor that individuals were receiving the right care in the right place. To support this strengthened commissioning there was a refocus on the quality of data and information so that those implementing commissioning intentions had access to the right information to ensure effective analysis and decision support.

6.3.5 Within Transforming Care there was a renewed commitment to strengthen regulation and inspection. The Care Quality Commission (CQC) were required to further refine its inspection methodology for mental health and learning disability hospital services, and to ensure that regulatory action is taken. Central to this was an explicit commitment that CQC would work with other partners to develop a clear approach for ensuring that unacceptable mental health and learning disability services were closed through use of its enforcement powers.

6.3.6 In 2017 NHS England followed up with model service specifications within the Transforming Care Programme in the context of “Building the Right Support – National Service Model “ as a resource for commissioners, The model service specifications particularly focussed on (1) enhanced and intensive support, (2) community based forensic support, and (3) acute learning disability inpatient services. These 3 aspects of the service model describe the specialist health and social care provision aimed specifically at supporting people with a learning disability who display behaviour that challenges.

6.3.7 The review team subsequently met with senior officers from the Kent and Medway Integrated Care System who had been responsible for implementation of Transforming Care within their system as strategic commissioners. Their overall conclusion was that Transforming Care had been effective in ensuring a more targeted approach particularly in relation to admission avoidance through more effective gate keeping, and the provision of the dynamic support framework, which was delivered through an inter-agency forum to ensure effective strategies were in place for individuals identified at risk of admission. Additionally, they had received funding from NHSE to improve access to 24/7 intensive support teams. Transforming Care had also ensured that there were fortnightly reviews of all inpatients with a clear focus on the trajectory and progress over time for the individual.

6.3.8 In Kent and Medway there had been a renewed effort in terms of governance with the development of a new governance framework and an oversight board to ensure that partners were accountable for commitments and performance. However even with this strengthened focus 66% of the original population identified still were awaiting resettlement. They reported that there had been some issues in relation to effective working with the Ministry of Justice in relation to those individuals who were within justice domain, and in some situations local authorities had been slow to undertake and progress housing needs assessments. Positives had been the development of a Positive Behaviour Support framework of accredited providers, and a central source of capital funding to support bids for discharge plans for individuals who had specialist accommodation needs. More recently in the early part of 2022 they had found an increase in crisis referrals which they felt could be an acuity surge related to the aftermath of Covid.

6.3.9 At a national level organisations such as Mencap and the Challenging Behaviour Foundation monitor the monthly published data from NHSE and provide a commentary on progress. This reflects a view that whilst Transforming Care has provided an effective framework for the delivery of enhanced services to people with learning disabilities and/or autism whose behaviour can challenge the improvement has been slower than originally hoped for within specified targets, and there is a concern nationally about the growing number of young people being treated within inpatient settings.

6.4 Commissioning of Health and Social Care services in Northern Ireland.

6.4.1 Up until April of 2022 the responsibility for the commissioning of health and social care services sat with the Regional Health and Social Care Board (HSCB) and the Public Health Agency (PHA) in partnership. These bodies set their key priorities and areas for action within a commissioning plan, in response to a Commissioning Plan Direction issued by the Department of Health.

6.4.2 For our purposes we wanted to look particularly at the commissioning plan for 2019/2020, as this identified some actions which were required in light of the exposure of significant abuse of individuals living in MAH which was managed by the BHSCT. The commissioning plan also identifies how resources will be allocated to Health and Social Care Trusts and other providers to maintain existing services and develop new provision.

6.4.3 There are a few general points of note in relation to the 2019/20 commissioning plan. There was little reference in the earlier sections of the document to the needs of people with learning disability in terms of emerging issues or key policy and strategy. It did refer to the production of the “Power to People “Report in 2017 looking at the possible solutions to the challenges facing the Adult Social Care and Support System in Northern Ireland. Additionally, it highlighted the continued commitment of strategic commissioners to supporting Personal and Public Involvement to improve patient and client experience. Central to this would be the embedding of co-production within collaborative working of health and social care systems, including the adoption of co-production and co-design models for the development of new and re-configured services.

6.4.4 In terms of the financial resources made available to Trusts and other providers to meet the needs of people with learning disabilities and their families this amounted to 6.58% of the total allocation for health and social care in Northern Ireland, which comes to approximately £342 million. It should be noted that these allocations may not meet the full cost of services and there may be additional cost pressures emerging for certain groups.

6.4.5 In terms of the specific commissioning commitments in relation to learning disability services made within the 2019/2020 HSCB & PHA Commissioning Plan, these are laid out in a separate short chapter of the overall report. There is a commitment to continue to adopt the Bamford Report principles when developing services for people with learning disabilities, with a particular emphasis on supporting integration, empowerment and ‘ordinary lives’. There was also commitment to co-produce with a broad range of stakeholders including people with learning disability and their families, a Learning Disability Service Model (LDSM) based on a regional review of services. Within the population sections of the plan there was no specific reference to the numbers

of people with learning disabilities, although the plan did note that, “the number of people with a learning disability and the levels of accompanying complex physical and mental health needs continues to grow in Northern Ireland.”

6.4.6 There were 2 strategic priorities identified which are of relevance to the resettlement programme for people with learning disabilities. The first states “Effective arrangements should be in place to address deficits in assessment and treatment in LD inpatient units as highlighted by the Independent Review of MAH (and other incidents affecting NI patients in private LD hospitals). In relation to this priority the Provider Requirement was, “Trusts should demonstrate plans to develop community based assessment and treatment services for people with a learning disability with a view to preventing unnecessary admissions to LD hospital and to facilitate timely discharge. (CPD2.8)”

6.4.7 The second of the strategic priorities was, “Effective arrangements should be in place to complete the resettlement and address the discharge of people with complex needs from learning disability hospitals to appropriate places in the community (CPD 5.7). In relation to this priority the Provider Requirement stated, “Trusts should demonstrate plans to work in partnership with service providers and other statutory partners to develop suitable placements for people with complex needs.”

6.4.8 In addition there was a specific Skills Mix/Workforce area identified within the commissioning plan for action. This highlighted that, “Effective arrangements should be in place to develop multi-disciplinary services in community settings to address the actions required within the Independent Review of MAH.” The Provider Response required in relation to this area was that “Trusts should demonstrate plans to recruit multi-disciplinary teams to build the community infrastructure to support people with a learning disability outside of hospital settings. Trusts should demonstrate plans to work with their independent sector partners to build the skills and capacity of their workforces to enable them to support and sustain people with complex needs in their community placements.”

6.4.9 These elements of the HSCB’s commissioning plan clearly laid out the expectations of both the Department through its directive and the HSCB/PHA response to progress actions directly relevant to the delivery of the resettlement programme in Northern Ireland. HSCT’s would have been expected to reflect these within their Trust Delivery Plans (TDP’s) so that commissioners had an understanding of the actions Trust’s proposed which could then be monitored at a regional level for progress.

6.4.10 In subsequent sections we will look at how these clear commissioning intentions were executed and to what extent these requirements were delivered.

6.5 Commissioning of Specialist Housing with Support for People with Learning Disabilities in Northern Ireland.

6.5.1 In order to consider how the Trusts were to meet the objectives laid out above it is important to understand the role of the Northern Ireland Housing Executive (NIHE) and housing associations/charities in terms of the provision of specialist housing with support for adults with learning disabilities. The NIHE is the largest social housing landlord in Northern Ireland; it is required to regularly examine housing conditions and housing requirements; it is also required to draw up a wide ranging programme to meet these needs. For individuals with housing needs that have additional support needs this is addressed through the Supporting People Programme. The Supporting People Programme helps people to live independently in the community and is administered by the NIHE in Northern Ireland on behalf of the Department for Communities. The Supporting People Programme grant funds approximately 85 delivery partners that provide over 850 housing support services for to up to 19,000 service users across Northern Ireland, with the total programme operating an annual budget of £72.8m in 2021/22. In relation to schemes for people with learning disability, the current provision has the potential to support 1334 individuals in 149 accommodation-based schemes. With an annual budget of £16.3 million.

6.5.2 The 2015 review of Supporting People recommended the introduction of a strategic, intelligence led approach to identify current and future patterns of need. Consequently, the NIHE and partners developed a Strategic Needs Assessment (SNA). This provides a comprehensive picture of housing needs for people who require additional care and support. It highlighted that people who are living with learning disability mostly require accommodation-based support rather than floating support as their disability is lifelong. A time-bound floating support intervention in these cases is not deemed an adequate intervention. Although floating support services offer the opportunity to allow individuals to remain in their own homes, respondents noted that this does not negate the need for accommodation services for those living with a greater complexity of need.

6.5.3 In terms of the SNA for people with learning disability they conclude that the analysis of current need suggests that there is an undersupply of 224 units. Research previously commissioned by the NIHE (2016) in reference to the resettlement of individuals living with learning disabilities from long stay

institutions highlighted that for these people there are several elements of supported housing services that are important:

- location or at least access to public transport network,
- safety
- Integration into the community.

6.5.4 These are important to the individuals to allow for their own independence and the feel of being part of a community. It is apparent from their research that the demand for learning disability services and in particular autism services has increased due to improved diagnosis and treatment services, which in turn will lead to an increased demand on housing support services. As the future calculations show, it is estimated that there will be an undersupply of 479 units for this cohort within a ten-year period.

6.5.5 Additionally, the SNA highlights the important issue of access to capital for housing development. Some providers have highlighted that capital investment would allow them to provide the required level of service to meet the growing demand as well as a wider range of housing support services.

6.5.6 It also refers to some early joint planning work between the NIHE, HSCB and HSCT's in relation to improving planning for the needs of people with learning disabilities. The information gathered and analysed in 706 person pilot conducted by HSCB with HSCTs for people with learning disability the report identifies could help inform future strategic needs assessment particularly if standardised approach were developed.

6.6 How commissioning operated in practice to deliver the resettlement programme for the people awaiting resettlement from MAH.

6.6.1 The commissioning plan from the HSCB/PHA had made an explicit requirement for the resettlement of the remaining people awaiting discharge to be progressed at pace.

6.6.2 In order to progress the HSCB convened a number of groups to support this process. There was a Mental Health/Learning Disability Strategic Leadership Group comprising senior leaders from the Directorate of Children and Social Care in the HSCB and the Directors responsible for learning disability services in each of the Trusts. This group had a leadership role across the whole of mental health and learning disability services, and held a collective strategic responsibility for the delivery of resettlement. This group sponsored 2 subgroups which comprised officers of the HSCB and senior operational staff

from the Trusts, including the Assistant Directors/Co-Directors responsible for learning disability services. Initially this only included representation from Belfast, Northern and South Eastern Trusts as the remaining people in MAH awaiting discharge were the responsibility of these organisations by virtue of the individual's original place of residence. These subgroups were (1) the Regional Learning Disability Operational Group (RLDOG) which included some representation from NIHE, and other agencies such as RQIA, and (2) Community Integration Programme (CIP) which looked more specifically at the issues pertaining directly to the resettlement programme.

6.6.3 The review team were able to observe and participate in all of the above groups and in addition had specific meetings with each of the Trust's senior leadership teams responsible for learning disability resettlement.

6.6.4 It was positive that the HSCB had created a structure of groups and meetings to progress the resettlement programme and address related issues, particularly in relation to access to learning disability hospital beds for assessment and treatment. There was a clear commitment from senior leaders to support the delivery of the resettlement programme and to work jointly to face and address the significant challenges.

6.6.5 However we felt that overall the commissioning of services was poorly framed and lacked effective performance management. This meant that the HSCB (and more recently SPPG) has struggled to achieve timely impact in ensuring the Trusts secured new homes for the people awaiting discharge from MAH.

6.6.6 There were a number of particular weaknesses which the review team identified. The HSCB were using a basic table to monitor the status of the individuals in the target population, which the review team assisted with re-design. Updates on this revised 'tracker tool' were sometimes only provided after chase up, and often not validated by the respective Trust AD/Co-Director, so may not have been reliable. Attendance at these key meetings was generally poor and inconsistent, contributed to in some instances by the too frequent changes in personnel in significant delivery or planning roles. Hopefully this report will be a catalyst for the SPPG to review with its partners the effectiveness of both CIP and RLDOG.

6.6.7 Whilst colleagues from other agencies – NIHE and RQIA – were involved in RLDOG it was sometimes unclear how they were expected to engage in the activity to progress schemes and proposals at speed. In particular the housing professionals held a wealth of information and data about activity in the existing system and had expertise in both design and delivery of housing schemes which wasn't always drawn on by colleagues from health and social care. Housing colleagues described how they felt the inter-agency working had

become less evident and effective in recent years, partly due to the lack of stable leadership and management arrangements at times in health and social care. They felt that some of the current senior staff lacked the understanding of the housing and Supporting People sector that their predecessors had demonstrated.

6.6.8 Whilst there was a verbalised commitment to working collaboratively, this was sometimes hampered by poor communication between the key partners. This was especially significant where a lead Trust was developing or planning a scheme which had the potential to provide accommodation for individuals from other Trusts. In some instances plans had not been shared with other partners which meant they weren't sighted on proposals for developments to be located in their Trust area, without their involvement in the planning, which had potential to place demand and pressure on local learning disability and other services.

Perhaps the most significant area of concern was the scrutiny of the proposed accommodation schemes and the supporting business cases to develop those schemes by the HSCB and individual Trust Boards. This rarely involved rigorous assurance that the planning for schemes would deliver new accommodation for individuals awaiting resettlement within a reasonable timescale. Subsequently the stated ambition that all people awaiting discharge from MAH would be resettled by the end of 2019 was completely missed, with slow progress verging on inertia beyond that point.

6.6.9 Having set out the regional landscape for strategic commissioning of health, social care and housing we will move in the next sections to look at how Trusts have progressed the individualised care planning (Chapter 7) and local commissioning of new provision to progress the resettlement plans developed for individuals.(within Chapter 8)

6.6.10 Across the system the review team were concerned that there were significant examples of poor or slow decision making, limited communication to support a fully collaborative approach, and weak management grip to address practical barriers that delayed positive outcomes being achieved – an example of this was transition/discharge plans being delayed for sometimes lengthy periods because required adaptations to property had not been completed, or legal advice in relation to placement matters had not been satisfactorily addressed.

6.6.11 There were a few legitimate challenges faced by the HSC system which we acknowledge compromised delivery within agreed timescales. The obvious challenge across the whole system was the global pandemic and the significant impact this had on capacity. This impacted further on workforce issues which all parts of the system described as placing them under real difficulties. Less likely to have been anticipated were the issues in relation to building and

estates , as new providers experienced unprecedented pressures in relation to the escalating cost and reduced supply of building materials which slowed the delivery of some schemes.

6.6.12 It is worth noting that all of the Trusts had engaged with some of the well-known providers in the not-for-profit sector, several of whom had a well-tested track record of meeting community demand for care and support to individuals with learning disability and behaviour that can challenge. This had resulted in a small number of resettlements being achieved through the design and delivery of high-quality singleton placements. Some of the families that we had engaged with told us stories of truly transformational and life changing experiences when their relative moved on from hospital to these schemes, and we will return to this in Chapter 8 when we look at the Operational Delivery of Care and Support.

6.6.13 However, it should also be noted that generally the review team found that Trusts often initiated planning for proposed new accommodation schemes without fully exploring the opportunities for potential provision within either existing or re-designed provision. If this had been possible then options for resettlement could have been developed in a much more speedy way.

6.7 Shaping the Independent Health and Social Care Market for People with Learning Disability

6.7.1 In the last few decades across the UK and more widely we have seen a significant shift away from hospital based long term care for people with learning disability towards community based provision. This shift has been driven by a clearer commitment to respecting the human rights of people with learning disabilities which has been enshrined in health and social policy.

6.7.2 Large scale institutional care has been replaced by a mixed economy of alternative care arrangements ranging from large scale group living to individualised specialist housing with dedicated care and support.

6.7.3 In England the responsibilities for market shaping are enshrined in the Care Act (2014) which states that each local authority “Must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person wishing to access services in the market:

- Has a variety of providers to choose from who (taken together) provide a range of services
- Has a variety of high quality services to choose from

- Has sufficient information to make an informed decision about how to meet the needs in question."

6.7.4 The Care Act reinforces that commissioning should be at the heart of personalised care and support. This includes commissioning with health and care organisations but goes further to include engagement with community development and working with other agencies, for example the community sector.

6.7.5 Whilst a similar statutory responsibility is not placed on HSC Trusts, they do have legal responsibilities to provide services, and should do this not only through direct provision but also by purchasing services from independent sector providers. Implicit within these broader responsibilities is a need to support and shape the market to ensure robust supply and to secure value for the public purse.

6.7.6 The review team found that health, social care and housing agencies held significant data on the current market provision relating to services for people with learning disability. RQIA hold information on each registered provider of nursing or residential care and can provide information not just on the capacity of those providers but also can provide quality information through a highly regulated inspection process. In addition, they are responsible for registering the domiciliary care element of supported living schemes which are responsible for providing the support element. We were impressed by the data that the NIHE hold relating to the 149 accommodation based supported living schemes which included both activity and financial data relating to both housing and HSC investment in these schemes, where the balance of the funding for each scheme is based on a functional analysis of the housing support vs care needs of the clients within the scheme.

6.7.7 However, the review team found that this data was not routinely shared by partners across the sector and that there was no strategic overview of what the market was providing for adults with learning disability across Northern Ireland, and at what cost. Given the availability of significant data we would expect that both strategic and local commissioners of care and housing would undertake some analysis to develop a 'supply map' of care and specialist housing for people with learning disability in Northern Ireland. This could inform strategic commissioning and market shaping, but it would also be of benefit to care managers, individuals seeking care and their families so that they understood the options available to them which could promote choice. This should be a live and dynamic picture of supply.

6.7.8 The review team gathered information from a range of sources, and undertook some analysis to establish an initial supply map, and identify commissioning trends. We will address within the recommendations. Below is a table which shows the overall range and location of registered care settings and supported living schemes in Northern Ireland. This sector provides accommodation capable of meeting a diverse range of needs, all located within the community. In total there are somewhere in the region of 2,500 places in the community for people with learning disabilities and a significant minority of the schemes have been devised to accommodate individuals who additionally have mental health difficulties or behaviour that can challenge. The cost of care across the sector is highly variable and is linked directly to the level of support and care required. For those individuals who live in the registered care sector all of the care costs are met by health and social care (although there could be a small number of 'self-funders'). HSC Trusts purchase places in registered care setting either through block contract or on a 'spot purchased' basis for individuals.

	Learning Disability	Residential Care Places		Supported Living	
	Disabilty /Nursing Home places	Statutory	Independent	Statutory	Independent
BHSCT	4 N-Homes/103 Places	6 RCH/39 Places	4 RCH/40 Places	7 Schemes	18 Schemes
NHSCT	8 N-Homes/247 Places	2 RCH/15 Places	6 RCH/58 Places	6 Schemes	27 Schemes
SHSCT	6 N-Homes/166 Places	0 RCH/0 Places	6 RCH/57 Places	13 Schemes	11 Schemes
SEHSCT	2 N-Homes/ 55 Places	2 RCH/15 Places	11RCH/180 Places	5 Schemes	38 Schemes
WHSCT	1 N- Homes/ 35 Places	5RCH/55 Places	6 RCH/ 88Places	2 Schemes	15 Schemes
Total	21 N- Homes /606 Places	15RCH/123 Places	33 RCH/423 Places	33 Schemes	109 Schemes
				Total of SP = 1420 Supporting People Tenancies/144Schemes	

(RCH – Registered Care Home) Fig 2

6.7.9 For those living within the housing with support provision the individual is usually funded through a combination of rental income which is commonly paid through housing benefit, an element for housing support paid from Supporting People funds, and then a care element paid for by the placing HSC Trust. Obviously in the case of supported living, the financial costs are spread more across 2 government departments – communities and health – and then arranged through the NIHE and HSC Trusts. In supported living the individual will have a secured tenancy, which ensures rights as a tenant under the relevant housing legislation. Additionally, the individual will be eligible to apply for

personal benefits and therefore could have more disposable income which can support greater financial choice.

6.7.10 The review team undertook a preliminary analysis of the market and in this context there were some interesting features of the market in Northern Ireland which merit some note. There are vacancies across all sectors, although the data on this wasn't readily held or available when we asked for it from Trusts, yet when talking to providers they all reported some level of vacancy across provision. For some providers in the private sector this was a particular issue in terms of sustainability, and they stated a willingness to work with local commissioners to adapt their services to be more appropriate to need and demand both now and in the future. Across the supported living sector there was somewhere in the region of 5% vacancy, which whilst relatively small did provide some opportunities to meet emerging demand, although the SNA completed by the NIHE indicates that they believe there is under provision for people with learning disability at present.

6.7.11 HSC Trusts continue to be a major direct provider of services to this client group both in registered care and supported living. Trusts operate 31% of the registered care settings for people with learning disabilities accounting for almost a quarter of the registered care places. In the supported living accommodation schemes 24% of the schemes were operated by the local HSC Trust. There is considerable variability in the extent to which Trusts continue to operate as providers. For instance, the SHSCT operate 55% of the supported living schemes in its area, but the WHSCT operates 11% of the supported living schemes in their area. This raises some interesting questions which the review team haven't fully explored in terms of the delineation of roles for Trusts both as commissioners and providers of care.

6.7.12 In relation to the registered nursing home sector these are all private sector operators. There are 21 specialist learning disability nursing homes in Northern Ireland, and the majority are operated by local providers some of whom have entered the market because of a family related interest in learning disability care or are led by professionals who previously worked within statutory services. However, 60% of the specialist nursing homes are located within 2 Trust areas of the NHSCT and SHSCT, with the majority in the NHSCT.

6.7.13 Further strategic inquiry is merited in relation to the type of need being met by statutory versus non-statutory as anecdotally this appeared to be based on historical context rather than based on strategic decisions. There could be a rationale for the HSC Trusts continuing to be such a significant provider, especially if this was to meet a category of need that the market for social care had struggled with, but again anecdotally this didn't appear to be the case.

Providers pointed out that as statutory providers were using Agenda for Change terms and conditions in employment arrangements within their direct provision, this placed Trusts at a tactical advantage in terms of recruitment and retention of staff. We will return to this issue in the later section on workforce.

6.7.14 Engagement with Private Sector Providers: we engaged with provider sector providers through a number of focus group sessions organised by 2 of the network organisations representing providers across the independent sector. These were ARC (NI) and Independent Health Care Providers (IHCP). The sector engaged very readily in the review and were keen to give their views and share their experiences of working within the wider system. Generally, providers, especially those in the private sector, felt that the resettlement teams and HSC Trusts had not engaged them in a strategic discussion about the sector's potential in meeting the needs of people awaiting discharge from long stay institutions. Several providers described that whilst they may not have been considered in the first instance, there were several occasions where they had been asked to consider and had admitted some individuals who had experienced unsuccessful placements elsewhere. In these cases several of the subsequent placements had gone on to be both successful in terms of client outcomes and stability over time.

6.7.15 Generally, providers expressed concern about the lack of effective partnership between commissioners and providers. In particular they felt that HSC Trusts were unwilling to engage in negotiations around 'risk-sharing' in terms of contractual measures that ensure a reasonable level of income to support the borrowing necessary to allow capital development and borrowing. This was more of an issue for smaller providers who were newer to the market. Providers also expressed a general view that whilst there was extensive engagement with HSC Trusts care management staff and contracting teams in relation to contract review, there was little discussion about forward planning or potential for service development. Additionally, several providers worked with a number of commissioning agencies or HSC Trusts and commented on the variability in processes and overall approach. Given the size of Northern Ireland there definitely should be consideration given to the development of a commissioning collaborative operating under a single commissioning framework. Nursing and independent residential care providers commented that they were being expected to operate under out of date nursing/residential care contracts with amendment through letter of variation, and these arrangements were not fit for purpose. This proved unsatisfactory, particularly in the context of the complexity of need of some of the clients.

6.7.16 The statutory sector within health and social care have organised their activity through the Social Care Procurement Board (SCPB) which was chaired by the

Director of Children and Social Care at the HSCB/SPPG with representation from each of the 5 Trusts and legal services. The SCPB has been going through a 'refresh' process to review its role and how it operates. Its revised draft terms of reference include:

The Social Care Procurement Board will:

a) Develop a Social Care Regional Procurement Plan that places all approved procurement projects within the overarching strategic commissioning landscape and includes the rationale for each procurement project being taken forward.
b) Ensure any request for a regional procurement project is only approved when the project can demonstrate a clear and unambiguous link with the Programme for Government and strategic commissioning plan for a related programme for care.
c) Establish a Social Care Procurement Project Delivery sub group for the operational management of the Social Care Regional Procurement Plan, with the Chair of the sub group to be a member of the Social Care Procurement Board.
d) Establish additional specialist sub groups in response to strategic commissioning needs.

6.7.17 Whilst it is encouraging to see this renewing of the SCPB it is imperative that they engage effectively in broader strategic engagement with providers so that commissioning strategies are informed and shaped with intelligence from the sector itself. There needs to be a recognition that the commissioned services with independent sector constitute a multi-million pound investment which has a massive impact on the lives of people with disability. Additionally, as elsewhere in the rest of the UK and Europe there is a growing recognition of the demographic shift in the population of adults with learning disability/ASD and behaviour that challenges leading to massive increases in demand which are related to the exponential growth in numbers of people diagnosed with LD and ASD, and the improved life expectancy of people with learning disability.

6.7.18 Several Trusts have provided us with information about provider engagement events or have established regular provider forums, to improve their partnership working. This would be best progressed through greater regional collaboration which could be supported by the SCPB's prioritisation of this important area of work.

6.7.19 Critical to this work will be developing an understanding of the pricing structure for care, and in particular the significant variation in costs across the sector. It will be important to understand both financial viability and financial sustainability of this relatively small cohort of specialist providers.

6.8 Finance and Value for Money

6.8.1 Commissioners, both strategic (regional) and local (within Trusts) have a broad duty to ensure value for money in relation to all expenditure within the public purse. This responsibility is scrutinized by the Northern Ireland Office who can pursue Value for Money Audits in relation to key areas of work.

6.8.2 The review team were not required in the context of the terms of reference for this review to undertake a detailed analysis of the costs associated with the resettlement programme, but there are a number of observations that we would make in the context of strategic commissioning.

6.8.3 The review team have had discussions with finance officers within the HSCB regarding the commissioning of learning disability services, including the services provided at MAH and the alternatives being proposed through the resettlement schemes.

6.8.4 The costs associated with the funding of MAH is linked to the funding of the resettlement costs. In the past a 'dowry' system applied where each individual being resettled from a long stay hospital received an allocated sum to support their resettlement, but there was a broad acceptance that the dowry was often insufficient to cover the costs of the placement. Whilst the dowry was person specific once it was no longer required to support that named individual, then it could be incorporated in to the base funding for future community placements at some point.

6.8.5 In more recent years this has been replaced with a requirement that the HSCB would receive costed proposals for the resettlement of an individual, directly linked to the cost of a placement or place within a newly developed scheme, and there is an approval process. This requires the HSC Trust to submit a client specific business case for each individual with complex needs, in which the Trust is required to lay out provisions for capital and on-going revenue costs, and should demonstrate value for money to the public purse. The business case must also demonstrate what elements, if any, are funded through sources of funding outside of health, usually housing/supporting people funds. This include access to personal benefits – housing and welfare payments, rental costs, or Supporting People funding towards housing support and some elements of management costs within schemes.

6.8.6 In broad terms the costs associated with the funding for MAH is linked to the funding of the resettlement costs. There would have been an assumption that a certain proportion of resettlement costs were linked to an expectation of ward closure and decommissioning of beds as the patient population reduced. In reality there should have been a decommissioning plan agreed between the BHSCT and HSCB linked to the resettlement programme, but this doesn't appear to have been put in place.

6.8.7 In recent years the number of patients leaving the hospital has been relatively low. However in addition the number of patients remaining in MAH is substantially lower that the commissioned beds. Costs within MAH have

escalated dramatically as there has been an increased reliance on funding of substantial agency staff to replace staff who have been placed on suspension during the course of the PSNI investigation.

6.8.8 This has meant that in the last several years the BHSCT has had to seek additional funds non-recurrently from the HSCB to cover these additional substantial cost pressures.

6.8.9 The other factor to consider is the cost of the alternative homes that are being commissioned for people moving on from MAH through resettlement. Through the 'tracker tool' the Trusts have reported on discharge planning for each individual and where there is a scheme either nearing completion or with a costed business case approved they provide indicative costs. Not all Trusts provide this information, but based on the return from the NHSCT the annual costs of the new provision range from £212k to £500k per annum for the majority of clients. It should be noted that there was one client who had costs significantly higher than has been quoted in the range but as this was deemed an exceptional individual with what could be considered the most complex needs that individual hasn't been included in the range.

6.8.10 As stated previously the SCPB will need to consider benchmarking the costs of these specialist community placements so that SPPG, HSC Trusts and others can establish what 'value for money' looks like in this domain. Additionally it has to be recognised that the community placements should provide significant quality of life benefits to those individuals who have previously lived in MAH.

6.8.11 Whilst the review team did not have access to detailed cost per bed data for MAH, based on our discussions with finance officers it would appear that the cost of hospital bed in MAH per annum currently is significantly higher than even the highest costed placement within the range of placements provided by NHSCT, and substantially higher than the estimated average cost of a community placement. In addition it has to be considered that for placements in specialist supported living schemes, a proportion of the costs will be shared with housing.

6.8.12 In the context of the position laid out above there needs to be consideration of the opportunity costs in this situation. A simple definition of 'opportunity cost' is "opportunity cost is the forgone benefit that would have been derived from an option not chosen or pursued". The review team consider that if the resettlement of the target group of patients had been achieved more quickly and within the timescale of the original directive from the Permanent Secretary in 2018, then there were opportunities for cost efficiencies in relation to the cost of community placement relative to the cost of continuing hospital placement for these individuals. This may be open to alternative interpretation and debate, but there is certainly merit in considering this as part of any more formal evaluation of the resettlement programme.

6.9 Recommendations

In summary the conclusions and recommendations from this chapter are:

- The DoH needs to produce an overarching strategy for the future of services to people with learning disability and their families, to include a Learning Disability Service Model.
- In the context of the overarching strategy the SPPG will develop a commissioning plan for the development of services going forward. This should include the completion of resettlement for the remaining patients awaiting discharge from MAH, and progress the re-shaping of future specialist LD hospital services.
- Strategic commissioners within health, care and housing should convene a summit with NIHE, Trusts, Independent Sector representatives, and user/carer representation to review the current resettlement programmes so that there is an agreed refreshed programme and plan for regional resettlement.
- The SPPG and NIHE/Supporting People should undertake a joint strategic needs assessment for the future accommodation and support needs of people with learning disability/ASD in Northern Ireland
- The Social Care Procurement Board should urgently review the current regional contract for nursing/residential care and develop a separate contract for specialist learning disability nursing/residential care.

7. Individualised Care Planning

In this section we will review the policies, and discharge planning guidance in place nationally to identify good practice; critically review the individualised care planning arrangements in place in each of the 5 HSC Trusts and assess their effectiveness.

7.1.0 As part of evidence gathering, the review team issued a questionnaire to all 5 HSC Trusts requesting confirmation of the assessment tools and care planning procedures and processes relied on to support discharge planning.

7.1.2 Engagement with family carers and provider organisations, provided rich information to the review team in regards to the effectiveness and experience of discharge planning and this feedback highlighted a gap between the perception of statutory HSC Trust teams leading the discharge planning and the experience of other stakeholders.

7.1.3 The review team analysed the information returned by HSC Trusts and completed a review of research and available guidelines and best practice relating to individualised care planning. The review of policy and guidelines highlighted the need to plan discharge from the moment of admission. The Care Quality Commission- Brief Guide; discharge planning from Learning Disability assessment and treatment units August 2018, (ctrl click) provides a useful checklist of what needs to be in place for effective discharge planning;

- At the point of admission, the care plan should include a section on 'when I leave hospital' and the discharge plan discussed at each meeting
- Ensure family and the individual are involved with clear goals agreed
- Discharge plans need to contain a date, an identified provider and discharge address
- Evidence that the person is being supported to develop skills for independence and living in the community
- Evidence that information is shared appropriately with providers to prepare for discharge with the outcomes of assessment and treatment clearly stated.

7.1.4 There are a range of relevant Guidelines to inform effective assessment and care planning. NICE guidelines- 'Challenging Behaviour and Learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges' (ctrl click) highlights the importance of understanding the cause of behaviour and need for thorough assessments so that steps can be taken to help people change their behaviour The DoH Guidance 'Positive and Proactive Care: reducing the need for restrictive

interventions (2014) (ctrl click) is also based on a positive and proactive care approach The Care Quality Commission, Brief Guide: Positive behaviour support (PBS) for people with behaviours that challenge (2018) (ctrl click) provides the policy position and helpful good practice case examples.

7.1.5 Promoting Quality Care' Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability services(May 2010) (ctrl click) states that a crisis plan should be included in the care plan and specify triggers and warning signs with explicit proactive and preventative strategies in the care plan. Effective assessment and care planning is central to supporting the transition of individuals from hospital to the community who have highly individual communication and support needs. Guidance and policy highlight that an essential lifestyle plan alongside the positive behaviour support plan should be central to discharge planning in addition to core assessment tools. The Centre for the advancement of PBS-(BILD) (ctrl click) advocate a whole organisational approach to embed PBS with all staff having a basic understanding of PBS and its value base. The learning from resettlement placements that have broken down and feedback from families and care providers highlights that positive support plans have not always been in place and that further work is required to ensure regional standardisation in regards to the quality of assessments and the tools used.

7.1.6 Questionnaires returned by HSC Trusts highlighted a lack of consistency regionally in the documentation used to develop care plans supporting a person's transition from Learning Disability hospital to the community. HSC Trusts use a range of assessment templates which are not always collated into one document. All HSC Trusts used the Northern Ireland Single Assessment Tool (NISAT) DoH Procedural Guidance- February 2019 (ctrl click). However, this comprehensive care management assessment tool is generic and not sufficiently person centred. Some Trusts, appropriately supplemented the NISAT with a range of assessment tools, including 'Essential Lifestyle plans 'Promoting Quality Care assessment, Functional assessment, Motivation assessment scale and Behaviour support plan. If a person is displaying challenging behaviours, a functional assessment can help uncover the reasons behind that behaviour. Knowing the function, allows changes to be made that reduce challenging behaviour. It is essential that discharge planning is person centred and that the information is accessible and available to all the stakeholders involved in supporting the person to move on from hospital. This highlights that assessment tools will only be effective if the organisational culture is based on positive behaviour support for people with behaviours that challenge and staff trained to understand and evaluate communication and to implement proactive and preventative strategies in response to triggers and warning signs to avoid escalation and crisis. Review of strategic policy across

England, Scotland and ROI confirmed that all prioritised the development of a positive behaviour framework.

7.1.7 The review team recommend that HSC Trusts collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans. The review team recommend that the learning disability strategy / learning disability service model to be progressed by DoH takes the evidence base for PBS and learning from other UK nations into consideration.

7.1.8 The discharge process requires sufficient flexibility to ensure agility and prevent the process being risk averse, however, an overarching pathway that maps out who does what at critical stages of the process is required. The review found that there is no overarching resettlement/ discharge policy that informs the roles and responsibilities of the range of organisations, teams and individuals involved. Indicative timelines for case transfers between teams and organisations is required so that individuals and their families know what to expect at each stage of the transitions pathway. The review team recommend that HSC Trusts collaborate with all stakeholders to develop a resettlement pathway and operational procedure.

7.1.9 Most Trusts were clear that it is the community HSC Trust that has the lead role for discharge planning rather than the hospital team however, this was not consistently applied regionally. The review team worked with all HSC Trusts throughout the period of the review with agreement reached that the community HSC Trust held responsibility and accountability to lead resettlement planning once the patient had been identified as ready for discharge. The community HSC Trust will be reliant on the MAH team who have the contemporaneous experience of caring for the patient to provide clinical information and input to the care plan however the community HSC Trust should hold a challenge function in addressing any discharge delay.

7.1.10 The MAH resettlement co-ordinator has a central role in facilitating meetings and coordinating the information the hospital team need to share with community Trusts and provider organisations. Provider organisations had to develop their own care plans from information shared by the MAH team and the assessment completed by the relevant HSC Trust, whilst getting to know the patient during in-reach. They reported significant weaknesses with this approach.

7.1.11 It was generally recognised that it is a complex task to develop care plans for community living based on behaviours and triggers evident in an institutional setting. This highlighted that the community teams should lead the discharge

care planning processes with active collaboration with families and provider organisations which was not always evident in the review.

7.1.12 Learning from failed placements and engagement events with provider organisations and with families, highlighted that not all care plans were robust in highlighting the key issues and risks for the individual. Families shared their experience of resettlement placements breaking down within weeks and months of the trial placement with recurring themes; staff not knowledgeable or trained in Positive Behaviour approach, inexperienced staff relying on physical interventions and care plans that did not reflect the level of support that would be required in the community.

7.1.13 Families were confused by the process of handover between teams due to a lack of clarity regarding the roles of the community learning disability team, the dedicated resettlement team and the MAH team when a patient is discharged on trial. Families were unclear of the process for standing down the resettlement team and transitioning to the community learning disability team. Some families who had experienced placement breakdown during trial resettlement felt that the process was too focused on the MAH multi-disciplinary team for advice and support rather than involvement and wraparound services from the community learning disability team. Some families expressed the view that their loved family member was returned to MAH at the first challenge when more should have been done to sustain the community placement. There should be a clear process mapped out through the resettlement pathway providing clarity of roles and mapping out indicative timeframes for transitions between teams for patients and families long the resettlement pathway.

7.1.14 Care providers reported a negative experience of care planning due to gaps in the information that should have been provided by HSC Trusts. Assessments were stated to be based on the current behaviours in an institutional setting and not on the hopes and dreams that should be central to strength based person centred planning

7.1.15 There was insufficient evidence of the learning from things going wrong being used to improve discharge planning regionally and no evidence provided that the learning is shared with care providers. Care providers also highlighted that the focus tends to be on what has gone wrong rather than on what is going right and that the HSC system should collate the learning from successful placements. The review team recommend that HSC Trusts collaborate with key partners to share the learning when things have gone wrong as well as the success factors when resettlement has worked well and celebrate positive resettlement stories.

7.1.16 The review team were tasked to review the care plans for all the service users in MAH and critically analyse the actions taken to identify and commission suitable community placements. The terms of reference asked the review team to look specifically at the MAH population profile by the length of time the person has been in MAH, where they were admitted from and if resettlement has already been trialled. The analysis of the thirty six current in-patients and 4 patients on extended leave is presented in the following charts.

Table 1.1 MAH current population by length of stay (Inclusive of 36 in-patients and 4 patients on extended leave).

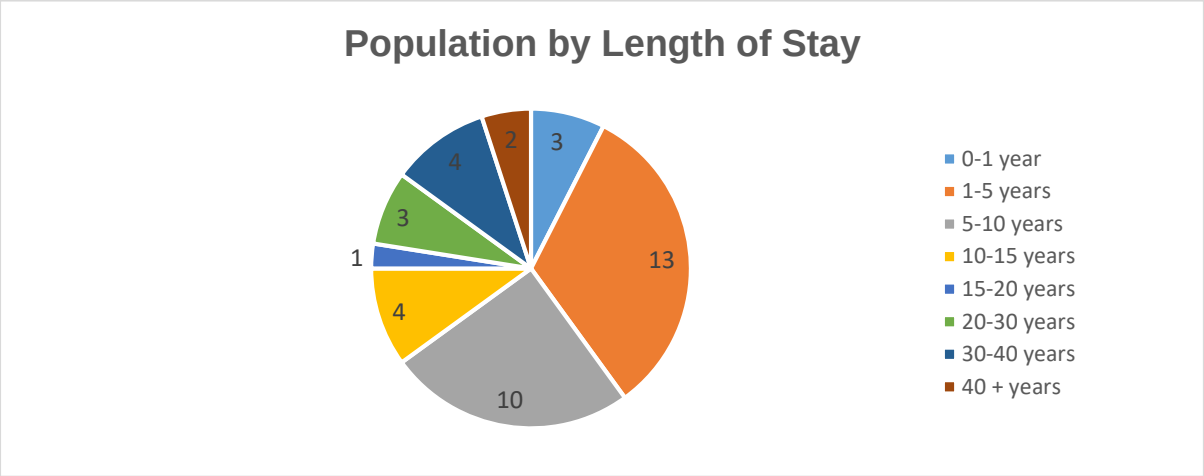


Fig 3

7.1.17 The original Patient Target List (PTL) was established to target long-stay patients for resettlement who had been in-patient at MAH for more than one year in 2007. The analysis of length of stay of the current in-patient population identified ten patients from the PTL list who have not been resettled of whom six have been in MAH over thirty years and 2 in MAH over forty years. The range of lengths of stay for the remaining 16 delayed discharge patients not on the PTL list, varies by HSC Trust. SEHSCT range between 2 and 4 years. BHSCT range between 2 and seven years and NHSCT range between 2 and ten years.

7.1.18 The hospital has been virtually closed to admissions over the past 2 years however, it is of note that the 3 admissions in the past year were all BHSCT patients. Two of these admissions were from a respite facility managed by BHSCT and one from a facility managed by an independent sector provider. It is clear that HSC Trusts are responding to a higher level of acuity and risk in the community than previously however, further action is needed to embed hospital avoidance measures through community treatment and intensive support to prevent further admissions and adding to the delayed discharge population.

7.1.19 The impact of new admissions on a long stay population is significant due to the challenge of managing very diverse and competing needs. The majority of patients in MAH are NOT on active treatment and should be progressing on a skills development and transitions pathway. Unplanned new admissions have the potential to impact on the opportunities and quality of life for longer stay patients if the focus in the hospital is on managing risk and crisis response. It is critical that community based crisis response and intensive support services are further developed to prevent crisis admissions.

Table1.2 MAH Admitted From

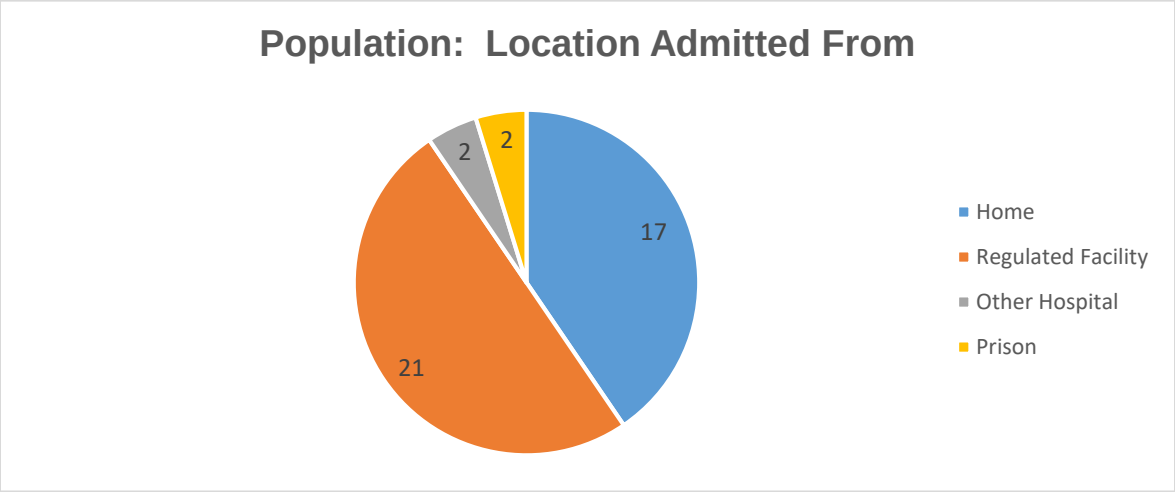


Fig 4

7.1.20 Patients with longer lengths of stay were more likely to have been admitted from home, but those admitted in more recent years were likely to have been admitted from a range of regulated facilities. Two patients transferred from prison and 2 of the MAH patients transitioned from the children's inpatient facility the Iveagh centre. Children & Young People with learning disability were not in scope for this review however, feedback from family carers stressed that a lifecycle approach to planning is essential to effectively project and plan for transitions and that children, young people and their family carers should have a say and input into planning adult services as a key stakeholder. Analysis of the data relating to where patients have been admitted from, highlights that recent admissions have all been from regulated learning disability facilities managed by both statutory and independent sector providers. The review team did not see evidence of the learning from these crisis admissions however, the evidence base and policy/commissioning direction in England and Scotland highlights the need to step up wraparound intensive support services to meet the needs of the individual but also to wraparound the staff teams often struggling to respond.

7.1.21 The review team had the opportunity to visit people in supported living environments who had previously been transferred to medium secure hospital in the UK and were now successfully returned to their home community. The success factors in sustaining the placement reported by both the Independent sector provider and the Trust was the level of collaboration, responsive and pro-active interventions by the Trust Learning disability forensic team. The independent sector care staff talked about the importance of building relationships and trust with statutory colleagues. The Welsh Government's 'Improving Lives Programme (2018) placed particular emphasis on communication and effective working relationships at all levels across the system. The emphasis on these 'softer' skills within the Improving Lives programme of change is significant. The review team received feedback from statutory, independent sector providers and from families highlighting concerns about the lack of openness, trust and respect in relationships. Families reported that lack of continuity of key workers has impacted on developing trusted relationships alongside the fact that their trust in the HSC system has been broken due to the allegations of abuse at MAH. Care Providers and HSC Trusts expressed negative experiences in the contracting and monitoring of services due to a lack of trust.

7.1.22 It is critical that community based intensive wraparound services are developed to prevent placement breakdown and prevent hospital admission. However there is also a need to get back to basics and spending time repairing and building relationships which should be informed by the values underpinning the HSC Collective leadership strategy (ctrl click) to ensure effective person centred planning and collaboration with all relevant stakeholders

Table1.3 MAH current population Number of previous trial placements

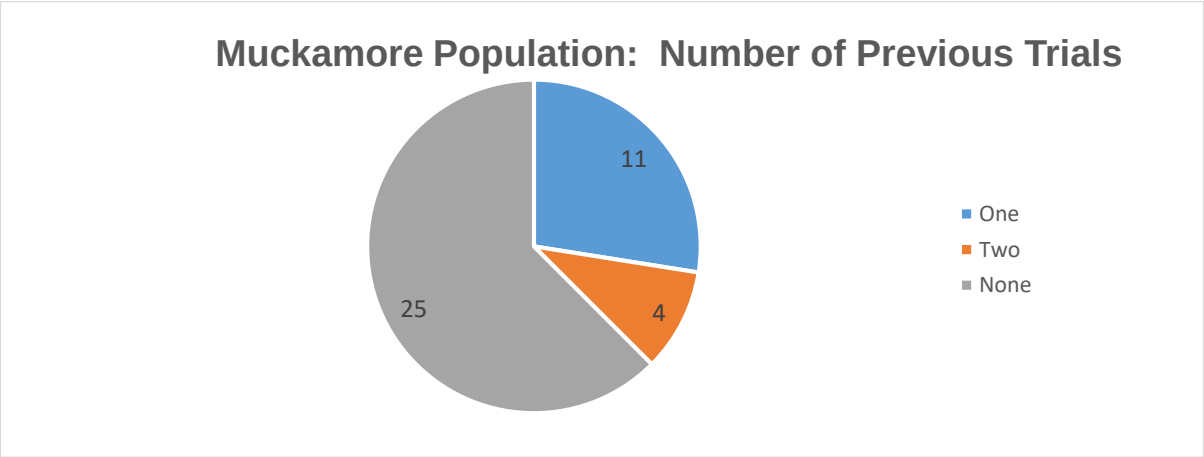


Fig 5

7.1.23 In regards to previous trial resettlement, the analysis confirmed that all PTL long-stay patients had at least one previous trial placement with one PTL patient

who had been offered 2 placements but would not leave the hospital. A small number of patients who had become institutionalised by having lived most of their adult lives in hospital were distressed by the experience of trial resettlement, which were then unsuccessful. This is a key reminder that whilst we should be ambitious for timely resettlement the primary importance is getting the resettlement right first time in order to prevent further breakdown causing trauma and distress. The majority of patients who have not yet had a previous trial placement are the more recent admissions or the small number of patients subject to a hospital order with restrictions with step down from detention requiring collaboration with the Department of Justice.

7.1.24 MAH serves 3 HSC Trusts, the BHSCT which manages the hospital, the NHSCT and SEHSCT. The WHSCT has its own Learning Disability in-patient beds at Lakeview Hospital and the SHSCT has its own Learning Disability in-patient beds at Dorsey hospital. There are a few out of area placements. SHSCT has one patient in MAH. NHSCT has one patient in Dorsey and one patient in Lakeview.

7.1.25 At commencement of the Review of Resettlement, there was a total of sixty Learning Disability in-patients delayed in discharge regionally; 46 at MAH, 8 in Dorsey Hospital and 8 in Lakeview Hospital.

7.1.26 The review team established the baseline MAH Population in June 2021 and updated the population baseline as of 11th July 2022. It is encouraging to note that there have been ten discharges between June 2021 and July 2022 however 3 admissions. The NHSCT had the highest in-patient numbers at commencement of the review however, BHSCT now has the highest number of in-patients.

Table 1.1: Patients by HSC Trust – June 2021

Trust of Residence	Number of In-Patients
NHSCT	21
BHSCT	16
SEHSCT	8
SHSCT	1
WHSCT	0
Total	**46**

Fig 6

Table 1.2: - Patients by HSC Trust-11th July 2022

Trust of Residence	Number of In-Patients
NHSCT	14
BHSCT	15
SEHSCT	6
SHSCT	1
WHSCT	0
Total	**36**

Fig 7

7.1.27 The review team critically evaluated the progress of resettlement plans as devised by the responsible Trust for each patient in MAH and reviewed all business cases which have been completed or are still in process, to identify any strategic or operational barriers and make recommendations for actions to accelerate the delivery of proposed pipeline schemes. The review team reviewed the data submitted by all 5 Trusts on the monthly tracker to HSCB/SPGG and met with Northern Ireland Housing Executive, Supporting People leads to validate information relating to Supporting People schemes. Through this analysis, the review team identified individuals where plans are absent or weak requiring alternative plans.

7.1.28 At the outset, the review team met with the Director and senior management team of each of the 5 HSC Trusts to discuss their approach to discharge planning, to clarify the specific plans in place for each patient and the business cases being progressed directly by the Trust or reliance on schemes being progressed by another HSC Trust. The review team assessed discharge plans against deliverability and timescale for discharge. There were common issues raised by all HSC Trusts with the key challenge to discharge noted as workforce recruitment and capability alongside gaps in the community services infrastructure required to maintain community placements.

7.1.29 Tracking resettlement from the 1980's, has seen a clear move over the years from large institutional settings to smaller nursing and residential homes in the community and progression to supported living models based on single tenancy or small number of people sharing

7.1.30 The focus currently has moved to new build bespoke schemes that have a minimal design to delivery timeline of between 2 and 5 years which has become a significant delay factor. BHSCT has 3 capital schemes in the pipeline. Minnowburn which was a BHSCT only scheme for 5 patients and the On-Site and Forensic schemes to accommodate patients from all 3 HSC Trusts. The timelines for the new build schemes have drifted and most are still at an early stage of development. The review team view the uncertainty of

projected discharge dates for these capital schemes as unacceptable and highlighted the requirement for alternative options to be pursued.

7.1.31 The review team were concerned that robust needs assessments had not been completed for patients identified for the On-Site and Forensic schemes resulting in a lack of clarity about the appropriate service model and whether registration of the On-Site scheme should be for a nursing home or residential facility. Robust Needs assessment should be the basis for any procurement or service development. It was a recurring issue throughout the review that insufficient attention has been given to needs assessment at individual case and population level.

7.1.32 The review team obtained information from Supporting People and data from RQIA in regards to regulated nursing and residential schemes which highlighted vacancies in current schemes. Feedback from provider organisations suggests that Trusts have not worked sufficiently with provider organisations to explore how current capacity could be customised to meet need with view to speed of implementation. This requires fresh thinking and imagination based on robust needs assessment. It would appear that the HSC system has become risk averse and focused on bespoke new build schemes.

7.1.33 HSC Trusts need to be clear about risk appetite based on robust Assessment of Need/Risk and analysis of what is working for similar needs in the community. Delivering this challenging agenda also requires a corporate and regional approach to ensure the relevant skill set promotes fresh thinking and delivery.

7.1.34 HSC Trusts narrative and reporting in relation to resettlement plans was repetitive, providing reassurance rather than assurance based on evidence. Trust Boards should have challenged the timelines presented for resettlement and queried contingency arrangements for expediting earlier discharges. At the commencement of the review, all HSC Trusts reported that discharge plans were in place for the majority of their patients however the review team's analysis identified that most plans were still at scoping stage and therefore lacked the robustness and detail required to establish a reliable trajectory for tracking performance. Delegated Statutory Function reports for all HSC Trusts focused on the lack of community living options, rather than on breach of Human Rights and did not provide the assurance required. There was insufficient challenge by Trust Boards and the HSCB/SPGG.

7.1.35 Four discharge placements had already been commissioned and had been available from commencement of the review including 3 planned discharges to Cherryhill (BHSCT Supported living). One of the Cherryhill discharges was delayed due to the wait for minor adaptation work. This matter should have

been escalated for urgent approval through senior management rather than rely on routine processes. Three of the Cherryhill discharges were delayed due to staffing shortfall and requirement to recruit additional staff. In light of the fact that discharge placements for 3 patients were available, there should have been a more strategic approach taken in regards to deployment of the workforce with view to reducing the MAH in-patient population. BHSCT had a strategic focus on the stability of the MAH workforce with daily monitoring and reporting given the reliance on agency staff. This appeared to impact on decision making about using agency staff to transition with the patient until sufficient staff could be recruited and trained. The bigger picture of reducing the population through more flexible utilisation of the workforce to expedite the discharges was raised by the Co-Director but not progressed. The complexity of the logistics associated with workforce allocation cannot be underestimated however, the delay and drift in discharging 3 patients added to the staffing pressures in MAH. Prioritising a consultation with legal services in relation to the fourth patient who had a placement already commissioned by community LD services was agreed but not actioned, resulting in drift. In this specific case, the community HSC Trust and the BHSCT should have been working more collaboratively to an agreed action plan. It was concerning to note the drift in these specific cases despite the opportunities being highlighted to the involved HSC Trusts by the review team. Whilst there are recognised delays associated with new build schemes there should have been more focus on those discharges that could have been expedited more speedily.

7.1.36 The review team completed an analysis of resettlement plans, revised the performance tracker tool and provided advice to HSC Trusts on the immediate actions required to accelerate resettlement and strengthen reporting and accountability arrangements.

- Advice to Trusts to rethink the deliverables to focus on speed of implementation given the unacceptable timelines for new build schemes still at initial development stage
- Advice to BHSCT to extend the TOR for the On-Site project chaired by Director to include the Forensic scheme given the inter-dependencies for the NHSCT and SEHSCT on both schemes
- Advice to NHSCT to engage the care provider for the new build scheme Braefields, to agree concurrent admissions rather than the eighteen month phased implementation as planned.
- Advice to Trusts to review available capacity in the nursing home and residential/ supported living schemes and agree how placements could be tailored to meet need
- Advice to Trusts to urgently re-assess patients identified for the Forensic scheme and bring forward individual discharge solutions.

- Advice to all Trusts to prioritise the focus on individual cases with an increased potential for early discharge rather than focus on new build schemes.

7.1.37 The landscape changed throughout the period of the review, with HSC Trusts revising their plans in recognition of the long lead in time for new build schemes. The review team welcome the fresh thinking and renewed collaboration between the Belfast, South Eastern and Northern Trusts evident from April 2022 resulting in solution focused workshops to address the long standing challenges associated with delayed discharge. Consideration was given to the development of an interim model on the MAH so that patients pending discharge to community placements would be cared for in a social care model as part of transition planning. However, due to the continuing pressure on workforce availability and capability which is evident in MAH, the thinking is rapidly changing with re-focus on building individual placement discharge options rather than on an interim on-site social care solution. The review team completed a stocktake of all plans at commencement and end of the review fieldwork and will present the analysis on progress on a Trust by Trust basis and summarise the projected discharges by end March 2023.

7.1.38 The SEHSCT was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and are now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for 4 patients appear to be realistic and deliverable. The Trust plans to discharge 2 patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from 1 patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and 1 young person who transferred from a children's facility.

7.1.39 The NHSCT's discharge planning was based on 2 new build schemes and a number of individual bespoke placements. The NHSCT was reliant on the BHSCT delivering the On-Site scheme for 1 patient and the forensic scheme for 1 patient. The NHSCT has robust plans in place for six NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023. Two patients have commissioned placements at named schemes with discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all 3 learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of patients from Dorsey and Lakeview In summary the NHSCT has made

significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefield scheme from end April to end August 2022.

7.2 BHSCT – Regional Role as the Trust Responsible for MAH

7.2.1 Reducing the MAH population is a strategic priority and should be a significant measure in providing assurance about safe and effective care in MAH. Reducing the population would defacto reduce workforce challenges and support the remodelling of the hospital site with view to re-establishing patient flow and acute admissions. The Leadership and Governance report (2020) highlighted that the Trust focus on resettlement came at the cost of scrutiny of the Safety and Quality of care of those in-patient. Given that BHSCT has the lead role for the management of MAH as well as the delivery of 2 schemes that other HSC Trusts were co-dependent on, namely the Forensic and On-Site schemes, a review of BHSCT Board agenda and minutes for 1 year, 2020/21 was completed by the review team to identify the level of scrutiny and challenge to address the delayed discharges from MAH.

7.2.2 The analysis of Trust Board minutes confirmed that MAH is a substantive standing agenda item at each Trust Board with update report and papers on safety metrics and workforce presented by the MH/LD Director. Updates on the number of patients in MAH are provided however, there was limited scrutiny in regards to the resettlement plans for BHSCT patients or the capital business cases in development.

7.2.3 The review team found that the pendulum appears to have swung to a primary focus at Belfast HSC Trust Board on the development of safety metrics and workforce stability with limited challenge to the timelines proposed for resettlement of BHSCT in-patients.

7.2.4 The following updates on the MAH population and resettlement plans were provided to Belfast Trust Board by the Director of Mental Health and Learning Disability services.

- Oct 2020 Director reported 43 patients, 2 on trial and 1 on home leave. Further 5 BHSCT discharges expected to proceed.
- Dec 2020 Director reported- 47 patients – 3 on trial. NHSCT-20, BHSCT-17, SEHCT-8, SHSCT-1, WHSCT-1
- April 2021- Number of patients noted as 43 - 2 on trial resettlement and 1 on extended home leave. Expect another 5 discharges of BHSCT patients in the next 6-months by September 2021.

The Executive Director of Social Work reported satisfactory compliance with requirements specified in the Delegated Statutory Functions Scheme of delegation. The DSF report- noted 6 successful discharges and further 5 on trial resettlement with plans in place for a further 16 resettlements. The report noted a lack of community placements for LD impact on delayed discharge.

- Nov 2021- Director for strategic development updated on planning for On-Site business case.4 patients meet criteria. Outline specification drawn up and shared with capital panning team. Design team secured to complete feasibility study of the MAH site. Steering group has held 4 meetings.
- January 2022- Director update- 39 patient- 4 on trial and 1 on extended leave only 2 on active treatment. Chairman sought clarification on timeframe for the On-Site resettlement business case. Director reported that the timeframe for the On-Site scheme was 2024/2025. Further business case to be developed for forensic scheme- Requires identification of appropriate site.
- BHSCT's Delegated Statutory Functions report 2021/22 lacked scrutiny from Trust Board. It is of note that BHSCT reported that resettlement plans were in place for 15 patients and no plan in place for 1 patient.

7.2.5 Analysis of the regular updates to Belfast HSC Board and through the Delegated Statutory Function reports in regards to progress on resettlement, highlight the repetitive narrative based on plans in the early stages of development which were not robust enough to provide assurance in regards to projected discharge dates.

7.2.6 Whilst the Chairman of the BHSCT sought clarification on timeframe for the On-Site resettlement business case on 1 occasion and Director advised that the timeframe for scheme completion was 2024/2025, this appears to have been accepted rather than discussed or challenged.

7.2.7 BHSCT's dedicated resettlement team was funded for 2 community integration co-ordinators and a Social Worker to develop Essential Lifestyle plans. The Social Work post and 1 of the coordinator posts are vacant. A senior manager post established to review SEA's and develop an action plan on the lessons learned is also vacant.

7.2.8 BHSC Trust had 16 patients in MAH at commencement of the independent review and still has 15 patients in MAH at 11th July 2022. Our analysis of the current position for BHSCT in regards to revised planning is that BHSCT has robust discharge plans in place for 2 patients to transition to current nursing home and supported living vacancies by September 2022. However, the plans for the remaining 13 patients have not been confirmed in regards to named scheme or estimated discharge date and remain plans in development. There are 3 major challenges for revised plans, Workforce recruitment, re-registration

of schemes and most significantly the time required to engage and gain agreement from family carers. This is a dynamic environment and the summary and trajectory provided by the review team reflects the position at 11th July 2022.

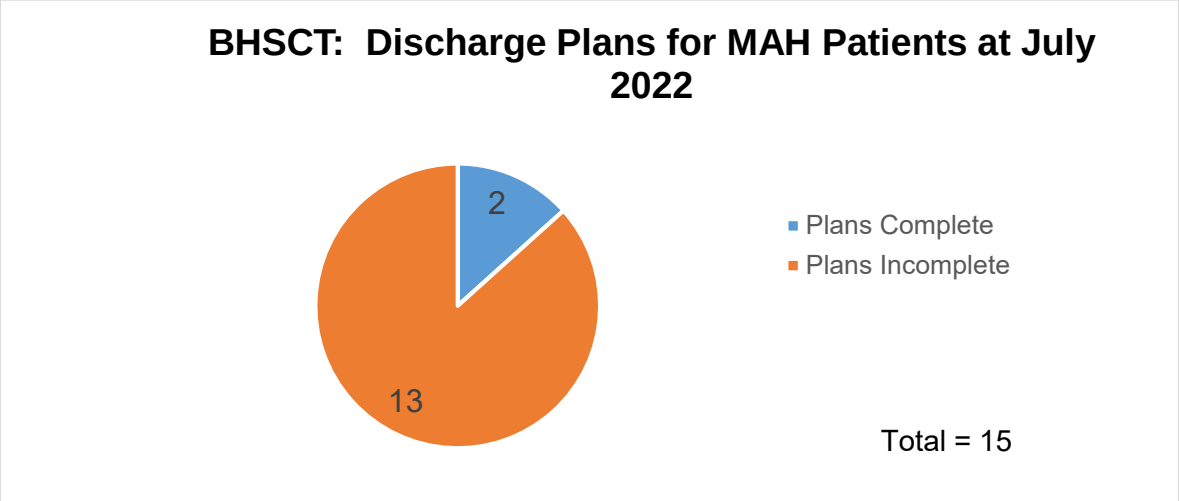


Fig 8

7.2.9 The review team considered in detail how the Trusts developed plans, proposals and accommodation services to meet the aggregated needs of this group as identified through their individual care plans in Chapter 8.

7.3 SEHSCT - Resettlement plans

7.3.1 SEHSCT completed a number of capital business cases some years ago significantly reducing the Trust's long-stay in-patient population to eight patients at commencement of the review and 6 in- patients at 11th July 2022.

- The Trust was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and The Trust is now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for four patients appear to be realistic and deliverable. The Trust plans to discharge two patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from one patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and one young person who transferred from a children's facility.

- SEHSCT has a new build scheme in development in partnership with a care provider but recognised that this will not be a viable option for MAH discharges given the long lead in time
- It is of note that one SEHSCT patient has been on extended home leave with an extended support package from March 2020 with family taking the patient home at the onset of the Covid pandemic. BHSCT also had one patient on extended home leave for similar reasons. An evaluation of how the extended home leave placements have been maintained for this lengthy period without return to MAH should be completed to inform future support models aimed at admission avoidance.

7.3.2 The review team have used the Care Quality Commission - Brief Guide; definition that a discharge plan needs to have an identified care provider, an address and a discharge date to be agreed as a discharge plan. The review team used this definition to assess the robustness of the SEHSCT updated discharge plans. SEHSCT has a confirmed placement at Mallusk scheme for one patient with discharge expected in August 2022. The Trust has commissioned a nursing home placement for one patient with discharge date in August 2022. SEHSCT expect an additional patient to transfer to a specialist facility in the Republic of Ireland with discharge expected by September 2022. Three of the SEHSCT 6 patients have robust discharge plans and imminent discharge dates. A plan is in development for one patient and 2 patients do not have a robust plan.

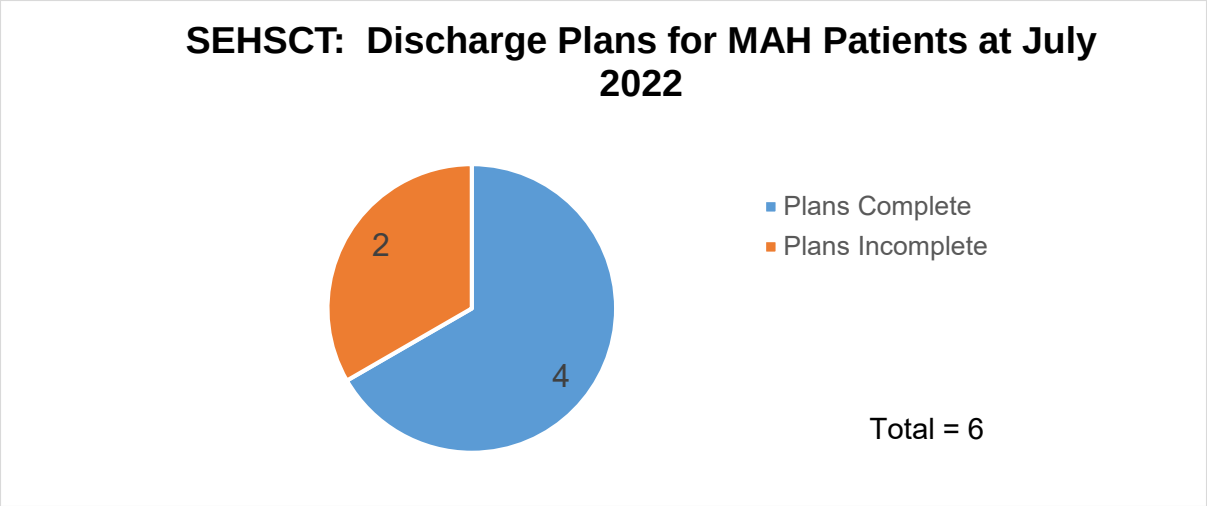


Fig 9

7.4 Northern HSC Trust – Resettlement plans

7.4.1 Historically the NHSCT has been reliant on hospital admission resulting in the highest number of patients to resettle regionally. At the outset of the independent review, the NHSCT had nineteen delayed discharge patients in

Muckamore Abbey Hospital, 1 patient delayed in Lakeview Hospital and 1 patient delayed in Dorsey Hospital

7.4.2 The Northern HSC Trust's discharge planning was based on two new build schemes and a number of individual bespoke placements. The Northern HSC Trust was reliant on the Belfast HSC Trust delivering the On-Site scheme for one patient and the forensic scheme for one patient. The NHSCT has robust plans in place for 6 NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023.Two patients have commissioned placements at named schemes with discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all three Learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of their patients from Dorsey and Lakeview Hospitals. In summary the Northern HSC Trust has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work for the Braefields scheme moving the handover date from end April to end August 2022.

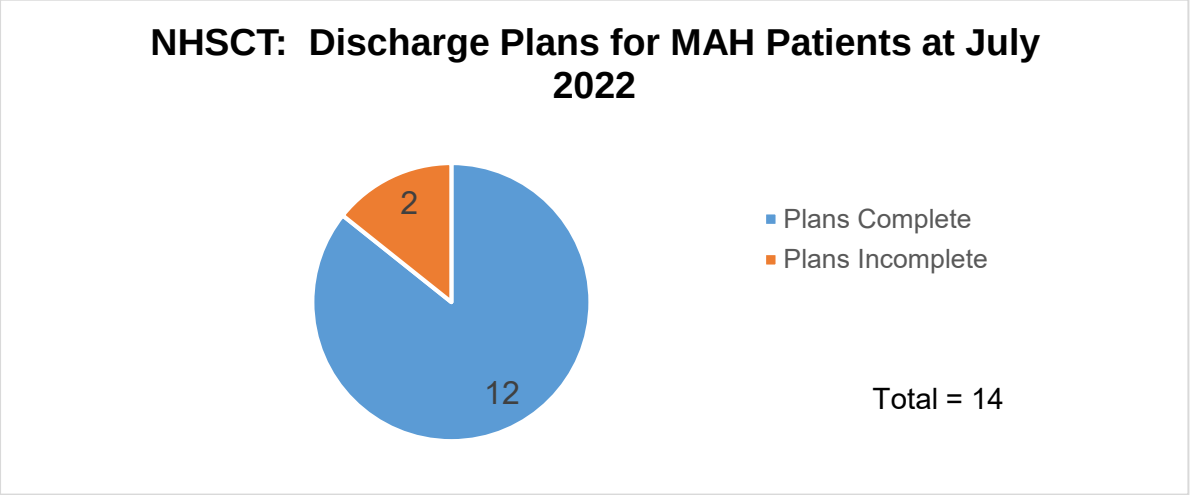


Fig 10

Key findings; the analysis of the review of Individualised care planning has highlighted a number of concerns and themes

- HSC Trusts were not responsive to data requests with responses missing deadlines and monthly performance monitoring templates not being robustly completed with key data missing or not updated.
- The narrative from HSC Trusts was repetitive and had not been sufficiently challenged by HSC Trust Executive teams, Trust Boards or the HSCB/ SPPG resulting in significant delay in identifying and challenging the lack of progress.

- Proposed discharge plans were not assessed against an agreed definition for a discharge plan, namely that a plan requires a confirmed care provider, confirmed scheme address and confirmed estimated discharge date to be agreed as a robust discharge plan.
- HSC Trusts were asked by the review team to validate the data supplied by RQIA and Supporting People and provide additional data on housing with support placements not captured in the NIHE and RQIA data sets. A questionnaire was developed by the review team to collate data from HSC Trusts to establish a regional supply map. The response from HSC Trusts was poor and not reliable. The HSCB/SPGG completed an exercise in 2020 to complete Needs assessment for Housing with Support. The variation regionally in demand reflected the poor quality of the information returned by HSC Trusts based on a range of interpretations of the questions.
- There is a need to get back to basics to ensure effective person centred planning and collaboration with all relevant stakeholders in the development of discharge plans. There appeared to be a lack of dialogue between HSC Trusts and providers to share the lessons learned from failed placements. The learning from trial placement breakdowns should inform discharge planning and will only be achieved through an integrated care approach based on partnership and collaboration.

Recommendations

- SPPG needs to strengthen performance management across the HSC system to move from performance monitoring to active performance management holding HSC Trusts to account.
- SPPG should establish a regional Oversight Board to manage the planned and safe resettlement of those patients not currently under active assessment or treatment
- Consideration needs to be given to building highly specialist community based crisis response support teams to promote admission avoidance.
- A regional positive behaviour framework should be developed with the standard of training for all staff working in learning disability services made explicit in service specifications and procurement.
- Learning disability strategy / service model to be progressed by DoH should incorporate the evidence base for PBS and learning from other UK nations
- HSC Trusts should collaborate with all stakeholders to develop a resettlement pathway and operational procedure.
- HSC Trusts should ensure that the lived experience of the person and their family is effectively represented in care planning processes and the role of

family carers as advocates for their family member is recognised and respected.

- HSC Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans

8. Operational Delivery of Care and Support

In the previous chapters we have talked about the strategic and commissioning framework for services, and also have considered the importance of good individualised care planning. In this chapter we need to consider the delivery of care and support and the experience of the individuals who have gone through resettlement and their families.

It is worth briefly revisiting what the current mapping of accommodation, care and support services looks like. There are 21 specialist LD nursing homes in NI offering a total of 606 places; there are a total of 48 residential care homes (15 statutory and 33 independent) offering a total of 546 places (123 statutory residential care places and 423 independent residential care places); and there are 149 accommodation based supported living schemes for people with learning disabilities offering a total of 1334 places across Northern Ireland.

8.1 Range of provision available:

8.1.1 There is a really impressive array of different types of homes for people with learning disabilities, and this diversity reflects the heterogeneous nature of the learning disability who will have a wide range of needs and wishes that need to be considered for each individual. This diverse picture also reflects significant variation in the cost of care, again dependent on a range of factors but primarily the needs of the individual and the staffing associated with those needs to ensure a safe and stable quality of care can be routinely delivered. In this context schemes which are designed and very bespoke to the particular needs of an individual will be higher than for those living in group living environments, where there may be ‘economy of scale’ factors to reduce the care costs. There has to be a recognition that for some individuals living with other people poses too significant a challenge and their needs can only be met in living alone situations, although there is always a need to ensure that these individuals have access to social relationships and community interaction as appropriate. Some providers have moved to try some innovation through congregated settings, but with separate living accommodation.

Range of provision available throughout Northern Ireland

Fig 11

8.1.2 The broad thrust within the Bamford Review had been towards smaller group living options, and away from large congregated community settings. The bar chart below shows the spread of size within accommodation-based supported living schemes funded through Supporting People and HSC funding agreements, and the general trend is in favour of smaller schemes. Whilst this is a welcome change of direction the emerging policy and strategic positions in relation to both learning disability and adult social care within Northern Ireland will need to address the sustainability of funding as demand increases linked to the demographic changes that we can expect for this population.

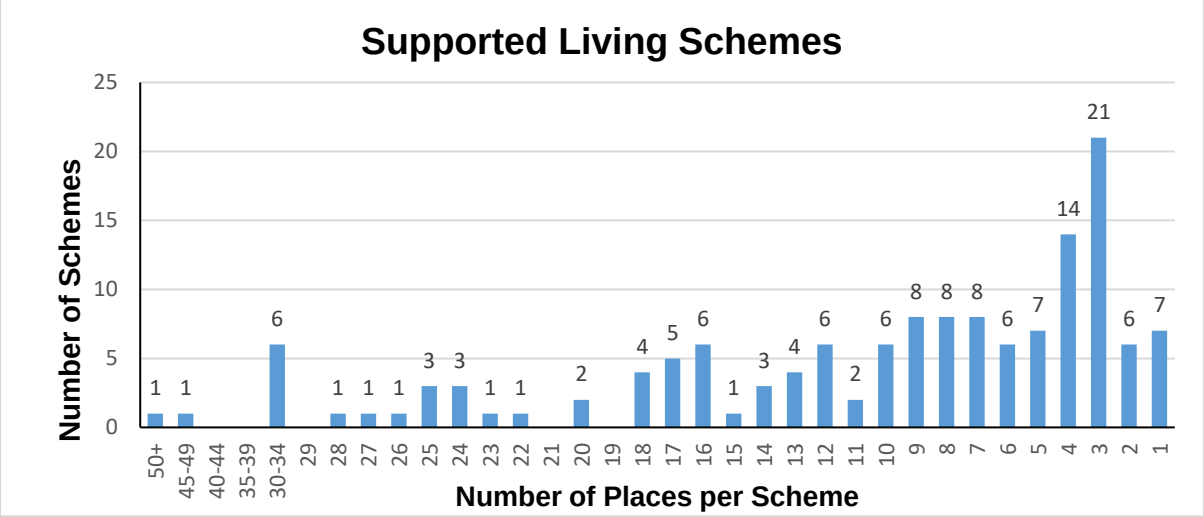


Fig 12

8.1.3 It is also important to recognise that within the independent sector it is highly probable that in the current population of residents and tenants within their settings that there will be individuals with similar needs profiles to those individuals who are awaiting resettlement from hospital. The sector has already demonstrated a readiness to meet the needs of individuals with complex needs often relating to co-morbidity of learning disability and mental health issues along with behaviour that can challenge. We heard several success stories which should be a strong foundation for understanding what works well for this group of especially vulnerable individuals.

8.2 Workforce

8.2.1 It is fair to say that across all stakeholders workforce was the single biggest concern, both in terms of the existing and future provision. Providers and NISCC as the regulator of the social care workforce expressed concern about the continuing need to develop a skilled and stable workforce across the sector. The inability to both recruit and retain a social care workforce was a massive risk for the sustainability of the existing provision and the most significant barrier for the proposed new developments. This has seriously hampered progress of several of the resettlement schemes which it is hoped will provide new homes for existing people living in MAH.

8.2.2 The models supporting the development of many of the new schemes are psycho-social rather than medical. Therefore the workforce will need to have skills in the delivery of psychological and social interventions, along with an understanding of the need to re-refer to specialist clinical services as and when appropriate. Most providers were now adopting Positive Behaviour Support as central to their service offer, although we heard concerns expressed by the

Royal College of Psychiatrists about the 'fidelity' of this approach which was often variable in both delivery and positive outcomes. There was certainly some anecdotal evidence to suggest that in some settings some of the least qualified and experienced staff were working with some of the clients with most complex needs. This sometimes resulted in poor continuity linked to high turnover of staff.

8.2.3 However the workforce issue was also a mixed picture. Some of the more established providers with a longer track record of service provision had better ability to recruit and retain staff, and some of the not for profit organisations had also recruited specialists in psychology or positive behaviour support to provide consultancy and support to their own provision. We also heard some providers describe how they had expanded the skill base within their teams by recruiting professionals from other disciplines such as teaching or youth and community work. Similarly we were impressed that some of the private providers described very stable teams, who were generally recruited from the local community with high rates of retention.

8.2.4 We have commented in an earlier section about the issues related to differential rates of pay, and particularly the disparity between statutory and non-statutory services in terms of Agenda for Change profiled pay in services provided by HSC Trusts. Whilst rates of pay are going to vary across the sector there needs to be some discussion within the sector to ensure that this isn't operated in a way that becomes a barrier to stability within the workforce. An integrated workforce strategy that looked at staffing across the whole landscape of learning disability services should be linked to the Learning Disability Strategy and Service Model, and should provide better learning and developmental opportunities as well as supporting greater mobility across sectors and roles. The review team are encouraged that MDAG has oversight of a regional workforce review across adult learning disability teams and services. This review has a wide scope of the learning disability workforce across statutory, private and independent sectors. A multi-disciplinary team has been put in place to undertake this important piece of work which is expected to complete in 2023; a survey has been undertaken to establish the baseline of the current workforce as of 31st March 2022.

8.3 Quality of Care within Services

8.3.1 Given the size and nature of the sector it has to be recognised that quality could be variable. However, there was certainly encouraging signs that would suggest that services were of good quality in many settings. RQIA have a responsibility to inspect registered care settings and in doing so seek the views of residents and staff. Generally in most registered care settings these are positive, with

positive comments about compassionate and caring staff in many settings. Whilst it could be argued that these may be more subjective than objective observations, RQIA are working with ARC and PCC through projects like “Tell It Like It Is” to ensure that there are a range of ways of accessing the views of people living within these settings and their families.

8.3.2 The review team were able to visit one particularly innovative example of a bespoke placement for a young man who was living with learning disability and ASD, and who was being supported to live on his own with 24/7 on-site support. He had successfully been transitioned back from a long term specialist placement in another part of the UK. The staff team supporting him were especially attuned to designing support appropriate to his needs and tolerances, as well as addressing the significant risks both within his home setting and when accessing the community.

8.4 Resettlement Process and Outcomes:

8.4.1 Broadly speaking the resettlement process could be split in to 3 phases – (1) pre-placement which included assessment and consultation to identify suitable placement opportunity; (2) transition phase which focuses on the planned move and immediate monitoring and support intensively immediately after placement; and (3) ongoing post placement support, including contingency plan to manage ‘crisis’.

8.4.2 One area of concern was that the region didn’t appear to have developed a regionally agreed resettlement/transitions pathway for people who were transitioning from hospital settings. Several stakeholders raised this as a concern. Families felt that they were insufficiently involved in developing these plans at times of a critical move. We asked the BHSCT as the lead Trust in terms of resettlement to provide us with the resettlement pathway, and after a gap of several weeks they issued us with a ‘draft resettlement pathway’ which we believe was produced without consultation with other Trusts, families or providers. Whilst it was good to see a willingness to develop an agreed pathway, we would have expected it to have previously been in place and to have gone through a co-production process. Consequently there was a great deal of variability to the quality of pre-placement arrangements and transition plans.

8.4.3 There were key issues which an agreed pathway and protocol could have resolved. Central within this would be where the primary responsibility for resettlement lay – especially what role the hospital multi-disciplinary team had in relation to the process relative to the role and responsibilities of the receiving/home Trust who would have on-going responsibility for supporting the

placement. We certainly were told of a concern that the hospital teams held an overly prominent level of sway in terms of choice of placement and the parameters of moves, including the extent to which 'leave' was extended for lengthy periods beyond the point where the individual had left the hospital. Several providers commented that the assessment of the client's needs provided by the hospital was sometimes not fit for purpose in terms of how they would devise a plan of care and support appropriate to the new care setting. Often the hospital had limited experience or understanding of how the client might be in other community-based settings. There was a general view that hospital perspectives could be overly risk averse, and rarely acknowledged the significant experience of the more established providers. The review team drew a conclusion that it was imperative that Community Learning Disability Teams/Services of the receiving/home Trust needed to take the lead during the transition phase and to act as an effective bridge between the hospital at the point leading up to discharge and the provider as they accepted the client.

8.4.4 Sadly several of the families that were willing to share their experience had gone through a process of placement break down, and we heard some harrowing accounts of how placement disruption was handled. However it is important to note that for many of these individuals and their families the system continued to support them and ultimately they found suitable new homes.

8.4.5 In terms of the third phase of post-placement support, again we heard of a very mixed picture from providers. Some providers talked about a lack of clarity between the roles of different teams.

8.4.6 Where systems described placements going well there were a number of key features which are worthy of note. The extent to which the 'new' staff supporting the client had an opportunity to begin to establish a working relationship and understand the individual and how best to meet their needs was an important foundation stone. Plans that had considered contingency if things started to go wrong were more robust, and in particular access to additional dedicated support from local Trust services at times when a crisis was emerging was particularly important. There is some variability between HSC Trusts in relation to the extent that they have been able to develop these specialist levels of support, although all are making moves in that direction. One provider described that their ability to support some individuals with very high levels of challenge and potential risk because of the responsiveness of the Trust services when they 'put up the flag'. In this scenario it was the strong and established partnership between the provider and the Trust services – clinical and commissioning – that gave them the resilience to support a number of individuals with the highest levels of need. In this situation there was clear evidence of effective communication, joint working and mutual respect and

support, all of which was focused on keeping the client at the centre of the process.

8.4.7 Whilst in all areas we heard about providers and local commissioners having engagement through contract review processes, there didn't appear to be well established broader engagement across the sector to support more effective partnership working. We felt that at a time when the health and social care system is committed to further development of integrated care systems, that there could be some work done here to support an integrated care pathway for these individuals with significant complexity of need.

8.5 Local Commissioning by HSC Trusts of Accommodation Schemes to address the needs of Individual Resettlement Plans

8.5.1 In chapter 7 the review team laid out what we found in relation to the evidence for good individualised care planning and the current level of practice. In order to find accommodation solutions for the individuals awaiting resettlement the Trusts needed at a local level to commission, either singly or jointly, new schemes that could meet the requirements for this clearly identified population.

8.5.2 There was distinct variation in relation to how effectively the development of new accommodation schemes was executed by individual Trusts.

8.5.3 Positively the NHSCT had worked well with a small number of trusted providers to develop several schemes which then had the potential to accommodate most of their remaining patients from MAH. At the time of the review this had ensured that business cases had been approved for social care and housing funding as appropriate, and the development of these schemes had reached completion of the buildings and were now moving to transition planning contingent on successful recruitment and staffing of the schemes.

8.5.4 Historically the NHSCT had historically been reliant on hospital admission resulting in them having the highest number of patients to resettle regionally. At the outset of the independent review, the NHSCT had 19 delayed discharge patients in MAH, 1 patient delayed in Lakeview Hospital and 1 patient delayed in Dorsey Hospital

8.5.5 The NHSCT's discharge planning was based on 2 new build schemes and a number of individual bespoke placements. The NHSCT was reliant on the BHSCT delivering the On-Site scheme for 1 patient and the forensic scheme for 1 patient. The NHSCT has robust plans in place for six NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023. Two patients have commissioned placements at named schemes with

discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all 3 learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of patients from Dorsey and Lakeview In summary the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefield scheme from end April to end August 2022.

8.5.6 The Mallusk new build scheme was completed 2021 with 2 admissions to date with significant and unacceptable delay in the care provider recruiting sufficient staff to support further admissions to the remaining six places. This scheme will accommodate another 4 NHSCT patients and 1 SEHSCT patient.

8.5.7 The Braefields new build scheme for seven places has been developed to accommodate six patients from Muckamore and 1 NHSCT patient in Lakeview hospital. The NHSCT patient in Dorsey. Hospital is in the process of transitioning to a vacancy in a community scheme by end July 2022.

8.5.8 The NHSCT plans to discharge twelve MAH patients prior to end March 2023 to named and commissioned placements. These plans are viewed as robust – 6 to Braefields, 4 to Mallusk and the other 2 patients to named supported living and nursing home vacancies. The plans for the remaining 2 MAH patients are in development and not yet robust. The review team remain confident that the Mallusk and Braefields schemes will come to completion within the coming 6 – 9 months, and that this would allow the majority of the NHSCT clients to transition to their new homes. Whilst there had been some slippage in the time scale, their robust plans had supported effective review and senior leaders within the Trust engaged effectively with providers to challenge poor progress against agreed timescales.

8.5.9 SEHSCT completed a number of capital business cases some years ago significantly reducing the Trust's long-stay in-patient population to eight patients at commencement of the review and six in- patients at 11th July 2022.

8.5.10 The SEHSCT, by working effectively in tandem with the NHSCT had been able to support the delivery of a number of schemes that would offer new homes to their remaining patients/clients. SEHSCT had the smallest number of clients remaining and relied on a mix of engagement with the collaborative inter-Trust schemes, and singleton or bespoke solutions. This allowed them to demonstrate that they had robust plans with a realistic potential of positive outcomes, although again recruitment difficulties for providers tended to be the limiting or constraining factor which delayed delivery.

8.5.11 The SEHSCT was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and are now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for 4 patients appear to be realistic and deliverable. The Trust plans to discharge 2 patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from 1 patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and 1 young person who transferred from a children's facility.

8.5.12 SEHSCT has a new build scheme in development in partnership with a care provider but recognised that this will not be a viable option for MAH given the long lead in time, and therefore will be likely to meet future emerging need.

8.5.13 It is of note that 1 SEHSCT patient has been on extended home leave from MAH with an extended support package since March 2020 with family taking the patient home at the onset of the Covid pandemic. BHSCT also had 1 patient on extended home leave for similar reasons. An evaluation of how the extended home leave placements have been maintained for this lengthy period without return to MAH should be completed to inform future support models aimed at admission avoidance.

8.5.14 The Belfast HSC Trust (BHSCT) was an outlier in terms of its ability to successfully progress robust plans to deliver resettlement outcomes for the 15 patients who were their responsibility. However, it is worth making a few contextual comments in relation to the Belfast Trust's system wide responsibility. BHSCT had management responsibility for the provision of the hospital services provided at MAH, which dated back over an extended period of time. This meant that the Director and Co-Director in BHSCT responsible for learning disability services were balancing the ongoing delivery of the MAH hospital services, which faced significant safeguarding and staffing issues following the allegations of abuse, alongside the responsibility to support the resettlement not only of their own clients, but also of the patients in MAH who originated from other Trust areas. It should be noted that the HSCB had funded some additional dedicated staff posts within BHSCT to support the regional resettlement programme(detailed in chapter 7), and that the HSCB had provided substantial additional non-recurrent funding in light of the financial pressures associated with the heavy reliance on agency staffing within MAH staffing levels. The review team acknowledge that this placed the leadership team in BHSCT under considerable pressure, and it is to be regretted that this appears to have hampered their commitment to delivering the overarching resettlement requirements.

8.5.15 The BHSCT had through its planning processes proposed that the majority of its clients could be resettled through a number of dedicated new schemes. The primary focus of the new schemes was around 3 groups of patients. The first of these was patients who had been described as having a 'forensic' profile and required specialist provision specific to their needs. The second group was a small number of patients, most of whom had lived in MAH for several decades, and for whom it now appeared there should be a dedicated 'on-site 'provision' that would allow them to remain in situ but within a new or re-purposed accommodation on the hospital site. The third group were 5 patients, all from the BHSCT area, who had been identified for a new provision within the Belfast.

8.5.16 To meet the needs of these 3 distinct group of patients within MAH BHSC Trust's resettlement plans centred on 3 new build schemes in development since 2019. The 3 capital build schemes were planned to accommodate ten of the BHSCT patients. One patient for the On-Site scheme, 4 patients for the forensic scheme and 5 patients for the Minnowburn scheme which was a proposed development but not projected to be ready until at least 2025. The review team met with Northern Ireland Housing Executive's Supporting People leads in regards to the planning process for the Belfast Trust's Supporting People schemes in development and the strategic outline case (SOC) submitted for the forensic scheme and the process and timelines for full business case and delivery. Supporting People also provided update on discussions with BHSC Trust in regards to their plans for the Minnowburn proposal. The review team analysed the SOC submitted by the Trust and minutes of the Strategic Advisory Board meetings chaired by NIHE Supporting People Director. The review team noted confusion and drift in the range of schemes submitted by BHSCT as strategic outline cases. The SOC was drafted and submitted by a senior planning manager with extensive experience of previous resettlement schemes. When this manager retired it would appear that both organisational memory and experience were lost when he left, resulting in drift with SOC not progressing to full business cases as agreed.

8.5.17 At commencement of the review, the plan for the forensic scheme was a 12 place extension to an existing scheme, Knockcairn/Rusyhill. The original plan was for a twelve placement scheme to accommodate both MAH patients and BHSCT community clients and a strategic outline case (SOC) was submitted to Supporting People. Further analysis concluded that this design would not meet the needs of the remaining forensic population. Supporting People advised the review team that the full business case for the forensic scheme was anticipated in October 2019 but not received- Supporting People also highlighted that no funding from Supporting People has been ring-fenced therefore BHSCT will require to fund both capital and revenue funding.

8.5.18 BHSCT then asked a Housing Association to identify a suitable site for a new build scheme. Seven sites were identified however, location of the majority of sites were unsuitable for a forensic scheme due to proximity to high density areas. Preferred sites were identified in both the NHSC Trust and SEHSCT areas with the second confirmed as the most suitable. Given the inter-dependencies of the NHSCT and SEHSCT on this scheme all 3 HSC Trusts should have been collaborating on decision making but this was not the case, and the other Trusts were unaware of these proposals. Given the delays in progressing the business case, the NHSCT and SEHSCT are now scoping alternative individual placements with view to agreeing more timely discharge dates for their forensic patients.

8.5.19 The Belfast Trust Co-Director has now advised the Housing Association to take no further action to purchase a site pending further discussion in relation to needs assessment and current demand for a forensic new build scheme. The forensic scheme has been in development since 2019. Priorities have changed over the 3 years the outline case has been in development undermining the planning assumptions underpinning the proposed scheme. The process highlights confusion and drift and illustrates poor planning and delivery.

8.5.20 Minnowburn scheme for 5 BHSCT patients. The Minnowburn scheme requires disposal of a current BHSCT property/ site through Public sector trawl with an eight stage process and earliest delivery timeframe 2024/25 Whilst this scheme is in development it will not be ready until at least 2025. Alternative individualised discharge plans are now required given the long lead in time for project delivery.

8.5.21 MAH On-Site Provision: The picture in relation to the ‘on-site’ provision was particularly confused. The DoH had made it clear to Trusts that there should be consideration given to an on-site re-provision for those individuals for whom MAH had effectively been the only home they had known as adults. Whilst the letter from the DoH refers to a small number anticipated to be less than 10, at the point where the review team were considering the revised plans for individuals, only 4 patients had been identified as potentially requiring the onsite facility. The letter was clear that this provision should be separate from the assessment and treatment provision within the hospital. Four long-stay patients met the criteria identified; 1 BHSCT client, 1 NHSCT client and 2 SEHSCT clients. A project team was established chaired by the BHSCT Director and membership included SEHSCT and NHSCT representatives along with other key stakeholders. A design team was appointed to compete a feasibility study. In our meetings with senior staff responsible for learning disability services at the time in BHSCT there was a lack of clarity as to what type of provision was required, in terms of models of nursing provision, or social care and housing.

There seemed to be lengthy delays in establishing the feasibility of re-purposing some of the existing hospital estate and the associated indicative costs. In recent months due to the escalating concerns about the delay in the progression of plans for this provision by BHSCT the 2 other Trusts responsible for 3 of the 4 targeted clients have decided that the proposed on-site provision no longer represents the best option for their individuals and are pursuing other potential solutions. In light of this the BHSCT will need to consider how best to meet the needs of the 1 remaining patient who was in the cohort of 4.

8.5.22 Whilst all of these schemes had been in development since 2019 or earlier, at the point of the review in early 2022 none of these schemes had progressed beyond the most preliminary stages and given the dynamic position in terms of changes in the needs of the broader population the rationale underpinning the original cases for the schemes became unsustainable. In reality there were not credible plans in place for delivery of these schemes, and both capital and revenue funding had not been secured.

8.5.23 We have previously referenced the significant changes in leadership and planning roles, which was particularly apparent within BHSCT. This meant that there never seemed to be a maintained momentum for delivery of these proposed schemes through a rigorous project management approach. Given these difficulties and delays the projects failed to progress beyond the drawing board stage, and in the most recent discussions the other Trusts have indicated that they are pursuing alternatives to the proposed joint venture for a forensic scheme and on-site provision; they now want to consider separate provision on a smaller scale for their own clients. This has effectively meant that the considerable time and effort expended in the original proposals have not delivered and were ineffective. Additionally, it means that the assurances provided to the BHSC Trust Board regarding the robust plans being in place for the individuals concerned was not underpinned by realistic and deliverable planned schemes.

8.5.24 However, the recent ‘refresh’ of the senior operational leadership within the Learning Disability Team at BHSCT has brought some encouraging signs of a new approach. They are urgently reviewing all their plans, in the context of the rapidly changing picture as other Trusts review and accelerate plans for individuals. The additional catalyst for this revised approach and more rapid progress relates to the significant supply and financial pressures that the staffing situation in MAH is creating. In this context the BHSCT has shown a real willingness to look at re-purpose and re-design of some existing provision as an alternative to new build options. This could significantly improve the speed of the resettlement for the BHSCT residents who are patients in MAH, although these proposals are at a very early stage of consideration and have

yet to be tested fully in terms of feasibility, and acceptability to the individuals who will be offered these accommodation options, and their families.

8.5.25 Recent contingency planning due to staffing pressures at MAH and request to HSC Trusts to bring forward alternative plans to replace the capital schemes with lengthy and unpredictable delivery dates, has changed the discharge planning position for the 3 HSC Trusts with patients in MAH. BHSCT are responding positively to this new challenge and are scoping discharge options. The Trust has identified supported living schemes in the BHSCT area with under occupancy which may provide viable discharge options. These plans are in an early stage of development but show promise. The Care Quality Commission- Brief Guide; discharge planning from Learning Disability assessment and treatment units (August 2018), highlights that a discharge plan needs to have an identified care provider, an address and a discharge date. The review team have used this as the basis for judging if the discharge options proposed by all HSC Trusts are robust enough to provide confidence and predictability in regards to timeline for discharge.

8.5.26 BHSC Trust had 16 patients in MAH at commencement of the independent review and still has 15 patients in MAH at 11th July 2022. Our analysis of the current position for BHSCT in regards to revised planning is that BHSCT has robust discharge plans in place for 2 patients to transition to current nursing home and supported living vacancies by September 2022. However, the plans for the remaining 13 patients have not been confirmed in regards to named scheme or estimated discharge date and remain plans in development. There are 3 major challenges for revised plans, Workforce recruitment, re-registration of schemes and most significantly the time required to engage and gain agreement from family carers. This is a dynamic environment and the summary and trajectory provided by the review team reflects the position at 11th July 2022.

8.6 Lessons Learnt and Evaluation:

8.6.1 We know that many stakeholders within the overall system are committed to supporting a learning culture, which adopts a ‘lessons learnt approach’. Organisations like RQIA have supported the adoption of Quality Improvement [QI] methodologies in supporting providers to promote continuous improvement within their services, and as previously identified the work that RQIA, ARC and the Patient and Client Council are doing within the ‘Tell It Like It Is' Project are encouraging. However, we were disappointed that there didn’t appear to have been any systematic evaluation of the experience of individuals who had been resettled, both successfully and unsuccessfully. It felt that there were opportunities to undertake some audit activity and also to consider whether

there is scope for pre and post placement Quality of Life measures to be applied so that there is some empirical evidence of the improvement in individual's lives. Although many people told us stories, both good and bad, of the experience of people during the resettlement process we didn't come across any evidence of this being properly documented, and consequently the voices of the people at the centre of this process often went unheard. There is undoubtedly potential for a more formal evaluation of the experience of those who have been resettled contributing to a better understanding of what works well and what doesn't.

8.6.2 On a positive note leaders and citizens across the system talked passionately about the need for better sharing of good practice models, and the need to ensure that the stories about the valued lives of people with learning disability must be communicated through a positive narrative available to the public and society at large in Northern Ireland. This laudable ambition is one that we believe everyone involved in this process would willingly support.

8.7 Recommendations

- The sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that it there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.
- HSC Trusts should urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning and promote good practice through a collaborative approach to service improvement.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better.

9. Safeguarding

In this chapter we will consider the legislation and policy relating to Adult Safeguarding in Northern Ireland, the learning from RQIA inspections, the findings from previous independent investigations of failures in the care provided to vulnerable adults and the views and concerns of family carers and their lived experience relating to safeguarding.

9.1 We have talked in previous chapters about the fact that the confidence of family carers in the HSC system's ability to Safeguard and protect people with a learning disability has been impacted significantly due to findings of abuse at MAH. We gathered evidence through our direct engagement with family carers which included family carers whose loved one has already been resettled and living in the community, as well as MAH family carers. All raised safeguarding as a significant concern with the review team. Family carers provided feedback to the review team about the actions they wish to see addressed in regards to their concerns about adult safeguarding and protection and their views and experiences will be explored later in this chapter.

9.2 It is important to set the concerns and expectations of family carers and the findings of this review in the context of Adult Safeguarding legislation, policy and practice in Northern Ireland.

9.3 A review of Safeguarding policy and practice was not within the scope of this review however, the review team analysed the findings from previous independent investigations of failures in the quality of care provided to vulnerable adults in Northern Ireland to inform our recommendations about individualised care planning and the commissioning and procurement of services to support discharges from Northern Ireland's Learning Disability Hospitals.

9.4 The recommendations arising from the 'Home Truths' report on the Commissioner for Older People's investigation into Dunmurry Manor care home (2018) and the CPEA Independent whole systems review into safeguarding at Dunmurry Care Home (2020) have resulted in a draft 'Adult Protection Bill' (July 2021) which will introduce additional protections to strengthen and underpin the adult protection process; provide a legal definition of an 'adult at risk' and in need of protection and define the duties and powers on all statutory, voluntary and independent sector organisations. An Interim Adult Protection Board (IAPB) was established in February 2021. It is clear to the review team that significant steps have been taken by the Department of Health to update legislation and policy in regards to adult safeguarding.in Northern Ireland in response to the learning from failures in care.

9.5 The Muckamore Departmental Assurance Group (MDAG) was established to monitor the effectiveness of the HSC system's response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff. The action plan monitored by MDAG, includes an action to complete a review of Adult Safeguarding culture and practices at MAH to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. This action is focused on safeguarding culture at MAH however, our engagement with the wider HSC and care providers highlighted variation both in practice and attitudes cross the Trusts. RQIA inspections of other learning disability hospitals in Northern Ireland also highlight ongoing concern about standards of safeguarding practice.

9.6 Current Safeguarding policy and practice is guided by; 'Prevention and Protection in Partnership Policy' (DHSSPS) 2015 and the adult Safeguarding Operational Procedures – 'Adults at Risk of Harm and Adults in Need of Protection' (HSCB) 2016. The policy highlights that adult safeguarding arrangements should prevent harm from happening and protect adults at risk. Safeguarding is a continuum from taking steps to prevent harm through to protection highlighting that safeguarding is everyone's business and not just the business of statutory safeguarding teams. The stories shared by family carers later in this chapter and in chapter 10, put the spotlight on psychological and emotional harm and fact that more could have and should have been done to prevent harm.

9.7 RQIA carried out a review of safeguarding in Mental Health and Learning Disability hospitals (2013) looking specifically at the effectiveness of safeguarding arrangements. A recommendation from the RQIA review was that the DHSSPS should prioritise the publication of the Adult Safeguarding Policy framework. RQIA published a follow up report, Safeguarding of Children and Vulnerable Adults in MH/LD Hospitals in NI (2015) following inspection in the Southern HSC Trust.

9.8 The Bamford Review of Mental Health & Learning Disability recommended a new comprehensive legislative framework for mental capacity legislation and reformed mental health legislation for Northern Ireland. This has been taken forward by the implementation of the Mental Capacity Act (NI) 2016 which has a Rights based approach and brings new safeguards in regards to deprivation of liberty and consent. The Mental Capacity Act (NI) 2016 provides a statutory framework for people who lack capacity to make a decision for themselves and provides a substitute decision making framework. The Act is being implemented in phases. Phase one implemented from December 2019 included provision of Deprivation of Liberty Safeguards (DOLS') and a DOLS Code of Practice. DOH (April 2019) The Mental Capacity Act (NI) 2016 is intended to protect the human rights and interests of the most vulnerable people in society who may be unable to make decisions for themselves and offer enhanced protections to people

lacking capacity. The Act is principles-based and sets out in statute that it must be established that a person lacks capacity before a decision can be taken on their behalf. It emphasises the need to support people to exercise their capacity to make decisions where they can. This legislation will change and shape practice across learning disability services with a focus on Best Interests. Decision making in complex areas such as the use of CCTV will be addressed in more detail later in this chapter.

9.9 Whilst progress has been made in regards to legal safeguards for decision making in respect of individuals who lack capacity and in regards to placing adult safeguarding on a statutory footing, incidents highlighting concerns about safeguarding and restrictive practices remain current in practice.

9.10 This is evidenced in an RQIA inspection report following an unannounced inspection at Lakeview Learning Disability Hospital between August and September 2021 which identified a number of matters of significant concern in relation to adult safeguarding and incident management. A further inspection was completed in February 2022 which found that progress had been made in a number of areas however, there had been limited progress with regards to adult safeguarding and incident management. The RQIA inspection report noted areas for improvement relating to adult safeguarding including a review of the use of CCTV to support adult safeguarding.

9.11 The 'Way to Go' report made a recommendation that In addition to CCTV's safeguarding function as a tool to prevent harm rather than as a means to ensure safe and compassionate care, CCTV should be used proactively to inform training and best practice developments at MAH CCTV needs to be considered This recommendation is included in the MDAG action plan and the BHSCT CCTV policy group continue to engage with stakeholders to reach agreement, on best practice in MAH .The review team were advised that Questionnaires have been issued to family members, carers, patient and staff to seek feedback and engagement around the use of CCTV on site

9.12 CCTV was a central issue of concern for MAH families in the context of discharge planning. Some of the MAH family carers stressed the importance of CCTV in providing them with assurance. Families stressed that CCTV has been central to establishing abuse at MAH and that they hold significant concerns about CCTV not being in place in community settings. The review team were advised about one case where this issue created delay in progressing plans for discharge due to the Trust and the family holding differing views of what could be put in place. During engagement events with families, the review team were advised that some families see the need for CCTV as a consequence of their loved one being the subject of abuse at MAH and that maintaining similar monitoring in the community setting is an important bridge for these families. The debate on the use of CCTV between the family and the Trust in one case could be a barrier to discharge with potential to cause delay. CCTV played an important role in

recording potentially abusive behaviour by staff in Dunmurry Manor Care Home, Winterbourne View as well as MAH. The initial concerns were not initiated by CCTV but rather used to explore concerns raised by family which led to the identification of concerns. Given the importance family carers placed on CCTV, the review team reviewed the actions taken by RQIA to address this issue.

9.13 RQIA issued Guidance on the use of overt closed circuit televisions (CCTV) for the purpose of surveillance in regulated establishments and agencies (May 2016) The guidance was aimed at assisting registered providers in meeting the best interests of service users when considering the use of overt CCTV systems and reminds them of the requirements of the Data Protection Act 1998 and Article 8 of the European Convention on Human Rights-Right to respect for private and family life. The guidance states that CCTV should not be used in rooms where service users normally receive personal care and that a policy must be in place which outlines the provider's position on the use of CCTV. The RQIA also commissioned Queen's University Belfast to carry out a review of the effectiveness of the use of CCTV in care home settings (January 2020) which was commissioned in response to concerns regarding the quality of care and the potential for abuse in care home settings. The research highlighted that this is a complex ethical matter in the context of existing law and guidance. Expectations on the use of CCTV creates tensions between the needs of residents, family members and those providing care. The review completed on behalf of RQIA concluded that there was insufficient research evidence to support the proposed use of CCTV in care home settings.

9.14 Given the importance placed on this issue by some MAH families, the review team recommend further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.

9.15 The review team considered how the feedback provided by families in regards to their concerns about safeguarding should contribute to the discharge planning process and in supporting an individual through the transition process to a home in the community. Family carers were clear in their feedback to the review team that they have an active role in safeguarding by staying observant and alert to concerns and any change in their loved one's presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family. MAH family carers expressed concern and frustration due to the visiting restrictions required at MAH in response to the Covid pandemic.

9.16 The following patient story highlights a family's concern about the care arrangements and impact of the living environment on their son. The family highlighted to the review team that the focus at MAH has been on physical abuse of patients by staff but that in their case their concern is about psychological and emotional abuse.

'Family shared the story of their son who returned to MAH following a traumatic breakdown in trial resettlement placement after six months. His parents advised that they have not been advised to date that their son has been the subject of physical abuse, however, they highlighted that their son has suffered emotional and psychological abuse associated with both his in-patient stay in MAH and in regards to a trial resettlement placement. The family expressed concern about the quality of care in both the community placement and in MAH. Their experience of the community placement which had been a new build resettlement scheme was that it operated as a mini institution rather than to the vision of supported living that they had expected. The family were advised after the decision to end the placement was made by the care provider who did not think their son was compatible with other residents. The family experience of discharge planning and trial resettlement has not been positive and they reflected that the discharge planning was not effective and caused harm to their son due to the care provider not being in a position to meet his needs.

The family advised that since his return to MAH their son has regressed. The family expressed further concern about the impact of the Covid restrictions on visiting and in the reduction of the range of activities available which the family believe is detrimental to preparation for their son leaving MAH. The family talked about their experience of MAH being poor and their confidence in the HSC system significantly impacted.'

9.17 This story about the lived experience of a patient, highlights that transitions between services should be handled smoothly and systematically with attention given to ensuring the person's individual needs are well communicated between services. It also highlights that family carers should be seen as important partners in the care planning approach. The chapter on individualised care planning provides further case examples when communication between services was not as effective as it should have been. For individuals with behaviour that may challenge, it is critical that discharge planning is progressed in line with 'Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability services' (2010) with a clear Safety Plan agreed and the family consulted about what is needed to safeguard and protect. The written care plan needs to detail any risks as well as what should happen in a crisis. We give further consideration to good discharge planning in the chapter on individualised care planning, highlighting the need for regional standardisation on the range of assessment and care planning tools used to ensure that individuals are safeguarded. A Person centred safety management plan should be central alongside a functional assessment and essential lifestyle plan and the family fully consulted and engaged in the resettlement planning process. We also highlighted that the risk assessment should be shared with relevant agencies and that the specialist knowledge and communication skills required to care for the individual should be defined and embedded in commissioning specifications and contracts.

9.18 Independent sector providers provided feedback to the review team on their experience of the adult safeguarding policy and procedures in practice which highlighted variation across trust areas. Care providers reflected variation in regards to thresholding of safeguarding referrals and variation in the attitude and support from different safeguarding teams. The review team recommend the review of Adult Safeguarding culture MAH is extended across community settings to address the experiences of key stakeholders including families and care providers.

9.19 Care providers also raised the use of restraint and the need to ensure appropriate focus on management strategies that enable preparation for discharge to the community. There has been growing recognition of the importance of reducing the need for restraint and restrictive intervention. DoH launched a public consultation on a draft regional policy on the use of restrictive practices in HSC settings in July 2021. It is critical that further review and analysis of incidents across all care providers in learning disability services is progressed to ensure learning and to inform the DoH review. The review team did not see evidence of effective sharing of learning from the analysis of incidents and SAI's with independent sector providers.

9.20 Feedback from family carers about safeguarding policy and procedures highlighted concerns that investigations were not progressed in a timely way which causes anxiety for the family. Trusts have highlighted workforce capacity issues. Given the impact of the ongoing PSNI investigation of alleged abuse at MAH and the evidence being provided to the Public Inquiry, more needs to be done to address the impact of delay in safeguarding investigations for families. Engagement with family carers highlighted that their concerns about safeguarding relate to current experience as well as the historic allegations of abuse which are the subject of ongoing police investigation and the focus of the Public Inquiry. It is critical that the experience of individuals and their family carers is heard and addressed.

Recommendations

In summary the conclusions and recommendations from this chapter are

- Further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- Contracts or service specifications for services for people with a learning disability should ensure that safeguarding requirements are adequately highlighted and that arrangements for monitoring are explicit.
- HSC should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.

- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one's living environment rather that a visiting room.
- HSC Trusts should have arrangements in place to share learning about safeguarding trends and incidents with care providers.

10. Advocacy and Carer Engagement

This section will address the extent to which engagement strategies employed by HSC Trusts and collectively by the HSC system as a whole have been effective in supporting the delivery of the MAH resettlement programme; the extent to which families and patients were engaged in decision- making around resettlement and to what extent Advocacy support was provided.

Sincere thanks are owed to the family carers who engaged with the review team and so generously shared their personal experiences and stories. The families provided the review team with rich information about their lived experience which has shaped the findings for this review.

10.1 Participation and engagement with a wide range of stakeholders was central to the review however, the priority for the review team was to hear the voice of people with a learning disability and their family carers who have lived experience of delayed discharge and the resettlement journey. This was achieved in a number of ways;

- The review team issued a letter to every family with a loved one in MAH extending an invitation to contribute to the review of resettlement. Meetings were held at a neutral venue in the NHSCT, SEHSCT and BHSCT areas to bring families in each HSC Trust area together to hear their individual stories and common experiences.
- Some families did not wish to attend a public meeting but wished to meet with the review team. This was facilitated by home visits and zoom calls.
- The review team met with the 2 family carer representatives on the Muckamore Departmental Assurance group.
- The review team met with families of people who have already been resettled from MAH and whose placements have been successful
- The review team visited individuals with learning disability resettled in their community placement.
- The review team met patients and staff at MAH.
- The review team met with the Patient Client Council in regards to their role in providing Advocacy and supporting families involved in the MAH Public Inquiry.
- Meetings were arranged with Voluntary and Independent Care provider organisations who facilitated meetings with families.
- Engagement with RQIA - to learn about user experience from Inspections

10.2 Engagement strategies employed across the HSC

10.2.1 The Health and Personal Social Services (Quality, Improvement and Regulation) Order 2003 (ctrl click) applied a statutory duty of quality on the HSC Boards and Trusts. The 5 key quality themes which remain relevant to this review are:

- Corporate leadership and accountability of organisations
- Safe and effective care
- Accessible, flexible and responsive services
- Promoting, protecting and improving health and social well being
- Effective communication and information

10.2.2 The quality standards launched in 2006 (ctrl click) includes a standard for effective communication and information. HSC organisations are expected to have active participation of service users and carers and the wider public based on openness and honesty and effective listening.

10.2.3 The Bamford review recommended independent advocacy highlighting the need to support individuals to express and have their views heard. The principle of involving people in decisions about their care has been embedded in policy for many years. In 2012, the Department for Health and Personal Social Services (DHSSPS) launched a 'Guide for Commissioners- Developing Advocacy services' (ctrl click) introducing principles and standards. The DoH 'Co-Production Guide for Northern Ireland (2018) (ctrl click) recognised that co-production takes time and is a developmental process based on building relationships to support effective partnership working with service users and carers.

10.2.4 In the BHSCT's Serious Adverse Incident investigation report, 'A Way to Go', advocacy in MAH was described as '*not as uncomfortably powerful as it should be*' and stated 'it *is possible that the long association that advocacy services have had with the hospital and the impact of protracted delayed discharges have blunted its core purpose*'. The report also acknowledges that 'episodic contact is unhelpful' however, did not address the question of how family members, where they exist, are supported to act as the primary advocate for their loved ones as active partners in their care.

10.2.5 There is significant learning from the Scottish Government's approach to citizenship and involvement. 'A stronger Voice' Independent Advocacy for people with Learning Disability 2018 (Scottish Commission for LD) (ctrl click) states that Independent Advocacy can empower people

- To be listened to
- Understand what is happening and why decisions are made

- Be involved in decision making processes
- Become more confident and able to self-advocate

10.2.6 The review team sought to establish the engagement strategies in place across the HSC system at a population and individual case level. It was evident that all HSC Trusts have a formal infrastructure in place at organisational level to meet their patient and public engagement duty through established committees. This review however, was primarily focused on the experience of individuals and families and the extent to which their voice was heard at individual case level and in influencing the policy and practice in learning disability services.

10.2.7 The Muckamore Abbey Assurance Group (MDAG) has 2 family carers as members representing the views of families with lived experience. At Departmental and HSCB/SPPG level there is limited evidence of engagement and involvement of service users and carers in the development of policy, however, ensuring that this is effective and that the experience of individuals is one of being respected and valued is challenging. The Covid pandemic significantly impacted on business as usual, however, there is limited evidence of meaningful engagement with individuals and carers prior to the pandemic or currently in the range of learning disability work streams led by HSCB/SPPG.

10.2.8 There is variation in the engagement strategies within learning disability services in each of the HSC Trusts however, all HSC Trusts are continuing to review and improve the arrangements in place.

10.2.9 This was evident in BHSCT who have an action plan in place to address the recommendations arising from the 'Review of Leadership and Governance at MAH' (2020) (ctrl click) which includes a 'Communication and Engagement plan' the appointment of an engagement lead for learning disability and a non-Executive Director undertaking a lead for learning disability at Board level and being a visible champion for people with a learning disability and carers. The terms of reference for a range of engagement Forums were shared with the review team. There is a separate forum for MAH families with regular newsletters. The forum for community learning disability has a number of sub-groups to engage carers about transitions and accommodation. The BHSCT was the first Trust to establish a Carers Lead post to represent the views of people with lived experience of learning disability however, this post is now vacant. Whilst this is a positive step, further work and time is required to improve the number of families involved and engaged in the learning disability forums. There are only a small number of the MAH families actively involved in the MAH forum which reflects a significant level of disengagement due to

the breach of trust experienced by families following disclosure of abuse at MAH. The review team completed home visits with MAH families who have lost trust in the BHSCT and whose level of anger, pain and ongoing concerns about Safeguarding and Quality of service at MAH, highlight that a trauma informed and reconciliation approach is needed. The review team observed a number of occasions when engagement about a specific issue may have had a better outcome if the engagement and direct discussion with the family had been escalated to Director Level. Two discharge coordinator posts based at MAH had been funded to coordinate discharges across all patients. One of the discharge coordinator posts is now vacant. The resettlement team at MAH has reduced in size over the past year with an additional post-holder who had completed person-centred planning not filled. The NHSCT and SEHSCT lead the discharge planning for their own patients however, central coordination is required to arrange discharge meetings and to ensure that the range of information required from the MAH teams is available. The review team recommend that BHSCT considers the demand and capacity in the MAH resettlement team.

10.2.10 The NHSCT have also revised their approach to engagement and invited the review team to a public meeting organised by the Trust to engage their MAH families. A key learning point from this engagement event was the recognition that all of the families who attended in person on the evening had a shared experience of being involved in discharge planning for the new Braefields scheme. The families expressed the view that it is their perception that families have deliberately been kept apart and that the principle of stronger together should be embedded so that families can offer each other mutual support and identify common concerns and themes. This raises the need for the HSC system to recognise and value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.

10.2.11 The NHSCT strengthened their resettlement team recently, appointing a senior manager with oversight responsibility for monitoring progress against resettlement plans. The NHSCT is also in the process of appointing a lead Carers post to work in partnership with the senior management team to influence learning disability policy and service development. The review team met with NHSCT families who had a poor experience of communication however, there was positive feedback from a number of families about the relationship with the Trust's resettlement co-ordinator who has been in post for a lengthy period. The continuity of the relationship was valued by the families and highlights the importance of a key worker role, described to by families as the go to person for families trying to navigate across complex services.

10.2.12 SEHSCT has a long established Carers Forum for Learning disability who engage with the Trust in regards to policy and service development but also provide advocacy and representation of the views of people with learning disability and carers. The SEHSCT's in-patient population has reduced to just six patients whose age and range of needs are very diverse. A young person who transitioned a few years ago from a children's in-patient facility, a patient on detention though a Hospital Order with restrictions and an individual in his late 70's who has lived most of his adult life in MAH. The Trust's engagement with the remaining families is though the key worker, as the discharge solutions needed for the remaining patients are bespoke and highly personalised. The Trust had a dedicated post ensuring Essential Lifestyle discharge planning for all SEHSCT MAH patients transitioning to the community over the past years. This post is now vacant. There is evidence that using the tools of essential lifestyle planning is effective in developing a meaningful person-centred discharge plan. The review team recommend that all HSC Trusts embed essential lifestyle planning in the discharge pathway.

10.2.13 In summary, it is encouraging to see that the engagement strategies in all of the HSC Trusts have developed, but further time and effort is required to address the hurt and harm experienced by MAH families and to build the relationships and bridges needed to facilitate honest and mature dialogue and co-production. Overall across the HSC system, the voice of carers was not sufficiently evident within the leadership processes and there was limited evidence at all levels of effective co-production with carers.

10.3 The Voice of People in MAH - extent to which families and patients were engaged in decision- making around resettlement

10.3.1 Most of the families who attended the engagement meetings had previous experience of a trial resettlement that had broken down and were keen to share their experience of discharge planning and what went wrong.

10.3.2 There was not one voice but there were recurring themes from the review team's engagement with MAH families.

- Lack of trust, anger and families reporting invisibility of LD services
- Significant Safeguarding concerns
- Traumatic impact of abuse disclosures given the blind trust families had over many years seeing MAH as safety net
- not being involved or respected as expert by experience
- not being involved in relevant care planning meetings
- Experience of at least one trial placement breakdown

10.3.3 Some families talked about the culture and attitudes they had experienced over the years with HSC staff trying to 'persuade' them to accept a placement with a number of families referring to passive aggressive through to hostile approaches. Families referred to not being valued or acknowledged as experts by experience.

The following story of a mother's experience highlights the impact of culture and unhelpful communication styles;

10.4 A Mother's Story

10.4.1 Shared the story of a trial placement for her son which broke down within months. The family felt that the environment was appropriate however staff were not adequately trained or competent. Mother did not feel listened to or respected as an expert by experience who knew the triggers and warning signs that staff should have been attentive to. Family expressed the view that MAH did not provide enough information about relevant incidents on the care plan

10.4.2 When asked what needed to improve, the review team were advised by the family that resettlement needed to be accelerated and the following areas addressed;

- Better training for staff and assessment of competencies in key areas.
- An understanding of trauma and recognition of the experience and impact on families as well as their loved ones.
- Family carers valued as experts by experience and fully included in all decisions and meetings
- Better communication – Improvement needed to ensure communication is respectful and effective.
- Possibly some tools like a carers charter; an explicit statement of expectations and principles

10.4.4 The review team were advised that the family have experienced a breach of trust and confidence in the Trust and wider HSC system. The feedback provided to the review team confirmed that further work is required to ensure that all families feel effectively engaged in decision-making around resettlement and the monitoring of trial placements.

10.4.5 A number of families spoke to the review team about the importance of getting the culture, leadership and model of care right. The stories shared by families demonstrate the need for a tiered advocacy framework so that issues of complexity or dissension can be supported and facilitated more effectively

through independent advocacy. Families also told the review team that they have increasingly escalated to legal advocacy through the courts when the issues are systemic about failure to commission a service rather than about individual care planning.

10.5 Patient Story

10.5.1 The family confirmed that significant discharge planning had been progressed prior to the trial resettlement placement and expressed their disappointment and anger that the placement broke down within weeks resulting in their family member being returned to MAH without the family being advised in advance. The family had visited the trial placement daily and witnessed that the care staff were not competent to provide the care required. The family highlighted that the focus should not be on the number of staff required but on the culture, leadership and support the staff receive in addition to training and skills development. The family hold the HSC Trust accountable for commissioning the service and feel that HSC Trusts need to seek assurance that care staff have the appropriate competences.

10.5.2 The family believe that timely resettlement is in the best interests of their loved one and are actively involved in the planning for another trial discharge. The learning from the failed trial resettlement for the family was that they should be seen as a member of the multi-disciplinary team and involved in all meetings and decisions about care.

10.6 The Voice of People who have been successfully resettled

10.6.1 The review team met with a number of families whose family member has been resettled for some time. The narrative and experience of discharge planning and transition arrangements between MAH and the community are in stark contrast to the experiences shared by current families. It is of note that resettlement in the 1990's was strategically led and was progressed at scale with families reporting clarity about the process. This is best summarised through the story of a father who was very resistant to resettlement when the process commenced.

10.7 Lessons from what has gone well- A Father's story

10.7.1 The family of this young man were not keen on resettlement as they believed that their son was settled at MAH and that he was safe and secure. They were fearful of the unknown and had no experience or understanding of supported living services. The family advised that discharge was well planned and that

they had been able to consider a number of options. What has worked is that the care provider is open with the family who are made aware if their son's behaviour is changing. The staff identify the triggers that may result in deterioration and discuss with the family. The family advised the review team that their main concern prior to transition was safeguarding in the community. The family view the ability to visit their son flexibly and unannounced in his own home as providing then with real time assurance about his care rather than the formality of appointments. The family advised that the outcomes that demonstrate that resettlement has improved the quality of life for their son are numerous including the level of engagement he enjoys in activities in his own community, the fact that the parent/ child relationship has changed with their son supported to make adult decisions and personal choices about how he wishes to celebrate birthdays and Christmas. The family compared their son's life now to when he was in MAH and advised that he is living a fulfilling life and is central to his care planning. The family's advice in regards to what can be done to expedite or improve resettlement planning was quite simply 'Get it Done'.

10.8 Story of a young man with very complex behavioural needs living in Supported Living

10.8.1 The review team met with a young man now supported in a specialist supported living placement in the community having previously experienced admissions to MAH and other specialist in-patient facilities. The sustainability of this placement for a young man with very complex needs and challenging behaviour was stated by the care provider to be down to the partnership working between the care provider and the statutory learning disability team. The care provider uses a Positive behaviour approach with staff trained and competent in the methodology. The care provider highlighted that the responsiveness and wraparound support from the statutory team at times of increased challenge, actively reduces the potential for placement breakdown. The review team spoke to the young man and his care staff directly who described the full and active life the young man experiences and the support he receives to make personal choices. Additional positive outcome has been improvement in the young person's physical health with weight loss through a fun focused activity schedule. It was helpful for the review team to see an example of positive behaviour approach in action. The care staff reported that the model provides them with the support they need and they feel part of a wider specialist team.

10.8.2 This young man has needs equivalent too many of the patients in MAH who have been discharge delayed many years and this story is a helpful reminder that supported living models rather than new build bespoke are effective for

individuals whose behaviour can challenge. Voluntary sector care provider organisations stressed to the review team that the primary focus should be on a Positive behaviour approach and a skilled and competent workforce not just on the built environment.

10.9 Extent Advocacy support was provided regarding resettlement

10.9.1 The Review of Leadership and Governance at MAH recommended that the BHSCT should review and develop advocacy arrangements at MAH to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

10.9.2 BHSCT has recently commissioned an independent review of advocacy services which is due to report by September 2022.

10.9.3 There are a number of Advocacy service providers engaging with MAH families. NHSCT commission independent advocacy services from Mencap for their families. SHSCT commission independent advocacy services from Disability Action for their families and Bryson House provides the independent advocacy service for both Belfast and SEHSCT. Families reported confusion about the roles of the various advocates involved, which is heightened when there is more than one advocate involved with the family.

10.9.4 The landscape has become more confusing for families with the Patient Client Council (PCC) providing direct advocacy support to MAH families. The review team met with the PCC Chief Executive and senior management team, who advised that PPC had been asked to provide support during the Leadership and Governance review feedback to families. In addition, the PPC provided a report on the engagement with current and former patients, families and carers regarding the terms of reference of the Public Inquiry. The PCC are now acting as the Independent Advocate for the Public Inquiry into MAH. As a result, the PPC has appointed a dedicated worker to build relationships with MAH families. The review team did not see evidence that the impact of the extended role for PCC on the long-standing commissioned independent advocacy services was considered or discussed between the various advocacy providers. Families reported that current arrangements are confusing and reported a lack of clarity about definition of advocacy, lack of clarity about roles and provided examples when an advocate from PCC and Bryson house were working at cross purposes. The situation was resolved but further review is required. The review of advocacy services commissioned by the BHSCT should bring forward recommendations to address the concerns raised by families.

10.9.5 Some families welcomed the relationship with the advocate involved with the family but struggled to provide examples when the advocate had made a difference in the resettlement outcome. There was confusion between a befriending and advocacy role with families stressing that it was the relationship they appreciated rather than the challenge function.

10.9.6 The following patient and carer story highlight the key issues raised by families in regards to advocacy. The strongest message was that family carers should be the first and primary step in advocating for their loved one.

10.10 Story of Long-Stay patient and experience of Advocacy

10.10.1 A mother met with the review team to share the story of her son who has been in-patient at MAH for some time. The story tells of a family who have maintained close contact with their son. The family have dreams for their son to experience community living with enhanced personal choices and less bound by hospital routines. However, a trial resettlement went badly wrong with the police being called by the care provider and their son being traumatically returned to MAH. The family believe the placement broke down because the care staff did not have the competencies to cope with behaviour that challenges. The family did not feel they were involved in care planning and expressed the view that they were advised by professionals rather than consulted.

10.10.2 The family talked about their experience with advocacy and felt strongly that the family are the strongest advocates in speaking up for their son. The family expressed confusion as there have been 2 advocates involved with the family and they are unclear about their respective roles. Family did not know why advocates became involved and state their view was not sought on the matter. The family advised that their experience of advocacy has not been positive and referred to the fact that the advocates turn up at meetings but the family were not able to identify when the advocate had made a difference. The family expressed the view that advocates had agreed on occasion to do something but did not follow up. The family felt that they are the only ones in their son's life for the long haul and will continue to speak up for their son. The family do not call themselves advocates but felt they provide a strong voice for their son.

10.10.3 The review team have reviewed the Terms of Reference for the comprehensive review of advocacy commissioned by BHSCT. The issues raised by families should be addressed by that review.

10.10.4 Other family carers reflected on current concerns about Safeguarding and the Quality of care in MAH. The families acknowledged that the Covid pandemic impacted on routine business but expressed concern that patient activities

being curtailed directly impacted on quality of life and preparing for transition to the community. Families also reported that the visiting restrictions implemented in response to the Covid pandemic raised anxiety about safeguarding arrangements due to visits being electronic or having to pre-book visiting with no access to their loved ones ward or living environments. Family carers feel they have an active role in Safeguarding by staying observant and alert to concerns and any change in presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family

10.10.5 Whilst there is relationship complexity across the wide range of stakeholders involved in the resettlement pathway, there is an urgent need to repair relationships and build trust. Families stressed to the review team that professionals talk about services but for the families it is their lives. The change that families want to see in the culture and attitudes across HSC services does not require radical reorganisation. The HSC Collective Leadership strategy (2017) (ctrl click) describes the values needed to promote shared leadership across boundaries and partnership working between those who work in HSC and the people they serve. Families stressed the need for a return to basics to achieve effective person centred planning and involvement of families in all meetings about care and decisions based on openness and respect. A regional one system approach and effective engagement and partnership working with family carers will be required to ensure the effective delivery of the final stage of the MAH resettlement programme

Recommendations

- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.
- Family members should be listened to and receive a timely response when they advise things are deteriorating
- Advocacy support should be available and strengthened at all stages of care planning-HSC Trusts must ensure that there is a clear pathway and clarification to explain the role of different advocacy services.
- HSC Trusts should utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families
- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences
- HSC Trusts should improve communication and engagement with families when placements are at risk of breakdown

- Families should be seen as integral to the care planning and review process and invited to all meetings
- A regional policy on the use of CCTV in learning disability community placements should be co-produced with relevant stakeholders.

11. Conclusions

Conclusions

11.1 The review team were determined from the outset of the review to ensure that the experience and voice of those with lived experience and their family carers informed the solutions and actions required to expedite resettlement .The review draws on the experience of people with learning disability who have been successfully resettled and those who have experienced breakdown and returned to MAH. The stories shared with the review team by family carers, brings into stark reality the impact that the allegations of abuse at MAH has had on family carers. In contrast, the stories shared by family members who have experienced successful resettlement, provide evidence of the positive outcomes and improved quality of life their loved ones are now experiencing.

11.2 It is important not to underestimate the challenge of planning for the resettlement of the remaining population whose needs are complex. The review team considered the learning from the policy and practice evidence base in relation to resettlement programmes across the UK and Republic of Ireland and a detailed analysis is contained in Chapter 4. Transforming Care for People with Learning Disabilities - Next Steps" was published in January 2015 The report identified a significant change in direction in the policy and practice in relation to gatekeeping admission to specialist learning disability settings, alongside dedicated strategies for admission avoidance and more effective discharge planning. Actions that should be considered for Northern Ireland include;

- providing enhanced vigilance and service coordination for people displaying behaviours which may result in harm or placement breakdown;
- Establish a Dynamic Support Database to provide focus on individuals at risk of placement breakdown and development of proactive rather than reactive crisis driven response-
- Implementation of a Positive Behaviour Service framework and provider engagement
- Effective Assessment tools/ Discharge planning meetings- Complex care co-ordinators to focus on transition plans
- More detailed tracker tool to support analysis and performance management to create a master database-history of discharges, re-admissions and trends.

11.3 Feedback from a wide range of stakeholders highlighted the need to refresh the strategic policy and service model for Learning Disability in Northern Ireland.

The above actions should be central to policy development but will require system leadership at all levels across the HSC.

11.4 The Learning Disability resettlement programme in the 1990s was successful overall, achieving a significant reduction in the long-stay population. The success factors appear to be that the resettlement programme was strategically and regionally led with ring fenced funding agreed across Department for Communities and the DOH with robust project management monitoring progress against targets. The current resettlement programme would benefit from a similar approach as it is currently a bottom up approach and lacks cohesion and direction. The data provided by the Trusts on progress on resettlement plans was not adequately scrutinised internally in the Trusts or externally by the HSCB/SPPG. The review team advised the HSCB/SPPG officers on actions to establish a more effective tracker tool to improve performance management.

11.5 In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia and drift. It is critical that a one system approach is developed in Northern Ireland to address the silo working and duplication that remains across the 5 HSC Trusts involved in supporting individuals who are awaiting discharge from learning disability hospitals. The review team were pleased to see improved collaborative working led by the three directors within the past few months to seek solutions to the delayed discharge challenge and agree mutual aid in response to supporting MAH

11.6 The importance of and necessity to build trusted relationships was evident at strategic and operational leadership levels but more so in relation to building effective partnership working with individuals and families with lived experience of using services. The review team did not see evidence of effective engagement of people who use learning disability services or their family carers influencing the numerous learning disability work streams established by HSCB/SPPG to contribute to and influence the resettlement agenda. Whilst the review team did see evidence of new initiatives in the BHSCT and NHSCT to build an infrastructure to support engagement with family carers, they do not yet reach the MAH families who have disengaged due to the breach of trust they have experienced. People with a learning disability and their family carers should be respected as experts by experience with Trusts building co-production into all levels across the HSC system.

11.7 Family carers raised safeguarding as a significant concern and the review team recommend further engagement with care providers, family carers and Trusts to discuss their expectations and concerns about CCTV.

11.8 The area of strategic commissioning also requires a refreshed approach. Strategic commissioning needs to be underpinned by a strong assessment of needs. It was a recurring finding at strategic and operational levels that needs assessment was not robust. The review team identified models of commissioning which could inform improvements in Northern Ireland. "Integrated Commissioning for Better Outcomes" was published in 2018 to support health and social care economies to transform their services through a person centred approach to commissioning which is focussed on the needs of the local area. In Kent and Medway a new governance framework and an oversight board has been established to ensure that partners were accountable for commitments and performance. Accountability needs to be strengthened across HSC in Northern Ireland in regards to performance management against resettlement.

11.9 Engagement with independent sector care providers and Supporting People leads highlighted to the review team that knowledge and memory has been lost due to the turn-over in senior leaders most especially in BHSCT. Further work is required to build effective working relationships with key strategic partners to address barriers to resettlement.

11.10 The review team sourced data from RQIA and Supporting People in regards to the number of placements and schemes for learning disability and sought additional information from Trusts to form the basis of a supply map as seen in chapter 6. There does not appear to have been any analysis or strategic oversight to inform market shaping and this should be addressed by HSCB/SPPG and Trusts to inform strategic and micro commissioning.

11.11 Further development of social care procurement is urgently required and the review team recommends the development of a commissioning collaborative. Training and skills development on commissioning and procurement is required across the system.

11.12 The review team reviewed the care planning tools used by Trusts to support discharge planning. There is variation across the Trusts and the review team recommends that work is progressed to develop an over-arching resettlement pathway and standardise assessment tools to ensure that the needs of patients are considered as outlined in chapter 7. The learning from placement breakdowns highlights that discharge plans on occasion have not been sufficiently robust.

11.13 The review team scrutinised the current care plans for all the service users in MAH and critically analysed the actions taken by the responsible Trust to identify and commission suitable community placements. The analysis of length

of stay, the location the patient was admitted from and number of previous trial placements is presented in chapter 7.

11.14 The review team have assessed the robustness of discharge plans using the Care Quality Commission definition of a plan .Namely there has to be a named provider, address and confirmed discharge date. If this detail is not available the plan is incomplete. It is critical going forward that there is clarity and consistency in Trusts reporting on progress against discharge plans. The review team recognise that there are plans in development for some patients that show promise but in establishing a trajectory the system should only rely on plans that meet the definition outlined.

11.15 The South Eastern and Northern Trusts had taken steps some years ago to plan capital schemes that have already delivered or due to be operational in the next months. The BHSCT is an outlier in this regard with three capital business cases still in the early stage of development with the earliest date for completion 2025/26. The NHSCT and SEHST had been co-dependent on two of the three BHSCT schemes namely the forensic and on-site for a small number of their patients but are now pursuing other placements options.

11.16 As a result SEHSCT in-patient population at MAH has reduced to 6 patients. Robust plans are in place for 4 patients with no plan yet in place for two forensic patients. Two of the SEHSCT patients will be discharged by end August 2022 and an additional placement by end September 2022.

11.17 NHSCT has made good progress in delivering 2 new build schemes. Mallusk and Braefields which is due to complete end August 2022. NHSCT has taken additional steps to commission a number of individual placements in current schemes and plans to discharge 14 NHSCT patients by March 2023 This includes 12 MAH patients and the two NHSCT in out of area placements in Dorsey and Lakeview hospitals. NHSCT has 2 patients in MAH with plans not yet complete. the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefields scheme from end April to end August 2022.

11.18 BHSCT has been reliant on the 3 capital business cases providing for 10 BHSCT patients. This includes the Minnowburn scheme for 5 BHSCT patients and the Forensic and On-Site schemes. Given the long lead in time BHSCT is

now seeking alternative options to facilitate a more timely discharge. Whilst the BHSCT has adopted a refreshed approach with view to utilising available voids the plans are not yet complete. As a consequence only 2 of the 15 BHSCT patients have robust plans in place and 13 have plans that are not complete.

Reduction in Number of Patients in MAH between June 2021 and July 2022 and trajectory for Robust planned discharge by end March 2023

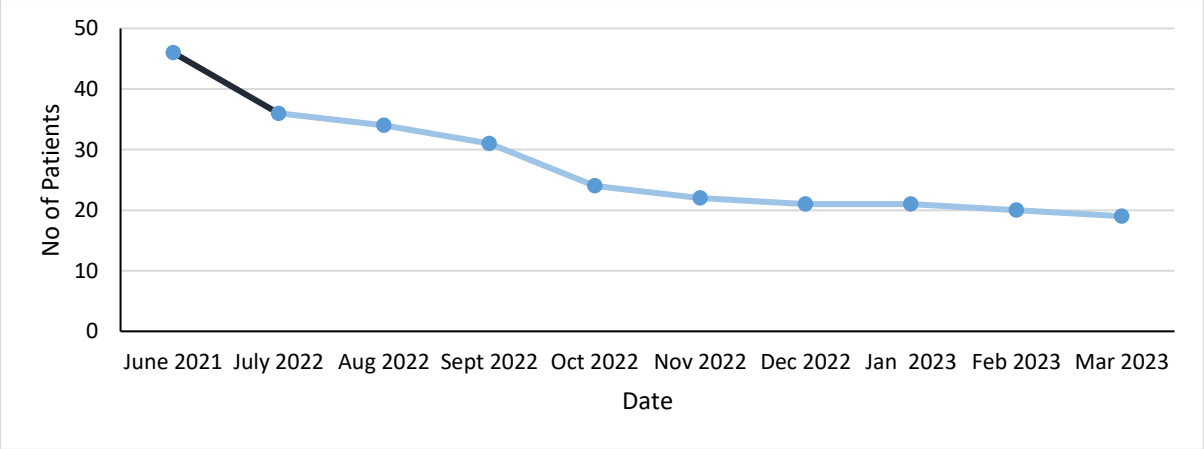


Fig 13

11.19 Fig 13 illustrates the discharge trajectory based on robust plans and robust timeframes. This is a conservative trajectory and the review team have confidence that further individual discharges will be progressed. It is encouraging to note that Trusts have responded to the recent challenge to develop contingency plans and that schemes in planning for some time now have confirmed discharge dates. The MAH population at 11th July 2022 was 36 in-patients, Fig 13 shows that the projected in-patient position by end March 2023 based on completed discharge plans is expected to reduce to 19 patients with potential for further individual discharges. Based on the analysis of the Trusts discharge plans against the Care Quality Commission definition of a discharge plan it is reasonable to assume that a further 17 patients will be discharged by end March 2023.

12. Recommendations

DOH

- The DoH should produce an overarching strategy for the future of services to people with learning disability/ASD and their families, to include a Learning Disability Service Model.

- The Learning Disability sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.

- People with a learning disability and their family carers should be respected as experts by experience and co-production built into all levels of participation and engagement across the HSC system.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better and a regional programme to tell the positive stories of those who have moved on, to include audit of proved clinical and quality of life outcomes.

SPPG

- In the context of the overarching strategy the SPPG should develop a commissioning plan for the development of services going forward. This will include the completion of resettlement for the remaining patients awaiting discharge from MAH, and progress the re-shaping of future specialist LD hospital services.
- SPPG should establish a regional Oversight Board to manage the planned and safe resettlement of those patients not currently under active assessment or treatment or deemed multi-disciplinary fit for discharge across all specialist learning disability inpatient settings in Northern Ireland.
- SPPG needs to continue to strengthen performance management across the HSC system to move from performance monitoring to active performance management, and effectively holding HSC Trusts to account.
- SPPG should develop a more detailed tracker tool to create a master database of discharges, readmissions and trends and establish a clear definition of a discharge plan to provide clear projections about the trajectory for discharge and progress over time.

- The Social Care Procurement Board should urgently review the current regional contract for nursing/residential care and develop a separate contract and guidance for specialist learning disability nursing/residential care.
- The SPPG and NIHE/Supporting People should undertake a joint strategic needs assessment for the future accommodation and support needs of people with learning disability/ASD in Northern Ireland.

SPPG and Trusts

- Strategic commissioners within health, care and housing should convene a summit with NIHE, Trusts, Independent Sector representatives, and user/carer representation to review the current resettlement programmes so that there is an agreed refreshed programme and explicit project plan for regional resettlement.
- SPPG and Trusts should develop a database of people displaying behaviours which may result in placement breakdown to provide enhanced vigilance and service coordination ensuring targeted intervention to prevent hospital admission and support regional bed management.

Trusts

- Trust Boards should strengthen oversight and scrutiny of plans relating to resettlement of people with learning disability/ASD in specialist learning disability hospitals.
- A regional positive behaviour support framework should be developed through provider engagement with the standard of training for all staff working in learning disability services made explicit in service specifications and procurement.
- HSC Trusts should collaborate with all stakeholders to urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans.
- HSC Trusts should ensure that the lived experience of the person and their family is effectively represented in care planning processes and the role of family carers as advocates for their family member is recognised and respected.
- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy at all stages of care planning and develop a clear pathway clarifying the role of different advocacy services.

- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences and utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families.
- The review team recommends a review of the needs and resettlement plans for all forensic patients delayed in discharge from LD Hospitals.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning about safeguarding trends and incidents and promote good practice through a collaborative approach to service improvement.
- Further consultation with individuals, family carers and care providers should be progressed to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- HSC Trusts should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.
- HSC Trusts should ensure that Contracts or service specifications for services for people with a learning disability have safeguarding requirements adequately highlighted and that arrangements for monitoring are explicit.
- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one's living environment rather that a visiting room.

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Appendices

Appendix 1: The Review Team

The HSCB appointed a 2 person review team who were required to possess a strong understanding of health and social care policy and practice in Northern Ireland and Great Britain along with extensive experience in leadership roles directly related to health and social care.

The review team comprised:

Bria Mongan

Ian Sutherland

Appendix 2: Biographies

Bria Mongan and Ian Sutherland

Bria Mongan

Bria has significant Executive level experience within Health and Social Care organisations. Bria completed a Masters in Social Work in 1980 and remains registered as a social worker with the NISCC. Bria retired in May 2020 following a forty year career in Health and Social Care services working across all programmes of care. Prior to retirement, Bria was the Executive Director of Social Work and Director of Children's services in South Eastern HSC Trust. Bria previously was the Director of Adult Services and Prison Healthcare and was accountable for leading mental health and learning disability services including leadership in resettlement programmes. Bria is currently an associate with the HSC Leadership centre.

Ian Sutherland

Ian is an experienced leader in health and social care. He is a psychology graduate, who trained as a social worker in Nottingham in 1986, and completed an MSc in Health and Social Services Management at the University of Ulster in 1994. He has worked as a practitioner and senior leader in both Northern Ireland and England, holding three Director posts. His most recent leadership role was as Director of Adults and Children Services in Medway Local Authority, England. In this role he led partnership commissioning between health and social care in relation to delivery of the Better Care Fund objectives. He has served as a Trustee of the Social Care Institute for Excellence, and is currently an associate with the HSC Leadership Centre in Belfast.

Exhibit 3

From: Dr Michael McBride
Chief Medical Officer

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

To: DoH G3's, G5's and equivalents
(Chief Professional Officers/Deputy Chief Professional Officers, SMOs etc.)

Date: November 2018

HSC REPORTING OF AN EARLY ALERT

The purpose of this memo is to remind Departmental staff of the procedures to be followed when a Health and Social Care (HSC) representative notifies the Department of an Early Alert.

Early Alert System

The Early Alert protocol requires HSC Chief Executives and their senior staff to notify the Department in a prompt and timely way of events which have occurred which may require urgent attention by Minister, Policy Leads or Chief Professional Officers.

Given the number of staff changes in the Department at Senior Officer level (defined as Permanent Secretary, Deputy Secretary, Chief Professional Officer, Assistant Secretary and professional equivalents) the internal protocol for the operation of the Early Alert System has been reviewed and revised. A copy of the revised protocol is attached.

The guidance issued to HSC organisation on the operation of the Early Alert System to can be accessed at: https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-64-16.pdf

If you have any queries about the operation of the revised protocol please contact Brian Godfrey, Head of Safety Strategy Unit in the first instance.

Dr Michael McBride
Chief Medical Officer

TAB A

DEPARTMENT OF HEALTH PROTOCOL FOR EARLY ALERT SYSTEM: NOVEMBER 2018

1. This protocol sets out the operational arrangements for the Department's Early Alert system, which is designed to ensure;

   - The Department and Minister are provided with timely information on significant events which have occurred within the Health and Social Care (HSC) system; and;

   - The Department maintains a central record of such notifications and any subsequent action.

2. There may be instances where HSC colleagues share information 'informally' with a Departmental Officer about events or issues without any reference to the terms 'Early Alert' or 'Serious Adverse Incident'. In these instances the Departmental Officer **should explicitly** clarify whether the matter is being raised with the Department as an Early Alert and, if appropriate, the HSC representative should be instructed to use the Early Alert notification process to advise the Department of the event/issue. Criteria for events which should be reported through this channel have been notified to the HSC via circular 'HSC-SQSD-64/16' and can be accessed - https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-64-16.pdf

3. It is also important to note that the Early Alert System does not remove the requirement for HSC organisations to assess significant events against the criteria for Serious Adverse Incidents.

4. The key operating components of the Early Alert System are as follows:

   a. **Initial contact by telephone call from HSC organisation to DoH**

INVESTORS IN PEOPLE

- It will be the responsibility of a senior representative (at Director level or higher) in the reporting HSC organisation to contact by telephone **a Senior Officer in the Department (Permanent Secretary, Deputy Secretary, Chief Professional Officer, Assistant Secretary or professional equivalents)** to provide initial warning that an event has occurred.

- **The Senior Officer in the Department who receives the initial contact will determine any immediate action required by the Department including the provision of Lines to Take to the Information Office if considered appropriate in advance of the submission of the completed Early Alert pro-forma by the reporting HSC organisation.** A prompt list to assist Senior Officers to ascertain the appropriate level of information at this stage from the reporting organisation is included in this guidance.

- The Senior Officer should remind the HSC representative making the notification of the need to give proper initial consideration as to whether or not the incident also meets the criteria to be reported as an SAI.

- The Senior Officer should also remind the HSC representation making the notification of the need to consider and comply with any other possible requirements to report or investigate the event they are reporting in line with any other relevant applicable guidance or protocols (e.g. Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), Professional Regulatory Bodies, the Coroner etc.)

b. **Submission of Early Alert proforma to the Department by the HSC organisation**

- It will be the responsibility of the reporting organisation to follow up the initial telephone notification by forwarding a completed pro-forma

providing further details of the incident to earlyalert@health-ni.gov.uk within 24 hours of the initial telephone notification. Senior Officers who are contacted by a HSC organisation should remind the HSC representative making the notification of the need to complete the pro-forma and email it to the Department within this timescale. Upon receipt of the pro-forma, Safety Strategy Unit will register the incident as an Early Alert and allocate a reference number.

c. **On receipt of the completed proforma from the HSC organisation**

- Safety Strategy Unit (SSU) will be responsible for forwarding the completed notification to appropriate policy/professional colleagues within the Department to provide details of the event. In some instances, the event could cover a number of policy areas in which case SSU will attempt to identify a lead policy area however will also copy into the issuing email other policy areas that may apply.

- Policy/professional colleagues on review of the notification should then consider any further action they need to initiate. This may include, for example; further liaison with SSU in regards to clarification of the lead policy area; liaison with the HSC organisation to ascertain further details surrounding the event, reminding the HSC organisation to give proper consideration as to whether or not the event also meets the criteria to be categorised as an SAI; the need to identify, consider and comply with any other possible requirements to report or investigate the event in line with any other relevant applicable guidance or protocols (e.g. statutory and non-statutory requirements to notify other organisations such as the Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), Professional Regulatory Bodies, the Coroner etc.); liaison with the Department's Information Office regarding handling arrangements including preparation of a submission to Minister or any other immediate action deemed necessary such as the need for regional action to alert other providers to a potentially significant issue.

- Details of any action which they initiate in response to the Early Alert should also be copied to **earlyalert@health-ni.gov.uk**. This will facilitate Safety Strategy Unit in maintaining a central record of any follow up action taken by the Department in response to individual notifications.

d. **Maintaining Records of Departmental Action**

- Safety Strategy Unit will maintain a central record of events including details of any necessary follow up action which may be initiated by policy/professional colleagues.

TAB A

Early Alert Prompt List for Departmental Senior Officers

Reporting Criteria under which event is being notified (tick as appropriate)

1. Urgent regional action is required
2. The need to contact patients/clients about possible harm
3. Press release about harm
4. Potential or actual media interest
5. Police involvement
6. Events involving children
7. Suspension of staff or breach of statutory duty

Prompt List

- Establish what happened and when.
- Is urgent action required by the Trust, DoH or any other body? (e.g. is action necessary to ensure no further patients are affected within Trust and regionally/nationally; to mitigate impact on affected patients; to investigate the event; to manage impact on service and staff; to communicate with patients/public, staff, regulatory bodies, police, Coroner etc.)
- If yes, summary of what has been done?
- What is the scope of the event – restricted to the Trust or potentially wider?
- What is the likely scale/number of patients affected/possibly affected?
- Remind caller to submit Early Alert proforma to DoH and HSCB within 24 hours.
- Remind caller to consider if event is an SAI and to follow up appropriately.
- Ask caller to send you a copy of Trust press statement (holding or other) if available.
- Decide if immediate action required by DoH (including internal action/communications).
- Send details of the call by e-mail to earlyalert@health-ni.gov.uk

Exhibit 4

NOTE OF BI-MONTHLY MEETING BETWEEN DHSSPS & RQIA, 10 JANUARY 2012, CASTLE BUILDINGS

Present

Michael McBride, CMO, DHSSPS
Andrew Browne, SQU, DHSSPS
Billy Baird, SQU, DHSSPS

Eamon McCool – Student Placement, DHSSPS

Glenn Houston, Chief Executive, RQIA
Maurice Atkinson, Director of Corporate Services, RQIA
Phelim Quinn, Director of Operations & Chief Nurse Adviser, RQIA
David Stewart, Medical Director, RQIA
Theresa Nixon, Director of Social Work, RQIA

Apologies

Jim Livingstone, Director, Safety, Quality & Standards Directorate, DHSSPS

Introduction

Michael McBride welcomed RQIA representatives to the meeting, explaining that his involvement in bi-monthly meetings would be to chair two meetings per year, whilst Jim Livingstone would chair the remainder of the bi-monthly meetings. These arrangements would dovetail with other accountability arrangements, including Andrew McCormick's chairing of the Accountability Review Meetings.

RQIA representatives asked that condolences on their behalf be expressed to Jim Livingstone on the sad loss of his mother.

1. Previous Minutes & Matters Arising

Meeting agreed note of previous meeting.

On matters arising, Phelim Quinn outlined progress on regulation of private dental establishments. Currently some 102 practices were registered. RQIA expects that a total of 250 dental practices will be registered by the end of next month. Some 65 practices have not applied for registration, whilst some 35 applications are incomplete. RQIA, rather than issuing a further reminder, would endeavour to encourage registration by these practices by means of telephone calls and discussions with the BDA, at least until 31 March 2012.
Glenn Houston emphasised RQIA's concerns that any strategy for the handling of dentists' resistance to registration after 31 March 2012, if necessary, be clearly worked out in discussion with legal advisers.

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Michael McBride agreed to discuss the issue with Donncha O'Carolan with a view to seeking his views on potential options to persuade, as yet, unregistered practices to apply for registration. RQIA agreed to compile a list of recurrent issues arising through the registration process and to submit these to the Department for consideration in support of any process to assist reticent dentists.

[Action: DHSSPS]

2. 2011/12 Reviews Up-Date

David Stewart, with input from Theresa Nixon, provided an up-date on ongoing reviews as follows:

- **Mixed Gender Accommodation** field work completed and approaching finalisation of draft report;
- **Children under 18 on Adult Wards** –In process of writing up of draft. Potentially to be submitted to RQIA Board February or March;
- **Carers' Issues (to include Phase 2 NISAT)** – Expected to be completed by May 2012;
- **Radiology Review – Phase 2** – Now with Department;
- **Revalidation – Primary Care Services** – Now on RQIA website;
- **Out of Hours Social Work Services** – Deferred;
- **Application of NICE/NPSA Guidance** – Review starting in 2013/14;
- **.Learning Disability Community Services** – (Baseline: to be followed up in 2012-2015) – discussions had taken place with the HSC Trusts. RQIA had also written to Christine Jendoubi outlining a number of issues and concerns requiring clarity or agreement in order to take forward. Michael McBride said he was content for RQIA to discuss with Christine Jendoubi, but remained available to raise with Christine, should this be necessary;

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- **Risk Assessment – Mental Health & Addiction Services** – RQIA had already met the five HSC Trusts and planned validation visits in February;
- **Patient Journey via A&E** – RQIA has met with policy leads on a number of occasions and with Chief Nursing Officer to discuss. Review is also likely to address safety in wards. Review will run into next financial year, 2013/14. Secondary Care Unit in the Department is also involved;
- **Cardiovascular Framework** – Likely to be completed by the end of April and to be followed up through a meeting with Jim Livingstone and a potential stakeholder event;
- **Safeguarding Arrangements** – Review is ongoing and will encompass a series of 25 inspections. Potential completion end of May 2012.

The Department confirmed that the **Joint Protocol for Investigation of Alleged Cases & Suspected Cases of Abuse of Vulnerable Adults Review** was currently with Minister for approval.

3. Protocol for Handling Reviews by RQIA

Glenn Houston said that the RQIA Board had expressed a desire to find ways to reduce the time between completion of the field work by RQIA on reviews and publication and considered that it would be timely to review the Protocol timescales and indeed the wording of the Protocol as it related to commissioned work, Freedom of Information issues and press handling, as examples.

Michael McBride agreed that discussions between the Department (Andrew Browne) and RQIA (David Stewart) should take place with a view to exploring and making recommendations for a revised Protocol as appropriate. He also recommended inclusion of a review of the process whereby RQIA forwards draft review reports to the Department and the Department's acknowledgement of those draft reports, indicating that clear instructions for acknowledgement within 48 hours should be incorporated into the process.

[Action: DHSSPS/RQIA
See also action @ Item 8]

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4. Revenue Resource limit (RRL) 2012/13 – Dental Regulation

Glenn Houston referred to RQIA's business case, as submitted to the Department in the Autumn of 2011 and to Jim Livingstone's response in November, which confirmed that proposals had been submitted to finance colleagues. He said that the Board was anxious to know how the matter was to be resolved and were concerned to ensure consistency and robustness of approach to regulation of private dental establishment through a guarantee of recurrent funding into and beyond 2013/ 2014. Effectively RQIA were seeking an amendment to the RRL letter issued in April 2011confirming the RRL position for 2012/13 and beyond, indicating the additional amount sought for regulation of the private dental sector.

Andrew Browne confirmed his understanding that Jim Livingstone had discussed the issue with finance colleagues who have indicated that efforts will be made to meet the costs.

[Action: DHSSPS]

5. Review of Standards for Regulated Establishment and Agencies

Phelim Quinn expressed concerns that the pace of change of service models for the caring services was moving ahead of the intentions of the current regulations and standards, eg for nursing and domiciliary care, particularly intensive and palliative care. He cited, as an example, supported living services, which were presently considered under the umbrella of domiciliary care agencies yet did not quite fit into that category.

He referred to the fact that some of the published standards were dated whilst some remain in draft. He continued that it was RQIA's view that a point had been reached where a debate on the adequacy of, and the piece-meal approach to, the development of standards was essential.

Michael McBride accepted the point being made on the issue of regulations and standards, but had reservations about the Department's capacity, at this stage, to carry out a broad review of regulations and standards. He agreed however, that a discussion on the matter, particularly high priority areas needing urgent attention and in light of current financial and resource restraints, was important. He agreed to institute arrangements for a small working group to be set up to address the main issues around standards including examining standards already published and requiring to be updated, those in process of drafting and those still to be addressed.

RQIA agreed to prepare a briefing paper as background for preliminary discussions.

[Action: DHSSPS (Working Group) & RQIA Background Paper]

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6. Service Frameworks Accountability & Review

RQIA acknowledged receipt of Michael McBride's letter of 22 December 2011. Meeting agreed that relevant discussion had taken place in the context of the RQIA Review of the Cardiovascular Framework to be completed by RQIA towards the end of April 2012.

7. Draft Corporate Strategy

Maurice Atkinson agreed to forward a draft finalised (on foot of consultation) version of the 2012-2015 RQIA Corporate Strategy to the Department as soon as possible for submission to DFP for approval, as required by the Management Statement and Financial Memorandum.

[Action: RQIA]

8. Prison Health Care

David Stewart gave notice of a proposed joint review at Maghaberry prison in March 2012 to be carried out jointly with HMIP and CJI. RQIA would report specifically on prison health care within a chapter of the review report. RQIA had already met with Eugene Rooney in the Department to discuss protocols and relevant standards.

Glenn Houston emphasised the need to anticipate appropriate handling arrangements within the context of the Review Protocol to ensure that significant recommendations and findings for health care at the prison are handled and brought quickly to DHSSPS Minister's attention in order to dovetail in a timely manner, approval for publication of the whole report with CJI Minister's approval of the remainder of the report.

Michael McBride agreed that amendment to the reviews protocol should be considered to take these points on board, in order to alert Minister quickly and that Eugene Rooney in the Department should be made aware of these concerns.

[Action: DHSSPS]

9. Mental Health & Learning Disability [Escalations]

Theresa Nixon addressed briefly examples of escalation issues at Muckamore and Lakeview where, for instance, improved action in order to protect patients' dignity could, in RQIA's assessment, be carried out. Discussions had taken place with the HSC Trust.

Michael McBride expressed strongly his view that there was no justification for failure to take the necessary precautions to ensure patients' safety and dignity at all times. However he noted from RQIA that the Trust had provided assurances in letters of response to the escalation procedure that RQIA's concerns would be addressed

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urgently. Glenn Houston confirmed that if RQIA's concerns were not urgently addressed, they would be further escalated to the service commissioner and to the Department.

10. Independent Sector Inspections (Last 12 Months)

Michael McBride thanked Phelim Quinn for provision of RQIA's report, at his request, on Independent Hospitals and Clinics currently registered and issues arising. Phelim Quinn confirmed that there were no pressing issues in relation to registration of independent clinics and hospitals.

Michael McBride paid tribute to RQIA's comprehensive web-site, which he had recently been perusing. He emphasised the need to review how advice was delivered to the independent health care sector and to identify gaps. He alluded briefly to the type of advice currently contained on the links to NHS choices on the NI direct website in relation to PIP Breast Implants, which for instance, gave limited advice on issues related to plastic surgery. He invited Glenn Houston to provide its views and thoughts on this area, after some consideration.

[Action: RQIA]

11. Quality 2020

Glenn Houston confirmed receipt of the Quality 2020 strategy document and indicated that RQIA would give some thought to its role. Michael McBride was scheduled to present the document to the RQIA Board. Jim Livingstone will be returning to this issue.

12. A.OB.

A brief discussion took place in relation to Andrew McCormick's letter of 22 December 2012 on "Consent to Accessing Confidential Information". RQIA confirmed that it could continue to carry out the full range of functions, whilst the Department considered the legal position in consultation with legal advisers.

Glenn Houston referred to the appointment of 3 new board members indicating that induction arrangements would take place in the coming week.

Michael McBride said that he would copy RQIA into his letter of response to Professor Sir Bruce Keogh, Medical Director, NHS with regard to his recommendation for a re-examination of the private cosmetic treatment sector, particularly with regard to regulation.

[**Action: DHSSPS]**

DRAFT

Exhibit 5

NOTE OF BI-MONTHLY MEETING BETWEEN DHSSPS & RQIA
15 May 2013, 2.00pm, Boardroom, RQIA, 9th Floor, Riverside Tower

Present

RQIA

- Glenn Houston, Chief Executive
- Maurice Atkinson, Director of Corporate Services
- Kathy Fodey, Director of Regulation and Nursing
- David Stewart, Director of Reviews

Department

- Fergal Bradley, Safety Quality & Standards Directorate
- Conrad Kirkwood, Safety Quality & Standards Directorate
- Billy Baird, Safety Quality & Standards Directorate

Apologies

- Theresa Nixon, Director of Mental Health & Learning Disability & Social Work

In attendance

- Katie Symington, Board and Executive Support Manager

1. Previous Minutes – Matters Arising

1.1 Independent Health Care Fees

Billy Baird confirmed that the Department would seek legal advice on the issue of Independent Health Care Fees. He confirmed that he had received the paper regarding Independent Clinics from RQIA and was satisfied with content.

Glenn Houston confirmed that invoices will not be issued by RQIA to clinics providing laser services until further clarification on annual fees has been obtained from the Department.

Agreement that RQIA should continue to charge a registration fee to clinics providing laser services, however an annual fee will not be sought, pending further clarification. Billy Baird confirmed that agreement will be sought on the definition of on Independent Hospital.

<u>Resolved Actions</u>

DHSSPS to provide clarification to RQIA on Independent Health Care fees

Independent Hospital definitions to be agreed (DHSSPS)

1.2 Revised Enforcement Policy and Procedures

Glenn Houston confirmed that the revised Enforcement Policy and Procedures have been submitted to the Department. The Policy and Procedures are available on the RQIA website and regulated services have been informed.

Glenn Houston highlighted to the Department that within the 2003 Order there is provision for the RQIA to issue an Improvement Notice to an HSC Trust. The Department will be made aware should RQIA issue Improvement Notices in the future.

1.3 Cherry Tree Care Home

Glenn Houston noted that the draft Terms of Reference for the review of Cherry Tree Care Home are currently with DHSPSSNI. Glenn Houston noted that independent experts will be invited to participate in this review once the terms of reference have been agreed.

1.4 Hebron House/ Bawn Cottage

Glenn Houston noted that the SHSCT Vulnerable Adults Investigation is ongoing; the Trust will notify RQIA once this investigation has concluded. The PSNI investigation is also ongoing.

RQIA have now issued Transport Scheme Guidance for all registered providers, as this was identified as an issue within the Vulnerable Adults investigation.

1.5 Finance/ Service Development Bids

Conrad Kirkwood confirmed that the Department have received the finance bids from RQIA and they have been passed to the relevant Finance personnel. Conrad Kirkwood confirmed that once the Department has made a decision RQIA will be informed.

<u>Resolved Actions</u>

DHSSPS to inform RQIA of outcome of finance/ service development bids

1.6 Board Governance Self-Assessment Tool

Glenn Houston confirmed that this document has been sent to the Department. The change in Board members from 14 April 2013 was noted. Glenn Houston noted that no formal Board development plan was in place for Board members. However, Board members are subject to an appraisal and attend relevant training on the roles and responsibility of non-Executive Directors.

1.7 Approval of Annual Business Plan 2013/14

Confirmation was provided that Paddy Woods has approved RQIA's Business plan, 29 March 2013. A letter of allocation was received on 15 May 2013 from Peter Toogood. The Department to ensure that the finance team have the correct email addresses for RQIA personnel.

Resolved Actions

DHSSPNI to ensure that finance team have correct email addresses for RQIA staff members

1.8 RQIA Board Recruitment

Glenn Houston noted that Dr Ian Carson has contacted the Public Appointments Unit to request an extension in Board member tenure for 4 Board members, whose tenure ends in August 2013. The Public Appointments Unit will liaise with Dr Carson regarding the next recruitment round.

1.9 Business Services Transformation Project/ Finance Procurement Logistics

Glenn Houston informed the DHSPSSNI that RQIA is currently preparing final accounts, however information is difficult to obtain from the FPL system and a question also remains around the quality of information provided.
At the last Audit Committee Meeting the Internal Audit Report on finance systems highlighted six priority one recommendations, all of which relate to the FPL system. These issues largely refer to the functionality of the system and cannot be resolved, except by an effective intervention by BSO with the software provider.

The issue of FPL was brought to the RQIA Board meeting on 9 May 2013. Board members were concerned by the issues raised and the lack of assurance provided by BSO and requested that Glenn Houston write to the Chief Accounting Officer. Fergal Bradley confirmed that this issue should be raised through the normal channels and must be addressed. Fergal Bradley stated that he would discuss this matter with Julie Thompson, SRO.
Glenn Houston noted that Paddy Woods is attending the next Audit Committee meeting on 27 June 2013; Fergal Bradley to confirm.

Resolved Actions

Fergal Bradley to raise issues surrounding FPL with Julie Thompson
Fergal Bradley to confirm Paddy Woods' attendance at Audit Committee, June 2013

2 Review programme update

A paper was tabled detailing the RQIA Review Programme Status, 25 March 2013 – 15 May 2013.
Three reports are currently with the Department; Review of Management of Controlled Drugs in Hospitals, Hospitals at Nights and Weekends, Baseline Assessment and Review of Community Services for Adults with a Learning Disability, Baseline Assessment and Review of Community Services for Children with a Disability.

Dr Stewart confirmed that three reviews are well advanced:

- NICE: Implementation Process (with an anticipated date for submission to the Department of the middle of June 2013).
- Specialist Sexual Health Services Review and Theatre Practice (will be drafted this week).
- Fostering Services Review, (brought forward and will focus solely on fostering services and not adoption services).

Dr Stewart noted that the fieldwork for the Review of The Oversight of Patient Finances in Residential Settings should be completed by the end of June 2013.

The Review of the Care of Older People on Acute Hospital Wards will be undertaken via a series of inspections by the Infection Prevention Hygiene Team (supplemented by RQIA Nursing Inspectors, as well as lay reviewer input). These inspections will commence in September 2013 and run for a six month period.

Dr Stewart noted page four of the report which shows the review planning activity. Dr Stewart also highlighted that the Review team are awaiting confirmation of a contact for one of the upcoming reviews.

Fergal Bradley will seek clarification on the Disadvantaged groups as detailed in the Access to Services by Disadvantaged Groups Review.

Dr Stewart noted that he is meeting with John Maguire in relation to the Respiratory Service Framework Report in order to move forward with this review.

<u>Resolved Actions</u>

Fergal Bradley will seek clarification on the Disadvantaged groups as detailed in the Access to Services by Disadvantaged Groups Review.

3 Current Enforcement & Escalations

Kathy Fodey provided an update on Maine Nursing Home in the Northern Trust which has one unexplained death. A police investigation and a Vulnerable Adults Investigation is pending. A Notice of Proposal has been issued to this Nursing home, with no new admissions until further notice.
Kathy Fodey noted that a letter of escalation has been sent to the Belfast Trust in relation to Iveagh Care Home and Somerton Road Children's Home. The Belfast Trust will follow up on these escalations.

4 Mental Health/ Learning Disability Update

Slievemore Nursing Unit

Kathy Fodey provided an update with regard to Slievemore Nursing Unit, which was the subject of an unannounced inspection on 3 January 2013, which indicated that the facility was operating to all intents and purposes as a Nursing Home. The Western Trust does not intend to register the unit as a Nursing Home and noted that it will close on 31 May 2013.
Glenn Houston informed the Department that the Older Persons Commissioner has contacted RQIA to ask for flexibility in relation to the closing date of 31 May 2013. Glenn Houston confirmed that RQIA had responded confirming support for the Commissioner's proposal to engage with the families.
Glenn Houston has written a letter to Elaine Way, copied to the Older Persons Commissioner, confirming RQIA's response.

Ennis Ward, Muckamore Abbey

Glenn Houston noted that following concerns raised in relation to Ennis Ward, the Belfast Trust initiated a Vulnerable Adults Investigation. Three staff were suspended; one member of staff has since been re-introduced. The PSNI has concluded its investigation and has forwarded a report to the Public Prosecution Service. Glenn Houston will keep the Department informed of any further developments.

5 Minimum Standards – Working Groups Progress

Confirmation was provided that three sets of Minimum Standards are currently being reviewed; Nursing Home Standards, Childrens' Homes Standards and the Independent Health Care Standards.
The Independent Health Care Standards will be sent to the Minister for approval in June 2013.
Kathy Fodey requested that the standards are shared with RQIA before they are finalised.
Glenn Houston requested that the Department provide Regulations and Standards for Foster Care Services, as currently fostering services are not regulated or inspected.

6 Independent Review of RQIA 2013

Confirmation was provided by Fergal Bradley that further agreement is required on the format and funding of the Review of Arm's Length Bodies. The Department will provide further information to RQIA with regard to the Review, once available.

Resolved Actions

DHSSPS to provide further information to RQIA with regard to the Independent Review, once available.

7 Quality 2020

Fergal Bradley confirmed that the stakeholder element of Q2020 was currently underway.

8 Marie Stopes International Clinic Belfast (MSI)

Glenn Houston advised that RQIA had received an application for registration from Marie Stopes International and that a pre-registration inspection would take place in due course. Glenn confirmed that RQIA had sought and received Senior Counsel opinion of the interpretation of the relevant legislation as it applied to MSI. Glenn advised that he intended to write to Dr McCormick to make him aware of the legal advices received and the requirement that RQIA should consider the application on its merits.

The Department confirmed that they are also seeking legal opinion on Marie Stopes International. Glenn Houston raised the issue of the absence of minimum standards on which to regulate this service.
Fergal Bradley confirmed that work is proceeding to complete the Independent Health Care Standards which would be subject to public consultation.

9 AOB

Dr Stewart provided an update with regard to Part II and Part IV Doctors. The process for the approval of Part II and Part IV Doctors by RQIA was inherited from the Mental Health Commission, with the Trust applying to the Mental Health Commission on behalf of the Doctor. No process is currently in place for Independent Doctors or retired Doctors. RQIA is currently taking steps to introduce a Policy and Procedure for the approval of Part II and Part IV Doctors.

Theresa Nixon and Dr Stewart met with Judges Weir, McFarland and Philpott on Monday 13 May 2013 to discuss Part II Doctors. RQIA are currently putting into place a procedure to grant Part II status to a Doctor who provides work for Mental Health Tribunals.

Date of Next Meeting – Tuesday 2 July 2013, 14:00, Castle Buildings

Summary of action points			
No.	Owner	Detail	Complete
1	SQSD	Reply required to Glenn Houston's letter re regulation of fee	Reply issued 16 April 2013
2	SQSD/RQIA	To set up Q2020 Stakeholder Event after summer	
3	RQIA	Meeting to be set up to discuss regulation of fees	Meeting has been arranged for Monday 24 June 2013
4	RQIA	Two final drafts for bids for additional resources to be supplied to the Department	Business cases issued to the DHSSPS on 12 April 2013
5	RQIA	Subject to approval by the RQIA Board, RQIA to share legal advice in respect of regulation of MSI with Perm Sec	Legal advice shared with DHSSPS on 29 April 2013
6	RQIA	To share Board Governance Self Assessment Tool with SQSD for feedback	Shared on 26 Mar and feedback provided on 27 Mar
7	SQSD	To ask policy lead to share issue in respect of Cherry Tree with RQIA	Letter issued by Dept on 26 Mar
8	RQIA	To write to Perm Sec concerning its revised enforcement procedure	Letter sent to DHSSPS on 10 April 2013
9	RQIA	To address minor points and share final version with SQSD	Shared on 27 Mar and approved on 29 Mar
10	SQSD	To advise as to the likely date for appointment of new RQIA Board Members	Advice issued by SQSD to RQIA on 28 Mar
11	SQSD	To advise policy leads re current position re Hebron/Bawn House	Policy leads advised on 27 Mar
12	SQSD	To include regulation of fostering arrangements discussion in a subsequent meeting	Drafting of regulations on Fostering Services being progressed by Child Care Unit. Commencement Order and miscellaneous amendments to related legislation

			being progressed by Safety & Quality Unit . RQIa will be kept up to date on progress.
13	SQSD	DHSSPS to provide clarification to RQIA on Independent Health Care fees	Meeting held between DHSSPS and RQIA on 24 June 2013 to clarify
14	SQSD	Independent Hospital definitions to be agreed	Draft amendment to definition to "approved place" within Fees & Frequency Regulations being considered by RQIA on foot of meeting of 24 June 2013 before further discussions with DSO
15	SQSD	DHSSPS to inform RQIA of outcome of finance/ service development bids	
16	SQSD	DHSSPNI to ensure that finance team have correct email addresses for RQIA staff members	
17	SQSD	Fergal Bradley to raise issues surrounding FPL with Julie Thompson	
18	SQSD	Paddy Woods' attendance at Audit Committee, June 2013 to be confirmed	Conrad Kirkwood attending
19	SQSD	Fergal Bradley will seek clarification on the Disadvantaged groups as detailed in the Access to Services by Disadvantaged Groups Review.	
20	SQSD	DHSSPS to provide further information to RQIA with regard to the Independent Review	

Exhibit 6

NOTE OF MID YEAR ASSURANCE AND ACCOUNTABILITY MEETING BETWEEN DHSSPS AND RQIA ON 26 NOVEMBER 2012 – PART A

ATTENDING:

RQIA
Ian Carson - Chair
Glenn Houston - Chief Executive

Department
Andrew McCormick – Permanent Secretary
Paddy Woods - DCMO
Billy Baird - SQSD

Apologies:
Michael Mc Bride, CMO

1 Introduction

1.1 Andrew McCormick welcomed RQIA representatives to the meeting. In inviting Ian Carson 's comments on the effectiveness of the RQIA Board he acknowledged the strength of RQIA's current operations.

1.2 Ian Carson confirmed that he was confident of and satisfied with the performance of the RQIA board, in terms of the skills mix of its individual members and the board's capacity, as a whole to perform its functions. The recruitment process was underway for 5 replacement board members to replace those who had come to the end of their tenure.

1.3 RQIA was presently undergoing an EFQM assessment and he presented a copy of the relevant submission. The RQIA Board have enthusiastically welcomed the exercise as an opportunity for the Board's performance to be independently assessed.

1.4 In response to Ian Carson's request for clarity on the position as regards the ALB self assessment exercise Andrew McCormick confirmed that this was in process of being rolled out.

1.5 Ian Carson welcomed the proposed Capacity and Capability Review of RQIA planned for the 2013 year, seeing it as another opportunity to rate the effectiveness of RQIA.

Strategic Issues & Direction

2.1 Ian Carson considered that RQIA's role might expand to preliminary work in supporting the Department in advance of, for example, Departmental decisions to take special measures, and in this respect he was conscious of the comparison of RQIA against the wider functional role of the CQC. He particularly mentioned two

developments in England, the United Bristol NHS Trust had been issued with a warning demanding improvement within a week and a recent unannounced inspection of Basildon and Thurrock University Hospital NHS foundation Trust Paediatric Care prompted by a number of serious incidents and as a result of which immediate improvement was demanded

.

2.2 Andrew McCormick acknowledged the point of an RQIA presence as worthy of exploring particularly in acute settings where the balance of risks against activity and resources is an ever present issue.

2.3 Glenn Houston, in referring to the limited powers of the Health and Personal Social Services (Quality improvement and Regulation) (Northern Ireland) Order 2003 considered a review of the extent of the powers of the Order merited. He saw an inconsistency of approach in terms of sanctions and escalation policy between the regulated sector and the HSC, particularly in areas such as mental health and learning disability hospitals. He suggested, for example, that enhancement of the legislation to provide the RQIA with authority to issue improvement notices to HSC Trusts should merit consideration. He said that risk based inspection activity was drawing inspectors away from normal planned regulatory activities. As a consequence RQIA would be recruiting lay inspectors to cover.

2.4 Glenn Houston gave notice that the RQIA proposed to bring a number of business cases to the Department, reflecting increased capacity requirements not least to take account of the above mentioned pressures but also to reflect the fact that in 2009, RQIA took on the Mental Health Commission role and more recently the regulation of private dentistry. He stressed that whilst the majority of inspectors examined the independent sector, there was increasing pressure to look at a range of statutorily provided services.

2.5 Ian Carson supported these concerns particularly with regard to some HSC acute sector services. RQIA's current interventions in the HSC were either planned or commissioned and in this respect he considered a change of powers reflective of powers now held by CQC in England were worthy of consideration by the Department.

2.6 Glenn Houston confirmed the appointment of Kathy Fodey as Director of Nursing and Regulation with effect from 1st February 2013 and welcomed her appointment. He considered that for the future a further discussion was necessary with the Department around essential criteria within job specifications, in the event of another senior appointment vacancy arising within RQIA.

3. Specific Issues or Concerns

3.1 Glenn Houston reported that Pat Troop had been approached by the PSNI on foot of the Pseudomonas Review Report. He understood that

an approach to the PSNI had been made by the family of the third child to die in the neo natal unit of the RVH. There was no indication of the PSNI intentions beyond.

3.2 Glenn Houston also reported that Tracey McNeill, Marie Stopes International (MSI) has indicated to RQIA that a wholly private medical practitioner will be appointed in due course thus rendering RQIA subject to regulation in accordance with the current legislation. Furthermore he reported that within the corresponding legislation applying in Wales , the term “in that establishment” existed to mean that MSI would be subject to regulation in Wales whether a medical practitioner delivered services elsewhere within the health service or not.

3.3 Glenn Houston also confirmed that arising from a recent FOI request to the Department regarding correspondence with MSI that RQIA had no objection to the release of 2 letters between RQIA and MSI which had been shared with the Department.

3.4 Glenn Houston drew attention to RQIA’s issue of a Notice of Proposal to the proprietors of Hebron House/ Bawn Cottage, Mr & Mrs Wylie, which was due to expire on 7 December 2012 . To date no formal representations had been received. Thereafter, assuming no representations, it was a possibility that RQIA would move to issue a Notice of Decision with the effect that any consequent challenge would be a matter to be taken to the Care Tribunal. He also said on a wider note that a BSO counter fraud investigation was in process.

3.5 Glenn Houston flagged up the potential for a larger resource of inspectors (currently 2) within RQIA, examining financial aspects of regulated facilities.

NOTE OF MID YEAR ASSURANCE AND ACCOUNTABILITY MEETING BETWEEN DHSSPS AND RQIA ON 26 NOVEMBER 2012 – PART B

ATTENDING:

RQIA
Ian Carson - Chair
Glenn Houston - Chief Executive
Maurice Atkinson - Director of Corporate Services
Theresa Nixon - Director of Mental Health and Learning

Department
Andrew McCormick – Permanent Secretary
Paddy Woods - DCMO
Christine Jendoubi - Director of Mental Health, Disability and Older People Policy
Peter Toogood - Director of Finance
Billy Baird - Safety & Quality Unit

Apologies:
RQIA
David Stewart - Director of Reviews
Muriel Dickson - Acting Director Nursing & Regulation
Department
Michael Mc Bride - CMO
Fergal Bradley - Head of Central Arms Length Body Governance Unit
Conrad Kirkwood - Deputy Director, Safety Quality & Standards Directorate

1. Minutes & Action points Previous Meeting

1.1 The Minutes of the previous meeting were agreed.

1.2 On outstanding action points Ian Carson confirmed that RQIA had received the Terms of Reference for the proposed Capacity & Capability Review and that once considered by the RQIA Board at its next meeting on 13 December RQIA would forward comments to the Department. Recruitment of new Board members was in process with outgoing Board members terms extended to April 2013 meantime.

2. Governance Corporate

2.1 Paddy Woods in noting that there had been no significant internal control issues and no priority one findings reported within the mid year assurance statement, sought assurances on progress with Priority 2 and 3 recommendations. He also alluded to RQIA's substantial compliance with 18 of the Controls Assurance Standards and 8 criteria where moderate compliance had been achieved and sought assurances on action in these areas.

2.2 Maurice Atkinson confirmed that RQIA was on track to complete necessary action on audit recommendations and had action plans in place to address in the course of the year, areas where substantial compliance with controls assurance standards had not been achieved.

2.3 Glenn Houston added that the NIHR Report "In Defence of Dignity" which had made recommendations for RQIA and which were being progressed, had urged relevant training for staff with a requirement for minimum standards to be examined. The Department had already commenced a review of standards with input from RQIA. He expressed RQIA's desire to remain involved, as necessary, with this exercise.

3. Personal Public Involvement

In response to Paddy Woods request for an update on PPI activity, Glenn Houston presented a report on RQIA's PPI activities and invited any comments, in due course from the Department.
Ian Carson and Glenn Houston reported attendance at a PCC workshop the previous week and confirmed that a PPI forum was in place within RQIA.

4. Resources (2012/2013)

4.1 Peter Toogood, in referring to the previous year's surrender and the award of additional recurrent grant to RQIA of £250K from the 2012/2013 year, sought assurances regarding in year spend, particularly confirmation that all vacancies had been filled. Glenn Houston confirmed that all vacancies had been filled. RQIA was maintaining a close scrutiny of spend. Relevant to this is RQIA's consideration of the appointment of lay inspectors which has the potential to use up any surplus resources. RQIA will however declare any identified surplus in a timely fashion.

4.2 Peter Toogood reminded RQIA representatives about recent guidance on preparation of business cases and compliance with guidance before submission to the Department. He also drew attention to revised external consultancy guidance and on gateway reviews. In welcoming the unqualified 11/12 audit opinion with no Priority 1 findings, he briefly detailed the Priority 2 and 3 recommendations and sought assurances that resolutions were fully addressed. Maurice Atkinson confirmed that action on all audit recommendations was carried out under the oversight of the Audit Committee.

5. Service Delivery Performance

Glenn Houston presented a copy of RQIA's quarterly Corporate Performance Report for period ending 30 September 2012,as recently presented to the RQIA Board and which detailed progress on targets within the 2012/13 Business Plans.

6. Other Significant Operational Issues & Risks

6.1 Andrew McCormick asked if RQIA had any other significant issues or risks to highlight.
Glenn Houston said that all **reviews scheduled for the 11/12 year** had not been completed on planned schedule, but all would be finalised and published by December 2012, subject to Departmental clearance of the **Under 18s in Hospital Adult Wards Review Report.** The delay in the 11/12 review programme could have an impact on the existing work programme as indeed does the cumulative effect of follow up inspections related to identified risks arising from routine inspections. Such impacts upon the work programme would of course be identified within RQIA's risk register.

6.2 Christine Jendoubi confirmed that she was content with liaison arrangements between RQIA and the Department on mental health and learning disability issues.

6.3 Paddy woods commended RQIA for its achievements as independent regulator but expressed concern if regulatory responsibilities were held back by other demands. He confirmed that the Department had identified no significant risks for RQIA at present.

6.3 Glenn Houston referred to correspondence between RQIA and the Department, in which RQIA had expressed concern about **the scope of the 2003 Order** to enable RQIA to require providers to facilitate to access to confidential personal information of residents of nursing and residential care homes without breaching the Data Protection Act. He indicated that meetings had taken place with both the Information Commissioner and Chris Matthews in the Department and the view was that the provision within Article 43(2) (a) of the Order, enabling access without permission where it was not practicable otherwise, mitigated against the risks for RQIA, pending amendment of the Order. This issue would of course remain on the RQIA risk register meantime

6.4 Glenn Houston expressed concern about the detail of the Department's proposed **Priorities Check List** for business plans, expressing a preference to retain the style of business plan as RQIA currently described for 12/13. However he acknowledged that if the Department insisted on a catch all approach, RQIA would accord.

7. AOB

7.1 Theresa Nixon expressed concerns about current staffing levels and the skills mix at **Muckamore and Longstone** mental health and learning disability facilities operated by the HSC Trusts. RQIA is working pro-actively with the Trusts on this and are trying to triangulate

all issues and concerns but have meantime, received a note of concern from parents and relatives.

7.2 In due course RQIA will forward a safeguarding report addressing issues around all 33 HSC Trusts mental health and learning faciities. Glenn Houston will be meeting Fionnula McAndrew to discuss the regulatory position applying to such facilities, including Ralph's Close.

7.3 Ongoing issues of concern included:
Maine Nursing Home involving death of a resident and suspension of a staff member with ongoing PSNI investigation;

Nazareth Lodge ongoing PSNI investigation into death of resident;

Community Treatment House where Housing Association ran an unregistered nursing home. Closed after 28 days notice from RQIA to accord with regulations.

Home Acute Care Treatment House operating as a flagship HSC Trust development as a home for persons in need but no clarity as to whether residents or tenants.

Ferrone Drive operated as a house of multiple occupation and operated by the Western HSC Trust – issues about registration and minimum standards and questions about the context in which such facilites register the domiciliary care element.

7.4 Andrew McCormick agreed that whatever the model of care, it was essential that such establishments and agencies be examined within the context of the regulations. Christine Jendoubi agreed that the onset of intermediate treatment centres required discussion. She considered that these fell to be registered as residential care homes**.[ACTION DHSSPS]**

7.5 Glenn Houston reiterated concerns about so called housing schemes where people in need of care were being set up as tenants and expressed a willingness to become involved in a short life working group to discuss. Christine Jendoubi agreed that the matter was one for the Department's Mental Health and Learning Disability Directorate to lead. **[ACTION DHSSPS]**

8. **Conclusion**
Andrew McCormick in concluding the meeting thanked RQIA representatives for a very constructive meeting addressing a broad range of important issues and concerns

Exhibit 7

From: Neil Magowan

Date: 16 July 2013

To: Maura Briscoe

RQIA ACCOUNTABILITY MEETING - TUESDAY 23 JULY 2013

You asked for some background briefing on LD issues of concern in last 6 months for the above RQIA Accountability meeting. A pre-brief is being held on 18 July 2013 3.00 pm Room C5.11.

Hebron House/Bawn Cottage (Armagh)

- Concerns regarding the providers - evidence of serious financial abuse of residents.
- In November 2012 RQIA issued a Notice of Proposal to withdraw registration for Hebron House and Bawn Cottage.
- In March 2013, a Review Panel decided, on legal advice, that RQIA should not proceed to issue the notices of intention to withdraw registration after consideration of a formal representation by Solicitor for the registered providers of Bawn Cottage and Hebron House.
- There are three agencies are involved in the *ongoing* investigations (RQIA, SHSCT and PSNI), in addition the BSO instituted a counter-fraud investigation and informed the PSNI.
- RQIA will consider afresh any further evidence coming to light as a result of the continuing investigations by the Trust and the PSNI.
- The Department is continuing to monitor the position, encouraging all parties to cooperate in providing all the necessary information to enable the investigations to be completed, and their recommendations to be implemented, without undue delay.
- Minister has recently expressed concerns about “putting all the responsibility onto the home” and passing onus for payment entirely to the claimant. Official’s advice would be that due process should be followed and a review

examining the actions of all the relevant parties, including the Southern Trust and the RQIA, should occur to see what lessons can be learned, when the investigations (and any actions arising) have been completed.

Maine Nursing Home (Randalstown)

- It has been the subject of an ongoing investigation from 2012 by PSNI regarding a death in 2011. Two members of staff (a nurse and healthcare assistant) were suspended; whilst the healthcare assistant was reinstated in early 2013, there were subsequent allegations made against her by other members of staff. She was subsequently suspended again.

- A further sudden death occurred on 8 April 2013 - the PSNI is investigating and the home is subject to a formal HSE investigation, linked to the latest death and possible negligence by management/staff.

- RQIA indicated the intention to deregister home and, following a meeting on 15 July with the owners, Mrs McGoldrick has indicated that she will no longer be the registrant. The de-registration relates to non compliance of standards over a period of time, largely relating to staff training and role/function of manager. With reducing moral and staff are leaving/sick, etc, continuity of immediate care is very difficult.

- Due to the highly complex needs of residents it will be very difficult to re-locate them into another community setting, assuming that one was available. This is likely to cause a lot of distress to families, etc and may generate media interest with a backdrop of an ongoing murder inquiry and now another recent death.

Bohill Nursing Home (Coleraine)

- There were a number of “incidents” notified in March 2013 which gave rise to significant concerns.
- Several whistleblowing issues relating to quality of care – RQIA involved.

- 2 SAIs – ie deaths of nursing home patients who were admitted to hospital – e.g. dehydration- where patients died and there was concern about the care within the Home. Both being investigated under SAI procedures.
- High turnover of staff in facility.
- Culture and management style of concern – care manager suspended.
- Also a legal case is pending in April 2013 regarding assault in the facility – PSNI are involved in investigation.

Meadowbank (Londonderry)

- In February 2013 the Department was notified about an anonymous allegation of physical and emotional abuse of residents at Meadowbank Nursing Home for adults with a learning disability in the Western Trust area.
- Safeguarding action was initiated and the PSNI informed.
- A staff member from the home was suspended.
- Four Seasons then invoked a 2nd precautionary suspension.

Three Islands Nusing Home (Toomebridge)

- In January 2013 the Department was notified by telephone about a case of potential misappropriation of residents' funds at Three Islands Nursing Home, a home for 35 learning disability residents.
- Safeguarding action was initiated and the PSNI was informed.
- The care of the patients was not an issue and RQIA did not issue a closure notice.
- Advised that over a long period of time, it would appear, funds belonging to residents were used to paint buildings, provide new flooring and community transport, etc.
- There was no attempt to cover this situation up and the Home may have considered that it was appropriate to spend funding in this way to enhance wellbeing of the residents. It is anticipated that the amount potentially misused could be in the region of £500,000.

Craigowen Housing Association
(Glencraig, Mourne Grange and Clanabogan)

- Heather Cousins, Deputy Secretary of DSD wrote to Sean Holland on 8 May 2013 following an inspection of Craigowen Housing Association. She drew attention to the preliminary findings of that inspection which highlights serious concerns relating to the condition of some housing stock owned by Craigowen.
- Assurances were provided on the care and welfare of residents and tenants.
- RQIA carried out an estates inspection in May 2013 and a draft inspection report is currently being prepared which will include an itemised note about each of the issues highlighted by DSD.
- DSD colleagues are keen to meet RQIA when it publishes its Inspection Report of Glencraig.
- Sean Holland replied to Heather Cousins on 10 July 2013.

Muckamore – Ennis Ward

- In November 2012 the Department and HSC Board were notified by way of an Early Alert notice, about a case of alleged physical and verbal abuse involving four patients at Ennis Ward in Muckamore Abbey Hospital.
- This was subsequently converted to a Serious Adverse Incident – which remains open, pending the Trust Final Report on the incident (normally on completion of the Police Investigations).
- Safeguarding action was taken in respect of the patients and three members of staff were placed on precautionary suspension pending the outcome of the investigations. It is understood that one of the staff, a junior nurse, was subsequently reinstated.
- All relevant organisations (PSNI, Trusts, RQIA and the Department) were notified.
- The PSNI have been leading on the investigation of suspected criminal activity. I understand that the Police believe there is sufficient evidence to consider taking forward charges of common assault and ill treatment in relation to 2 members of Belfast Trust staff and they submitted a file for

consideration by the PPS in March 2013. Any decision to prosecute rests of course, with the PPS.

- In the meantime, the 2 members of staff concerned remain on precautionary suspension, pending the outcome of both the police investigation and that of the Trust into the professional conduct of both staff members. One member of staff is a Registered Nurse and the NMC has been kept informed of the progress of this investigation. The other staff member is employed as a Health Care Assistant and is thus not subject to any regulatory processes.
- RQIA will continue to inspect Ennis Ward unannounced.

RQIA BASELINE ASSESSMENT AND REVIEW OF COMMUNITY SERVICES - FOR ADULTS WITH A LEARNING DISABILITY
RQIA BASELINE ASSESSMENT AND REVIEW OF COMMUNITY SERVICES - FOR CHILDREN WITH A DISABILITY

- RQIA submitted to the Department two draft reports on its baseline assessment and review of the composition and function of the five Health and Social Care (HSC) Trusts disability services for adults with learning disabilities and children with disabilities.
- The review for each area would be undertaken in two stages. *Phase 1* would provide a baseline assessment of teams for adults with a learning disability and children with a disability and of service provision as at 1 April 2011. *Phase 2* (2014-2015) will involve an assessment of the quality and effectiveness of HSC Trusts Learning Disability Services for adults and disability services for children against the Department's Learning Disability Service Framework.
- The Department provided comments on both reports. It is anticipated that the *Phase 1* reviews will be published by end of July 2013.

BUSINESS AREA	POSITION
1. MENTAL HEALTH AND LEARNING DISABILITY	
1.1 MHLD INFORMATION SYSTEM OUTLINE BUSINESS CASE	The MHLD Information System Outline Business Case was approved by DoH November 2017. RQIA has made a bid to the HSCB e-Health Programme Board for capital monies in 2017-18 and 2018-19 to fund this initiative. A formal PRINCE2 project will be initiated as £20k has been allocated this year for the new information system to be implemented in 2018-19. Interviews will be held for a project manager week commencing 12 January 2018.
1.2 PRISON HEALTHCARE	An announced joint CJI, ETI and RQIA inspection of Woodlands Youth Agency took place November 2017. Draft findings have been issued to CJI on 5 January 2018. It is anticipated that the report will be completed and issued before the end of March. The Magilligan inspection report was published in December 2017. The report highlighted the positive work around prisoner rehabilitation and progress made at the facility since it was last inspected. The Inspection team also welcomed the innovative work undertaken to improve provision for disabled and older prisoners and improvements in relation to health care of prisoners. The inspection team welcomed improvements for those prisoners who were known to the mental health services. A joint recommendation had been made regarding the introduction of a more robust procedure for monitoring prisoner management of in-possession medication. RQIA welcome the joint work between NIPS and SEHSCT regarding the development of the prison wide drugs and alcohol strategy. A further inspection of Maghaberry will be undertaken later in 2018 and an inspection will also be undertaken of The Safety of Prisoners held by the Northern Ireland Prisons to follow up on the recommendations made in the October n Service involving visits to Maghaberry, Magilligan, Hydebank Wood (YOC) and Ash House Women's Prison in 2014 report. A meeting will be held between RQIA and DoH to discuss the future publication of joint prison reports.

MAHI - STM - 300 - 312

1.3 MHLD INSPECTIONS	The MHLD Directorate have completed four inspections of MHLD wards (Two in SHSCT, one in WHSCT and one in NHSCT) since the last bi monthly meeting. **Improvements noted since previous inspections:** **SHSCT** • The ward had been assigned a link person within the estates department who addressed all urgent environmental issues in a timely manner. Ward staff had devised an environmental audit tool to track all environmental issues on the ward. • The quality of the care documentation recorded on the patient electronic information system (PARIS) had improved. **Key areas identified for improvement are as follows:** **SHSCT** • There was lack of governance oversight on the use of restrictive practices. The frequency of restrictive practices such as physical interventions, seclusion and rapid tranquilisation was been recorded onto the Datix System to inform care and practice. Physical interventions were not included on the nursing dashboard. A number of incidents which had taken place on the ward during the previous year had been fully investigated but not been closed on the DATIX system. This recommendation had been made for the second time. • The ward's televisions had not been encased in cabinets as directed in the ward's previous ligature risk assessment. £15K has now been identified to complete this work as this recommendation has also been repeated for a second time. **Improvements noted since previous inspections:** **WHSCT** • Significant work had been undertaken to address ligature points within the ward. This included the fitting of new doors and window handles, grab rails and window blinds. This led to a letter of serious concerns being sent to the Director of Nursing requesting an action plan which has now been received by RQIA. This demonstrates that satisfactory action is being taken by the Trust to address the issues raised. **Key areas identified for improvement are as follows:** **WHSCT** • Patients transferred from another ward did not have the required dementia care pathway assessment completed. • Whilst improvements were noted regarding the wards ligature risk assessment all patients must have an

	individual risk assessment in relation to environmental ligatures. **NHSCT** **Improvements noted since previous inspections:** • There were 13 previous areas for improvement identified of which 11 were met and 2 were partially met. The ward continues to support patients in recovery and their reintegration back into the community. **Key areas identified for improvement are as follows:** • An inspection was undertaken of Carrick 4 Holywell Hospital on 13 December 2017. RQIA is concerned about the continuing pressure on staff of managing risk because of the design and layout as two wards have been combined into one resulting in an increased number of ligature points and blind spots in this ward. The ward's ligature audit indicates that Carrick 4 has over 300 ligature points but there was no associated plan of work available. The ward team continue to undertake individual and ward risk assessments to manage the risk. The Trust have been asked to provide RQIA with an action plan to address the ligature points identified in the audit. RQIA noted that this risk is included in the Trust risk register. It would be helpful in view of the number of restated areas for improvement made by RQIA regarding improvements required to this environment if RQIA could be advised of the current position regarding the NHSCT Adult Services Directorate's Capital Priorities Review (CPR) 2016/17. **Inspection Report – Delayed Discharge – Learning Disability Hospitals** The findings from the inspection report are in draft and are being reviewed internally by RQIA staff. A follow up meeting with be held with the HSCB and the DoH policy lead in due course to discuss the findings.
1.4 MHLD **ESCALATION**	One letter of serious concern was issued to the WHSCT in relation to a lack of progress in implementing two areas for improvement namely Risk Assessments and updating of Policies and Procedures. • There was no record of who contributed to the promoting quality care dementia risk assessment and no management plan in place to deal with the assessed risk. Under Policy and Procedures • The current trust policy on recording fluid balance charts will be extended until the regional policy is received and approved?

	A follow-up discussion will be held with the Director of Nursing regarding these matters and to agree a timeline for the completion of these policies in early January.
1.5 EARLY ALERTS	RQIA inspected Cranfield Ward Two (Muckamore Abbey Hospital) on the 20 December 2017 to review staffing levels as a result of whistleblowing allegations. Three care assistants have commenced in post and three other staff were deployed following the closure of Erne ward and two other staff have returned from sick leave. Staffing levels from the 6th December to 16th December 2017 indicated that 29% of shifts have not achieved the required staffing levels. Staffing levels are now monitored daily by the Ward Manager, is on the Trust risk register and continuing attempts are being made to address staff shortages through the use of Agency staff.

2. REGULATION DIRECTORATE	MAHI - STM - 300 - 315
2.1 REGISTRATION	

Residential care beds in nursing homes

Position as at 21 December 2017	
Services still undecided (3 providers)	**7**
Application forms issued and still to be returned	**14**
Application forms received and being processed	**29**
Certificates issued	**62**
Applications withdrawn (homes closed)	**2**

- To date 81% of services have completed the application process
- All service provides who are 'undecided' have been contacted, advice and guidance has been provided.

Letter issued in relation to Grenfell Tower: Fire Safety in premises

Following the tragedy of the fire at Grenfell Tower in July 2017, the Cabinet Office in London communicated with Northern Ireland Adverse Incident Centre to coordinate a Northern Ireland response to communicating a fire safety message. NIAIC contacted RQIA Estates team to request that RQIA would communicate a similar message to Private healthcare providers in Northern Ireland. The request was to draw attention to buildings over a certain height and those with cladding.

Shortly before receipt of this request in July 2017, we had issued a letter to all registered services drawing attention to a range of fire safety information and advice including RQIA updated and reissued Guidance on Service Users Smoking in Residential Care and Nursing Homes. A review of care homes identified one establishment over the height limit and this home had completed a consultation with NIFRS and implemented a range of increased safety measures which were completed in April 2017. No buildings were known to have external cladding. Based on the potential for providers to ignore a second letter, or to mistake it as a duplicate, issued so soon after the first, a judgement call was to defer the issue of a further letter on Fire Safety to later in the year to ensure a reinforced message. A letter was issued December 2017 to all registered establishments and agencies including HSC Trusts. At the liaison meeting, it was noted that whilst the risk may have been low, it would have been more prudent to develop and issue the communication as soon as the request was made.

Four Seasons Healthcare

FSHC continue to provide regular update to RQIA in respect of their process of refinancing of debt which has received media attention. CQC have a market oversight function and continue to closely track progress with the ongoing restructuring discussions. CQC market oversight regulatory responsibility is to advise local authorities if they

	believe that services are likely to be disrupted as a result of business failure. RQIA are included in the list of organisations to be notified if this were to be likely. Andrea Sutcliffe, Chief Inspector at CQC has stated "I would like to confirm at this point in time we do not believe that services are likely to be disrupted as a result of business failure."
2.2 INSPECTION	**General** • Statutory target of is on course to be achieved. **Audit** As part of our ongoing programme to improve our systems and processes, two audit processes have recently been completed of our inspection process for nursing homes. Internal audit review on Nursing Home Inspections to review compliance with appropriate planning, review and reporting. The objectives of the audit were to ensure: • the Authority has robust governance arrangements, and policies and procedures in place for inspections carried out by the Nursing Home Team • appropriate planning systems are in place to ensure that RQIA can meet its statutory function in relation to inspections of Nursing Homes • robust inspection processes and systems are in place and also robust follow up processes for areas for improvement - (requirements and recommendations) • robustness of report quality review process • robustness of enforcement action and compliance with corresponding policy and procedures • key performance targets for inspection services are identified, monitored and reported. The draft audit findings received a satisfactory level of assurance of the system of governance, risk management and control. **Peer review of Inspection Process** RQIA invited Care Inspectorate Scotland to undertake a peer review of our inspection process Terms of reference included: • To describe the process for review, analysis and decision making of inspection findings to include why, how and when we escalate. • To review the mechanisms whereby RQIA discharges our statutory responsibilities as a regulator

in respect of the review of information and intelligence and inspection findings in order to bring about improvement

- To prepare a report which identifies good practice and makes recommendations for improvement, as necessary

Conclusion

- Information gathering and recording was thorough and was used to inform decision making about when to take action. The organisation has capacity to be responsive to concerns by inspecting services more frequently if required.
- With regards to the case study, immediate regulatory action was taken following inspection, resulting in enforcement activity and ultimately service improvement. The organisation took into account a range of factors in their decision making and utilised the principle of the least punitive and therefore most proportionate response they could.

Stakeholder engagement

In advance of the publication of the COPNI investigation report into care provided at Dunmurry Manor Nursing Home, RQIA will review the methods of engagement with patient, relatives and staff in care homes in order to identify methods that are working well and areas where further improvement would be beneficial.

Fees and Frequency of Inspection / Risk Framework

In preparation for the introduction of changes to the fee structure and frequency of inspections, we have been progressing with the development of a risk based tool to schedule inspections and then further to respond to information and intelligence received. This work has been aided by the expertise of Professor Brian Taylor from University of Ulster who has been assisting in the analysis of available data to predict risk indicators. Further workshops are planned with the aim of developing a draft tool to share with relevant stakeholders.

Unregistered Facilities Accommodating Looked After Children

RQIA is aware of an increasing number of unregistered facilities accommodating looked after children. This is a regional issue arising from the need to accommodate young people aged sixteen plus with complex needs who are unable to be accommodated in main stream children's homes. RQIA is working closely with the HSCB in a solution focused piece of work to explore how these young people can be effectively and safely cared for. The resultant outworking of this piece of work will be presented to the DoH for their consideration.

	MAHI - STM - 300 - 318
2.3 ENFORCEMENT	**Enforcement** All enforcement action (except children's services) is published on our website. Recent enforcement included: • **Failure to Comply Notices** - Compliance was achieved at Redburn Clinic Nursing Home - Compliance inspection due at Lisadian Nursing Home on 20 January - Compliance was achieved at Knockmoyle Nursing Home on recruitment issues • **Serious concerns meetings** - We held five meetings to discuss issues arising from inspection and received assurance from the registered providers on their action plan to deliver improvement. This included two Nursing homes, one Children's Home and two Dental Practices. • **Appeal to the Care Tribunal** - An appeal was lodged by Runwood Homes Ltd against a decision to cancel registration. This appeal is progressing through the Care Tribunal. • **Representations and Decision Making Panels** - No panels have been required since the last update

3. REVIEWS (HEALTHCARE INSPECTIONS, AUDITS / GUIDELINES and REVIEW PROGRAMME)	
3.1 HEALTHCARE INSPECTIONS	**NIAS Unannounced Hygiene Inspection Programme** **NIAS Unannounced Hygiene Inspection Programme** - Formal correspondence regarding lifting / extending of Improvement Notices issued by RQIA on 8 November 2017. Improvement Notices in relation to corporate leadership and organisational accountability remain in place. - Follow up inspections related to these Improvement Notices will be carried out in early 2018 and the inspection schedule will be extended to include other ambulance stations. - Plan to meet with DoH policy lead on 26 January to discuss future work with NIAS. **ACUTE HOSPITAL Unannounced Inspection Programme (HIP)** o Phase 2 Programme – inspection activity is now complete, though update meetings in relation to RBHSC and Causeway are planned for early 2018. o Reports for Lagan Valley, Mater Hospital and Royal Belfast Hospital for Sick Children were published on 14 December 2017. o RQIA and NIMDTA jointly establishing a Clinical Trainee Associate Programme; training to commence in January 2018. o RQIA and Trust Medical Directors to jointly establish panel of senior Doctors to act as peer reviewers for HIP programme (agreed through Medical Leaders Forum on 4 September 2017). Call for applications to be issued January 2018 (deferred from November 2017). o Causeway Hospital: Inspection 20–23 November 2017. Issues identified in relation to: disconnected care delivery (within and between specialisms/disciplines), lack of planned/scheduled ward rounds, lack of participation/engagement in multi-disciplinary team meetings, gaps in communication, shortages in ward staffing (nursing, phlebotomy, pharmacy), poor staff morale (ward nursing staff, junior medical staff). - Feedback provided to NHSCT CEx and Executive Team on 22 November 2017. - Letter of concern re inspection findings sent to NHSCT on 8 December 2017, Trust response received on 15 December 2017; will be followed up in early in 2018. - Royal Belfast Hospital for Sick Children: Re-inspection: 11–13 December 2017. Issues identified in relation to: operation/function of short stay assessment unit (SSAU), nursing leadership for Barbour Ward, case mix and complexity of children on Barbour Ward as currently used/configured, retention of specialist children's nurses, lack of collaborative working (including both clinical and managerial staff) to deliver improvement. Work is required at regional level to deliver new/refreshed care pathways and systems. - Feedback provided to the BHSCT CEx and Executive Team on completion of inspection. The trust will

develop an immediate action plan to address issues identified during the inspection.

- To meet with the Trust in February 2018 to review the action plan and discuss progress in relation to areas for improvement.
    - Phase 2 Programme –stakeholder feedback/engagement event with HSC and DoH colleagues planned for 9 February 2018.
    - Phase 3 Programme – planning commencing; engagement meetings will be held from January onwards; inspections to commence in/after April 2018.

HYGIENE AND CLEANLINESS Inspection Programme

- Inspection to Rehabilitation Ward, Causeway Hospital undertaken as part of acute hospital inspection programme (20–24 November 2017), following increased incidence of Clostridium difficile infections May 2017. Findings evidence ward infection prevention/control measures have been strengthened and learning identified/implemented. Four risk and intelligence based inspections completed, with an additional IPC inspection to Marie Curie with the Independent Healthcare Team.

AUGMENTED CARE Inspection Programme

- Neonatal Care – Year 3. Seven units to be inspected by March 2018; five units inspected to date (Antrim, Altnagelvin, Royal, Craigavon and Ulster). Daisy Hill and South West Acute scheduled into programme for January–March 2018. This will complete the three year programme of inspection to neonatal units. Findings demonstrate implementation of previous action plans, improvement in care/services and evidence of QI initiatives being implemented at unit level.
- Adult Critical Care– Year 3. One inspection to be completed in each HSC Trust during quarter one, April – June, 2018–2019. Inspections will be carried out using risk-based approach to determine units to be inspected. This will complete the three year programme of inspection to critical care units.
- All other Augmented Care areas (renal, haematology, oncology etc) to be progressed using a risk-based approach to inspection during April 2018–March 2019 schedule. This will give a base-line of information in relation to compliance against standard inspection audit tools. There are 11 areas to be inspected.
- Following completion of Neonatal and Critical Care Year 3, discussion required wrt future programme approach and implementation; meeting with DoH scheduled for 20 February 18 which will be followed by discussion with key stakeholders/groups (including NNNI and CCaNNI).

3.2 INDEPENDENT HEALTHCARE: INSPECTIONS	**Independent Healthcare Team** **MAHI - STM - 300 - 321** • There are a total of 456 services either registered or in the process of registration. • As of 6 December 2017, 66% of these inspections had been completed and the remainder are planned. **Dental Regulation** • RQIA wishes to meet with relevant DoH colleagues in early 2018 to discuss learning/intelligence gathered since the introduction of dental regulation in 2011/12 and how this will inform planned frequency/methodology in relation to dental inspections moving into 2018/19. RQIA is seeking flexibility wrt inspection frequency and/or methodology into 2018/19 (using a risk-informed approach). • Compliance with the regulations and standards is being achieved in the majority of practices; we continue to see a very small number of providers who are not compliant in relation to staff recruitment and selection. • Since April 2017, three meetings were held with providers with the intention to issue Failure to Comply Notices – resulting in one provider receiving a Notice. • Serious concerns meetings were held with three providers during 2017/18. An additional serious concerns meeting is scheduled for 12 January 2018 wrt two registered dental practices (involving the same registered person) in relation to non-compliance with infection prevention & control, decontamination, and recruitment & selection of staff. **Unregistered Cosmetic Laser Services** • We continue to pursue a number of cosmetic laser services operating without registration. • The total number of successful prosecutions in respect of these services is seven. • The court date in respect of two services planned for 6 October 2017 was deferred until 1 December 2017. However the cases were not heard on 1 December 2017 as the summons could not be served. In one case the business had closed and in the second case the defendant was not on site. BSO legal team has confirmed that they will continue to pursue serving of the summons in respect of this service. • BSO legal team has advised the IHC team to revisit gathering evidence in respect of six historical laser services. To date, this exercise has confirmed that two of the establishments are no longer providing cosmetic laser services. Evidence in respect of the other four services continues to be pursued. **Independent Medical Agencies (IMAs)** • Head of Programme participated in national planning/listening workshop in relation to IMAs hosted by CQC in London on 26 October 2017. • We are reviewing our position in relation to IMAs, using intelligence gathered from the above mentioned workshop and previous teleconferences, and taking account of our approach in this area over previous

	years. A meeting was held on 21 December involving Director, Head of Programme and Senior Inspector. We plan to update EMT and Board members in early 2018. **Independent Hospitals and Hospices** • Correspondence from Deputy CMO (Dr Woods) on 1 September 2017 indicated that DoH wishes to discuss a potential Review of Governance Arrangements within Private/Independent Hospitals. • RQIA Chief Executive and Medical Director met with DoH on 30 October 2017 to discuss. • Outline of planned approach for initial scoping exercise to be worked up by RQIA and shared with DoH mid-January (deferred from mid-December).
3.3 RQIA AUDITS / GUIDELINES	**Audits** **2018/2019 funded Audit Programme**: total of 14 applications received – 9 for quality improvement work, 4 for audit work and 1 to develop local guidelines. Initial assessment of applications received shortlisted 5 for interview in January. **2017/2018 Audit Programme**: 2 audits at fieldwork, 4 audits at analysis and 1 guideline at literature review. **STICkS Phase 2: Safe transitions in care checklists**: A ward round weekend handover project in surgical units - **Risk identified** – no response from 3 of 6 participating hospitals. **Action taken** – Decision to complete project with data for three hospitals (Antrim, Craigavon and Ulster). Draft report due end of January 2018. **2016/2017 Audit Programme**: 9 audits at reporting stage, 2 undergoing analysis, no risks currently identified. **Regional Audit of Tension Free Vaginal Tape (TVT audit):** Meeting with Project lead and RQIA 14 December 2017 to review QA comments. Publication mid-January 2018. This topic continues to attract significant media interest with recent communication from an MLA regarding a publication date. **Guidelines** **Ten guidelines from 2009 to 2014 are due for review:** Two guidelines are currently being updated: 1. Guideline on the Use of the Mental Health (Northern Ireland) Order 1986-2011: Release from medical duties for consultants is an ongoing issue – however the project is still moving forward and has identified

	areas where changes may need to be considered including Deprivation of Liberty, patient right to replace their nearest relative, referral to Mental Health Review Tribunal with regard to a person who lacks capacity. 2. Caring for people with a Learning Disability in General Hospital Settings: Review of 2010 guideline has completed. Final version with Project Lead. An E-Learning Tool has subsequently been developed to support the reviewed guideline. Eight guidelines are being scoped with regard to requirement for update and contact has commenced with lead professionals involved in last update/iteration of each guideline. Letter to be issued to Chief Executives and HSC partners which will highlight previous GAIN guidelines now superseded by NICE guidelines. This will be followed by removal of identified GAIN guidelines from the RQIA website.
3.4 DOH COMMISSIONED AUDITS AND PROJECTS	**Regional Audit: Implementation of a Regional 'Policy for the Identification and Labelling of Invasive Lines and Tubes**'. Individual Trust reports have been shared with Trust Chief Executives, CMO and DoH. Independent Healthcare Providers (IHCP) composite report will be made available to Chief Executives, Directors and Regional Managers of each IHCP. Transfer of operational responsibility to RQIA of data collection and cleansing as part of the **National Confidential Inquiry into Suicide and Homicide (NCISH) by people with Mental Illness** - Data sharing Agreement (DSA) has been granted with signed copy received from NISRA. Commencement of revised local data collection systems has been agreed for early January 2018, in line with NISRA mortality data extract.
3.5 REVIEW PROGRAMME	**Review Programme: June 2017 to September 2018:** **Review of the Out-of-Hours (OOH) General Practitioner (GP) Service (RQIA Initiated)** Reference Panel met on 14 December 2017 and discussed further terms of reference and methodologies. Terms of reference to be finalised with DoH. Expert Review Team established. Methodologies comprise: • Provider engagement via profiling and governance questionnaire, as well as observational visits • Service user engagement via PCC telephone line and questionnaires distributed by OOH providers and promoted on websites and Twitter • Engagement with GPs via HSC Board, Local Medical Committees, BMA and RCGP • Visits by expert Review Team scheduled for end February and end March 2018 **Review of Service Frameworks (DoH Commissioned)**

Draft terms of reference being finalised and meeting arranged with DoH leads for 11 January 2018. Background research continuing including collation of relevant papers/documentation from DoH; consideration of alternative models; consideration of original aims of framework in light of current transformation programme under Delivering Together.

Review of Implementation of Clinical Guideline CG174 Intravenous Fluid Therapy in Adults in Hospital (DoH Commissioned)

Draft terms of reference shared with DoH in November. Meeting with representatives from Reference Panel on 14 December 2017. Methodologies comprise:

- Ward Level Audit: sample of relevant wards and audit tools being worked up, with intention to utilise Foundation Year 2 Doctors to assist in fieldwork
- Engagement with healthcare professionals prescribing and administering IV fluids via electronic questionnaire and semi-structured interviews
- Governance arrangements questionnaire to all Trusts, HSC Board and PHA
- Engagement with education and training providers
- Meetings with senior management across HSC Trusts (including NIAS)

Reviews to be timetabled:

- **Review of Implementation of NICE NG29 Intravenous Fluid Therapy in Children and Young People in Hospital (DoH Initiated)** – this review is likely to commence in Spring 2018.
- **Review of Learning Disability: Community Services: Phase II (Children) (RQIA Initiated). Timescale for this review** is November 2017-September 2018
- **Review of Child Protection Arrangements: Phase II: Interagency Working (RQIA Initiated).** Initiation of the Phase II review will be dependent upon completion of Phase I (currently at FA checking with HSC Trusts) and will progress following discussion with DoH.
- **Potential Review of Governance in Private/Independent Hospitals:** see update under Independent Hospitals and Hospices.

Review Programme April 2016 to June 2017:

Five reviews **reporting**, RQIA will update DoH wrt expected timescales in mid January:

- Review of Governance Arrangements for Child Protection in the HSC in Northern Ireland: Phase I (RQIA Initiated) – with Trusts and HSC Board/PHA for factual accuracy checking.
- Review of the Implementation of The Developing Better Eyecare Partnerships Strategy (RQIA Initiated) – with HSC Board for factual accuracy checking.
- Review of Crisis Resolution and Home Treatment Services for Mental Health and Learning Disability across

	Northern Ireland (RQIA Initiated) – internal quality assurance at RQIA. • Review of General Paediatric Surgery in Northern Ireland (RQIA Initiated) – internal quality assurance at RQIA. • Review of the Use of Restraint and Seclusion (DoH Commissioned) – internal quality assurance at RQIA. The Review of Specialist Renal Services in HSC Trusts (DoH Commissioned) is in contingency at present and requires further discussion with DoH.

MAHI - STM - 300 - 325

<table>
<tr><td>4. CORPORATE SERVICES</td><td>MAHI - STM - 300 - 326</td></tr>
<tr><td>4.1 CURRENT AND PROJECTED FINANCIAL POSITION 2017-18</td><td>The implementation of the Workforce Review has necessitated holding a number of vacant posts unfilled in order to ensure flexibility in re-structuring the organisation and achieving the benefits of the Review. As a result of this RQIA will have a significant underspend at the year-end and a break-even position will only be achieved through a phased non-recurring easement to DoH. In November 2017 an easement of £300K was made to DoH and a second easement will be made in January 2018. As at 30 November 2017 the projected underspend is estimated to be circa £166.5K.

BSO did not meet the deadline for submission of a business case to DOH for VES funding. RQIA's bid for VES monies will now not be considered until January 2018.</td></tr>
<tr><td>4.2 FINANCIAL PLANNING SCENARIOS 2018-19 AND 2019-20</td><td>On 28 November 2017 the DoH Director of Finance wrote to RQIA confirming that financial planning for 2018-19 and 2019-20 had commenced. The Director of Finance has indicated that it is unlikely that any budget settlement will be sufficient to meet all the increasing demands facing health and social care services. RQIA has therefore been asked to develop a range of savings proposals to provide for a reduction of up to 5% of the 2017-18 opening budget in 2018-19 increasing to 10% in 2019-20.

In financial terms this would indicatively mean:

<table>
<tr><th>RQIA</th><th>2018-19
5% reduction (£k)</th><th>2019-20
10% reduction (£k)</th></tr>
<tr><td>17/18 Opening allocation</td><td>6,707</td><td>6,707</td></tr>
<tr><td>Saving</td><td><u>335</u></td><td><u>671</u></td></tr>
<tr><td>Allocation after reduction</td><td>6,372</td><td>6,036</td></tr>
</table>

Costs pressures such as pay uplifts are to be absorbed within existing baseline budget allocations.

RQIA's Financial Scenario Plan 2018-19 and 2019-20 was submitted to DoH by the deadline of 13 December 2017.</td></tr>
</table>

4.3 GOVERNANCE	An internal audit of Inspections (Nursing Homes) has been completed, providing a satisfactory level of assurance.
4.4 CONTROLS ASSURANCE STANDARDS / ASSURANCE FRAMEWORK 2018-19	At a recent meeting Joanne Elliott, DoH informed ALBs that each policy lead in the Department has been asked to develop a more appropriate and proportionate approach to assurance as an alternative to CASs which will come into effect in 2018-19. She is developing a Paper summarising these proposed approaches which will be issued to ALBs in January for information and comment. RQIA plan to make greater use of internal audit on a targeted and phased basis in the areas covered by the CASs to provide assurance to the Audit Committee and Board.
MEDIA INTEREST	During November and December, RQIA received significant coverage in relation to the impact of nursing shortages on hospital, mental health and regulated services. RQIA is due to meet the Chief Nursing Officer in January 2018 to discuss these concerns. In December, RQIA published its reports of its acute hospital inspections of the Mater and Lagan Valley hospitals and the Royal Belfast Hospital for Sick Children. The report on the childrens' hospital attracted significant print media coverage, with an editorial in the Irish News linking the issues highlighted within this report to staff shortages.

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

From: Paddy Woods (DCMO) cc G5/G6

Date: 24 January 2018

To: TMG

RQIA Bi-Monthly Meetings and Update Reports

RQIA are required to produce a comprehensive update report for consideration at bi-monthly sponsorship meetings with CMO Group staff. The most recent bi-monthly meeting was held on 9 January 2018 and the corresponding update report is now attached for your information (**Annex A**).

The report is also being circulated to relevant policy leads at G5 & G6 level and should they require further information regarding a particular issue, this can be sought either directly from RQIA or through sponsor branch who will liaise with RQIA to arrange any appropriate briefings or direct engagement.

Any queries in relation to this memo should be directed to Steven White (steven.white@health-ni.gov.uk).

Dr Paddy Woods
Deputy Chief Medical Officer

Annex A

RQIA Bi-monthly update paper - 09 Ja

Exhibit 10

From:	Rocks, Dennis
To:	Lee, Mark (DoH)
Cc:	Redmond, Maire; Toogood, Peter; Adell, Tomas; Wilson, Ryan (DoH); Holland, Sean; Pengelly, Richard; Scullion, Sean; Dawson, Andrew; Geoghegan, Lourda
Subject:	Notification of Inspection: Muckamore Abbey Hospital
Date:	29 July 2021 16:04:00
Attachments:	L01_notification_MAH_020426_280721.pdf

Unannounced Inspection – Muckamore Abbey Hospital

To note that RQIA inspectors are undertaking an unannounced inspection of MAH from 28-30 July 2021.

We will only be contacted by RQIA if there is an issue/problem they need to bring to our attention. Otherwise engagements/discussions will be exclusively between the Trust and RQIA.

Head of the DoH Muckamore Abbey Review Team has already been sent a copy of the email from RQIA

Dennis

From: Hayley Barrett <Hayley.Barrett@rqia.org.uk>
Sent: 28 July 2021 09:01
To: Dawson, Andrew <Andrew.Dawson@health-ni.gov.uk>; Ruddy, Donna <Donna.Ruddy@health-ni.gov.uk>; Geoghegan, Lourda <Lourda.Geoghegan@health-ni.gov.uk>
Cc: Briege Donaghy <Briege.Donaghy@RQIA.org.uk>; Emer Hopkins <Emer.Hopkins@RQIA.org.uk>; Lynn Long <Lynn.Long@rqia.org.uk>; Wendy McGregor <wendy.mcgregor@RQIA.Org.Uk>; Paulina Spychalska <Paulina.Spychalska@rqia.org.uk>
Subject: Notification of Inspection: Muckamore Abbey Hospital

"This email is covered by the disclaimer found at the end of the message."

Dear Colleagues

Please see below notification email that was forwarded to the Belfast Trust, Dr Jack regarding the RQIA Hospital Inspection in Muckamore Abbey Hospital.

Thank you
Hayley

Hayley Barrett
Business Manager
The Regulation and Quality Improvement Authority

We have moved:
7th Floor, Victoria House
15-24 Gloucester Street
Belfast

BT1 4LS

Tel: 028 9536 1872

Email: hayley.barrett@rqia.org.uk
Web: www.rqia.org.uk
Twitter: @RQIANews

Assurance, Challenge and Improvement in Health and Social Care

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From:	Enforcement Mailbox
Cc:	Malachy Finnegan; Lourda Geoghegan; Hayley Barrett
Subject:	Enforcement Documentation - Muckamore Abbey Hospital (RQIA ID 20426)
Date:	16 August 2019 14:11:45
Attachments:	FTC_3_notice_MD_16082019.pdf FTC_4_notice_MD_16082019.pdf FTC_5_notice_MD_16082019.pdf

"This email is covered by the disclaimer found at the end of the message."

Sent on behalf of Olive Macleod, Chief Executive, RQIA

I wish to inform you that enforcement action has been taken by RQIA for the above named service. Confirmation of this action is attached.

You may wish to draw this to the attention of relevant colleagues.

Kind regards

Paula Weir
Administration Team Supervisor
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Tel: 028 9536 1948 (direct line)

Email: paula.weir@rqia.org.uk
Web: www.rqia.org.uk
Twitter: @RQIANews

Assurance, Challenge and Improvement in Health and Social Care

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THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY

IMPROVEMENT NOTICE PURSUANT TO ARTICLE 39 OF THE HEALTH and PERSONAL SOCIAL SERVICES (QUALITY IMPROVEMENT and REGULATION) (NORTHERN IRELAND) ORDER 2003

IN Ref No: IN000003	**Issue Date:** 16 August 2019
Health and Social Care Trust: Belfast Health and Social Care Trust (RQIA ID: 020426)	**Address:** Belfast Health and Social Care Trust Trust Headquarters A Floor Belfast City Hospital 51 Lisburn Road Belfast BT9 7AB
Responsible Person: Mr Martin Dillon, Chief Executive	

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

Failure to Comply:

4.3 Criteria

The organisation:

(i) undertakes systematic risk assessment and risk management of all areas of its work;
(j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their

job, including compliance with:
- *Departmental policy and guidance;*
- *professional and other codes of practice; and*
- *employment legislation.*

(n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(f) has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure: protection of health, welfare and safety of staff.

5.3.3 Promoting Effective Care

The organisation:

(c) promotes a culture of learning to enable staff to enhance and maintain their knowledge and skills;
(d) ensures that clinical and social care interventions are carried out under appropriate supervision and leadership, and by appropriately qualified and trained staff, who have access to appropriate support systems.

Specific failings identified in respect of the considered criteria:

The Belfast Health and Social Care Trust (the Trust) has failed to comply with the considered criteria (as above) by failing to demonstrate that it is ensuring that nurse staffing at ward level and across the Muckamore Abbey Hospital (MAH) site is planned and managed on the basis of assessed patient need.

From 26 to 28 February 2019, we carried out an unannounced inspection of MAH. We found evidence of insufficient nurse staffing at ward level: to meet patients' prescribed level of observation; to appropriately manage patients' physical health care needs; and to implement and execute appropriate therapeutic care plans for patients. In line with our enforcement procedures we invited the Trust to an Intention to Serve an Improvement Notice Meeting on 7 March 2019. At that meeting we discussed our concerns with senior Trust representatives who provided us with details of a number of actions to address the identified issues.

The actions included: i) that additional staff had been recruited; ii) that patients' prescribed levels of observation would be achieved; iii) that daily checks of the wards would be completed; iv) that clear escalation arrangements would be implemented and assured; v) that co-operation and staff resources from other Trusts had been sought; and vi) that improvement work had commenced to develop the role of Allied Health Professionals and Specialist Behaviour Nurses in the hospital.

We determined that the actions / measures described by the Trust were a constructive response, which would improve the capacity of frontline staff and Trust management to provide safe and effective care to patients in MAH.

We carried out a further unannounced inspection of MAH from 15 to 17 April 2019. The purpose of our second inspection was to assess progress regarding the Trust's action plan and to follow up on assurances provided by the Trust during the Intention to Serve meeting on 7 March 2019. Progress was noted in relation to management and oversight of patients' physical healthcare needs.

During this inspection we experienced difficulty in accurately confirming nursing staff requirements as compared to nursing staff provision across the hospital. We could not see evidence of planning and/or allocation of nurse staffing on the basis of assessed patient need. We noted a mismatch between information supplied by site managers and that supplied by ward staff/ward managers with regard to nursing staff requirements and provision.

Although site managers described escalation arrangements in place in the context of staffing challenges, we were not assured that these arrangements were working effectively, or that ward staff/managers were appropriately supported when they experienced challenges in relation to staffing.

We received additional information from the Trust in respect of nurse staffing on 22 July 2019. While numbers of staff were described, this information was not placed in the context of assessed patient need at ward and hospital level. We appreciate that the numbers of staff required to meet the patients' assessed needs may fluctuate on a daily basis. Our concerns relate to the lack of evidence during our engagements with the Trust; and in subsequent correspondence, that staffing at ward level and across the site is managed and assured on the basis of assessed patient need.

In line with our enforcement procedures we invited the Trust to an Intention to Serve an Improvement Notice meeting on 14 August 2019. At that meeting senior Trust representatives described the challenges they experience in relation to staffing the hospital. They outlined work currently in progress and planned over coming months to stablisie the current staffing model and to assure that the model is meeting assessed patient need. It is our view that this work will support the Trust to achieve the actions outlined in this notice.

Trust representatives described potential future models for staffing in the hospital. Development and implementation of these models will be strengthened by the Trust working in partnership with the Health and Social Care Board, the Public Health Agency, other HSC Trusts and the Department of Health.

Improvements necessary to achieve minimum compliance:

The Belfast Health and Social Care Trust Board, Chief Executive, and Executive Team must:

1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at Muckamore Abbey Hospital, which:

   a) is based on the assessed needs of the current patient population *and*
   b) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.

2. Implement an effective process for oversight and escalation of challenges relating to staffing aross the hospital site; this should include ward sisters, hospital managers, Trust senior managers and/or the Executive Team as appropriate.

3. Implement effective mechanisms to evidence and assure it's compliance with good practice in respect of the current staffing model and associated escalation measures.

4. Engage the support of, and work in partnership with, other HSC organisations (including the Health and Social Care Board, the Public Health Agency and HSC Trusts) to define future model(s) for nurse staffing in mental health and learning disability in-patient services / wards. The design and testing of future staffing models must be supported by appropriate assurance processes and tools.

The Trust Chief Executive may make written representations to the Chief Executive of RQIA regarding the issue of an Improvement Notice, within one month of the date of serving this notice.

Date by which compliance must be achieved: 16 November 2019

Signed.....

Director of Improvement and Medical Director

This notice is made under Articles 38 and 39 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Department of Health, Social Services and Public Safety, Quality Standards for Health and Social Care (March 2006).

It should be noted that failure to comply with the measures identified in this Improvement Notice may result in further enforcement action by RQIA.

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY

IMPROVEMENT NOTICE PURSUANT TO ARTICLE 39 OF THE HEALTH and PERSONAL SOCIAL SERVICES (QUALITY IMPROVEMENT and REGULATION) (NORTHERN IRELAND) ORDER 2003

IN Ref No: IN000004	**Issue Date:** 16 August 2019
Health and Social Care Trust: Belfast Health and Social Care Trust (RQIA ID: 020426)	**Address:** Belfast Health and Social Care Trust Trust Headquarters A Floor Belfast City Hospital 51 Lisburn Road Belfast BT9 7AB
Responsible Person: Mr Martin Dillon, Chief Executive	

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

Failure to Comply

4.3 Criteria

The organisation:

(f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;
(g) has systems in place to ensure compliance with relevant legislative requirements;
(h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

(i) undertakes systematic risk assessment and risk management of all areas of its work.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

Specific failings identified in respect of the considered criteria:

The Belfast Health and Social Care Trust (the Trust) has failed to comply with the considered criteria (as above) by failing to ensure that a robust financial governance framework is in place for effective management of patients' finances within Muckamore Abbey Hospital (MAH).

From 26 to 28 February 2019, we carried out an unannounced inspection of MAH. Our inspection team identified concerns in relation to a potential failure to refer patients appropriately to the Office of Care and Protection; non-completion of patient property records; inconsistency in completion of ledgers at ward level; and an apparent omission to make a safeguarding referral in the context of financial governance arrangements for one patient. In line with our enforcement procedures we invited the Trust to an Intention to Serve an Improvement Notice Meeting on 7 March 2019.

At that meeting we discussed our concerns with senior Trust representatives who provided us with details of a number of actions to address the identified issues. The actions included: i) that outstanding referrals to the Office of Care and Protection had been made; ii) that an outstanding safeguarding referral had been made; iii) that the Trust would undertake a review of its Patient Finances and Private Property Policy and undertake an audit to ensure appropropriate implementation of this policy; and iv) that the Trust would undertake an audit of compliance with financial governance arrangements across the hospital.

We determined that the actions / measures described by the Trust were a constructive response, which would improve governance arrangements with respect to oversight and management of patients' finances in MAH.

We carried out a further unannounced inspection of MAH from 15 to 17 April 2019 (second inspection). Our inspection team evidenced limited progress in relation to financial governance arrangements. We confirmed that a safeguarding referral in relation to one patient had been made.

We undertook a further announced inspection of MAH on 1 July 2019. The specific focus of this third announced inspection was financial governance, including how the Trust discharges its responsibilities on patient's behalf in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. Our inspection team evidenced limited progress in relation to areas previously identified as requiring improvement. We remained concerned about aspects of financial governance in the hospital including: evidence of appointee-ship arrangements for some patients; processes for regular review of patients' financial circumstances; and systems to inform decision-making regarding referrals to the Office of Care and Protection.

On 1 August 2019 we received correspondence from a senior Trust representative indicating that the Trust recognises the above challenges.

In line with our enforcement procedures we invited the Trust to an Intention to Serve an Improvement Notice meeting on 14 August 2019. At that meeting senior Trust representatives provided a copy of the Trust's action plan to address the areas for improvement previously identified and highlighted above. The Trust has confirmed that this planned work will include engagement with relevant partner agencies.

Improvement necessary to achieve minimum compliance:

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

1. That the Trust is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986.

2. In respect of those patients in receipt of benefits for whom the Trust is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits.

3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and Trust's policy and procedures; this includes:

    a) that appropriate records of patients' property are maintained;

    b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role;

    c) that audits by senior managers of records retained at ward level are completed in accordance with Trust policy;

    d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital.

The Trust Chief Executive may make written representations to the Chief Executive of RQIA regarding the issue of an Improvement Notice, within one month of the date of serving this notice.

Date by which compliance must be achieved: 16 November 2019

Signed Dr Nowela Geoghegan

Director of Improvement and Medical Director

This notice is made under Articles 38 and 39 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Department of Health, Social Services and Public Safety, Quality Standards for Health and Social Care (March 2006).

It should be noted that failure to comply with the measures identified in this Improvement Notice may result in further enforcement action by RQIA.

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY

IMPROVEMENT NOTICE PURSUANT TO ARTICLE 39 OF THE HEALTH and PERSONAL SOCIAL SERVICES (QUALITY IMPROVEMENT and REGULATION) (NORTHERN IRELAND) ORDER 2003

IN Ref No: IN000005	**Issue Date:** 16 August 2019
Health and Social Care Trust: Belfast Health and Social Care Trust (RQIA ID: 020426)	**Address:** Belfast Health and Social Care Trust Trust Headquarters A Floor Belfast City Hospital 51 Lisburn Road Belfast BT9 7AB
Responsible Person: Mr Martin Dillon, Chief Executive	

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

Failure to Comply:

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(a) has effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes and appropriate interagency approaches;

(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

Specific failings identified in respect of the considered criteria:

The Belfast Health and Social Care Trust (the Trust) has failed to comply with the considered criteria (as above) by failing to ensure effective safeguarding arrangements are implemented and assured within Muckamore Abbey Hospital (MAH).

From 26 to 28 February 2019, we carried out an unannounced inspection of MAH. Our inspection team did not find evidence of effective deployment of safeguarding referrals, of the implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A structural disconnect between professional staff was evident. In line with our enforcement procedures we invited the Trust to an Intention to Serve an Improvement Notice meeting on 7 March 2019.

At that meeting we discussed our concerns with senior Trust representatives who provided us with details of a number of actions to address the concerns identified. These included: i) following any potential safeguarding incident or allegation a multi-disciplinary risk assessment would be completed to determine best action and outcome for the patient(s) and staff member(s); ii) confirmation that work would progress to support staff to develop their understanding of risk assessment and to enable multi-disciplinary teams to provide a safe environment for staff to learn and to improve confidence in their practice.

We determined that the actions/measures described by the Trust were a constructive response, which would improve the safeguarding arrangements within MAH. We advised that in line with the anticipated improvements in staffing on individual wards and across the hospital site (as advised at that time), the deployment of staff who have been the subject of a safeguarding referral should be reviewed. We also advised that in circumstances which give rise to multiple and repeated safeguarding referrals for the same patient, it is essential that there is a multi-disciplinary team approach to addressing potential root causes giving rise to and or influencing repeated referrals.

We carried out a further unannounced inspection of MAH from 15 to 17 April 2019. Our inspection team evidenced limited progress in relation to safeguarding arrangements. We remained concerned about implementation of learning arising from safeguarding investigations and evience that the outcomes from safeguarding investigations were positively impacting patient well-being. We noted that meaningful implementation of protection plans was a challenge.

On 19 July 2019, and on 9 August 2019, RQIA was notified of two incidents of an adult safeguarding nature in MAH. We were concerned about the quality and timeliness of the information provided with respect to both of these matters.

In line with our enforcement procedures we invited the Trust to an Intention to Serve an Improvement Notice Meeting on 14 August 2019. At that meeting senior Trust representatives described work in progress to improve the current arrangements with respect to adult safeguarding in MAH. This work is ongoing and includes engagement with patients, carers, and staff within and outwith the Trust. It is our view that this work will support the Trust to achieve the actions outlined in this notice.

Improvement necessary to achieve minimum compliance:

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must:

1. Implement effective arrangements for adult safeguarding at Muckamore Abbey Hospital and ensure:

   a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations;

   b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively;

   c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care;

   d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding is improved.

2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, Trust senior managers and / or the Executive team as appropriate.

3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.

The Trust Chief Executive may make written representations to the Chief Executive of RQIA regarding the issue of an Improvement Notice, within one month of the date of serving this notice.

Date by which compliance must be achieved: 16 November 2019

Signed.....Dr Maria Geoghegan.....
Director of Improvement and Medical Director

This notice is made under Articles 38 and 39 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Department of Health, Social Services and Public Safety, Quality Standards for Health and Social Care (March 2006).

It should be noted that failure to comply with the measures identified in this Improvement Notice may result in further enforcement action by RQIA.

From:	Paulina Spychalska
To:	McBride, Michael
Cc:	Carson, Jane; "rqia.reports@health-ni.gov.uk"; Bradley, Fergal; Holland, Sean; Olive Macleod; Lourda Geoghegan; Emer Hopkins; Lynn Long; Alan Guthrie; Malachy Finnegan
Subject:	RQIA Art 4 Letter: Muckamore Abbey Hospital
Date:	05 March 2019 09:15:36
Attachments:	ROIA_Article4_DoH_Letter_MAH_05032019.pdf

"This email is covered by the disclaimer found at the end of the message."

Good morning

Please find attached for your attention an Article 4 letter form Mrs Olive Macleod, Chief Executive, Regulation and Quality Improvement Authority, in relation to Muckamore Abbey Hospital.

Kind Regards
Paulina

Paulina Spychalska
Admin Team Supervisor
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Tel: 028 9536 1949 (direct line)
Email: Paulina.Spychalska@rqia.org.uk
Web: www.rqia.org.uk
Twitter: @RQIANews

Assurance, Challenge and Improvement in Health and Social Care

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

Assurance, Challenge and Improvement in Health and Social Care

Our ref: 020426/IN033250

06 March 2019

Private and Confidential

Dr Michael McBride
Chief Medical Officer
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Dear Dr McBride

I write in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to advise you of serious concerns identified by the Regulation and Quality Improvement Authority (RQIA) in relation to care, treatment and services as currently provided for patients in Muckamore Abbey Hospital (MAH).

You will be aware that RQIA has responsibility to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention and/or loss or damage to property under the Mental Health (Northern Ireland) Order 1986 and the Health and Social Care Reform Act (Northern Ireland 2009). Under Article 35 (1) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, RQIA conducts inspections and makes reports on arrangements by statutory bodies for the purpose of monitoring and improving the quality of health and personal social services.

This correspondence follows RQIA's unannounced inspection undertaken last week, from 26 to 28 February 2019 (inclusive), during which our multidisciplinary inspection team assessed care and treatment provided to patients currently in MAH. Our inspection team also assessed risk management, oversight and governance arrangements within and across the hospital during last week's inspection. A number of important findings emerged from our unannounced inspection, as summarised below:

1. Staffing - there was evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to implement and execute appropriate therapeutic care plans for patients, or to appropriately manage patients' physical health care needs. Due to staff shortages at ward level, staff are at times unable to appropriately fulfil their responsibilities and this is impacting on the quality and assurance of care delivered and is in itself a source of anxiety for staff.

9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

tel: 028 9536 1111
email: info@rqia.org.uk
web: www.rqia.org.uk
twitter: @RQIANews

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EFQM Leading Excellence
SYSTEM CERTIFICATION BMTRADA ISO 9001

Staff morale has been particularly impacted by events of the last 18 months and this is a significant cause for concern. Staff currently in the hospital (both front-line and managerial) have displayed enormous resilience, they are to be commended for their dedicated service to the patients in MAH, however they now require additional support and resources in order to continue to provide safe care and to plan for transition of the hospital's overall function and operating model.

2. Patients' physical health care needs - evidence of an appropriate system to ensure that patient's physical health care needs were addressed was lacking. Patients did not have their physical health appropriately monitored, did not access health screening appropriate to gender and/or age, and did not have appropriate access to primary care services. Additionally, some patients prescribed antipsychotic medications did not experience appropriate monitoring of related parameters of physical health (per the hospital's antipsychotic monitoring protocol).

3. Financial governance - concerns were identified in relation to failure to refer patients appropriately to the Office of Care and Protection, lack of awareness of management responsibilities relating to finances for detained patients, non-completion of patient property records and variation in completion of ledgers at ward level. There was also an apparent omission to make a safeguarding referral in the context of financial arrangements for one detained patient.

4. Safeguarding practices - our inspection team did not find evidence of effective deployment of safeguarding referrals, of implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A structural disconnect between professional staff was evident within the current safeguarding arrangements.

5. Restrictive practices (seclusion) - there was evidence that current seclusion practices across the hospital site are not in line with best practice guidelines.

6. Hospital governance - although arrangements have been established with a view to strengthening governance and appropriately identifying and managing risks across the hospital, our inspection team could not evidence that these arrangements were having the required impact on safety and effectiveness of care for patients or on the health and well-being of staff.

7. Discharge/relocation planning – ward staff reported they do not have current information regarding planning for some patients who have completed their active assessment and treatment and are awaiting discharge from MAH, this is challenging as family members/carers contact ward staff to seek their advice in relation to potential discharge options for their relatives (this is to be expected as ward staff are likely to be most familiar with patients' care needs). Despite several requests we (RQIA) have not received robust information in relation to discharge planning for patients who are delayed leaving the hospital. We have discussed one potential option with Belfast HSC Trust for 9 patients, however we have yet to receive any paperwork to register this service – this in the context of the Trust advising they wish to commence this service in April 2019 and Trust staff reporting (during our inspection) that they were working closely with RQIA.

We consider that the governance and operational systems across MAH fall below that which is required as set out in the Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (DoH, March 2006):

1. Theme 1 - Corporate Leadership and Accountability of Organisations: The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

2. Theme 2 - Safe and Effective Care: Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

3. Theme 4 - Promoting, Protecting and Improving Health and Social Well-being: Has structures and processes in place to promote and implement effective partnership arrangements, to contribute to improvements in health and social well-being and promote social inclusion and a reduction in inequalities.

4. Theme 5 - Effective Communication and Information: The HPSS communicates and manages information effectively, to meet the needs of the public, service users and carers, the organisation and its staff, partner organisations and other agencies.

The current position is of concern. Upon completion of our unannounced inspection last week we held a detailed feedback session with senior Trust staff on the MAH site (8.30am to 10.30am Friday 1 March 2019).
This was a helpful meeting, Trust colleagues accepted our assessment of the current position and agreed that immediate action is required to address the findings outlined above.

We plan to meet with the Chief Executive and members of the Trust's Executive Management Team on Thursday of this week (Thursday 7 March 2019). This will be an 'Intention to Serve' meeting which will provide us and the Trust with an opportunity to discuss our intention to issue a number of Improvement Notices to the Trust to address 6 of the 7 areas outlined above.

Given the current position we are now recommending that DoH agrees and implements a special measure for Belfast Health and Social Care Trust in relation to MAH. The special measure we recommend is the establishment of two taskforces – (i) a taskforce to stabilise the hospital site, in support of patients currently receiving care and staff delivering that care, and (ii) a taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community.

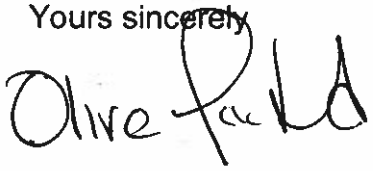
This recommendation is made with a view to improving the care and treatment of patients currently in MAH, to ensuring appropriate governance systems/arrangements are in place, and to effecting appropriate planning for patients who have completed their active assessment/treatment and who will relocate out of MAH to the community in the coming months.

We would stress the importance of ensuring that MAH is recognised as a service providing for all HSC Trusts (not just Belfast HSC Trust), the hospital has in-patient beds for three Trusts (Belfast, Northern and South-Eastern), however we understand all Trusts may currently have patients in the hospital. Therefore all Trusts and the Commissioner will need to work earnestly together to effect the required improvements. Given the challenges described Trust and/or Commissioner colleagues may wish to seek expert advice from colleagues working in other parts of the UK and this may well be very beneficial to informing and assisting the work required.

You may wish to receive a more detailed update on the key themes emerging from our unannounced inspection last week (as set out above), to this end Dr Lourda Geoghegan and I will be happy to meet with you and DoH colleagues to discuss the relevant areas. We would not be available Friday (8 March) of this week or Thursday (14 March) or Friday (15 March) next week, otherwise we are happy to meet if this would be helpful.

We will continue to support improvement work in relation to care and services delivered to patients in MAH, and as always we will keep you informed of the outcome of any future work.

Yours sincerely



Mrs Olive Macleod
Chief Executive

Cc –

Dr Lourda Geoghegan, Director of Improvement and Medical Director, RQIA
Mrs Emer Hopkins, Deputy Director, RQIA
Mrs Lynn Long, Assistant Director (Acting), RQIA
Mr Alan Guthrie, Inspector, RQIA
Mr Malachy Finnegan, Communications Manager, RQIA
Mr Sean Holland, Chief Social Work Officer DoH
Mr Fergal Bradley, Director of Safety, Quality and Standards, RQIA Sponsor Branch DoH

Exhibit 13

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

The Quality Standards for Health and Social Care

SUPPORTING GOOD GOVERNANCE AND BEST PRACTICE IN THE HPSS

March 2006

FOREWORD BY THE MINISTER

The people of Northern Ireland are entitled to the highest standards of health and social care. Having standards in place to ensure that people have the right care wherever they live in Northern Ireland is a fundamental principle of reform and modernisation of the health and social care system.

I am committed to putting patients, clients and carers first. The *Quality Standards for Health and Social Care* set out the standards that people can expect from Health and Personal Social Services (HPSS). In developing these standards, my aim is to raise the quality of services and to improve the health and social wellbeing of the people of Northern Ireland. At the heart of these standards are key service user and carer values including dignity, respect, independence, rights, choice and safety.

The standards have five key quality themes:

- Corporate leadership and accountability of organisations;
- Safe and effective care;
- Accessible, flexible and responsive services;
- Promoting, protecting and improving health and social well-being; and
- Effective communication and information.

The publication of the quality standards is an important milestone in the process of putting patients first. They will be used by the new Regulation and Quality Improvement Authority to assess the quality of care provided by the HPSS. The new Authority will be looking to see how the HPSS provide quality services and will be reporting their findings both to the Department and to the public.

Given the rapidly changing environment in which the HPSS now operates including changes arising from the Review of Public Administration, it is important that these standards do not become outdated or serve to stifle innovation. Therefore, the standards will be reviewed by the end of 2008.

SHAUN WOODWARD MP
Minister for Health, Social Services and Public Safety

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Section 1: Introduction to the Development of Standards

1.1 Introduction

Almost 95% of the population of Northern Ireland makes contact with health and social services on an annual basis. This contact may be through primary care services, community care services or through hospitals. In all of these contacts, people are entitled to the highest standards of health and social care.

This document sets out clearly for the public, service users and carers, and those responsible for the commissioning, planning, delivery, and review of services, the quality standards that the Department considers people should expect from Health and Personal Social Services (HPSS). It represents a significant step in the process of placing the needs of the service user and carer, and the wider public, at the centre of planning, delivery and review of health and social care services.

1.2 Background to the development of standards

Quality improvement is at the forefront of the development of health and social care services in Northern Ireland. These improvements are centred around five main areas, which are an integral part of modernisation and reform:

- setting of standards – to improve services and practice;
- improving governance in the HPSS - in other words, the way in which the HPSS manages its business;
- improving the regulation of the workforce, and promoting staff development through life-long learning and continuous professional development;
- changing the way HPSS organisations are held to account for the services they provide; and
- establishing a new, independent body to assess the quality of health and social care.

The consultation document “Best Practice – Best Care”, published in April 2001, sets out the detail of this framework to improve the quality of care. This included links to national standard setting bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE).

1.3 Improving governance in health and social care

The outcome of the Review of Public Administration, announced in November 2005, signalled major changes to the structure and functions of HPSS organisations. Regardless of these changes there remains a statutory duty of quality on HSS Boards and Trusts. This means that each organisation has a legal responsibility for satisfying itself that the quality of care it commissions and/or provides meets a required standard. This requirement is just as important as the responsibility to demonstrate financial regularity and propriety. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care. This process is known as *Governance*.

1.4 The setting of standards

In addition to drawing on national and professional standards, a range of local standards is being developed to enhance governance arrangements in the HPSS. These include controls assurance standards, so that by 2006-07, there will be a comprehensive set of specific assurance standards, which the HPSS can use to assess compliance against the required attainment levels. In addition, a number of care standards have been developed to facilitate the inspection and regulation of specific health and social care services provided by the HPSS and the independent sector. These care standards are specified in legislation and will be inspected, regulated and monitored by a new organisation called the Health and Personal Social Services Regulation and Improvement Authority (the Regulation and Quality Improvement Authority - RQIA).

The development of the *Quality Standards for Health and Social Care*, as outlined in this document, is intended to complement standards already issued or currently in development. Consequently, evidence of compliance with existing or new standards, such as professional standards, charter standards, controls assurance and/or care standards will form part of the evidence of practitioner or organisational commitment to these new quality standards.

1.5 What is a standard?

A standard is a level of quality against which performance can be measured. It can be described as ‘essential’- the absolute minimum to ensure safe and effective practice, or ‘developmental’, - designed to encourage and support a move to better practice. The *Quality Standards for Health and Social Care*, which are contained in this document, are classed as essential.

Given the rapidly changing environment in which the HPSS operates, it is important that standards do not become outdated or serve to stifle innovation.

To prevent this, standards need to be regularly reviewed and updated. It will be the Department's responsibility, drawing on the best evidence available, including advice, reports and/or information from the RQIA, to keep the quality standards under consideration, with a formal review being completed by the end of 2008.

1.6 Why are standards important?

Raising and maintaining the quality of services provided by the HPSS is a major objective for all involved in the planning, provision, delivery and review of health and social care services. Currently, there remains unacceptable variation in the quality of services provided, including timeliness of delivery and ease of access.

In order to improve the quality of these services, change is needed, underpinned and informed by a more cohesive approach to standards development.

Standards:

- give HPSS and other organisations a measure against which they can assess themselves and demonstrate improvement, thereby raising the quality of their services and reducing unacceptable variations in the quality of services and service provision;
- enable service users and carers to understand what quality of service they are entitled to and provide the opportunity for them to help define and shape the quality of services provided by the HPSS and others;
- provide a focus for members of the public and their elected representatives, to consider whether their money is being spent on efficient and effective services, and delivered to recognised standards;
- help to ensure implementation of the duty the HPSS has in respect of human rights and equality of opportunity for the people of Northern Ireland; and
- promote compliance, and underpin the regulation and monitoring of services to determine their quality and safety and to gauge their continuous improvement.

By promoting integration, these *Quality Standards for Health and Social Care* will contribute to the implementation of clinical and social care governance in the HPSS and will be used by HPSS and other organisations, service users and carers, the wider public and the RQIA to assess the quality of care provision.

1.7 The five quality themes

There are five quality themes on which the standards have been developed to improve the health and social well-being of the population of Northern Ireland. These themes have been identified through consultation with service users, carers and HPSS staff and through a review of standards developed elsewhere at local, national and international level.

The five quality themes are:

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

1.8 Assessing quality

The RQIA was established by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and began work on 1 April 2005. It has two main functions:

- inspection and regulation of specified health and social care services provided by the HPSS and the independent sector; and

- inspection and review of the services provided by the HPSS in Northern Ireland.

The RQIA has a general duty to encourage improvements in the quality of services commissioned and provided by HPSS and other organisations. It will promote a culture of continuous improvement and best practice through inspection and review of clinical and social care governance arrangements.

The RQIA has taken over responsibility for the registration, inspection and regulation of providers of care, for example, residential care, nursing homes and day care facilities. On a phased basis, the RQIA will assume further responsibilities over the coming years, including reporting on the quality of care provided by the HPSS. Where serious and/or persistent clinical and social care governance problems come to light, it will have a key role to play, in collaboration with other regulatory and inspectoral bodies, in the investigation of such incidents. It will report on its findings to the Department and to the public.

1.9 How will the standards be used to measure quality?

The RQIA, in conjunction with the HPSS, service users and carers, will agree how the standards will be interpreted to assess service quality. It is envisaged that specific tools will be designed to allow the RQIA to measure that quality and to assist the HPSS in assessing themselves. Once developed, not only will these tools assess HPSS structures and processes but they will also contribute to the assessment of clinical and social care outcomes.

Whilst it is for the RQIA to provide guidance on what assessment methods it will use, it is recognised that collecting the evidence to demonstrate that relevant standards have been successfully achieved may be a time consuming process for the HPSS. Therefore, information that is currently compiled on existing standards will also be able to be used to contribute to the demonstration of achievement for these standards.

The RQIA will commence reviewing clinical and social care governance within the HPSS in 2006/07, using the five themes contained within this document. RQIA will report on the quality of care provided by the HPSS following its review. This approach will promote quality improvement across organisations.

Section 2: Values and Principles Underpinning the Standards

2.1 Introduction

There are three key premises, which underpin these quality standards and are central to all aspects of planning, provision, delivery, review and improvement of the HPSS. They are that:

- people in receipt of services should be actively involved in all decisions affecting their lives and should fully contribute to any planning for, delivery and evaluation of, services;

- clinical and social care governance in the HPSS must take account of the organisational structures, functions and the manner of delivery of services currently in place. Clinical and social care governance must also apply to all services provided in community, primary, secondary and tertiary care environments;

- service users and carers should be fully valued by HPSS staff who, in turn, should be valued by service users, carers and others.

2.2 The values underpinning the Standards

The quality of a service provided is dependent on managers and HPSS staff basing their practice on the following values and principles; these complement those already outlined in the care standards for independent agencies, establishments and certain other services provided by HPSS organisations.

They are:

DIGNITY AND RESPECT	The uniqueness and intrinsic value of the individual is acknowledged and each person is treated with dignity and respect. This is applicable to service users, carers, staff and others who come in contact with services.
INDEPENDENCE	A balance between the promotion of independence and risk taking is needed. Service users have as much control as possible over their lives. Service users are informed about risk whilst being protected against unreasonable risks.
PROMOTION OF RIGHTS	In the context of services delivered to them, the individual and human rights of service users are promoted and safeguarded. Where necessary, appropriate advocacy arrangements are put in place.
EQUALITY AND DIVERSITY	Equality of opportunity and positive outcomes for service users and staff are promoted; their background and culture are valued and respected.
CHOICE AND CAPACITY	Service users are offered, wherever possible, according to assessed need and available resources, the opportunity to select independently from a range of options based on clear and accurate information, which is presented in a manner that is understood by the service user and carer.
PRIVACY	Service users have the right to be free from unnecessary intrusion into their affairs and there is a balance between the consideration of the individual's safety, the safety of others and HPSS organisational responsibilities.
EMPOWERMENT	Service users are enabled and supported to achieve their potential in health and social well-being. Staff are supported and developed to realise their ability and potential.
CONFIDENTIALITY	Information about service users and staff is managed appropriately and everyone involved in the service respects confidential matters.
SAFETY	Every effort is made to keep service users, staff and others as safe as is possible. In all aspects of treatment and care, service users are free from exploitation, neglect or abuse.

2.3 The principles underpinning the Standards

The following principles are fundamental to the development of a quality service.

PUBLIC AND SERVICE USER INVOLVEMENT	The views and experiences of service users, carers, staff and local communities are taken into account in the planning, delivery, evaluation and review of services. Service users and carers, wherever possible, are involved in, and informed about, decisions made when they seek access to or receive services during their treatment or care.
SAFETY AND EFFECTIVENESS	Systems are in place to ensure that the safety of service users, carers, staff and the wider public, as appropriate, underpin all aspects of health and social care delivery. For example, the imperative to protect children and vulnerable adults may take precedence over the specific wishes of the service user and their carers. In addition, the protection of staff may need to be balanced with the specific wishes of service users, carers, families and friends. Quality systems are in place to enable staff to play a full and active role in providing effective and efficient health and social care services for all who use these services. Staff are fully supported, regularly supervised and appropriately trained and educated, to provide safe and effective health and social care services.
ROBUST ORGANISATIONAL STRUCTURES AND PROCESSES	Robust organisational structures and processes are in place, which are regularly reviewed to promote safe and effective delivery of care. Timely information is shared and used appropriately to optimise health and social care.
QUALITY of SERVICE PROVISION	Policies, procedures and activities are in place to encourage and enable continuous quality improvement. Service developments and provision are based on sound information and knowledge of best practice, as appropriate.

Section 3: Format of the Standards

3.1 The five quality themes

The five quality themes are applicable to the whole of the HPSS, including those services, which are commissioned or provided by HPSS organisations and family practitioner services. They are underpinned by the duty of quality on HSS Boards and Trusts. Where care is commissioned outside Northern Ireland, commissioners must ensure that the quality of care is commensurate with these and other associated standards.

The five quality themes, encompassing the standards, are set out in sections four to eight of this document. These are:-

- Corporate Leadership and Accountability of Organisations (Section 4);
- Safe and Effective Care (Section 5);
- Accessible, Flexible and Responsive Services; (Section 6);
- Promoting, Protecting and Improving Health and Social Well-being (Section 7); and
- Effective Communication and Information (Section 8).

3.2 Format of the standards

Each theme has a **title**, which defines the area upon which the standard is focused. Then, a **standard statement** will explain the level of performance to be achieved. The reason why the standard is seen to be important will be covered by the **rationale**. The standard statement will then be expanded into a series of **criteria**, which will provide further detail of areas for consideration by the HPSS and by RQIA.

Section 4: Corporate Leadership and Accountability of Organisations (Theme 1)

4.1 Standard Statement

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

4.2 Rationale

The HPSS must provide effective leadership and a clear direction to make the most of its resources (people, skills, time and money), and to deliver high quality services to the public in as safe an environment as is possible. The aim is to ensure a competent, confident workforce and an organisation that is open to learning and is responsive to the needs of service users and carers. This will facilitate staff in the organisation to take individual, team and professional responsibility in order to promote safe, sustainable and high quality services. The organisation needs to maintain and further enhance public confidence.

4.3 Criteria

The organisation:

a) has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability;

b) has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance;

c) has processes in place to develop leadership at all levels including identifying potential leaders of the future;

d) actively involves service users and carers, staff and the wider public in the planning and delivery, evaluation and review of the corporate aims and objectives, and governance arrangements;

e) has processes in place to develop, prioritise, deliver and review the organisation's aims and objectives;

f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;

g) has systems in place to ensure compliance with relevant legislative requirements;

h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

i) undertakes systematic risk assessment and risk management of all areas of its work;

j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- Departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation.

k) undertakes robust pre-employment checks including:

- qualifications of staff to ensure they are suitably qualified and are registered with the appropriate professional or occupational body;
- police and Protection of Children and Vulnerable Adults checks , as necessary;
- health assessment, as necessary; and
- references.

l) has in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning, facilitate professional and regulatory requirements, and informs the organisation's training, education and workforce development;

m) has a training plan and training programmes, appropriately funded, to meet identified training and development needs which enable the organisation to comply with its statutory obligations; and

n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.

Section 5: Safe and Effective Care (Theme 2)

5.1 Standard Statement

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

5.2 Rationale

A quality service is one which is safe, effective and sustainable. Diminished standards on safety reflect a poor quality of service. The provision of health and social care is complex and will never be one hundred percent error-free. However, more can always be done to avoid injury and harm to service users, from the treatment and care that is intended to help them. This is an integral part of continuous quality improvement. Services must be delivered in a way that appropriately manages risk for service users, carers, staff, the public and visitors. Where an adverse incident has occurred or has been prevented from happening (a near miss), then systems need to be in place to assist individuals and organisations to learn from mistakes in order to prevent a reoccurrence.

It is acknowledged, however, that in some situations, living with a risk can be outweighed by the benefit of having a lifestyle that the individual really wants and values. In such circumstances, risk taking can be considered to be a positive action. Health and social care staff need to work in partnership with service users and carers to explore choices and agree on how risk can be managed and minimised for the benefit of individual service users, carers, families and communities.

The promotion of safe care must be complemented by the provision of effective care. Care should be based on the best available evidence of interventions that work and should be delivered by appropriately competent and qualified staff in partnership with the service user. Systems and processes within organisations should facilitate participation in, and implementation of, evidence-based practice.

This theme of “Safe and Effective Care” has been subdivided into three areas:

- ensuring safe practice and the appropriate management of risk;
- preventing, detecting, communicating and learning from adverse incidents and near misses; and
- promoting effective care.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

a) has effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes and appropriate interagency approaches;

b) acknowledges and promotes the central place that patients, service users and carers have in the prevention and detection of adverse incidents and near misses;

c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

d) promotes effective interagency working in relation to raising awareness of the risk factors associated with abuse, including domestic violence and in the promotion of effective interagency responses;

e) has a safety policy in place which takes account of the needs of service users, carers and staff, the public and the environment; and

f) has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure:

- efficacy and comparability of outcomes in health and social care;
- compliance with professional and other codes of practice;
- effective and efficient procedures for obtaining informed consent for examination, treatment and/or care;
- accurate, timely and consistent recording of care given or services provided and associated outcomes;
- protection of health, welfare and safety of staff;
- awareness raising and staff knowledge of reporting arrangements for adverse incidents and near misses, and whistleblowing arrangements when poor performance and/or unsafe practice in examination, treatment or care comes to light;
- there is choice where food and/or fluid is provided, which reflects cultural and spiritual preferences and that procedures are in place to promote the safe handling of food and a healthy diet;

- safe practice in the selection, procurement, prescription, supply, dispensing, storage and administration of medicines across the spectrum of care and support provided, which complies with current medicines legislation;

- promotion of safe practice in the use of medicines and products, particularly in areas of high risk, for example:

    - intrathecal chemotherapy;
    - blood and blood products;
    - intravenous fluid management;
    - methotrexate;
    - potassium chloride; and
    - anticoagulant therapy.

- risk assessment and risk management in relation to the acquisition and maintenance of medical devices and equipment, and aids and appliances across the spectrum of care and support provided;

- promotion of general hygiene standards, and prevention, control and reduction in the incidence of healthcare acquired infection and other communicable diseases;

- appropriate decontamination of reusable medical devices;

- safe and effective handling, transport and disposal of waste, recognising the need to promote the safety of service users and carers, staff and the wider public, and to protect the environment;

- interventional procedures and/or any new methods undertaken by staff are supported by evidence of safety and efficacy;

- address recommendations contained in RQIA reports (when available), service and case management reviews; and

- participation in and implementation of recommendations contained in local or national enquiries, where appropriate, e.g. National Confidential Enquiries.

5.3.2 Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses

The organisation:

a) has systems and processes in place to prevent, identify, assess and manage and review adverse incidents and near misses across the spectrum of care and support provided;

b) promotes an open and fair culture, rather than one of blame and shame, to encourage the timely reporting and learning from adverse incidents and near misses;

c) has reporting systems in place to collate, analyse and learn from all adverse incidents, and near misses, share knowledge and prevent reoccurrence of adverse incident or near miss; and

d) has systems in place that promote ongoing communication with service users and carers when treatment or care goes wrong, and puts in place an individual care plan to minimise injury or harm.

5.3.3 Promoting Effective Care

The organisation:

a) provides relevant, accessible, information to support and enhance service user and carer involvement in self-management of their health and social care needs;

b) promotes a person-centred approach and actively involves service users and carers in the development, implementation, audit and review of care plans and care pathways;

c) promotes a culture of learning to enable staff to enhance and maintain their knowledge and skills;

d) ensures that clinical and social care interventions are carried out under appropriate supervision and leadership, and by appropriately qualified and trained staff, who have access to appropriate support systems;

e) uses recognised clinical and social care standards and outcomes as a means of measuring health and social care quality;

f) promotes the implementation of evidence based practice through use of recognised standards and guidelines including guidance from the Department, NICE, SCIE and the National Patient Safety Agency (NPSA);

g) has in place systems to promote active participation of staff in evidence based practice, research, evaluation and audit;

h) has systems in place to prioritise, conduct and act upon the findings of clinical and social care audit and to disseminate learning across the organisation and the HPSS, as appropriate;

i) provides regular reports to the organisation's executive and non-executive board directors on clinical and social care governance arrangements and continuous improvement in the organisation; and

j) promotes the involvement of service users and carers in clinical and social care audit activity.

Section 6: Accessible, Flexible and Responsive Services (Theme 3)

6.1 Standard Statement

Services are sustainable, and are flexibly designed to best meet the needs of the local population. These services are delivered in a responsive way, which is sensitive to individual's assessed needs and preferences, and takes account of the availability of resources.

Each organisation strives to continuously improve on the services it provides and/or commissions.

6.2 Rationale

To meet the needs of local communities and to narrow inequalities in health and social well-being, services should take account of the current and anticipated needs of the local community. Service users, carers, front line staff and the wider public should be meaningfully engaged in all stages of the service planning and decision-making cycle. Assessment of need should be undertaken in partnership with the statutory, voluntary, private and community sectors. This should be informed by the collation and analysis of information about the current health and social well-being status of the local population, unmet need, legislative requirements, and evidence of best practice and review of current service provision. Service planning should also take account of local and regional priorities and the availability of resources.

In order to promote systematic approaches to the development of responsive, flexible and accessible services for the local population and for individuals, this theme has been sub-divided into two main areas:

- service planning processes; and
- service delivery for individuals, carers and relatives.

6.3 Criteria

6.3.1 Service Planning Processes

The organisation:

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

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

c) promotes service design and provision which incorporates and is informed by:

- information about the health and social well-being status of the local population and an assessment of likely future needs;
- evidence of best practice and care, based on research findings, scientific knowledge, and evaluation of experience;
- principles of inclusion, equality and the promotion of good relations;
- risk assessment and an analysis of current service provision and outcomes in relation to meeting assessed needs;
- current and/or pending legislative and regulatory requirements;
- resource availability; and
- opportunities for partnership working across the community, voluntary, private and statutory sectors.

d) has service planning and decision-making processes across all service user groups, which take account of local and/or regional priorities;

e) has standards for the commissioning of services which are readily understood and are available to the public; and

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

6.3.2 Service Delivery for Individuals, Carers and Relatives

The organisation:

a) ensures that all service users, carers and relatives are treated with dignity and respect and that their privacy is protected and promoted, including, where appropriate, the use of advocates and facilitators;

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

c) ensures that information, where appropriate, is provided in a number of formats, which may include, large print, audio format on tape or compact disc, computer readable format, Braille, etc. and is:

- written in easy to understand, non-technical language;
- laid out simply and clearly;
- reproduced in a clear typeface;
- available on the internet; and
- in the preferred language of the reader, as necessary;

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

e) ensures that individual service user information is used for the purpose for which it was collected, and that such information is treated confidentially;

f) promotes multi-disciplinary team work and integrated assessment processes, which minimise the need for service users and carers to repeat basic information to a range of staff; and

g) provides the opportunity for service users and carers to provide comment on service delivery.

Section 7: Promoting, Protecting and Improving Health and Social Well-being (Theme 4)

7.1 Standard Statement

The HPSS works in partnership with service users and carers, the wider public and with local and regional organisations to promote, protect and improve health and social well-being, and to tackle inequalities within and between geographic areas, socio-economic and minority groups, taking account of equality and human rights legislation.

7.2 Rationale

Individuals, families and carers have a major part to play in their own and their dependents' health and social well-being. Although many factors influence the health and social well-being of individuals, many of these factors are societal issues and are outside the control of individuals. Examples include poverty, social exclusion, poor education, unemployment, crime, and poor housing. Resolving these issues requires a broad-based approach and concerted action by a wide range of people and agencies including the statutory, voluntary, community and business sectors. The HPSS, working in partnership with these other agencies and community groups, should actively seek to influence and support better decision-making, and establish systems to promote and improve the health and social well-being of the public and to reduce inequalities. The goal is to improve the health and social well-being of the population of Northern Ireland, by increasing the length of their lives, improving the quality of life through increasing the number of years spent free from disease, illness, or disability, and by providing better opportunities for children and support for families.

7.3 Criteria

The organisation:

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

b) actively involves the services users and carers, the wider public, HPSS staff and the community and voluntary sectors, in the planning and development of local solutions to improve health and social well-being and to reduce inequalities;

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

d) actively pursues equality screening and, where appropriate, equality impact assessment in compliance with section 75 of the Northern Ireland Act 1998;

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

f) collects, collates, develops and uses health and social care information to assess current and future needs of local populations, taking account of health and social well-being inequalities;

g) has effective and efficient emergency planning processes and co-ordinated response action plans in place, as appropriate, to deal with major incidents or emergency situations and their aftermath. The planning processes and action plans are compliant with Departmental guidance;

h) has processes to engage with other organisations to reduce local environmental health hazards, as appropriate;

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

j) has systems to promote a healthier, safer, and “family friendly” workforce by providing advice, training, support and, as appropriate, services to support staff;

k) has quality assured screening and immunisation programmes in place, as appropriate, and promotes active uptake among service users, carers and the public;

l) uses annual public health and social care reports in the development of priorities and planning the provision and delivery of services; and

m) provides opportunities for the use of volunteers, as appropriate.

Section 8: Effective Communication and Information (Theme 5)

8.1 Standard Statement

The HPSS communicates and manages information effectively, to meet the needs of the public, service users and carers, the organisation and its staff, partner organisations and other agencies.

8.2 Rationale

Good communication and effective use of information are the basis for decision-making by individuals, the public and organisations. They ensure that all relevant facts are collated and used to inform treatment and care, and the assessment, planning, service delivery and resource allocation processes. For information to be useful, it needs to be in an understandable format, accessible to those who need it and readily available. The communication and information management processes within an organisation must take account of the needs of service users and carers, staff and the public and the media, and any legislative or regulatory requirements. Protecting personal information and confidentiality are important to ensure that information is appropriately communicated to those who need to know and effectively used to inform any decisions made. The HPSS should be sensitive to the range of information needs required to support individuals, communities and the organisation itself.

8.3 Criteria

The organisation has:

a) active participation of service users and carers and the wider public. This includes feedback mechanisms appropriate to the needs of individual service users and the public;

b) an effective information strategy and communication strategy, appropriate to the needs of the public, service users and carers, staff and the size, functions and complexity of the organisation;

c) an effective and integrated information technology and information systems which support and enhance the quality and safety of care and provision of services;

d) system(s) and process(es) in place to ensure that urgent communications, safety alerts and notices, standards and good practice guidance are made available in a timely manner to relevant staff and partner organisations; these are monitored to ensure effectiveness;

e) clear communication principles for staff and service users, which include:

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

f) clear information principles for staff and service users, which include:

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

g) the organisation has effective training for staff on how to communicate with service users and carers and, where needed, the public and the media;

h) effective records management policies and procedures covering access and the completion, use, storage, retrieval and safe disposal of records, which it monitors to assure compliance and takes account of Freedom of Information legislation;

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

j) effective and efficient procedures for obtaining valid consent for examination, treatment and/or care;

k) an effective complaints and representation procedure and feedback arrangements, which is made available to service users, carers and staff and which is used to inform and improve care, treatment and service delivery; and

l) a range of published up-to-date information about services, conditions, treatment, care and support options available, and how to access them both in and out of service hours, which are subject to regular audit and review.

APPENDIX 1

GLOSSARY OF TERMS

Adverse incident	Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.
Carer	Carers are people who, without payment, provide help and support to a family member or friend who may not be able to manage at home without this help because of frailty, illness or disability.
Care plan	The outcome of an assessment. A description of what an individual needs and how these needs will be met.
Care Standards	Care Standards are service specific standards currently being developed. They will cover a range of services provided by public, voluntary and private organisations such as nursing homes, residential homes, independent clinics etc.
Clinical and Social Care Governance	A framework within which HPSS is accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.
Community care	Health and social services aimed at supporting individuals to remain safely in their own homes for as long as possible.
Community development	Consultation with, and involvement of local communities and groups in improving health and social well-being of the community.
Controls Assurance Standards	These standards focus on key areas of potential risk and help HPSS organisations demonstrate that they are doing their reasonable best to manage themselves and protect stakeholders from risk. They support effective governance.
Equality impact assessment	Consideration of a policy having regard to its impact on and the need to promote equality of opportunity between: persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation, men and women generally, persons with a disability and persons without and between persons with dependants and persons without.
Evidence based practice	Provision of services which are based on best practice as proven by research findings, scientific knowledge and evaluation of experience.
Family Practitioner Services (FPS)	The principal primary care services i.e. family doctors, opticians, dentists and pharmacists.
HPSS (Health and Personal Social Services)	An organisation which either commissions or provides health and social services, e.g. HSS Boards, Strategic Health and Social Care Authority, a Trust providing hospital and community services, a local commissioning body, and Family Practitioner Services.

NPSA	The National Patient Safety Agency promotes safe practice in clinical care and supports the development of solutions and the cascade of learning to reduce areas of high risk.
Person-centred assessment	An assessment, which places the individual at the centre of the process and which responds flexibly and sensitively to his/her needs.
Primary care	The many forms of health and social care and/or treatment accessed through a first point of contact provided outside hospitals e.g. family doctors, pharmacists, nurses, allied health professionals (physiotherapists, psychologists, dieticians etc) social workers, care assistants, dentists, opticians and so on.
Secondary care	Specialist services usually provided in an acute hospital setting following referral from a primary or community healthcare professional.
Statutory duty	A legal responsibility.
Statutory sector	Government-funded organisations e.g. HSS Boards, Strategic Health and Social Services Authority, Trusts, Special Agencies and Local Commissioning Groups.
Tertiary care	Highly specialised services usually provided in an acute hospital setting by medical and other staff with expertise in a particular medical specialty.

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Produced by:
Department of Health, Social Services and Public Safety,
Castle Buildings, Belfast BT4 3SQ

Telephone (028) 9052 8332

Textphone (028) 9052 7668

www.dhsspsni.gov.uk

March 2006

Ref: 223/06

Exhibit 14

Belfast Health and Social Care Trust
caring supporting improving together

Chief Executive
Mr Martin Dillon

Chairman
Mr Peter McNaney, CBE

Our ref: MD/amu

8 March 2019

Mr Richard Pengelly
Permanent Secretary/HSC Chief Executive
Department of Health
Room C5.11
Castle Buildings
Stormont
BELFAST
BT4 3SQ

Dear Richard

Re: Muckamore Abbey Hospital (MAH) Action Plan Update

Further to RQIA's Unannounced Inspection undertaken at MAH last week and their letter to me on 5 March 2019 and their subsequent Article 4 letter, dated 6 March 2019, to the Chief Medical Officer, I am writing to update you on the ongoing improvement work around the following:

1. Governance, Inter Trust working, and the appointment of an independent expert 'critical friend'.

2. The collective action being taken by the Belfast, Northern and South Eastern Trusts to ensure that care provided to the current patients in Muckamore Abbey Hospital is safe, effective and compassionately delivered by sufficient and appropriately trained staff.

3. The action being taken by all three Trusts to move on discharge planning for patients in Muckamore Abbey Hospital who no longer require hospital care and treatment.

I will also write under separate cover to provide a full update on the arrangements being made to speedily conclude the viewing of the historical CCTV footage (it is now in the possession of the PSNI) and on the action being taken by the Trust in relation to progressing of the investigation process into the alleged abuse of patients by staff.

Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100,** www.belfasttrust.hscni.net

However, before setting out the 3 updates referred to above I want to provide an update on the Trust's meeting with RQIA on the 7 March 2019 to discuss matters arising from RQIA's Unannounced Inspection of Muckamore Abbey Hospital last week. During the meeting the Trust provided RQIA with further substantial information, evidence, and assurance in response to their findings that emerged from the inspection. In attendance at the meeting were Director colleagues from Northern, South Eastern and Belfast Trust as well as myself. This permitted us to evidence the joint 'task force' working ongoing to stabilise the hospital with particular reference to the collective effort being made to ensure safe and resilient staffing levels. Set out below is a summary of the substance of the responses provided to RQIA yesterday under the headings set out in their letter of the 6 March to the Chief Medical Officer.

(a) Staffing and Staff Morale

The Trust provided detailed information on the arrangements to ensure that the wards at MAH are safely staffed at all times to meet the needs of patients. These include effective staff planning measures, appropriate escalation arrangements, the use of bank and agency staff and the daily monitoring of staffing levels by the lead nurses, the service manager and oversight by the Deputy Director of Nursing. With regard to staff care and the bolstering of morale the Trust referenced the range of support being provided to the staff. The Trust acknowledged that staff morale would likely continue to be impacted until the outstanding CCTV viewing was complete. The Trust also undertook to take immediate action to work with ward sisters/charge nurses to bolster confidence in relation to personal interventions and MAPA holds.

(b) Patient physical healthcare needs

The Trust advised RQIA that a locum consultant physician has been identified and two band 5 nurses are being appointed to ensure that patients' health care needs are fully assessed within the next month. This will include appropriate health screening for age and gender.

(c) Financial Governance

The Trust advised RQIA that BSO Internal Audit had conducted a robust audit in 2015/16 and had expressed a satisfactory Audit opinion. The Trust further advised that all appropriate referrals to the Office of Care and Protection have now been made.

(d) Review of adult safeguarding

The three Trusts emphasised the need for a review of Adult Safeguarding Policy. The Trust advised that it was moving to quickly improve processes so that incidents are addressed by the multi-disciplinary team to determine the best action and outcome for the individuals concerned.

Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

(e) Restrictive Practices

The Trust informed RQIA that the Restrictive Practice Policy has been redrafted to reflect the Royal College of Psychiatry guidance. This will be shared with families, staff and other stakeholders in the next few weeks.

Given the closure of PICU the use of alternative de-escalation facilities is under review. Input from the advice from the independent expert is vital in moving this forward.

(f) Hospital Governance

As RQIA has acknowledged arrangements have been implemented to strengthen governance and appropriately manage risk across the hospital using a weekly governance meeting and using a set of core safety metrics including use of seclusion, staffing levels etc. The Trust recognised that this commenced in 2019 and will time to embed. The daily presence of the Director on site will further strengthen this as will the ongoing implementation and rollout of a daily safety huddle. The appointment of an independent expert will refine this and the Trust is confident that this will further ensure safe, effective and compassionate care.

(g) Regional action/discharge relocation planning

All three Trusts confirmed their commitment to move on discharge planning for those patients with delayed discharges. Furthermore it was advised monthly meetings take place with Assistant Directors and Directors from South Eastern Trust and Northern Trust to facilitate delayed discharge and all Trusts have well developed plans in place for implementation in the coming year.

We also have developed a service model for the prevention of admission and the provision of intensive support including home treatment with all Directors of Learning Disability. The IPT is being developed, currently support by the HSCB.

We also undertook to ensure ward staff are fully aware of patient discharge plans.

A copy of our preliminary QIP in response to RQIA's findings is attached to this letter.

I will now cover the three key areas on the ongoing improvement work.

1. Governance, Inter Trust working, and the appointment of an independent expert 'critical friend'

In the past week, I have freed Mrs Marie Heaney, Director of Adult, Social and Primary Care from most of her Director portfolio to allow her to focus exclusively on stabilising the hospital and to ensure care is safe, effective and compassionate.

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Marie has enlisted Director colleagues from Northern and South Eastern Trusts to come alongside her to work collectively and collegiately in pursuit of this agenda given that MAH provides a Regional Service and that Trusts and the HSCB need to work together to bring about the required improvements in the models of care. These collective actions include those aimed at ensuring safe staffing levels and their on-going resilience. Dr Cathy Jack, in her role as Deputy Chief Executive, will chair an Assurance Group that will report to Executive team and Trust Board. It will monitor progress with the various action plans and will direct corrective action if required. Colleagues from other Trusts will be in attendance at these fortnightly Assurance meetings. We are also sourcing an independent expert from East London NHS Foundation Trust - a CQC exemplar Trust with Intellectual Disability Services - to sit on the Assurance Group (Dr Ian Hall has been identified).

2. The collective action being taken by the Belfast, Northern and South Eastern Trusts to ensure that care provided to the current patients in Muckamore Abbey Hospital is safe, effective and compassionately delivered by sufficient and appropriately trained staff

The key actions being pursued in ensuring care is set out below assuring care is safe.

Safe Staffing Levels

To ensure the wards are safely staffed on an ongoing basis rosters are planned in a timely and effective manner for all wards ensuring the correct skill mix and number of staff allocated per shift meet patient needs. The ward sisters or nurse in charge are fully aware how to escalate any changes in staffing needs to the lead nurse or on call nurse manager out of hours. Ward sisters will ensure the effective use of the E-roster system to support this. The use of bank and agency support assistants and nursing staff is currently augmenting ward staffing; we have 26WTE bank and permanent agency staff currently deployed across MAH wards to ensure consistent and effective cover. The daily monitoring of nurse staffing levels by lead nurses and the service manager, is overseen by the Deputy Director of Nursing who for additional assurance, is currently based in MAH. There is fortnightly reporting to the Trusts Director Oversight Group in respect of nursing staff utilisation and immediate escalation as required out with this process.

We are also working collaboratively with both NHSCT and SEHSCT to support nurse staffing with a number of their staff providing cover at present. There are plans in place to develop a more regular arrangement, some of which include asking staff to temporarily relocate to MAH, the details of which is in development. This is particularly important in the development of robust contingency arrangements should further staff suspensions be required or if additional staff take sickness leave.

All Trusts have ongoing recruitment and with approximately 11% nurse vacancies across the Province, this is a challenge for all Trusts. We have ongoing recruitment and retention strategies within Belfast Trust and collectively with sister Trusts, particularly Northern and South Eastern Trusts.

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Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

There will also be further development of the role of AHPs and behavioural specialist staff to support meaningful activities for patients.

The workforce team have designed an interim nursing workforce model using Telford, which has been shared with the PHA for consideration. A review of staffing needs for patients who are considered ready for discharge is being undertaken in line with a social care model with a view to preparing these patients for discharge. This is a new concept for the care of these patients, which will require regional consideration and discussion.

We will continue to work with the HSCB's Delivering Care Group to design normative staffing levels for Learning Disability once this work commences.

Safe Use of Seclusion

The Trust has redrafted the Restrictive Practice Policy to reflect Royal College of Psychiatry guidance. This will be shared with families, staff and other stakeholders in the next few weeks.

Use of seclusion is reviewed weekly for each patient by the multi-disciplinary team and planning identified and incorporated into the care plan. Given the closure of PICU the use of alternative de-escalation facilities is under review and the input from our independent expert is vital in moving this forward.

Safe Ongoing Monitoring for Safety

(a) Contemporaneous CCTV viewing

Contemporaneous CCTV viewing is occurring on a weekly basis over a range of shifts randomly selected. Since this commenced there have been no adult safeguarding issues raised and a number of good practices have been observed (see attached February report)

(b) Weekly Live Governance meeting led by the Director

The weekly live governance meeting has been implemented and is being developed to include all five aspects of the Charles Vincent measurement and monitoring for safety. This bundle of safety metrics both at a ward and site level include for example; episodes of seclusion; staffing levels; leadership walk rounds and contemporaneous CCTV viewing.

Safe Physical Healthcare

A process to ensure all physical health checks including screening for diabetes, hypertension and cholesterol will be completed in the next 4 weeks for all inpatients

Key Actions to Assuring Care is Effective

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Effective Safeguarding

We recognise that the current model of Adult Safeguarding practice within the hospital needs to change. This was highlighted in the SAI Review Report "A Way to Go" (November 2018). We have hosted a workshop facilitated by Margaret Flynn on the 18 February 2019 and are now in the process of developing a practice development programme.

Key Actions to Assuring Care is Compassionate

Compassionate Care of Patients

As part of the SAI action plan we have several initiatives in place to improve the lived experience of people who are currently living in Muckamore Abbey Hospital.

These include the review of day care and the implementation of "My Activity Plan" for all patients. We have decommissioned the current advocacy model and are co-producing a new advocacy model with families.

We plan to further develop meaningful involvement with families and carers with individual meetings with all families having already happened. We have appointed a dedicated carer consultant and who will develop an agreed model of family oversight and involvement in the care provided by the hospital.

Work has been undertaken to remove barriers to improve access to healthcare screening including Action Cancer to undertake breast screening. We are also in the process of implementing Happy Faces systems for patients in Muckamore Abbey to help them express their experience in real time.

Compassionate Care of Staff

It is acknowledged that in the current context of ongoing analysis of historic CCTV footage, a live disciplinary, and a PSNI investigation it is difficult to make significant impact on staff morale however a range of measures are in place with more planned. Key support include:

- Full time counsellor in place
- Occupational health clinic available on site
- A Keeping in touch system for absent staff
- Development of psychological services strategy
- Roll out of face to face stress assessment tool
- Establishment of alternative well-being measures
- Ongoing MAPA training which incorporates the use of videoing to capture best practice.

Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

3. **The action being taken by all three Trusts to move on discharge planning for patients in Muckamore Abbey Hospital who no longer require hospital care and treatment**

We have undertaken a comprehensive review of all patients whose discharges are delayed. We have undertaken comprehensive review of all patients whose discharge is delayed. We have successfully discharged 27 patients last year and this has significantly reduced the number of patients remaining in hospital.

Complex discharge plans are in place for all Belfast Trust patients, which have been developed in collaboration with wards, families, housing, and support providers.

Belfast Trust has refurbished 9 dwellings at Oldstone, Antrim, renamed Cherry Hill, and the recruitment of staff is underway. This will allow the discharge of a further 9 patients. Regular discussion is ongoing with RQIA in respect of registration and timescales for occupancy.

There have also been discussions with key providers and strategic meetings held with:-

- Autism Initiatives
- PRAXIS
- Positive Futures
- Housing Executive (SPT)

A comprehensive Action Plan addressing points 1, 2 and 3 above is appended.

Belfast Trust fully accepts the gravity and complexity of this situation and in order to achieve the best possible outcomes for patients we would ask for your help and support from the Department of Health in the following ways:

(1) Ongoing support from the Departmental policy leads in delivering this challenging agenda.

(2) We would welcome the Department's endorsement and agreement to secure an independent expert from East London NHS Foundation Trust.

(3) We would also be grateful if the Department would invite Mr Joe Rafferty, Chief Executive of Mersey Care NHS Foundation Trust could be asked to send a small team of experts around reducing seclusion over to visit MAH and work with the clinical teams.

(4) Support for any business case arising from the new models of care across all professions. We would also value your support for the development of new models of care across all professions.

Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

(5) Similar assistance (which the Trust deeply appreciates) to that provided in relation to the neurology recall. This to include the organising and handling of such MLA and other stakeholder briefings required.

(6) Help and support around media and other external messaging.

I trust you find the collective approach being taken to stabilise the hospital, ensure safe, effective and compassionate care and the other action plans to be satisfactory.

If you require any further information or clarification please do not hesitate to contact me.

Yours sincerely

Martin Dillon
Chief Executive

Encs

Copy

Mr Peter McNaney, Chairman, Belfast Trust
Dr Michael McBride, Chief Medical Officer, DoH (RQIA Sponsor)
Mr Sean Holland, Chief Social Worker, DoH
Prof Charlotte McArdle, Chief Nursing Officer, DoH
Mrs Olive MacLeod, Chief Executive, RQIA
Mr Oscar Donnelly, Divisional Director Mental Health, Learning Disability and Community Well-being, Northern Trust
Ms Bria Mongan, Director of Adult Services South Eastern Trust

Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

Exhibit 15

From:	Paulina Spychalska
To:	Woods, Paddy
Cc:	McBride, Michael; Carson, Jane; "rqia.reports@health-ni.gov.uk"; Bradley, Fergal; Holland, Sean; Olive Macleod; Lourda Geoghegan; Emer Hopkins; Lynn Long; Alan Guthrie; Dawson, Jerome; Gordon, Lesley
Subject:	RQIA Art 4 Letter: Muckamore Abbey Hospital
Date:	14 March 2019 16:57:40
Attachments:	Article4_DoH_Letter_MAH_LG_14.03.19.pdf

"This email is covered by the disclaimer found at the end of the message."

Good afternoon Dr Woods

Please find attached for your attention an Article 4 letter form Dr Lourda Geoghegan, Covering Chief Executive/ Medical Director & Director of Improvement, Regulation and Quality Improvement Authority, in relation to Muckamore Abbey Hospital.

Kind Regards
Paulina

Paulina Spychalska
Admin Team Supervisor
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Tel: 028 9536 1949 (direct line)
Email: Paulina.Spychalska@rqia.org.uk
Web: www.rqia.org.uk
Twitter: @RQIANews

Assurance, Challenge and Improvement in Health and Social Care

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The Regulation and Quality Improvement Authority

Assurance, Challenge and Improvement in Health and Social Care

Our ref: 020426/IN033250

14 March 2019

Private and Confidential

Dr Paddy Woods
Deputy Chief Medical Officer
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Dear ~~Dr Woods~~ Paddy

I write in Dr McBride's absence and in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to update you on serious concerns identified by the Regulation and Quality Improvement Authority (RQIA) in relation to care, treatment and services as provided for patients in Muckamore Abbey Hospital (MAH).

This correspondence follows RQIA's unannounced inspection to MAH from 26 to 28 February 2019 inclusive, and our earlier correspondence to DoH in which we outlined six areas of serious concern which emerged during our inspection (6 March 2019).

You will be aware that we held an 'Intention to Serve Improvement Notices' meeting with Belfast HSC Trust on 7 March 2019. During that meeting Belfast Trust colleagues were provided with an opportunity to outline and discuss evidence/information relating to each of the six areas of concern identified. We subsequently received correspondence from the Trust's Chief Executive (8 March 2019) which set out in detail the work Belfast Trust is progressing in relation to improving care and treatment of patients currently in MAH. The Trust also forwarded a written outline of their response to feedback from our unannounced inspection and a copy of MAH Inter-Trust Safe Compassionate and Effective care Action Plan 2018/19, both documents setting out a range of actions currently in progress and/or planned for MAH.

After thorough consideration of Belfast Trust's representation at our meeting on 7 March 2019 and of the additional information provided by the Trust to RQIA, determinations have now been made in relation to each of the six areas of serious concern identified. I attach a detailed outline of our assessment of each of these areas and our determination in relation to each, as also advised to Belfast Trust's Chief Executive today (see Annexe 1).

9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

tel: 028 9536 1111
email: info@rqia.org.uk
web: www.rqia.org.uk
twitter: @RQIANews

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You will note that we have determined not to serve Improvement Notices to Belfast Trust at this point in time. You will also note that we have advised the Trust we will continue to closely monitor each of the six areas of concern and the quality of care and treatment delivered to patients in MAH. We will seek evidence of improvement resulting from the actions/measures Belfast Trust is now progressing either as the main provider of care in MAH and/or in conjunction with other providers, in particular with Northern and South-Eastern HSC Trusts.

In our correspondence of 6 March 2019, we recommended that DoH agrees and implements a special measure for Belfast HSC Trust in relation to MAH. Our assessment is that the above recommendation remains valid. The special measure we recommended is the establishment of two taskforces –

(i) *a taskforce to stabilise the hospital site, in support of patients currently receiving care and staff delivering that care in MAH* – Belfast Trust has refreshed its arrangements for oversight and governance of MAH (per Annexe 1) including securing active input from colleagues in Northern and South-Eastern Trusts (whom MAH also serves) and securing national expert advice and assistance from two NHS Foundation Trusts (East London and Mersey Care) – this work and these actions collectively could now be aligned under the auspices of one taskforce focusing on MAH site delivery;

(ii) *a taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community* – given the scale and complexity of work to be progressed in the coming months and to ensure delivery of the Permanent Secretary's commitment to family members of patients/residents in MAH (that the resettlement process will be completed by end of 2019) we would highlight the pressing need for focus and momentum in relation to resettlement work – this work is likely to require expertise and input from staff not only within DOH and HSC but from across other government departments and the public and independent sectors in Northern Ireland.

As previously advised, this recommendation is made with a view to supporting Belfast Trust (and the two other HSC Trusts served by MAH), to improving the care and treatment of patients currently in MAH, to ensuring appropriate governance systems/arrangements are in place, and to effecting appropriate planning for patients who have completed their active assessment/treatment and who will relocate out of MAH to accommodation in the community over the coming months.

You may wish to receive a more detailed update on the key themes emerging from our unannounced inspection to MAH and our work to date with Belfast Trust to address the serious concerns identified. To this end Mrs Olive Macleod and I will be happy to meet with you and DoH colleagues to discuss the relevant matters. Mrs Macleod is on leave today and tomorrow (14 and 15 March 2019) and I will be on leave for most of next week (w/c 18 March 2019). Otherwise we will be happy to review availability to meet during w/c 25 March 2019.

We will continue to support improvement work in relation to care and services delivered to patients in MAH, and as always we will keep you informed of the outcome of any future work.

Yours sincerely

Dr Lourda Geoghegan
Covering Chief Executive
Medical Director & Director of Improvement

Cc –

Mrs Olive Macleod, Chief Executive, RQIA
Mrs Emer Hopkins, Deputy Director, RQIA
Mrs Lynn Long, Assistant Director, RQIA
Mr Alan Guthrie, Inspector, RQIA
Dr Michael McBride, Chief Medical Officer, DoH
Mr Sean Holland, Chief Social Work Officer DoH
Mr Fergal Bradley, Director of Safety, Quality and Standards, RQIA Sponsor Branch DoH
Mr Jerome Dawson, Acting Director Mental Health, Disability and Older People DoH

Enc

Annexe 1 – RQIA Determination in Relation to Areas of Serious Concern as Advised to Belfast HSC Trust on Thursday 14 March 2019

1. **Staffing**: *RQIA found evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to appropriately manage patients' physical health care needs and to implement and execute appropriate therapeutic care plans for patients.*

   (a) Belfast Trust has provided new information indicating that seven additional nursing professionals (learning disability) have been recruited and are commencing employment this week in MAH (w/c 11 March 2019).

   (b) Belfast Trust management has provided a robust assurance that ward staffing levels will be appropriate to ensure all patients will have their prescribed level of observations completed.

   (c) Belfast Trust management has confirmed that daily physical checks of ward staffing levels will be undertaken, clear escalation arrangements will be implemented and assured, and that the hospital's e-rostering system will be used to effectively deploy and monitor staffing levels.

   (d) Belfast Trust has sought co-operation and staff resources from other Trusts, specifically Northern Health and Social Care Trust (Northern Trust) and South Eastern Health and Social Care Trust (South Eastern Trust), to assist with providing adequate nursing cover for wards in the hospital. Representatives from Northern Trust and South Eastern Trust have confirmed their commitment to assisting Belfast Trust in this regard.

   (e) Belfast Trust has advised that improvement work has commenced to further develop the role of Allied Health Professionals and specialist behavioural nurses, to support meaningful activities for patients/residents in MAH.

RQIA remains concerned at the large number of vacancies that exist currently in the hospital, which greatly exceeds the number of additional staff recently recruited. RQIA would also highlight that the monitoring and escalation arrangements in relation to staff shortages, described as in place prior to our unannounced inspection, did not accurately identify the impact of these shortages on the care and treatment experienced by patients on some wards.

It is determined that collectively the above described actions/measures are a constructive response, which will improve the capacity of frontline staff and Trust management to immediately deliver safe and effective care to patients in MAH.

Determination - an Improvement Notice in relation to Staffing will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

2. **Patients' physical health care needs**: *Evidence of an appropriate system to ensure that patient's physical health care needs were addressed was lacking. Patients did not have their physical health appropriately monitored, did not access health screening appropriate to gender and/or age, and did not have appropriate access to primary care services. Additionally, some patients prescribed antipsychotic medications did not experience appropriate monitoring of related parameters of physical health.*

   (a) Belfast Trust has advised of the imminent appointment of two medical physicians (staff grade doctors) and two nursing professionals to MAH, who will undertake the required work to ensure a plan is in place for each patient in respect of their physical healthcare needs, this work to be complete within four weeks.

   (b) Belfast Trust has confirmed that an alert has been issued to all medical and senior nursing staff in MAH regarding monitoring of patients in receipt of antipsychotic medication (per protocol), medical consultant staff have confirmed that monitoring is now in place, and an audit is planned for w/c 11 March 2019 and results will be shared with RQIA in due course.

   (c) Belfast Trust has recognised and acknowledges that, moving forward, all specialist nursing staff (learning disability) will need to understand and oversee management of the physical healthcare needs of patients receiving care in MAH.

It is determined that the above described actions measures are a constructive response which will improve the quality of provision in respect of the physical healthcare needs of patients currently in MAH.

Determination - an Improvement Notice in relation to Physical Healthcare Needs will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

3. **Financial governance**: *Concerns were identified in relation to a failure to refer patients appropriately to the Office of Care and Protection, non-completion of patient property records and variation in completion of ledgers at ward level. There was also an apparent omission to make a safeguarding referral in the context of financial arrangements for one detained patient.*

(a) Belfast Trust has confirmed that outstanding referrals to the Office of Care and Protection have been made (referrals relate to seven patients).

(b) Belfast Trust has confirmed that the outstanding safeguarding referral (as referred above) has now been made.

(c) Belfast Trust has confirmed it will review its Patient Finances and Private Property Policy and will undertake an audit of its activity to assure appropriate implementation of this policy.

(d) Belfast Trust will undertake an audit of compliance with financial procedures across all wards to assure appropriate implementation of financial governance throughout the hospital.

RQIA notes the Trust's feedback in relation to the most recent internal audit assessment/report on patients' finances in MHLD (2015/16), which provided a satisfactory opinion. However, we would highlight that this opinion is now some three years old and the Trust requires appropriate assurance that arrangements relating to financial governance are sufficiently robust.
It is determined that the above described actions/measures are a constructive response which will improve the oversight and management of patient property and finances across the hospital site.

Determination - an Improvement Notice in relation to Financial Governance will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

4. **Safeguarding practices**: *Our inspection team did not find evidence of effective deployment of safeguarding referrals, the team did not find evidence of the implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A structural disconnect between professional staff was also evident within the current safeguarding arrangements.*

(a) Belfast Trust has provided a firm commitment that following any potential safeguarding incident or allegation a multidisciplinary risk assessment will be completed to determine the best action and outcome for the patient(s) and staff member(s) in question.

(b) Belfast Trust recognises that work is needed to support staff to develop their understanding of risk assessment and protection, and to enable multi-disciplinary teams to provide a safe environment for staff to learn, to adapt to CCTV use and to improve confidence in their own practice.

(c) Belfast Trust has confirmed it has commenced planning for a practice development module, utilising input from an external critical friend, to support improvements in safeguarding practice across all staff groups in MAH (initial workshop held on 18 February 2019).

RQIA advises that in line with the anticipated improvements in staffing on individual wards and across the hospital site, the practice of deploying staff who have been subject of a safeguarding referral to work with patients involved in the same safeguarding referral should be reviewed. We would highlight that in circumstances which give rise to multiple and repeated safeguarding referrals for the same patient, it is essential that there is a team approach to addressing potential root causes giving rise to and/or influencing these repeated referrals (as distinct from focusing on the referral process and repeated investigations).

It is determined that the above described actions/measures are a constructive response which have potential to improve the Trust's position in relation to its safeguarding practices and local on-site implementation of the regional safeguarding policy.

Determination - an Improvement Notice in relation to Safeguarding Practices will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

5. **Restrictive practices (seclusion):** *There was evidence that current seclusion practices across the hospital site were not in line with best practice guidelines.*

(a) Belfast Trust has advised that use of seclusion is currently monitored across all wards and is discussed on a weekly basis at a multi-disciplinary governance meeting, use of seclusion will form part of a core set of data for regular review at hospital live governance and assurance meetings.

(b) Belfast Trust has confirmed that it has undertaken a review of its seclusion policy (in line with Royal College of Psychiatry guidelines); the refreshed policy is to be available w/c 18 March 2019 and will now be subject of engagement with families, staff and advocacy organisations.

(c) Belfast Trust has asked East London NHS Foundation Trust to act as a critical friend to provide support and challenge as it works through its approach to and use of restrictive practices in general and seclusion specifically.

(d) Belfast Trust has confirmed it will approach Mersey Care NHS Foundation Trust to seek expert input and support in its work on use of restrictive practices in general and seclusion specifically.

RQIA remains concerned that following the closure of the PICU, the physical environments currently utilised for seclusion across a number of wards in MAH do not meet best practice guidelines. It is likely this issue will be particularly challenging for the trust to address and will require further detailed consideration with assistance from national experts (as referred above). We would recommend that as an early first step the Trust should agree and implement clear definitions in relation to various practices in this context (e.g. seclusion, de-escalation, practice agreed as part of management/care plan etc.).

It is determined that the above described actions/measures are a constructive response which have potential to improve the Trust's position in relation to its use of restrictive practices, in particular seclusion.

Determination - an Improvement Notice in relation to Restrictive Practices (seclusion) will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

6. **Hospital governance**: *Although initial arrangements have been established with a view to strengthening governance and appropriately identifying risks across the hospital, the inspection team did not find evidence that these were having the required impact on the safety and effectiveness of care or on staff health, well-being and morale.*

   (a) Belfast Trust has outlined detailed arrangements to strengthen local governance on the MAH site using an evidence based safety measurement and monitoring framework. A core set of metrics to underpin this work is in development.

   (b) Refreshed arrangements include on-site presence and leadership from the Trust's Director of Adult, Social and Primary Care whom the Chief Executive has confirmed is now dedicated to work relating to MAH.

   (c) The two other Trusts served by MAH confirmed their support for strengthened governance arrangements (at meeting on 7 March 2019), through their Directors of Adult Services and Prison Health Care (South Eastern Trust) and of Mental Health and Learning Disability and Community Services (Northern Trust).

   (d) Belfast Trust has confirmed the introduction of a daily safety huddle (wards) and a weekly safety pause (hospital) across the MAH site.

   (e) Belfast Trust's Medical Director and Deputy Chief Executive will now chair a recently introduced weekly assurance meeting.

(f) Belfast Trust has advised a range of measures to support staff, these include; the presence of a counsellor on MAH site, the presence of Occupational Health on-site, a keeping in touch system for absent staff, the development of a psychological services strategy for staff and the introduction of a stress assessment tool.

It is determined that the above described actions/measures are a constructive response which have potential to improve the Trust's position in relation to its governance and oversight of MAH.

Determination - an Improvement Notice in relation to Hospital Governance will not be served at this time. RQIA will continue to monitor this aspect of care closely and will seek evidence of improvement resulting from the above described actions/measures.

ENDS

Exhibit 16

From: Jerome Dawson
Acting Director, MHDOP

Date: 20th March 2019

To: Richard Pengelly

UNANNOUNCED RQIA INSPECTION AT MUCKAMORE ABBEY HOSPITAL – FURTHER UPDATE AND ADVICE

Issue:	Further update and advice on the RQIA unannounced inspection of Muckamore from 26th-28th February 2019.
Timescale:	Urgent
FOI Implications:	Any request will be considered in line with the provisions of the FoI Act.
Presentational issues:	Due to ongoing media interest in relation to Muckamore, this issue is likely to attract media attention. RQIA issued a short statement on 7th March in response to a media enquiry.
Recommendation:	It is recommended that you: (i) Note the information/evidence outlined in the Belfast Trust's written response attached at **Annex A**; (ii) Note the further letter from RQIA of 14th March attached at **Annex B**; (iii) Agree to meet with RQIA; and (iv) Agree the draft response to the RQIA attached at **Annex C**.

Introduction

1. In my submission of 6th March, I advised that the Belfast Trust was due to meet with the RQIA the following day to provide their feedback on the findings of the

unannounced inspection at Muckamore Abbey Hospital (MAH) from 26th to 28th February. A short summary of the outcomes of that meeting (also attended by the Northern and South Eastern Trusts) was sent to you by email on 7th March, which included a reference to the Belfast Trust's intention to write to you in response to the RQIA letter of 5th March.

2. Mr Dillon's letter was received on 8th March and is attached at **Annex A.** We understand that Mr Dillon also wrote in similar terms to the RQIA. We have also now received a further letter from the RQIA dated 14th March, attached at **Annex B**. The content of these letters is summarised below.

Belfast Trust response

3. As previously advised following our meeting with the Belfast Trust last week, the broad thrust of their response is that they were already aware of many of the issues raised by the RQIA, and have been working hard to address them.

4. Attached to their letter is an Inter-Trust Action Plan which provides details of the significant number of actions being taken by the Belfast, Northern and South Eastern Trusts to ensure that the care provided in MAH is safe, effective and compassionately delivered by sufficient and appropriately trained staff. The Action Plan also outlines the actions being taken to reduce the delayed discharge population in MAH.

5. Significantly, in terms of governance, the Belfast Trust advise that the Director of Adult, Social and Primary Care has been released from most of her portfolio to focus exclusively on this work, and that the Deputy Chief Executive of the Trust is to chair an Assurance Group reporting directly to the Executive Team and Trust Board. This group will meet fortnightly, and will include representatives from other Trusts. Its role will be to monitor progress against the Action Plan and take corrective action if required. The Trust is also sourcing an independent expert, Dr Ian Hall, from East London NHS Foundation Trust – a CQC exemplar Trust with Intellectual Disability Services – to sit on the Assurance Group.

6. Drawing from the work and actions outlined in their Action Plan, the letter from the Belfast Trust also addresses each of the 7 areas of concern set out in the RQIA's letter of 5th March. These were as follows:

   (i) **Insufficient staffing** at ward level impacting on quality and assurance of care, and the significant impact on **staff morale** of recent events at MAH;

   (ii) Absence of appropriate systems to ensure **physical healthcare needs of patients** are being met, with specific concerns around monitoring of patients prescribed anti-psychotic drugs;

   (iii) Number of **financial governance** issues, including failure to make appropriate referrals to the OCP, and a specific omission to make a safeguarding referral;

   (iv) Lack of evidence of effective deployment of **adult safeguarding** referrals, implementation of learning and improved outcomes for patient well-being;

   (v) **Restrictive Practices** (seclusion) not in line with best practice guidelines;

   (vi) Enhanced **governance arrangements** not having required impact on care of patients/staff health and well-being;

   (vii) Awareness levels among ward staff of **discharge planning** for patients, and lack of robust information supplied to RQIA on these plans.

7. In relation to staffing, the Belfast Trust advises that it has arrangements in place to ensure that MAH is **safely staffed** at all times to meet the needs of patients. These include effective staff planning measures, appropriate escalation arrangements, the use of bank and agency staff, and daily monitoring by lead nurses, the hospital service manager and oversight by the Deputy Director of Nursing who is currently based in MAH for additional assurance. The Belfast Trust is also working collaboratively with both the Northern and South Eastern Trusts, with a number of their staff providing nursing cover at present, and plans are being developed to formalise these arrangements including temporary

relocation of staff to MAH. An interim nursing workforce model using Telford has been designed, and a review of staffing needs for patients ready for discharge is currently under consideration.

8. The Belfast Trust has also acknowledged in its response the significant, and likely continuing, impact on **staff morale** of the ongoing police investigation and CCTV viewing, providing details of a range of measures that have been taken to ameliorate this, and more are planned. Supports include the appointment of a full time counsellor, availability on site of occupational health, a keeping in touch system for absent staff, development of psychological services strategy, roll-out of face to face stress assessment tool, establishment of alternative well-being measures, ongoing MAPA training. The Belfast Trust has also undertaken to take immediate action to work with ward sisters/charge nurses to bolster confidence in relation to personal interventions and MAPA holds.

9. The **physical healthcare** needs of patients in Muckamore has been a long-standing issue. To ensure that these are fully assessed within the next month, a locum consultant physician and two band 5 nurses have been identified. This will include appropriate health screening for diabetes, hypertension and cholesterol.

10. In relation to the **financial governance** issues raised, the Belfast Trust has advised that all appropriate referrals have now been made to the OCP, and that BSO had completed a robust audit in 2015/16 with a satisfactory outcome being recorded. As this is some 3 years old, the Trust would need to seek further appropriate assurances (as noted in the RQIA's letter of 14th March).

11. The Belfast Trust has already acknowledged in the wake of the SAI Report "A Way To Go" (November 2018) that **safeguarding practices** in MAH need to change, and have indicated in their letter that they are moving quickly to improve processes, and following a workshop hosted by Margaret Flynn on 18th February are in the process of developing a practice development programme.

12. Also in the wake of the SAI report, work has already begun to review the Belfast Trust's **restrictive practices** policy and a re-draft is expected to be shared with families, staff and stakeholders in the next few weeks. Given the closure of PICU, the use of alternative de-escalation facilities is also under review, and the Trust are seeking to invite a small team of experts from the Mersey Care NHS Foundation Trust to visit MAH to advise on reducing seclusion and work with clinical teams.

13. In terms of the **governance arrangements** in place in MAH, as acknowledged by the RQIA, these have already been enhanced to include weekly live governance meetings using core safety metrics at ward and site level, such as use of seclusion, staffing levels. The Belfast Trust recognises that it will take time for these arrangements to embed, and to further support this has decided to locate the Director, who has been released from other duties to focus on this work, in the MAH site. As mentioned already, an additional Assurance Group is also to be established, and the appointment of an independent expert from East London NHS Foundation Trust will provide important advice and assistance in this regard.

14. On the issue of **discharge planning**, the Belfast Trust have undertaken to ensure ward staff are fully aware of patient discharge plans, and a commitment was given by all three Trusts present at the meeting with RQIA to move on discharge planning for those patients in MAH whose discharge has been delayed. Twenty-seven patients were successfully discharged last year, and a comprehensive review of all remaining patients has been undertaken. Monthly Assistant Director and Director meetings currently take place, and all Trusts have well-developed plans in place for implementation in the coming year. The Belfast Trust also advise that a new service model for the prevention of admission, and the provision of intensive support including home treatment has been developed.

15. In conclusion, the Belfast Trust has acknowledged the gravity and complexity of the situation, and seeks the Department's support on a variety of fronts, specifically:

(i) ongoing support from policy leads;
(ii) endorsement of engagement of "critical friend" from East London NHS Foundation Trust as part of the governance enhancements;
(iii) extending an invitation to an expert team from Mersey Care NHS Foundation to advise on restrictive practices;
(iv) Support for any business cases arising from the development of new models of care;
(v) Similar assistance to that provided in relation to the neurology recall, including handling of MLA briefings; and
(vi) Help and support around media and external messaging.

RQIA letter of 14th March

16. The RQIA letter of 14th March provides a detailed assessment of six of the areas of concerns identified in their original correspondence of 6th March and their determination in relation to each having considered the information provided by the Trusts at the meeting on 7th March and subsequently by the Belfast Trust in writing. While the letter raises several additional points for the Belfast Trust to address in relation to financial governance, safeguarding practices and seclusion, the key outcome is that the RQIA have decided **not** to serve Improvement Notices at this time, but will continue to closely monitor each of the areas, and seek evidence of improvement.

17. However, in relation to its recommendation regarding the implementation of a special measure in the form of two taskforces to stabilise the hospital and oversee the delayed discharges/relocation planning, the RQIA has concluded that it remains valid and offers the Department an opportunity to meet to discuss in more detail. This issue is discussed further below.

Special Measure

18. As evidenced by the information already provided by the Belfast Trust and acknowledged by the RQIA in its further letter, it is clear that there is a significant amount of joined up "task-force" working already ongoing with the

focused aim of stabilising MAH, and delivering on the discharge planning programme of work that now needs to be done.

19. Furthermore, in recognition of the scale and complexity of this work, the governance arrangements put in place following the allegations of abuse in MAH and the commissioning of the SAI report in early 2018 have now been further enhanced by for example weekly live governance meetings on site, the release of a full-time Director from her normal duties in the Belfast Trust to focus solely on the improvement programme, the setting up of an Assurance Group to be chaired by the Deputy Chief Executive and the decision to engage an external "critical friend" to advise. This Group will meet fortnightly and have representation from other Trusts. The relevant LD Assistant Directors and Directors also meet monthly to discuss discharge planning.

20. In addition, the HSCB has recently established a Mental Health and Learning Disability Improvement Board chaired by the Director of Social Care. It consists of all relevant Trust Directors and also includes representation from the PHA/Nursing. In addition, the RQIA has been invited to join. I also sit on this Board and attended its second meeting on 11th March. The intention is that this Board will act as the Regional Oversight Group for all the work being taken forward to deliver on your resettlement/delayed discharge commitments.

21. It is also worth noting that external expertise has been secured on the independent panel engaged by the HSCB/PHA to lead on the review of Learning Disability acute care and treatment being taken forward as an expedited workstream of the wider transformation project to develop a new service model for learning disability. The HSCB-led MH and LD Improvement Board also acts as the Project Board for this project and the expedited acute care workstream.

22. We have also recently agreed to set up monthly check point meetings involving the Belfast Trust and the HSCB/PHA and others as appropriate to provide you with the relevant assurances in relation to the various strands of work involved in ensuring the ongoing safe operation of the hospital and successfully

delivering on the SAI report recommendations, and your commitments. We are currently considering what additional internal resources we may require to support this work, and a separate submission in regard to this will follow.

23. In light of the above, it is not immediately clear what added value the two taskforces recommended by the RQIA would have. That said, given the sheer scale and complexity of the challenges that lie ahead (and the responses we have received to date in relation to your request for a clear articulation of the issues involved in overcoming the barriers/obstacles to completing on the resettlement process and addressing delayed discharges to inform an action plan), it would be entirely reasonable and proportionate to consider how we in DoH might offer further support to the wider system as it seeks to take forward this significant programme of work.

24. We have already begun to do this, and if you are content with this approach, we will discuss this further with colleagues in the HSCB and the Belfast Trust, initially to address the specific areas of support requested by the Belfast Trust in their letter as summarised at paragraph 15 above.

Meeting with RQIA

25. As noted above, the RQIA have offered to meet with the Department so that they can provide a more detailed update on the key themes emerging from their unannounced inspection of Muckamore Abbey Hospital. We could at that meeting ask the RQIA to explain the rationale behind their recommendations for two task forces to be established, in light of the measures and work ongoing/undertaken to date by the Trusts involved, the HSCB and the Department.

26. It is recommended that you accept the invitation to meet with the RQIA.

27. While we can agree when the meeting has been arranged who should support you, I would suggest that the meeting should include Sean Holland, Charlotte McArdle and myself as a minimum, to represent the policy and professional perspectives in this area of work.

28. A draft response to the RQIA's letters dated 6th and 14th March is attached at **Annex C** for your consideration based on the above advice.

Recommendation

29. In summary, it is recommended that you:

(i) Note the information/evidence outlined in the Belfast Trust's written response attached at **Annex A**;

(ii) Note the further letter from RQIA of 14th March attached at **Annex B**;

(iii) Agree to meet with the RQIA; and

(iv) Agree the draft response to the RQIA attached at **Annex C**.

Jerome Dawson
Ext. 20724

cc**:** Sean Holland
Charlotte McArdle
Michael McBride
Jackie McIlroy
Rodney Morton
Ian McMaster
Andrew Dawson
David Gordon
Alison McCaffrey
Sean Scullion
Kim Burns

ANNEX A

LETTER FROM BELFAST TRUST DATED 8.3.19 PLUS ATTACHMENTS

Letter to Mr R Pengelly re MAH.pdf

Summary of MAH Safeguarding Review

RQIA Action Plan (002).docx

BELPRTBCH104_BCH_AFLR_M_02_4468_

ANNEX B

LETTER FROM RQIA DATED 14.3.19

Article4_DoH_Letter
_MAH_LG_14.03.19.p

ANNEX C

DRAFT LETTER TO RQIA

Olive McLeod

Chief Executive

RQIA

9th Floor Riverside Tower

5 Lanyon Place

Belfast

BT4 3SQ

Dear

MUCKAMORE ABBEY HOSPITAL – UNANNOUNCED INSPECTION

Your letters of 6th and 14th March to the Chief Medical Officer and his deputy regarding the unannounced inspection of Muckamore Abbey Hospital on 26th-28th February refer.

Firstly, I am grateful to the RQIA for the work it has undertaken in relation to the unannounced inspection of Muckamore, and for the notification of the findings and the subsequent outcome of your meeting with Belfast Trust on 7th March. I note in particular your decision not to serve improvement notices at this time, and to continue to monitor the six areas of concern closely.

With regard to your recommendation to implement a special measure for the Trust, I note and take assurance from the measures in place across the HSC system to oversee the significant amount of joined up task force working already ongoing with the focused aim of stabilising MAH, and delivering on the discharge planning programme of work that now needs to done. It is my intention to ensure that this important work is fully supported by all parts of the HSC system, and in doing so to be mindful of the need not to overburden any one part of it, including the Belfast Trust, at this crucial time.

As you suggest, I would be very happy to meet to discuss this matter further.

Please contact Suzanne Ferris in my office (Suzanne.Ferris@health-ni.gov.uk) to arrange a meeting as soon as possible.

Yours sincerely

RICHARD PENGELLY

Exhibit 17

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Olive McLeod
Chief Executive
RQIA
9th Floor Riverside Tower
5 Lanyon Place
Belfast
BT4 3SQ

Castle Buildings
Upper Newtownards Road
BELFAST, BT4 3SQ

Tel: 02890520559
Fax: 02890520573

Email: richard.pengelly@health-ni.gov.uk

Our ref: RP3765
SSUB-0183-2019

Date: 22 March 2019

Dear Olive

MUCKAMORE ABBEY HOSPITAL – UNANNOUNCED INSPECTION

Your letters of 6th and 14th March to the Chief Medical Officer and his deputy regarding the unannounced inspection of Muckamore Abbey Hospital on 26th-28th February refer.

Firstly, I am grateful to the RQIA for the work it has undertaken in relation to the unannounced inspection of Muckamore, and for the notification of the findings and the subsequent outcome of your meeting with Belfast Trust on 7th March. I note in particular your decision not to serve improvement notices at this time, and to continue to monitor the six areas of concern closely.

With regard to your recommendation to implement a special measure for the Trust, I note and take assurance from the measures in place across the HSC system to oversee the significant amount of joined up task force working already ongoing with the focused aim of stabilising MAH, and delivering on the discharge planning programme of work that now needs to done. It is my intention to ensure that this important work is fully supported by all parts of the HSC system, and in doing so to be mindful of the need not to overburden any one part of it, including the Belfast Trust, at this crucial time.

As you suggest, I would be very happy to meet to discuss this matter further. Please contact Suzanne Ferris in my office (Suzanne.Ferris@health-ni.gov.uk) to arrange a meeting as soon as possible.

Yours sincerely

RICHARD PENGELLY

Exhibit 17

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

Assurance, Challenge and Improvement in Health and Social Care

30 April 2019

Private and Confidential

Dr Michael McBride
Chief Medical Officer
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Dear Dr ~~McBride~~ Michael

I write in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and further to my earlier correspondences of 06 and 14 March 2019, to advise you of RQIA's continuing serious concerns in relation to care, treatment and services as currently provided for patients in Muckamore Abbey Hospital (MAH).

As you know we undertook an unannounced inspection of MAH two months ago (26 to 28 February 2019, inclusive), during which our multidisciplinary inspection team assessed care and treatment provided to patients as well as risk management, oversight and governance arrangements within and across the hospital. A number of areas of concern emerged from that inspection. These related to staffing, patients' physical healthcare, financial governance, safeguarding practices, restrictive practices (seclusion) and hospital governance.

You will be aware that RQIA held an 'Intention to Serve Improvement Notices' meeting with Belfast HSC Trust on 07 March 2019. During this meeting we discussed evidence/information relating to each of the six areas of concern with the Chief Executive and Executive Directors in the Trust. Belfast Trust subsequently forwarded a written outline of their work in relation to care and treatment provided in MAH and a copy of their MAH Inter-Trust Safe Compassionate and Effective Care Action Plan 2018/19 to the Permanent Secretary in DoH, this correspondence was copied to RQIA (dated 08 March 2019).

After thorough consideration of Belfast Trust's representation at our 'Intention to Serve' meeting on 07 March 2019 and of additional written information provided by the Trust to DOH, and copied to RQIA, we determined not to serve Improvement Notices at that point in time. Dr Geoghegan's correspondence of 14 March 2019 outlines the assurances provided by Belfast Trust in this context and the rationale informing our determinations in respect of each of the areas of concern. We shared a written summary of our

9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

tel: 028 9536 1111
email: info@rqia.org.uk
web: www.rqia.org.uk
twitter: @RQIANews

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SYSTEM CERTIFICATION BMTRADA ISO 9001

determinations with Belfast Trust (dated 14 March 2019). In our correspondence we stressed the importance of robust implementation of the Trust's action plan/quality improvement plan (QIP) to ensure immediate improvements in the care and treatment delivered on the MAH site. We also indicated that, given the significant concerns identified, RQIA would monitor and assess progress over the subsequent weeks.

I can now advise that our team undertook a further unannounced inspection of MAH from 15 to 17 April (inclusive). The purpose of this second inspection was to assess progress regarding the Trust's action plan/QIP and to follow-up on assurances provided by the Trust during discussion at our 'Intention to Serve' meeting and in correspondence to DoH (copied to RQIA). I am disappointed to report that our inspection team evidenced limited progress in relation to the areas of concern previously identified. I have outlined some of the main findings from our second inspection below:

1. Staffing
    a. While the Trust advised during our 'Intention to Serve' meeting that seven Band 5 nursing professionals had been recruited, were undergoing induction and were due to commence in MAH w/c 11 March 2019, it is now apparent that this has not been the case. The seven Band 5 nurses were agency staff who did not commence working in MAH on the date advised, in fact seven agency nurses had various start dates between 25 Mar and 24 Apr 2019. We are now aware that up to five experienced Band 7 nurses will move from their current roles/posts in MAH in the near future and two other senior staff are also moving from their current roles/posts. To date no additional nurses have been secured through collaborative working arrangements with Northern and South-Eastern Trusts. Since our inspection in February a further four staff have been placed on precautionary suspension.

    b. During this inspection we experienced considerable difficulty with regard to accurately confirming nursing staff requirements as compared to nursing staff provision across the hospital. We could not evidence robust planning of nurse staffing on the basis of assessed patient need. We noted a mismatch between information supplied by site managers and that supplied by ward staff/ward managers. Although site managers described escalation arrangements in relation to staffing challenges we were not assured that these arrangements are working effectively, we remain concerned that ward staff/managers are not appropriately supported when they experience challenges in relation to staffing.

    c. Staff morale remains a significant cause for concern. As highlighted previously staff providing front-line care have displayed enormous resilience, they are to be commended for their dedicated service to patients and patients' families. We remain concerned for the health and wellbeing of staff, particularly nursing staff, who are experiencing enormous challenge and who may not be able to avail of comfort

breaks or finish their working hours on time due to the demands of providing care in these complex and challenging circumstances. Staff have reported that they do not feel appropriately supported.

2. Patients' physical health care needs – we found evidence of completion of annual checks of physical health for most patients in the hospital (52 patients' checks completed, 3 patients on leave, 8 patients declined). We also found evidence of appropriate monitoring of physical health parameters of patients receiving antipsychotic medications (per protocol). These are improvements since our previous inspection in February. We did not find evidence of robust assessment and/or planning to ensure patients are included in appropriate population screening programmes (breast, cervical, AAA and/or diabetic retinopathy screening). While there was evidence of some consideration of how many patients might need a particular screening test (e.g. mammography), we could not evidence a hospital-wide system to identify, arrange and assure appropriate participation of patients in population screening programmes relevant to their age and gender.

3. Financial governance – during this inspection we confirmed that a safeguarding referral had been made in relation to the financial arrangements for one detained patient (lack of referral identified during our February inspection). We could not, however, evidence progress in relation to the other aspects of financial oversight and governance which remains a cause for significant concern. We could not evidence appropriate documentation relating to appointee-ship arrangements for 6 of 13 patients, we could not identify improvements in completion of patient property records or in completion of ledgers at ward level. Monthly monitoring of ward finances by senior site managers was inconsistently completed, and when completed lacked evidence of appropriate assurance. Inspectors reviewed the report of a previous financial audit undertaken the Trust's internal audit team (2015) and noted that many of the items leading to priority one and two recommendations in that report were similar to those identified in this and our previous inspection. We could not evidence work relating to the Trust's planned audit of financial procedures across the site, to be undertaken during April 2019 (as advised in the Trust's action plan/QIP).

4. Safeguarding practices – as in our previous inspection, we did not find evidence of implementation of learning arising from safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. Due to the complexity and mix of patients in some wards and with current staffing levels, we noted that meaningful implementation of protection plans is a significant challenge. A structural disconnect between professional staff was again evident within the current safeguarding arrangements for the hospital.

5. Restrictive practices (seclusion) – the Trust has recently updated its seclusion policy which is out for review/comment with staff and carer/family representatives. The overall use of seclusion is reducing and inspectors

noted that care staff are appropriately recording and monitoring seclusion when used, seclusion is discussed at MDT meetings and at weekly live governance meetings. However we remain concerned about the environments currently used for seclusion across the hospital site. While the seclusion suite remains unavailable and PICU remains closed, the environments used for seclusion will not meet required standards. While the Trust has indicated it is seeking expert assistance from two NHS Foundation Trusts with regard to the use of restrictive practices in general and seclusion specifically, we remain concerned that site managers do not appear to appreciate the considerable distance between arrangements and practices as outlined in the Trust's updated seclusion policy and practices as currently implemented in the hospital. Our inspection team was particularly concerned that staff involved in managing patients with challenging behaviour (in particular patients for whom restraint and/or seclusion may be required) do not appear to be supported through structured debriefing and there are limited/few opportunities to identify and share learning in a meaningful way.

6. Hospital governance – the Trust has established arrangements to strengthen governance and to identify and manage risks across the hospital. These arrangements include a weekly live governance meeting, a weekly safety pause and a ward-based safety huddle which is currently being piloted on two wards. A hospital SITREP has also been established and this is reported weekly. While these arrangements are to be welcomed, frontline staff indicated that they are not clear about the role and function(s) of the various meetings and arrangements. Our inspection team could not clearly determine the linkages between the constituent parts of the governance system. We noted discrepancies in information reported through various parts of the hospital's operating and governing systems. We could not evidence that these arrangements were having the required impact on safety and effectiveness of care for patients or on the health and well-being of staff.

Upon completion of this unannounced inspection we held a detailed feedback session with senior Trust staff (3.00pm to 5.30pm, Wednesday 17 April 2019).

This week we have been contacted by staff working in MAH, under our whistleblowing arrangements, to report concerns regarding current staffing levels and patient safety within the hospital. Staff have advised us of their perception that there are communication challenges between staff working in front line and management. This information aligns with findings identified during our inspection.

Given that we have been able to demonstrate limited progress only in relation to assurances previously provided and in light of recent contacts by staff to RQIA (as above), we are now recommending that DoH implements a special measure for Belfast Trust in relation to MAH.

We recommend the establishment of two taskforces – (i) a taskforce to stabilise the hospital site, in support of patients currently receiving care and of staff delivering that care, and (ii) a taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community.

I would highlight a pressing need to ensure that senior operational nursing leadership is provided in the hospital as soon as possible. It is essential that frontline nursing staff now receive appropriate support as they continue to deliver care in the most complex and challenging environments.

You may wish to receive a more detailed update on key findings of our inspection and the matters outlined above. Dr Geoghegan will be on leave from 04 to 13 May 2019, otherwise we are happy to confirm our availability to meet.

We will continue to support improvement in care and services delivered to patients in MAH, and as always we will keep you informed of our future work.

Yours sincerely

Dr Lourda Geoghegan

Mrs Olive Macleod OBE
Chief Executive

Copy to Dr Lourda Geoghegan, Medical Director and Director of Improvement, RQIA
Ms Emer Hopkins, Deputy Director, RQIA
Mrs Lynn Long, Assistant Director, RQIA
Mr Alan Guthrie, Inspector, RQIA
Malachy Finnegan, Communications Manager, RQIA
Mr Sean Holland, Chief Social Work Officer, DoH
Mr Fergal Bradley, RQIA Sponsor Branch, DoH
Dr Paddy Woods, Deputy Chief Medical Officer, DOH

From: **Linda Greenlees**
Acting Head of Quality Regulation, Policy and Legislation

Date: **3 May 2019**

1. **Dr Woods**
2. **Dr Michael McBride**

RQIA LETTER 30 APRIL 2019:
UNANNOUNCED INSPECTION OF MUCKAMORE ON 15 -17 APRIL2019.
RECOMMENDING SPECIAL MEASURES

Issue:	**RQIA have written to you following a recent unannounced inspection of Muckamore Abbey Hospital from 15-17 April 2019. In their letter RQIA are advising you of their continuing serious concerns in relation to care, treatment and services currently provided for patients in Muckamore Abbey Hospital (MAH). RQIA continue recommending that the Department implements a special measure for BHSCT, specifically in relation to Muckamore.**
Timing:	**Urgent**
Recommendation:	**That you note and share the content of this submission as input to any formal response to RQIA's letter by Mental Health Disability and Older Peoples Directorate.**

Background

1. RQIA have written to you on 30 April 2019 (attached at Annex A), following an unannounced inspection of Muckamore Abbey Hospital (MAH), undertaken from 15-17 April 2019. This letter follows two previous correspondences on 06 and 14 March 2019 which along with this letter set out a number of important findings that emerged in relation to:

    - Staffing;
    - Patients' physical health care needs;
    - Financial governance;
    - Safeguarding practices;
    - Restrictive practices (seclusion);
    - Hospital governance; and
    - Discharge/ relocation planning

2. RQIA's letter of 06 March 2019, following their unannounced inspection of MAH on 26-28 February 2019, recommended that the Department agree and implement a special measure for Belfast HSCT, specifically in relation to MAH. The special measure that RQIA recommended is the establishment of two taskforces:

    (i) A taskforce to stabilise the hospital site, in support of patients currently receiving care and staff delivering that care; and
    (ii) A taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community.

3. RQIA again wrote to Dr Woods (in your absence) on the 14 March 2019, providing an update in determinations made following RQIA's 'Intention to Serve Improvement Notices' meeting with the Belfast HSC Trust on the 07 March 2019.

4. Following RQIA's consideration of the Trust's representation at the meeting and of additional information received from the Trust which detailed the work it was progressing in relation to improving care and treatment of patients at MAH, RQIA made determinations relating to the following six areas of serious concern

    - Staffing;
    - Patients' physical health care needs;
    - Financial governance;
    - Safeguarding practices;
    - Restrictive practices (seclusion); and
    - Hospital governance.

5. RQIA determined that in respect of all six areas that an improvement notice would not be served at that time and that RQIA would continue to monitor the above six aspects of care closely and seek evidence of improvement resulting from actions/measures by the Belfast HSC Trust.

6. In their letter of 14 March 2019 RQIA also advised that their recommendation, that the Department agrees and implements a special measure for Belfast HSCT in relation to MAH, remained valid. Permanent Secretary has been updated on these issues by Mental Health, Disability and Older Peoples Directorate (MHDOP).

7. Permanent Secretary wrote to Olive Macleod, RQIA Chief Executive, on the 22 March 2019 in response to RQIA's letters of 06 and 14 March 2019. He subsequently met with the RQIA Chief Executive and Medical Director/Director of Improvement and senior DoH Officials on 25 March to discuss inspection findings.

8. RQIA, in their letter of 30 April 2019, are advising that their unannounced inspection on 15-17 April 2019 was to assess progress regarding the Trust's action plan/Quality Improvement plan and to follow up on assurances provided by the Trust during discussion at the 'Intention to Serve Improvement Notices' meeting with the Belfast HSC Trust on the 07 March 2019 and in subsequent correspondence from the Trust to the Department.

9. RQIA are disappointed to report that their inspection team evidenced limited progress in relation to the areas of concern previously identified and they have outlined some of the main findings from their second inspection in their latest letter.

10. RQIA are now recommending that the Department implements a special measure for Belfast HSCT in relation to MAH. The special measure that RQIA recommend is the establishment of two taskforces:

    (iii) A taskforce to stabilise the hospital site, in support of patients currently receiving care and staff delivering that care; and

    (iv) A taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community.

11. RQIA have raised the potentially significant implications for the safety and quality of the service being provided to patients in Muckamore Abbey Hospital under their statutory responsibilities, as set out below. It is worth noting that the recommendation of special measures by RQIA has only happened a small number of times.

12. RQIA have also highlighted a pressing need to ensure that senior operational nursing leadership is provided in the hospital as soon as possible. RQIA have advised that it is essential that frontline nursing staff now receive appropriate support as they continue to deliver care in the most complex and challenging environments.

13. RQIA have advised that they would be happy to meet to discuss the relevant issues and provide a more detailed update.

RQIA's Statutory Responsibilities

14. Under Article 4 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, known as the 2003 Order, RQIA has a duty to keep the Department informed about the provision of services and in particular about their availability and quality.

15. Under Article 35 of the 2003 Order, RQIA conducts inspections of statutory bodies and makes reports on those inspections. If they find that services are of an unacceptably poor quality or there are significant failings in the way the body is being run, then RQIA **must** make a report of its view to the Department. In its report, RQIA may recommend that the Department take special measures in relation to the body in question with a view to improving the services for which it is responsible or the way the body is being run.

16. Under Article 39 of the 2003 Order, RQIA may serve an improvement notice on a Trust if they believe that the Trust is failing to comply with the minimum standards.

17. RQIA have only made recommendations of special measures and issued improvement notices to HSC Trusts on a few occasions, the most recent being in relation to the NI Ambulance Service in 2018.

Departmental Response

18. Whilst RQIA are recommending that the Department implements a special measure, this decision is one for the Department and you will wish to formally raise this with Sean Holland and Permanent Secretary. Normally, it would be for Sean Holland as policy lead to recommend that this special measure should be put in place. It will be important to have clarity around lines of responsibility should the special measure be agreed. There are a number of

actions for the policy lead to take before and during implementation of a special measure:

- Prepare a submission and advice to the Permanent Secretary, including a letter to the Belfast Trust advising them of the introduction of the special measure (this submission is intended to be used as part input for any such submission);
- Regular communication and liaison with the HSC Board and Trust;
- Ensuring that effective governance arrangements are in place around the special measure;
- Monitoring the impact of the actions being taken by the HSC to address the concerns which have led to the special measure;
- Development of a communication/media handling strategy in conjunction with the press office, given the potential for significant media interest; and
- Ongoing liaison with RQIA.

19. If introduced, the special measure will remain in place until the policy lead is in a position to recommend to Permanent Secretary that it be removed and any such recommendation would be expected to be based on evidence that the concerns which have led to the special measure being introduced have been addressed.

20. The policy lead may specifically request, through you as RQIA sponsor, that RQIA should undertake further inspections on behalf of the Department to assess progress in relation to the areas of concern they have identified.

21. RQIA may continue to undertake a series of further unannounced inspections to assess the effectiveness of any action undertaken to address their concerns. Decisions around further inspections would normally take account of the arrangements put in place by the Department around special measures should they be applied to the Trust in relation to Muckamore. As is normal practice, unless they are undertaken at our direction, the Department will only be advised of any such further inspections on the day of the inspection.

22. RQIA may still choose to serve Improvement Notices on BHSCT in relation to MAH. However, should the Department choose to apply special measures RQIA would need to consider what additional benefit might accrue by issuing any improvement notices to the Trust.

23. On the 02 May 2019 you met with Chris Matthews; Jerome Dawson; Rodney Morton and Paddy Woods to discuss the Departmental response in relation to RQIA's letter of escalation and a summary of concerns of a member of staff who contacted RQIA.

24. You subsequently emailed, on the 02 May 2019, Sean Holland and Charlotte McArdle advising them of the meeting and that at the meeting the following was discussed and agreed in principle subject to further discussion with Sean as policy lead:

    a) Meeting to include BHSCT, RQIA, HSCB and ourselves in order that we arrive at a reconciled position and view as a Department in relation to: safety of current service; adequacy of support arrangements to staff; progress or otherwise on matters previous identified; need for additional regional or external expertise to support the Trust.
    b) Regional Coordination Group – jointly chaired by HSCB and PHA. (most probably Marie and Mary)
    c) Departmental Assurance Group chaired by Charlotte and you with input from my team as you both require with RQIA as members.

25. Your email further advised Sean and Charlotte that most of this largely builds on that currently or previously in place and all present at the meeting were agreed should provide greater support and appropriate challenge to the Trust, coordination by HSCB and PHA given regional nature of the service and the reassurances we all require from a policy and professional perspective and would we believe address the further recommendation of RQIA for a regional task group.

Recommendation

26. That you note and share the content of this submission as input to any formal response to RQIA's letter by Mental Health Disability and Older Peoples Directorate.

Linda Greenlees

Quality Regulation, Policy and Legislation

CC: Paddy Woods
Sean Holland
Charlotte McArdle
Rodney Morton
Chris Matthews
Jerome Dawson
Ian McMaster
Fergal Bradley
Steven White

ANNEX A

Article4_DoH_Letter
_MAH_30.04.19.pdf

MAHI - STM - 300 - 436

From: Carson, Jane
To: Carson, Jane
Subject: FW: Meeting this am
Date: 27 June 2024 11:55:01

Jane Carson
PS/Prof Sir Michael McBride
Block C5
Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ

Tel: 028 9052 0658

From: McBride, Michael <Michael.McBride@health-ni.gov.uk>
Sent: Thursday, May 2, 2019 9:38 PM
To: McArdle, Charlotte <Charlotte.McArdle@health-ni.gov.uk>; Holland, Sean <Sean.Holland@health-ni.gov.uk>
Cc: Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>; Morton, Rodney <Rodney.Morton@health-ni.gov.uk>; Woods, Paddy <Paddy.Woods@health-ni.gov.uk>
Subject: RE: Meeting this am

Charlotte,

Many thanks. Honestly not a problem, Rodney very ably articulated the professional nursing considerations and his current assessment and understanding following further consideration of the correspondence received and discussions to date.

We all recognised the need for further clarification and reconciliation of the Trust's position and RQIA's assessment during their most recent inspection as soon as possible. In this respect the update from Brenda is somewhat more reassuring.

As you indicate most of that agreed this morning has already been established in some form or other. Coincidentally I had occasion to speak with Cathy in respect of the Breast Assessment Consultation and a proposed meeting with clinical colleagues late morning. She raised the RQIA correspondence which they had just received. Cathy also indicated that the Trust would welcome external support.

I have no doubt from our conversation that the scale of the task particularly in respect of staffing is proving extremely challenging and that any further regional coordination or assurance arrangements the Department felt now necessary and appropriate would be very much welcomed.

I am content to leave further discussion to you and Sean in respective policy and professional roles and to be involved as you need. I have asked Ian McMaster to provide any expert professional medical input your require.

Please let me know if I can be of any further support. Probably helpful if Paddy or I are involved in the planned meeting with the Trust, HSCB and RQIA from a sponsorship perspective. I am also very happy to provide any other support as you both feel necessary.

Michael

Sent with BlackBerry Work
(www.blackberry.com)

From: McArdle, Charlotte <Charlotte.McArdle@health-ni.gov.uk>
Date: Thursday, 02 May 2019, 8:52 pm
To: McBride, Michael <Michael.McBride@health-ni.gov.uk>, Holland, Sean <Sean.Holland@health-ni.gov.uk>
Cc: Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>, Morton, Rodney <Rodney.Morton@health-ni.gov.uk>, Woods, Paddy <Paddy.Woods@health-ni.gov.uk>
Subject: RE: Meeting this am

Michael

Many thanks for convening the meeting and apologies I couldn't be there.

I agree that this approach is now necessary. Sean and I have had conversations about how we can best have an overview of the improvements the Belfast Trust need to make versus providing support to the HSC system as a regional service. Sean had put in place a monthly meeting with the Trust/HSCB/PHA but the development of the RQIA escalation and whistle blowing letter now makes the need for oversight and assurance more urgent and frequent. I agree this needs to be a partnership between HSCB/PHA and Marie and Mary are best placed to co chair.

I have spoken to Brenda Creaney today who has provided assurances that whilst not ideal she is confident that nurse staffing levels are safe. This is highly dependant on long term agency staff.

She also confirmed that she will provide any addition information the department requires in this regard and acknowledges the need for increased nursing support provided by independent sources. Brenda is now clear that issues of communication

between the ward nursing team, the MDT and operational management requires attention in order to safeguard residents.

Regards
Charlotte

Sent with BlackBerry Work
(www.blackberry.com)

From: McBride, Michael <Michael.McBride@health-ni.gov.uk>
Date: Thursday, 02 May 2019, 2:21 pm
To: Holland, Sean <Sean.Holland@health-ni.gov.uk>, McArdle, Charlotte <Charlotte.McArdle@health-ni.gov.uk>
Cc: Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>, Morton, Rodney <Rodney.Morton@health-ni.gov.uk>, Woods, Paddy <Paddy.Woods@health-ni.gov.uk>
Subject: Meeting this am

Sean, Charlotte,

We had a constructive meeting this morning to discuss our Departmental response in relation to recent letter of escalation from RQIA and yesterday's summary of concerns of a member of staff who contacted RQIA.

In attendance: Chris Matthews; Jerome Dawson; Rodney Morton; Paddy Woods.

We discussed and agreed in principle subject to further discussion with you Sean as policy lead:

1. Meeting to include BHSCT, RQIA, HSCB and ourselves in order that we arrive at a reconciled position and view as a Department in relation to: safety of current service; adequacy of support arrangements to staff; progress or otherwise on matters previous identified; need for additional regional or external expertise to support the Trust.
2. Regional Coordination Group – jointly chaired by HSCB and PHA. (most probably Marie and Mary)
3. Departmental Assurance Group chaired by Charlotte and you with input from my team as you both require with RQIA as members.

Most of this largely builds on that current in place or previous in place and all were agreed should provide greater support and appropriate challenge to the Trust, coordination by HSCB and PHA given regional nature of the service and the reassurances we all require from a policy and professional perspective and would we believe address the further recommendation of RQIA for a regional task group.

Jerome, please share with Chris as I'm sure he's back on our system yet.

Michael

RQIA BI-MONTHLY UPDATE REPORT – November 2018

ASSURANCE DIRECTORATE UPDATE

The Care Home Team (Nursing and Residential)

On 1 October 2018 the former Nursing Home Team and Residential Care Home Team amalgamated to form The Care Home Team. This has been a positive change, well received by staff and it is believed that it will provide cohesive governance and oversight of the care home sector going forward. Recent recruitment has brought this team to its full staff complement.

Care Home Enforcement

Since 26 September 2018 there have been three serious concerns meetings with nursing homes. Robust action plans were presented in respect to the regulatory breaches, providing us with the necessary assurances that the issues had been addressed.

A further nursing home where a failure to comply notice had been extended to the full three month period is now in compliance following inspection on 21 September 2018.

A residential care home where a failure to comply notice had been issued regarding medicine management, is now back in compliance following an inspection on 17 October 2017.

An intention to issue a failure to comply notice meeting in relation to medicine management was held with a nursing home on 17 October 2017. A robust action plan was presented in relation to the regulatory breaches, providing assurances that the issues had been addressed and the notice therefore was not served.

Residential care beds in nursing homes (at 19 October 2018)

Services still undecided	**5**
Application forms issued and still to be returned	**1**
Application forms received and being processed	**6**
Certificates issued	**100**
Applications withdrawn	**2**

Representatives from RQIA met with DLS and junior counsel on 10 October 2018 to discuss the legal advice shared by the Independent Health Care Provider (IHCP); and to consider the intention of the law and the consistency of our approach. Advice is being sought from Junior Counsel regarding RQIA's interpretation of the regulations. In his opinion, RQIA should stand by their decision for separate registrations in order to ensure that businesses are structured effectively to enable appropriate regulation and inspection activity. Before RQIA take any further action, floor plans and other essential documents have been forwarded to Counsel for review. A final formal written opinion will follow.

Runwood Homes Ltd

Following notification of a further change to the senior management team responsible for Northern Ireland, we meet with Responsible Individual and the new Northern Ireland Director of Operations. Assurances included, an outline of the senior management structure, reporting arrangements to the Responsible Individual and internal governance arrangements that should be followed in communication with RQIA.

An application for the new residential care home in Enniskillen - Meadowview (previously registered as Ashbrooke) is ongoing. A fee has been received. We are awaiting a completed registered manager application and this will trigger a pre inspection visit.

Early Alert – Four Seasons Health Care (FSHC) and Runwood Homes

An Early Alert was issued to the Department on 8 October 2018 regarding financial restructuring of Four Seasons Health Care and the further extension of the standstill arrangements. The early alert also advised of issues in relation to finances within Runwood homes LTD following publication of the COPNI report.

An update was provided on 17 October 2018 to advise that there is still no plan in place regarding sale of the homes and that the deadline regarding the "standstill" agreement is 19 October 2018. A meeting took place on 31 October 2018 with Four Seasons Health Care.

Drumclay (Ebbay Ltd)

RQIA was advised on 10 September 2018 of Ebbay Ltd's intention to give formal notification to cancel the registration of Drumclay Nursing Home in Enniskillen. RQIA continue to progress this application with a closure date of 12 December 2018. RQIA continue to meet weekly with the Western Trust as part of the oversight group. The Western Trust is liaising closely with Ebbay Ltd representatives in terms of a number of options currently being explored.

RaDaR

A further workshop on the RaDaR model is to take place on 5 November 2018 at 12.00-16.00 at Innovation Lab, Springfield Road, Belfast. Early indications are that the scores are reflective of inspector opinion about the need for a second inspection. The purpose of the workshop is to consider the dynamic element of the tool. An invitation has been extended to the DoH to attend. As this is not possible the Director of Assurance has accepted an invitation to make a presentation on RaDaR to Departmental staff shortly. Interest in this model has been shown by CQC and Care Inspectorate Scotland, and an invitation has been extended to them.

Human Rights Training

Following the recommendations of the COPNI Home Truths report, All inspectors in the Care Homes Team have recently received bespoke training in human rights. This training will be rolled out to all RQIA inspectors by mid-November and

EMT and Board members in the new year. RQIA is implementing a programme of work to ensure the Human Rights approach is embedded in all practice. We are reviewing our inspection methodology to include the use of Human Rights based language within reports. RQIA is co-hosting also with IHCP two workshops on Human Rights on the 23 and 30 November 2018.

Agencies, Day Care, Estates, Finance and Pharmacy

Domiciliary Care Agencies:

The number of domiciliary care agencies registered with RQIA remains at 297. One agency's registration was voluntarily cancelled on the basis of a merger with another. One application for registration of a Belfast agency has been completed since the previous report.

RQIA continue to receive and process applications from individuals and organisations proposing to carry on domiciliary care agencies. RQIA inspectors have identified five registered domiciliary care agencies that have not become operational since first becoming registered. RQIA is concerned that assurances obtained at the point of registration cannot be relied upon given the time that elapsed since registration. Consideration is being given to imposing a condition on the registration of these agencies to ensure that further assessment of their capacity to provide safe, effective and compassionate care is undertaken prior to becoming operational. There is a time lag between some agencies being registered and commencing operations. A legal view is being sought from DLS in respect of whether RQIA can impose a condition on the registration of the provider to inform RQIA of the effective date of operation.

Nursing Agencies

There are currently 42 registered nursing agencies with a further 14 applications in progress. Seven applicants who are proposing to have registered offices in England, RQIA is seeking legal advice on how RQIA can robustly regulate these services if there registered office is outside the NI Jurisdiction and will advise DoH accordingly.

RQIA has been advised of an incident in which a member of care staff supplied by a nursing agency to work in a care home is alleged to have arranged for an associate to undertake their shifts in the home. While the supply of non-nursing staff by nursing agencies is not activity that falls to be regulated by RQIA, the potential for users of regulated services to come to harm is significant in the absence of appropriate governance arrangements. This incident occurred in a Runwood Home but RQIA has shared these

concerns across the care homes sector by letter and reminded all providers of residential and nursing homes of their responsibility to ensure compliance with the regulations and standards regarding recruitment practices.

Day Care Settings

Eight registered providers provide day care in Northern Ireland and run 19 day centres. Of these 19 day centres, 29 additional satellite units were developed. RQIA established a project to regularise the registration of these services. The revised position in relation to 'satellite units' that falls to be registered as a day care setting is still being worked through by trusts following further information issued by RQIA. It is expected that some providers will be required to make a formal application to operate as a stand-alone unit. An update will be provided to DoH at the next meeting.

Estates

RQIA has reviewed the memorandum of understanding (MoU) between itself and the Northern Ireland Fire and Rescue Service. The final MoU was finalised and signed off by both parties in late September 2018 and was published on RQIA's website on 30 October 2018.

Finance

RQIA finance inspectors continue to focus on the safeguarding of service users' finances in residential homes and nursing homes. Some supported living domiciliary care agencies have also been inspected and areas for improvement have been identified. These include monitoring and oversight of service users' finances and seeking appropriate assurances that there are additional safeguards in place over and above the self-assessment declaration returns made by providers. RQIA wrote to each trust to ask them to review their compliance with their responsibilities under the DHSSPS Circular Reference: HSC (F) 15-2016 'Safeguarding of Service Users' Finances within Residential and Nursing Homes and Supported Living Settings' RQIA is going to provide short guidance for the sector on best practice in the management of residents' monies and a workshop is planned with ARC in due course to discuss this matter.

Medicine management

RQIA pharmacist inspectors continue to focus on ensuring that there are safe systems in place for the management of service users' medicines in care homes. Their expertise has also been utilised this year in the inspections/reviews undertaken by RQIA in the prisons, independent healthcare, mental health and learning disability programme and the outpatient services in Belfast Trust. This focus will mean that the number of care homes inspected this year will be reduced. The care home inspection schedule is kept under review to ensure that inspections are prioritised if concerns about medicines are identified.

Medicines Management Workshops

In conjunction with NICE, the pharmacist inspectors organised three very successful workshops across Northern Ireland in September with care home providers and managers. The use of scenarios led to discussion on best practice and feedback from the participants was extremely positive.

Enforcement

Bluebird (Holywood) (domiciliary care agency)

A failure to comply notice was issued to this agency on 8 August 2018 in relation to repeated failures to establish and maintain a system for monitoring the quality of services provided. A follow up inspection was undertaken on 15 October 2018 and compliance with the regulations was noted resulting in the lifting of the notice.

Partnership working

- RQIA has been in contact with the Department for Economy's Employment Agencies Inspectorate (EAI) regarding the concerns identified relating to the supply of non-nursing care staff by nursing agencies to regulated services. A meeting is being convened in November 2018 to explore the development of a memorandum of understanding between RQIA and the EAI.
- RQIA staff had a positive meeting with BHSCT quality and governance representatives on 8 October 2018 to explore improved ways of escalating concerns and sharing information regarding the commissioning and provision of domiciliary care. Trust colleagues have agreed to share information relating to a range of quality issues which will assist inspectors to make informed regulatory responses. RQIA staff are planning to replicate this joint working across the remaining Trusts.

- RQIA inspectors of domiciliary care agencies and day care settings have co-produced 'easy read' accessible report templates, with service users of Domiciliary Care Supported Living Services, for the purpose of ensuring that inspection findings are more accessible to service users with communication needs. RQIA has also has the support of speech and language therapy colleagues from the South Eastern and Northern Health and Social Care Trusts in the promotion of effective communication with a range of service users.
- RQIA has organised further 'Winter Pressures' workshops on the 6 and 7 November 2018 and these will be aimed at providers of domiciliary care; inputs have been secured from the Public Health Agency, local councils and NIAS.
- RQIA staff have committed to presenting information about complaints and recruitment to two groups of social care managers at forthcoming NISCC events.
- RQIA staff have attended and presented at a Northern Ireland Federation of Housing Associations event on 9 October 2018. This event highlighted challenges in the provision of good quality housing to users availing of supported living type domiciliary care.

Children's Team

Unregistered facilities accommodating young people

A regional workshop was co-hosted by RQIA and the HSCB and was attended by all trust senior management teams with representation from DoH. The event generated a range of options and potential solutions' to address the current situation. The outcomes of this workshop will be detailed in a paper which will be prepared by the HSCB. RQIA will continue to engage with the HSBC to follow up agreed actions with respective trusts.

A paper on the 'numbers of unregulated placements made by trusts of 16 / 17 year old young people in Northern Ireland' was presented to the Audit Committee on 18 October. The paper detailed the background and scoping the extent of this matter and will be revised and presented to the Board and DoH in due course.

Monthly monitoring returns

RQIA will co-host a regional workshop with the BHSCT on 9 November 2018, which will involve all trusts' senior management teams. The purpose of the workshop is to disseminate the newly revised monthly monitoring report template and conclude this piece of work. The objective is to ensure a uniform approach regionally to reporting on the operation of children's homes via this template. Subject to Belfast Trust agreeing to the use of this template, further dialogue will be held with the other four trusts and

the HSC Board.

VOYPIC

RQIA have consulted with VOYPIC to facilitate a peer assessment model to be applied to the inspection of children's homes. A plan with costings is pending.

Serious Concerns

Since the last bi-monthly one serious concerns meeting was held with in relation to a breach of the Statement of Purpose (SOP) of a respite unit. A robust action plan was agreed to return the home to compliance and no further action was required.

QUALITY IMPROVEMENT DIRECTORATE (HEALTHCARE INSPECTIONS, MENTAL HEALTH, AUDITS / GUIDELINES and REVIEW PROGRAMME

HEALTH AND SOCIAL CARE (HSC) PROGRAMME

INSPECTIONS IN THESE PROGRAMMES ARE UNDERTAKEN IN THE CONTEXT OF THE QUALITY STANDARDS FOR HEALTH AND SOCIAL CARE (2006)

Northern Ireland Ambulance Service - Unannounced Hygiene Inspection Programme

- Three Improvement Notices for Broadway, Bangor and Craigavon Stations relating to the Corporate Leadership and Accountability quality standard remain in place until 31 October 2018.
- We met with NIAS on 5 October 2018 to discuss implementation of their improvement plan. The meeting was positive and the Trust outlined refreshed governance systems and processes to support oversight of infection prevention and control and cleanliness standards across the organisation. We will assess the service after 31 October 2018 to gain assurance as to the progress NIAS has made over the six months of the Improvement Notices. Following this assessment a decision will be made with regard to lifting/maintaining the Improvement Notices.

Acute Hospitals - Unannounced Inspection Programme (HIP)

- As part of the QA process, inspection reports for South West Acute, RBHSC (2nd inspection) and Causeway hospitals are being edited by the head of the Business Unit.
- We continue to monitor the RBHSC in relation to improving the governance and accountability arrangements relating to SSPAU (short stay paediatric assessment unit) and plans for refurbishment of Barbour Ward.

Phase III HIP

- The HSC Healthcare Team has now commenced a programme of unannounced inspections of outpatient departments in the Belfast Trust.
- Over the period 11 – 26 October 2018, unannounced inspections have been carried out to outpatient departments across the Belfast Trust (Musgrave Park Hospital, Belfast City Hospital, RBHSC, Mater Hospital and Royal Hospital sites). Themes identified during these inspections will form part of the overall report into the Review of Governance Arrangements in Outpatient

departments within the Belfast Trust (as prompted by the neurology patient recall in the Belfast Trust).
- This inspection methodology will subsequently be spread to other Trusts across the region as part of Phase III of HIP.

Unannounced Hygiene Inspection Programme
- A risk based programme is continuing using intelligence from PHA surveillance reports/intelligence, whistleblowing, complaints etc received by RQIA.
- On 4 October 2018 a follow up inspection to Ward 15A Ulster Hospital was carried out. This was as a result of areas for improvement in general environment, sharps and patient equipment, identified during an inspection on 17 May 2018. This inspection has demonstrated improvement with good standards of environmental cleaning and adherence to best practice for infection prevention and control.

Augmented Care – Unannounced Inspection Programme
- **Neonatal Care – Year 3**: As previously reported we are seeing reliability in systems and processes in these settings (having reached the end of our Three year inspection programme). We await formal correspondence from the DoH to advise HSC Trusts and the neonatal network to collaboratively progress and re-orientate our approach in this area of assurance.

- **Adult Critical Care – Year 3**: We have completed our three year risk based approach to inspection. As with the neonatal care inspections, we are also seeing reliability in the systems and processes within the critical care units inspected.
- In taking forward our new approach to assurance in critical care, we will meet with the Critical Care Network on 5 December 2018. As with the neonatal network, we await formal correspondence from the DoH to advise HSC Trusts and the Critical care Network to collaboratively progress and re-orientate our approach in this area of assurance to one of self- assessment with periodic Inspection by the RQIA Healthcare Team.

- **All other Augmented Care areas** - This inspection programme will recommence upon completion of our adult critical care programme (above), and will adopt a risk based approach. Based on findings of inspections undertaken in 2016/2017 our inspection activity in this programme will initially focus on outpatient services which provide augmented care.

Protected Disclosure (Northern Trust)
- On 18 September 2018 a member of staff from the Northern Trust made a protected disclosure to RQIA. The staff member alleges that in May 2017 two children received substandard care in Antrim Area Hospital, care which may have involved low sodium levels. A member of RQIA staff subsequently met with the whistle blower to obtain further details. RQIA wrote to the Chief Executive of the Northern Trust seeking the Trust's confirmation of quality of care provided to both children. A response has now been received from the Trust which is being analysed by RQIA staff.

INDEPENDENT HEALTHCARE (IHC) PROGRAMME

INSPECTIONS IN THESE PROGRAMMES ARE UNDERTAKEN IN THE CONTEXT OF THE HEALTH AND PERSONAL SOCIAL SERVICES (QUALITY IMPROVEMENT AND REGULATION) (NORTHERN IRELAND) ORDER 2003 & THE INDEPENDENT HEALTHCARE REGULATIONS (NORTHERN IRELAND) 2005

Independent Healthcare Team

Dental Regulation

Quinn Dental
At the announced inspection of Quinn Dental on 4 October 2018, concerns were identified in relation to infection prevention and control, decontamination and the management of a medical emergency. Mr Quinn attended a concerns meeting at RQIA on 10 October 2018 and provided assurances that the identified issues had been addressed and that the improvements would be sustained. As a result no enforcement action was necessary.

Online Medical Services/Independent Medical Agencies (IMAs)

We have reviewed our approach to the regulation of online medical services. An options appraisal paper was presented to the RQIA Board for discussion on 20 September 2018. A copy of this paper has been forwarded to DoH. A plan will be confirmed to progress the preferred option from January 2019, subject to agreement with DoH.

Independent Hospitals and Hospices

Inspection Methodology – Provider Workshop
We are preparing to hold a workshop on 3 December 2018 to share information with the independent hospitals and hospices in relation to our revised inspection methodology, which will be implemented in IHC from January 2019. Refreshed inspection methodology will include a larger multi-disciplinary inspection team, an enhanced focus on organisational and clinical governance, regular multi-disciplinary debriefing and immediate post-inspection feedback to senior managers/management team. Inspection methodology for independent hospitals will now be similar to that underpinning inspections across HSC hospitals.

INSPECTIONS IN THIS PROGRAMME ARE UNDERTAKEN IN THE CONTEXT OF THE IONISING RADIATION (MEDICAL EXPOSURE) REGUATIONS (NORTHERN IRELAND) 2018

Ionising Radiation Incident

- On 25 May 2018, RQIA received a notification from the Belfast Trust, of a nuclear medicine incident, whereby a patients foetus was affected by a treatment provided. A planned visit/inspection was undertaken with Belfast Trust on 14 June 2018 (including an expert team member from Public Health England). A copy of the report has been forwarded to the Belfast Trust for factual accuracy checking.

International Atomic Agency

- The International Atomic Energy Agency will be carrying out an Integrated Regulatory Review Service Mission in the UK during October 2019, following the UK's departure from the European Union. In preparation for this a UK wide self-assessment will be completed and be coordinated by the Office for Nuclear Regulation (ONR).
- The self- assessment for RQIA has been completed and returned. The RQIA Board was informed on 20 September 2018. The next stage is analysis, identification of any gaps in the process and development of an action plan to address these gaps.

Stakeholder Workshop

A radiation stakeholder workshop involving all trusts and independent organisations will be held on 7 November 2018, to discuss the new Ionising Radiation (Medical Exposure) Regulations which came into operation in February 2018.

MENTAL HEALTH AND LEARNING DISABILITY (MHLD) PROGRAMME

INSPECTIONS TO MHLD IN-PATIENT WARDS ARE UNDERTAKEN IN THE CONTEXT OF THE MENTAL HEALTH (NI) ORDER 1986 AND THE QUALITY STANDARDS FOR HEALTH AND SOCIAL CARE (2006)

Belfast HSC Trust

Our MHLD Team completed an unannounced inspection of four of the five acute inpatient care mental health services in Belfast HSC Trust on the 3-5 October 2018, using a refreshed inspection methodology. Refreshed methodology included a larger multi-disciplinary inspection team, an enhanced focus on organisational and clinical governance and immediate post-inspection feedback to senior responsible managers within Belfast Trust. The team comprised of ten inspectors, two lay assessors, a peer reviewer and two administrative support staff. The inspection evidenced a number of macro concerns across the services. These included:

- Transfer of patients between wards
- The management of patients' physical health care needs
- The ethos, statement of purpose and running of the PICU
- Referrals between the PICU and the Shannon clinic
- The use and management of PRN medication

Inspectors evidenced a number of positive areas of practice and developments since the previous inspection. These included the introduction of a new patient care delivery system (PIPPA), a good standard of mental health nursing care, positive relationships between patients and staff and good multi-disciplinary team working.

Southern HSC Trust

- During a scheduled unannounced inspection of Cloughmore Ward, Bluestone Unit, RQIA identified a concern relating to nurse staffing levels. Having reviewed this information in conjunction with other intelligence held by RQIA, with respect to nurse staffing levels across the Bluestone Unit, an urgent teleconference call was arranged with senior representatives from the Southern Trust. Adequate assurances with respect to nurse staffing levels were not provided during this teleconference call, and as a result an unannounced inspection to the remaining five wards in the Bluestone Unit was undertaken on Friday 31 August 2018.

A follow up unannounced inspection to Bluestone Unit took place on Sunday 16 September 2018. The following issues were identified during the inspection:

1. Staffing levels – in general across Bluestone Unit and in particular in Dorsy and Rosebrook wards. Inspectors were concerned about the level of staffing given the complexity of patients and the prescribed patient observations on the ward; Inspectors actively considered recommending that the whole unit should cease to receiving acute admissions – however they were advised that beds in Bluestone Unit were the only MH/LD beds available for the region on 16 September 2018;
2. Use of seclusion (extra care suite) in Rosebrook, Inspectors were concerned about the understanding and use of seclusion/extra care suite by staff on the ward; documentation relating to use of seclusion was poor and inconsistent; staff reported varying understanding and approaches to the use of seclusion/extra care as part of meaningful and therapeutic care delivery;
3. Serious incident in Dorsy ward, Inspectors were concerned about a recent incident (involving patient with a knife) which required attendance from PSNI and Regional Tactical Response Unit. RQIA received an action plan from the trust. A meeting was held with Southern Trust on 12 October 2018.

A serious concerns teleconference was held with the Trust on 20 September 2018 due to concerns identified. At this meeting the Trust updated RQIA on the use of seclusion, a serious incident not previously advised to RQIA and measures currently in progress to address staffing challenges. The Trust continues to have problems retaining current staff and recruiting new staff. RQIA has raised these concerns and the wider inspection findings (inspection on 16 September 2018) with HSCB and DOH. A further serious concerns meeting was held with the Trust Chief Executive and Senior Representatives on 12 October 2018. The Trust outlined actions currently in progress to address the above findings, RQIA will continue to monitor this situation.

Prison Healthcare

- The final report of the joint Maghaberry prison inspection undertaken in April 2018 was to the Chief Medical Officer on 27 September 2018. Findings of this inspection indicate that health care is an improving picture and was reasonably good. The Criminal Justice Inspectorate (CJI) will forward a copy of their press release 48 hours before publication of this report. The date for publication has not been confirmed.
- RQIA is currently working jointly with the Criminal Justice Inspectorate, on a thematic inspection of the four Northern Ireland Prisons, with a focus on the 'Safety of Prisoners'. The formal inspection programme (fieldwork) commenced in early September 2018 and is continuing, follow up inspections and meetings are in progress.
- One matter has been escalated to the South Eastern HSC Trust and Northern Ireland Prison Service as it required urgent attention during week 3 of this inspection (escalated on 19 September 2018). This was in relation to the poor standard of

hygiene and cleanliness of the Care and Supervision Unit (CSU). RQIA, in accordance with our role as members of the National Preventative Mechanism (NPM), also escalated this concern due to our concern relating to inhumane and degrading conditions.

- RQIA will update DoH regarding the approach to the publication of the report of this inspection in line with agreed procedures.

SAFEGUARDING REVIEW PANEL REPORT, MUCKAMORE ABBEY HOSPITAL (MAH)

- In November 2017 a number of staff were suspended from MAH. A review of CCTV evidence was commenced and in total 13 staff were suspended from MAH. There is an ongoing investigation being led by the PSNI. As a result Belfast Trust commissioned Margaret Flynn to undertake a Level 3 SAI investigation into safeguarding arrangements at MAH. On 15 August 2018, RQIA received a draft report of this Level 3 SAI review from the Designated Review Officer (DRO) for this SAI in HSCB, as the draft report refers to RQIA. A copy of the draft SAI report was also shared by Belfast Trust. Commentary on the draft SAI report has been provided by RQIA to the DRO on 19 October 2018. RQIA has requested a meeting with DRO.
-

MHLD ICONNECT INFORMATION SYSTEM

- Work continues on system build for I-Connect MHLD build. The project is on track for completion by December 2018. There are currently eleven open risks, all risks have been identified as low/medium and are being appropriately managed.

PART II DOCTORS APPOINTMENT PROCESS (MH ORDER 1986)

- Our proposal regarding refreshing arrangements for appointment of Part II Doctors was unanimously supported at a meeting of the Medical Leaders Forum on 25 June 2018. The new proposal will mean that individual Consultant Psychiatrists will submit application for Part II status to their Trust Clinical Director (CD), who will make a recommendation to RQIA on the basis of that application. An RQIA panel will approve Part II status based on the Trust CD's recommendation. This change was initially planned for implementation from 1 October 2018, following discussion with our Board refreshed arrangements will now be implemented from 1 January 2019.

REVIEWS PROGRAMME

Neurology Patient Recall, Belfast Trust
RQIA is leading three strands of work as requested by DoH:

(i) Governance Review of Outpatient Services in the Belfast Trust, with a particular focus on Neurology and other High Volume Specialties
Fieldwork is continuing, with findings from a governance questionnaire and meetings with the Expert Review Panel and a wide range of staff from the Trust and HSC Board and PHA, being analysed to inform the review report. A series of unannounced inspections to outpatient sites across the Trust has also taken place – see section on Phase III HIP, under our Healthcare (HSC) Inspection Programme. Patient engagement has commenced with direct engagement by lay assessors and RQIA staff during our unannounced inspections along with an online survey. This engagement will be supplemented by focus groups. This review is scheduled to complete in December 2018.

(ii) Expert Review of Clinical Case Notes of Patients of Dr X's who have Deceased in the previous 10 Years
Meetings to inform planning are continuing and an information sub-group has been established, which is liaising with the regional information group, facilitated by the HSC Board and PHA. Expertise to undertake this expert review work is currently being discussed and sourced.

(iii) Review of Governance (Corporate and Clinical) relating to Health Services delivered by Independent Sector Hospitals in Northern Ireland
Terms of reference are being finalised and an expert review panel is currently being established. This review is scheduled to complete in June 2019. This work will be underpinned by the inspections by the Independent Healthcare Team, using our revised inspection methodology.

Inquiry into Hyponatraemia Related Deaths (IHRD/O'Hara)
RQIA is leading and facilitating the regional Assurance Working Group which is part of the DoH-led programme on implementation of IHRD Recommendations. A draft Assurance Framework has been developed by RQIA and submitted to DoH (w/c 7th May). The first meeting of the formal IHRD Assurance Working Group took place on 15 October 2018, the next meeting is scheduled for 03 December 2018.

Review of Serious Adverse Incidents (SAIs) to inform IHRD Working Group on SAIs
Finalised terms of reference have been agreed with the Expert Review Team and will now be discussed with DoH. A sampling

frame for the review of SAIs has been reviewed and an audit tool is being worked up, with input from the Expert Review Team. Arrangements for access to relevant data from each of the SAIs is to be discussed with the Trusts. Methodology for engagement with families involved in SAIs during the identified reporting period is currently being discussed and is to be finalised by the Expert Review Team.

Other Review Work

Reviews in progress - Out of Hours GP Services (RQIA Initiated) and the Review of the Implementation of Clinical Guideline CG174 Intravenous Fluid (IV) Therapy in Adults in Hospital (DoH Commissioned) - first drafts of these reports are currently in development/drafting.

The following REVIEWS are IN PROGRESS:

Name of Review	Status
Review of Out-of-Hours (OOH) General Practitioner (GP) Service (RQIA Initiated)	First draft of report competed, in internal drafting.
Review of Implementation of Clinical Guideline CG174 Intravenous Fluid Therapy in Adults in Hospital (DoH Commissioned)	First draft of report competed, in internal drafting. We will publish a report of regional interim findings and a short report to each Trust. A letter has been forwarded to DoH outlining challenges in relation to systems/processes for oversight of implementation of NICE guidance in Northern Ireland.
Review of Service Frameworks (DoH Commissioned)	Review paused, as agreed with DoH, as part of the re-prioritisation of the Reviews Programme.
Review of Children with a Disability (RQIA Initiated)	At scoping stage.
Review of how Trusts Commission Services from the Independent Sector (DoH Commissioned)	Details of commission and scope of work currently being worked up.
Reviews in QA Process	

Review of Developing Eyecare Partnerships	QA process completing, submission to DoH early November 2018.
Review of General Paediatric Surgery	QA process is completing, submission to DoH mid November 2018.
Review of Acute Emergency Mental Health	Returned from factual accuracy check. QA process to complete, submission to DoH late November 2018.
Review of Use of Restraint and Seclusion	At final drafting stage, for factual accuracy, QA process to complete, publication early 2019.
Review of Renal Services	Requires further fieldwork, analysis and drafting; timescale is influenced by processes above and review of programme priority areas (per IHRD and Neurology work programmes.

RQIA Clinical Audit and Quality Improvement Prototypes

Audit

2018/19 Programme

We are funding six pieces of work – 3 audits and 3 quality improvement initiatives during 2018/19:
All audits and quality improvement initiatives have commenced and are at fieldwork stage. A robust monitoring is in place and any concerns/issues will be identified and escalated at an early stage.

2017/2018 Programme

All outstanding audit reports from our 2017/18 Audit Programme have now been completed and have been uploaded to the RQIA website. We would wish to thank all audit team leads and participants for work in undertaking and completing these audits.

One guideline (planning home births in Northern Ireland) which was scheduled to finish in September 2018 is on track.

BUSINESS SUPPORT UNIT UPDATE

Workforce Review

Following interviews, Jennifer Lamont was appointed Head of Business Support and has been in post since 15 October 2018. Dermot Parsons has been appointed as Deputy Director of Assurance and is due in post on 13 November 2018. The position of Deputy Director of Improvement has been offered to the successful candidate, a further update will be provided shortly.

Work is ongoing to revise job descriptions identified in the workforce review. We are considering the resource needs of the Business Support Unit with the intention of creating new posts including a Business Manager in due course.

A business plan and risk register for the Unit is currently under development.

Financial Allocation 2018-19

An allocation of £6.5 million was made available to RQIA for 2018/19. This included a recurring reduction of 2% (£134k). RQIA have also received non-recurring funding in respect of VES of £190k and a number of interested staff have been offered and accepted VES with this tranche of staff will leave between December 2018 and March 2019. Enquiries are ongoing with DoH to fund other VES applications received. Due to delays in the recruitment of staff RQIA will be making an easement to DoH to ensure we break even at year end.

The restructuring of RQIA has commenced following the outcome of the Workforce Review carried out in 2017/18. As a result of this a number of posts have or will be advertised in the coming months. Due to the likely delay in individuals taking up posts it is anticipated that there will be significant slippage against budget. £180k has already been declared and the RRL reduced accordingly. £20k has also been deducted from our capital budget for the MHLD iConnect project.

Significant pay slippage against year to date budget is a result a combination of leavers, delays in filling newly created posts and VES. RQIA continues to work with BSO Shared Services to manage the significant delays in banding, recruiting and filling new posts. A significant non-recurrent easement is currently being finalised to be declared in early November.

RQIA is currently preparing a business case for additional funding for a full time senior solicitor to support the work of the case note review of deceased patients of Dr Watt. This can be funded internally until the end of March 2019 but is a cost pressure thereafter. It is likely that the post will be required for around two years.

Sickness Absence

RQIA sickness absence is currently on target at 7.8%. However, a number of long-term absences are to be resolved in the near future and we expect this figure to reduce significantly.

Information

Under the leadership of Rachel Stewart, RQIA continues to improve its capacity and capacity to use information effectively and produce intelligence about individual establishments and the system as a whole. Uptake of the webportal for submitting notifiable events has increased from 55% in August 2017 to 99% currently. This has resulted in a significant saving in processing time and an

increase in the data available for analysis within iConnect. Plans are now in place to increase the scope of forms submitted via the webportal.

A number of strategic alliances have been formed with other organisations across the HSC including NIAS, DoH, GRO and PHA. RQIA are also now represented at the HSC Information Standards Board and UK wide Healthcare Regulator Analyst Network. This has resulted in an increase in awareness of how the wide range of information available throughout the HSC could inform the inspection and review activities of the RQIA. The information analysts have currently sourced and carried out initial quality assurance checks on information sources including hospital admissions, ambulance calls and registered deaths for people normally resident in one of RQIA's registered services in order to assess their value and relevance to the work of RQIA.

Internal Audit

Two internal audits have been competed in 2018/19. RQIA's Performance Management Audit and Risk Management both reported that RQIA has a satisfactory system of control in place. A number of priority two and three recommendations were made and are on target for completion. In respect of the audit of compliance with the Permanent Secretary's instructions on travel, Internal Audit have reported that RQIA has a satisfactory system of control in place.

MSFM

The MSFM has been received for approval by the Board and signature of Chief Executive.

Media

RQIA responded to a number of media queries relating to various aspects of our work, including: RQIA's regulation of Runwood Homes care homes; the investigation at Muckamore Abbey Hospital relating to allegations of abuse of patients by staff; the MRSA outbreak in the neonatal unit of Royal Jubilee Hospital; COPNI report into Dunmurry Manor Care Home; and the Baseline Audit of Forensic Mental Health and Learning Disability Services.

Political Engagement

In conjunction with other health regulators/bodies (GMC, NISCC, Pharmaceutical Society NI, NICON), RQIA attended the UUP conference in October 2018, and will attend the DUP, Alliance Party, SDLP and Sinn Féin conferences throughout 2018-19. Since the last bi-monthly meeting, RQIA's Chief Executive and Communications Manager met with Alliance Party health spokesperson, Paula Bradshaw MLA, to provide an update on our work. Further meetings with the other political party health spokespersons have also been sought.

Complaints and Compliments

Since the last bi-monthly meeting no formal complaints have been received about RQIA.

Four compliments were received from service users and relatives about services we inspect. One in respect of a day care centre and three in relation to nursing homes. A compliment was also received from a manager of a nursing home regarding the inspector and lay assessor during an inspection.

NOTE OF MID YEAR ASSURANCE AND ACCOUNTABILITY MEETING BETWEEN DHSSPS AND RQIA ON 26 NOVEMBER 2012 – PART B

ATTENDING:

RQIA
Ian Carson - Chair
Glenn Houston - Chief Executive
Maurice Atkinson - Director of Corporate Services
Theresa Nixon - Director of Mental Health and Learning

Department
Andrew McCormick – Permanent Secretary
Paddy Woods - DCMO
Christine Jendoubi - Director of Mental Health, Disability and Older People Policy
Peter Toogood - Director of Finance
Billy Baird - Safety & Quality Unit

Apologies:
RQIA
David Stewart - Director of Reviews
Muriel Dickson - Acting Director Nursing & Regulation
Department
Michael Mc Bride - CMO
Fergal Bradley - Head of Central Arms Length Body Governance Unit
Conrad Kirkwood - Deputy Director, Safety Quality & Standards Directorate

1. Minutes & Action points Previous Meeting

1.1 The Minutes of the previous meeting were agreed.

1.2 On outstanding action points Ian Carson confirmed that RQIA had received the Terms of Reference for the proposed Capacity & Capability Review and that once considered by the RQIA Board at its next meeting on 13 December RQIA would forward comments to the Department. Recruitment of new Board members was in process with outgoing Board members terms extended to 14 April 2013 meantime.

2. Governance Corporate

2.1 Paddy Woods in noting that there had been no significant internal control issues and no priority one findings reported within the mid year assurance statement, sought assurances on progress with Priority 2 and 3 recommendations. He also alluded to RQIA's substantial compliance with 18 of the Controls Assurance Standards and 8 criteria where moderate compliance had been achieved and sought assurances on action in these areas.

2.2 Maurice Atkinson confirmed that RQIA was on track to complete necessary action on audit recommendations and had action plans in place to address, in the course of the year, areas where substantive compliance with controls assurance standards had not been achieved.

2.3 Glenn Houston added that the NIHRC Report "In Defence of Dignity" which had made recommendations for RQIA and for DHSSPS which were being progressed, had urged relevant training for staff with a requirement for minimum standards to be examined. The Department had already commenced a review of the minimum standards for nursing home care, with input from RQIA. He expressed RQIA's desire to remain involved, as necessary, with this exercise.

3. Personal Public Involvement

In response to Paddy Woods request for an update on PPI activity, Glenn Houston presented an overview report on RQIA's PPI activities and invited any comments, in due course from the Department.
Ian Carson and Glenn Houston reported attendance at a PCC workshop the previous week and confirmed that a PPI forum was in place within RQIA.

4. Resources (2012/2013)

4.1 Peter Toogood, in referring to the previous year's surrender and the award of additional recurrent grant to RQIA of £250K from the 2012/2013 year, sought assurances regarding in year spend, particularly confirmation that all vacancies had been filled. Glenn Houston confirmed that all vacancies had been filled but that an underspend had accrued from the first quarter. RQIA was maintaining a close scrutiny of spend and is forecasting breakeven. Relevant to this is RQIA's consideration of the appointment of bank inspectors which has the potential to use up any surplus resources. Should the end of year projection change, RQIA will declare any identified surplus in a timely fashion.

4.2 Peter Toogood reminded RQIA representatives about recent guidance on preparation of business cases and compliance with guidance before submission to the Department. He also drew attention to revised external consultancy guidance and on gateway reviews. In welcoming the unqualified 11/12 audit opinion with no Priority 1 findings, he briefly detailed the Priority 2 and 3 recommendations and sought assurances that resolutions were fully addressed. Maurice Atkinson confirmed that action on all audit recommendations was carried out under the oversight of the Audit Committee.

5. Service Delivery Performance

Glenn Houston presented a copy of RQIA's quarterly Corporate Performance Report for period ending 30 September 2012,as recently presented to the

RQIA Board and which detailed progress on key performance targets within the 2012/13 Business Plan.

6. Other Significant Operational Issues & Risks

6.1 Andrew McCormick asked if RQIA had any other significant issues or risks to highlight.
Glenn Houston said that all planned **reviews scheduled for the 11/12 year** had not been completed, but all would be finalised and published by December 2012, subject to Departmental clearance of the **Under 18s in Hospital Adult Wards Review Report.** The delay in the 11/12 review programme could have an impact on the existing work programme, as indeed does the cumulative effect of follow up inspections related to identified risks arising from routine inspections. Such impacts upon the work programme would of course be identified within RQIA's risk register.

6.2 Christine Jendoubi confirmed that she was content with liaison arrangements between RQIA and the Department on mental health and learning disability issues.

6.3 Paddy woods commended RQIA for its achievements as independent regulator but expressed concern if regulatory responsibilities were held back by other demands. He confirmed that the Department had identified no significant risks for RQIA at present.

6.3 Glenn Houston referred to previous correspondence between RQIA and the Department, in which RQIA had expressed concern about **the scope of the 2003 Order** to enable RQIA to require providers to facilitate access to confidential personal information of service users without breaching the 2003 Order and the Data Protection Act. He indicated that meetings had taken place with both the Information Commissioner and Chris Matthews in the Department and the view was that the provision within Article 43(2) (a) of the 2003 Order, enabling access without permission where it was not practicable otherwise, mitigated against the risks for RQIA, pending amendment of the Order. This issue would of course remain on the RQIA risk register meantime.

6.4 Glenn Houston expressed concern about the detail of the Department's proposed **Priorities Check List** for business plans, expressing a preference to retain the style of business plan as RQIA currently described for 12/13. However he acknowledged that if the Department insisted on a catch all approach, RQIA would accord.

7. AOB

7.1 Theresa Nixon expressed concerns about current staffing levels and the skills mix at **Muckamore and Longstone** mental health and learning disability facilities operated by the HSC Trusts. RQIA is working pro-actively with the Trusts on this to triangulate all issues and concerns but have meantime, received a note of concern from parents and relatives.

7.2 In due course RQIA will forward a safeguarding report addressing issues around all 33 HSC Trusts mental health and learning disability wards across the five Trusts. RQIA will be meeting Fionnuala McAndrew to discuss the regulatory position applying to such facilities, including Ralph's Close.

7.3 On-going issues of concern included:
Maine Nursing Home involving death of a resident and suspension of a staff member, with on-going PSNI investigation;

Nazareth Lodge, on-going PSNI investigation into death of resident;

Community Treatment House (BHSCT) where Trust and a Housing Association ran an unregistered nursing home. Closed after 28 days notice from RQIA to accord with regulations.

Home Acute Care Treatment House operating as a flagship HSC Trust development as a home for persons in need but no clarity as to whether residents or tenants.

Ferrone Drive (WHSCT) operated as a house of multiple occupation – issues about registration and minimum standards and questions about the context in which such facilities register the domiciliary care element.

7.4 Andrew McCormick agreed that whatever the model of care, it was essential that such establishments and agencies be examined within the context of the regulations. Christine Jendoubi agreed that the onset of intermediate treatment centres required discussion. She considered that these fell to be registered as residential care homes**.[ACTION DHSSPS]**

7.5 Glenn Houston reiterated concerns about so called housing schemes where people in need of care and supervision were being set up as tenants and expressed a willingness to become involved in a short life working group to discuss. Christine Jendoubi agreed that the matter was one for the Department's Mental Health and Learning Disability Directorate to lead. **[ACTION DHSSPS]**

8. **Conclusion**
Andrew McCormick in concluding the meeting thanked RQIA representatives for a very constructive meeting addressing a broad range of important issues and concerns

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> FYDIBOHF23SPDLT)/cn=Recipients/cn=1021954]
> To:Briscoe, Maura[EX:/o=NIGOV/ou=Exchange Administrative Group
> FYDIBOHF23SPDLT)/cn=Recipients/cn=1067714]
> Cc:Wallace, Colin[EX:/o=NIGOV/ou=Exchange Administrative Group
> FYDIBOHF23SPDLT)/cn=Recipients/cn=1550081]
> Cc:Baird, Billy[EX:/o=NIGOV/ou=Exchange Administrative Group
> FYDIBOHF23SPDLT)/cn=Recipients/cn=0510415]
> Cc:Woods, Paddy[EX:/o=NIGOV/ou=Exchange Administrative Group
> FYDIBOHF23SPDLT)/cn=Recipients/cn=1067570]
> Cc:McBride, Michael[EX:/o=NIGOV/ou=Exchange Administrative Group
> FYDIBOHF23SPDLT)/cn=Recipients/cn=9999965]
> Cc:Holland, Sean[EX:/o=NIGOV/ou=Exchange Administrative Group
> FYDIBOHF23SPDLT)/cn=Recipients/cn=1274024]
> Cc:McMinn, Colin[EX:/o=NIGOV/ou=Exchange Administrative Group
> FYDIBOHF23SPDLT)/cn=Recipients/cn=0691114]
> Cc:Magowan, Neil[EX:/o=NIGOV/ou=Exchange Administrative Group
> FYDIBOHF23SPDLT)/cn=Recipients/cn=0128090]
> Received-Date:11/02/2013
> Received-Time:15:01 (LocalTime)
> Sent-Date:11/02/2013
> Sent-Time:15:01 (LocalTime)
> Subject:DH1/13/36291 : MM/0027/2013 - Glenn Houston - Unannounced
> Inspection Ennis Ward, Muckamore Abbey Hospital
> Maura
>
> Please see attached correspondence from RQIA to Colm Donaghy which outlines
> a number of serious matters arising from an inspection of Ennis Ward at
> Muckamore Abbey Hospital on 29 January (as a follow up to an inspection on
> 13 November 2012). The issues include:
>
> Staffing levels
> Lack of evidence of input to Behavioural Plans from Behavioural Support
> Services (this was a quality improvement plan recommendation from the
> November inspection)
> Limited opportunities for quiet areas for patients
> Significant numbers of locked doors
> No access to bedrooms and personal belongings during the day due to locked
> doors
> No clear protection plans in the five cases examined (despite the
> expectation that these would have been developed since November
>
> RQIA has called a meeting on 11 February to discuss the issues with the
> Trust. You may wish to consider the issues from your policy perspective
> and seek sufficient assurances that the matters are resolved.
>
> Regards
>
>
> Conrad Kirkwood
> Safety & Quality Unit

> Ph: 02890 5(22003)
>
>

The Regulation and Quality Improvement Authority

MM/0027/2013

[redacted]

0 8 FEB 2013

[redacted]

1 February 2013

Our Ref: MC/PC/CH

Private and Confidential

Mr Colm Donaghy
Chief Executive
BHSCT
Trust Headquarters
A Floor
Belfast City Hospital
Lisburn Road
Belfast
BT9 7AB

Dear Mr Donaghy

Unannounced Inspection Ennis Ward, Muckamore Abbey Hospital

RQIA undertook an unannounced inspection of Ennis Ward, Muckamore Abbey Hospital on 29 January 2013.

The inspection focused on the safeguarding arrangements on the ward, following the allegations of abuse of patients made by a third party to RQIA on 8 November 2012. I am advised that the allegations are currently subject of a vulnerable adult investigation, which I understand is being led by the PSNI. The inspection of 29 January 2013 is part of the ongoing monitoring and scrutiny of Ennis Ward. This also included unannounced inspections on 13 November and 20 December 2012.

A number of concerns arose during this latest inspection, which I wish to bring to your attention under the RQIA Escalation Policy.

Staffing

The number of staff allocated to the ward, week beginning 27 January 2013 was in accordance with the pre-assessed numbers determined by BHSCT. The ward manager or nurse in charge is included in this total, therefore cannot be fully committed to the roles of both managing the ward and nursing patients. This raises concerns about the correct number of staff to holistically meet the complex needs of 17 patients on this ward.

Additionally, for significant periods during the night two staff are allocated to this ward, (e.g. 28 - 29 January 2013, 23.00 – 07.00, and 29 - 30 January 2013, 02.00- 07.00).

9th Floor, Riverside Tower, 5 Lanyon Place, Belfast BT1 3BT Northern Ireland
tel: 028 9051 7500 fax: 028 9051 7501 email: info@rqia.org.uk web: www.rqia.org.uk
Established under The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003

At the time of the inspection, two patients required observation at 15 minute intervals, between 23.00 – 07.30. In considering the layout of the ward; the complex needs of patients; the possibility that one or more patients may require assistance during the night; and the required level of observations, RQIA is concerned that insufficient numbers of staff are available to holistically meet the complex needs of patients on this ward.

RQIA would request that the trust undertakes a risk assessment, to review the staffing arrangements, to ensure that sufficient numbers of staff are available to holistically meet the needs of patients across the 24 hour period.

Behavioural Support

The profile of patients on the ward is such that many display a range of behaviours that are difficult to manage. These behaviours impact on the safety, dignity and well-being of all patients on the ward. For instance, one patient removes their clothing repeatedly. A high level of unpredictable aggressive behaviour was noted across the ward. RQIA and the trust's Safeguarding Strategy Panel were assured by the independent monitor, and verbally by the service manager, that there were appropriate behavioural plans in place for these patients, particularly the patients identified regarding the alleged abusive practices. However, inspectors examined five relevant sets of patients' notes and found that there was no evidence of input from Behavioural Support Services before, or since, these allegations were made. This was also noted in the patients' notes examined during the unannounced inspection of 13 November 2012, and a recommendation was made in the quality improvement plan. No behavioural plans were evident within the notes.

RQIA requires assurance that these vulnerable patients have access to the full range of therapeutic and clinical interventions, targeted at specific behaviour management, to support and appropriately address their presenting needs.

Environment

There are three distinct areas of this ward, and the layout must be considered when assessing the observation and supervision needs of patients. The noise levels on the ward can be disturbing for patients and staff. There are limited opportunities for patients to avail of quiet areas. One inspector was informed that a patient chooses to isolate herself in a back hall. It has been noted by inspectors, and raised at the safeguarding strategy meetings, the impact that the narrow corridor to the dining areas has in relation to patient safety. Here, the patients congregate and jostle each other to gain access to the dining room.

Furthermore, there are a significant number of locked doors on this ward, with entry and exit controlled by staff. This means that patients are very restricted

in the space available to them, and their movements are continually monitored and controlled by staff. Patients did not have access to their bedrooms and personal belongings during the day. It would appear that all patients are subject to the same level of restriction, regardless of their individual needs and abilities. This should be considered by the trust in the context of safeguarding the human rights of patients.

RQIA concluded that the environment is not conducive to meeting the needs of the patients on this ward. RQIA would ask the trust to consider whether other more suitable accommodation could be provided within the Muckamore site, or that appropriate adaptations could be made to Ennis Ward to improve the environment for both patients and staff.

Protection Plans

In view of the serious nature of the allegations made on 8 November 2013, RQIA would have expected that clear protection plans were devised and implemented, to safeguard and protect all patients on this ward.

As previously stated, five sets of patients' notes were examined and whilst inspectors noted that there were references to protection plans and review of protection plans in the nursing and medical notes, no clear protection plans were evident in any of the notes examined.

The vulnerable adult referral forms included responses from the designated officer, often advising that patients be kept separated, or advice was given that enhanced monitoring should be put in place. No guidance as to how this should be achieved was evident in the notes. This information had not been included in care plans.

RQIA requires assurances that individual protection plans are clearly documented and reviewed to ensure their effectiveness for all patients on the ward with immediate effect.

In view of the concerns highlighted, I invite the trusts' designated responsible managers to meet with RQIA on 11 February 2013 at 09.00 at our offices, to discuss these issues and to receive adequate assurance in relation to patient care and safeguarding. Mrs Theresa Nixon, Director of Mental Health, Learning Disability and Social Work, Mr Patrick Convery, Head of Programme, and the relevant inspector will be present at this meeting.

I look forward to your continued cooperation in addressing these important matters.

Yours sincerely

Glenn Houston
Chief Executive

cc: Mr John Compton, Chief Executive, Health and Social Care Board
Dr Michael McBride, Chief Medical Officer, DHSSPS

Update on MHLD Bi-lateral Liaison Meeting
DHSSPS – 14 September 2016

1. Funding for Business Case for Part IV Doctors (Mental Health)

At the RQIA Board meeting on 24 March 2016, the Director of Mental Health, Learning Disability and Social Work, Ms Theresa Nixon, provided an update on the additional costs by RQIA in the delivery of the Mental Health Part IV statutory function.

RQIA will require to use any slippage accrued in year pending view from DoH about recurrent funding to support this cost.

2. Revised Inspection Methodology of Mental Health and Learning Disability Wards

Meetings have been held internally by RQIA to consider inspection approaches in MHLD, Regulation and Health Care Inspection. Any further changes in methodology will be shared with the sector and DoH in due course.

3. iConnect MHLD Information System

The project team has met to begin work for phase 3 of iConnect, with the objective of implementing a patient centred MHLD Information System to replace all existing 17 databases and spreadsheets used. Funding is required recurrently from DoH to support the implementation of Phase 3.

A business case was forwarded to the DoH on 7 June 2016. RQIA awaits feedback in this matter.

4. Amendments to the 2003 Order

A discussion was held with the DHSSPS on 14 January 2016 by the Director of MHLD regarding Part 6 of the Mental Health (NI) Order 1986 which requires to be repealed in view of the Mental Capacity Act 2016.

The Director of MHLD agreed to review the relevant provisions that RQIA believe need to be incorporated into the Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003.

An extensive exercise was undertaken by RQIA to review the provisions contained in the 1986 Order which were not transferred to the 2003 Order. A paper was forwarded by the Director of MHLD to Finola McGrady, DoH, for further consideration. It is expected that a meeting will be convened during Quarter 3, 2016-17 to discuss this matter.

5. UK NPM Update

Work continues involving a number of UK Regulators across the UK to review the pathways the pathways and transitions between places of detention. This is being undertaken in two phases; evidence gathering (in year one, 2016/17) based on the findings from phase 1, making recommendations and strengthening NPM monitoring (year two, 2017/18).

The lists of projects are as follows:

- Pathways from police custody arising from mental health issues (led by Rachel Lindsay, CJINI)
- Transition from children to adult custodial provision (Deputy Children's Commissioner, England)
- Pathways between secure mental health settings (lead Colin McKay, CE, Mental Welfare Commission Scotland)
- Pathways from prison to mental health settings and vice versa (lead Paul Turbuck, HMIP)
- Pathways from Immigration Removal Centres to mental health settings and vice versa (lead to be agreed at meeting in September 2016)

Progress of these working groups will be reviewed by the Director of Mental Health, Learning Disability and Social Work at the next UK NPM meeting in Cardiff on 14 September 2016. RQIA has representation on four of these sub groups.

6. Issues of Concern in MHLD Directorate

A. Beechcroft CAMHS Inpatient Unit

An unannounced inspection was undertaken at Beechcroft in July 2016 due to concerns regarding the levels of:

- Absconding and likelihood of harm to young people when absent from the facility
- Concerns expressed by the PSNI to the Belfast Trust about their ability to discharge their statutory function and safeguard and protect young people in this facility
- A complaint from a staff member about staff having to deal with violence / aggression on a daily basis with no support from line managers
- Concerns raised with Children's Commissioner regarding absconding, transfer of children between Beechcroft, Lakewood and Juvenile Justice and communication with parents

The inspection report identified ten areas for improvement; a report has been issued to the Belfast Trust for factual accuracy on 9 September 2016.
RQIA remains concerned about:

- the classification by Beechcroft of some serious adverse incidents, some of which RQIA believe meet the criteria for investigation under the HSC Board procedure for the deporting and follow up of SAI's. Two cases have been referred to the HSC Board for further review.
- The trust have also been asked to review the use of restraint and rapid tranquillisation to ensure that practice complies with Article 5 of the Human Rights Act 1998. One young person was noted to require restraint on 34 occasions with rapid tranquillisation administered on 13 occasions in the last six month period. The

potential for a breach of article 43 rights under the ECHR requires to be considered by the trust. Further action is required in care planning recording and risk management.

RQIA is unclear about the timeline for the review by the HSCB of secure facilities for terms of reference and would wish for the DoH to give urgent consideration to this matter.

B. Erne Ward

An unannounced inspection was undertaken of Erne Ward on 19/ 21 July. Serious concerns were raised about the fire risk assessment, cleanliness of the ward, hygiene, care documentation, record keeping and governance.

The Belfast Trust has since provided an updated report indicating that corrective action has been taken by Senior Management. RQIA will follow up progress made at the next inspection.

C. Moylena Ward/ MAH

A whistleblowing disclosure was made to RQIA on 30 August 2016 regarding alleged understaffing and cleanliness of ward.

An unannounced inspection was undertaken on the 2 September 2016. The allegations made by the whistleblower were not substantiated. Two recommendations were made for improvement regarding staffing.

7. Review of Perinatal Mental Health

The fieldwork for the review of Perinatal Mental health was completed 5-9 September 2016. A summit event will be held in Antrim on 30 September, Antrim Civic Centre, to obtain final views from stakeholders. DoH are invited to attend. A presentation will be made by Lindsey Robinson; PHA will also be in attendance.

The Review of Services for Adults with a Learning Disability in the Community Report is completed in draft and with DoH for review. RQIA await the response.

8. Letter of Escalation

There have been no letters of escalation in the last two months.

THERESA NIXON
DIRECTOR OF MENTAL HEALTH, LEARNING DISABILITY AND SOCIAL WORK
14 September 2016

Exhibit 25

RQIA BI-MONTHLY UPDATE REPORT – 8 MARCH 2017

Business Area	Position	RQIA Comments
1. MENTAL HEALTH AND LEARNING DISABILITY		
1.1 MHLD INFORMATION SYSTEM	• A strategic outline business case was forwarded to the eHealth Management Group, HSC Board, on 7 June 2016. The SOC was considered in August 2016 by this group. • RQIA met representatives from the HSC Board on 4 November 2016 to discuss the minor changes required to the business case. The DoH has advised that following recent changes to Business Case guidance they do not now need to see/ comment on the SOC. DoH have further advised they will consider the OBC and have recommended it contain more detail about any links with Trust systems. Business Case currently in draft form by RQIA.	
1.2 REPLICATION OF RELEVANT EXISTING POWERS UNDER THE MENTAL HEALTH (NORTHERN IRELAND) 1986 TO THE MENTAL CAPACITY ACT	• A discussion was held with the DHSSPS on 14 January 2016 by the Director of MHLD regarding Part 6 of the Mental Health (NI) Order 1986 which require to be repealed in view of the Mental Capacity Act 2016. • The Director of MHLD agreed to review the relevant provisions that RQIA believe need to be incorporated into the Mental Capacity Act. • An extensive exercise was undertaken by RQIA to review the provisions contained in the 1986 Order which were not transferred to the 2003 Order. • A paper was forwarded by the RQIA Director of MHLD to Finola McGrady, DoH, for further consideration. • A meeting date has been agreed with Andrew Dawson on 2 February 2017 at 14:30 to discuss this matter.	• RQIA has sought clarity from DoH regarding legal application of Article 116 by RQIA was being sought following the meeting of 2 February 2017.

1.3 MENTAL CAPACITY ACT - IMPLEMENTATION GROUP	• RQIA has responded to all 20 chapters. It is difficult in the absence of some discussion and scenario planning to respond fully to the issues.	• The Implementation Group are reviewing the current responses and helpfulness of this approach and will advise RQIA of next steps.
1.4 ISSUES OF CONCERN IN MENTAL HEALTH	**1. Ward 27 at Ulster Hospital : 7-10 November 2016** • Concerns were noted in relation to ward environment due to its layout and design • RQIA have raised the possibility of other options with SEHSCT but no solution to this problem is possible in the interim. • The Trust state that they require capital funding of their business case from DoH to make the required improvements.	• Response received from DoH indicating funding will be considered alongside other pressures. • RQIA is seeking a view from the Department regarding the likelihood of any capital funding in 2017-2018 iro this business case.

	2. Unannounced Inspection Rathlin Ward at Knockbracken Healthcare Park 14-16 November 2016 • Concerns were also raised regarding maintenance of the ward environment. A new caretaker has since being employed who will ensure daily monitoring of the environment.	• A letter of serious concern to trust will be followed up at next inspection.
	3. Unannounced inspection Tobernaveen Lower 22 Holywell Hospital – 24 November 2016 • An unannounced inspection of Tobernaveen ward was undertaken on 22-24 November. • The original plumbing of this ward no longer meets the needs of the ward due to the age of the building. • There are a number of leaks throughout the building which are almost impossible to eradicate and patients complained about the damp and mould and smells emanating from these conditions.	• A letter of concern was sent to Fergal Bradley, Head of Quality and Regulation and Improvement Unit, DoH on 7 December 2016. • A letter of serious concern sent to trust will be followed up at next inspection.
	4. Unannounced Inspection Inver 1 at Holywell Hospital - 29 November-1 December • An unannounced inspection of Inver 1 ward was undertaken on 29 November to 1 December and found 91 ligature points, nine of which were in the seclusion room.	• RQIA is seeking a view from the DoH regarding the likelihood of any

	• RQIA has concerns about the quality and safety of the ward environments on Tobernaveen Upper and Inver 1 as expressed in RQIA correspondence to DoH on 7 December 2016. • RQIA is cognisant of delay in funding the NHSCT business cases and is concerned with how often they can restate the same recommendation if the trust is unable to make the required improvements without additional capital funding.	capital funding in 2017-2018 iro this business case.
	5. Unannounced Inspection Erne Ward 1 & 2, Muckamore Abbey Hospital 21 December 2016 • RQIA undertook an unannounced inspection of Erne Ward 1 and 2 following allegations from a whistle-blower regarding staff shortages and overcrowding of patients on the wards. There were also issues of concern regarding the privacy/ dignity of patients with one bedroom window having no blind or screening. • RQIA found that the main communal room was very confined, particularly for patients who were displaying clear aggressive behaviours in the same area. Staff were finding it difficult to ensure the safety of other patients. • Nine unannounced inspections have taken place of the following wards since December 2016. • Elm / Lime ward in Tyrone and Fermanagh Hospital – 3 and 5 January 2017. • Avoca Ward in Knockbracken Healthcare Park – 11 and 13 January 2017. Three areas were identified for improvement. • Six Mile Low Secure Ward / Muckamore Abbey Hospital – 31 January 2017 to 2 February 2017. • Addiction / Treatment Unit in Tyrone / Fermanagh Hospital – 1 and 2	• Response received on 6 January 2017 from (Acting) Head of Learning Disability Services indicating appropriate proactive action taken to address deficiencies identified.

	February 2017. • Lagan Valley (Ward 12) : 6 and 8 February (A letter of functional care dementia > 65 category • Clare Ward – Knockbracken Healthcare Park – 7 and 8 February 2017 • Iveagh Children's Learning Disability Ward : 20 and 22 February 2017. • Tobernaveen Centre, Holywell Hospital – 21 and 23 February 2017. • Valentia Ward, Knockbracken Healthcare Park – 28 February 2017 to 2 March 2017 (Dementia) • No letters of formal escalation were required following these inspections.	• A letter of serious concern was forwarded to the Assistant Director of Adult Mental Health Services for Older Persons, Primary Care and Nursing, South Eastern Health and Social Care Trust regarding: ➢ Environmental Health and Safety Assessment / Audit, Fire Safety and Fire Risk Assessment. ➢ Ligature Risk Assessment / Profiling Beds.
1.5 PERINATAL MENTAL HEALTH REVIEW	• RQIA received feedback from DoH regarding Perinatal Mental Health on 5 January 2017. • Minor amendments will be made to the report as requested. RQIA plan	

	to publish the report week commencing 16 January 2017. • RQIA have been informed by Lindsey Robinson that she is intending to convene a major event at City Hall on the 3 March 2017, regarding the lack of Perinatal Services in Northern Ireland. • RQIA has been asked to speak at this event. The Maternal Mental Health Alliance and other mental health charities have been asked to present issues from carers also. • Lindsay Robinson intends to request representation from Department of Health at this event. Director of Mental Health has advised Andrew Dawson of this matter. Date has been rescheduled to Wednesday, 10 May 2017.	
1.6 LETTERS OF ESCALATION	• There have been no letters of escalation in the last two months.	
1.7 PRISON HEALTHCARE	• In conjunction with CJI a first 'low impact' inspection of Maghaberry carried out on 5 – 7 September 2016, with report published. • Ash House/ Hydebank Wood May 2016 inspection – reports were published on 27 October 2016. • A further 'low impact' inspection will be carried out in conjunction with HMIP/CJI in 2017 and an inspection to Magilligan HMIP also in 2017 • A meeting took place between with the RQIA mental health / primary care team with the senior management of SEHSCT on 5 January 2017 to consider the Trust Quality Improvement/ Reform of Prison Health Care Plan • A joint Drug Misuse strategy is now being progressed for each organisation to sign off and implement. • The Northern Ireland Prison Service and the South Eastern Trust are drafting a joint Self Harm and Suicide Prevention strategy which will be concluded shortly. • The Justice Minister has clarified that there will only be one review with terms of reference that will reflect the wider justice and health agenda.	• RQIA is requesting the Department provide a copy of the terms of reference for

	RQIA would like DoH to provide a copy of the terms of reference for this review. • Meeting held with HSC Board Prison Commissioning Group on 3 March 2017 to review handling of SAIs and issues regarding monitoring of prescribed drugs by GPs.	this review. • Further discussion will be held with Commissioner and DoH re. inspection standards.
1.8 OVERSPEND BY PART IV DOCTORS	• A large increase in cost has been noted in year in respect of the additional time and travel incurred in providing opinions on medical treatment plans (overspend may be in region a minimum of £65k at year end. This will be flagged as a cost pressure if no funding is made available by DoH to support the additional costs. • RQIA is proposing to revert to their traditional methodology for the scrutiny of treatment plans to save costs. RQIA will share a proposal regarding this matter with DoH in 2017.	
1.9 PROPOSAL FOR NEW DEVELOPMENT BY BELFAST TRUST	• Information about a proposed new Supported Living development of 23 bungalows at Abbey Road, Muckamore for people with a learning disability has been brought to the attention of RQIA. • Some of the people who have spoken to RQIA and objected to the proposal are concerned that the proposed model may run counter to the recommendations of Equal Lives, may not conform with standard 28 of the DoH service framework for learning disability and potentially could contravene the UN convention on the rise of people with disabilities.(Article 19). • It is unclear to RQIA if the proposal has the full support of the Belfast HSC Trust. • A meeting has been suggested by some of the objectors with Cecil Worthington, Director Social Work/ Children's Community Services and Adult Social & Primary Care Services of the Belfast Trust, to discuss this	No further update received by RQIA.

	matter further.	

2. REGULATION & NURSING UPDATE		

2.1 REGISTRATION	• A meeting between RQIA, DoH and HSCB identified the need to conduct a data validation exercise on the number of **residential beds in Nursing Homes**. A census template has been drafted and shared with all parties for comment.
	• We await the outcome of the consultation on proposed changes to **Fees and Frequencies** of Inspection Regulations. Feedback provided to DoH on a range of regulatory issues out with the scope of this particular consultation have been shared with us and we are considering all comments to identify key themes and any learning.
	• **Adult social care and reform:** we continue to participate in this review and we will be in attendance at three planned forthcoming workshops on
	  • Monday 6th March at Oxford Island, Craigavon: focusing on **Choice, Control and Community Engagement**
	  • Tuesday 7th March at the City Hotel in Derry: focusing on **Building Capacity and Sustainability**
	  • Wednesday 8th March at Malone House in Belfast: focusing on **Workforce**
	• **Competition and Markets Authority**: to note that the CMA market study team will be in Belfast to hold a roundtable discussion with representatives from the RQIA, Department and the Board/ Health Trusts. The meeting will be held at Ofcom's offices (Landmark House, The Gasworks, 5 Cromac Quay, Belfast BT7 2JD), between 10am-12pm on Tuesday 21 March.
	• **Four Seasons Health Care**: FSHC continue to engage proactively to provide high level updates on the continuing review of their portfolio in Northern Ireland and on their ongoing financial position.	

2.2 INSPECTION	• **Statutory target:** we anticipate that the statutory minimum number of	

	inspections as set out within the fees and frequencies of inspection regulations will be met. • **Workforce:** to note that two estates inspectors and one pharmacy inspector posts have been released through VES to achieve efficiency savings. The impact will result in a reduced number of medicines management and premises management inspections. • **Making Recommendations and Requirements:** following a review and update to our enforcement procedures, we intend to move away from the language of "making requirements and recommendations" within Quality Improvement Plans and to replace this with referring to instances where we have identified "Failure to comply with regulations" and "Failure to comply with standards". This language is commensurate with the 2003 Order. • **COPNI Investigation** Dunmurry Manor : RQIA have received notification that the Commissioner of Older People is conducting an investigation into the care, treatment and experience of older people living in Dunmurry Manor Care Home covering events leading up the home's opening in 2014 until the end of the investigation. • **Children's Services:** As we complete the 2016/ 17 inspection year, a series of engagements with HSC Trusts are planned to share learning and identify best practice.	
2.3 ENFORCEMENT	• **Prosecution** action in respect of **Laser** beauty clinics for failing to register continues. To date there has been 5 successful prosecutions. Of these one service is now registered, one service has made application to register, three services have ceased trading. • **Dental World Ltd**: On 14th October the General Dental Council accepted an application from Mr McMitchell for Voluntary Erasure from the professional register. As a consequence of this action, RQIA on 10 January 2017 issued a Notice of Decision to cancel registration of Mr McMitchell for each of six registered dental practices. These practices are no longer registered to provide private dental treatment. To note that we	

	have received application from a new provider to undertake private dentistry at these establishments. • **Runwood Homes:** there are 11 Nursing Homes in the portfolio. During an unannounced care inspection at Dunmurry Manor on 26 October 2016, RQIA identified concerns regarding the care, staffing, and governance arrangements at this home. As a result of these concerns, RQIA issued three notices of failure to comply with regulations to this service. Following an inspection on 27 January 2017, the service achieved compliance in relation to staffing, however, further improvement was required to achieve compliance in care and governance arrangements. On 6 February 2017, RQIA issued a notice of proposal to impose conditions of registration on Dunmurry Manor. Further inspections are planned to monitor compliance and we will receive monthly monitoring reports • **Children's services:** Failure to comply notices have been issued to services in Northern Trust for breach of statement of purpose in Ardarath House and Barn Court. Compliance was achieved by SEHSCT in respect of Cuan Court. • **Lakewood Regional Secure Care Centre:** to note that compliance was achieved on 16 February against five failure to comply notices.	

3. REVIEWS		
HEALTH CARE INSPECTION TEAM **3.1 HYGIENE AND CLEANLINESS INSPECTION**	• 3 inspections completed with preliminary finding and reports sent to Trusts. Reports being assessed for factual accuracy checking and return of provider compliance plan. • Following up of report/recommendations from previous inspections ongoing.	
3.2 AUGMENTED CARE INSPECTIONS	• Neonatal Care – Year 2 complete and reports published prior to July. Currently reviewing Year 3 programme. • Critical Care – Year 2 complete and reports published prior to July. Currently reviewing Year 3 programme. • All other Augmented Care e.g. renal, haematology – Year 1 commenced. One inspection completed February 2016, further scheduled. 1 inspection to be carried out in each HSC trust by end March 2017.	
3.3 ACUTE HOSPITAL INSPECTION PROGRAMME	• Phase 1 – All trust reports with completed improvement plan published (Antrim, Royal, Ulster, Craigavon, Altnagelvin) • Phase 2 – Inspection to Daisy Hill 5 – 7 Dec 16 completed, report with completed improvement plan return to be sent to DoH/Trust 9 March 2017, publication 16 March 2017. • Phase 2 – Inspection to Mater, 16 – 18 January 2017. Preliminary findings sent to trust, writing report • Phase 2 – Inspection to Lagan Valley, next in inspection programme 2017.	
3.4 NIAS	• Meeting with NIAS, 8 February 2017. **NIAS** audit tools reviewed and updated with NIAS input. Pilot to be carried out by end March 2017, commencing inspections in 2017 – 2018 schedule.	

3.5 POLICE CUSTODY	• No inspection activity planned this year.	
3.6 GAIN AUDITS: FIELDWORK STAGE	• **Northern Ireland Asthma Audit-** Report by end of March 2017. • **Reducing Hospital Admissions of People with Dementia in Nursing Homes: The Role of Anticipatory Care Planning-** Phase 1 Draft report received. • **Clinical Case Note Audit of Late Term Stillbirths (=/>37 weeks) in 2016**- Fieldwork completed February 2017. • **Audit of Quality and Outcomes of Key performances in Regional Forensic Services-** Fieldwork to be completed March 2017. • **STICkS – Safe Transitions in Care Checklists: A ward-round handover project -** Full fieldwork completed. Report by end of March 2017. • **Where are the red cells being transfused in Northern Ireland? -** Full data collection to be completed by early March with full report by end of March 2017.	
3.7 GAIN AUDITS: REPORT WRITING STAGE	• **Northern Ireland COPD Audit** - Full report currently out for consultation, this includes quality assurance checks, peer review and factual accuracy checks. • **Quality Improvement eLearning Training Programme To Support The GAIN Guidelines For Caring for People with Learning Disabilities in a Hospital Setting -** Fieldwork completed by December 2016. Draft report by March 2017. • **Audit of hospital discharge letter to GPs**- Draft report completed December 2016. Full report received. Sign mid-March 2017.	
3.8 GAIN GUIDELINES: FIELDWORK STAGE	• **Post Take Ward Rounds in Acute Medicine Units –** Draft guideline written and to be submitted by end of March 2017. • **The management of Adult Convulsive Status Epilepticus -** Direction	

	changed to educational guideline. Draft report received February 2017. • **Towards Safe and Effective Care – Supporting Domiciliary Care Workers to meet the NISCC Standards of Conduct and Practice –** Guideline completed by end of March 2017.	
3.9 GAIN GUIDELINES: WRITING STAGE	• **Prevention, diagnosis and management of hyponatremia in labour and the immediate post-partum period** - Guideline completed February 2017, launch of guideline March 2017.	
3.10 GAIN PROJECTS: DOH COMMISSIONED	• **GAIN project focusing on Learning from Serious Adverse Incidents (SAIs) arising from Suicide, Homicide and Serious Self Harm** - Report completed December 2016. • **GAIN Project Identifying Learning from Serious Adverse Incidents (SAIs)** - Report should be completed by end of March 2017. • **NCEPOD Data information**- Data access received. Training from Manchester 30 March 2017. • **Regional Scoping Exercise of National Audit Participation by Northern Ireland's Health and Social Care Trusts-** Final report complete and with DoH.	
3.11 PROJECTS: GAIN COMMISSIONED	• **Review of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Setting** - 2010 Guideline to be reviewed this may slip into May 2017. • **Re-audit of Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings** – will carry over into May 2017	
3.12 GAIN REVIEWS: PUBLISHED/ TO BE PUBLISHED	• **Review of Perinatal Mental Health Services**: Published on 17 January 2017. • **Review of Governance Arrangements in HSC Organisations that Support Professional Regulation:** Published on 20 January 2017.	

	• **Review of the Regional Emergency Social Work Service**: Published on 25 January 2017.	
3.13 REVIEWS: REPORT DRAFTING STAGE	• **Review of Maternity Services:** Report due back from DoH on 1 March 2017. • **Review of Access to Plastic Surgery (DoH Commissioned):** Report to be submitted to DoH on 3 March 2017. • **Review of the Dental Action Plan: Phase II: Report** undergoing factual accuracy prior to it being submitted to DoH in April 2017. • **Review of Renal Services:** Report undergoing factual accuracy prior to it being submitted to DoH in April 2017. • **Review of Governance Arrangements for Child Protection in the HSC in Northern Ireland** (RQIA Initiated): Report currently being drafted.	
3.14 REVIEWS: FIELDWORK STAGE		
3.15 REVIEWS: YEAR 2: 2016/2017: PLANNING	**Initial Planning underway for**: • Discussions underway to examine reviews for Year 3 (2017/2018)	
3.16 REVIEWS: RESHEDULED / NEW	• **Review of Suicide Prevention Services:** Agreed to move this review into the next Review Programme, when the new Suicide Strategy for NI will have been embedded. • **Removal of Review of Bereavement Care**: Consider moving to the next Review Programme.	

4. THREE YEAR REVIEW PROGRAMME		
4.1 Review Programme 2015-2018	The programme was published on 1 April 2015 and can be found at: http://www.rqia.org.uk/cms_resources/Three_Year_Review_Programme_2015-18.pdf	
5. CORPORATE ISSUE – INCLUDING FINANCE, RISK, RRL AND GOVERNANCE ISSUES		
5.1 FINANCIAL POSITION 2016-17	• Based on the financial position at the end of January 2017, the projected end-of-year position is break-even with an estimated underspend of £14K. • The projected end-of-year out-turn is being kept under review by the Executive Management Team.	
5.2 VOLUNTARY EXIT SCHEME (VES)	• RQIA was allocated revised VES ring-fenced funding of £243,000 and the VES application process was completed in December 2016. • This resulted in 8 staff (7.13 WTEs) being offered VES with an annual savings of £226,000. • These staff will leave RQIA in Quarter 4 2016-17.	
5.3 FINANCIAL SCENARIO PLAN 2017-18	• RQIA has submitted a Financial Scenario Plan 2017/18 to DoH based on 2/5/10/15% savings targets for submission to DoH on 18 January 2017. • This equates to £137K/£342K/£684K/£1,027K respectively.	
5.4 GOVERNANCE	• DoH has initiated an investigation following receipt of whistleblowing letters. • An audit of GAIN has been completed. A satisfactory level of assurance has been provided with two Priority 1, two Priority 2 and one Priority 3 weaknesses having been identified. • DoH has commissioned Public Concern at Work Public Concern at Work to undertake a review of RQIA, NIGALA and NIFRS's whistleblowing	

	arrangements.	
5.5 CORPORATE STRATEGY 5.6 2017-21	• The draft Corporate Strategy 2017-21 was approved by the RQIA Board on 19 January 2017. • An eight week public consultation is running from 25 January to 22 March 2017. • Two public engagement events are being held on 6 and 7 March 2017.	

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BUSINESS AREA	POSITION
1. MENTAL HEALTH AND LEARNING DISABILITY	
1.1 MHLD INFORMATION SYSTEM OUTLINE BUSINESS CASE	A Project Manager has been appointed. The role of SRO is the Director of MHLD and Social Work. The project will be completed in December 2018.
1.2 PRISON HEALTHCARE	An announced joint CJI, ETI and RQIA inspection of Woodlands Youth Agency took place November 2017 with report expected by end of March. The outcome of the Regional Review of Specialty Services for Children and Young people may have implications for Woodlands. A further inspection of Maghaberry will be undertaken in 2018 in addition to an inspection of The Safety of Prisoners involving visits to Magilligan, Hydebank Wood (YOC) and Ash House Women's Prison. The terms of reference for these inspections is being agreed currently with CJI. The eighth annual NPM report on monitoring places of detention was issued by HMIP on 20 February 2018. In terms of custodial care for children in NI practice was found to be safe, unlike England and Wales. The next UK NPM meeting will be hosted by Northern Ireland in Belfast at the Policing Authority on the 25-26 April 2018. The report is available at: https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2018/02/6.4122_NPM_AR2016-17_v4_web.pdf
1.3 MHLD INSPECTIONS	The MHLD directorate have completed nine scheduled inspections of MHLD wards since the last bi-monthly (two in BHSCT, four in NHSCT, one in SEHSCT, one in SHSCT and one in WHSCT) up until 20 February 2018. RQIA have identified challenges across all mental health wards inspected relating to patients transferring from other trusts, concerns in relation to lack of sharing of information from the patient's host trust i.e. care information, patient history and risk assessments. This has been a particular problem at weekends with out of trust placements. RQIA have observed difficulties in Trusts sharing information between the PARIS information systems as trusts use different modules and versions that do not interface. RQIA has raised concerns at the regional bed management group, particularly in relation to new patients not known to services. RQIA continue to highlight areas for improvement at this group. The Department of Health is represented by and Dr Ian McMaster and Ms Ann Mooney on this working group.

One whistleblowing correspondence was received in relation to Muckamore since the last bi-monthly meeting. As a consequence of this whistleblowing an inspection was completed on 20 December relating to unsafe staffing levels.

Two concerns were substantiated regarding reduced staffing levels and non-adherence to trust policy on enhanced observations. RQIA will follow up the areas for improvement identified in the next 3 months.

Key improvements noted since previous inspections and areas identified for improvement:

Shannon Clinic

Improvements were noted from the last inspection of Shannon Clinic in relation to consistency in medical practice as a clinical lead has been appointed with governance work streams set up to promote consistency. Plans submitted to build a female only ward has been delayed which continue to cause difficulties with management of the mixed gender population in Ward 2. The impact on patients is that unwell female patients are having to be admitted directly to the ward with more settled male patients who have progressed from Ward 1 acute admission. This increases the risk in relation to the vulnerability of both female and male patients. An impact on the patient flow through Shannon was also noted as some male patients had to transfer directly to ward 3 from ward 1 due to risks to vulnerable females. RQIA have identified a number of areas for improvement and expect the QIP response from the Trust by 7 March 2018.

NHSCT (PICU)

Lissan 1 and Inver 1 (PICU) which are located on the Holywell site, continue to manage patients as best as possible by updating risk assessments despite a high number of environmental ligature points and design/structural issues. Two rooms were recently condemned by the Trusts estates department in Inver ward, due to risk of roof collapsing (the occupational therapy room and a store adjacent to the laundry room) due to concerns about the fabric of the ceiling. The Trust business case is outstanding for a new acute inpatient mental health admissions facility.

Concerns were noted in relation to timely sharing of information in relation to admissions and discharges from both these wards. RQIA have requested the Trust to complete an audit of admissions and discharges into Lissan 1 and Inver 1. The audit findings will be examined at the next inspection.

An unannounced inspection of Ross Thomson Unit was undertaken on 13 February 2018. Issues were raised for the second time regarding the use of the ward as an assessment centre for patients presenting through the emergency department with mental health problems. This compromises the privacy and dignity for patients on the ward. RQIA has asked the Trust to review the colocation of this service as an immediate priority and we will complete a follow up

	visit to ensure improvements have been made shortly. An unannounced inspection of Tobernaveen Ward Centre was undertaken on 18 February 2018. Four areas for improvement were identified. • Concerns were raised regarding the emergency response resuscitation equipment. • Staff from this unit are required to respond to emergency calls to four other buildings. • Risk assessments were found to be out of date. • Patients mix on this ward aged from 21 – 87. This Ward is primarily for treatment of patients living with dementia. These areas for improvement have been restated for the second time. The QIP is expected from the Trust and RQIA will meet with the Director of this service to seek assurance that these matters will be addressed urgently and currently are on the Director's risk register. RQIA received assurance from the Trust that these issues are on the Mental Health Directorate risk register **SEHSCT** An inspection of Lagan Valley, Ward 12 was undertaken on 22 – 23 January 2018. The ward environment is not in keeping with the Standards for Inpatient Mental Health Services Royal College of Psychiatrists 2016. The Trust advised that a risk assessment to address the patient and safety issues highlighted by RQIA specifically in relation to the number of ligatures points and a faulty emergency alarm system on this ward is in place but was not available for inspection. RQIA have requested a copy of this risk assessment. RQIA will discuss with policy lead for mental health their concerns regarding the ward environment of the four wards in South Eastern Trust Mental Health. The Trust intend to invite the Chief Social Services Officer and Chief Medical Officer to these wards to review the quality of the environment. The Director of MHLD and Social Work intends to meet with the CSSO to discuss her concerns about the ward environments. **SHSCT** An inspection of Silverwood Ward RQIA found gaps in the recording of physical interventions on the DATIX system. The Trust has since informed that these gaps have been addressed. Assurance will be assessed at the next inspection.
1.4 MHLD ESCALATION	One letter of serious concern was issued to the WHSCT in relation to a lack of progress in implementing two areas for improvement namely Risk Assessments and updating of Policies and Procedures.

	A follow-up discussion was held with the Director of Nursing Dr Eve Brown regarding these matters to agree a timeline for the completion of these policies. This area for improvement was first stated after an inspection in **June 2015**. This area for improvement has now been restated for a third time and the Trust have been advised that this requires to be reviewed urgently. A further letter was sent to the Director of Nursing on 12 February 2018 advising that we were unable to accept the revised QIP from the Trust and the delay in implementing an area for improvement in relation to the Fluid Balance Policy. RQIA have asked that the Director of Nursing escalate this matter to the Chief Executive and provide assurance that appropriate actions will be taken to address the areas for improvement. RQIA received assurance from Trusts that these issues are on their Mental Health Directorate risk register.
1.5 SERIOUS ADVERSE INCIDENTS	A draft paper has been prepared by RQIA outlining the practical difficulties we have identified w meeting the requirements of the 1986 Order since the revised 2016 HSCB SAI procedures have been put in place. Level 1 summary reports are heavily redacted and are of little or no value to allow RQIA to assess if there is evidence of deficiencies in care and treatment or to facilitate learning and improvement. As a consequence RQIA must now request copies of the full report from the Trust resulting in delays. RQIA is also advising of delays in completion of SAI review reports. RQIA have raised this concern at the SAI Sub Group meeting on 14 February 2018. RQIA have been advised that the HSC Board is reviewing this with the trusts. Three cases involving the death of prisoners are due to be reviewed by the Coroner in the coming months. We have received assurance from the SEHSCT that they are addressing their backlog and have[provided assurance that actions are taken immediately rather than waiting for the outcome of the final report. A number of trusts are stating that there is limited learning in many of the SAI's they are completing. RQIA was involved in reviewing a SAI report that also contained a number of findings from a coroner's inquest in Birmingham including the fact that the trust did not have a protocol stipulating the arrangements for notifying service users or follow up arrangements on discharge. This creates a risk that service users/ carers may not be aware of follow up appointments. RQIA has noted a variation on how this is undertaken regionally. RQIA by agreement with the NHSCT will share the new protocol with the other four trusts and seek their agreement to adopt this. RQIA is also organising a workshop with the five trusts regarding confidentiality and information sharing in acute mental health assessments on the 6 March 2018. An invitation will be issued to DoH to invite them to attend. RQIA note the recommendation contained in the O'Hara report and await further direction from DoH in this matter.

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1.6 ANNUAL JOINT RQIA/RCPPSYCH CONFERENCE INVOLVING PART II AND PART IV CONFERENCE	The annual Joint Psych in Learn RQIA Part II and Part IV Consultant Psychiatrist Workshop was held in Belfast Castle and attracted a large attendance. A moving and instructive personal perspective was provided by Hamish Elvidge, Founder of the Matthew Elvidge Trust who told the story of his son's death by suicide and the lack of family involvement at any stage in his care. He stressed that even when authority has not been given to share information, professionals can still listen to families. He asked, in conclusion, that 3 things be done: 1. Review how trusted friends and family can be involved in Patients assessment, treatment and care; 2. Review how consent is sought; 3. Implement the Consensus Statement. RQIA and Royal College of Psychiatrists are organising a joint workshop to discuss this matter further with the five HSC Trusts in relation to improvements on 6 June 2018.
1.7 REVIEW OF FORMER GAIN GUIDELINES MENTAL HEALTH (NORTHERN IRELAND) ORDER 1986	A working group was established by RQIA in early February 2018 involving Bernadette Hamilton representing the ASW Forum, together with Dr Caroline Donnelly, Dr Peter Sloan from the Belfast trust and Dr Roinin McNally, from the South Eastern Trust, and Patrick Convery from RQIA to update the former GAIN Guidelines for use of the Mental Health (NI) Order 1986. A future workshop will be organised involving all relevant stakeholders to disseminate the revised RQIA guidelines in Spring 2018.
1.8 QUALITY IMPROVEMENT INITIATIVE IN CHILDREN'S SERVICES	The children's team have piloted a new inspection methodology in three trust areas. This outcomes based approach was in response to the recommendations made by the Munroe reports (2010). This pilot involved tracking a young person's journey through the care system to determine how statutory agencies work collaboratively to meet the needs of looked after young people. Policy leads are aware of this pilot. Although a worthwhile and valuable exercise, the work was time and resource intensive and extended beyond the remit of RQIA's regulatory functions. However, given the nature and scope of the work it might be better utilised if taken forward as a quality improvement initiative by individual trusts aligned to their oversight and governance responsibilities. RQIA is developing a paper to share the learning gained from this exercise with trusts. We will support the trusts in the continuation of this methodology and make a determination on its effectiveness at the close of the 2018/19 inspection year.

1.9 UNREGISTED FACILITIES ACCOMMODATING LOOKED AFTER CHILDREN	RQIA is aware of an increasing number of unregistered facilities accommodating looked after children. This is a regional issue arising from the need to accommodate young people aged sixteen plus with complex needs who are unable to be accommodated in main stream children's homes. RQIA is working closely with the HSCB in a solution focused piece of work to explore how these young people can be effectively and safely cared for. RQIA met with the HSCB children's commissioners to agree an action plan to address key concerns identified jointly by both agencies. A project plan is being developed to take forward proposals and this will be shared with DoH in due course. This matter is currently on the HSCB risk register and RQIA is checking if this is currently on the Trust risk register.
2. REGULATION DIRECTORATE	
2.1 REGISTRATION	**Residential care beds in nursing homes** **Position as at 28 February 2018** Services still undecided (2 providers) **5** Application forms issued and still to be returned **6** Application forms received and being processed **28** Certificates issued **73** Applications withdrawn (homes closed) **2** A further letter has been issued to relevant providers on 23 February requesting that they complete the registration process and we have given a four week deadline to 23 March 2018. We will continue to work with the remaining two providers to reach a mutually agreeable solution.
2.2 INSPECTION	**General** We are on target to meet the statutory minimum number of inspections. **Fees and Frequency of Inspection / Risk Framework** We have initiated a review of systems to identify factors that would signal services of higher risk. This Risk Adjusted, Dynamic and Responsive (RADaR) inspection framework will consider three separate but co-dependent elements of: - Dynamic data modelling: data and intelligence available to us is analysed to identify signs of increasing

	risk. We have identified a number of relevant data sources and work is ongoing to quality assure the data. These indicators will be tested from April to October 2018. - Scaled inspection tools: a series of eight key factors have been identified as relevant predictive indicators of risk. We are developing interval scales for each factor which will be used within a statistical model, which will be tested from April to October 2018 for nursing and residential care homes. - Reactive and responsive element where the professional judgement of inspectors will continue to review emerging information and determine if an urgent unannounced inspection is required at any time
2.3 ENFORCEMENT	**Enforcement** All enforcement action (except children's services) is published on our website. Recent enforcement included: **Failure to Comply Notices issued** - Recruitment practice in Alpine House Residential Care Home. - Three failure to comply notices were issued to Glenabbey residential home regarding non-reporting of notifiable events, incomplete competency and capability assessments of staff and a lack of robust governance and oversight arrangements in relation to monthly monitoring reports. A notice of proposal to cease admissions was issued on 27 February 2018. **Serious concerns meetings** - We held twelve meetings to discuss issues arising from inspection and received assurance from the registered providers on their action plan to deliver improvement. This included seven Nursing homes, one Residential Care Home, and one Domiciliary Care Agency. Three meeting relating to medicines management were also held. • **Appeal to the Care Tribunal** An appeal was lodged by Runwood Homes Ltd against a decision to cancel registration. This appeal is progressing through the Care Tribunal. • **Representations and Decision Making Panels** No panels have been required since the last update • **COPNI** We continue to correspond with the Commissioner regarding the findings of the investigation into Dunmurry Manor Care Home.

3. REVIEWS (HEALTHCARE INSPECTIONS, AUDITS, GUIDELINES and REVIEW PROGRAMME)	
3.1 HEALTHCARE INSPECTIONS	**NIAS Unannounced Hygiene Inspection Programme** ➢ Improvement Notices (Broadway and Bangor Stations) in place to 28 January, meeting held with DoH policy lead 26 January to discuss forward approach. Spot check visits to Broadway and Bangor Stations on 11 January, hygiene and cleanliness in both stations good. ➢ Follow up inspections relating to Improvement Notices undertaken on 5, 6 and 8 February plus additional unannounced inspection to Craigavon Station – concerns identified regarding overall Trust governance and assurance systems, and training and education in relation to hygiene and cleanliness, significant concerns also identified regarding hygiene and cleanliness in Craigavon Station and vehicles working out of this station. ➢ Intention to Serve (Improvement notices) meeting held with NIAS C Ex and members of senior team on 14 February, decision made (i) to extend two notices already in place with regard to time and scope (Broadway and Bangor) – date of extension to 16 April, and (ii) to issue two notices in relation to Craigavon Station addressing (a) corporate leadership and accountability - date of implementation to 16 April and (b) ensuring safe practice and the appropriate management of risk – date of implementation to 19 March. ➢ Fact-finding visits undertaken to 22 Ambulance Stations and vehicles associated with these stations across all 5 NIAS divisions on 22 February (5 teams of 2 RQIA inspectors) – mixed findings: Western and Belfast divisions – generally good, South-Eastern division – reasonably good, Northern and Southern division – significant challenges identified. ➢ Preliminary findings discussed with NIAS C Ex, DoH policy lead, DoH sponsor branch (for RQIA) on 23 and 26 February. Serious concerns meeting scheduled for 2 March with NIAS and DoH. ➢ RQIA has recommended to DoH (correspondence of 31 February) that a special measure is now implemented for NIAS to ensure urgent improvements are delivered in relation to infection prevention/control and associated Trust governance and assurance systems. **ACUTE HOSPITAL Unannounced Inspection Programme (HIP)** ➢ Phase 2 HIP inspection activity is now complete, inspection reports for South-West Acute, Causeway Hospitals and RHHSC (2nd inspection) will be published on Wednesday 28 March. Report of main themes arising through Phase 2 inspections to follow (as per Phase 1 report), currently anticipated for circulation/sharing w/c 9 April. ➢ Follow-up work is continuing with BHSCT regarding RBHSC inspection findings and with NHSCT

regarding Causeway Hospital inspection findings.

- Meeting held with NHSCT on 24 January to discuss progress in relation to Causeway findings (inspection 20-23 Nov 17), next meeting scheduled for 12 March. Areas for improvement include –
  - disconnected care delivery within and between specialisms/disciplines,
  - planned/scheduled ward rounds,
  - participation/engagement in multi-disciplinary team meetings,
  - communication across and between disciplines,
  - shortages in ward staffing (nursing, phlebotomy, pharmacy) *and*
  - staff morale (ward nursing staff, junior medical staff).
- Meeting held with BHSCT on 23 February to discuss progress in relation to RBHSC findings (inspection 11-13 Dec 17), next meeting agreed for 2 months (date tbc). Areas for improvement include –
  - short stay assessment unit (SSAU),
  - nursing leadership for Barbour Ward,
  - case mix and complexity of children on Barbour Ward as currently used/configured,
  - retention of specialist children's nurses,
  - collaborative working (including both clinical and managerial staff) to deliver improvement, *and*
  - work to deliver new/refreshed care pathways and systems.
- Stakeholder workshop held on Friday 9 February to review Phase II of HIP, representation from all Trusts, DoH and Universities (QUB, UU and OU nursing), actions agreed to include work addressing – PPI/public engagement, information & intelligence underpinning inspections, finalisation of 'well-led' inspection tool, plain English inspection reports, establishment of HIP Advisory Group (workshop participants agreed to become members).
- Phase 3 HIP – planning commenced, inspection activity to commence after 1 April 2018. Phase III HIP will offer a learning opportunity to Trust Non-Executive Directors (NEDs) to participate in a hospital inspection, liaison with Trusts to introduce and offer this opportunity will be discussed and actioned with RQIA Chair (Professor McColgan).

AUGMENTED CARE Inspection Programme

- **Neonatal Care – Year 3** Seven units to be inspected by 31 March, this will complete the three year programme of inspection to neonatal units. Findings demonstrate implementation of previous action plans, improvement in care/services and evidence of QI initiatives being implemented at unit level.
- **Adult Critical Care– Year 3** One inspection to be completed in each HSC Trust April – June (i.e. Q1 2018–2019). Inspections will be carried out using risk-based approach to determine units to be inspected. This will complete the three year programme of inspection to critical care units.
- **All other Augmented Care areas** (renal, haematology, oncology etc) to be progressed using a risk-

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	based approach to inspection from 1 April 18 to 31 March 19. This will give a base-line of information in relation to compliance against standard inspection audit tools. ➢ Following completion of year 3 of both Neonatal and Critical Care inspection programmes discussion is now required regarding future approach to assurance of best practice in these clinical areas. Meeting with DoH (sponsor branch and policy leads) to be re-scheduled (20 February deferred) which will be followed by discussion with key stakeholders/groups (including NNNI and CCaNNI). Future assurance is likely to include both self-assessment and external assurance from RQIA.
3.2 INDEPENDENT HEALTHCARE: INSPECTIONS	**Dental Regulation** • Compliance with the regulations and standards is being achieved in the majority of practices; we continue to see a very small number of providers who are not compliant in relation to staff recruitment and selection. • Since April 2017, three meetings were held with providers with the intention to issue Failure to Comply Notices – resulting in one provider receiving a FtC Notice. • Serious concerns meetings were held with five providers during 2017/18. Most recent serious concerns meetings were held on (i) 12 January wrt two registered dental practices (involving the same registered person) in relation to non-compliance with infection prevention & control, decontamination, and recruitment & selection of staff and (ii) 15 February wrt recruitment and selection of staff. Follow-up inspections will be undertaken in relation to (i) and no further action in relation to (ii). **Unregistered Cosmetic Laser Services** • We continue to pursue a number of cosmetic laser services operating without registration. The total number of successful prosecutions in respect of these services is seven and two are currently awaiting court dates. **Independent Medical Agencies (IMAs)** • We are reviewing our position in relation to IMAs and plan to update EMT, our Board and DoH before end of Mar 2018. **Independent Hospitals and Hospices** • Inspection methodology for Independent hospitals and hospices will be refreshed from April onwards, methodology will be similar in nature to inspection of HSC hospitals (i.e. be multi-disciplinary in nature; include medical input and

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peer reviewers and lay assessors (as appropriate) be supported by regular debrief and continuous assessment/checking of key themes emerging during fieldwork).

- RQIA Chief Executive and Medical Director met with DoH on 30 October 2017 to discuss a potential Review of Governance Arrangements within Private/Independent Hospitals and a draft was shared with DoH on 26th January for consideration/comment Further discussion will confirm terms of reference for scoping exercise to inform this review.

3.3 RQIA AUDITS / GUIDELINES

Name of Audit	Status
How current practice of Prostate Specific Antigen (PSA) testing fits with local and national guidelines	Data Analysis. Extension agreed with Head of Programme until June 2018 (no associated cost)
STICkS – Safe Transitions in Care Checklists: A ward-round weekend handover project in surgical units – Phase 2	Report writing. Due to complete end of March 2018.
A regional Podiatry Audit of the Multidisciplinary Management of Rheumatological Foot Health Problems in Adults and Children	Report writing. Due to complete end of March 2018.
Regional Audit of Intravenous Thrombolysis Treatment For Acute Ischaemic Stroke (ISP) in NI	Report writing. Due to complete end of March 2018.
A regional retrospective audit of compliance with UTI regional guidelines in secondary care	Draft report received for quality assurance. Due to complete end of March 2018.
Reducing Hospital Admissions of People with Dementia in Nursing Homes: The Role of Anticipatory Care Planning	Draft report received for quality assurance. Due to complete end of March 2018.
Planning birth at home in Northern Ireland	In fieldwork. On track to complete September 2018.
Regional audit of vision services and vision finding in special education schools	Draft report received for quality assurance. Due to complete end of March 2018.

Audit of Quality and Outcomes of Key performances in Regional Forensic Services	Draft report received for quality assurance. Due to complete end of March 2018.
Clinical Case Note Audit of Late Term Stillbirths (=/>37 weeks) in 2016"	Report writing. Due to complete end of February 2018.
Regional audit of CMV Colitis	With external reviewer. Due to complete end of March 2018.
Tension-free Vaginal Tape (TVT) for Stress Urinary Incontinence (SUI) in Northern Ireland (2013)	Final report with Legal Team in relation to declaration of interests.
REVIEW - Guidelines on Caring For People with a Learning Disability in General Hospital Settings 2010	Complete
Guidelines On The Use Of The Mental Health (Northern Ireland) Order 1986 – 2011	Ongoing

3.4 REVIEW PROGRAMME

Name of Review	**Status**
Out-of-Hours (OOH) General Practitioner (GP) Service (RQIA Initiated)	Fieldwork currently in progress – 3 X OOH provider visits by Review Team w/c 26 Feb and 3 X visits scheduled for w/c19 Mar. Surveys of GPs and public (service users) in progress. Reference Group for Review continuing to meet regularly.
Review of Implementation of Clinical Guideline CG174 Intravenous Fluid Therapy in Adults in Hospital (DoH Commissioned)	Fieldwork currently in progress – self assessment questionnaires issued to Trusts, clinical audits at pilot stage, Trust governance visits scheduled for w/c 23 Apr.
Review of Service Frameworks (DoH Commissioned)	Initiating. DoH representatives have joined Project Team.
Review of Learning Disability: Community Services: Phase II (Children) (RQIA Initiated)	Scoping.

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Potential Review of Governance in Private/Independent Hospitals (DoH Commissioned)	Draft terms of reference and methodology for initial scoping exercise under consideration by DoH and RQIA.
Review of Governance Arrangements for Child Protection in the HSC in Northern Ireland: Phase I (RQIA Initiated)	Draft report with Review Team for final consideration. To be submitted to DoH w/c 12 Mar.

4. CORPORATE SERVICES	
4.1 CURRENT AND PROJECTED FINANCIAL POSITION 2017-18	The implementation of the Workforce Review has necessitated holding a number of vacant posts unfilled in order to ensure flexibility in re-structuring the organisation and achieving the benefits of the Review. As a result of this RQIA will have a significant underspend at the year-end and a break-even position will only be achieved through a phased non-recurring easement to DoH. In November 2017 an easement of £300K was made to DoH. As at 31 January 2018 the projected underspend is estimated to be circa £139K. A review of pay and non-pay assumptions has been carried out and a further easement will follow. RQIA received a ring-fenced allocation of £178,993 for VES on 23 January 2018. Currently we have a £55K underspend against the VES budget (included as part of the overall projected underspend above) which cannot be returned to DoH. The Chief Executive is working to ensure that VES funding is committed in line with the allocation.
4.2 FINANCIAL PLANNING SCENARIOS 2018-19 AND 2019-20	RQIA received no comments from DoH on the Financial Scenario Plan 2018-19 and 2019-20 which was submitted to DoH on 13 December 2017. We await notification of the 2018-19 RRL and associated savings target.
4.3 BUSINESS PLAN 2018-19	RQIA's Business Plan 2018-19 will be presented to RQIA's Board on 22 March 2018 for approval.
4.4 GOVERNANCE	• The revised Management Statement and Financial Memorandum (MSFM) was shared with RQIA's Board at a workshop on 22 February 2018. RQIA has prepared comments on the MSFM for discussion with DoH. The final version of the MSFM will be presented to the Board for approval. • The audit report on Regulation – Nursing Homes was finalised and issued on 22/1/18. A draft audit report on Information Governance is due to be issued to RQIA. Internal Audit has commenced work on the Governance and Board Effectiveness audit.

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	• A GDPR Action Plan has been developed and RQIA is working with BSO to prepare for the implementation of GDPR in May 2018.
4.5 CONTROLS ASSURANCE STANDARDS / ASSURANCE FRAMEWORK 2018-19	Joanne Elliott, DoH has shared an interim Progress Report with ALBs on the Department's approach to obtaining an appropriate and proportionate approach to assurance as an alternative to CASs which will come into effect in 2018-19. RQIA await the final version of the Report and will put in place new assurance arrangements as necessary.
4.5 BUSINESS OPTIMISATION PROJECT	RQIA has been notified that as part of the Belfast Optimisation Project new office accommodation will be made available in Belfast for ALBs in December 2021. This means that RQIA would extend its lease for one year and move into the new accommodation in 2022. RQIA will continue to engage with Siobhan White, RPM Project Manager on the transition to new office accommodation.
MEDIA INTEREST	During January and February, RQIA responded to a range of print and broadcast media queries relating to enforcement and public concerns in respect of regulated services. Enforcement action at Craigavon Ambulance Station received coverage in one media outlet (Sunday Life) in late February.

Exhibit 27

RQIA BI-MONTHLY UPDATE REPORT – March 2019

ASSURANCE DIRECTORATE UPDATE

Care Homes Team

Residential Care Beds in Nursing Homes

Position as at 28 February 2019	
Services still undecided	**5**
Application forms issued and still to be returned	**1**
Application forms received and being processed	**2**
Certificates issued	**104**
Applications withdrawn	**2**

Legal advice from Junior Counsel was received and reviewed in respect of the remaining outliers. A final letter has been issued to the three providers concerned advising that their preferred option must be communicated to RQIA by 29 March. We will provide a verbal update on progress at the meeting. The letter from Mr Holland to stakeholders in respect of this matter provided helpful clarity.

Enforcement Action

Two notices were served on a residential care home with a compliance date of 8 May.

A Notice of Decision to impose conditions on the registration of a nursing home came into effect on 13 February.

Three failure to comply notices were issued on residential home with a compliance date of 1 April 2019.

RADaR

A further workshop is planned for 3 May 2019 to consolidate the work so far and to look at implementing the approach

across the Assurance Directorate.

Four Seasons Health Care

The Chief Executive remains in contact with FSHC, the HSCB and DOH regarding this matter and the potential impact on the care home sector in Northern Ireland.

Regional Contingency Planning Group – Care Homes

RQIA attended a meeting of the Regional Contingency Planning Group for Care Homes on 7 January. The purpose of the group is to establish regular meetings and an emergency planning regional response. An emergency planning stakeholder workshop was held on 7 March to develop a Care Homes Business Continuity Regional Response Plan looking at each roles and responsibilities of each relevant agency.

Day Care, Agencies, Estates, Finance & Pharmacy

Day Care Settings – 'Satellite Units'

RQIA continues to work with the providers of day care settings operating 'satellite' services. These satellite units are required to be registered separately if they are providing day care in a different location from the day centres that they are associated with. There are 28 'satellite' units in operation and the providers operating the satellite units have indicated their intentions in respect as follows:

- 14 are to be registered separately as day care centres
- 14 do not require separate registration.

Day Care Settings – SHSCT review of day services

We are participating in the Southern HSC Trust review of day services. The project includes participation from various stakeholders across the sector. Our role is to provide input from the regulatory perspective as existing registered day care services are likely to be subject to some reconfiguration.

The Trust propose to discuss final plans with RQIA before submission to its Board for ratification.

Domiciliary Care

We are in the process of reviewing the registration of a small number of domiciliary care agencies which have not been operational since becoming registered. It is anticipated that we will propose to impose a condition on the registration of these agencies which will require the provider to notify us in advance of becoming operational. We will then undertake an inspection to ensure that the agency will operate in accordance with the standards and regulations.

We met with NISCC on 18 February to scope and develop best practice guidelines/safer recruitment principles for the domiciliary care sector. Further meetings are planned.

Domiciliary care reform meetings took place on 10 January and 25 February in partnership with RQIA, HSCB and Trusts to consider the proposed new model for the sector. We have been reviewing the proposed model and will advise DoH of any potential changes required to regulations and standards. Further meetings are scheduled for March and May.

The Assistant Director met with SEHSCT on 26 February to discuss the Trust's plans to pilot a model of domiciliary care provision that will be more outcomes focused.

Nursing Agencies

Providers have advised us of the demand for nursing staff across all sectors due in part to trusts commissioning services for individual with more complex needs in the community and who require nursing interventions.

A sixth of registered nursing agencies have offices outside of Northern Ireland with a further 18 service applications being processed by RQIA in this regard. Some applicants have advised us that they are making application to operate in Northern Ireland in response to requests by HSC Trusts to meet the complex nursing needs of individuals currently in receipt of hospital care. There are obvious issues in RQIA being unable to inspect agencies whose base is outside NI.

We are in the process of reviewing the registration of a small number of nursing agencies which have not been operational since becoming registered. It is anticipated that we will propose to impose a condition on the registration of these agencies which will

require the provider to notify us in advance of becoming operational. We will then undertake an inspection to ensure that the agency will operate in accordance with the standards and regulations. One agency has received a notice of proposal to impose this condition to their registration.

Adult Safeguarding Joint Protocol

We have agreed to attend a two day comprehensive review of the 'Protocol for Joint Investigation of Adult Safeguarding Cases' with the PSNI and other partners.

Children's Services

Enforcement Action

Two serious concerns meetings were held in respect of two children's homes and no further action was taken.

One failure to comply notice was served on another home with a compliance date of 7 May.

Unregistered Facilities Accommodating Young People

The DoH, HSCB and Trusts are meeting with the Department for Communities to review the reduction in funding for jointly commissioned projects. We will conclude our inspections of these services by the end of May and provide an overview report to DoH and HSCB on compliance with standards.

A proposal has been received from VOYPIC to introduce a care-experienced apprenticeship that would assist RQIA in the assessment of the quality of care provided in our children's homes and hospital facilities. We are currently considering this in light of resources available to fund the post.

Monthly Monitoring Reports

We are currently reviewing the monthly monitoring reports submitted to RQIA from children's homes to ensure the quality and

effectiveness of the information provided.

Learning Disability Centre

An unannounced inspection was undertaken on 24 and 25 January of a Learning Disability Children's Centre. An Article 4 letter was submitted to DoH on 30 January regarding our findings. A meeting was held with the HSCB on 30 January to review the number of young people who are delayed in their discharge from this centre.

Presentations

The Assistant Director of the Care Homes Team, made a presentation on 7 February to a Nurse & Midwife Development Programme for Band 5 & 6 Registered nurses on our roles and functions.

March will see the conclusion of the three half day workshops about best practice for medicines in domiciliary care that have been run regionally in conjunction with Northern Ireland Social Care Council (NISCC).

One of the issues raised at each of the workshops was the difficulty in getting medicines for clients dispensed into a monitored dosage system by community pharmacies. This situation may impact on the ability of providers to deliver their service safely. The length of time it will take to administer medicines out of boxes and bottles will increase the amount of time spent with each client. Managers advised that some clients took at least 10 medicines during the morning call.

IMPROVEMENT DIRECTORATE (HEALTHCARE INSPECTIONS, MENTAL HEALTH, AUDITS / GUIDELINES and REVIEW PROGRAMME

IMPROVEMENT DIRECTORATE

Northern Ireland Ambulance Service

On 13 February we carried out an unannounced inspection of Ballymena Ambulance Station. We found evidence of adherence to best practice in environmental cleanliness and infection prevention and control standards. The Trust-wide Improvement Notice has been extended until the 30th of June at the request of the Trust Chief executive.

Acute Hospitals – Unannounced Inspection Programme (HIP)

We continue to monitor the Royal Belfast Hospital for Sick Children in relation to improving the governance and accountability arrangements relating to the short-stay paediatric assessment unit and plans for refurbishment of Barbour Ward.

Three of four reports for the Phase 2 of the hospital inspection programme have now been published on our website and the final report is in final drafting (inspection of Causeway Hospital on 27 June 2018).

Phase 3 HIP

On 28 January 2019 we provided site-specific feedback to Trust staff on the findings from unannounced inspections to outpatient departments across the Belfast Trust (Musgrave Park Hospital, Belfast City Hospital, and Royal Belfast Hospital for Sick Children, Mater Hospital and Royal Victoria Hospital). As a result of escalation of issues identified during this programme, a meeting with Belfast Trust has taken place on13 March to discuss required actions to strengthen safeguarding measures across outpatient services.

We are currently in the planning phase to progress roll out of this unannounced inspection programme to all other Trust's Outpatient Departments.

Unannounced Hygiene Inspection Programme

We are continuing our risk-based programme using intelligence from a range of sources, including PHA surveillance reports/intelligence, whistleblowing and complaints to determine the need for inspections.

Following receipt of information about issues in respect of hygiene we undertook three inspections during the period. Where required, action plans were developed and improvements were found in one follow up inspection.

Adult and Neonatal Critical Care

On 12 February 2019 we met with the Critical Care and Neonatal Networks to agree the actions required to introducing a new collaborative model of inspection/assurance for oversight of HSC Critical Care and Neonatal Units. The Critical Care Network annual conference on 26 March received a presentation from the Director or Improvement/Medical Director on the new assurance arrangements, which will commence in April.

Other Augmented Care Areas

During January and February we continued our inspection programme in respect of other augmented care areas (renal dialysis, burns units, renal transplant units, haematology and oncology units and departments) in the HSC.

We have written to DoH to seek clarity on the current policy position in respect of inconsistencies relating to designation of clinical areas/services as augmented care settings.

Independent Hospitals and Hospices Inspection Methodology

In January we conducted unannounced inspections of independent hospitals and hospices using a revised multi-disciplinary inspection methodology. Inspections took place in Ulster Independent Clinic (23-24 January), Northern Ireland Hospice (13-15 February), and North West Independent Clinic (25-26 March). The new approach was successful in achieving a more robust inspection of these establishments. In all of these inspections governance and risk management was highlighted as an area requiring attention. Findings from these inspections will inform work in progress, regarding the Review of Governance in the

Independent sector.

IR(ME)R

The Department is aware from previous briefings that an issue had been found in Craigavon Area Hospital. A follow up inspection on the 6 March found that significant improvements have been achieved.

Review Programme

Neurology Patient Recall, Belfast Trust

MLAs received a briefing on the 7 March on progress in relation to the Neurology recall which was attended by the Director of Improvement/Medical Director.

The Director of Improvement/Medical Director also attended the Regional Coordinating Group meeting on the 1 March

(i) Governance review of outpatient services in the Belfast Trust, with a particular focus on neurology and other high volume specialties

The report of this review is currently at final drafting stage to be shared with DoH in due course.

(ii) Expert review of clinical case notes of patients of Dr X who have died in the previous 10 years

Work is ongoing to scope the various phases of this sensitive and complex review. A legal framework is under development to support the review and we are working on a robust mechanism to identify the patients to be included in the review.

(iii) Review of governance (corporate and clinical) relating to health services delivered by independent sector hospitals in Northern Ireland

The expert review team met in February and agreed terms of reference and commentary is awaited from DoH on this draft ToR. DoH has written to the independent hospitals and hospices to signal commencement of the review.

This work will be being complemented by the planned inspections of independent healthcare establishments.

Inquiry into Hyponatraemia-Related Deaths (IHRD)

We continue our work in leading and facilitating the regional IHRD Assurance Working Group which met on the 27 March 2019. Meetings of the subgroup addressing RQIA's specific remit commenced in January with the next meeting scheduled to take place in our offices in April and this will give group members the chance to speak to staff and ask questions about our role and functions as necessary.

Review of Serious Adverse Incidents (SAIs)

Draft terms of reference for this review are under consideration by DoH. We have secured an additional medical member – a senior Northern Ireland clinician - for the review team to provide expertise in governance and investigation. We have secured an additional Lay person for the review team and will source appropriate psychology input.

Audit, Guidelines and Quality Improvement Projects
2018/2019 Programme

Six pieces of work were funded (3 audits and 3 quality improvement projects) and five are on track to complete within the year One guideline, Planning Home Births in Northern Ireland expected to be published by the end of April.

2019/2020 Programme

Eleven applications for Quality Improvement and Audit Projects were received and four have been approved for completion in 2019/20. The two audits relate to Transient Ischaemic Attacks and hospital discharge information, and the two Quality Improvement Prototypes relate to colposcopy/cervical screening and the triaging of red flag referrals for oral cancer.

Mental Health and Learning Disability

Unannounced Inspection Programme

Three unannounced inspections have been carried out since the last brief in Muckamore abbey Hospital (26-28 February) and Gillis Ward in Saint Luke's hospital (22 February) Carrick and Evish Wards in Granhsa Hospital (13 March).

In Gillis Ward (in Saint Luke's hospital) concerns that had led to the inspection were not substantiated but a number of improvement areas were found these will be addressed through a Quality Improvement Plan to accompany the inspection report.

We carried out an unannounced inspection of Muckamore Abbey Hospital 26-28 February 2019. Feedback was provided to the Belfast Trust management team on 1 March 2019. A number of areas of concern were identified, relating to staffing, safeguarding, governance, patients physical health needs, restrictive practices. The areas of concern relate to staffing levels, management of patients' physical health care needs, financial governance, safeguarding practices, restrictive practices and hospital governance were evidenced as below the required standards. An article 4 letter has been forwarded to the DoH recommending special measures and an Intention to serve (improvement notices) meeting was held with the Belfast, Northern and South Eastern Trusts on 7 March 2019. Following this The BHSCT provided further information and has committed to making immediate improvements which will be kept under review and monitored through follow up inspection and a quality improvement plan. The Chief Executive and Medical Director/Director of Improvement met with the Permanent Secretary and senior DoH Officials on 25 March to discuss inspection findings.

A serious concerns meeting was held with the WHSCT on 25 March following an inspection of Carrick Ward in Gransha Hospital. The inspection identified concerns relating to fire safety, incident reporting, implementing of learning from SAIs and inspections, a quality improvement plan will accompany the inspection report.

Prison Health Care

Terms of reference are currently being worked-up between Criminal Justice Inspectorate (CJI) and RQIA to support inspection of police custody suites, inspections to take place in the coming year. We are finalising a report of our Joint inspection (with CJI) regarding prisoner safety.

BUSINESS SUPPORT UNIT UPDATE

BUSINESS SUPPORT UNIT

Media Interest

RQIA has responded to media queries relating to a range of care services. These include: the registration of Meadow View , a new residential care home in Enniskillen, on the site of the former Ashbrooke Nursing Home; RQIA's ongoing enforcement action at the NI Ambulance Service; and issues relating to care at Muckamore Abbey Hospital.

Engagement

RQIA's inaugural Membership Scheme forum took place on 25 March at Mossley Mill. This was attended by around 20 members who were given an opportunity to discuss how they wished to contribute to the work of RQIA. Discussion also took place on RQIA's inspection reports, guidance leaflets and website, and feedback was also provided on how we can make our information more accessible. RQIA is planning to involve smaller groups from our membership scheme in specific pieces of work –to help us improve how we present our inspection findings in a user friendly way; working with us to make our website easier to navigate; or joining our small team of lay assessors who work with us on inspections and reviews to bring a public focus to our work.

Political Engagement

During February RQIA met representatives of Sinn Fein to discuss RQIA's actions in response to concerns raised by parents of patients at Muckamore Abbey Hospital; and an update on progress on the neurology and SAI reviews. In partnership with NISCC, GMC, Pharmaceutical Society and the PCC, RQIA attended the Alliance Party Conference in March, which provided an opportunity to engage with political representatives at all levels and with party members on the role and work of RQIA.

Complaints and Compliments

We are currently managing two complaints against RQIA in line with the Policy and Procedure on Management and Handling of Complaints against RQIA. One is subject to a Stage 1 investigation, while a second is subject to a Stage 2 review. There is also

an ongoing Ombudsman investigation in respect of a complaint against RQIA dating from 2016.

A number of compliments about RQIA's work have been received recently. These include positive feedback from a peer reviewer involved in a hospital inspection. We have also received highly positive comment from relatives of service users at a number of regulated services including a residential care home and day care setting.

Memoranda of Understanding

The MOU with the NI Commission for Children and Young People (NICCY) was agreed in February 2019 and is available on the RQIA website.

An MOU has now been agreed and finalised and was sent to the Education and Training Inspectorate on 11 February 2019 for signature.

Current Legal Actions

There is one new legal action - the letter before action received in respect of the registration of Meadow View Care Home.

Workforce

The Deputy Director of Improvement is now in post. A temporary project manager has been recruited to support the review of inspection methodology – this will be formally advertised in due course.

Interviews for the vacant Assistant Director posts were carried out in March and BSO has been asked to issue formal letters of offer to the successful applicants.

Job descriptions are under preparation for senior inspector and head of intelligence posts. A business manager post is to be advertised shortly. Further workforce development depends on the availability of resources.

Financial Allocation 2018-19

We are on course to break even at year end. We have advised sponsor branch of the impact should the proposed savings plans

be applied as described.

Information

Following the success of online only submission of notifiable events, RQIA will move to online applications for three registration processes from 1st April 2019; Notification of manager absence; Voluntary application for cancellation; Variation to registration. Currently only around 50% of these are currently submitted online. Increased web-portal uptake for these processes will result in a significant saving in processing time.

Self-service reporting has been developed which enables inspectors to view service level reports between any date parameters at the click of a button. These reports include a visual timeline of events such as inspections, notifications and change of manager, enabling ease of analysis and identification of any potential issues and also have interactive functionality to enable more detailed analysis of any information included. Training has been provided at team meetings and feedback has been very positive. Work is ongoing to develop similar reports at a higher level e.g. by provider/service type/team and to include additional data such at the regular data feeds now being received from NIAS in respect of ambulance calls to nursing and residential homes in Northern Ireland.

The information analysts have received training in ArcGIS mapping software and are beginning to analyse and display geographical information in relation to services registered with RQIA and information in relation to these services. The team are working alongside colleagues in eHealth to explore other relevant sources of information which could be mapped in conjunction with RQIA services.

The Information Team have been working with the Communications Team to develop a statistical briefing containing high level statistical information which will be published quarterly from April 2019. The RQIA Information Team have also been working on evaluating and analysing information in relation to registration trends in nursing and residential homes in Northern Ireland since RQIA came into effect. A detailed report has been produced and will be published on the RQIA website following final validation checks.

Exhibit 28

RQIA QUARTERLY UPDATE REPORT – JANUARY 2020

ASSURANCE DIRECTORATE UPDATE

CARE HOMES TEAM

Residential Care Beds in Nursing Homes
This project is now complete with all providers in compliance with regulations effective from 20 December.

RADaR (Risk Adjusted Dynamic and Responsive)
Statistical analysis is ongoing in relation to the findings from the scaled inspection tool, the differences between residential and nursing homes' assessed level of risk and analysis of incident reporting in the days following admission to nursing homes. The information team met with Prof Brian Taylor from the University of Ulster on the 5 December to finalise an academic summary paper in relation to RADaR.

Four Seasons Health Care
The Chief Executive and senior management colleagues met with Four Seasons Health Care, HSCB and DoH on 26 November in relation to progress made regarding the sale of the healthcare group.

Meeting with COPNI
The Deputy Director of Assurance has engaged with colleagues from COPNI in relation to Owen Mor and other care homes. The Head of Business Support has reinitiated regular liaison meetings with her counterparts in COPNI.

Inspection Frequency / 2003 (Northern Ireland) Order/ Minimum Frequency
As discussed at the ground clearing meeting, we anticipate a shortfall against our requirement for the minimum frequency of inspections across a number of services. An update report on the recovery plan is monitored on a weekly basis.

DAY CARE, AGENCIES, ESTATES, FINANCE & PHARMACY

Easy Read Report Project
An Easy Read Report Project was piloted, in consultation with service users, from April to September. These reports describe the outcomes of inspections to people with an intellectual disability or cognitive impairment in an accessible format using simple words, large print and straightforward pictures.

To evaluate the effectiveness of the project, the services, and a number of service users, were given the opportunity to comment on their individual inspection reports. The results from the evaluation were very positive and highlighted that appropriately communicating our inspection findings is important to individual service users. The team will continue to produce easy read reports alongside their standard inspection reports.

Enforcement

Gosna
Following an urgent application to a Justice of the Peace on 23 October, we cancelled the registration of the Responsible Person for Gosna Care Agency Ltd, a domiciliary care agency in Belfast. An appeal has been lodged with The Care Tribunal regarding this matter.

Valley Nursing Home
During a detailed inspection on 16-17 December, we identified further serious concerns impacting directly on the care of patients at this home. On 27 December, as a result of continued failures at Valley Nursing Home, we issued a notice of proposal to cancel the registration of the Registered Person for this Home. All regional stakeholders have been notified of this decision.

CHILDREN'S TEAM

Unregistered Facilities Accommodating Young People
Members of the Children's Team attended the Jointly Commissioned Supported Accommodation Forum on 19 November, organised by the HSCB and NIHE. The Team delivered a presentation on the 16+ Supported Accommodation Report 2018/2019. Feedback from the event was encouraging as providers said they had benefitted from our inspectors' guidance and improvement approach to inspection.

Supported Lodgings Review
The terms of reference for the Supported Lodgings Review were received on 26 November; three inspections will now be commenced to inform the final report, which will be completed by 31 March.

Monthly Monitoring Reports
A Monthly Monitoring Report (MMR) is completed by a representative of the Registered Person following a visit to each children's home. It is submitted to RQIA each month. The Report is used as a form of intelligence by inspectors to monitor compliance and identify any concerns. The quality of information provided on MMRs is an ongoing concern and we are encouraging improvement through inspections and QIPs. Our most recent enforcement action identified that monitoring must be improved by providers, mainly Trusts, to drive forward improvement in areas such as fire safety, medicines management and staff training.

Engagement with Young People
A proposal for two peer apprentices is currently in development.

Ongoing engagement with VOYPIC is progressing to maximise inspectors' potential to hear young people's views about living in a children's home. We aim to communicate with groups of young people between January and April 2020 to improve our overall strategy of how we communicate with young people.

IMPROVEMENT DIRECTORATE (HEALTHCARE INSPECTIONS, MENTAL HEALTH, AUDITS / GUIDELINES and REVIEW PROGRAMME

IMPROVEMENT DIRECTORATE

HSC Healthcare

Hospitals Programme

Acute Hospitals
We continue to work collaboratively with the Belfast Trust to progress the areas for improvement identified during the inspection of the Royal Belfast Hospital for Sick Children. We are currently preparing a report of this inspection to share with the Belfast Trust for factual accuracy and with a view to potential publication and sharing with the Department of Health during January.

Outpatients Departments Inspections
In 2020 we plan to progress unannounced inspections to the four remaining Trusts' outpatients departments.

Augmented Care Inspection Programme
Using the augmented care inspection methodology we undertook an unannounced inspection following whistleblowing to the Royal Victoria Hospital Ward 4F Neurosurgery on 17 and 18 October. We identified areas of good practice in respect of infection prevention and control and governance arrangements. We did however identify a number of areas for improvement and have made recommendations within a quality improvement plan which will be monitored through follow-up inspections.

We await clarification from PHA in relation to the official definition of augmented care areas. We will plan further spot checks of critical care and neonatal care areas in keeping with agreed approach to assuring best practice in these settings for the 2019/20 inspection year.

Independent Hospitals
An Unannounced Inspection of Ulster Independent Clinic (UIC) took place on 4 November, following review of notifications received and assessment of monthly updates on the hospital's QIP submitted to RQIA. We are concerned that UIC does not have a 'live' and robust system for the oversight and management of medical governance within the hospital. We invited UIC to Failure to Comply (FTC) meeting which was held on 13 December, following which we decided to serve one FTC notice

addressing medical governance (systems and processes). We issued the FTC on Monday 23 December with compliance to be achieved by 23 February 2020. We advised DoH and attended a meeting with CMO, CNO and Sponsor Branch on Monday 23 December to discuss. We are currently seeking further information from the UIC.

Southern Health and Social Care Trust

We have been informed of a number of matters relating to services provided by the Southern Health and Social Care Trust. The particular service areas in the Trust which have come to our attention include:

- Obstetrics and gynaecology services – on 8 November the Trust informed us that the Trust has made a request to the Royal College of Obstetricians and Gynaecology to undertake an Invited Service Review (ISR) of obstetrics and gynaecology services delivered in Daisy Hill and Craigavon Hospitals. We understand that this request follows a review of information brought to the Trust attention through the Trust's whistleblowing arrangements and following receipt of feedback from NIMDTA.
- Infection prevention in acute services - on 8 November the Trust informed us that they have identified an increase in *Clostridium difficile* infections (CDI) in patients nursed on particular wards in Craigavon Hospital.
- Mental health services delivered in the Bluestone Unit - we received a number of concerns and notifications relating to this unit and services delivered. We shared our concerns on these with the Trust's Director of Mental Health & Disability via letter on 8 August 2019. We have also been advised of completion of an Invited Service Review (ISR) of the Bluestone Unit undertaken by the Royal College of Psychiatrists in July 2019, following an ISR request made by the Trust. On 6 September we met with Trust's Senior Management Team to discuss the main themes emerging from this ISR and plans for delivering improvements within acute in-patient mental health services. We requested and received the Trust's action plan relating to the recommendations advised by the ISR, which we determined to be lacking detail and clarity about how the Trust will deliver the necessary improvements.
- Concern Shared by the General Medical Council – we were contacted by the General Medical Council (GMC) on 6 December, who shared information with us which indicated the Trust undertook a local MHPS investigation (Maintaining High Professional Standards Formal Investigation - Case Manager Determination) in September 2018, which identified what the GMC's note describes as 'systemic concerns'. The GMC's Employer Liaison Adviser (ELA) has recommended that the Trust share two reports with RQIA (in redacted form) in relation to this investigation. We requested the Trust to share the details relating to the concern raised by the GMC, investigation undertaken by the Trust in 2018 and the full detail of specific actions that the Trust has taken and/or intends to take to address the concerns reported and the learning identified through that investigation.

We are requesting further clarity and/or update from the Trust Medical Director regarding the areas the outlined above to be

submitted to us by February.

Mental Health and Learning Disability

Belfast Health and Social Care Trust
The date for compliance with the three Improvement Notices issued in August 2019 in relation to Muckamore Abbey Hospital was 16 November. We met with the Belfast Trust representatives on 2 October and 22 November to discuss progress towards compliance with the actions outlined in their three Improvement Notices. We undertook a multidisciplinary inspection from 10 to 12 December, including an overnight visit, to assess the progress in respect of each of the notices and other areas of concern identified during inspections undertaken earlier this year. This was a very good inspection, there is evidence of considerable improvement across all of the areas assessed including the areas for which the Improvement Notices were served. We have now lifted all aspects of the notice relating to staff and all but one element in each of the other two notices (financial governance and safe guarding arrangements).

We continue to meet regularly with the PSNI and Belfast HSC Trust under Adult Safeguarding Joint Protocol arrangements in relation to historic adult safeguarding concerns. Dr Geoghegan attends monthly meetings of the Muckamore Departmental Assurance Group (MDAG) meetings as an observer.

Western Health and Social Care Trust
The date for compliance with the Improvement Notice issued in July 2019 in relation incident management in the acute mental health wards in Gransha and the Tyrone and Fermanagh sites was 22 October. We undertook a multidisciplinary inspection on 13 and 14 November to assess the progress in respect of the notice and other areas of concerns. Inspection findings resulted in extension of the improvement notice as the Trust had failed to fully comply with the actions identified in their action plan. We identified further areas of serious concerns in relation to overall PICU operating model, environmental fire risk, fluid management and physical health care, and governance. We met with senior Trust representatives on 20 December 2019 for the intention to serve an improvement notice meeting. At this meeting the Trust provided us with an update regarding the actions they are taking to progress the actions outlined in the Improvement Notice. We note that some progress towards compliance has been made. We await further information from the Trust in this regard before we make our determination.

Audit Mental Health (Northern Ireland) Order 1986 Form 10
We met with DOH and Clinical Directors of all Trusts to share the findings of our audit of Form 10s (completed by Trusts and subsequently forwarded to RQIA), which we receive in line with our functions under the Metal Health NI Order (1986). Both are

supportive of our plan to improve processes relating to completion of Form 10. We presented the findings from the audit to the Royal College of Psychiatrists training event on the 5 December. Planned work will include a focus on training and education, refreshed presentation of template Form 10 and strengthened assurance processes relating to completion.

South Eastern Health and Social Care Trust
Senior representatives from the SEHSCT Mental Health and Disability Directorate attended a serious concerns meeting on 25 October 2019 to share with us their plans for an interim solution to provide care to the mixed patient profile of Ward 27 Downshire. An extension to the current ward to accommodate patients who require psychiatric intensive care has been agreed and is scheduled to be completed by December 2021. Plans of the new build were shared with us. We are content that the new build will address ongoing concerns regarding the ward's mixed patient population.

Prison Health Care
We acted as core partners in a recent multiagency inspection of Hydebank Wood Collage and Ash House Womens Prison from 4 to 7 November. This inspection team included representatives from RQIA, HMIP, CJI and ETI. A number of recommendations have been agreed and a joint report is in development with all partners involved in the inspection.

Police Custody Health Care
During the first two weeks of December we undertook joint inspections with the Criminal Justice Inspectorate of police custody suites across Northern Ireland. Findings of this inspection are currently being analysed and recommendations are being developed.

Review Programme

We published our Review of General Paediatric Surgery in Northern Ireland on 13 December 2019.

The following reviews are in progress:

Governance Review of Outpatient Services in the Belfast Trust, with a particular focus on Neurology and other High Volume Specialties
The draft report has been through factual accuracy with the Belfast Trust and updated, where appropriate. A final version of the review report has been shared with the DoH on 21 November 2019 and we await advice from the DoH in relation to a publication date.

Review of Governance Arrangements in Independent (Private) Hospitals and Hospices in Northern Ireland
We held two workshops with our internal Review Team in October 2019 to analyse emerging findings and to underpin the content of this review report. We are currently drafting the review report and plan to submit the draft report to the DoH in February 2020.

Expert review of clinical case notes of patients of Dr X who have died in the previous 10 years
We continue to progress preparatory work for this sensitive and complex review and are finalising our Legal Framework in respect of receiving patient records. Our approach to be adopted in respect of accessing the records of those patients who have deceased has been challenging in order to ensure it is aligned to best practice, taking into account the legal and ethical issues which may arise during the course of the review. This has been discussed with our stakeholders and General Healthcare Policy Branch at DoH. We have written to the Patient Advisory Committee for advice in respect of the approach which we propose to take. This will allow us to finalise our Legal Framework and commence the request for patient records.

Review of Serious Adverse Incidents (SAIs)
This review is currently in fieldwork and we have completed our engagement with staff in the HSC Trusts and the Integrated Care Team at the HSC Board who participated in a series of focus groups / meetings for those staff who have been involved in an SAI and for those who have reviewed SAIs. We also have online surveys open for staff to complete. A few HSC staff requested direct contact with members of our Expert Review Team and this has been accommodated. We held meetings with Trust executive teams and senior managers during November 2019. However, our meetings with trust executives and senior managers at the Western Trust and the HSC Board / PHA scheduled for November and December 2019 respectively will be rescheduled for January / February 2020 at the request of these organisations, due to industrial action at the time. Our Expert Review Team has agreed to commence the patient / family engagement in January 2020, following the Christmas period, as this is seen as a sensitive time for these patients / families.

Review of Vulnerable Prisoners
Preparatory work to support this review has commenced and we held a workshop in December 2019 to fully scope the review. The review will include all prisons and is aiming to complete within one year of commencement.

DoH Review of Urgent and Emergency Care
We are currently providing some project management input into this DoH review in respect of a review of patient flow exercise which will be undertaken to examine the profile of patients attending each level 1 Emergency Department. This exercise is designed to inform and support the broader data analysis and modelling undertaken as part of the wider review.

Audit, Guidelines and Quality Improvement (QI) Prototypes

2018-2019 Programme
All projects completed and published on RQIA website.

2019-2020 Programme
We continue to support the four audit projects and two quality improvement prototypes.

2020-2021 Programme
We have closed the funding application process for 2020-2021 Programme. We received three audit and seven quality improvement applications. We are currently assessing applications and plan to meet applicants and make decisions relating to funding of projects for the coming financial year in January.

BUSINESS SUPPORT UNIT UPDATE

BUSINESS SUPPORT UNIT

Media Interest

Since the last meeting there has been significant print, broadcast and online media interest in a range of RQIA's activities.

Enforcement actions at a number of services received considerable coverage. Following Owen Mor Nursing Home, Derry, achieving compliance with regulations (failure to comply notices and conditions of registration) the Chief Executive was interviewed on BBC Radio Foyle welcoming the improvement for patients at this home. Over the new year, the Chief Executive was also interviewed for BBC Newsline (TV)/ Radio Ulster Evening Extra and Good Morning Ulster on the rationale for our decision to move to close Valley Nursing Home in Clogher. There was also interest from a range of outlets in our role in relation to mental health services at Muckamore Abbey, Bluestone in Craigavon, and Western Trust mental health services. The Director of Improvement and Medical Director was interviewed for BBC Newsline before Christmas, welcoming improvements seen at Muckamore Abbey Hospital, described in the media as the first good news about this service in two years. We also responded to queries in relation to our review of deceased patients of neurologist Dr Watt.

Social Media

RQIA's Communications team has developed a number of short animations to inform the public about our work and to provide guidance in raising a concern about care services. These are available on RQIA's Twitter account @RQIANews (which has over 4,000 followers), on our YouTube channel and via our website. During its first week on Twitter, our concerns animation has been viewed almost 900 times.

Engagement

RQIA's Communications Team attended the HSC Involve Fest, which showcased the role of personal and public involvement in shaping, supporting and improving health and social care provision in Northern Ireland. This provided an opportunity for RQIA to engage with a range of stakeholders from across the HSC.

Political Engagement

RQIA complied with relevant guidance relating to public communication and engagement during the election period and did not undertake any political engagement.

Complaints

Since the last meeting we received two complaints about RQIA. Neither met the requirements for investigation under RQIA's Complaints policy and were directed to the relevant bodies. Both dated back several years falling outside timescales for investigation, and related to issues where RQIA has no involvement or remit.

Current Legal Actions

We have received two 'statements of claim' for the next stage of proceedings in relation to McVicker and Bell (deceased) v Runwood Homes and RQIA.

Valley Nursing Home (MPS) Ltd lodged an appeal to the Care Tribunal in October 2019 in respect of a NOD issued to Valley Nursing Home to place conditions of registration on the service (cease admissions and provide RQIA with monthly monitoring reports).

Workforce

We appointed a Director of Assurance, Head of Information and Intelligence, five senior inspectors and an admin supervisor following interviews in October and November. We are currently in the process of a recruitment exercise for the Deputy Director of Assurance.

Information

Online submissions of manager absences; voluntary application for cancellation and variation to registration have been varied. In November 100% of variations, 74% of manager absences, 80% of cancellation applications and 35% of manager applications were submitted through the web portal. As such the registration are planning to target communication to service providers to try and increase online submission rates particularly in relation to manager absences. We will continue to monitor submission rates

on a monthly basis.

Information analysts are continuing to develop their skills in relation to ArcGIS mapping software. Unique Property Reference Numbers (UPRN's) have now been assigned to each service and have been input to iConnect. The team have produced maps showing where services have been registered and closed in the last few years.

The information team continue to produce a quarterly statistical briefing containing high level statistical information in relation to core RQIA activity. The next report will be published in January. Work is also ongoing to collate a suite of summary reports. Agencies and dental reports are currently undergoing final quality assurance before they are published.

Extensive analysis has now been carried out in relation to information received from the Northern Ireland Ambulance Service (NIAS) on a quarterly basis. This information has given useful insight into practices in nursing and residential homes. Findings have been shared with NIAS and we plan to meet with them in January to discuss the possibility of receiving this information on a more regular basis.

Finance

DoH recently requested urgent input into a review of its financial position. RQIA made an easement of £60K to DoH in December.

Current Enforcement Action

Name of Service	Type of enforcement	Date of Issue	Compliance required by
NI Ambulance Service Headquarters (NIAS, Mr M Bloomfield)	1 x IN	21 December 2018	31 March 2020
Western HSC Trust, Directorate of Adult Mental Health and Disability Services (Beech, Lime and Elm wards) Tyrone and Fermanagh Hospital, Omagh and Carrick and Evish wards (Grangewood Hospital, L'Derry) (Dr A Kilgallen)	1 x IN	22 July 2019 20 December 2019	22 October 2019 TBC
Valley Nursing Home, Clogher (Valley Nursing Home (MPA) Ltd)	1 x NOP 1x NOD 1 x NOP	24 July 2019 18 September 2019 27 December 2019	Ongoing – appeal lodged with Care Tribunal To cancel registration of Mr P Warren Gray in respect of Valley NH
Muckamore Abbey Hospital (Belfast HSC Trust)	3 x IN 2 x IN (extended)	16 August 2019 19 December 2019	16 November 2019 19 March 2020
TW Care Services Ltd DCA, Ballymena (Mrs O Gahadza)	1 x FTC	16 December 2019	16 March 2020
Ulster Independent Clinic, Belfast (Ms Diane Graham)	1 x FTC	23 December 2019	23 February 2020

On 26 November 2019 a children's home operated by the SEHSCT was issued with four FTC notices relating to: fire precautions (compliance required by 12 December 2019); medicines management; employment of staff; and monthly monitoring (compliance is required by 27 January 2020) for three notices other than the fire safety notice, with. A notice of proposal (26 November) and subsequently a notice of

decision (6 January) were also issued to cease further admissions to the service until compliance is achieved with regulations.

Conditions of Registration

RQIA has placed conditions on a number of dormant services requiring them to notify RQIA should they wish to become operational. These are:

- Angels Recruitment Agency Ltd. (Nursing Agency) Londonderry (Mr D Duffy)
- Angels Recruitment Agency Ltd. (Domiciliary Care Agency) Londonderry (Mr D Duffy)
- Fortview (Residential Care Home) Dromore, Co Tyrone (Mr P Tolan)
- Peniel Nursing Care Services (Domiciliary Care Agency), Belfast (Mrs S Law)
- Pine Lodge (Residential Care Home), Belfast (BHSCT)

Exhibit 29

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

From: Fergal Bradley
Head of Quality Regulation
and Improvement Unit

cc G5/G6

Date: 11 February 2020

To: TMG

RQIA Quarterly Liaison Meetings and Update Reports

RQIA are required to produce a comprehensive update report for consideration at the quarterly liaison meetings with sponsorship branch.

The most recent quarterly liaison meeting was held on 23 January 2020 and the corresponding update report is now attached for your information (**Annex A**).

The report is also being circulated to relevant policy leads at G5 & G6 level and should they require further information regarding a particular issue, this should be sought through sponsor branch who will liaise with RQIA to arrange any appropriate briefings or direct engagement.

Any queries in relation to this memo should be directed to Steven White. (steven.white@health-ni.gov.uk).

Fergal Bradley
Head of Quality Regulation and Improvement Unit

Annex A

Quarterly Template 09012020.docx

Medical Leaders Forum – 14th January 2019

Organisation Updates – Forum Members

PHA – Dr Adrian Mairs

- Diabetes Prevention Program (NI)

Type 2 diabetes mellitus (T2DM) is one of the most common long term health conditions in Northern Ireland (NI), associated with significant morbidity, mortality and healthcare costs. The prevalence of diabetes continues to increase, and the Health and Social Care Board (HSCB) estimates that by 2027 there will be a further 45,000 cases of Type 2 patients across NI. The risk of developing T2DM is strongly linked to modifiable health behaviours, in particular diet and weight. While it is recognised that there is a need for wider population level interventions, throughout the life course, to reduce the incidence of Type 2 Diabetes, there is clear evidence that intensive behaviour change intervention in individuals who are at high risk is effective in preventing or delaying progression to T2DM.

The program will use an evidence-based, NICE PH 38 compliant programme, selected by a procurement exercise. This has already been tested in the UK and will be delivered by suitably qualified staff employed in the 5 Health and Social Care Trusts in Northern Ireland. It will promote behaviour changes to delay or prevent the onset of Type 2 diabetes. The programme is designed for patients, aged 18 years and over, identified as being at high risk of developing Type 2 diabetes either because of HbA1c in the 42-48mmol range or a fasting blood glucose of 5.5-6.9 mmol in the preceding 3 months.

The initiative involves 18 hours of group work delivered by Trust based health coaches over an 8-10 month period. The first training program for coaches is planned for the 15th January 2019 and the program will be being introduced into N Ireland from February 2019 onwards. Access to the program will be via electronic referrals from primary care.

- Pandemic Flu Guidance

Following discussions with the DoH (NI) the PHA and HSCB have agreed to lead on the development of the NI Extreme Surge Framework. A Task and Finish Group consisting of nominated representatives from the HSCB and PHA will review current NI guidance, identify gaps and develop a plan to take forward work on necessary elements to address gaps. The updated regional guidance for NI will be submitted by the end of June to the Department for consideration and approval.

- Homelessness and homeless hub

The purpose of this project is to enhance services for people who are experiencing homelessness within Belfast, in the first instance. The longer term aim being to expand potential models across N. Ireland. The project aims to establish (by Jan 2019) a team/resources that primarily targets those who are homeless and will benefit from direct access to healthcare at ‘street level’ – the service will also in-reach to hostels and other facilities as required. The team will work from a city centre based facility. The project is funding from Transformation monies (£300k) and is therefore fixed term.

Core membership (some of below are already in place – full team in place by end Feb)

- Team leader / senior nurse (to support overall development of the hub)
- Emergency Dept nurse (given frequent attendance of homeless individuals in this setting – ensure appropriate
- Healthcare nurse
- Podiatry
- Social work
- GP input from 2 practices in Belfast, each to provide 2 clinical sessions per week (via a specific Primary Care LES)

The team will interface with other key Trust services, for example, addiction services, childcare, social services, etc.

- Screening update: DESP Consultation

Diabetic eye disease is one of the leading causes of blindness. The NI Diabetic Eye Screening Programme (NIDESP) aims to detect diabetic eye disease at an early stage and prevent sight loss in those with diabetes aged 12 years and over. At present, the NIDESP is delivered in two ways:

Mobile: in most Trust areas, screeners travel to each GP practice (approximately 280 in total) to carry out the screening test for diabetic patients in that practice.

Fixed: in the Western HSC Trust area the screening test is carried out in six fixed health and social care sites (hospitals, GPs and Health and Wellbeing Centres).

Main problems with the current model:

- It is becoming difficult to offer screening every 12 months, as recommended in national quality standards
- Screeners have to travel to a large number of practices (sites), and spend longer at each because of the rising numbers to be screened
- GP practices are increasingly over stretched and finding a dedicated room for screening in each can cause delays

The NIDESP is therefore undergoing a modernisation project to ensure that it remains a sustainable service and continues to improve in line with national standards. As part of this project, the model for delivering the screening programme has been reviewed, three potential service delivery options are now been considered:

a public consultation has been initiated (by the PHA) over 12 weeks, from 7 January to 01 April 2019.

Option 1 - Fixed HSC sites throughout Northern Ireland

Option 2 - Fixed GP sites throughout Northern Ireland

Option 3 - High Street optometry based service

Further detail including the consultation document, summary and a link to the consultation questionnaire is available at https://consultations.nidirect.gov.uk/hsc-public-health-agency/nidespconsultation/

HSCB – Dr Sloan Harper

Unscheduled Care performance

During the Christmas and new year holiday period emergency departments generally performed well compared to 2017/18, other than a rise in numbers waiting over the weekend of 5th / 6th January and which has continued up to 10th January.

A detailed analysis is being prepared and HSCB and Public Health Agency are meeting with the five Trusts and Ambulance Service on the afternoon of 14th January to review performance and learn from this year's experience.

Financial Performance

Individual Trusts aside, the HSC system is predicting financial break even for 2018/19. Providers however are experiencing significant difficulties in filling posts and this, rather than need, is driving breakeven.

Transformation Projects

The HSCB and PHA continue to work with Trusts and Primary Care in deploying Transformation Funds for 2018/19. A very significant number of business cases have been completed although, as for core business, the ability to fill posts is a huge challenge and is likely to result in slippage on the overall spend.

Primary Care Pressures

GP Out Of Hours services and GP Practices in particular are finding it very challenging to fill posts and medical slots in GP Out Of Hours. The number of GP Trainee positions has increased significantly over the past 3 years from 65 to 111, although at this point around 20% of positions remain unfilled for 2019/20.

The addition of Practice Based Pharmacists to all practices in Northern Ireland and a smaller number of Advanced Nurse Practitioners is helping to stabilise the impact of the available GP workforce although Community Pharmacy has recently experienced some difficulty in securing locums as Pharmacists take up positions in practices.

HSCB Closure

The project to close the HSCB Board will reach final report stage at the end of January 2019. A significant range of issues has been identified. The majority of these can be resolved, some through the passing of amended legislation. The reports from HSCB Directorates will provide the project team with the information they require to prepare for and deliver the change process.

Medical Leaders Forum – 14th January 2019
Organisation Updates – Forum Members

BHSCT – Dr Cathy Jack

1. Adult EDs are under pressure and there is often patients waiting on trolleys for a hospital bed. Elective non urgent surgery not booked until end of January.
2. Muckamore hospital currently closed for admissions given staffing issues – remains under daily review by Divisional SMT. Investigation continues regarding CCTV.
3. Significant nursing vacancies across Trust but especially in theatres – potential impact on regional surgery and ability to meet cancer pathways
4. Three Schwartz rounds in RBHSC completed – feedback excellent
5. New Directions 2 feasibility study completed being presented to Key Stakeholders

NHSCT – Dr Seamus O'Reilly

WHSCT – Dr Dermot Hughes

SHSCT – Dr Maria O'Kane

SEHSCT – Dr Charlie Martyn

NIAS – Dr Nigel Ruddell

HSC SAFETY FORUM – Dr Mark Roberts

NIBTS – Dr Kieren Morris

1. The Infected Blood Inquiry is proceeding. NIBTS is a core participant and has completed a search of all relevant documentation. Data files are being uploaded to the inquiry website and a detailed catalogue of inventory is being maintained. The Inquiry team held a public meeting 20 November 2018 in Belfast and a further meeting is planned for Dungannon in March 2019.

   The Department of Health is chairing a steering group of core participants to coordinate actions and responses for all HSC organisations.

2. The NIBTS Agency Board has approved a platelet strategy paper which details collection targets, regulatory compliance issues and proportions of apheresis platelet component donations and pooled platelets for the medium term of 3-5 years.
3. NIBTS has completed an adult stem cell volunteer donor strategy which is out to consultation with key stakeholders across HSC.

RQIA – Dr Lourda Geoghegan

Medical Leaders Forum – 14th January 2019
MAHT - STM - 300 - 538
Organisation Updates – Forum Members

GAIN – Dr Tom Trinick

NIMDTA –Professor Keith Gardiner

1. Placement Quality Project **–** A presentation will be made during the meeting on 14 January 2019 on this project by Dr SallyAnne Phillips (Associate Dean) and Dr Gillian Blayney (ADEPT Fellow)

2. Foundation Summit 1 April 2019
   As follow up to Placement Quality work on the Foundation Programme, HSC service and educational leaders, DoH, HSCB and PHA colleagues and representatives from the GMC and BMA will be invited by QUB and NIMDTA to attend a Foundation Summit **"Redefining F1"** on Monday 1 April 2019 at Riddel Hall, QUB to consider how the wider system can work together to improve the experience of F1 trainees working and training in NI.

3. Single Employer Project –Implementation of a Single Employer arrangement for trainees in Dental Core, Clinical Radiology and Trauma and Orthopaedics is planned to commence in August 2019. Steering and Working Groups are meeting regularly under the leadership of DoH Workforce Policy.

4. Broad Based Training – This is a new 2-year programme involving 10 trainees (2/Trust) rotating through medicine, paediatrics, psychiatry and GP to commence in August 2019

5. Internal Medicine Phase 1- Internal Medicine will commence in August 2019 to replace core medicine. This programme provides 3 months training in Intensive Care and 3 months in Geriatric Medicine for all trainees. Trainees wanting to enter Group 1 higher medical specialty training (involving dual training with Internal Medicine Phase 2) will need to complete 3 years in the programme whereas trainees wanting to enter Group 2 higher medical training specialties may leave the programme after 2 years. NIMDTA is waiting to hear if funding will be made available to facilitate the ICU attachments integral to the new curriculum

6. RCOG Trainee Evaluation Survey. Outstanding results again for NI I 2018 – with Antrim and Altnagelvin O&G units both being rated by trainees as being among the top 10 units in the UK

7. Irish Clinical Academic Training. Two trainees from NI (Dr Graeme Greenfield and Dr Claire Potter) have been successful in obtaining highly prestigious 4-year fellowships from the Wellcome Irish Clinical Academic Training Programme – to commence in August 2019.

8. Recruitment for Round 1 – about to commence.

9. GMC and Academy of Medical Royal Colleges Flexibility agenda. NIMDTA remain very concerned about the plans by the GMC and AoMRC to recognise experience gained outside training towards achievement of a CCT – and the potential implications for patient safety, stability of services and disintegration of structured training programmes in the UK.

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10. Vulnerable Training Programme – NIMDTA has been analysing the vulnerability of training programmes – which may relate to a variety of insufficiencies - number of consultants, interest of consultants in training, interest of consultants in leading a training programme, number of units. NIMDTA has prepared a paper on vulnerable training programmes and would seek to present this paper at the next Medical Leaders' Forum in March 2019

QUB – Professor Pascal McKeown

CCIO Group – David Wilson

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Exhibit 31

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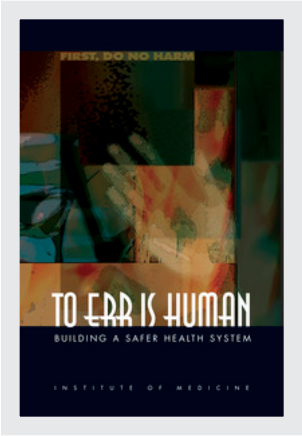

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TO ERR IS HUMAN

Building a Safer Health System

Linda T. Kohn, Janet M. Corrigan, and
Molla S. Donaldson, *Editors*

Committee on Quality of Health Care in America

INSTITUTE OF MEDICINE

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The serpent has been a symbol of long life, healing, and knowledge among almost all cultures and religions since the beginning of recorded history. The serpent adopted as a logotype by the Institute of Medicine is a relief carving from ancient Greece, now held by the Staatliche Museen in Berlin.

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COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA

WILLIAM C. RICHARDSON (*Chair*), President and CEO, W.K. Kellogg Foundation, Battle Creek, MI
DONALD M. BERWICK, President and CEO, Institute for Healthcare Improvement, Boston
J. CRIS BISGARD, Director, Health Services, Delta Air Lines, Inc., Atlanta
LONNIE R. BRISTOW, Past President, American Medical Association, Walnut Creek, CA
CHARLES R. BUCK, Program Leader, Health Care Quality and Strategy Initiatives, General Electric Company, Fairfield, CT
CHRISTINE K. CASSEL, Professor and Chairman, Department of Geriatrics and Adult Development, Mount Sinai School of Medicine, New York City
MARK R. CHASSIN, Professor and Chairman, Department of Health Policy, Mount Sinai School of Medicine, New York City
MOLLY JOEL COYE, Senior Vice President and Director, West Coast Office, The Lewin Group, San Francisco
DON E. DETMER, Dennis Gillings Professor of Health Management, University of Cambridge, UK
JEROME H. GROSSMAN, Chairman and CEO, Lion Gate Management Corporation, Boston
BRENT JAMES, Executive Director, Intermountain Health Care, Institute for Health Care Delivery Research, Salt Lake City, UT
DAVID McK. LAWRENCE, Chairman and CEO, Kaiser Foundation Health Plan, Inc., Oakland, CA
LUCIAN LEAPE, Adjunct Professor, Harvard School of Public Health
ARTHUR LEVIN, Director, Center for Medical Consumers, New York City
RHONDA ROBINSON-BEALE, Executive Medical Director, Managed Care Management and Clinical Programs, Blue Cross Blue Shield of Michigan, Southfield
JOSEPH E. SCHERGER, Associate Dean for Clinical Affairs, University of California at Irvine College of Medicine
ARTHUR SOUTHAM, Partner, 2C Solutions, Northridge, CA
MARY WAKEFIELD, Director, Center for Health Policy and Ethics, George Mason University
GAIL L. WARDEN, President and CEO, Henry Ford Health System, Detroit

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Study Staff

JANET M. CORRIGAN, Director, Division of Health Care Services, Director, Quality of Health Care in America Project
MOLLA S. DONALDSON, Project Co-Director
LINDA T. KOHN, Project Co-Director
TRACY McKAY, Research Assistant
KELLY C. PIKE, Senior Project Assistant

Auxiliary Staff

MIKE EDINGTON, Managing Editor
KAY C. HARRIS, Financial Advisor
SUZANNE MILLER, Senior Project Assistant

Copy Editor

FLORENCE POILLON

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Reviewers

This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the Institute of Medicine in making the published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and the draft manuscript remain confidential to protect the integrity of the deliberative process. The committee wishes to thank the following individuals for their participation in the review of this report:

GERALDINE BEDNASH, Executive Director, American Association of Colleges of Nursing, Washington, DC
PETER BOUXSEIN, Visiting Scholar, Institute of Medicine, Washington, DC
JOHN COLMERS, Executive Director, Maryland Health Care Cost and Access Commission, Baltimore
JEFFREY COOPER, Director, Partners Biomedical Engineering Group, Massachusetts General Hospital, Boston
ROBERT HELMREICH, Professor, University of Texas at Austin

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LOIS KERCHER, Vice President for Nursing, Sentara-Virginia Beach General Hospital, Virginia Beach, VA
GORDON MOORE, Associate Chief Medical Officer, Strong Health, Rochester, NY
ALAN NELSON, Associate Executive Vice President, American College of Physicians/American Society of Internal Medicine, Washington, DC
LEE NEWCOMER, Chief Medical Officer, United HealthCare Corporation, Minnetonka, MN
MARY JANE OSBORN, University of Connecticut Health Center
ELLISON PIERCE, Executive Director, Anesthesia Patient Safety Foundation, Boston

Although the individuals acknowledged have provided valuable comments and suggestions, responsibility for the final contents of the report rests solely with the authoring committee and the Institute of Medicine.

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Preface

To Err Is Human: Building a Safer Health System. The title of this report encapsulates its purpose. Human beings, in all lines of work, make errors. Errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing. Cars are designed so that drivers cannot start them while in reverse because that prevents accidents. Work schedules for pilots are designed so they don't fly too many consecutive hours without rest because alertness and performance are compromised.

In health care, building a safer system means designing processes of care to ensure that patients are safe from accidental injury. When agreement has been reached to pursue a course of medical treatment, patients should have the assurance that it will proceed correctly and safely so they have the best chance possible of achieving the desired outcome.

This report describes a serious concern in health care that, if discussed at all, is discussed only behind closed doors. As health care and the system that delivers it become more complex, the opportunities for errors abound. Correcting this will require a concerted effort by the professions, health care organizations, purchasers, consumers, regulators and policy-makers. Traditional clinical boundaries and a culture of blame must be broken down. But most importantly, we must systematically design safety into processes of care.

This report is part of larger project examining the quality of health care

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in America and how to achieve a threshold change in quality. The committee has focused its initial attention on quality concerns that fall into the category of medical errors. There are several reasons for this. First, errors are responsible for an immense burden of patient injury, suffering and death. Second, errors in the provision of health services, whether they result in injury or expose the patient to the risk of injury, are events that everyone agrees just shouldn't happen. Third, errors are readily understandable to the American public. Fourth, there is a sizable body of knowledge and very successful experiences in other industries to draw upon in tackling the safety problems of the health care industry. Fifth, the health care delivery system is rapidly evolving and undergoing substantial redesign, which may introduce improvements, but also new hazards. Over the next year, the committee will be examining other quality issues, such as problems of overuse and underuse.

The Quality of Health Care in America project is largely supported with income from an endowment established within the IOM by the Howard Hughes Medical Institute and income from an endowment established for the National Research Council by the Kellogg Foundation. The Commonwealth Fund provided generous support for a workshop to convene medical, nursing and pharmacy professionals for input into this specific report. The National Academy for State Health Policy assisted by convening a focus group of state legislative and regulatory leaders to discuss patient safety.

Thirty-eight people were involved in producing this report. The Subcommittee on Creating an External Environment for Quality, under the direction of J. Cris Bisgard and Molly Joel Coye, dealt with a series of complex and sensitive issues, always maintaining a spirit of compromise and respect. Additionally the Subcommittee on Designing the Health System of the 21st Century, under the direction of Donald Berwick, had to balance the challenges faced by health care organizations with the need to continually push out boundaries and not accept limitations. Lastly, under the direction of Janet Corrigan, excellent staff support has been provided by Linda Kohn, Molla Donaldson, Tracy McKay, and Kelly Pike.

At some point in our lives, each of us will probably be a patient in the health care system. It is hoped that this report can serve as a call to action that will illuminate a problem to which we are all vulnerable.

William C. Richardson, Ph.D.
Chair
November 1999

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Foreword

This report is the first in a series of reports to be produced by the Quality of Health Care in America project. The Quality of Health Care in America project was initiated by the Institute of Medicine in June 1998 with the charge of developing a strategy that will result in a *threshold improvement* in quality over the next ten years.

Under the direction of Chairman William C. Richardson, the Quality of Health Care in America Committee is directed to:

- review and synthesize findings in the literature pertaining to the quality of care provided in the health care system;
- develop a communications strategy for raising the awareness of the general public and key stakeholders of quality of care concerns and opportunities for improvement;
- articulate a policy framework that will provide positive incentives to improve quality and foster accountability;
- identify characteristics and factors that enable or encourage providers, health care organizations, health plans and communities to continuously improve the quality of care; and
- develop a research agenda in areas of continued uncertainty.

This first report on patient safety addresses a serious issue affecting the

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quality of health care. Future reports in this series will address other quality-related issues and cover areas such as re-designing the health care delivery system for the 21st Century, aligning financial incentives to reward quality care and the critical role of information technology as a tool for measuring and understanding quality. Additional reports will be produced throughout the coming year.

The Quality of Health Care in America project continues IOM's long-standing focus on quality of care issues. The IOM National Roundtable on Health Care Quality described how variable the quality of health care is in this country and highlighted the urgent need for improving it. A recent report issued by the IOM National Cancer Policy Board concluded that there is a wide gulf between ideal cancer care and the reality that many Americans experience with cancer care.

The IOM will continue to call for a comprehensive and strong response to this most urgent issue facing the American people. This current report on patient safety further reinforces our conviction that we cannot wait any longer.

Kenneth I. Shine, M.D.
President, Institute of Medicine
November 1999

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Acknowledgments

The Committee on the Quality of Health Care in America first and foremost acknowledges the tremendous contribution by the members of two subcommittees. Both subcommittees spent many hours working through a set of exceedingly complex issues, ranging from topics related to expectations from the health care delivery system to the details of how reporting systems work. Although individual subcommittee members raised different perspectives on a variety of issues, there was no disagreement on the ultimate goal of making care safer for patients. Without the efforts of the two subcommittees, this report would not have happened. We take this opportunity to thank each and every subcommittee member for their contribution.

SUBCOMMITTEE ON CREATING AN ENVIRONMENT FOR QUALITY IN HEALTH CARE

J. Cris Bisgard (*Cochair*), Delta Air Lines, Inc.; Molly Joel Coye, (*Cochair*), The Lewin Group; Phyllis C. Borzi, The George Washington University; Charles R. Buck, Jr., General Electric Company; Jon Christianson, University of Minnesota; Charles Cutler, formerly of The Prudential HealthCare; Mary Jane England, Washington Business Group on Health; George J. Isham, HealthPartners; Brent James, Intermountain Health Care; Roz D.

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Lasker, New York Academy of Medicine; Lucian Leape, Harvard School of Public Health; Patricia A. Riley, National Academy of State Health Policy; Gerald M. Shea, American Federation of Labor and Congress of Industrial Organizations; Gail L. Warden, Henry Ford Health System; A. Eugene Washington, University of California, San Francisco School of Medicine; and Andrew Webber, Consumer Coalition for Health Care Quality.

SUBCOMMITTEE ON BUILDING THE 21ST CENTURY HEALTH CARE SYSTEM

Don M. Berwick (*Chair),* Institute for Healthcare Improvement; Christine K. Cassel, Mount Sinai School of Medicine; Rodney Dueck, HealthSystem Minnesota; Jerome H. Grossman, Lion Gate Management Corporation; John E. Kelsch, Consultant in Total Quality; Risa Lavizzo-Mourey, University of Pennsylvania; Arthur Levin, Center for Medical Consumers; Eugene C. Nelson, Hitchcock Medical Center; Thomas Nolan, Associates in Proc-ess Improvement; Gail J. Povar, Cameron Medical Group; James L. Reinertsen, CareGroup; Joseph E. Scherger, University of California, Irvine; Stephen M. Shortell, University of California, Berkeley; Mary Wakefield, George Mason University; and Kevin Weiss, Rush Primary Care Institute.

A number of people willingly and generously gave their time and expertise as the committee and both subcommittees conducted their deliberations. Their contributions are acknowledged here.

Participants in the Roundtable on the Role of the Health Professions in Improving Patient Safety provided many useful insights reflected in the final report. They included: J. Cris Bisgard, Delta Air Lines, Inc.; Terry P. Clemmer, Intermountain Health Care; Leo J. Dunn, Virginia Commonwealth University; James Espinosa, Overlook Hospital; Paul Friedmann, Bay State Hospital; David M. Gaba, V.A. Palo Alto HCS; Larry A. Green, American Academy of Family Physicians; Paul F. Griner, Association of American Medical Colleges; Charles Douglas Hepler, University of Florida; Carolyn Hutcherson, Health Policy Consultant; Lucian L. Leape, Harvard School of Public Health; William C. Nugent, Dartmouth Hitchcock Medical Center; Ellison C. Pierce Jr., Anesthesia Patient Safety Foundation; Bernard Rosof, Huntington Hospital; Carol Taylor, Georgetown University; Mary Wakefield, George Mason University; and Richard Womer, Children's Hospital of Philadelphia.

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Other individuals provided data, information and background that significantly contributed to the committee's understanding of patient safety. The committee would like to particularly acknowledge the contributions of Charles Billings, now at Ohio State University and designer of the Aviation Safety Reporting System; Linda Blank at the American Board of Internal Medicine; Michael Cohen at the Institute for Safe Medication Practices; Linda Connell at the Aviation Safety Reporting System at NASA/Ames Research Center; Diane Cousins and Fay Menacker at U.S. Pharmacopeia, Martin Hatlie and Eleanor Vogt at the National Patient Safety Foundation; Henry Manasse and Colleen O'Malley at the American Society of Health-System Pharmacists; Cynthia Null at the Human Factors Research and Technology Division at NASA/Ames Research Center; Eric Thomas, at the University of Texas at Houston; Margaret VanAmringe at the Joint Commission on Accreditation of Health Care Organizations; and Karen Williams at the National Pharmaceuticals Council.

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A special thanks is also provided to colleagues at the IOM. Claudia Carl and Mike Edington provided assistance during the report review and preparation stages. Ellen Agard and Mel Worth significantly contributed to the case study that is used in the report. Wilhelmine Miller expertly arranged the workshop with physicians, nurses and pharmacists and ensured a successful meeting. Suzanne Miller provided important assistance to the literature review. Tracy McKay provided help throughout the project, from coordinating literature searches to overseeing the editing of the report. A special thanks is offered to Kelly Pike. Her outstanding support and attention to detail was critical to the success of this report. Her assistance was always offered with enthusiasm and good cheer.

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TO ERR IS HUMAN

Building a Safer Health System

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Executive Summary

The knowledgeable health reporter for the *Boston Globe*, Betsy Lehman, died from an overdose during chemotherapy. Willie King had the wrong leg amputated. Ben Kolb was eight years old when he died during "minor" surgery due to a drug mix-up.[1]

These horrific cases that make the headlines are just the tip of the iceberg. Two large studies, one conducted in Colorado and Utah and the other in New York, found that adverse events occurred in 2.9 and 3.7 percent of hospitalizations, respectively.[2] In Colorado and Utah hospitals, 6.6 percent of adverse events led to death, as compared with 13.6 percent in New York hospitals. In both of these studies, over half of these adverse events resulted from medical errors and could have been prevented.

When extrapolated to the over 33.6 million admissions to U.S. hospitals in 1997, the results of the study in Colorado and Utah imply that at least 44,000 Americans die each year as a result of medical errors.[3] The results of the New York Study suggest the number may be as high as 98,000.[4] Even when using the lower estimate, deaths due to medical errors exceed the number attributable to the 8th-leading cause of death.[5] More people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).[6]

Total national costs (lost income, lost household production, disability and health care costs) of preventable adverse events (medical errors result-

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ing in injury) are estimated to be between $17 billion and $29 billion, of which health care costs represent over one-half.[7]

In terms of lives lost, patient safety is as important an issue as worker safety. Every year, over 6,000 Americans die from workplace injuries.[8] Medication errors alone, occurring either in or out of the hospital, are estimated to account for over 7,000 deaths annually.[9]

Medication-related errors occur frequently in hospitals and although not all result in actual harm, those that do, are costly. One recent study conducted at two prestigious teaching hospitals, found that about two out of every 100 admissions experienced a preventable adverse drug event, resulting in average increased hospital costs of $4,700 per admission or about $2.8 million annually for a 700-bed teaching hospital.[10] If these findings are generalizable, the increased hospital costs alone of preventable adverse drug events affecting inpatients are about $2 billion for the nation as a whole.

These figures offer only a very modest estimate of the magnitude of the problem since hospital patients represent only a small proportion of the total population at risk, and direct hospital costs are only a fraction of total costs. More care and increasingly complex care is provided in ambulatory settings. Outpatient surgical centers, physician offices and clinics serve thousands of patients daily. Home care requires patients and their families to use complicated equipment and perform follow-up care. Retail pharmacies play a major role in filling prescriptions for patients and educating them about their use. Other institutional settings, such as nursing homes, provide a broad array of services to vulnerable populations. Although many of the available studies have focused on the hospital setting, medical errors present a problem in any setting, not just hospitals.

Errors are also costly in terms of opportunity costs. Dollars spent on having to repeat diagnostic tests or counteract adverse drug events are dollars unavailable for other purposes. Purchasers and patients pay for errors when insurance costs and copayments are inflated by services that would not have been necessary had proper care been provided. It is impossible for the nation to achieve the greatest value possible from the billions of dollars spent on medical care if the care contains errors.

But not all the costs can be directly measured. Errors are also costly in terms of loss of trust in the system by patients and diminished satisfaction by both patients and health professionals. Patients who experience a longer hospital stay or disability as a result of errors pay with physical and psychological discomfort. Health care professionals pay with loss of morale and frustration at not being able to provide the best care possible. Employers

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and society, in general, pay in terms of lost worker productivity, reduced school attendance by children, and lower levels of population health status.

Yet silence surrounds this issue. For the most part, consumers believe they are protected. Media coverage has been limited to reporting of anecdotal cases. Licensure and accreditation confer, in the eyes of the public, a "Good Housekeeping Seal of Approval." Yet, licensing and accreditation processes have focused only limited attention on the issue, and even these minimal efforts have confronted some resistance from health care organizations and providers. Providers also perceive the medical liability system as a serious impediment to systematic efforts to uncover and learn from errors.[11]

The decentralized and fragmented nature of the health care delivery system (some would say "nonsystem") also contributes to unsafe conditions for patients, and serves as an impediment to efforts to improve safety. Even within hospitals and large medical groups, there are rigidly-defined areas of specialization and influence. For example, when patients see multiple providers in different settings, none of whom have access to complete information, it is easier for something to go wrong than when care is better coordinated. At the same time, the provision of care to patients by a collection of loosely affiliated organizations and providers makes it difficult to implement improved clinical information systems capable of providing timely access to complete patient information. Unsafe care is one of the prices we pay for not having organized systems of care with clear lines of accountability.

Lastly, the context in which health care is purchased further exacerbates these problems. Group purchasers have made few demands for improvements in safety.[12] Most third party payment systems provide little incentive for a health care organization to improve safety, nor do they recognize and reward safety or quality.

The goal of this report is to break this cycle of inaction. The status quo is not acceptable and cannot be tolerated any longer. Despite the cost pressures, liability constraints, resistance to change and other seemingly insurmountable barriers, it is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort. "First do no harm" is an often quoted term from Hippocrates.[13] Everyone working in health care is familiar with the term. At a very minimum, the health system needs to offer that assurance and security to the public.

A comprehensive approach to improving patient safety is needed. This approach cannot focus on a single solution since there is no "magic bullet" that will solve this problem, and indeed, no single recommendation in this report should be considered as *the* answer. Rather, large, complex problems

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require thoughtful, multifaceted responses. The combined goal of the recommendations is for the external environment to create sufficient pressure to make errors costly to health care organizations and providers, so they are compelled to take action to improve safety. At the same time, there is a need to enhance knowledge and tools to improve safety and break down legal and cultural barriers that impede safety improvement. Given current knowledge about the magnitude of the problem, the committee believes it would be irresponsible to expect anything less than a 50 percent reduction in errors over five years.

In this report, safety is defined as freedom from accidental injury. This definition recognizes that this is the primary safety goal from the patient's perspective. Error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. According to noted expert James Reason, errors depend on two kinds of failures: either the correct action does not proceed as intended (an error of execution) or the original intended action is not correct (an error of planning).[14] Errors can happen in all stages in the process of care, from diagnosis, to treatment, to preventive care.

Not all errors result in harm. Errors that do result in injury are sometimes called preventable adverse events. An adverse event is an injury resulting from a medical intervention, or in other words, it is not due to the underlying condition of the patient. While all adverse events result from medical management, not all are preventable (i.e., not all are attributable to errors). For example, if a patient has surgery and dies from pneumonia he or she got postoperatively, it is an adverse event. If analysis of the case reveals that the patient got pneumonia because of poor hand washing or instrument cleaning techniques by staff, the adverse event was preventable (attributable to an error of execution). But the analysis may conclude that no error occurred and the patient would be presumed to have had a difficult surgery and recovery (not a preventable adverse event).

Much can be learned from the analysis of errors. All adverse events resulting in serious injury or death should be evaluated to assess whether improvements in the delivery system can be made to reduce the likelihood of similar events occurring in the future. Errors that do not result in harm also represent an important opportunity to identify system improvements having the potential to prevent adverse events. Preventing errors means designing the health care system at all levels to make it safer. Building safety into processes of care is a more effective way to reduce errors than blaming individuals (some experts, such as Deming, believe improving processes is

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the only way to improve quality[15]). The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system. This does not mean that individuals can be careless. People must still be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.

Health care is a decade or more behind other high-risk industries in its attention to ensuring basic safety. Aviation has focused extensively on building safe systems and has been doing so since World War II. Between 1990 and 1994, the U.S. airline fatality rate was less than one-third the rate experienced in mid century.[16] In 1998, there were no deaths in the United States in commercial aviation. In health care, preventable injuries from care have been estimated to affect between three to four percent of hospital patients.[17] Although health care may never achieve aviation's impressive record, there is clearly room for improvement.

To err is human, but errors can be prevented. Safety is a critical first step in improving quality of care. The Harvard Medical Practice Study, a seminal research study on this issue, was published almost ten years ago; other studies have corroborated its findings. Yet few tangible actions to improve patient safety can be found. Must we wait another decade to be safe in our health system?

RECOMMENDATIONS

The IOM Quality of Health Care in America Committee was formed in June 1998 to develop a strategy that will result in a threshold improvement in quality over the next ten years. This report addresses issues related to patient safety, a subset of overall quality-related concerns, and lays out a national agenda for reducing errors in health care and improving patient safety. Although it is a national agenda, many activities are aimed at prompting responses at the state and local levels and within health care organizations and professional groups.

The committee believes that although there is still much to learn about the types of errors committed in health care and why they occur, enough is known today to recognize that a serious concern exists for patients. Whether a person is sick or just trying to stay healthy, they should not have to worry about being harmed by the health system itself. This report is a call to action to make health care safer for patients.

The committee believes that a major force for improving patient safety

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is the intrinsic motivation of health care providers, shaped by professional ethics, norms and expectations. But the interaction between factors in the external environment and factors inside health care organizations can also prompt the changes needed to improve patient safety. Factors in the external environment include availability of knowledge and tools to improve safety, strong and visible professional leadership, legislative and regulatory initiatives, and actions of purchasers and consumers to demand safety improvements. Factors inside health care organizations include strong leadership for safety, an organizational culture that encourages recognition and learning from errors, and an effective patient safety program.

In developing its recommendations, the committee seeks to strike a balance between regulatory and market-based initiatives, and between the roles of professionals and organizations. No single action represents a complete answer, nor can any single group or sector offer a complete fix to the problem. However, different groups can, and should, make significant contributions to the solution. The committee recognizes that a number of groups are already working on improving patient safety, such as the National Patient Safety Foundation and the Anesthesia Patient Safety Foundation.

The recommendations contained in this report lay out a four-tiered approach:

- establishing a national focus to create leadership, research, tools and protocols to enhance the knowledge base about safety;
- identifying and learning from errors through immediate and strong mandatory reporting efforts, as well as the encouragement of voluntary efforts, both with the aim of making sure the system continues to be made safer for patients;
- raising standards and expectations for improvements in safety through the actions of oversight organizations, group purchasers, and professional groups; and
- creating safety systems inside health care organizations through the implementation of safe practices at the delivery level. This level is the ultimate target of all the recommendations.

Leadership and Knowledge

Other industries that have been successful in improving safety, such as aviation and occupational health, have had the support of a designated agency that sets and communicates priorities, monitors progress in achiev-

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ing goals, directs resources toward areas of need, and brings visibility to important issues. Although various agencies and organizations in health care may contribute to certain of these activities, there is no focal point for raising and sustaining attention to patient safety. Without it, health care is unlikely to match the safety improvements achieved in other industries.

The growing awareness of the frequency and significance of errors in health care creates an imperative to improve our understanding of the problem and devise workable solutions. For some types of errors, the knowledge of how to prevent them exists today. In these areas, the need is for widespread dissemination of this information. For other areas, however, additional work is needed to develop and apply the knowledge that will make care safer for patients. Resources invested in building the knowledge base and diffusing the expertise throughout the industry can pay large dividends to both patients and the health professionals caring for them and produce savings for the health system.

RECOMMENDATION 4.1 Congress should create a Center for Patient Safety within the Agency for Healthcare Research and Quality. This center should

- **set the national goals for patient safety, track progress in meeting these goals, and issue an annual report to the President and Congress on patient safety; and**
- **develop knowledge and understanding of errors in health care by developing a research agenda, funding Centers of Excellence, evaluating methods for identifying and preventing errors, and funding dissemination and communication activities to improve patient safety.**

To make significant improvements in patient safety, a highly visible center is needed, with secure and adequate funding. The Center should establish goals for safety; develop a research agenda; define prototype safety systems; develop and disseminate tools for identifying and analyzing errors and evaluate approaches taken; develop tools and methods for educating consumers about patient safety; issue an annual report on the state of patient safety, and recommend additional improvements as needed.

The committee recommends initial annual funding for the Center of $30 to $35 million. This initial funding would permit a center to conduct activities in goal setting, tracking, research and dissemination. Funding should grow over time to at least $100 million, or approximately 1% of the $8.8 billion in health care costs attributable to preventable adverse events.[18]

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This initial level of funding is modest relative to the resources devoted to other public health issues. The Center for Patient Safety should be created within the Agency for Healthcare Research and Quality because the agency is already involved in a broad range of quality and safety issues, and has established the infrastructure and experience to fund research, educational and coordinating activities.

Identifying and Learning from Errors

Another critical component of a comprehensive strategy to improve patient safety is to create an environment that encourages organizations to identify errors, evaluate causes and take appropriate actions to improve performance in the future. External reporting systems represent one mechanism to enhance our understanding of errors and the underlying factors that contribute to them.

Reporting systems can be designed to meet two purposes. They can be designed as part of a public system for holding health care organizations accountable for performance. In this instance, reporting is often mandatory, usually focuses on specific cases that involve serious harm or death, may result in fines or penalties relative to the specific case, and information about the event may become known to the public. Such systems ensure a response to specific reports of serious injury, hold organizations and providers accountable for maintaining safety, respond to the public's right to know, and provide incentives to health care organizations to implement internal safety systems that reduce the likelihood of such events occurring. Currently, at least twenty states have mandatory adverse event reporting systems.

Voluntary, confidential reporting systems can also be part of an overall program for improving patient safety and can be designed to complement the mandatory reporting systems previously described. Voluntary reporting systems, which generally focus on a much broader set of errors and strive to detect system weaknesses before the occurrence of serious harm, can provide rich information to health care organizations in support of their quality improvement efforts.

For either purpose, the goal of reporting systems is to analyze the information they gather and identify ways to prevent future errors from occurring. The goal is not data collection. Collecting reports and not doing anything with the information serves no useful purpose. Adequate resources and other support must be provided for analysis and response to critical issues.

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RECOMMENDATION 5.1 A nationwide mandatory reporting system should be established that provides for the collection of standardized information by state governments about adverse events that result in death or serious harm. Reporting should initially be required of hospitals and eventually be required of other institutional and ambulatory care delivery settings. Congress should

- **designate the National Forum for Health Care Quality Measurement and Reporting as the entity responsible for promulgating and maintaining a core set of reporting standards to be used by states, including a nomenclature and taxonomy for reporting;**
- **require all health care organizations to report standardized information on a defined list of adverse events;**
- **provide funds and technical expertise for state governments to establish or adapt their current error reporting systems to collect the standardized information, analyze it and conduct follow-up action as needed with health care organizations. Should a state choose not to implement the mandatory reporting system, the Department of Health and Human Services should be designated as the responsible entity; and**
- **designate the Center for Patient Safety to:**

(1) convene states to share information and expertise, and to evaluate alternative approaches taken for implementing reporting programs, identify best practices for implementation, and assess the impact of state programs; and
(2) receive and analyze aggregate reports from states to identify persistent safety issues that require more intensive analysis and/or a broader-based response (e.g., designing prototype systems or requesting a response by agencies, manufacturers or others).

RECOMMENDATION 5.2 The development of voluntary reporting efforts should be encouraged. The Center for Patient Safety should

- **describe and disseminate information on external voluntary reporting programs to encourage greater participation in them and track the development of new reporting systems as they form;**
- **convene sponsors and users of external reporting systems to evaluate what works and what does not work well in the programs, and ways to make them more effective;**
- **periodically assess whether additional efforts are needed to address gaps in information to improve patient safety and to encourage**

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health care organizations to participate in voluntary reporting programs; and

- **fund and evaluate pilot projects for reporting systems, both within individual health care organizations and collaborative efforts among health care organizations.**

The committee believes there is a role both for mandatory, public reporting systems and voluntary, confidential reporting systems. However, because of their distinct purposes, such systems should be operated and maintained separately. A nationwide mandatory reporting system should be established by building upon the current patchwork of state systems and by standardizing the types of adverse events and information to be reported. The newly established National Forum for Health Care Quality Measurement and Reporting, a public/private partnership, should be charged with the establishment of such standards. Voluntary reporting systems should also be promoted and the participation of health care organizations in them should be encouraged by accrediting bodies.

RECOMMENDATION 6.1 Congress should pass legislation to extend peer review protections to data related to patient safety and quality improvement that are collected and analyzed by health care organizations for internal use or shared with others solely for purposes of improving safety and quality.

The committee believes that information about the most serious adverse events which result in harm to patients and which are subsequently found to result from errors should not be protected from public disclosure. However, the committee also recognizes that for events not falling under this category, fears about the legal discoverability of information may undercut motivations to detect and analyze errors to improve safety. Unless such data are assured protection, information about errors will continue to be hidden and errors will be repeated. A more conducive environment is needed to encourage health care professionals and organizations to identify, analyze, and report errors without threat of litigation and without compromising patients' legal rights.

Setting Performance Standards and Expectations for Safety

Setting and enforcing explicit standards for safety through regulatory and related mechanisms, such as licensing, certification, and accreditation,

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can define minimum performance levels for health care organizations and professionals. Additionally, the process of developing and adopting standards helps to form expectations for safety among providers and consumers. However, standards and expectations are not only set through regulations. The actions of purchasers and consumers affect the behaviors of health care organizations, and the values and norms set by health professions influence standards of practice, training and education for providers. Standards for patient safety can be applied to health care professionals, the organizations in which they work, and the tools (drugs and devices) they use to care for patients.

RECOMMENDATION 7.1 Performance standards and expectations for health care organizations should focus greater attention on patient safety.

- **Regulators and accreditors should require health care organizations to implement meaningful patient safety programs with defined executive responsibility.**
- **Public and private purchasers should provide incentives to health care organizations to demonstrate continuous improvement in patient safety.**

Health care organizations are currently subject to compliance with licensing and accreditation standards. Although both devote some attention to issues related to patient safety, there is opportunity to strengthen such efforts. Regulators and accreditors have a role in encouraging and supporting actions in health care organizations by holding them accountable for ensuring a safe environment for patients. After a reasonable period of time for health care organizations to develop patient safety programs, regulators and accreditors should require them as a minimum standard.

Purchaser and consumer demands also exert influence on health care organizations. Public and private purchasers should consider safety issues in their contracting decisions and reinforce the importance of patient safety by providing relevant information to their employees or beneficiaries. Purchasers should also communicate concerns about patient safety to accrediting bodies to support stronger oversight for patient safety.

RECOMMENDATION 7.2 Performance standards and expectations for health professionals should focus greater attention on patient safety.

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• Health professional licensing bodies should

(1) implement periodic re-examinations and re-licensing of doctors, nurses, and other key providers, based on both competence and knowledge of safety practices; and
(2) work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action.

• Professional societies should make a visible commitment to patient safety by establishing a permanent committee dedicated to safety improvement. This committee should

(1) develop a curriculum on patient safety and encourage its adoption into training and certification requirements;
(2) disseminate information on patient safety to members through special sessions at annual conferences, journal articles and editorials, newsletters, publications and websites on a regular basis;
(3) recognize patient safety considerations in practice guidelines and in standards related to the introduction and diffusion of new technologies, therapies and drugs;
(4) work with the Center for Patient Safety to develop community-based, collaborative initiatives for error reporting and analysis and implementation of patient safety improvements; and
(5) collaborate with other professional societies and disciplines in a national summit on the professional's role in patient safety.

Although unsafe practitioners are believed to be few in number, the rapid identification of such practitioners and corrective action are important to a comprehensive safety program. Responsibilities for documenting continuing skills are dispersed among licensing boards, specialty boards and professional groups, and health care organizations with little communication or coordination. In their ongoing assessments, existing licensing, certification and accreditation processes for health professionals should place greater attention on safety and performance skills.

Additionally, professional societies and groups should become active leaders in encouraging and demanding improvements in patient safety. Setting standards, convening and communicating with members about safety, incorporating attention to patient safety into training programs and collabo-

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rating across disciplines are all mechanisms that will contribute to creating a culture of safety.

RECOMMENDATION 7.3 The Food and Drug Administration (FDA) should increase attention to the safe use of drugs in both pre- and post-marketing processes through the following actions:

- **develop and enforce standards for the design of drug packaging and labeling that will maximize safety in use;**
- **require pharmaceutical companies to test (using FDA-approved methods) proposed drug names to identify and remedy potential sound-alike and look-alike confusion with existing drug names; and**
- **work with physicians, pharmacists, consumers, and others to establish appropriate responses to problems identified through post-marketing surveillance, especially for concerns that are perceived to require immediate response to protect the safety of patients.**

The FDA's role is to regulate manufacturers for the safety and effectiveness of their drugs and devices. However, even approved products can present safety problems in practice. For example, different drugs with similar sounding names can create confusion for both patients and providers. Attention to the safety of products in actual use should be increased during approval processes and in post-marketing monitoring systems. The FDA should also work with drug manufacturers, distributors, pharmacy benefit managers, health plans and other organizations to assist clinicians in identifying and preventing problems in the use of drugs.

Implementing Safety Systems in Health Care Organizations

Experience in other high-risk industries has provided well-understood illustrations that can be used to improve health care safety. However, health care management and professionals have rarely provided specific, clear, high-level, organization-wide incentives to apply what has been learned in other industries about ways to prevent error and reduce harm within their own organizations. Chief Executive Officers and Boards of Trustees should be held accountable for making a serious, visible and on-going commitment to creating safe systems of care.

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RECOMMENDATION 8.1 Health care organizations and the professionals affiliated with them should make continually improved patient safety a declared and serious aim by establishing patient safety programs with defined executive responsibility. Patient safety programs should

- **provide strong, clear and visible attention to safety;**
- **implement non-punitive systems for reporting and analyzing errors within their organizations;**
- **incorporate well-understood safety principles, such as standardizing and simplifying equipment, supplies, and processes; and**
- **establish interdisciplinary team training programs for providers that incorporate proven methods of team training, such as simulation.**

Health care organizations must develop a culture of safety such that an organization's care processes and workforce are focused on improving the reliability and safety of care for patients. Safety should be an explicit organizational goal that is demonstrated by the strong direction and involvement of governance, management and clinical leadership. In addition, a meaningful patient safety program should include defined program objectives, personnel, and budget and should be monitored by regular progress reports to governance.

RECOMMENDATION 8.2 Health care organizations should implement proven medication safety practices.

A number of practices have been shown to reduce errors in the medication process. Several professional and collaborative organizations interested in patient safety have developed and published recommendations for safe medication practices, especially for hospitals. Although some of these recommendations have been implemented, none have been universally adopted and some are not yet implemented in a majority of hospitals. Safe medication practices should be implemented in all hospitals and health care organizations in which they are appropriate.

SUMMARY

This report lays out a comprehensive strategy for addressing a serious problem in health care to which we are all vulnerable. By laying out a concise list of recommendations, the committee does not underestimate the many barriers that must be overcome to accomplish this agenda. Significant

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changes are required to improve awareness of the problem by the public and health professionals, to align payment systems and the liability system so they encourage safety improvements, to develop training and education programs that emphasize the importance of safety and for chief executive officers and trustees of health care organizations to create a culture of safety and demonstrate it in their daily decisions.

Although no single activity can offer the solution, the combination of activities proposed offers a roadmap toward a safer health system. The proposed program should be evaluated after five years to assess progress in making the health system safer. With adequate leadership, attention and resources, improvements can be made. It may be part of human nature to err, but it is also part of human nature to create solutions, find better alternatives and meet the challenges ahead.

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A Comprehensive Approach to Improving Patient Safety

This report proposes a comprehensive approach for reducing medical errors and improving patient safety. The approach employs market and regulatory strategies, public and private strategies, and strategies that are implemented inside health care organizations as well as in their external environment. To achieve a threshold improvement in patient safety, all of these strategies must be employed in a balanced and complementary fashion.

This introductory chapter first discusses patient safety within the overall context of improving quality. The objective of the Quality of Health Care in America Project is to lay out a strategy for achieving a threshold improvement in quality over the coming decade. Patient safety is one of three domains of quality concerns. A general model of how the external environment influences health care organizations to improve different domains of quality is presented and the model is then discussed as it applies to patient safety, the focus of this first report of the Quality of Health Care in America Committee. Second, the chapter provides a roadmap to the remainder of the report by briefly describing the chapters that follow.

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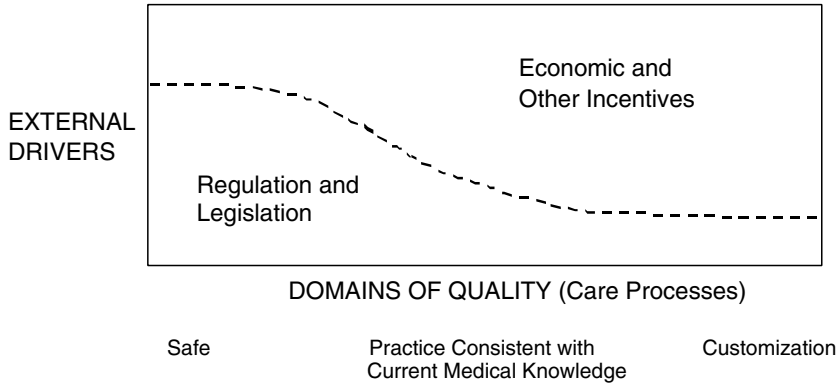
PATIENT SAFETY: A CRITICAL COMPONENT OF QUALITY

A general model of the influence of the environment on quality, as shown in Figure 1.1, contains two primary dimensions. The first dimension identifies domains of quality. These include: safe care, practice that is consistent with current medical knowledge and customization. The second dimension identifies forces in the external environment that can drive quality improvement in the delivery system. These have been grouped into two broad categories: regulatory/legislative activities, and economic and other incentives.

Safety, the first domain of quality, refers to "freedom from accidental injury." This definition is stated from the patient's perspective. As discussed in chapter 2 of this report, health care is not as safe as it should be.

The second domain refers to the provision of services in a manner that is consistent with current medical knowledge and best practices. Currently,



External Drivers: Two categories of factors that can influence quality improvement—regulation and legislation, and economic and other incentives such as actions by purchasers and consumers or professional and community values.

Safe: Freedom from accidental injury. Requires a larger role for regulation and oversight authority.

Practice Consistent with Current Medical Knowledge: Best practices, incorporating evidence-based medicine.

Customization: Meeting customer-specific values and expectations. Requires a larger role for creative, continuous improvement and innovation within organizations and marketplace reward.

FIGURE 1.1 A general model of the influence of the external environment on quality.

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there is a great deal of variability in medical practice and, oftentimes, a lack of adherence to medical standards based on scientific evidence.[1]

The third domain exemplifies the ability to meet customer-specific values and expectations, permitting the greatest responsiveness to individual values and preferences and maximum personalization or customization of care. Strong policy directives are difficult to implement in this area because of the variety of individual needs and preferences.

Previous work by the IOM categorized quality problems into misuse (avoidable complications that prevent patients from receiving full potential benefit of a service), overuse (potential for harm from the provision of a service exceeds the possible benefit) and underuse (failure to provide a service that would have produced a favorable outcome for the patient).[2] Within this framework, issues of misuse are most likely to be addressed under safety concerns. Issues of overuse and underuse are most likely to be addressed under the domain of practice consistent with current medical knowledge.

Activities in the external environment are grouped under two general categories: (1) regulation and legislative action and (2) economic and other incentives (or barriers). Regulation and legislation include any form of public policy or legal influence, such as licensing or the liability system. Economic and other incentives constitute a broad category that includes the collective and individual actions of purchasers and consumers, the norms and values of health professionals, and the social values of the nation and local communities.

Regulation and legislative action can influence quality in health care organizations in two ways. First, it can empower the chief executive officer and governance of health care organizations to take action internally to improve quality. It provides a call to action from the external environment that requires a response inside the organization, and lack of an appropriate response generally results in certain sanctions. Second, it requires *all* health care organizations to make minimum investments in systems for quality, thus creating a more level playing field throughout the industry. It should also be noted, however, that regulation and legislation can also create disincentives for quality, such as lax or conflicting standards.

Marketplace incentives direct the values, culture, and priorities of health care organizations and reward performance beyond the minimum. One way this can happen is by purchasers and consumers requesting and using information to direct their business to the best organizations and providers in a community. Both public and private purchasers can be a strong influence, although public purchasers (especially the Health Care Financing Adminis-

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tration) are perceived as a potentially stronger force because of the size of the population they cover as a single purchaser and also because of the additional demands they can bring through conditions of participation and other oversight responsibilities. In health care, efforts to make comparative performance data available in the public domain to assist purchasers and consumers in identifying high quality providers are just starting to emerge through activities such as the Health Plan Employer Data and Information Set (HEDIS) of the National Committee for Quality Assurance (NCQA) and the Consumer Assessment of Health Plans (CAHPs) survey from the Agency for Healthcare Research and Quality (AHRQ).

Although purchasing activities are a major component of the marketplace, health care is not driven by only economic factors. Incentives come from other directions as well, including the norms, values and standards of health professionals and social values of communities. Professional groups, such as medical societies, specialty groups and associations, play a role in defining norms and standards of practice, and setting expectations and values, beginning with training and education and continuing into practice. Such standards and values not only influence the members of a profession, but also the expectations of consumers and others. Additionally, health professionals and health care organizations are expected to respond to social demands, such as caring for the uninsured or working collaboratively to improve health status in local communities. Media, advocacy, and others also influence organizational and professional behavior, but do so indirectly, often working through other parties that have direct influence, such as purchasers and consumers.

Activities in the external environment interact with each other in various ways for the different domains of quality. As noted by the curve in Figure 1.1, the committee believes regulation and legislation play a particularly important role in assuring a basic level of safety for everyone using the health system. Economic, professional and other incentives can, and should, reinforce that priority. On the other hand, the customization of care to meet individual needs and preferences is more driven by economic and other incentives, with regulation and legislation potentially playing a supportive or enabling role. Encouraging practice consistent with current medical knowledge is reflected as a joint responsibility.

The committee believes that a basic level of safety should be assured for all who use the health system and a strong regulatory component is critical to accomplishing this goal. In most industries, ensuring safety is a traditional role of public policy, enforced through regulation. A regulatory authority

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generally defines minimum levels of capability or expected performance. Through some type of monitoring mechanism (e.g., surveillance system, complaint or reporting system, inspections), problems can be identified and corrective action taken to maintain the minimum levels of performance.

However, the committee recognizes that regulation alone will not be sufficient for achieving a significant improvement in patient safety. Careful alignment of regulatory, economic, professional and other incentives in the external environment is critical if significant improvements in safety are to occur. In developing its recommendations, the committee sought a careful balance between the regulatory/legislative influences and the influence of economic and other incentives. The precise balance that will prove most successful in achieving safety improvements is unknown. Ongoing evaluation should assess whether the proper balance has been achieved relative to safety or if refinement is needed.

The committee's strategy for improving patient safety is for the external environment to create sufficient pressure to make errors so costly in terms of ability to conduct business in the marketplace, market share and reputation that the organization *must* take action. The cost should be high enough that organizations and professionals invest the attention and resources necessary to improve safety. Such external pressures are virtually absent in health care today. The actions of regulatory bodies, group purchasers, consumers and professional groups are all critical to achieving this goal. At the same time, investments in an adequate knowledge base and tools to improve safety are also important to assist health care organizations in responding to this challenge.

ORGANIZATION OF THE REPORT

Following is a brief description of each of the remaining chapters in the report. As a whole, these chapters lay out a rationale for taking strong actions to improve patient safety; a comprehensive strategy for leveraging the actions of regulators, purchasers, consumers, and professionals; and a plan to bolster the knowledge base and tools necessary to improve patient safety.

Chapter 2 of this report, Errors in Health Care: A Leading Cause of Death and Injury, reviews the literature on errors to assess current understanding of the magnitude of the problem and identifies a number of issues that inhibit attention to patient safety. A general lack of information on and awareness of errors in health care by purchasers and consumers makes it impossible for them to demand better care. The culture of medicine creates

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an expectation of perfection and attributes errors to carelessness or incompetence. Liability concerns discourage the surfacing of errors and communication about how to correct them. The lack of explicit and consistent standards for patient safety creates gaps in licensing and accreditation and lets health care organizations function without some of the basic safety systems in place. The lack of any agency or organization with primary responsibility for patient safety prevents the dissemination of any cohesive message about patient safety. Given the gaps in the external environment, it should come as no surprise that the health care delivery system is not as responsive as it could be to concerns about patient safety. The external environment is not creating any requirement or demand for the delivery system to reduce medical errors and improve the safety of patients.

Chapter 3, Why Do Errors Happen?, offers a discussion of several concepts in patient safety, including a number of definitions for terms used throughout this report. The chapter describes leading theory on why accidents happen and the types of errors that occur. It also explores why some systems are safer than others and the contribution of human factors principles to designing safer systems.

Chapters 4 through 8 of the report lay out a set of actions that the external environment can take to increase attention by the delivery system to issues of patient safety. They also identify a set of actions that the delivery system can pursue in response. The combination of proposed strategies seeks to build a national focus on patient safety, make more and better information available, set explicit standards for patient safety, and identify how health care organizations can put safety systems into practice.

Chapter 4, Building Leadership and Knowledge to Improve Patient Safety, discusses the need for a focal point for patient safety. The lack of a clear focal point makes it difficult to define priorities, call for action where needed, or produce a consistent message about safety. Other high-risk industries can identify an agency or organization with accountability for monitoring and communicating about safety problems. No such focal point exists in health care. The chapter discusses the role of national leadership to set aims and to track progress over time in achieving these aims, the need to develop and fund a safety agenda, and approaches for improving dissemination and outreach about safety to the marketplace and to regulators and policy makers.

Chapter 5, Error Reporting Systems, discusses reporting systems as one means for obtaining information about medical errors. A number of public and private reporting systems currently exist, some focused on very specific

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issues, such as medications, and others are more broad based. However, collecting reports on errors is only part of the picture. Analyzing and using the information is how improvements can occur. This chapter discusses the role and purpose of error reporting systems, how to maximize the availability and use of reports, and the contribution of existing reporting systems.

Chapter 6, Protecting Voluntary Error Reporting Systems from Legal Discovery, identifies the legal constraints on protecting data submitted to voluntary reporting systems. Health care organizations are concerned that sharing information about medical errors will expose them to litigation. The unwillingness to share such information means that errors remain hidden and the same errors may be repeated in different organizations. The chapter discusses the legal and practical options available for protecting data to let providers and health care organizations more openly discuss issues related to medical error and patient safety so that errors can be prevented before they result in serious harm or death.

Chapter 7, Setting Performance Standards and Expectations for Safety, discusses the need for explicit and consistent standards for patient safety. Such standards not only define minimum expected levels of performance, but also set expectations for purchasers and consumers. The roles of licensing and accrediting bodies are discussed relative to standards for health care organizations, professionals, and drugs and medical devices. The roles of purchasers and professional groups in setting expectations are also discussed.

Chapter 8, Creating Safety Systems in Health Care Organizations, discusses actions within the delivery system to improve patient safety. The goal for improving patient safety is to affect the delivery of care. Health care organizations have to make certain that systems are in place to ensure patient safety, but they also have to build in mechanisms for learning about safety concerns and for continuous improvement. The chapter discusses the importance of an organizational commitment to safety and the need to incorporate safety principles into operational processes.

Before proceeding further, it is useful to identify what this report is *not*. Three distinct issues that have been raised during various discussions on patient safety are not addressed here. First, the committee recognizes that a major force for improving patient safety is intrinsic motivation, that is, it is driven by the values and attitudes of health professionals and health care organizations. This report, however, focuses primarily on the external environment and the policy and market strategies that can be employed to encourage actions by health professionals and health care organizations. It is

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hoped that actions in the external environment will lead to implementation of a specific set of actions within health care organizations. Although some health care organizations are already implementing the recommended actions absent any incentives from the external environment, the external environment can motivate a broader response.

Second, worker safety is often linked with patient safety. If workers are safer in their jobs, patients will be safer also. Sometimes, the actions needed to improve patient safety are ones that would also improve worker safety. Procedures for avoiding needlesticks or limiting long work hours are aimed at protecting workers but can also protect patients. Thus, although worker safety is not the focus of this report, the committee believes that creating a safe environment for patients will go a long way in addressing issues of worker safety as well.

The third issue is that of access to care. This report is focused on making the delivery of care safer for patients who have access to and are using the health care system. Safe care is an important part of quality care. Although safe care does not guarantee quality, it is a necessary prerequisite for the delivery of high-quality care. However, the committee also recognizes the relationship that exists between access and quality. When someone needs medical care, the worst quality is no care at all.

Access continues to be threatened in today's health care marketplace. For many people the lack of insurance creates a significant barrier to access. The uninsured typically use fewer services than the insured, are more likely to report having cost and access problems, and are less likely to believe that they receive excellent care.[3] However, access is not just a concern of the uninsured. Even people with insurance are growing uneasy about their access to care. Employers are reducing coverage for workers and their dependents.[4] Inadequate coverage compromises access and creates inequities between those who have complete coverage and full access and those who have partial coverage and partial access. Insufficient coverage also creates concerns about the affordability of care, either because services are not covered at all or because significant out-of-pocket payments, such as copayments and deductibles, are involved. Although financial burden is a significant barrier to access, other factors interfere as well, such as poor transportation, language, and cultural barriers.[5]

When access to care is threatened, the ability to make a threshold change in quality is also threatened. Although it is not being addressed in this report, those dealing with overall quality concerns will also have to consider problems of access.

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2
Errors in Health Care: A Leading Cause of Death and Injury

Health care is not as safe as it should be. A substantial body of evidence points to medical errors as a leading cause of death and injury.

- Sizable numbers of Americans are harmed as a result of medical errors. Two studies of large samples of hospital admissions, one in New York using 1984 data and another in Colorado and Utah using 1992 data, found that the proportion of hospital admissions experiencing an adverse event, defined as injuries caused by medical management, were 2.9 and 3.7 percent,[1] respectively. The proportion of adverse events attributable to errors (i.e., preventable adverse events) was 58 percent in New York, and 53 percent in Colorado and Utah.[2]
- Preventable adverse events are a leading cause of death in the United States. When extrapolated to the over 33.6 million admissions to U.S. hospitals in 1997, the results of these two studies imply that at least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors.[3] Even when using the lower estimate, deaths in hospitals due to preventable adverse events exceed the number attributable to the 8th-leading cause of death.[4] Deaths due to preventable adverse events exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).[5]

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- Total national costs (lost income, lost household production, disability, health care costs) are estimated to be between $37.6 billion and $50 billion for adverse events and between $17 billion and $29 billion for preventable adverse events.[6] Health care costs account for over one-half of the total costs. Even when using the lower estimates, the total national costs associated with adverse events and preventable adverse events represent approximately 4 percent and 2 percent, respectively, of national health expenditures in 1996.[7] In 1992, the direct and indirect costs of adverse events were slightly higher than the direct and indirect costs of caring for people with HIV and AIDS.[8]
- In terms of lives lost, patient safety is as important an issue as worker safety. Although more than 6,000 Americans die from workplace injuries every year,[9,10] in 1993 medication errors are estimated to have accounted for about 7,000 deaths.[11] Medication errors account for one out of 131 outpatient deaths and one out of 854 inpatient deaths.
- Medication-related errors occur frequently in hospitals; not all result in actual harm, but those that do are costly. One recent study conducted at two prestigious teaching hospitals found that almost two percent of admissions experienced a preventable adverse drug event, resulting in average increased hospital costs of $4,700 per admission or about $2.8 million annually for a 700-bed teaching hospital.[12] If these findings are generalizable, the increased hospital costs alone of preventable adverse drug events affecting inpatients are about $2 billion for the nation as a whole.
- Hospital patients represent only a fraction of the total population at risk of experiencing a medication-related error. In 1998, nearly 2.5 billion prescriptions were dispensed by U.S. pharmacies at a cost of about $92 billion.[13] Numerous studies document errors in prescribing medications,[14,15] dispensing by pharmacists,[16] and unintentional nonadherence on the part of the patient.[17] Medication errors have the potential to increase as a major contributor to avoidable morbidity and mortality as new medications are introduced for a wider range of indications.

This chapter provides a summary of findings in the literature on the frequency and cost of health care errors and the factors that contribute to their occurrence.

INTRODUCTION

Although the literature pertaining to errors in health care has grown steadily over the last decade and some notable studies are particularly strong

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methodologically, we do not yet have a complete picture of the epidemiology of errors. Many studies focus on patients experiencing injury and provide valuable insight into the magnitude of harm resulting from errors. Other studies, more limited in number, focus on the occurrence of errors, both those that result in harm and those that do not (sometimes called "near misses"). More is known about errors that occur in hospitals than in other health care delivery settings.

Synthesizing and interpreting the findings in the literature pertaining to errors in health care is complicated due to the absence of standardized nomenclature. For purposes of this report, the terms error and adverse event are defined as follows:

An error is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).[18]

An adverse event is an injury caused by medical management rather than the underlying condition of the patient. An adverse event attributable to error is a "preventable adverse event."[19] *Negligent adverse events represent a subset of preventable adverse events that satisfy legal criteria used in determining negligence (i.e., whether the care provided failed to meet the standard of care reasonably expected of an average physician qualified to take care of the patient in question).*[20]

When a study in the literature has used a definition that deviates from the above definitions, it is noted below.

Medication-related error has been studied extensively for several reasons: it is one of the most common types of error, substantial numbers of individuals are affected, and it accounts for a sizable increase in health care costs.[21–23] There are also methodologic issues: (1) prescription drugs are widely used, so it is easy to identify an adequate sample of patients who experience adverse drug events; (2) the drug prescribing process provides good documentation of medical decisions, and much of this documentation resides in automated, easily accessible databases; and (3) deaths attributable to medication errors are recorded on death certificates. There are probably other areas of health care delivery that have been studied to a lesser degree but may offer equal or greater opportunity for improvement in safety.

Efforts to assess the importance of various types of errors are currently hampered by the lack of a standardized taxonomy for reporting adverse events, errors, and risk factors.[24,25] A limited number of studies focus di-

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rectly on the causes of adverse events, but attempts to classify adverse events according to "root causes" are complicated by the fact that several interlocking factors often contribute to an error or series of errors that in turn result in an adverse event.[26,27] In recent years, some progress toward a more standardized nomenclature and taxonomy has been made in the medication area, but much work remains to be done.[28]

The following discussion of the literature addresses four questions:

1. How frequently do errors occur?
2. What factors contribute to errors?
3. What are the costs of errors?
4. Are public perceptions of safety in health care consistent with the evidence?

HOW FREQUENTLY DO ERRORS OCCUR?

For the most part, studies that provide insight into the incidence and prevalence of errors fall into two categories:

1. General studies of patients experiencing adverse events. These are studies of adverse events in general, not studies limited to medication-related events. These studies are limited in number, but some represent large-scale, multi-institutional analyses. Virtually all studies in this category focus on hospitalized patients. With the exception of medication-related events discussed in the second category, little if any research has focused on errors or adverse events occurring outside of hospital settings, for example, in ambulatory care clinics, surgicenters, office practices, home health, or care administered by patients, their family, and friends at home.

2. Studies of patients experiencing medication-related errors. There is an abundance of studies that fall into this category. Although many focus on errors and adverse events associated with ordering and administering medication to hospitalized patients, some studies focus on patients in ambulatory settings.

Adverse Events

An adverse event is defined as an injury caused by medical management rather than by the underlying disease or condition of the patient.[29] Not all, but a sizable proportion of adverse events are the result of errors. Numerous

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studies have looked at the proportion of adverse events attributable to medical error. Due to methodologic challenges, far fewer studies focus on the full range of error—namely, those that result in injury *and* those that expose the patient to risk but do not result in injury.

The most extensive study of adverse events is the Harvard Medical Practice Study, a study of more than 30,000 randomly selected discharges from 51 randomly selected hospitals in New York State in 1984.[30] Adverse events, manifest by prolonged hospitalization or disability at the time of discharge or both, occurred in 3.7 percent of the hospitalizations. The proportion of adverse events attributable to errors (i.e., preventable adverse events) was 58 percent and the proportion of adverse events due to negligence was 27.6 percent. Although most of these adverse events gave rise to disability lasting less than six months, 13.6 percent resulted in death and 2.6 percent caused permanently disabling injuries. Drug complications were the most common type of adverse event (19 percent), followed by wound infections (14 percent) and technical complications (13 percent).[31,32]

The findings of the Harvard Medical Practice Study in New York have recently been corroborated by a study of adverse events in Colorado and Utah occurring in 1992.[33] This study included the review of medical records pertaining to a random sample of 15,000 discharges from a representative sample of hospitals in the two states. Adverse events occurred in 2.9 percent of hospitalizations in each state. Over four out of five of these adverse events occurred in the hospital, the remaining occurred prior to admission in physicians' offices, patients' homes or other non-hospital settings. The proportion of adverse events due to negligence was 29.2 percent, and the proportion of adverse events that were preventable was 53 percent.[34] As was the case in the New York study, over 50 percent of adverse events were minor, temporary injuries. But the study in New York found that 13.6 percent of adverse events led to death, as compared with 6.6 percent in Colorado and Utah. In New York, about one in four negligent adverse events led to death, while in Colorado and Utah, death resulted in about 1 out of every 11 negligent adverse events. Factors that might explain the differences between the two studies include: temporal changes in health care, and differences in the states' patient populations and health care systems.[35]

Both the study in New York and the study in Colorado and Utah identified a subset of preventable adverse events that also satisfied criteria applied by the legal system in determining negligence. It is important to note that although some of these cases may stem from incompetent or impaired providers, the committee believes that many could likely have been avoided had better systems of care been in place.

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Extrapolation of the results of the Colorado and Utah study to the over 33.6 million admissions to hospitals in the United States in 1997, implies that at least 44,000 Americans die in hospitals each year as a result of preventable medical errors.[36] Based on the results of the New York study, the number of deaths due to medical error may be as high as 98,000.[37] By way of comparison, the lower estimate is greater than the number of deaths attributable to the 8th-leading cause of death.[38]

Some maintain these extrapolations likely underestimate the occurrence of preventable adverse events because these studies: (1) considered only those patients whose injuries resulted in a specified level of harm; (2) imposed a high threshold to determine whether an adverse event was preventable or negligent (concurrence of two reviewers); and (3) included only errors that are documented in patient records.[39]

Two studies that relied on both medical record abstraction and other information sources, such as provider reports, have found higher rates of adverse events occurring in hospitals. In a study of 815 consecutive patients on a general medical service of a university hospital, it was found that 36 percent had an iatrogenic illness, defined as any illness that resulted from a diagnostic procedure, from any form of therapy, or from a harmful occurrence that was not a natural consequence of the patient's disease.[40] Of the 815 patients, nine percent had an iatrogenic illness that threatened life or produced considerable disability, and for another two percent, iatrogenic illness was believed to contribute to the death of the patient.

In a study of 1,047 patients admitted to two intensive care units and one surgical unit at a large teaching hospital, 480 (45.8 percent) were identified as having had an adverse event, where adverse event was defined as "situations in which an inappropriate decision was made when, at the time, an appropriate alternative could have been chosen."[41] For 185 patients (17.7 percent), the adverse event was serious, producing disability or death. The likelihood of experiencing an adverse event increased about six percent for each day of hospital stay.

Some information on errors can also be gleaned from studies that focus on inpatients who died or experienced a myocardial infarction or postsurgical complication. In a study of 182 deaths in 12 hospitals from three conditions (cerebrovascular accident, pneumonia, or myocardial infarction), it was found that at least 14 percent and possibly as many as 27 percent of the deaths might have been prevented.[42] A 1991 analysis of 203 incidents of cardiac arrest at a teaching hospital,[43] found that 14 percent followed an iatrogenic complication and that more than half of these might have been prevented. In a study of 44,603 patients who underwent surgery between

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1977 and 1990 at a large medical center, 2,428 patients (5.4 percent) suffered complications and nearly one-half of these complications were attributable to error.[44] Another 749 died during the same hospitalization; 7.5 percent of these deaths were attributed to error.

Patients who died during surgery requiring general anesthesia have been the focus of many studies over the last few decades. Anesthesia is an area in which very impressive improvements in safety have been made. As more and more attention has been focused on understanding the factors that contribute to error and on the design of safer systems, preventable mishaps have declined.[45–48] Studies, some conducted in Australia, the United Kingdom and other countries, indicate that, today, anesthesia mortality rates are about one death per 200,000–300,000 anesthetics administered, compared with two deaths per 10,000 anesthetics in the early 1980s.[49] The gains in anesthesia are very impressive and were accomplished through a variety of mechanisms, including improved monitoring techniques, the development and widespread adoption of practice guidelines, and other systematic approaches to reducing errors.[50]

Lastly, some studies have relied on incident reporting systems to identify and analyze errors. For example, in Australia, 324 general practitioners participating voluntarily in an incident reporting system reported a total of 805 incidents during October 1993 through June 1995, of which 76 percent were preventable and 27 percent had the potential for severe harm.[51] These studies provide information on the types of errors that occur but are not useful for estimating the incidence of errors, because the population at risk (i.e., the denominator) is generally unknown.

Medication-Related Errors

Even though medication errors that result in death or serious injury occur infrequently, sizable and increasing numbers of people are affected because of the extensive use of drugs in both out-of-hospital and in-hospital settings. In 1998, nearly 2.5 billion prescriptions were dispensed in U.S. pharmacies at an estimated cost of about $92 billion.[52] An estimated 3.75 billion drug administrations were made to patients in hospitals.[53]

In a review of U.S. death certificates between 1983 and 1993, it was found that 7,391 people died in 1993 from medication errors (accidental poisoning by drugs, medicaments, and biologicals that resulted from acknowledged errors by patients or medical personnel), compared with 2,876 people in 1983, representing a 2.57-fold increase.[54] Outpatient deaths due

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to medication errors rose 8.48-fold during the 10-year period, compared with a 2.37-fold increase in inpatient deaths.

Medication Errors in Hospitals

Medication errors occur frequently in hospitals. Numerous studies have assessed the incidence of adverse drug events (ADEs), defined as an injury resulting from medical intervention related to a drug.[55] Not all ADEs are attributable to errors. For example, a patient with no history of allergic reactions to drugs, who experiences an allergic reaction to an antibiotic, has suffered an ADE, but this ADE would not be attributable to error. However, an error would have occurred if an antibiotic was prescribed to a patient with a history of documented allergic reactions, because the medical record was unavailable or not consulted. We discuss only those studies of ADEs that identified the subset of ADEs determined to be preventable (i.e., attributable to errors).

In an analysis of 289,411 medication orders written during one year in a tertiary-care teaching hospital, the overall error rate was estimated to be 3.13 errors for each 1,000 orders written and the rate of significant errors to be 1.81 per 1,000 orders.[56] In a review of 4,031 adult admissions to 11 medical and surgical units at two tertiary care hospitals, Bates et al. identified 247 ADEs for an extrapolated event rate of 6.5 ADEs per 100 nonobstetrical admissions, and a mean number per hospital per year of approximately 1,900 ADEs.[57] Twenty-eight percent were judged preventable.

In a study of patients admitted to coronary intensive care, medical, surgical, and obstetric units in an urban tertiary care hospital over a 37-day period, the rate of drug-related incidents was 73 in 2,967 patient-days: 27 incidents were judged ADEs; 34, potential ADEs; and 12, problem orders.[58] Of the 27 ADEs, five were life threatening, nine were serious, and 13 were significant. Of the 27 ADEs, 15(56 percent) were judged definitely or probably preventable. In a study of prescribing errors detected and averted by pharmacists in a 631-bed tertiary care teaching hospital between July 1994 and June 1995, the estimated overall rate of errors was 3.99 per 1,000 medication orders.[59]

Children are at particular risk of medication errors, and as discussed below, this is attributable primarily to incorrect dosages.[60,61] In a study of 101,022 medication orders at two children's teaching hospitals, a total of 479 errant medication orders were identified, of which 27 represented potentially lethal prescribing errors.[62] The frequency of errors was similar at

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the two institutions, 4.9 and 4.5 errors per 1,000 medication orders. The error rate per 100 patient-days was greater in the pediatric intensive care units (PICUs) than in the pediatric ward or neonatal intensive care units, and the authors attribute this to the greater heterogeneity of patients cared for in PICUs and the broad range of drugs and dosages used. In a four-year prospective quality assurance study, 315 medication errors resulting in injury were reported among the 2,147 neonatal and pediatric intensive care admissions, an error rate of one per 6.8 admissions.[63] The frequency of iatrogenic injury of any sort due to a medication error was 3.1 percent—one injury for each 33 intensive care admissions.

Not surprisingly, the potential for medication-related error increases as the average number of drugs administered increases. In a prospective cohort study of 4,031 adult admissions to 11 medical and surgical units in two tertiary care hospitals (including two medical and three surgical ICUs), the rate of preventable ADEs and preventable potential ADEs in ICUs was 19 events per 1,000 patient-days, nearly twice the rate of non-ICUs.[64] When adjusted for the number of drugs used in the previous 24 hours or ordered since admission, there were no differences in error rates between ICUs and non-ICUs.

Current estimates of the incidence of medication errors are undoubtedly low because many errors go undocumented and unreported.[65–68] For example, in a study of patients admitted to five patient care units at a tertiary care hospital during a six month period in 1993, it was found that incident reports were filed with the hospital's quality assurance program or called into the pharmacy hotline for only three of the 54 people experiencing an adverse drug event.[69]

Some errors are also difficult to detect in the absence of computerized surveillance systems. In a study of 36,653 hospitalized patients, Classen et al. identified 731 ADEs in 648 patients, but only 92 of these were reported by physicians, pharmacists, and nurses.[70] The remaining 631 were detected from automated signals, the most common of which were diphenhydramine hydrochloride and naloxone hydrochloride use, high serum drug levels, leukopenia, and the use of phytonadione and antidiarrheals.

Medication Errors in Ambulatory Settings

There is evidence indicating that ADEs account for a sizable number of admissions to inpatient facilities, but we do not know what proportion of these ADE-related admissions are attributable to errors. One study found

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that between three and 11 percent of hospital admissions were attributable to ADEs.[71] A review of 14 Australian studies published between 1988 and 1996 reported that 2.4 to 3.6 percent of all hospital admissions were drug related, and between 32 and 69 percent were definitely or possibly preventable. Drug groups most commonly involved were cytotoxics, cardiovascular agents, antihypertensives, anticoagulants, and nonsteroidal anti-inflammatory drugs.[72]

ADEs also result in increased visits to physician offices and emergency departments. In an analysis of 1,000 patients drawn from a community office-based medical practice who were observed for adverse drug reactions, adverse effects were recorded in 42 (4.2 percent), of which 23 were judged to be unnecessary and potentially avoidable.[73] In an analysis of 62,216 visits to an emergency department by patients enrolled in a health maintenance organization (HMO), it was found that 1,074 (1.7 percent) were related to medication noncompliance or inappropriate prescribing.[74]

There is a sizable body of literature to document the incidence of patient noncompliance with medication regimens, but less is known about the proportion of noncompliance attributable to medical error (defined as accidental or unintentional nonadherence to a therapeutic program) as opposed to intentional noncompliance. In a meta-analysis of seven studies, Sullivan et al. estimate that 5.5 percent of admissions can be attributed to drug therapy noncompliance, amounting to 1.94 million admissions and $8.5 billion in hospital expenditures in 1986.[75] Similar results were obtained by Einarson in a meta-analysis of 37 studies published between 1966 and 1989, which found that hospital admissions caused by ADEs, resulting from noncompliance or unintentionally inappropriate drug use, ranged from 0.2 to 21.7 percent with a median of 4.9 percent and a mean of 5.5 percent.[76] Patient noncompliance is clearly an important quality issue, but it should be emphasized that we do not know the extent to which noncompliance is related to errors.

FACTORS THAT CONTRIBUTE TO ERRORS

Studies of Adverse Events

Patient safety problems of many kinds occur during the course of providing health care. They include transfusion errors and adverse drug events; wrong-site surgery and surgical injuries; preventable suicides; restraint-related injuries or death; hospital-acquired or other treatment-related infections; and falls, burns, pressure ulcers, and mistaken identity. Leape et al.

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have characterized the kinds of errors that resulted in medical injury in the Medical Practice Study as diagnostic, treatment, preventive, or other errors (see Box 2.1).

More than two-thirds (70 percent) of the adverse events found in this study were thought to be preventable, with the most common types of preventable errors being technical errors (44 percent), diagnosis (17 percent), failure to prevent injury (12 percent) and errors in the use of a drug (10 percent). The contributions of complexity and technology to such error rates is highlighted by the higher rates of events that occur in the highly technical surgical specialties of vascular surgery, cardiac surgery, and neurosurgery. In hospitals, high error rates with serious consequences are most likely in intensive care units, operating rooms and emergency departments.

Thomas et al., in their study of admissions to hospitals in Colorado and Utah experiencing adverse events, found that about 30 percent were attributable to negligence.[77] The hospital location with the highest proportion of

BOX 2.1
Types of Errors

Diagnostic
- Error or delay in diagnosis
- Failure to employ indicated tests
- Use of outmoded tests or therapy
- Failure to act on results of monitoring or testing

Treatment
- Error in the performance of an operation, procedure, or test
- Error in administering the treatment
- Error in the dose or method of using a drug
- Avoidable delay in treatment or in responding to an abnormal test
- Inappropriate (not indicated) care

Preventive
- Failure to provide prophylactic treatment
- Inadequate monitoring or follow-up of treatment

Other
- Failure of communication
- Equipment failure
- Other system failure

SOURCE: Leape, Lucian; Lawthers, Ann G.; Brennan, Troyen A., et al. Preventing Medical Injury. *Qual Rev Bull.* 19(5):144–149, 1993.

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negligent adverse events (52.6 percent) was the emergency department. The authors note the complexity inherent in emergency medical care and point to the need to improve teamwork and standardize work procedures.

Other studies have made similar attempts to classify errors. Dubois and Brook studied 49 preventable deaths from 12 hospitals, and found that for those who died of a myocardial infarction, preventable deaths reflected errors in management; for cerebrovascular accident, most deaths reflected errors in diagnosis; and for pneumonia, some deaths reflected errors in management and some reflected errors in diagnosis.[78] In an analysis of 203 cardiac arrests at a teaching hospital, Bedell et al. found that of the half that might have been prevented, the most common causes of potentially preventable arrest were medication errors and toxic effects, and suboptimal response by physicians to clinical signs and symptoms.[79]

Studies of Medication Errors

Ensuring appropriate medication use is a complex process involving multiple organizations and professionals from various disciplines; knowledge of drugs; timely access to accurate and complete patient information; and a series of interrelated decisions over a period of time. As shown in Box 2.2, errors can creep into this process at various points. Some errors are errors of commission (e.g., administration of improper drug), while others are errors of omission (e.g., failure to administer a drug that was prescribed).

Medication errors are often preventable, although reducing the error rate significantly will require multiple interventions. In the study of prescribing errors conducted by Lesar et al.,[80] the most common factors associated with errors were decline in renal or hepatic function requiring alteration of drug therapy (13.9 percent); patient history of allergy to the same medication class (12.1 percent); using the wrong drug name, dosage form, or abbreviation (11.4 percent for both brand name and generic name orders); incorrect dosage calculations (11.1 percent); and atypical or unusual and critical dosage frequency considerations (10.8 percent). The most common groups of factors associated with errors were those related to knowledge and the application of knowledge regarding drug therapy (30 percent); knowledge and use of knowledge regarding patient factors that affect drug therapy (29.2 percent); use of calculations, decimal points, or unit and rate expression factors (17.5 percent); and nomenclature—for example incorrect drug name, dosage form, or abbreviations (13.4 percent).

Many studies have identified inappropriate prescribing as a particu-

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BOX 2.2
Medication Use Processes

Prescribing
- Assessing the need for and selecting the correct drug
- Individualizing the therapeutic regimen
- Designating the desired therapeutic response

Dispensing
- Reviewing the order
- Processing the order
- Compounding and preparing the drug
- Dispensing the drug in a timely manner

Administering
- Administering the right medication to the right patient
- Administering medication when indicated
- Informing the patient about the medication
- Including the patient in administration

Monitoring
- Monitoring and documenting patient's response
- Identifying and reporting adverse drug events
- Reevaluating drug selection, regimen, frequency and duration

Systems and Management Control
- Collaborating and communicating amongst caregivers
- Reviewing and managing patient's complete therapeutic drug regimen

SOURCE: Nadzam, Deborah M., Development of medication-use indicators by the Joint Commission on Accreditation of Healthcare Organizations. *AJHP*. 48:1925–1930, 1991.

larly important factor in accounting for medication errors. In an analysis of 1987 National Medical Expenditure Survey data, it was found that physicians prescribe potentially inappropriate medications for nearly a quarter of all older people living in the community.[81] In a study of 366 consecutive patients admitted to a department of cardiology, "definite" or "probable" drug events (i.e., adverse drug reactions and dose-related therapeutic failures) accounted for 15 admissions, of which five were judged to be due to error in prescription and another five judged to have been avoidable had appropriate measures been taken by prescribing physicians.[82] In an analysis of 682 children admitted to a Congenital Heart Disease Center at a teaching hospital in the United Kingdom, 441 medication errors were reported by

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nurses, doctors, and pharmacists, of which prescribing errors accounted for 68 percent, followed by administration errors (25 percent) and supply errors (seven percent).[83] In Burnum's[84] analysis of 1,000 patients drawn from a community office-based medical practice who experienced adverse drug reactions, 23 patients were judged to have experienced an "unnecessary and potentially avoidable" event, 10 of which were due to physician error (i.e., six due to administration of a drug not indicated and four to improper drug administration).

Physicians do not routinely screen for potential drug interactions, even when medication history information is readily available. In an analysis of 424 randomly selected visits to a hospital emergency department, 47 percent led to added medication, and in 10 percent of the visits in which at least one medication was added, the new medication added a potential adverse interaction.[85] In all cases, a medication history was recorded on the patients and available to the physicians.

Errors can occur in the dispensing of drugs by pharmacists. In a recent investigation of pharmacists, the Massachusetts State Board of Registration in Pharmacy estimated that 2.4 million prescriptions are filled improperly each year in Massachusetts.[86] Eighty-eight percent of the errors involved giving patients the wrong drug or the wrong strength.

Errors in the ordering and administration of medications are common in hospitals. Bates et al.,[87] in an analysis of more than 4,000 admissions to two tertiary care hospitals, found that about 28 percent of 247 adverse drug events were preventable and most of these resulted from errors that occurred at the stages of ordering and administration. Davis and Cohen[88] in their review of the literature and other evidence on errors report an error rate of 12 percent to be common in the preparation and administration of medications in hospitals. In a study of medication orders at two children's teaching hospitals, Folli et al.[89] found that errors occurred in almost five out of every 1,000 orders and that the most prevalent error was overdose.

Patients make errors too. With greater emphasis on community-based long-term care, increased ambulatory surgery, shorter hospital lengths of stay, and greater reliance on complex drug therapy, patients play an increasingly important role in the administration of drugs. Greenberg et al.[90] found that 4.3 percent of the elderly enrolled in Medicare social HMOs required assistance with the administration of medications. The inability to manage complex drug therapies explains why some elderly are in institutional rather than community-based long-term-care settings.[91]

Automated information and decision support systems are effective in reducing many types of errors. In an analysis of admissions to 11 medical

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and surgical units at two tertiary care hospitals, Leape et al.[92] identified 334 errors as the causes of 264 preventable ADEs and potential ADEs. About three out of four errors were caused by one of seven types of systems failures (drug knowledge dissemination, dose and identity checking, patient information availability, order transcription, allergy defense, medication order tracking, and interservice communication), and all could have been improved by better information systems that disseminate knowledge about drugs and make drug and patient information readily accessible at the time it is needed.

Computerized drug order entry systems have much potential to reduce errors. In a study of 379 consecutive admissions to three medical units at an urban tertiary care hospital, 10,070 medication orders were written and 530 medication errors were identified (5.3 errors per 100 orders). More than half of the medication errors involved at least one missing dose of a medication.[93] Of the 530 medication errors, five (0.9 percent) resulted in adverse drug events that were judged preventable, and another 35 represented potential adverse drug events (i.e., medication errors with the potential for injury but in which no injury occurred). Physician computer order entry could have prevented 84 percent missing dose medication errors, 86 percent of potential adverse drug events, and 60 percent of preventable adverse drug events. However, more sophisticated technology is not the only option; involving pharmacists in reviewing drug orders significantly reduced the potential harm resulting from errant medication orders.[94,95]

THE COST OF ERRORS

In addition to the unfortunate health consequences suffered by many as a result of medical error, there are direct and indirect costs borne by society as a whole as a result of medical errors. Direct costs refer to higher health care expenditures, while indirect costs include factors such as lost productivity, disability costs, and personal costs of care.

Based on analysis of 459 adverse events identified by reviewing the medical records of 14,732 randomly selected 1992 discharges from 28 hospitals in Colorado and Utah, Thomas et al. estimated the total costs (lost income, lost household production, disability and health care costs) to be nearly $662 million of which health care costs totaled $348 million.[96] The total costs associated with the 265 of the 459 adverse events that were found to be preventable were $308 million, of which $159 million represented health care costs. Based on extrapolation to all hospital admissions in the United

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States, the authors estimate the national costs of adverse events to be $37.6 billion and of preventable adverse events to be $17 billion. The total national costs associated with adverse events was approximately 4 percent of national health expenditures in 1996. In 1992, the direct and indirect costs of adverse events were slightly higher than the direct and indirect costs of caring for people with HIV and AIDS.

It has been estimated that for every dollar spent on ambulatory medications, another dollar is spent to treat new health problems caused by the medication.[97] Studies of the direct costs of medication-related errors fall into three categories; (1) population-based studies of patients in a community or health plan; (2) studies of medication-related errors that occur in hospitals; and (3) studies of medication-related errors that occur in nursing homes.

One estimate places the annual national health care cost of drug-related morbidity and mortality in the ambulatory setting as high as $76.6 billion in 1994.[98] Not all drug-related morbidity and mortality is preventable, but numerous studies document errors in prescribing,[99,100] dispensing by pharmacists,[101] and unintentional nonadherence on the part of the patient.[102]

Medication-related errors occur frequently, most do not result in actual harm, but those that do are costly. One recent study conducted at two prestigious teaching hospitals found that almost two percent of admissions experienced a preventable ADE, resulting in an average increased length of stay of 4.6 days and an average increased hospital cost of nearly $4,700 per admission.[103] This amounts to about $2.8 million annually for a 700-bed teaching hospital, and if these findings are generalizable, the increased hospital costs alone of preventable adverse drug events affecting inpatients are about $2 billion for the nation as a whole.

In a matched case-control study of all patients admitted to a large teaching hospital from January 1990 through December 1993, it was found that adverse drug events complicated 2.43 admissions per 100.[104] Controls were matched to cases on primary discharge diagnosis related group (DRG), age, sex, acuity, and year of admission. The occurrence of an ADE was associated with an increased length of stay of 1.91 days and an increased cost of $2,262. The increased risk of death among patients experiencing an adverse drug event was 1.88.

Other studies corroborate the high cost of medication-related errors. One study conducted in a university-affiliated medical center hospital estimated that the annual costs of treating the 1,911 medication-related problems identified through the hospital's voluntary reporting system in 1994

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totaled slightly less than $1.5 million.[105] Bloom has estimated that $3.9 billion was spent in 1983 to manage the preventable gastrointestinal adverse effects of nonsteroidal anti-inflammatory drugs.[106]

Medication-related errors also occur in nursing homes. For every dollar spent on drugs in nursing facilities, $1.33 is consumed in the treatment of drug-related morbidity and mortality, amounting to $7.6 billion for the nation as a whole, of which $3.6 billion has been estimated to be avoidable.[107]

PUBLIC PERCEPTIONS OF SAFETY

Although the risk of dying as a result of a medical error far surpasses the risk of dying in an airline accident, a good deal more public attention has been focused on improving safety in the airline industry than in the health care industry. The likelihood of dying per domestic jet flight is estimated to be one in eight million.[108] Statistically, an average passenger would have to fly around the clock for more than 438 years before being involved in a fatal crash. This compares very favorably with a death risk per domestic flight of one in two million during the decade 1967–1976. Some believe that public concern about airline safety, in response to the impact of news stories, has played an important role in the dramatic improvement in safety in the airline industry.

The American public is aware that health care is less safe than some other environments, but to date, it has made few demands on the health care industry to demonstrate improvement. In a public opinion poll conducted by Louis Harris & Associates for the National Patient Safety Foundation, the health care environment was perceived as "moderately safe" (rated 4.9 on a scale of one through seven where one is not safe at all and seven is very safe).[109] Respondents viewed the health care environment as much safer than nuclear power or food handling, but somewhat less safe than airline travel or the work environment.

Americans have a very limited understanding of health care safety issues. When asked, What comes to mind when you think about patient safety issues in the health care environment? 28 percent of respondents did not mention anything, 20 percent mentioned exposure to infection, 13 percent cited the general level of care patients receive, and 11 percent cited qualifications of health professionals.[110] When asked about the main cause of medical mistakes, respondents most frequently cited carelessness or negligence (29 percent) of health care professionals, who are overworked, worried, or stressed (27 percent).

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Most people learn about medical mistakes through anecdotes. More than four out of five respondents have heard about a situation in which a medical mistake was made.[111] When asked how they heard about the most recent medical mistake, 42 percent cited a friend or relative; 39 percent, television, newspaper, or radio; and 12 percent, personal experience.

Most people view medical mistakes as an "individual provider issue" rather than a failure in the process of delivering care in a complex delivery system. When asked about possible solutions to prevent medical mistakes, actions rated very effective by respondents were "keeping health care professionals with bad track records from providing care" (75 percent) and "better training of health care professionals" (69 percent).[112]

There are numerous factors that might contribute to the "disconnect" between public perceptions and actual health care error rates. The various accreditation and licensure programs for health care organizations and providers have been promoted as "Good Housekeeping Seals of Approval," yet they fail to provide adequate assurance of a safe environment. Reducing medical errors and improving patient safety are not an explicit focus of these processes. Even licensed and accredited organizations may have implemented only rudimentary systems and processes to ensure patient safety.

For the most part, media coverage has been limited to occasional reporting of anecdotal cases. The impact of anecdotal information on safety may also be less effective in health care than in the nuclear waste or airline industries, where an individual event often impacts dozens or hundreds of people at a time.

Patient safety is also hindered through the liability system and the threat of malpractice, which discourages the disclosure of errors. The discoverability of data under legal proceedings encourages silence about errors committed or observed. Most errors and safety issues go undetected and unreported, both externally and within health care organizations.

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3
Why Do Errors Happen?

The common initial reaction when an error occurs is to find and blame someone. However, even apparently single events or errors are due most often to the convergence of multiple contributing factors. Blaming an individual does not change these factors and the same error is likely to recur. Preventing errors and improving safety for patients require a systems approach in order to modify the conditions that contribute to errors. People working in health care are among the most educated and dedicated workforce in any industry. The problem is not bad people; the problem is that the system needs to be made safer.

This chapter covers two key areas. First, definitions of several key terms are offered. This is important because there is no agreed-upon terminology for talking about this issue.[1] Second, the emphasis in this chapter (and in this report generally) is about how to make systems safer; its primary focus is not on "getting rid of bad apples," or individuals with patterns of poor performance. The underlying assumption is that lasting and broad-based safety improvements in an industry can be brought about through a systems approach.

Finally, it should be noted that although the examples may draw more from inpatient or institutional settings, errors occur in all settings. The concepts presented in this chapter are just as applicable to ambulatory care,

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home care, community pharmacies, or any other setting in which health care is delivered.

This chapter uses a case study to illustrate a series of definitions and concepts in patient safety. After presentation of the case study, the chapter will define what comprises a system, how accidents occur, how human error contributes to accidents and how these elements fit into a broader concept of safety. The case study will be referenced to illustrate several of the concepts. The next section will examine whether certain types of systems are more prone to accidents than others. Finally, after a short discussion of the study of human factors, the chapter summarizes what health care can learn from other industries about safety.

An Illustrative Case in Patient Safety

Infusion devices are mechanical devices that administer intravenous solutions containing drugs to patients. A patient was undergoing a cardiac procedure. This patient had a tendency toward being hypertensive and this was known to the staff.

As part of the routine set-up for surgery, a nurse assembled three different infusion devices. The nurse was a new member of the team in the operating room; she had just started working at the hospital a few weeks before. The other members of the team had been working together for at least six months. The nurse was being very careful when setting up the devices because one of them was a slightly different model than she had used before.

Each infusion device administered a different medication that would be used during surgery. For each medication, the infusion device had to be programmed according to how much medication would flow into the patient (calculated as "cc's/hour"). The medications had different concentrations and each required calculation of the correct dose for that specific patient. The correct cc's/hour were programmed into the infusion devices.

The anesthesiologist, who monitors and uses the infusion devices during surgery, usually arrived for surgery while the nurse was completing her set-up of the infusion devices and was able to check them over. This particular morning, the anesthesiologist was running behind from a previous surgery. When he arrived in the operating room, the rest of the team was ready to start. The anesthesiologist quickly glanced at the set-up and accepted the report as given to him by the nurse.

One of the infusion devices was started at the beginning of surgery. About

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WHY DO ACCIDENTS HAPPEN?

Major accidents, such as Three Mile Island or the *Challenger* accident, grab people's attention and make the front page of newspapers. Because they usually affect only one individual at a time, accidents in health care delivery are less visible and dramatic than those in other industries. Except for celebrated cases, such as Betsy Lehman (the *Boston Globe* reporter who died from an overdose during chemotherapy) or Willie King (who had the wrong leg amputated),[2] they are rarely noticed. However, accidents are a form of information about a system.[3] They represent places in which the system failed and the breakdown resulted in harm.

The ideas in this section rely heavily upon the work of Charles Perrow

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halfway through the surgery, the patient's blood pressure began to rise. The anesthesiologist tried to counteract this by starting one of the other infusion devices that had been set up earlier. He checked the drip chamber in the intravenous (IV) tubing and did not see any drips. He checked the IV tubing and found a closed clamp, which he opened. At this point, the second device signaled an occlusion, or blockage, in the tubing by sounding an alarm and flashing an error message. The anesthesiologist found a closed clamp in this tubing as well, opened it, pressed the re-start button and the device resumed pumping without further difficulty. He returned to the first device that he had started and found that there had been a free flow of fluid and medication to the patient, resulting in an overdose. The team responded appropriately and the patient recovered without further incident.

The case was reviewed two weeks later at the hospital's "morbidity and mortality" committee meeting, where the hospital staff reviews cases that encountered a problem to identify what happened and how to avoid a recurrence. The IV tubing had been removed from the device and discarded. The bioengineering service had checked the pump and found it to be functioning accurately. It was not possible to determine whether the tubing had been inserted incorrectly into the device, whether the infusion rate had been set incorrectly or changed while the device was in use, or whether the device had malfunctioned unexpectedly. The anesthesiologist was convinced that the tubing had been inserted incorrectly, so that when the clamp was open the fluid was able to flow freely rather than being controlled by the infusion device. The nurse felt the anesthesiologist had failed to check the infusion system adequately before turning on the devices. Neither knew whether it was possible for an infusion device to have a safety mechansim built into it that would prevent free flows from happening.

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and James Reason, among others. Charles Perrow's analysis of the accident at Three Mile Island identified how systems can cause or prevent accidents.[4] James Reason extended the thinking by analyzing multiple accidents to examine the role of systems and the human contribution to accidents.[5] *"A system is a set of interdependent elements interacting to achieve a common aim. The elements may be both human and non-human (equipment, technologies, etc.)."*

Systems can be very large and far-reaching, or they can be more localized. In health care, a system can be an integrated delivery system, a centrally owned multihospital system, or a virtual system comprised of many different partners over a wide geographic area. However, an operating room or an obstetrical unit is also a type of system. Furthermore, any element in a system probably belongs to multiple systems. For example, one operating room is part of a surgical department, which is part of a hospital, which is part of a larger health care delivery system. The variable size, scope, and membership of systems make them difficult to analyze and understand.

In the case study, one of the systems used during surgery is the automated, medication adminstration system, which includes the equipment, the people, their interactions with each other and with the equipment, the procedures in place, and the physical design of the surgical suite in which the equipment and people function.

When large systems fail, it is due to multiple faults that occur together in an unanticipated interaction,[6] creating a chain of events in which the faults grow and evolve.[7] Their accumulation results in an accident. *"An accident is an event that involves damage to a defined system that disrupts the ongoing or future output of that system."*[8]

The *Challenger* failed because of a combination of brittle O-ring seals, unexpected cold weather, reliance on the seals in the design of the boosters, and change in the roles of the contractor and NASA. Individually, no one factor caused the event, but when they came together, disaster struck. Perrow uses a DEPOSE (**D**esign, **E**quipment **P**rocedures, **O**perators, **S**upplies and materials, and **E**nvironment) framework to identify the potential sources of failures. In evaluating the environment, some researchers explicitly include organizational design and characteristics.[9]

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In the case study, the accident was a breakdown in the delivery of IV medications during surgery.

The complex coincidences that cause systems to fail could rarely have been foreseen by the people involved. As a result, they are reviewed only in hindsight; however, knowing the outcome of an event influences how we assess past events.[10] *Hindsight bias* means that things that were not seen or understood at the time of the accident seem obvious in retrospect. Hindsight bias also misleads a reviewer into simplifying the causes of an accident, highlighting a single element as the cause and overlooking multiple contributing factors. Given that the information about an accident is spread over many participants, none of whom may have complete information,[11] hindsight bias makes it easy to arrive at a simple solution or to blame an individual, but difficult to determine what really went wrong.

Although many features of systems and accidents in other industries are also found in health care, there are important differences. In most other industries, when an accident occurs the worker and the company are directly affected. There is a saying that the pilot is always the first at the scene of an airline accident. In health care, the damage happens to a third party; the patient is harmed; the health professional or the organization, only rarely. Furthermore, harm occurs to only one patient at a time; not whole groups of patients, making the accident less visible. *

In any industry, one of the greatest contributors to accidents is human error. Perrow has estimated that, on average, 60–80 percent of accidents involve human error. There is reason to believe that this is equally true in health. An analysis of anesthesia found that human error was involved in 82 percent of preventable incidents; the remainder involved mainly equipment failure.[12] Even when equipment failure occurs, it can be exacerbated by human error.[13] However, saying that an accident is due to human error is not the same as assigning blame. Humans commit errors for a variety of

*Public health has made an effort to eliminate the term, "accident," replacing it with unintentional injuries, consistent with the nomenclature of the International Classification of Diseases. However, this report is not focused specifically on injury since an accident may or may not result in injury. See Institute of Medicine, *Reducing the Burden of Injury*, eds. Richard J. Bonnie, Carolyn Fulco and Catharyn Liverman. Washington, D.C., National Academy Press, 1999).

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expected and unexpected reasons, which are discussed in more detail in the next two sections.

Understanding Errors

The work of Reason provides a good understanding of errors. He defines an error as the failure of a planned sequence of mental or physical activities to achieve its intended outcome when these failures cannot be attributed to chance.[14] It is important to note the inclusion of "intention." According to Reason, error is not meaningful without the consideration of intention. That is, it has no meaning when applied to unintentional behaviors because errors depend on two kinds of failure, either actions do not go as intended or the intended action is not the correct one. In the first case, the desired outcome may or may not be achieved; in the second case, the desired outcome cannot be achieved.

Reason differentiates between slips or lapses and mistakes. A slip or lapse occurs when the action conducted is not what was intended. It is an error of execution. The difference between a slip and a lapse is that a slip is observable and a lapse is not. For example, turning the wrong knob on a piece of equipment would be a slip; not being able to recall something from memory is a lapse.

In a mistake, the action proceeds as planned but fails to achieve its intended outcome because the planned action was wrong. The situation might have been assessed incorrectly, and/or there could have been a lack of knowledge of the situation. In a mistake, the original intention is inadequate; a failure of planning is involved.

In medicine, slips, lapses, and mistakes are all serious and can potentially harm patients. For example, in medicine, a slip might be involved if the physician chooses an appropriate medication, writes 10 mg when the intention was to write 1 mg. The original intention is correct (the correct medication was chosen given the patient's condition), but the action did not proceed as planned. On the other hand, a mistake in medicine might involve selecting the wrong drug because the diagnosis is wrong. In this case, the situation was misassessed and the action planned is wrong. If the terms "slip" and "mistake" are used, it is important not to equate slip with "minor." Patients can die from slips as well as mistakes.

For this report, *error is defined as the failure of a planned action to be completed as intended (e.g., error of execution) or the use of a wrong plan to achieve an aim (e.g., error of planning).* From the patient's perspective, not

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only should a medical intervention proceed properly and safely, it should be the correct intervention for the particular condition. This report addresses primarily the first concern, errors of execution, since they have their own epidemiology, causes, and remedies that are different from errors in planning. Subsequent reports from the Quality of Health Care in America project will consider the full range of quality-related issues, sometimes classified as overuse, underuse and misuse.[15]

Latent and Active Errors

In considering how humans contribute to error, it is important to distinguish between active and latent errors.[16] *Active errors occur at the level of the frontline operator, and their effects are felt almost immediately*. This is sometimes called the sharp end.[17] *Latent errors tend to be removed from the direct control of the operator and include things such as poor design, incorrect installation, faulty maintenance, bad management decisions, and poorly structured organizations*. These are called the blunt end. The active error is that the pilot crashed the plane. The latent error is that a previously undiscovered design malfunction caused the plane to roll unexpectedly in a way the pilot could not control and the plane crashed.

In the case study, the active error was the free flow of the medication from the infusion device.

Latent errors pose the greatest threat to safety in a complex system because they are often unrecognized and have the capacity to result in multiple types of active errors. Analysis of the *Challenger* accident traced contributing events back nine years. In the Three Mile Island accident, latent errors were traced back two years.[18] Latent errors can be difficult for the people working in the system to notice since the errors may be hidden in the design of routine processes in computer programs or in the structure or management of the organization. People also become accustomed to design defects and learn to work around them, so they are often not recognized.

In her book about the *Challenger* explosion, Vaughan describes the "normalization of deviance" in which small changes in behavior became the norm and expanded the boundaries so that additional deviations became acceptable.[19] When deviant events become acceptable, the potential for er-

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rors is created because signals are overlooked or misinterpreted and accumulate without being noticed.

Current responses to errors tend to focus on the active errors by punishing individuals (e.g., firing or suing them), retraining or other responses aimed at preventing recurrence of the active error. Although a punitive response may be appropriate in some cases (e.g., deliberate malfeasance), it is not an effective way to prevent recurrence. Because large system failures represent latent failures coming together in unexpected ways, they appear to be unique in retrospect. Since the same mix of factors is unlikely to occur again, efforts to prevent specific active errors are not likely to make the system any safer.[20]

In our case study, a number of latent failures were present:

- Multiple infusion devices were used in parallel during this cardiac surgery. Three devices were set up, each requiring many steps. each step in the assembly presents a possibility for failure that could disrupt the entire system.
- Each of the three different medications had to be programmed into the infusion device with the correct dose for that patient.
- Possible scheduling problems in the operating suites may have contributed to the anesthesiologist having insufficient time to check the devices before surgery.
- A new nurse on the team may have interrupted the "normal" flow between the team members, especially communication between the anesthesiologist and the nurse setting up the devices. There was no standardized list of checks between the nurse and anesthesiologist before starting the procedure.
- Training of new team members may be insufficient since the nurse found herself assembling a device that was a slightly different model. As a new employee, she may have been hesitant to ask for help or may not have known who to ask.

Focusing on active errors lets the latent failures remain in the system, and their accumulation actually makes the system more prone to future failure.[21] Discovering and fixing latent failures, and decreasing their duration, are likely to have a greater effect on building safer systems than efforts to minimize active errors at the point at which they occur.

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In the case study, a typical response would have been to retrain the nurse on how to assemble the equipment properly. However, this would have had no effect on weaknesses in equipment design, team management and communications, scheduling problems, or orienting new staff. Thus, free flow errors would likely recur.

Understanding Safety

Most of this chapter thus far has drawn on Perrow's normal accident theory, which believes that accident are inevitable in certain systems. Although they may be rare, accidents are "normal" in complex, high technology industries. In contrast to studying the causes of accident and errors, other researchers have focused on the characteristics that make certain industries, such as military aircraft carriers or chemical processing, highly reliable.[22] High reliability theory believes that accidents can be prevented through good organizational design and management.[23] Characteristics of highly reliable industries include an organizational commitment to safety, high levels of redundancy in personnel and safety measures, and a strong organizational culture for continuous learning and willingness to change.[24] Correct performance and error can be viewed as "two sides of the same coin."[25] Although accidents may occur, systems can be designed to be safer so that accidents are very rare.

The National Patient Safety Foundation has defined patient safety as the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the processes of health care.[26] Safety does not reside in a person, device or department, but emerges from the interactions of components of a system. Others have specifically examined pharmaceutical safety and defined it to include maximizing therapeutic benefit, reducing risk, and eliminating harm.[27] That is, benefit relates to risk. Other experts have also defined safety as a relative concept. Brewer and Colditz suggest that the acceptability of an adverse event depends on the seriousness of the underlying illness and the availability of alternative treatments.[28] The committee's focus, however, was not on the patient's response to a treatment, but rather on the ability of a system to deliver care safely. From this perspective, the committee believes that there is a level of safety that can and should be ensured. Safety is relative only in that it continues to evolve over time and, when risks do become known, they become part of the safety requirements.

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Safety is more than just the absence of errors. Safety has multiple dimensions, including the following:

- an outlook that recognizes that health care is complex and risky and that solutions are found in the broader systems context;
- a set of processes that identify, evaluate, and minimize hazards and are continuously improving, and
- an outcome that is manifested by fewer medical errors and minimized risk or hazard.[29]

For this report, *safety is defined as freedom from accidental injury*. This simple definition recognizes that from the patient's perspective, the primary safety goal is to prevent accidental injuries. If an environment is safe, the risk of accidents is lower. Making environments safer means looking at processes of care to reduce defects in the process or departures from the way things should have been done. Ensuring patient safety, therefore, involves the establishment of operational systems and processes that increase the reliability of patient care.

ARE SOME TYPES OF SYSTEMS MORE PRONE TO ACCIDENTS?

Accidents are more likely to happen in certain types of systems. When they do occur, they represent failures in the way systems are designed. The primary objective of systems design ought to be to make it difficult for accidents and errors to occur and to minimize damage if they do occur.[30]

Perrow characterizes systems according to two important dimensions: complexity and tight or loose coupling.[31] Systems that are more complex and tightly coupled are more prone to accidents and have to be made more reliable.[32] In Reason's words, complex and tightly coupled systems can "spring nasty surprises."[33]

In complex systems, one component of the system can interact with multiple other components, sometimes in unexpected or invisible ways. Although all systems have many parts that interact, the problem arises when one part serves multiple functions because if this part fails, all of the dependent functions fail as well. Complex systems are characterized by specialization and interdependency. Complex systems also tend to have multiple feedback loops, and to receive information indirectly, and because of

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specialization, there is little chance of substituting or reassigning personnel or other resources.

In contrast to complex systems, linear systems contain interactions that are expected in the usual and familiar production sequence. One component of the system interacts with the component immediately preceding it in the production process and the component following it. Linear systems tend to have segregated subsystems, few feedback loops, and easy substitutions (less specialization).

An example of complexity is the concern with year 2000 (Y2K) computer problems. A failure in one part of the system can unexpectedly interrupt other parts, and all of the interrelated processes that can be affected are not yet visible. Complexity is also the reason that changes in long-standing production processes must be made cautiously.[34] When tasks are distributed across a team, for example, many interactions that are critical to the process may not be noticed until they are changed or removed.

Coupling is a mechanical term meaning that there is no slack or buffer between two items. Large systems that are tightly coupled have more time-dependent processes and sequences that are more fixed (e.g., *y* depends on *x* having been done). There is often only one way to reach a goal. Compared to tightly coupled systems, loosely coupled systems can tolerate processing delays, can reorder the sequence of production, and can employ alternative methods or resources.

All systems have linear interactions; however, some systems additionally experience greater complexity. Complex interactions contribute to accidents because they can confuse operators. Tight coupling contributes to accidents because things unravel too quickly and prevent errors from being intercepted or prevent speedy recovery from an event.[35] Because of complexity and coupling, small failures can grow into large accidents.

In the case study, the medication adminstration system was both complex and tightly coupled. The complexity arises from three devices functioning simultaneously, in close proximity, and two having problems at the same time. The tight coupling arises from the steps involved in making the system work properly, from the steps required to assemble three devices, to the calculation of correct medication dosage levels, to the operation of multiple devices during surgery, to the responses when alarms start going off.

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Although there are not firm assignments, Perrow considered nuclear power plants, nuclear weapons handling, and aircraft to be complex, tightly coupled systems.[36] Multiple processes are happening simultaneously, and failure in one area can interrupt another. Dams and rail transportation are considered tightly coupled because the steps in production are closely linked, but linear because there are few unexpected interactions. Universities are considered complex, but loosely coupled, since the impact of a decision in one area can likely be limited to that area.

Perrow did not classify health care as a system, but others have suggested that health care is complex and tightly coupled.[37] The activities in the typical emergency room, surgical suite, or intensive care unit exemplify complex and tightly coupled systems. Therefore, the delivery of health care services may be classified as an industry prone to accidents.[38]

Complex, tightly coupled systems have to be made more reliable.[39] One of the advantages of having systems is that it is possible to build in more defenses against failure. Systems that are more complex, tightly coupled, and are more prone to accidents can reduce the likelihood of accidents by simplifying and standardizing processes, building in redundancy, developing backup systems, and so forth.

Another aspect of making systems more reliable has to do with organizational design and team performance. Since these are part of activities within organizations, they are discussed in Chapter 8.

Conditions That Create Errors

Factors can intervene between the design of a system and the production process that creates conditions in which errors are more likely to happen. James Reason refers to these factors as psychological precursors or preconditions.[40] Although good managerial decisions are required for safe and efficient production, they are not sufficient. There is also a need to have the right equipment, well-maintained and reliable; a skilled and knowledgeable workforce; reasonable work schedules, well-designed jobs; clear guidance on desired and undesired performance, et cetera. Factors such as these are the precursors or preconditions for safe production processes.

Any given precondition can contribute to a large number of unsafe acts. For example, training deficiencies can show up as high workload, undue time pressure, inappropriate perception of hazards, or motivational difficulties.[41] Preconditions are latent failures embedded in the system. Designing

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safe systems means taking into account people's psychological limits and either seeking ways to eliminate the preconditions or intervening to minimize their consequences. Job design, equipment selection and use, operational procedures, work schedules, and so forth, are all factors in the production process that can be designed for safety.

One specific type of precondition that receives a lot of attention is technology. The occurrence of human error creates the perception that humans are unreliable and inefficient. One response to this has been to find the unreliable person who committed the error and focus on preventing him or her from doing it again. Another response has been to increase the use of technology to automate processes so as to remove opportunities for humans to make errors. The growth of technology over the past several decades has contributed to system complexity so this particular issue is highlighted here.

Technology changes the tasks that people do by shifting the workload and eliminating human decision making.[42] Where a worker previously may have overseen an entire production process, he or she may intervene now only in the last few steps if the previous steps are automated. For example, flying an aircraft has become more automated, which has helped reduce workload during nonpeak periods. During peak times, such as take-off and landing, there may be more processes to monitor and information to interpret.

Furthermore, the operator must still do things that cannot be automated. This usually involves having to monitor automated systems for rare, abnormal events[43] because machines cannot deal with infrequent events in a constantly changing environment.[44] Fortunately, automated systems rarely fail. Unfortunately, this means that operators do not practice basic skills, so workers lose skills in exactly the activities they need in order to take over when something goes wrong.

Automation makes systems more "opaque" to people who manage, maintain, and operate them.[45] Processes that are automated are less visible because machines intervene between the person and the task. For example, automation means that people have less hands-on contact with processes and are elevated to more supervisory and planning tasks. Direct information is filtered through a machine (e.g., a computer), and operators run the risk of having too much information to interpret or of not getting the right information.

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In the case study, the infusion device administered the medication and the professional monitored the process, intervening when problems arose. The medication administration process was "opaque" in that the device provided no feedback to the user when the medication flowed freely and minimal feedback when the medication flow was blocked.

One of the advantages of technology is that it can enhance human performance to the extent that the human plus technology is more powerful than either is alone.[46] Good machines can question the actions of operators, offer advice, and examine a range of alternative possibilities that humans cannot possibly remember. In medicine, automated order entry systems or decision support systems have this aim. However, technology can also create new demands on operators. For example, a new piece of equipment may provide more precise measurements, but also demand better precision from the operator for the equipment to work properly.[47] Devices that have not been standardized, or that work and look differently, increase the likelihood of operator errors. Equipment may not be designed using human factors principles to account for the human–machine interface.[48]

In the case study, safer systems could have been designed by taking into consideration characteristics of how people use machines and interact with each other in teams. For example:

- Redesign the devices to default to a safe mode
- Reduce the difficulties of using multiple devices simultaneously
- Minimize the variety of equipment models purchased
- Implement clear procedures for checking equipment, supplies, etc., prior to begixnning surgery
- Orient and train new staff with the team(s) with which they will work
- Provide a supportive environment for identifying and communicating about errors for organizational learning and change to prevent errors.

Technology also has to be recognized as a "member" of the work team. When technology shifts workloads, it also shifts the interactions between team members. Where processes may have been monitored by several people, technology can permit the task to be accomplished by fewer people. This affects the distributed nature of the job in which tasks are shared among

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several people and may influence the ability to discover and recover from errors.[49]

In this context, technology does not involve just computers and information technology. It includes "techniques, drugs, equipment and procedures used by health care professionals in delivering medical care to individuals and the systems within which such care is delivered."[50] Additionally, the use of the term technology is not restricted to the technology employed by health care professionals. It can also include people at home of different ages, visual abilities, languages, and so forth, who must use different kinds of medical equipment and devices. As more care shifts to ambulatory and home settings, the use of medical technology by non-health professionals can be expected to take on increasing importance.

RESEARCH ON HUMAN FACTORS

Research in the area of human factors is just beginning to be applied to health care. It borrows from the disciplines of industrial engineering and psychology. *Human factors is defined as the study of the interrelationships between humans, the tools they use, and the environment in which they live and work.*[51]

In the context of this report, a human factors approach is used to understand where and why systems or processes break down. This approach examines the process of error, looking at the causes, circumstances, conditions, associated procedures and devices and other factors connected with the event. Studying human performance can result in the creation of safer systems and the reduction of conditions that lead to errors. However, not all errors are related to human factors. Although equipment and materials should take into account the design of the way people use them, human factors may not resolve instances of equipment breakdown or material failure.

Much of the work in human factors is on improving the human–system interface by designing better systems and processes.[52] This might include, for example, simplifying and standardizing procedures, building in redundancy to provide backup and opportunities for recovery, improving communications and coordination within teams, or redesigning equipment to improve the human–machine interface.

Two approaches have typically been used in human factors analysis. The first is critical incident analysis. Critical incident analysis examines a significant or pivotal occurrence to understand where the system broke down,

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why the incident occurred, and the circumstances surrounding the incident.[53] Analyzing critical incidents, whether or not the event actually leads to a bad outcome, provides an understanding of the conditions that produced an actual error or the risk of error and contributing factors.

In the case study, researchers with expertise in human factors could have helped the team investigate the problem. They could examine how the device performed under different circumstances (e.g., what the alarms and displays did when the medication flow changed), varying the setup and operation of the infusion device to observe how it performed under normal and abnormal conditions. They could observe how the staff used the particular infusion device during surgery and how they interacted with the use of multiple infusion devices.

A critical incident analysis in anesthesia found that human error was involved in 82 percent of preventable incidents. The study identified the most frequent categories of error and the riskiest steps in the process of administering anesthesia. Recommended corrective actions included such things as labeling and packaging strategies to highlight differences among anesthesiologists in the way they prepared their workspace, training issues for residents, work–rest cycles, how relief and replacement processes could be improved, and equipment improvements (e.g., standardizing equipment in terms of the shape of knobs and the direction in which they turn).

Another analytic approach is referred to as "naturalistic decision making."[54] This approach examines the way people make decisions in their natural work settings. It considers all of the factors that are typically controlled for in a laboratory-type evaluation, such as time pressure, noise and other distractions, insufficient information, and competing goals. In this method, the researcher goes out with workers in various fields, such as firefighters or nurses, observes them in practice, and then walks them through to reconstruct various incidents. The analysis uncovers the factors weighed and the processes used in making decisions when faced with ambiguous information under time pressure.

In terms of applying human factors research, David Woods of Ohio State University describes a process of reporting, investigation, innovation, and dissemination (David Woods, personal communication, December 17, 1998). Reporting or other means of identifying errors tells people where

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errors are occurring and where improvements can be made. The investigation stage uses human factors and other analyses to determine the contributing factors and circumstances that created the conditions in which errors could occur. The design of safer systems provides opportunities for innovation and working with early adopters to test out new approaches. Finally, dissemination of innovation throughout the industry shifts the baseline for performance. The experience of the early adopters redefines what is possible and provides models for implementation.

Aviation has long analyzed the role of human factors in performance. The Ames Research Center (part of the National Aeronautics and Space Administration) has examined areas related to information technology, automation, and the use of simulators for training in basic and crisis skills, for example. Other recent projects include detecting and correcting errors in flight; interruptions, distractions and lapses of attention in the cockpit; and designing information displays to assist pilots in maintaining awareness of their situation during flight.[55]

SUMMARY

The following key points can be summarized from this chapter.

1. Some systems are more prone to accidents than others because of the way the components are tied together. Health care services is a complex and technological industry prone to accidents.

2. Much can be done to make systems more reliable and safe. When large systems fail, it is due to multiple faults that occur together.

3. One of the greatest contributors to accidents in any industry including health care, is human error. However, saying that an accident is due to human error is not the same as assigning blame because most human errors are induced by system failures. Humans commit errors for a variety of known and complicated reasons.

4. Latent errors or system failures pose the greatest threat to safety in a complex system because they lead to operator errors. They are failures built into the system and present long before the active error. Latent errors are difficult for the people working in the system to see since they may be hidden in computers or layers of management and people become accustomed to working around the problem.

5. Current responses to errors tend to focus on the active errors. Although this may sometimes be appropriate, in many cases it is not an effec-

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tive way to make systems safer. If latent failures remain unaddressed, their accumulation actually makes the system more prone to future failure. Discovering and fixing latent failures and decreasing their duration are likely to have a greater effect on building safer systems than efforts to minimize active errors at the point at which they occur.

6. The application of human factors in other industries has successfully reduced errors. Health care has to look at medical error not as a special case of medicine, but as a special case of error, and to apply the theory and approaches already used in other fields to reduce errors and improve reliability.[56]

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4
Building Leadership and Knowledge for Patient Safety

Errors in the health care industry are at an unacceptably high level. A national commitment to achieve a threshold improvement in patient safety is needed. This will require strong leadership, specification of goals and mechanisms for tracking progress, and an adequate knowledge base. This chapter proposes the development of the Center for Patient Safety within the Agency for Healthcare Research and Quality (AHRQ) to serve as a focal point for these activities. Experience from other industries suggests that unless a Center is created or designated to keep attention focused on patient safety and enhance the base of knowledge and tools, meaningful progress is not likely. Although existing efforts to improve patient safety are valuable, they are inadequate. There is no way of knowing if these efforts are attending to the most critical issues or if they are actually reducing errors. There must be greater attention placed on evaluating current approaches for reducing errors and building new systems to improve patient safety.

RECOMMENDATIONS

RECOMMENDATION 4.1 Congress should create a Center for Patient Safety with the Agency for Healthcare Research and Quality. This Center should

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- **set the national goals for patient safety, track progress in meeting these goals, and issue an annual report to the President and Congress on patient safety; and**
- **develop knowledge and understanding of errors in health care by developing a research agenda, funding Centers of Excellence, evaluating methods for identifying and preventing errors and funding dissemination and communication activities to improve patient safety.**

National goals for safety should be established through a process involving consumers, providers, health care organizations, purchasers, researchers, and others. The goals should also reflect areas that represent opportunities for significant improvement. In carrying out its activities in the areas of research and dissemination, the Center for Patient Safety should collaborate with universities, research centers, and various groups involved in education and dissemination, such as the National Patient Safety Foundation.

The committee believes that initial annual funding of $30 to 35 million for a Center for Patient Safety would be appropriate. This initial funding would permit a center to conduct activities in goal setting, tracking, research and dissemination. Funding should grow over time to at least $100 million, or approximately 1% of the $8.8 billion in health care costs attributable to preventable adverse events (see Chapter 2). This level is modest compared to the resources devoted to other major health issues. The committee believes a 50% reduction in errors over five years is imperative.

WHY A CENTER FOR PATIENT SAFETY IS NEEDED

As discussed in Chapter 2, errors in health care are a leading cause of death and injury. Yet, the American public is seemingly unaware of the problem, and the issue is not getting the attention it should from leaders in the health care industry and the professions. Additionally, the knowledge that has been used in other industries to improve safety is rarely applied in health care. Although more needs to be learned, there are actions that can be taken today to improve safety in health care. Medical products can be designed to be safer in use, jobs can be designed to minimize the likelihood of errors, and much can be done to reduce the complexity of care processes.

Although multiple agencies are concerned with selected issues that influence patient safety, there is no focal point for patient safety in health care today. Public- and private-sector oversight organizations, such as state licen-

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sure units, accrediting bodies, and federal certification programs devote some attention to patient safety, but patient safety is not their sole focus. The National Patient Safety Foundation conducts educational programs, workshops, and various convening activities but its programs and resources are limited. The Food and Drug Administration (FDA) focuses only on drugs and devices through the regulation of manufacturers. The Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) mission is to improve quality of care through accreditation. This may include issues relevant to patient safety, but patient safety is not its sole focus. Many states operate reporting programs or other oversight programs for patient safety but they take a variety of approaches and focus.

Although anesthesiology applied some of the techniques of system analysis and human factors during the 1980s, the concepts are just beginning to diffuse through the health care industry. The advantage of this lag is that we can learn about building safe systems from the experiences of others. The problem is that there has to be a substantially greater commitment to getting more and better information to advance the science and apply the techniques to health care.

The next section describes how attention to safety issues has been applied in two areas: aviation and occupational health. Both of these examples illustrate how broad-based safety improvements can be accomplished.

HOW OTHER INDUSTRIES HAVE BECOME SAFER

The risk of dying in a domestic jet flight between 1967 and 1976 was 1 in 2 million. By the 1990s, the risk had declined to 1 in 8 million.[1] Between 1970 (when the Occupational Health and Safety Administration was created) and 1996, the workplace death rate was cut in half.[2] Health care has much to learn from other industries about improving safety.

Aviation

Health care is decades behind other industries in terms of creating safer systems. Much of modern safety thinking grew out of military aviation.[3] Until World War II, accidents were viewed primarily as individually caused and safety meant motivating people to "be safe." During the war, generals lost aircraft and pilots in stateside operations and came to realize that planning for safety was as important to the success of a mission as combat planning. System safety continued after the war when several military aviation

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safety centers were formed in the early 1950s. Human factors started to enter the picture at around the same time. In 1954, the Flight Safety Foundation was formed to design aircraft cockpits using better human engineering. In the mid-1960s, the University of Southern California began its first advanced safety management programs and included a heavy emphasis on human factors. By the 1970s, principles of system safety began to spread to other industries, including rapid rail and the oil industry.

Building on the successful experience and knowledge of military aviation, civilian aviation takes a comprehensive approach to safety, with programs aimed at setting and enforcing standards, accident investigation, incident reporting, and research for continuous improvement.

The Federal Aviation Administration (FAA), housed in the Department of Transportation, has regulatory oversight of the industry and an explicit charge for ensuring safety. Accident investigations are conducted by the National Transportation Safety Board (NTSB), an independent federal agency, which has no regulatory or enforcement power but can issue recommendations to the FAA for regulatory action. Confidential incident reporting (defined as an occurrence associated with the operation of an aircraft that affects or could affect the safety of operations) is conducted through the National Aeronautics and Space Administration Aviation Safety Reporting System (ASRS), which is discussed in Chapter 5.

Research into safety is an integral component of the aviation industry strategy. The national research agenda is set through several mechanisms. First, a formal process determined how to allocate approximately $60 million committed to the Aviation Safety Program for FY 2000 (Cynthia Null, Ames Research Center, personal communication, May 24, 1999). Workshops and meetings were held with multiple agencies and organizations to define the work in the specific program area; participants included NASA, FAA, Department of Defense, all levels of airline employees (pilots, maintenance workers, flight attendants, air traffic controllers), airlines, manufacturers, and others. Existing resources are being redirected consistent with the priorities. Other research that supports safety is funded through "base research" in which in-house researchers propose and carry out research projects for development. Research into human factors is part of the base research program.

The Aviation Safety Reporting System may also conduct "topical research," which could include structured callback studies on a certain topic or basic research. This area of work is funded within ASRS's main program, but funding is not often available (Linda Connell, Director of ASRS,

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personal communication, May 20, 1999). Human factors researchers at Ames may also tap into the ASRS database to generate hypotheses which can then be tested through other research.

Finally, the FAA itself maintains several databases that aggregate a variety of statistics (e.g., airline operations such as departures, hours and miles flown, history of safety recommendations to different parts of the industry and responses to them). FAA and NASA coordinate their research efforts to minimize duplication. For example, both agencies may jointly contribute to a single effort, or they may fund different, but complementary, aspects of an issue.

Charles Billings, M.D., designer and founder of the Aviation Safety Reporting System, has stated his belief that aviation would not be as safe as it is today without the FAA.[4] By setting standards, maintaining multiple databases to monitor trends, and supporting research to constantly improve systems, the FAA (in collaboration with other agencies such as NASA and NTSB) has made flying safer.

Occupational Health

The Occupational Safety and Health Act of 1970 created both the Occupational Safety and Health Administration (OSHA), housed in the Department of Labor, and its research arm, the National Institute for Occupational Safety and Health (NIOSH), housed in the Centers for Disease Control and Prevention (CDC) in the Department of Health and Human Services. OSHA's purpose is to encourage employers and employees to reduce workplace hazards and to implement new, or improve existing, safety and health programs. It provides for research in occupational health and safety, maintains reporting and record-keeping systems, establishes training programs, and develops and enforces mandatory standards for job safety and health.[5] OSHA is administered through a combined federal–state approach. States that develop their own programs and have an approved plan receive up to 50 percent of the plan's approved operating costs.

OSHA requires employers with 11 or more employees to routinely maintain records of occupational injury and illness as they occur. These records are not submitted to OSHA, but must be made available during inspection and shared with OSHA if the company is selected for an annual tracking survey. OSHA and the Bureau of Labor and Statistics both conduct sample surveys to collect the routine data maintained by companies. These surveys

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are used to construct population rates or to examine particular issues of concern.

A related incentive for employers to create a safe environment is the worker's compensation program. Under state law, employers must pay the premium for insuring workers against the medical costs of injuries sustained while on the job. Responsibility for the costs associated with workers compensation further encourages employers to improve the safety systems in their companies.

Responsibility for research and for identifying new safety improvements is housed in a separate agency. The National Institute for Occupational Safety and Health (NIOSH) has the responsibility for conducting research and making recommendations for the prevention of work-related illnesses and injuries.[6] It conducts and funds research on safety and health problems, provides technical assistance to OSHA, and recommends standards for OSHA adoption. Although OSHA provides input into the NIOSH research agenda, it is set mainly through input from other stakeholders, including company requests. Information gathered by NIOSH from these companies for research purposes is not shared with OSHA for regulatory purposes.

A major agenda for research was established in 1996 through the National Occupational Research Agenda (NORA). Input was obtained from 500 public and private organizations to provide a framework for safety research during the next decade and to guide intramural and extramural funding decisions. Twenty-one research priorities were selected and are now being implemented, mostly by shifting existing resources so that over time, more monies are directed to the priority areas. For example, in 1998, NIOSH and three institutes at the National Institutes of Health (NIH) committed $24 million over three years to certain priority areas.[7] For 1999, NIOSH's operating budget is $200 million, of which $156 million is for intramural and extramural research projects (Janice Klink, Associate Director for Policy, Planning, and Legislation, NIOSH, personal communication, May 19, 1999).

Lessons Learned

There are several key points to be taken from the experiences in aviation and occupational health. In each of these areas, there was a growing awareness of safety concerns and the need to improve performance. This led to comprehensive strategies, which included the creation of a national focal point for leadership, development of a knowledge base, and dissemination of information throughout the industry.

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In both areas, there is a designated government agency with regulatory responsibility for safety, which is separate from the agency responsible for research. Although the entity responsible for research may generate reports that are useful to the regulatory authority in setting standards, data and information collected from organizations are not available for use in enforcing standards on a particular organization.

Both areas recognized the need to rapidly expand the knowledge base on safety and to establish ongoing processes for the diffusion of this knowledge. The creation of a carefully constructed research agenda was developed with broad-based input from the industry and is implemented through both public- and private-sector programs to draw upon the best expertise in the academic and scientific communities.

Finally, substantial resources were devoted to these initiatives. Achieving steady improvement requires that adequate resources be sustained over a sufficient period of time. The safety improvements did not occur because of a one-time effort. The results were achieved through an ongoing commitment of resources and leadership.

Although some of these components can be found in health care today—regulatory oversight, research and dissemination—there is no cohesive effort to improve safety in health care, and the resources devoted to enhancing and disseminating the knowledge base are wholly inadequate. Given the experience of other industries, health care is not likely to make significant safety improvements without a more comprehensive, coordinated approach.

OPTIONS FOR ESTABLISHING A CENTER FOR PATIENT SAFETY

Objectives

The objectives of a Center for Patient Safety are to provide leadership for safety improvements throughout the industry, to establish goals and track progress in achieving results, and to expand the knowledge base for improving safety in health care.

A central objective of the Center for Patient Safety is to provide visibility to safety concerns. The leadership of the Center must possess the requisite expertise and stature to communicate with a broad audience to raise awareness of safety concerns and convene stakeholders to identify strategies for improving safety.

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Expanding the knowledge base requires the formulation and implementation of a research agenda. Such an agenda should include short-term, focused studies as well as long-term, population studies. Expanding the knowledge base also requires effective methods for diffusing the new knowledge to a variety of audiences, including those in the industry and the general public.

The Center should develop a limited number of high-priority goals based on careful analysis of areas in which improvements will result in the greatest gains in terms of reduced morbidity and mortality and reduced costs. Specific goals identify priority areas for the industry so the industry can respond supportively. Specific goals also provide a basis for tracking change. Safety efforts must be evaluated to determine whether actual improvements are being achieved and to ensure that resources are allocated to high-priority areas that will have the most impact on patients.

Implementation Options

The committee believes that an organization designated as the focal point for patient safety should have the following characteristics. First, it should be involved in a broader agenda for improving quality. Patient safety is part of general quality improvement, even if certain safety problems may utilize distinct knowledge and expertise. It would not be desirable to have one agency focused on quality issues and a separate agency focused on patient safety.

Second, the agency should possess the core competencies required to undertake the broad array of tasks identified. Although some may be carried out through partnership arrangements, the agency should have adequate expertise and funding to engage in strategic planning, convening, tracking, research and evaluation, and information dissemination activities.

Finally, the designated agency should be able to work collaboratively with other health- and non-health-related safety agencies. For example, it should consult with NTSB and ASRS to understand how an entire industry sets safety as a priority and becomes safer over time. Experts from OSHA may also offer guidance on their experience in encouraging companies to build safety systems within their own organizations. Collaboration with the National Patient Safety Foundation might be desirable in carrying out various agenda-setting and education activities.

The committee discussed three alternative organizational arrangements for a Center for Patient Safety. One option considered was the creation of a

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new, free-standing agency whose sole purpose is to focus on patient safety issues. A second alternative was to place such a center within NIH, as a defined division or institute. A third option was to place the proposed Center for Patient Safety within the AHRQ.

The committee decided that placing the Center within AHRQ was the best option for several reasons. Although a dedicated agency might be most able to maintain a focus on patient safety, this option should be pursued as a last resort, given the resources and time required to establish a new agency. NIH has the expertise and industry respect to drive a basic research agenda and has built partnerships with other agencies, but its agenda is already very broad and does not routinely involve analyses of systems of care or quality measurement or improvement.

AHRQ is already involved with a broad range of quality-of-care issues, including quality measurement, quality improvement, and identification of best practices. The Consumer Assessment of Health Plans (CAHPS) is a standardized measurement and reporting tool in which consumers report their experience with specific aspects of their health plans to assess the features that form the basis of overall satisfaction. The goal is to provide consumers and purchasers with objective information for choosing among health plans. Another initiative is the support of evidence-based practice centers. These are five-year contracts awarded to 12 institutions to review scientific literature on assigned clinical care topics and to produce evidence reports and technology assessments, conduct research on methodologies and the effectiveness of their implementation, and participate in technical assistance activities.

AHRQ also is engaged in activities specifically related to patient safety, and these activities constitute a good base of experience upon which to expand. AHRQ has sponsored research in the area of patient safety, specifically in the areas of medication errors, diagnostic inaccuracies, inaccurate information recall by patients, and system failures in adverse drug events.[8] A recent Memorandum of Understanding was executed with the National Institutes on Aging to cofund a grant to examine adverse drug events among a geriatric population in an ambulatory setting. Technologies tested in AHRQ-sponsored research that would improve patient safety include computerized monitoring of adverse drug events, computer-generated reminders for follow-up testing, standardized protocols, and computer-assisted decision making.

A new AHRQ endeavor initiated in 1998 is the establishment of Centers for Education and Research in Therapeutics (CERTs). CERTs will conduct

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research to increase understanding of ways to improve the appropriate and effective use of pharmaceuticals and other interventions to avoid adverse drug events. CERTs will also increase knowledge of the possible risks of new drugs and combinations of drugs, as they are prescribed in everyday practice. CERTs are being implemented in collaboration with FDA.[9]

AHRQ also has experience in collaborating with other relevant organizations. It has provided support for meetings on patient safety and is a member of the National Patient Safety Partnership, a public–private group dedicated to reducing preventable adverse medical events. AHRQ participates in the Quality Interagency Coordinating Committee (QuIC), which is developing an initiative on reducing medical errors. AHRQ also sponsors the User Liaison Program (ULP) as a vehicle to link states, local health policy makers and researchers to disseminate research to states, conduct workshops, and provide technical assistance.[10]

Finally, the agency's reauthorization legislation for FY 2000 is expected to include explicit language defining a focus on reducing medical errors and improving patient safety.

FUNCTIONS OF THE CENTER FOR PATIENT SAFETY

Creating an information infrastructure and building a better evidence base for patient safety are critical to taking a more strategic approach to reducing medical errors and improving patient safety. The goal is to improve decision making by policy makers, regulators, health care organizations, and others, so that decisions are based on evidence rather than anecdote. Good information can and should be used to guide the development and continuous improvement of standards and to support communication and outreach efforts.

The Center for Patient Safety should build an information infrastructure and resource for patient safety. It should have a broad agenda comprised of multiple programs. In its first five full years of existence, it should deliver the following products:

1. Establish a limited set of high-priority goals for improving patient safety based on expert opinion and review of the evidence on errors.
2. Assess progress toward national goals by compiling aggregate information from state adverse event reporting systems, voluntary reporting systems, health care organizations, and other sources; and periodically conducting a representative survey of health care organizations.
3. Develop a research agenda, conduct and fund intramural and extra-

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mural research to assess the magnitude of errors, and the role of human factors, and test and evaluate approaches for preventing errors.

4. Define feasible prototype systems (best practices) and tools for safety in key processes, including both clinical and managerial support systems for:

- medication systems (from prescribing to administering),
- operating rooms and surgery processes,
- emergency departments,
- management of diagnostic tests, screening, and information,
- intensive care units,
- neonatal intensive care units,
- care of frail elderly (e.g., falls, decubitus, etc.),
- the use of simulation and simulators in health care, and
- team training and crew resource management applications in health care.

5. Develop instructional methods, demonstration projects, and technical support to ensure widespread implementation of the prototype systems and tools identified above.

6. Conduct periodic evaluations of error reporting systems for two purposes: assessing the impact of mandatory reporting systems in various states and identifying best practices in program design and implementation; and assessing the usefulness of voluntary reporting systems in identifying important safety improvements and determining whether current levels of participation by health care organizations are adequate or additional incentives are needed.

7. Provide support to health care organizations for internal quality improvement demonstration projects to prevent and reduce errors.

8. Develop tools and methods for educating consumers about patient safety.

9. Issue an annual report on progress made to improve patient safety, and recommend changes for continuously improving patient safety to appropriate parties, such as FDA, states, accrediting agencies, professional associations, group purchasers, and health care organizations.

In setting the research agenda, the Center for Patient Safety should establish a formal process to gather input on priorities, methodologies and approaches for research. Advice should be obtained from a wide range of people and organizations who will use and can benefit from the availability of information. It should look at the experiences of other industries and the

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processes they employed, such as aviation and occupational health, as already described. Initial areas for attention might include the following:

- enhance understanding of the impact of various management practices (e.g., maximum work hours and overtime) on the likelihood of errors;
- apply safety methods and technologies from other industries to health care, especially human factors and engineering principles;
- increase understanding of errors in different settings (e.g., ambulatory or home care) and for vulnerable populations (e.g., children, elderly);
- establish baseline rates of specific types of errors and monitor trends;
- monitor error rates that accompany the introduction of new technologies; and
- increase understanding of the use of information technology to improve patient safety (e.g., automated drug order or entry systems, reminder systems).

In conducting research and developing prototype systems, the Center should consider providing support for the establishment of several Centers of Excellence in academic or applied research settings and which can gather expertise from diverse settings as needed. Centers of Excellence might focus on particular types of errors (e.g., medication-related errors), errors in particular settings or clinical specialties (e.g., intensive care), or types of interventions or strategies that might be applied across many areas and settings (e.g., interdisciplinary teams).

In establishing Centers of Excellence, the Center for Patient Safety will want to learn from and coordinate with the Veterans Health Administration (VHA), which has pursued a similar strategy on a much smaller scale. As part of its comprehensive program in improving patient safety throughout their delivery system, the Veterans Health Administration has committed $6 million to establish four Patient Safety Centers of Inquiry, focused on researching new knowledge in patient safety, with special emphasis on transferring safety technologies from other high-risk industries to health care, and on disseminating existing knowledge.[11]

It is also imperative that the Center for Patient Safety focus adequate attention on the communication of information on and knowledge of patient safety. The support and production of more and better information on medical errors and patient safety will be of little use without explicit mechanisms identified for dissemination of the information and recommended actions. Although dissemination of information is sometimes an afterthought, there are attributes that can improve outreach. Important factors that have

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been identified are translating raw data into summary measures and information that can be used; presenting information in formats that are tailored to different audiences; and providing multiple ways to access the information, such as print, television, radio, videotaped presentations, online services, and face-to-face presentations. The information also needs to be timely and to come from a credible source.[12]

At the present time, there are few objective sources for the latest information on patient safety. Improvements may be made in practice within health care organizations, but there is no way to disseminate such information to a broader audience. An important responsibility of the Center for Patient Safety should be to work to increase the frequency of communication about patient safety to multiple audiences. In carrying out its responsibilities to communicate information and knowledge on safety, the Center should work closely with existing organizations that have related objectives, including public and private organizations; policy, educational and accrediting entities; and quality oversight organizations.

The National Patient Safety Foundation (NPSF) is an existing organization that may be able to serve this resource and dissemination role. The National Patient Safety Foundation was formed by the American Medical Association in 1997 as an independent, nonprofit research and education organization, whose mission is to improve patient safety in the delivery of care. The AMA's goal was to establish linkages with other health care organizations dedicated to improving patient safety.

NPSF is well positioned to "translate" concerns and findings about patient safety between many different parties because of the broad base of representation on its board that can communicate with various constituencies and its proven ability to convene a mix of stakeholders. NPSF's core strategies include activities to raise awareness and foster communication and dialogue to enhance patient safety and to develop information, collaborative relationships, and educational approaches that advance patient safety.[13] It supports an annual grant program for innovative research to prevent patient injuries; has conducted a benchmark survey to capture consumer attitudes, experience and expectations about health care safety; conducts regional forums to bring together community and health leaders in local communities and convenes national conferences that brings together leaders in patient safety from around the world.[14] NPSF has also begun developing a clearinghouse function to collect patient safety information that can be accessed by both health professionals and consumers.

The National Patient Safety Partnership is a voluntary public–private partnership, comprised of the American Hospital Association, American

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Medical Association (AMA), American Nurses Association, Association of American Medical Colleges, JCAHO, National Patient Safety Foundation of the AMA, and Department of Veterans Affairs as charter members. Additional members include AHRQ, FDA, HCFA, NIOSH, and the Department of Defense, Health Affairs. Its primary concerns have focused on year 2000 (Y2K) issues and adverse drug events.[15]

The deliverables previously identified for the Center for Patient Safety include the development of tools and methods for educating consumers about patient safety. Although consumers are an important audience, there are many other constituencies that must be reached, including health professionals and managers, health care organizations, state and national policy makers, regulators, pharmaceutical companies and medical device manufacturers, professional groups and associations, medical and health care training centers, and various forms of media. Although AHRQ and the Center for Patient Safety will disseminate their work on patient safety through current mechanisms (e.g., reports, newsletters, Internet), the NPSF and the National Patient Safety Partnership are existing organizations that can support a broad approach for dissemination activities.

RESOURCES REQUIRED FOR A CENTER FOR PATIENT SAFETY

In determining what would be an adequate level of funding for a Center for Patient Safety, the committee considered three things: (1) research investments made to address health care issues of a similar magnitude; (2) investments in safety research in other industries; and (3) operating budgets for research initiatives with similar programs.

The United States invests significant resources in research to reduce the morbidity and mortality associated with various diseases and health concerns. As noted in Chapter 2, medical errors among hospitalized patients ranks as a leading cause of death, exceeding the number of deaths in 1997 due to motor vehicle accidents, breast cancer, or AIDS. NIH funding in 1998 for AIDS was estimated at $1.6 billion and for breast cancer, $433 million.[16] Another funding comparison in health care is to examine research centers that have a more focused agenda. The National Institute for Deafness and Other Communication Disorders has funding of approximately $230 million in FY99.[17] The National Institute of Nursing Research received funding of approximately $63 million in FY99.[18] These are examples of "smaller" institutes at NIH.

The success of other industries in improving safety is undoubtedly at-

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tributable in part to the commitment made to enhancing the knowledge base. As noted previously, the NIOSH operating budget for 1999 is $200 million, of which $156 million is for intramural and extramural research projects. The Aviation Safety Program at NASA Ames Research Center allocated approximately $60 million for FY 2000.

Another funding comparison is the resources devoted by AHRQ to different programs. In FY 1999, $2 million was appropriated for the CERTs, newly established research centers; twice that amount is expected for FY 2000 to continue funding.[19] The Evidence-Based Practice Centers at AHRQ are funded at more than $3 million per year (Nancy Foster, AHRQ, personal communication, July 22, 1999). AHRQ also conducts a Medical Expenditure Panel Survey for which almost $35 million was appropriated in FY 1999.[20]

Finally, the Veterans Health Administration created several centers within its own system devoted to research and improved understanding about medical errors. It committed $6 million over 4 years.

Initial annual funding of $30 to 35 million for the Center for Patient Safety would be reasonable. This estimate is based on the functions that the center is to perform. Goal setting would involve convening a broad set of audiences for input into goals and a research agenda. Regional meetings and other mechanisms may be employed to gather input. It is estimated that approximately $2 million would be needed for goal setting activities. Tracking progress on meeting goals would require periodic data collection from health care organizations. The Harvard Medical Practice Study reviewed over 31,000 hospital records and cost approximately $3 million. The development and implementation of a national survey is estimated at $5 million. To implement a research agenda, it is estimated that five Centers of Excellence would be formed, each with a specific focus of attention. Each Center of Excellence should be initially funded at $5 million, growing over time to $15 million each. Dissemination of information to the industry, general public, policy makers and others is estimated initially at $5 million. The estimate of initial funding seems modest in light of the investments made to address health concerns of similar magnitude.

The committee believes that the growth in the funding level is necessary to communicate to researchers, states, professional groups and health care organizations that this will be a sustained effort. In the absence of a significant long term commitment to funding, researchers are unlikely to re-orient their focus to patient safety. The patient safety initiatives of other groups, such as states, professional associations and health care organizations are likely to be far more successful if accompanied by a steady flow of new

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knowledge, tools, and prototype systems. It can take several years to create awareness about safety and build interest. The growth in funding recognizes that initial funding should be at a lower, but sufficient, level to begin work in the area, but should grow over time as the efforts evolve and expand.

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5 Error Reporting Systems

Although the previous chapter talked about creating and disseminating new knowledge to prevent errors from ever happening, this chapter looks at what happens after an error occurs and how to learn from errors and prevent their recurrence. One way to learn from errors is to establish a reporting system. Reporting systems have the potential to serve two important functions. They can hold providers accountable for performance or, alternatively, they can provide information that leads to improved safety. Conceptually, these purposes are not incompatible, but in reality, they can prove difficult to satisfy simultaneously.

Reporting systems whose primary purpose is to hold providers accountable are "mandatory reporting systems." Reporting focuses on errors associated with serious injuries or death. Most mandatory reporting systems are operated by state regulatory programs that have the authority to investigate specific cases and issue penalties or fines for wrong-doing. These systems serve three purposes. First, they provide the public with a minimum level of protection by assuring that the most serious errors are reported and investigated and appropriate follow-up action is taken. Second, they provide an incentive to health care organizations to improve patient safety in order to avoid the potential penalties and public exposure. Third, they require all health care organizations to make some level of investment in patient safety, thus creating a more level playing field. While safety experts recognize that

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errors resulting in serious harm are the "tip of the iceberg," they represent the small subset of errors that signal major system breakdowns with grave consequences for patients.

Reporting systems that focus on safety improvement are "voluntary reporting systems." The focus of voluntary systems is usually on errors that resulted in no harm (sometimes referred to as "near misses") or very minimal patient harm. Reports are usually submitted in confidence outside of the public arena and no penalties or fines are issued around a specific case. When voluntary systems focus on the analysis of "near misses," their aim is to identify and remedy vulnerabilities in systems before the occurrence of harm. Voluntary reporting systems are particularly useful for identifying types of errors that occur too infrequently for an individual health care organization to readily detect based on their own data, and patterns of errors that point to systemic issues affecting all health care organizations.

The committee believes that there is a need for both mandatory and voluntary reporting systems and that they should be operated separately. Mandatory reporting systems should focus on detection of errors that result in serious patient harm or death (i.e., preventable adverse events). Adequate attention and resources must be devoted to analyzing reports and taking appropriate follow-up action to hold health care organizations accountable. The results of analyses of individual reports should be made available to the public.

The continued development of voluntary reporting efforts should also be encouraged. As discussed in Chapter 6, reports submitted to voluntary reporting systems should be afforded legal protections from data discoverability. Health care organizations should be encouraged to participate in voluntary reporting systems as an important component of their patient safety programs.

For either type of reporting program, implementation without adequate resources for analysis and follow-up will not be useful. Receiving reports is only the first step in the process of reducing errors. Sufficient attention must be devoted to analyzing and understanding the causes of errors in order to make improvements.

RECOMMENDATIONS

RECOMMENDATION 5.1 A nationwide mandatory reporting system should be established that provides for the collection of standardized information by state governments about adverse events that result in death or serious harm. Reporting should initially be required

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of hospitals and eventually be required of other institutional and ambulatory care delivery settings. Congress should

- **designate the National Forum for Health Care Quality Measurement and Reporting as the entity responsible for promulgating and maintaining a core set of reporting standards to be used by states, including a nomenclature and taxonomy for reporting;**
- **require all health care organizations to report standardized information on a defined list of adverse events;**
- **provide funds and technical expertise for state governments to establish or adapt their current error reporting systems to collect the standardized information, analyze it and conduct follow-up action as needed with health care organizations. Should a state choose not to implement the mandatory reporting system, the Department of Health and Human Services should be designated as the responsible entity; and designate the Center for Patient Safety to:**

(1) convene states to share information and expertise, and to evaluate alternative approaches taken for implementing reporting programs, identify best practices for implementation, and assess the impact of state programs; and
(2) receive and analyze aggregate reports from states to identify persistent safety issues that require more intensive analysis and/or a broader-based response (e.g., designing prototype systems or requesting a response by agencies, manufacturers or others).

Mandatory reporting systems should focus on the identification of serious adverse events attributable to error. Adverse events are deaths or serious injuries resulting from a medical intervention.[1] Not all, but many, adverse events result from errors. Mandatory reporting systems generally require health care organizations to submit reports on all serious adverse events for two reasons: they are easy to identify and hard to conceal. But it is only after careful analysis that the subset of reports of particular interest, namely those attributable to error, are identified and follow-up action can be taken.

The committee also believes that the focus of mandatory reporting system should be narrowly defined. There are significant costs associated with reporting systems, both costs to health care organizations and the cost of operating the oversight program. Furthermore, reporting is useful only if it includes analysis and follow-up of reported events. A more narrowly defined program has a better chance of being successful.

A standardized reporting format is needed to define what ought to be

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reported and how it should be reported. There are three purposes to having a standardized format. First, a standardized format permits data to be combined and tracked over time. Unless there are consistent definitions and methods for data collection across organizations, the data cannot be aggregated. Second, a standardized format lessens the burden on health care organizations that operate in multiple states or are subject to reporting requirements of multiple agencies and/or private oversight processes and group purchasers. Third, a standardized format facilitates communication with consumers and purchasers about patient safety.

The recently established National Forum for Health Care Quality Measurement and Reporting is well positioned to play a lead role in promulgating standardized reporting formats, including a nomenclature and taxonomy for reporting. The Forum is a public/private partnership charged with developing a comprehensive quality measurement and public reporting strategy. The existing reporting systems (i.e., national and state programs, public and private sector programs) also represent a growing body of expertise on how to collect and analyze information about errors, and should be consulted during this process.[2]

RECOMMENDATION 5.2 The development of voluntary reporting efforts should be encouraged. The Center for Patient Safety should

- **describe and disseminate information on existing voluntary reporting programs to encourage greater participation in them and track the development of new reporting systems as they form;**
- **convene sponsors and users of external reporting systems to evaluate what works and what does not work well in the programs, and ways to make them more effective;**
- **periodically assess whether additional efforts are needed to address gaps in information to improve patient safety and to encourage health care organizations to participate in voluntary reporting programs; and**
- **fund and evaluate pilot projects for reporting systems, both within individual health care organizations and collaborative efforts among health care organizations.**

Voluntary reporting systems are an important part of an overall program for improving patient safety and should be encouraged. Accrediting bodies and group purchasers should recognize and reward health care organizations that participate in voluntary reporting systems.

The existing voluntary systems vary in scope, type of information col-

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lected, confidentiality provisions, how feedback to reporters is fashioned, and what is done with the information received in the reports. Although one of the voluntary medication error reporting systems has been in operation for 25 years, others have evolved in just the past six years. A concerted analysis should assess which features make the reporting system most useful, and how the systems can be made more effective and complementary.

The remainder of this chapter contains a discussion of existing error reporting systems, both within health care and other industries, and a discussion of the committee's recommendations.

REVIEW OF EXISTING REPORTING SYSTEMS IN HEALTH CARE

There are a number of reporting systems in health care and other industries. The existing programs vary according to a number of design features. Some programs mandate reporting, whereas others are voluntary. Some programs receive reports from individuals, while others receive reports from organizations. The advantage of receiving reports from organizations is that it signifies that the institution has some commitment to making corrective system changes. The advantage of receiving reports from individuals is the opportunity for input from frontline practitioners. Reporting systems can also vary in their scope. Those that currently exist in health care tend to be more narrow in focus (e.g., medication-related error), but there are examples outside health care of very comprehensive systems.

There appear to be three general approaches taken in the existing reporting systems. One approach involves mandatory reporting to an external entity. This approach is typically employed by states that require reporting by health care organizations for purposes of accountability. A second approach is voluntary, confidential reporting to an external group for purposes of quality improvement (the first model may also use the information for quality improvement, but that is not its main purpose). There are medication reporting programs that fall into this category. Voluntary reporting systems are also used extensively in other industries such as aviation. The third approach is mandatory internal reporting with audit. For example, the Occupational Safety and Health Administration (OSHA) requires organizations to keep data internally according to a standardized format and to make the data available during on-site inspections. The data maintained internally are not routinely submitted, but may be submitted if the organization is selected in the sample of an annual survey.

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The following sections provide an overview of existing health care reporting systems in these categories. They also include two examples from areas outside health care. The Aviation Safety Reporting System is discussed because it represents the most sophisticated and long-standing voluntary external reporting system. It differs from the voluntary external reporting systems in health care because of its comprehensive scope. Since there are currently no examples of mandatory internal reporting with audit, the characteristics of the OSHA approach are described.

Mandatory External Reporting

State Adverse Event Tracking

In a recent survey of states conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), it was found that at least one-third of states have some form of adverse event reporting system.[3] It is likely that the actual percentage is higher because not all states responded to the survey and some of the nonrespondents may have reporting requirements. During the development of this report, the Institute of Medicine (IOM) interviewed 13 states with reporting systems to learn more about the scope and operation of their programs. The remainder of this section relates to information provided to the IOM. Appendix D summarizes selected characteristics of the reporting systems in these states, and includes information on what is reported to the state, who is required to submit reports, the number of reports received in the most recent year available, when the program began, who has access to the information collected and how the state uses the information that is obtained. This is not intended as a comprehensive review, but rather, as an overview of how some state reporting systems are designed.

States have generally focused their reporting systems on patient injuries or facility issues (e.g., fire, structural issues). Reports are submitted by health care organizations, mostly hospitals and/or nursing homes, although some states also include ambulatory care centers and other licensed facilities. Although the programs may require reporting from a variety of licensed facilities, nursing homes often consume a great deal of state regulatory attention. In Connecticut, 14,000 of almost 15,000 reports received in 1996 were from nursing homes.

Several of the programs have been in place for ten years or longer, although they have undergone revisions since their inception. For example,

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New York State's program has been in place since 1985, but it has been reworked three times, the most recent version having been implemented in 1998 after a three-year pilot test.

Underreporting is believed to plague all programs, especially in their early years of operation. Colorado's program received 17 reports in its first two years of operation,[4] but ten years later, received more than 1000 reports. On the other hand, New York's program receives approximately 20,000 reports annually.

The state programs reported that they protected the confidentiality of certain data, but policies varied. Patient identifiers were never released; practitioner's identity was rarely available. States varied in whether or not the hospital's name was released. For example, Florida is barred from releasing any information with hospital or patient identification; it releases only a statewide summary.

The submission of a report itself did not trigger any public release of information. Some states posted information on the Internet, but only after the health department took official action against the facility. New York has plans to release hospital-specific aggregate information (e.g., how many reports were submitted), but no information on any specific report.

Few states aggregate the data or analyze them to identify general trends. For the most part, analysis and follow-up occurs on a case-by-case basis. For example, in some states, the report alerted the health department to a problem; the department would assess whether or not to conduct a follow-up inspection of the facility. If an inspection was conducted, the department might require corrective action and/or issue a deficiency notice for review during application for relicensure.

Two major impediments to making greater use of the reported data were identified: lack of resources and limitations in data. Many states cited a lack of resources as a reason for conducting only limited analysis of data. Several states had, or were planning to construct a database so that information could be tracked over time but had difficulty getting the resources or expertise to do so. Additionally, several states indicated that the information they received in reports from health care organizations was inadequate and variable. The need for more standardized reporting formats was noted.

A focus group was convened with representatives from approximately 20 states at the 12th Annual conference of the National Academy of State Health Policy (August 2, 1999). This discussion reinforced the concerns heard in IOM's telephone interviews. Resource constraints were identified, as well as the need for tools, methods, and protocols to constructively address the issue. The group also identified the need for mechanisms to im-

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prove the flow of information between the state, consumers, and providers to encourage safety and quality improvements. The need for collaboration across states to identify and promote best practices was also highlighted. Finally, the group emphasized the need to create greater awareness of the problem of patient safety and errors in health care among the general public and among health care professionals as well.

In summary, the state programs appear to provide a public response for investigation of specific events,[5] but are less successful in synthesizing information to analyze where broad system improvements might take place or in communicating alerts and concerns to other institutions. Resource constraints and, in some cases, poorly specified reporting requirements contribute to the inability to have as great an impact as desired.

Food and Drug Administration (FDA)

Reports submitted to FDA are one part of the surveillance system for monitoring adverse events associated with medical products after their approval (referred to as postmarketing surveillance).[6] Reports may be submitted directly to FDA or through MedWatch, FDA's reporting program. For medical devices, manufacturers are required to report deaths, serious injuries, and malfunctions to FDA. User facilities (hospitals, nursing homes) are required to report deaths to the manufacturer and FDA and to report serious injuries to the manufacturer. For suspected adverse events associated with drugs, reporting is mandatory for manufacturers and voluntary for physicians, consumers, and others. FDA activities are discussed in greater detail in Chapter 7.

Voluntary External Reporting

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

JCAHO initiated a sentinel event reporting system for hospitals in 1996 (see Chapter 7 for a discussion on JCAHO activities related to accreditation). For its program, a sentinel event is defined as an "unexpected occurrence or variation involving death or serious physical or psychological injury or the risk thereof." Sentinel events subject to reporting are those that have resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition, or an event that meets one of the following criteria (even if the outcome was

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not death or major permanent loss of function): suicide of a patient in a setting where the patient receives around-the-clock care; infant abduction or discharge to the wrong facility; rape; hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities; or surgery on the wrong patient or wrong body part.[7]

The Joint Commission requires that an organization experiencing a sentinel event conduct a root cause analysis, a process for identifying the basic or causal factors of the event. A hospital may voluntarily report an incident to JCAHO and submit their root cause analysis (including actions for improvement). If an organization experiences a sentinel event but does not voluntarily report it and JCAHO discovers the event (e.g., from the media, patient report, employee report), the organization is still required to prepare an acceptable root cause analysis and action plan. If the root cause analysis and action plan are not acceptable, the organization may be placed on accreditation watch until an acceptable plan is prepared. Root cause analyses and action plans are confidential; they are destroyed after required data elements have been entered into a JCAHO database to be used for tracking and sharing risk reduction strategies.

JCAHO encountered some resistance from hospitals when it introduced the sentinel event reporting program and is still working through the issues today. Since the initiation of the program in 1996, JCAHO has changed the definition of a sentinel event to add more detail, instituted procedural revisions on reporting, authorized on-site review of root cause analyses to minimize risk of additional liability exposure, and altered the procedures for affecting a facility's accreditation status (and disclosing this change to the public) while an event is being investigated.[8] However, concerns remain regarding the confidentiality of data reported to JCAHO and the extent to which the information on a sentinel event is no longer protected under peer review if it is shared with JCAHO (these issues are discussed in Chapter 6).

There is the potential for cooperation between the JCAHO sentinel event program and state adverse event tracking programs. For example, JCAHO is currently working with New York State so that hospitals that report to the state's program are considered to be in compliance with JCAHO's sentinel events program.[9] This will reduce the need for hospitals to report to multiple groups with different requirements for each. The state and JCAHO are also seeking to improve communications between the two organizations before and after hospitals are surveyed for accreditation.

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Medication Errors Reporting (MER) Program

The MER program is a voluntary medication error reporting system originated by the Institute for Safe Medication Practice (ISMP) in 1975 and administered today by U.S. Pharmacopeia (USP). The MER program receives reports from frontline practitioners via mail, telephone, or the Internet. Information is also shared with the FDA and the pharmaceutical companies mentioned in the reports. ISMP also publishes error reports received from USP in 16 publications every month and produces a biweekly publication and periodic special alerts that go to all hospitals in the United States. The MER program has received approximately 3,000 reports since 1993, primarily identifying new and emerging problems based on reports from people on the frontline.

MedMARx from the U.S. Pharmacopoeia

In August 1998, U.S. Pharmacopeia initiated the MedMARx program, an Internet-based, anonymous, voluntary system for hospitals to report medication errors. Hospitals subscribe to the program. Hospital employees may then report a medication error anonymously to MedMARx by completing a standardized report. Hospital management is then able to retrieve compiled data on its own facility and also obtain nonidentified comparative information on other participating hospitals. All information reported to MedMARx remains anonymous. All data and correspondence are tied to a confidential facility identification number. Information is not shared with FDA at this time. The JCAHO framework for conducting a root cause analysis is on the system for the convenience of reporters to download the forms, but the programs are not integrated.

Aviation Safety Reporting System at NASA

The three voluntary reporting systems described above represent focused initiatives that apply to a particular type of organization (e.g., hospital) or particular type of error (e.g., medication error). The Aviation Safety Reporting System (ASRS) is a voluntary, confidential incident reporting system used to identify hazards and latent system deficiencies in order to eliminate or mitigate them.[10] ASRS is described as an example of a comprehensive voluntary reporting system.

ASRS receives "incident" reports, defined as an occurrence associated

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with the operation of an aircraft that affects or could affect the safety of operations. Reports into ASRS are submitted by individuals confidentially. After any additional information is obtained through follow-up with reporters, the information is maintained anonymously in a database (reports submitted anonymously are not accepted). ASRS is designed to capture near misses, which are seen as fruitful areas for designing solutions to prevent future accidents.

The National Transportation Safety Board (NTSB) investigates aviation accidents. An "accident" is defined as an occurrence that results in death or serious injury or in which the aircraft receives substantial damage. NTSB was formed in 1967 and ASRS in 1976. The investigation of accidents thus preceded attention to near misses.

ASRS operates independently from the Federal Aviation Administration (FAA). It was originally formed under FAA, but operations were shifted to the National Aeronautics and Space Administration (NASA) because of the reluctance of pilots to report incidents (as differentiated from accidents) to a regulatory authority. FAA funds the ASRS, but NASA administers and manages the program independently. ASRS has no regulatory or enforcement powers over civil aviation.

ASRS issues alerts to the industry on hazards it identifies as needed (e.g., ASRS does not go through a regulatory agency to issue an alert or other communication; Linda Connell, Director of ASRS, personal communication, May 20, 1999). If a situation is very serious, it may issue an alert after only one incident. Often, ASRS has received multiple reports and noted a pattern. The purpose of ASRS alerts and other communications is to notify others of problems. Alerts may be disseminated throughout the industry and may also be communicated to the FAA to notify them about areas that may require action. ASRS does not propose or advocate specific solutions because it believes this would interfere with its role as an "honest broker" for reporters. As a result, although some reported problems may be acted upon, others are not. For example, ASRS has been notifying FAA and the industry about problems that have persisted throughout its 23-year history, such as problems with call signs. To date, no agency has been able to a find permanent solution. However, ASRS continues to issue alerts about the problem to remind people that the problem has not been solved.

ASRS maintains a database on reported incidents, identifies hazards and patterns in the data, conducts analyses on types of incidents, and interviews reporters when indicated. It sends out alert messages, publishes a monthly safety bulletin that is distributed to 85,000 readers and produces a semi-

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annual safety topics publication targeted to the operators and flight crews of complex aircraft. Quick-response studies may be conducted for NTSB and FAA as needed (e.g., if an accident occurred, they may look for similar incidents). ASRS receives over 30,000 reports annually and has an operating budget of approximately $2 million.[11]

A more recent program is the Aviation Safety Action Programs. The de-identification of reports submitted to ASRS means that organizations do not have access to reports that identify problems in their own operations. In 1997, FAA established a demonstration program for the creation of Aviation Safety Action Programs (ASAP).[12] Under ASAP, an employee may submit a report on a serious incident that does not meet the threshold of an accident to the airline and the FAA with pilot and flight identification. Reports are reviewed at a regular meeting of an event review committee that includes representatives from the employee group, FAA and the airline. Corrective actions are identified as needed.

Mandatory Internal Reporting with Audit

Occupational Safety and Health Administration

OSHA uses a different approach for reporting than the systems already described. It requires companies to keep internal records of injury and illness, but does not require that the data be routinely submitted. The records must be made available during on-site inspections and may be required if the company is included in an annual survey of a sample of companies.[13] OSHA and the Bureau of Labor Statistics both conduct sample surveys and collect the routine data maintained by the companies. These agencies conduct surveys to construct incidence rates on worksite illness and injury that are tracked over time or to examine particular issues of concern, such as a certain activity.

Employers with 11 or more employees must routinely maintain records of occupational injury and illness as they occur. Employees have access to a summary log of the injury and illness reports, and to copies of any citations issued by OSHA. Citations must be posted for three days or until the problem is corrected, whichever is longer. Companies with ten or fewer employers are exempt from keeping such records unless they are selected for an annual survey and are required to report for that period. Some industries, although required to comply with OSHA rules, are not subject to record-keeping requirements (including some retail, trade, insurance, real estate,

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and services). However, they must still report the most serious accidents (defined as an accident that results in at least one death or five or more hospitalizations).

Key Points from Existing Reporting Systems

There are a number of ways that reporting systems can contribute to improving patient safety. Good reporting systems are a tool for gathering sufficient information about errors from multiple reporters to try to understand the factors that contribute to them and subsequently prevent their recurrence throughout the health care system. Feedback and dissemination of information can create an awareness of problems that have been encountered elsewhere and an expectation that errors should be fixed and safety is important. Finally, a larger-scale effort may improve analytic power by increasing the number of "rare" events reported. A serious error may not occur frequently enough in a single entity to be detected as a systematic problem; it is perceived as a random occurrence. On a larger scale, a trend may be easier to detect.

Reporting systems are particularly useful in their ability to detect unusual events or emerging problems.[14] Unusual events are easier to detect and report because they are rare, whereas common events are viewed as part of the "normal" course. For example, a poorly designed medical device that malfunctions routinely becomes viewed as a normal risk and one that practitioners typically find ways to work around. Some common errors may be recognized and reported, but many are not. Reporting systems also potentially allow for a fast response to a problem since reports come in spontaneously as an event occurs and can be reacted to quickly.

Two challenges that confront reporting systems are getting sufficient participation in the programs and building an adequate response system. All reporting programs, whether mandatory or voluntary, are perceived to suffer from underreporting. Indeed, some experts assert that all reporting is fundamentally voluntary since even mandated reporting can be avoided.[15] However, some mandatory programs receive many reports and some voluntary programs receive fewer reports. New York's mandatory program receives an average of 20,000 reports annually, while a leading voluntary program, the MER Program, has received approximately 3,000 reports since 1993. Reporting adverse reactions to medications to FDA is voluntary for practitioners, and they are not subject to FDA regulation (so the report is not going to an authority that can take action against them). Yet, underreporting is still perceived.[16] Of the approximately 235,000 reports received

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annually at FDA, 90 percent come from manufacturers (although practitioners may report to the manufacturers who report to FDA). Only about 10 percent are reported directly through MedWatch, mainly from practitioners.

The volume of reporting is influenced by more factors than simply whether reporting is mandatory or voluntary. Several reasons have been suggested for underreporting. One factor is related to confidentiality. As already described, many of the states contacted faced concerns about confidentiality, and what information should be released and when. Although patients were never identified, states varied on whether to release the identity of organizations. They were faced with having to balance the concerns of health care organizations to encourage participation in the program and the importance of making information available to protect and inform consumers. Voluntary programs often set up special procedures to protect the confidentiality of the information they receive. The issue of data protection and discoverability is discussed in greater detail in Chapter 6.

Another set of factors that affects the volume of reports relates to reporter perceptions and abilities. Feedback to reporters is believed to influence participation levels.[17] Belief by reporters that the information is actually used assures them that the time taken to file a report is worthwhile. Reporters need to perceive a benefit for reporting. This is true for all reporting systems, whether mandatory or voluntary. Health care organizations that are trained and educated in event recognition are also more likely to report events.[18] Clear standards, definitions, and tools are also believed to influence reporting levels. Clarity and ease helps reporters know what is expected to be reported and when. One experiment tried paying for reporting. This increased reporting while payments were provided, but the volume was not sustained after payments stopped.[19]

Although some reporting systems that focus on adverse events, such as hospital patients experiencing nosocomial infections, are used to develop incidence rates and track changes in these rates over time, caution must be exercised when calculating rates from adverse event reporting systems for several reasons. Many reporting systems are considered to be "passive" in that they rely on a report being submitted by someone who has observed the event.[20] "Active" systems work with participating health care organizations to collect complete data on an issue being tracked to determine rates of an adverse event[21] (e.g., the CDC conducted an active surveillance study of vaccine events with four HMOs linking vaccination records with hospital admission records[22]).

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The low occurrence of serious errors can also produce wide variations in frequency from year to year. Some organizations and individuals may routinely report more than others, either because they are more safety conscious or because they have better internal systems.[23] Certain characteristics of medical processes may make it difficult to identify an adverse event, which can also lead to variation in reporting. For example, adverse drug events are difficult to detect when they are widely separated in time from the original use of the drug or when the reaction occurs commonly in an unexposed population.[24] These reasons make it difficult to develop reliable rates from reporting systems, although it may be possible to do so in selected cases. However, even without a rate, repetitive reports flag areas of concern that require attention.

It is important to note, however, that the goal of reporting programs is not to count the number of reports. The volume of reports by itself does not indicate the success of a program. Analyzing and using the information they provide and attaching the right tools, expertise and resources to the information contained in the reports helps to correct errors. Medication errors are heavily monitored, by several public and private reporting systems, some of which afford anonymous reporting. It is possible for a practitioner to voluntarily and confidentially report a medication error to the FDA or to private systems (e.g., MER program, MedMARx). Some states with mandatory reporting may also receive reports of medication-related adverse events. Yet, some medication problems continue to occur, such as unexpected deaths from the availability of concentrated potassium chloride on patient care units.[25]

Reporting systems without adequate resources for analysis and follow-up action are not useful. Reporting without analysis or follow-up may even be counterproductive in that it weakens support for constructive responses and is viewed as a waste of resources. Although exact figures are not available, it is generally believed that the analysis of reports is harder to do, takes longer and costs more than data collection. Being able to conduct good analyses also requires that the information received through reporting systems is adequate. People involved in the operation of reporting systems believe it is better to have good information on fewer cases than poor information on many cases. The perceived value of reports (in any type of reporting system) lies in the narrative that describes the event and the circumstances under which it occurred. Inadequate information provides no benefit to the reporter or the health system.

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DISCUSSION OF COMMITTEE RECOMMENDATIONS

Reporting systems may have a primary focus on accountability or on safety improvement. Design features vary depending on the primary purpose. Accountability systems are mandatory and usually receive reports on errors that resulted in serious harm or death; safety improvement systems are generally voluntary and often receive reports on events resulting in less serious harm or no harm at all. Accountability systems tend to receive reports from organizations; safety improvement systems may receive reports from organizations or frontline practitioners. Accountability systems may release information to the public; safety improvement systems are more likely to be confidential.

Figure 5.1 presents a proposed hierarchy of reporting, sorting potential errors into two categories: (1) errors that result in serious injury or death (i.e., serious preventable adverse events), and (2) lesser injuries or noninjurious events (near-misses).[26] Few errors cause serious harm or death; that is the tip of the triangle. Most errors result in less or no harm, but may represent early warning signs of a system failure with the potential to cause serious harm or death.

The committee believes that the focus of mandatory reporting systems should be on the top tier of the triangle in Figure 5.1. Errors in the lower tier are issues that might be the focus of voluntary external reporting systems, as well as research projects supported by the Center for Patient Safety and internal patient safety programs of health care organizations. The core reporting formats and measures promulgated by the National Forum for Health Care Quality Measurement and Reporting should focus first on the top tier. Additional standardized formats and measures pertaining to other

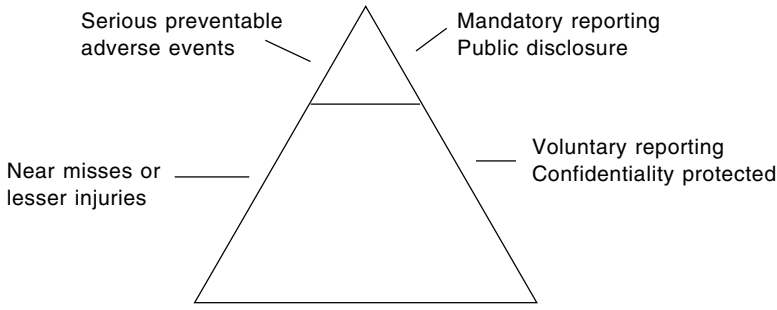

FIGURE 5-1 Hierarchy of reporting.

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types of errors might be promulgated in the future to serve as tools to be made available to voluntary reporting systems or health care organizations for quality improvement purposes.

The committee believes there is an important role for both mandatory and voluntary reporting systems. Mandatory reporting of serious adverse events is essential for public accountability and the current practices are too lax, both in enforcement of the requirements for reporting and in the regulatory responses to these reports. The public has the right to expect health care organizations to respond to evidence of safety hazards by taking whatever steps are necessary to make it difficult or impossible for a similar event to occur in the future. The public also has the right to be informed about unsafe conditions. Requests by providers for confidentiality and protection from liability seem inappropriate in this context. At the same time, the committee recognizes that appropriately designed voluntary reporting systems have the potential to yield information that will impact significantly on patient safety and can be widely disseminated. The reports and analyses in these reporting systems should be protected from disclosure for legal liability purposes.

Mandatory Reporting of Serious Adverse Events

The committee believes there should be a mandatory reporting program for serious adverse events, implemented nationwide, linked to systems of accountability, and made available to the public. Comparable to aviation "accidents" that are investigated by the National Transportation Safety Board, health care organizations should be required to submit reports on the most serious adverse events using a standard format. The types of adverse events to be reported may include, for example, maternal deaths; deaths or serious injuries associated with the use of a new device, operation or medication; deaths following elective surgery or anesthetic deaths in Class I patients. In light of the sizable number of states that have already established mandatory reporting systems, the committee thinks it would be wise to build on this experience in creating a standardized reporting system that is implemented nationwide.

Within these objectives, however, there should be flexibility in implementation. Flexibility and innovation are important in this stage of development because the existing state programs have used different approaches to implement their programs and a "best practice" or preferred approach is not yet known. The Center for Patient Safety can support states in identify-

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ing and communicating best practices. States could choose to collect and analyze such data themselves. Alternatively, they could rely on an accrediting body, such as Joint Commission for Accreditation of Healthcare Organizations or the National Committee for Quality Assurance, to perform the function for them as many states do now for licensing surveys. States could also contract with peer review organizations (PROs) to perform the function. As noted in Chapter 4, the Center for Patient Safety should evaluate the approaches taken by states in implementing reporting programs. States have employed a variety of strategies in their programs, yet few (if any) have been subject to rigorous evaluation. Program features that might be evaluated include: factors that encourage or inhibit reporting, methods of analyzing reports, roles and responsibilities of health care organizations and the state in investigating adverse events, follow-up actions taken by states, information disclosed to the public, and uses of the information by consumers and purchasers.

Although states should have flexibility in how they choose to implement the reporting program, all state programs should require reporting for a standardized core set of adverse events that result in death or serious injury, and the information reported should also be standardized.

The committee believes that these standardized reporting formats should be developed by an organization with the following characteristics. First, it should be a public–private partnership, to reflect the need for involvement by both sectors and the potential use of the reporting format by both the public and the private sectors. Second, it should be broadly representative, to reflect the input from many different stakeholders that have an interest in patient safety. Third, it should be able to gather the expertise needed for the task. This requires adequate financial resources, as well as sufficient standing to involve the leading experts. Enabling legislation can support all three objectives.

The National Forum for Health Care Quality Measurement and Reporting meets these criteria. The purpose of this public-private partnership (formed in May 1999) is to develop a comprehensive quality measurement and public reporting strategy that addresses priorities for quality measurement for all stakeholders consistent with national aims for quality improvement in health care. It is to develop a plan for implementing quality measurement, data collection and reporting standards; identify core sets of measures; and promote standardized measurement specifications. One of its specific tasks should relate to patient safety.

The advantage of using the Forum is that its goal already is to develop a

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measurement framework for quality generally. A focus on safety would ensure that safety gets built into a broader quality agenda. A public–private partnership would also be able to convene the mix of stakeholders who, it is hoped, would subsequently adopt the standards and standardized reporting recommendations of the Forum. However, the Forum is a new organization that is just starting to come together; undoubtedly some time will be required to build the organization and set its agenda.

Federal enabling legislation and support will be required to direct the National Forum for Health Care Quality Measurement and Reporting to promulgate standardized reporting requirements for serious adverse events and encourage all states to implement the minimum reporting requirements. Such federal legislation pertaining to state roles may be modeled after the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA provides three options for implementing a program: (1) states may pass laws congruent with or stronger than the federal floor and enforce them using state agencies; (2) they may create an acceptable alternative mechanism and enforce it with state agencies; or finally, (3) they may decline to pass new laws or modify existing ones and leave enforcement of HIPAA to the federal government.[27] OSHA is similarly designed in that states may develop their own OSHA program with matching funds from the federal government; the federal OSHA program is employed in states that have not formed a state-level program.

Voluntary Reporting Systems

The committee believes that voluntary reporting systems play a valuable role in encouraging improvements in patient safety and are a complement to mandatory reporting systems. The committee considered whether a national voluntary reporting system should be established similar to the Aviation Safety Reporting System. Compared to mandatory reporting, voluntary reporting systems usually receive reports from frontline practitioners who can report hazardous conditions that may or may not have resulted in patient harm. The aim is to learn about these potential precursors to errors and try to prevent a tragedy from occurring.

The committee does not propose a national voluntary reporting system for several reasons. First, there are already a number of good efforts, particularly in the area of medications. Three complementary national reporting systems are focused on medication errors: FDA, the Institute for Safe Medication Practice, and U.S. Pharmacopeia. The JCAHO sentinel events

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program is another existing national reporting program for hospitals that will also receive reports on medication and other errors. These reporting systems should be encouraged and promoted within health care organizations, and better use should be made of available information being reported to them.

Second, there are several options available about how to design such a voluntary reporting system. Better information is needed on what would be the best approach. At least three different approaches were identified. One is a universal, voluntary reporting system, modeled after ASRS. The concern with this approach is the potential volume of reports that might come forward when such a system is applied to health care. Another concern is that any single group is unlikely to have the expertise needed to analyze and interpret the diverse set of issues raised in health care. The experience of ASRS has shown that the analysts reviewing incoming reports must be content experts who can understand and interpret these reports.[28] In health care, different expertise is likely needed to analyze, for example, medication errors, equipment problems, problems in the intensive care unit (ICU), pediatric problems, and home care problems.

Another approach is to develop focused "mini-systems" that are targeted toward selected areas (e.g., those that exist for medications) rather than a single voluntary program. This approach would manage the potential volume of reports and match the expertise to the problems. It is possible that there should be different mini-systems for different issues such as medications, surgery, pediatrics, and so forth. If such mini-systems are formed, there should be a mechanism for sharing information across them since a report to one system may have relevance for another (e.g., surgical events that also involve medications).

A third possibility is to use a sampling approach. For example, in its postmarketing surveillance of medical devices, FDA is moving away from a universal reporting system for hospitals and nursing homes to one in which a representative sample of hospitals and nursing homes keeps complete data. Its pilot test found that both the quantity and the quality of reports improved when FDA worked with a sample of hospitals who were trained in error identification and reporting and could receive feedback quickly. By periodically renewing the sample, the burden on any organization is limited (although participation in the sample may have the side benefit of helping interested organizations build their internal systems and train practitioners in error detection).

Lastly, establishing a comprehensive voluntary reporting system mod-

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eled after ASRS would require an enormous investment of time and resources. The committee believes that recommending such an investment would be premature in light of the many questions still surrounding this issue.

The committee does believe that voluntary reporting systems have a very important role to play in enhancing understanding of the factors that contribute to errors. When properly structured, voluntary systems can help to keep participating health care organizations focused on patient safety issues through frequent communication about emerging concerns and potential safety improvement strategies. Voluntary systems can provide much-needed expertise and information to health care organizations and providers.

The continued development of voluntary reporting efforts should be encouraged. Through its various outreach activities, the Center for Patient Safety should describe and disseminate information on voluntary reporting programs throughout the health care industry and should periodically convene sponsors and users of voluntary reporting systems to discuss ways in which these systems can be made more effective. As a part of developing the national research agenda for safety, the Center for Patient Safety should consider projects that might lead to the development of knowledge and tools that would enhance the effectiveness of voluntary reporting programs. The Center should also periodically assess whether there are gaps in the current complement of voluntary reporting programs and should consider funding pilot projects.

In summary, this chapter and the previous chapter outlining the proposed Center for Patient Safety together describe a comprehensive approach for improving the availability of information about medical errors and using the information to design systems that are safer for patients. Although this chapter focuses on using reporting systems to learn about and learn from errors that have already occurred, Chapter 4 focused on how to create and disseminate new knowledge for building safer delivery systems. Both of these strategies should work together to make health care safer for patients.

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6
Protecting Voluntary Reporting Systems from Legal Discovery

Although all industries face concerns about liability, the organization of health care creates a different set of circumstances compared to other industries. In health care, physicians primarily determine the amount and content of care rendered. A hospital or clinic often produces the care directed by the physician. The consumer, purchaser, and health plan share in decisions to determine whether and how treatment decisions directed by the physician are paid, which influences access to care. Although some of these decisions could be under one umbrella, they are often dispersed across different and unrelated entities. Compared to other industries, there is no single responsible entity in health care that is held accountable for an episode of care. The physician, in particular, has a significant responsibility for the well-being of his or her patients and the decisions made concerning their care. This distinctive arrangement in organization and decision making in health care creates a unique set of liability issues and challenges in creating an environment conducive to recognizing and learning from errors.

The potential for litigation may sometimes significantly influence the behavior of physicians and other health care providers. Often the interests of the various participants in furnishing an episode of care are not aligned and may be antagonistic to each other. In this environment, physicians and other providers can be cautious about providing information that may be

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subsequently used against them. Thus, the prominence of litigation can be a substantial deterrent to the development and maintenance of the reporting systems discussed in this report.

Chapter 5 lays out a strategy to encourage greater recognition and analysis of errors and improvements in patient safety through a mandatory reporting system for errors that result in serious harm, and voluntary participation in error reporting systems that focus on "near misses" or errors resulting in lesser harm. The issue of whether data submitted to reporting systems should be protected from disclosure, particularly in litigation, arose early in the committee discussions. Members of the committee had different views. Some believed all information should be protected because access to the information by outsiders created concerns with potential litigation and interfered with disclosure of errors and taking actions to improve safety. Others believed that information should be disclosed because the public has a right to know. Liability is part of the system of accountability and serves a legitimate role in holding people responsible for their actions.

The recommendations contained in Chapter 5 and in this chapter reflect the committee's recognition of the legitimacy of the alternative views. The committee believes that errors that are identified through a mandatory reporting system and are part of a public system of accountability should not be protected from discovery. Other events that are reported inside health care organizations or to voluntary systems should be protected because they often focus on lesser injuries or non-injurious events that have the potential to cause serious harm to patients, but have not produced a serious adverse event that requires reporting to the mandatory system. Protecting such information encourages disclosure of problems and a proactive approach to correcting problems before serious harm occurs.

Although information about serious injuries and deaths due to errors should not be protected from discovery, it is important that information released to the public is accurate. As described in Chapter 5, mandatory reporting systems receive reports on adverse events, which are then investigated to determine whether an error occurred. The mere filing of a report should not, by itself, trigger release of information. Rather, information should be released after an investigation has been completed so the information that is released is accurate. This chapter focuses primarily on protecting information reported to voluntary systems, although aspects may also apply to protecting data submitted to mandatory systems until the information is ready for public release.

The committee believes that a different approach to promoting the col-

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lection, sharing, and analysis of such data (not considered in this chapter) would be to change the legal environment in which health care organizations and providers operate. Exclusive enterprise liability, shifting liability for medical injuries from individual practitioners to responsible organizations, has been suggested to possess several advantages over the current liability system.[1–3] One of these is to remove the fear of personal liability from individual health care workers, eliminating this incentive to hide errors. Another proposed reform, no-fault compensation for medical injuries, might promote reporting by eliminating the adversarial inquiry into fault and blame that characterizes the current liability system.[4] Workplace injuries to employees are handled within an example of such a no-fault, enterprise-liability system.[5]

Together, enterprise liability and no-fault compensation might produce a legal environment more conducive to reporting and analysis, without the elaborate legal and practical strategies needed to protect data under the current liability system. An analysis of enterprise liability and no-fault compensation systems is beyond the scope of the Quality of Health Care in America project, but the committee believes that the issue merits further analysis.

This chapter examines legal precedents and practical experiences bearing on how and to what extent information can be protected in error reporting systems when it leaves the health care organization that generated it. Legal protections like state peer review shields and laws created to protect a specific reporting system have much promise. Many current state peer review statutes, however, may not protect data about errors shared in collaborative networks, especially across state lines, or reported to voluntary reporting systems (e.g., independent data banks). A combination of practical and legal safeguards may be the best approach to protect the data in voluntary reporting systems from discoverability. The practical safeguards of anonymous reporting and de-identification (removal of identifying information after receipt of the report) can confer some, but not complete, protection. Statutory protection could add three benefits to some level of de-identification: (1) it could provide an added measure of security for the data; (2) it could protect from subpoena identifiable reporters and recipients of the reports; and (3) it could permit the reporting system to obtain and retain information that might identify the reports and reporters.

RECOMMENDATION

RECOMMENDATION 6.1 Congress should pass legislation to extend peer review protections to data related to patient safety and

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quality improvement that are collected and analyzed by health care organizations for internal use or shared with others solely for purposes of improving safety and quality.

Existing law often shields data about errors within an institution, but this protection may be lost when the data are transmitted elsewhere, for example, to other institutions collaborating in an error reduction initiative or to a voluntary reporting system. Unless such data are assured protection, people will be reluctant to discuss them and opportunities to improve will be lost. A more conducive legal environment is needed to encourage health care professionals and organizations to identify, analyze, and prevent errors without increasing the threat of litigation and without compromising patients' legal rights. Information about errors which have resulted in serious harm or death to patients and which are subject to mandatory reporting should not be protected.

INTRODUCTION

The systematic reporting and tracking of safety problems is an important approach to quality improvement. There are many ways to gather, maintain, and use safety-related data. Systems can vary considerably according to their key characteristics (e.g., type of events reported, who reports, voluntary or mandatory submission, location and maintenance of a data bank), which also affect the likelihood of vulnerability to discovery in legal process.

All such systems face two bedrock issues: (1) how to motivate health care practitioners and others to submit information, and (2) how to maintain reported data in a systematic way that is useful to practitioners. A central concern for both is the extent to which confidentiality of information should be maintained given a litigious society. Access to detailed information compiled by peer reviewers, risk managers, or others could greatly help a plaintiff's lawyer to build and prove a case. This in turn creates a strong disincentive to collect and report such information.

Plaintiffs' interest in and uses of information on errors depend on the level of identification of the data. A fully identified report will always be of interest to the plaintiff involved in the case reported. But even if the data are identified or aggregated by institution or physician, but not by patient, they may still be useful in claims against the institution for negligent supervision or credentialing—causes of action that are well known to the plaintiff's bar. Data from which all personal and organizational identifiers have been removed could still be used to prove some elements of certain types of cases,

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such as causation (e.g., injuries similar to the plaintiff's were caused by the same mechanism or problem; there was reason for the defendant to know of problems with a certain process or device). The latter use is probably not common today, possibly in part because of the scarcity of such data. The more that liability moves from individual focus to a focus on organizations, the more useful general information may become.

Plaintiffs can seek information from three components of a reporting system: (1) the original reporter; (2) the personnel who receive, investigate, or analyze the reports; and (3) the data per se as they reside in the data bank. The way in which plaintiffs can gain access to these targets is described in the next section. Two avenues are available to protect each of these targets: laws that prevent discovery and practical methods that render the reporter unfindable or the data unuseful to the plaintiff. These protections may apply differently to the three possible targets of discovery. They are described in more detail, along with the experience that reporting systems have had with them. The purpose of the analysis is to illuminate the legal policy and design choices facing those who want to protect data collection, sharing, and analysis of information on adverse events and errors.

The committee notes that protecting data in a reporting system as recommended in this chapter does not mean that the plaintiff in a lawsuit could not try to obtain such information through other avenues if it is important in securing redress for harm; it just means that the plaintiff would not be assisted by the presence of a reporting system designed specifically for other purposes beneficial to society.

THE BASIC LAW OF EVIDENCE AND DISCOVERABILITY OF ERROR-RELATED INFORMATION

Demands for information on errors can come from any of the plaintiffs in medical malpractice lawsuits, which are almost always based on state law.* Whether and when plaintiffs can obtain access to such data or have such information admitted as evidence at trial depend on the general rules of evidence and civil procedure, as applied by a state judge under particular

*Error data may be sought in other types of cases as well, such as antitrust or libel claims by physicians against medical organizations. Further, regulators may seek data on injuries, either under their general authority (notably, state licensing boards that can discipline practitioners) or under specific statutory schemes of regulation that mandate reporting and investigation of consequential errors (discussed below).

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circumstances. Rules vary by state, but most are similar to the federal rules described below. State differences are mentioned when relevant.

Trial Admissibility and the Rule of Relevance

The basic legal principle governing whether information can be used by a plaintiff in a civil trial is the rule of relevance. The formal threshold of relevance is quite low: whether the evidence would have "any tendency" to make any element of the cause of action (mainly, existence of negligence, causation of harm, presence of damages) more or less likely.[6] Moreover, trial judges are accorded broad discretion in judging whether an item of evidence is relevant,[7] and they make such determinations on a case-by-case basis.[8] In practice, then, a piece of evidence is relevant to a particular case if the judge says it is, unless there is no arguable basis for its relevance.

All relevant evidence is admissible at trial unless there is a specific exception or reason for it to be inadmissible,[9] such as the evidentiary privileges discussed below. The attorney–client privilege, for example, can prevent certain clearly relevant statements by the client from being introduced at trial.

Information on errors could be relevant to a malpractice lawsuit in three ways. First, if the data are reported about the *particular case in dispute*, so that the report and the litigation are about the identical circumstances, every piece of information would undoubtedly be relevant. This use of data would apply only to databases with identified data about errors that produce injury; the specific identification is what makes the information relevant, and the data would help establish liability in the lawsuit. The information could show negligence, causation (i.e., relation of the injury to the medical care that prompted the report), and possible damages.

Second, information about *similar occurrences* to the case in dispute is relevant to lawsuits that allege not merely one negligent occurrence, but negligence in a practitioners' engaging in a certain activity at all. It may be argued that an individual doctor's record makes it negligent to fail to refer a patient to a better-qualified practitioner. Similarly, a suit may allege negligent oversight in credentialing or supervision by the institution, medical group or health plan within which the doctor practices. In such a lawsuit, the plaintiff would argue that the occurrence of similar problems before the case in dispute should have or did put the defendant on notice of a pattern of problems that should have been corrected before the plaintiff's injury occurred. The previous occurrences would have to be similar in salient as-

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pects to the data sought from the bank, for example, a particular sort of complex surgery. This use of prior similar-occurrence data would require data identified at least by institution, because the notice has to be shown with respect to a particular defendant. In one case, for example, a plaintiff who was injured by implantation of a pacemaker was allowed access to records of other instances of pacemaker implantation to help make a case for negligent supervision of the physicians by the hospital.[10]

Third, data on *similar occurrences* might also be relevant in more limited ways—to help some lawsuits prove certain aspects of their cases. If, for example, there is a dispute about whether a particular instrumentality could have caused the injury ("causation"), evidence that it caused similar injuries in other instances could be relevant. Other points that could be proven with similar-occurrence data include the defendant's ability to correct a known defect (e.g., a systems weakness or device problem), the lack of safety for intended uses, and the standard of care. Using similar occurrences in this manner would not require identified data, and the similar instances could have come before or after the event that is the subject of the lawsuit.

A recent Florida case combined the notice and causation purposes of similar-occurrence evidence. An obese patient alleged that the defendant obstetrician injured her child by delivering her on a standard bed, rather than a drop-down bed. The court held that the records of other obese patients the doctor had delivered were relevant and discoverable. If other infants suffered similar injuries when a standard bed was used, this should have afforded the obstetrician notice that this method was deficient. Conversely, if no such injuries occurred when drop-down beds were used, this might be relevant for causation. In this instance, the other patients' names were removed from the records.[11] A similar rationale could easily apply to a collection of data on errors.

Pretrial Discoverability

The potential for discovery is even greater than indicated by the preceding section on trial admissibility. The requirement of relevance applies to whether a piece of evidence can be admitted into the record at trial. A pretrial process called "discovery" can extend a plaintiff's reach even further by allowing the plaintiff access to information that would not be admissible at the trial, but could *lead* to admissible evidence at the subsequent trial. Discovery is the process by which each party can obtain evidence in the possession of the other party and nonparties. It typically consists of requests for

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copies of documents and questions asked under oath of the other party (called interrogatories if written and depositions if oral). It may also extend to the production of physical objects or even the plaintiff's person for a medical examination. Persons or organizations that are not parties in a lawsuit can also be compelled to provide verbal, documentary, or physical evidence.

Relevance for discovery purposes is broadly and liberally construed. If there is a doubt about relevance, judges will generally permit discovery.[12] The information asked for need not be admissible at trial, as long as it reasonably might lead to the discovery of admissible evidence.[13] Therefore, a report of a medical error need not itself be admissible to be discoverable. The report could point the plaintiff toward relevant facts needed to prove the case. The report could inform the plaintiff, for example, of theories or conclusions about what contributed to the occurrence of the error. This knowledge could help direct the plaintiff's search for admissible evidence, for example, by suggesting the existence or importance of pertinent documents, witnesses, and questions that the plaintiff would not have otherwise considered.

Nonparties

Discovery can be obtained from nonparties as well as parties to the action. Nonparties include any person or organization that is not named in the lawsuit as being allegedly liable for the injury. They could include external data banks, quality consultants, accrediting bodies such as JCAHO, and other persons or organizations that have information on errors. Subject to the judge's approval, the party seeking discovery simply issues a subpoena to the nonparty for the information.[14] The same methods of discovery generally apply to nonparties as to parties, except that interrogatories (a set of written questions) normally cannot be used with nonparties. With regard to the scope of discovery, the major difference for nonparties is that, if compliance with the subpoena would impose a burden on the nonparty, the court may impose a higher standard of relevance on the request for discovery. Judges may also be more apt to limit the scope or duration of a party's probing of a nonparty's information.

Judges are given substantial discretion over discovery from nonparties as well as discovery from parties to the lawsuit. Thus, the person or entity that reported or shared the error information, independent investigators, organizations that maintain information on errors, and those who work for

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such organizations could be subject to subpoenas, as long as compliance with the subpoena would not impose an undue burden. Even a data bank that maintains information with no personal or organizational identifiers would not protect a reporter to the data bank from being compelled to testify under oath about his or her recollections of the case, if the reporter could be identified by the plaintiff. The ease of identifying the reporter in practice is variable. It could be straightforward, for example, if a single physician was responsible for all quality assurance reviews in a medical group. Similarly, those who receive, de-identify, investigate, and analyze reports could be compelled to testify if they could be identified with sufficient particularity to be served with a subpoena.

LEGAL PROTECTIONS AGAINST DISCOVERY OF INFORMATION ABOUT ERRORS

Three main types of legal protections can block the discovery of data on errors. These include (1) general rules of evidence (not restricted to the medical context), (2) the medical peer review privilege, and (3) special statutory privileges enacted for particular reporting systems. This section discusses each of the protections in turn, along with their limitations.

General Rules of Evidence

Three general rules of evidence could potentially protect error information from disclosure—the remedial action privilege, the attorney–client privilege, and the work product doctrine. Each has some applicability to reporting systems, but each also has significant limits.

Remedial Action

By a long-standing rule of evidence, a showing that remedial action has been taken after an injury cannot be admitted as proof that the injury resulted from negligence or a defective product. One rationale for this rule is to encourage defendants and potential defendants to improve safety, without having to worry that doing so might be taken as an admission of prior substandard practice. The other rationale for the rule is that remedial measures are not necessarily relevant to negligence: that is, one can seek to prevent nonnegligent as well as negligent injuries. All states but one have adopted this rule.[15]

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Some states have extended this rule to include self-evaluative reports or other postinjury analyses and reports. This might include evaluative reports on health care errors. The policy rationale for the rule would argue for this extension; without it, defendants might be unwilling to undertake the analyses needed to devise remedial measures. A California court, for example, recently held that the rule protected the records of peer review committees from discovery, independently from California's peer review statute, which also applied.[16]

However, other states have ruled the opposite way or have not yet reached the question of whether evaluative reports are protected.[17] Even in states that have extended the remedial measures rule to evaluative reports, protecting the reports outside of the institution involved in the lawsuit would require yet another extension of the rule. Another problem is that even if the reports are protected from being used by a plaintiff to prove the main elements of the cause of action (such as negligence), they could still be admissible for other purposes. A plaintiff could use them, for example, to impeach a witness (i.e., contradict a witness' testimony), prove causation, or prove the feasibility of taking preventive measures.[18]

Furthermore, the discovery privilege applies to critical evaluation (analysis, opinions, and conclusions) but not to facts of the event, so plaintiffs can still obtain factual information contained in the reports to support their case (e.g., what happened, who was there, what was said, whether the equipment was functioning normally).[19]

Attorney–Client Privilege

Communications with one's attorney are privileged from discovery. The purpose of the privilege is to encourage free communication between clients and lawyers so that clients may have the full benefit of legal advice. The privilege is nearly absolute, in that an opposing party can almost never argue that it should not be applied in particular circumstances.* It can be waived, however, by the client to whom it belongs; the attorney has a permanent obligation to the client and can never waive the privilege.

Attorney–client privilege will rarely if ever be useful in protecting reports sent to an external entity. Typically, the client is the medical institution,

*There are limited exceptions not relevant here, such as the duty of a lawyer as an officer of the court to report a client's plans to engage in future criminal activity.

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which generally includes only senior management for purposes of this privilege. A report from a floor or charge nurse, for example, may not qualify. The most important problem, however, is that even if a document is originally covered by the attorney–client privilege, once it is sent to any nonparty, including external data banks or independent collaborating institutions, it loses the protection of the privilege. In other words, sending a report to one's attorney does not immunize it from discovery if it is also used for other purposes.

Attorney Work Product Doctrine

This rule protects materials that are created by or on behalf of a lawyer in preparation for litigation. The purpose is to protect the thoughts and plans of the lawyer, and the privilege can be waived only by the lawyer. Some states do not apply this doctrine to protect reports on errors, not even those kept internal to an organization, such as incident reports.[20] These states view the reports as being generated in the ordinary course of business. In addition, the protection afforded by the work product doctrine is not absolute; it can be overcome if the other party has need of the materials and would be unable without hardship to obtain the equivalent information.[21] In this situation, the facts of the event can be discovered, but the thoughts, opinions, and plans of the lawyer remain protected (i.e., may be removed before the materials are produced in discovery).

Peer Review Privilege

The peer review privilege is the most promising existing source of legal protection for data on errors. This privilege is statutory and is specific to medical peer review within specified settings and meeting specified standards. Every state, except one, statutorily protect from discovery various records and deliberations of peer review committees.[*] [22,23] The quality improvement purpose of peer review is consistent with the purpose of reporting systems; the statutes' value in protecting reporting, however, depends on fitting the reporting system to the specifics of each protective statute.

[*]New Jersey is the exception, according to a 50-state survey of peer review statutes that was undertaken in part to understand how JCAHO's proposed "sentinel event" reporting would fare under the statutes.

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These statutes vary considerably in their reach and strength. Overall, this makes them a problematic source of legal protection for data on errors. Some protect only documents generated by the peer review committee, whereas others protect information provided to them. In addition, the treatment of incident reports within an institution, such as a hospital, varies by state. Some statutes have specific requirements for the composition of qualifying peer review committees (e.g., that physicians constitute a majority of the members). In some states, a hospital committee must be under the aegis of the medical staff, not the administrative staff.[24]

Some states restrict the privilege to in-hospital committees or committees of professional societies. Many statutes may not cover collaborations among institutions, even if all are within an integrated delivery system. The California statute is one of the broadest and might apply to collaborative reporting systems and external data banks. California defines a peer review body as including "a medical or professional staff of any licensed health care facility, a nonprofit medical professional society, or a committee whose function is to review the quality of professional care provided by the members or employees of the entity to which the committee belongs."[25] No statute expressly covers systems or collaborations that cross state lines.

States can develop statutes to accommodate reporting systems, such as in Oklahoma. In that state the law protects any information, including interviews, reports, statements, memoranda, or other data, that is provided "for use in the course of studies for the purpose of reducing morbidity or mortality." The recipients may use such information "only for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality." The findings and conclusions resulting from these studies are also protected. The Oklahoma Supreme Court has upheld the protection under this statute for records generated by a hospital infectious disease committee that reviewed every case involving infection in order to improve infection control.[26] It would appear possible to devise reporting systems that would meet the requirements of this statute.

Even when peer review information qualifies for the privilege, it may nonetheless be discoverable under some circumstances. The information may not be protected in allegations of negligent supervision or credentialing by an institution, because the performance of the peer review process is what is at issue in such claims. Some state medical licensing boards have gained access to peer review information for disciplinary purposes.[27] Some state courts employ a balancing test to determine whether a plaintiff should have access to facts contained in peer review documents (though not opin-

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ions or conclusions), balancing how crucial this is to the plaintiff (e.g., not available in any other way) against how much trouble and expense it imposes on the defendant.* Moreover, state or federal law enforcement authorities may be able to discover the information for use in criminal proceedings, although instances of criminal prosecution for medical errors are exceptionally rare. Many states' statutes prevent a plaintiff from compelling a member of the peer review committee to testify, but one might testify voluntarily.[28] To close this loophole, hospitals can adopt bylaws prohibiting staff members from disclosing any information obtained through the peer review committee.

There is federal protection for the practice of peer review under the Health Care Quality Improvement Act of 1986 (42 U.S.C. §§11101 et seq.). This statute establishes peer review immunity from damage suits when the participants act in good faith in any peer review process that meets the act's standards for structure and fair process. Peer review is defined quite broadly, and protected participants include everyone involved in the process, from investigators to witnesses to medical peers.

STATUTORY PROTECTIONS SPECIFIC TO PARTICULAR REPORTING SYSTEMS

Some statutes have been crafted to protect specific reporting systems. Examples of these follow, along with some indications of their success in practice. All provide limited precedent for protecting data.

National Practitioner Data Bank (NPDB)

The federal Health Care Quality Improvement Act of 1986 (42 U.S.C. §§11101 et seq.) requires all malpractice insurers and self-insurers to report claims paid on behalf of named practitioners to the NPDB maintained by the Health Resources and Services Administration (HRSA). Decisions affecting clinical privileges of physicians and dentists must be reported by hospitals, state boards or professional associations; hospitals and other entities may voluntarily submit reports on other practitioners. Practitioners are also allowed limited space in the data bank to comment on the information reported (often asserting that the payment was made solely for tactical legal

*An unknown but key issue is the extent to which general harm to incentives to generate data would enter into a court's balancing.

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reasons, not in recognition of medical failures). The reporting obligation is limited to specified formal determinations about consequential errors in medicine (claims settled, discipline meted out) and does not extend to simple observation of medical errors "in the field."

With regard to confidentiality, the act allows only designated authorized users to obtain information from the data bank, mainly hospitals and other health care organizations that credential practitioners. Regulations call for authorized users to use data only for credentialing or peer review and to keep data only within departments doing such authorized activities. The NPDB may not give information on any practitioner to any malpractice insurer, defense attorney, or member of the general public, although plaintiffs' attorneys may query the bank under very limited circumstances. Strong monetary penalties exist for unauthorized disclosures from the NPDB. Bills have often been filed in the Congress to "open up" the bank for public access, but these have always been opposed by federal authorities and have never been close to enactment. There is nonetheless substantial concern among practitioners that legislative change will eventually succeed.

Completeness of reporting is difficult to assess. Some physicians are said to avoid being reported to the data bank by settling lawsuits in the name of a corporate defendant and being dropped individually from the lawsuit. Insurers and corporate defendants, in turn, are said to report increased difficulty in settling claims because of the resistance of practitioners to being reported. HRSA sources interviewed said that they believe reporting is good, and said that occasional complaints referred to them almost always turn out to have been reported. HRSA interviewees said that there have been no known leaks from HRSA or from any contractor that has maintained the database. Complaints about leaks have been too general and non-specific to investigate.

The claims data in the data bank are effectively "protected" from discovery in a lawsuit involving the injury-producing error that was reported because the applicable lawsuit must already be over. Claim closure is what generates the duty to report, including information from the settlement. Plaintiffs might be interested in the data as similar-occurrence information, but no civil lawsuit subpoenas have been issued to the data bank; the protecting federal law preempts any attempts to obtain data for a state lawsuit. The NPDB does not face the problem of having to protect any investigators of reports, because it conducts no independent investigation, being prohibited by law from modifying information submitted in reports. Those who generate reports do face inquiries, however; when a physician is under re-

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view for privileges at a hospital, for example, the institution will routinely ask liability insurers and doctors about their reported history of malpractice and discipline, and no confidentiality applies.

Quality Improvement Organizations (QIOs)

Also known as peer review organizations (PROs), these entities monitor the utilization and quality of care for Medicare beneficiaries, including quality improvement projects, mandatory case review and oversight of program integrity (see Chapter 7). One responsibility involves the investigation and evaluation of instances of possibly substandard care provided to fee-for-service Medicare beneficiaries. Case review information with patient identifiers is not subject to subpoena in a civil action (42 CFR Section 476.140).

Veterans Health Administration System

The Veterans Health Administration (VHA) is planning to implement a voluntary, non-punitive reporting system on a pilot basis. This system is being designed after the aviation model (see Chapter 5) for eventual use throughout the VHA delivery system. A specific federal statute confers confidentiality for quality assurance within the VHA. The VHA's general counsel has not formally issued an opinion on whether the new reporting system will be protected by this statute, but VHA officials believe it will be. Because the system is not yet operational, there has been no opportunity for the statute's application to the reporting system to be challenged (the federal Tort Claims Act waives governmental immunity for the VHA, so it generally can be sued for medical malpractice).

Food and Drug Administration

Via its MedWatch system, the FDA receives reports from practitioners and manufacturers of serious adverse events and product problems related to medications and devices within its regulatory authority. Strict confidentiality rules apply to the identities of both reporters and patients; governing laws include the federal Privacy Act and the Freedom of Information Act. Agency regulations since 1995 have protected against disclosure of voluntary reports held by pharmaceutical, biological, and medical device manufacturers, by preempting state discovery laws.

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New York Patient Occurrence Reporting and Tracking System

New York operates a leading example of a type of state regulatory system that collects reports of various types of adverse events. Access to individual reports is protected by statute. This statutory shield was challenged and was upheld by the courts, according to interviewees. Reports from hospitals are also protected by the statute protecting internal investigative reports and incident reports. If the department conducts an investigation of a specific event (prompted by a report or by a patient's complaint) official action is taken by the state (e.g., a statement of deficiencies), and the public and the patient have access to these findings. Accordingly, reporters can expect information reported to become public.

PRACTICAL PROTECTIONS AGAINST THE DISCOVERY OF DATA ON ERRORS

Two practical methods have been used to try to assure those who report errors that their reports will not be used in civil lawsuits against them or their colleagues. The first is simply to promise confidentiality by operational practice, but without full legal support in case of subpoena. Some organizations have tried to abide by a promise not to disclose the reporter's identity, and so far, have apparently been successful. However they appear to be vulnerable to subpoena.

The second practical protection is to obtain and maintain the data in a manner that prevents identification of the reporter or the specific event, even if a plaintiff obtains access to the report. This can be done with anonymous reporting (in which case the data recipient never receives any identified information to begin with) and by de-identification of reported data (in which case the identity of the reporter is removed after receipt of the report, often after a short lag to permit clarification or additional information to be obtained from the reporter). This section relates experience with these methods.

Confidentiality by Promise and Practice

A promise of confidentiality is sometimes the only option available to private organizations today. Two organizational examples are described below. Operational practice to maintain confidentiality can also be important within organizations that have dual roles—quality improvement and enforce-

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ment—so that the information on errors is sequestered behind an internal curtain of confidentiality and made available only to those who need access to it for purposes of analysis and prevention. Even such a "firewall" may not have credibility for reporters. The Aviation Safety Reporting System, for example, was not fully trusted by reporters until it was moved from within the Federal Aviation Administration (FAA) to a separate agency, the National Aeronautics and Space Administration (NASA).

JCAHO's sentinel event system is a notable example of confidentiality based on promise and practice. When first proposed in 1996, the policy caused controversy among hospitals fearful of disclosure to JCAHO. JCAHO has since changed its policy to permit hospitals to disclose details through on-site inspection by JCAHO investigators so that information stayed inside the institution and was not reported externally to JCAHO. One legal fear is that disclosure of internal quality data to outside reviewers not under a peer review statute will lead to discovery from JCAHO in lawsuits; indeed, many fear that disclosure to JCAHO would invalidate even the nondiscoverability protections each hospital enjoys for its own data under its state peer review statute.* A practical fear is that involving numerous outsiders will increase the potential for security breaches. JCAHO is seeking federal statutory protection as a definitive solution to the problem.

The Medical Error Reporting (MER) System also relies on a promise of confidentiality. It receives identified reports of medication errors, almost exclusively from practitioners. The reporter is given the option of not being identified to the sponsoring organizations (see Chapter 5), FDA, and the relevant pharmaceutical company, but the reporter's identity is maintained within the MER data system. Sometimes, anonymous reports are received. Lawyers have requested and been given copies of general reports on a particular problem, but not specific case reports. The data bank has never been subpoenaed, but the director considers this to be a significant risk that likely contributes to substantial under reporting.

Anonymous Reporting

The intent of anonymous reporting is to ensure that the reporter cannot be identified from the report. The information, therefore, can be used primarily as unidentified similar-occurrence data to prove particular aspects of

*The 50-state survey on peer review noted above was undertaken as part of the reaction against the initial JCAHO proposal for mandatory reporting of identified information.

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a case, such as causation. The potential for this kind of generalized legal risk may not significantly deter reporting.

The use of anonymous reporting can reduce the effectiveness of the reporting system. On a practical level, a loss of information can occur because the data system is restricted to receive only the information transmitted initially by the reporter. The recipient cannot go back to the reporter to get clarification and additional information.

At a more fundamental level, some detailed information can be lost to the system because it might tend to identify the specific event or the reporter. This is especially true for injury-producing errors, because of the greater knowledge of the error possessed by a plaintiff compared with persons not involved in the event being reported. Plaintiffs know detailed information about their own cases that could enable each to identify with some certainty even an anonymous report or reporter about the specific injury being litigated. This information could include the dates of the event and the injury, nature and severity of the injury, type of facility, types of practitioners, and type and location of error. The names and types of specific equipment and drugs involved in the error, if any, also could help make the report identifiable to a plaintiff. As a result, information that is important to meet the needs of the reporting and analysis system might have to be omitted because it would serve to make the report identifiable to a plaintiff.

One example of an anonymous reporting system, is MedMARx. Hospitals submit reports on medication errors to MedMARx over the Internet, identified by a random number known only to the submitting hospital. This preserves anonymity, but allows the hospital to compare its experience to similar institutions. Because information is collected in a standardized format, the need to go back to the reporter for additional information is minimized. The usefulness of data for comparisons is enhanced by including "demographic" information on reporting hospitals (e.g., size, teaching status, location of error within hospital), but within categories sufficiently large to frustrate any attempt to identify reporters.

De-Identification

Two programs de-identify data as a practical protection against discovery. The Medical Event Reporting System for Transfusion Medicine (MERS-TM) is a private collaboration between blood centers and hospital transfusion services in Texas. Reports are generated within the protected quality assurance structures at each institution, but the Texas peer review

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statute may not apply to the data bank itself. Only near-miss data have been included to date, but the operators of the data bank are nonetheless extremely concerned about the possibility of receiving a subpoena. De-identification is the primary protection, but it causes them to lose information they would like to have about the reporting institution, such as the type of center, size, and location.

In the Aviation Safety Reporting System (ASRS), the reporter's name and contact information are retained temporarily in case additional information is needed. De-identification usually occurs within 72 hours of the initial receipt of the report. There has been no breach of identity of the reporter in more than 20 years of operation.

SUMMARY

Litigators have strong incentives and powerful legal tools to obtain information about errors to assist them in lawsuits for medical injuries. Many reporting systems contain information that would be useful to plaintiffs. The more that the content of a particular reporting system resembles the claims files of a medical liability insurer, the more attractive a target reporting system is for the plaintiffs. For example, a reporting system that focuses only on identified injury-causing errors from a small number of institutions is more attractive to plaintiffs than one that collects large numbers of nonidentified near misses from many different types of reporters in different states.

Fear of legal discoverability or involvement in the legal process is believed to contribute to underreporting of errors. Collaborative quality improvement efforts may be inhibited by the loss of statutory peer review protection that may occur when data are shared across institutions. Some form of protection appears necessary for each of the three components of an error reporting system: (1) the original reporters; (2) the various recipients of the information (including processors, investigators, de-identifiers, and analyzers); and (3) the reported information itself. Information voluntarily shared should be done with appropriate safeguards for patient confidentiality.

Legal protections are the only possible way to protect identified reporters, report recipients, and reports from discovery but legal protections are not without problems. Specific statutory protection for a particular reporting system may be the most desirable form of protection, but this may not be a realistic option for many systems. Some states' peer review statutes could be used by some types of reporting systems—for example in California and

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Oklahoma—but the assurance of protection is not ironclad. Other states' statutes would need revision to accommodate external data banks and collaborative efforts. This would require careful drafting that could survive state-by-state political processes, with careful attention to the scope of the protection, definitions of authorized users and uses, potential loopholes, and the like.

A more promising alternative, proposed recently by the Medicare Payment Advisory Commission (1999), is for Congress to enact protective federal legislation.[29] Such legislation could be enacted immediately and would not rely on actions to be taken by 50 different states.

Practical methods can be very useful in protecting nonidentified *reporters*, *recipients*, and *reported data*, but they also have some weaknesses, so reporters may not fully trust them. The level of protection of practical methods differs somewhat for the three components of reporting systems. *Reporters* could be protected from subpoena if all potentially identifying information is absent from the report, but anonymous reporting and de-identification may not be effective if the likely reporter can be identified readily by the plaintiff independent of the reports. This may occur, for example, when only one person is the logical or mandated reporter for an organization or department within the organization.

Similarly, *recipients* of reports (processors, investigators, etc.) might become identifiable to a plaintiff. A recipient who handles large numbers of reports may not remember details about any specific report. However, if an investigator spent some time on-site looking into a particular event, as might a JCAHO investigator examining a hospital's root cause analysis of a particular sentinel event, practical methods of protection would likely fail.

Any *reported data* of an injury-causing error can be protected from use in a lawsuit involving that specific reported injury by practical methods (anonymous reporting or de-identification). In nonidentified form, the report might still be useful to plaintiffs in other cases as a similar occurrence, but whether this type of use would deter reporting is an empirical question that might vary with the reporting system and might change over time. In addition, anonymous reporting and de-identified reporting both cause reports to lose some information. The information loss would likely be greatest for reports of injury-producing errors, which an informed plaintiff might seek.

Legal protections may help patch up the weaknesses of practical methods of protection. Depending on the nature of the reporting system (geographic catchment, type of reporters, number and type of events reported),

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legal protection may be a necessary supplement to practical protections for possibly identifiable reporters, recipients, and reports. Supplementary legal protection also could ameliorate the loss of data that might otherwise occur to preserve nonidentifiability. If legal use of similar-occurrence data does in fact deter reporting, then legal protection may be desirable to prevent even this type of use. The strongest legal protections would cover the entire chain of custody of the information, from its initial generation to its ultimate use. This strong form of protection is used, for example, in the Health Care Quality Improvement Act's protection for the peer review process.

The committee concludes that some combination of legal and practical protections would be best. Each alone is imperfect, but they are mutually reinforcing and together can provide the strongest assurance of confidentiality.

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8. Weinstein's Federal Evidence, 2nd ed., 1998, Vol. 2, Section 401.07.

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7
Setting Performance Standards and Expectations for Patient Safety

The development and availability of standards for patient safety can serve several purposes. They can either establish minimum levels of performance or can establish consistency or uniformity across multiple individuals and organizations. Another purpose for standards is that they set expectations. The process of developing standards can set expectations for the organizations and health professionals affected by the standards. The publication and dissemination of standards additionally helps to set expectations for consumers and purchasers.

Standards can be developed and used in public regulatory processes, such as licensure for health professionals and licensure for health care organizations, such as hospitals or health plans. Standards can also be developed through private voluntary processes, such as professional certification or organizational accreditation.

Although there are many kinds of standards in health care, especially those promulgated by licensing agencies and accrediting organizations, few standards focus explicitly on issues of patient safety. Furthermore, the current lack of safety standards does not allow consumers and purchasers to reinforce the need for safe systems from the providers and organizations with whom they have contact. All existing regulatory and voluntary standard-setting organizations can increase their attention to patient safety and should consistently reinforce its importance.

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Expectations for the performance of health professionals and organizations are also shaped by professional groups, purchasers and consumers, and society in general. Professional groups and leaders play a particularly important role in establishing norms and facilitating improvements in performance through educational, convening and advocacy activities. Large public and private group purchasers and purchasing coalitions also have the opportunity to shape expectations through marketplace decisions.

This chapter describes how performance standards and expectations can foster improvements in patient safety. Although this report has described the importance of a systems approach for reducing errors in health care, licensing and accreditation of individual practitioners and organizations can also play a role in reinforcing the importance of patient safety. The primary focus is on how existing models of oversight can be strengthened to include a focus on patient safety. In this report, the committee did not undertake an evaluation of the effectiveness of public and private oversight systems to affect quality of care. The committee recognizes, however, that as the organizational arrangements through which health care is delivered change, an evaluation may be appropriate since the existing models of oversight may no longer be adequate.

RECOMMENDATIONS

In the health care industry, standards and expectations about performance are applicable to health care organizations, health professionals, and drugs and devices. The committee believes there are numerous opportunities to strengthen the focus of the existing processes on patient safety issues.

RECOMMENDATION 7.1 Performance standards and expectations for heath care organizations should focus greater attention on patient safety.

- **Regulators and accreditors should require health care organizations to implement meaningful patient safety programs with defined executive responsibility.**
- **Public and private purchasers should provide incentives to health care organizations to demonstrate continuous improvement in patient safety.**

Changes within health care organizations will have the most direct impact on making care delivery processes safer for patients. Regulators and

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accreditors have a role in encouraging and supporting actions within health care organizations by holding them accountable for ensuring a safe environment for patients.

Health care organizations ought to be developing patient safety programs within their own organizations (see Chapter 8). After a reasonable period of time for health care organizations to set up such programs, regulators and accreditors should require patient safety programs as a minimum standard. The marketplace, through purchaser and consumer demands, also exerts influence on health care organizations. Public and private purchasers have three tools that can be employed today to demand better attention to safety by health care organizations. First, purchasers can consider safety issues in their contracting decisions. Second, purchasers can reinforce the importance of patient safety by providing relevant information to their employees or beneficiaries. There is increasing attention in providing information to aid in the selection of health coverage. Information about safety can be part of that process. Finally, purchasers can communicate concerns about patient safety to accrediting bodies to support stronger oversight for patient safety.

RECOMMENDATION 7.2 Performance standards and expectations for health professionals should focus greater attention on patient safety.

- **Health professional licensing bodies should**

(1) implement periodic reexaminations and relicensing of doctors, nurses, and other key providers, based on both competence and knowledge of safety practices; and
(2) work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action.

- **Professional societies should make a visible commitment to patient safety by establishing a permanent committee dedicated to safety improvement. This committee should**

(1) develop a curriculum on patient safety and encourage its adoption into training and certification requirements;
(2) disseminate information on patient safety to members at special sessions at annual conferences, journal articles and editorials, newsletters, publications and websites on a regular basis;

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(3) recognize patient safety considerations in practice guidelines and in standards related to the introduction and diffusion of new technologies, therapies, and drugs;
(4) work with the Center for Patient Safety to develop community-based, collaborative initiatives for error reporting and analysis and implementation of patient safety improvements; and
(5) collaborate with other professional societies and disciplines in a national summit on the professional's role in patient safety.

For most health professionals, current methods of licensing and credentialing assess knowledge, but do not assess performance skills after initial licensure. Although the state grants initial licensure, responsibility for documenting continued competence is dispersed. Competence may be considered when a licensing board reacts to a complaint. It may be evaluated when an individual applies to a health care organization for privileges or network contracting or employment. Professional certification is the current process for evaluating clinical knowledge after licensure and some programs are now starting to consider assessment of clinical skills in addition to clinical knowledge. Given the rapid pace of change in health care and the constant development of new technologies and information, existing licensing and accreditation processes should be strengthened to ensure that all health care professionals are assessed periodically on both skills and knowledge for practice.

More effective methods for identifying unsafe providers and better coordination between the organizations involved are also needed. The time between discovery of a problem, investigation, and action can currently last several years, depending on the issue and procedures for appeal or other processes. Efforts should be made to make this time as short as possible, while ensuring that practitioners have available the due process procedures to which they are entitled. States should also be more active in notifying other states when a practitioner's license is rescinded. Although unsafe practitioners are believed to be few in number and efforts to identify such individuals are not likely to improve overall quality or safety problems throughout the industry, such efforts are important to a comprehensive safety program.

Finally, professional societies and groups should become active leaders in encouraging and demanding improvements in patient safety. Setting standards, convening and communicating with members about safety, incorporating attention to patient safety into training programs, and collaborating across disciplines are all mechanisms that will contribute to creating a cul-

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ture of safety. As patient advocates, health care professionals owe their patients nothing less.

RECOMMENDATION 7.3 The Food and Drug Administration (FDA) should increase attention to the safe use of drugs in both pre- and postmarketing processes through the following actions:

- **develop and enforce standards for the design of drug packaging and labeling that will maximize safety in use;**
- **require pharmaceutical companies to test (using FDA-approved methods) proposed drug names to identify and remedy potential sound-alike and look-alike confusion with existing drug names; and**
- **work with physicians, pharmacists, consumers and others to establish appropriate responses to problems identified through postmarketing surveillance, especially for concerns that are perceived to require immediate response to protect the safety of patients.**

FDA's role is to regulate manufacturers for the safety of their drugs and devices; however, even approved drugs can present safety problems when used in practice. Drugs may be prone to error in use due to sound-alike or look-alike names, unclear labeling, or poorly designed packaging. FDA standards for packaging and labeling of drugs should consider the safety of the products in actual use. Manufacturers should also be required to use proven methods for detecting drug names that sound or look similar. If necessary, Congress should take appropriate action to provide additional enabling authority or clarification of existing authority for FDA to implement this action. Since not all safety problems can be predicted or avoided before a drug is marketed, FDA should also conduct intensive and extensive monitoring to identify problems early and respond quickly when serious threats are discovered in the actual use of approved drugs.

CURRENT APPROACHES FOR SETTING STANDARDS IN HEALTH CARE

Generically, standards can be used to define a process or outcome of care. The Institute of Medicine defines a quality standard as a minimum level of acceptable performance or results or excellent levels of performance or results or the range of acceptable performance or results.[1] Other definitions for standards have been enacted through legislation, such as the Occupational Safety and Health Act of 1970, which defines a safety and health standard as one that requires conditions, or the adoption or use of one or

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more practices, means, methods, operations or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment.[2] A variety of standards have also been defined through private organizations, such as the American Society for Testing and Materials (see Appendix B). The committee does not recommend one definition or type of standard over another, but recognizes that standards can be quite varied and that as standards specific to safety are developed, they could take multiple forms and focus.

In health care, standards are set through both public, regulatory initiatives and private, voluntary initiatives. Standards can apply to health care organizations, health professionals, and drugs and medical devices. For health care organizations (e.g., health plans, hospitals, ambulatory care facilities), standards are set through licensure and accreditation and, to some extent, requirements imposed by large purchasers, such as Medicare and Fortune 500 companies. For health care professionals, standards are set through state licensure, board certification, and accrediting and credentialing programs. For drugs and devices, the FDA plays a critical role in standard setting.

In general, current standards in health care do not provide adequate focus on patient safety. Organizational licensure and accreditation focus on the review of core processes such as credentialing, quality improvement, and risk management, but lack a specific focus on patient safety issues. Professional licensure concentrates on qualifications at initial licensure, with no requirements to demonstrate safe and competent clinical skills during one's career. Standards for drugs and medical devices concentrate on safe design and production, with less attention to their safe use. Current standards in health care leave serious gaps in ensuring patient safety.

PERFORMANCE STANDARDS AND EXPECTATIONS FOR HEALTH CARE ORGANIZATIONS

Standards and expectations for health care organizations may be established through oversight processes, primarily licensing and accreditation requirements. Additionally, large public and private purchasers may also impose demands on health care organizations. Each is discussed in this section.

Licensing and Accreditation

There is a great deal of variation in state licensure requirements for health care organizations. Responsibility for licensure rests at the state level,

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with each state setting its own standards, measurement, and enforcement. Although standards and measurement can be made more similar, enforcement is always likely to vary to some extent depending on the level of resources devoted by a state to this activity.

In many states, licensure and accreditation are intertwined. For hospital licensure, 44 states accept the Joint Commission on Accreditation of Healthcare Organization's evaluation, in whole or in part, as a condition for licensure (Margaret VanAmringe, JCAHO, personal communication, February 23, 1999). Some states may additionally require compliance with other standards related to building safety or medical care issues that are tracked in that particular state. The remaining states do not link hospital licensure and accreditation. Although the overwhelming tendency to use JCAHO increases the consistency of standards nationally, differences in application also contribute to the variation in ensuring patient safety. For licensure of health maintenance organizations (HMOs), some states rely on private accrediting bodies, primarily the National Committee for Quality Assurance (NCQA), to conduct reviews of health plans. It should also be noted that other health facilities, such as some ambulatory care centers or physicians' offices, may not be licensed at all and are generally not subject to traditional methods of oversight. One of the few mechanisms in place today that more broadly examines care in the ambulatory setting is managed care organizations.

Three private-sector agencies play a role in organizational accreditation: JCAHO, NCQA, and the American Accreditation Healthcare Commission/URAC. Each effort, to some degree, encompasses aspects of standard setting and performance measurement.

JCAHO accredits more than 18,000 health care organizations, including hospitals, health plans, home care agencies, and others.[3] Its longest-standing accreditation program applies to hospitals. JCAHO accredits hospitals for three-year periods based on compliance with its standards in the areas of patient rights and patient care: organizational performance; leadership; information management; and nursing and medical staff structures. Approximately 85 percent of hospitals are accredited by JCAHO. Both Joint Commission-accredited hospitals and those accredited by the American Osteopathic Association are deemed to meet Medicare conditions of participation. JCAHO is incorporating performance information into the accreditation process through its Oryx system, in which hospitals will collect clinical data on six measures and submit performance data on these measures. This

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system was introduced in 1997 and is required by the Joint Commission for a hospital to be accredited. Eventually hospitals will have to demonstrate specific Oryx performance to maintain their accreditation status.

NCQA accredits health plans for periods of one, two, or three years. The accreditation process covers areas related to quality improvement, credentialing, members' rights and responsibilities, preventive health services, utilization management, and medical records. Approximately 14 states incorporate accreditation into their licensure requirement for health plans; another six states require that health plans have external reviews, most of which are done by NCQA (Steve Lamb, NCQA, personal communication, March 2, 1999). A number of states also require that health plans serving public employees and/or Medicaid enrollees be accredited. NCQA's performance dataset, the Health Plan Employer Data and Information Set (HEDIS), looks at indicators of effectiveness of care, access or availability, satisfaction, health plan stability, use of services, and costs. Beginning in July 1999, accreditation criteria began to incorporate HEDIS measures, initially being used only if they increase a health plan's overall score.[4] Accreditation status will also change with the top 20 percent of health plans earning the status of "excellent."

URAC was established in 1990 and offers nine different accreditation programs for managed care organizations, such as health plan accreditation, health network accreditation, health utilization management accreditation, and network practitioner credentialing.[5] Individual managed care organizations can seek accreditation under different sets of programs depending on the range of services they offer. URAC accreditation focuses on preferred provider organization (PPO) and point-of-service (POS) plans. Approximately 22 states have incorporated Commission/URAC accreditation into their regulatory structures.

Purchaser Requirements and Demands

Both private and public purchasers have the ability to encourage health care organizations and providers to pursue continuous improvements in patient safety. Large group purchasers, such as Fortune 500 companies or the Health Care Financing Administration, and purchasing coalitions that provide insurance to large numbers of people are well positioned to exert considerable leverage in the marketplace.

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Private Group Purchasers

There are numerous examples of large private employers that incorporate quality issues into their decision-making process when selecting health plans and providers to offer to employees.[6] Xerox Corporation ranks health plans according to various quality indicators, including accreditation status, satisfaction ratings, and quality indicators. ARCO evaluates health plans based on 50 different quality and access criteria, and ties the employer contribution to the premium level of the highest-ranking plan. In a survey of 33 large purchasers in four states, 45 percent reported using HEDIS data (i.e., NCQA's Healthplan Employer Data and Information Set quality indicators), 55 percent reported using accreditation data, and 53 percent reported using consumer satisfaction survey data to choose a health plan.[7]

Although some large employers have incorporated quality considerations into their purchasing decisions, this is not the norm. A 1997 survey of 325 U.S. companies found that most employers consider provider network characteristics, but only a fraction consider quantifiable measures of access, quality or outcomes.[8] Another survey found that nearly two-thirds of mid-size and large employers are unfamiliar with NCQA accreditation, the most widely used accreditation program for health plans.[9]

Clearly, there is much opportunity for large employers to place greater emphasis on quality, and specifically patient safety, issues when making decisions to contract with a specific health plan and in the design of payment and financial incentive systems to reward demonstrated quality and safety improvements.

Health Care Financing Administration

As a major national purchaser of health care services, HCFA sets standards through payment policies and conditions of participation for the organizations with which it contracts. HCFA provides health insurance for 74 million people through Medicare, and in partnership with the states, Medicaid, and Child Health Insurance programs.[10] It also performs a number of quality-focused activities, including regulation of laboratory testing, surveys and certification, development of coverage policies, and quality improvement initiatives.

The peer review organizations (PROs) monitor the utilization and quality of care of Medicare beneficiaries through a state-based network.[11] They have three functions. First, they conduct cooperative quality improvement projects in partnership with other quality-focused organizations. Among the

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current projects are programs on diabetes, end-stage renal disease, influenza campaign, and quality improvement systems for managed care. Second, PROs conduct mandatory case review in response to beneficiary complaints, as well as educational and outreach activities. Third, they oversee program integrity by ensuring that Medicare pays only for medically necessary services. Patient safety has not been identified as a priority to date, however, HCFA is giving serious consideration to making patient safety a higher priority.[12]

Medicare and Medicaid survey and certification activities are aimed at ensuring that providers and suppliers for these programs meet health, safety, and program standards.[13] They deal with issues related to the effective and efficient delivery of care to beneficiaries, ensuring their safety while in health care facilities and improving their quality of care. HCFA relies on state health agencies as the principal agents to perform certification activities through their licensure activities. As already noted, state health departments, in turn, often rely on JCAHO as part of licensing a hospital.

STANDARDS FOR HEALTH PROFESSIONALS

Performance standards and expectations for health professionals may be defined through regulatory and other oversight processes, such as licensing, accreditation, and certification. Standards and expectations may also be shaped by professional societies and other groups that voluntarily promulgate guidelines or protocols and sponsor educational and convening activities.

Licensing, Certification, and Accreditation

Compared to facility licensure (as discussed in the previous section) there is even greater variation found in professional licensure. There are several reasons for this. First, professional licensure is structured through individual licensing boards for each regulated profession in the state.[14] The result is variation both within states and across states. Within states, there is little coordination of management or dissemination of information among different boards.[15] Across states, there is variation in what is considered a complaint and in the rate at which disciplinary action is taken. Variation in what is considered a "complaint" influences what is investigated and what can be shared and when. A call to the licensing board may be considered a complaint, or a complaint may be recognized only when there is a formal

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charge. It is not clear, therefore, when information can be shared: when something is filed (which may or may not lead to a charge), while it is being investigated, after there is a charge, or only if disciplinary action is taken. Inconsistencies permit unsafe practitioners to move to different jurisdictions before a complaint can be investigated and handled.[16]

Although not a comprehensive measure of effectiveness, there is wide variation in the rate at which state licensing boards take serious disciplinary actions against physicians, ranging from 0.85 per 1,000 physicians in Louisiana to 15.40 per 1,000 physicians in Alaska, based on data from the Federation of State Medical Boards.[17] Across the country, the rate was 3.76 actions per 1,000 physicians in 1998. States that appeared to be doing a better job (more disciplinary actions) tended to have better funding, and more staff, conducted proactive investigations (as opposed to waiting for complaints), used other available data (e.g., Medicare or Medicaid data), had good leadership, were independent from state medical societies and other parts of state government, and had a reasonable statutory framework for conducting their work. Board action can also be quite slow. For example, the Virginia Board of Medicine takes an average of more than two and a half years to resolve a case.[18]

The National Council of State Boards of Nursing has endorsed a mutual recognition model for interstate nursing practice to encourage reciprocal arrangements between states for licensing and disciplinary action (Carolyn Hutcherson, National Council of State Boards of Nursing, personal communication, June 1, 1999).[19] The goal would be to make licensure more like the rules used for a driver's license. That is, licensure is recognized across state lines, but the nurse would still be subject to the rules of a state while in that state (e.g., even if a driver's residence is in Maryland, the driver can still get a speeding ticket in Texas).

Another issue related to professional licensure is that there is no continuing assessment or required demonstration of performance after initial licensure is granted, except for physician assistants and emergency medical technicians.[20] In general, the state is involved in initial licensure or follow-up of complaints; processes for documenting continued competence are voluntary.

For example, physicians may voluntarily seek board certification through one of 24 specialty medical boards that have been approved by the American Board of Medical Specialties (ABMS).[21] The specialty boards set professional and educational standards for the evaluation and certification of physician specialists. Initial certification is granted by passing written and

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oral examinations. Recertification occurs at seven- to ten-year intervals, although not all boards require recertification. Recertification is granted based on self-assessment, examinations, and credentialing (e.g., unrestricted license, good standing in practice, hospital privileges (Linda Blank, American Board of Internal Medicine, personal communication, May 18, 1999). A minimum number of continuing education credits may also be required. At the present time, there is no assessment of practice skills, although some specialty boards have committed a broader and more timely assessment of competence.[22]

Another voluntary approach is the American Medical Accreditation Program (AMAP), which is being developed by the American Medical Association. AMAP is a voluntary process, begun in 1998, for the accreditation of individual physicians that is designed to measure and evaluate individual physicians against national standards and peer performance.[23] The program will evaluate physicians in five areas: (1) credentials; (2) personal qualifications (including ethical behavior and participation in continuing medical education, peer reviews, and self-assessment of performance); (3) environment of care (including a site review of office operations and medical records); (4) clinical processes (including standardized measures of key patient care processes and comparative feedback to the physician); and (5) patient outcomes (including standardized measures of patient outcomes, perceptions of care, and health status). Although this is a national program, it is being implemented on a state-by-state basis.

A comparable process is found in nursing, which recognizes specialty practice through board certification. One such specialty certifying body is the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association. Specialty certifying boards set professional and educational standards for the defined specialty and determine a mechanism for establishing continued competency through the recertification process, which occurs every three to five years, depending on the specialty. Although safety is not an explicit focus of certification exams, areas covered may relate to safety, for example, medication errors. Nurses may pursue certification voluntarily, although some states require it for licensure at advanced levels such as nurse practitioner (Ann Carey, R.N., American Nurses Credentialing Center, personal communication, July 20, 1999). Certifying organizations are exploring alternative ways to validate continued competency in addition to continuing education.

Health care organizations are also involved in assessing the continued performance of professionals when hiring nurses or credentialing physicians

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for hospital privileges, network membership, or employment. Again, there is little consistency in the standards used and little opportunity for communication across organizations. For example, an unsafe provider may be dismissed from one hospital, with no notification to the licensing board and limited ability for the next hospital to find out the reasons for the dismissal.

The Pew Health Professions Commission conducted an extensive investigation of licensure and continued competency issues. Its report identifies four places in which assessment of competency can occur: upon entry into practice, for continuing authorization to practice, reentry to practice, and after disciplinary action.[24] The report recommended increased state regulation to require health care practitioners to "demonstrate their competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs throughout their career." They note that considerations of competence should include not only the basic and specialized knowledge and skills, but also other skills such as "capacity to admit errors." In their view, the current system that relies on continuing education and disciplinary action after a problem has occurred is insufficient. The trend toward computer-based testing should facilitate greater attention to skill assessment in the future. Physician licensure tests and physician recertification are moving toward interactive, computer-based testing, and nursing is also testing a computerized system for initial licensure.[25]

The Role of Health Professional Societies and Groups

Professional societies, groups, and associations can play an important role in improving patient safety by contributing to the creation of a culture that encourages the identification and prevention of errors. Few professional societies or groups have demonstrated a visible commitment to reducing errors in health care and improving patient safety. Although it is believed that the commitment exists among their members, there has been little collective action. The exception most often cited is the work that has been done by anesthesiologists to improve safety and outcomes for patients.

Anesthesiology has successfully reduced anesthesia mortality rates from two deaths per 10,000 anesthetics administered to one death per 200,000–300,000 anesthetics administered (see Chapter 2). This success was accomplished through a combination of:

- technological changes (new monitoring equipment, standardization of existing equipment);

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- information-based strategies, including the development and adoption of guidelines and standards;
- application of human factors to improve performance, such as the use of simulators for training;
- formation of the Anesthesia Patient Safety Foundation to bring together stakeholders from different disciplines (physicians, nurses, manufacturers) to create a focus for action; and
- having a leader who could serve as a champion for the cause.[26]

To explore the ways that professional societies could improve patient safety, the Institute of Medicine (IOM) convened a one-day workshop on September 9, 1999 with 14 health professionals representing medicine, nursing, and pharmacy (workshop participants are included in the acknowledgments). These leaders are interested and involved in issues related to patient safety and are active in professional societies, although they did not participate in the workshop as representatives of these societies. Four broad roles were identified that could be employed, individually or in combination, to create a culture of safety. These roles are: (1) defining standards of practice; (2) convening and collaborating among society members and with other groups; (3) encouraging research, training and education opportunities; and (4) advocating for change.

One way that professional societies contribute to standards of practice is through the promulgation and promotion of practice guidelines. A number of professional groups have produced practice guidelines and defined best practices in select areas. Guidelines produced by the American College of Cardiology (ACC) and the American Heart Association Task Force of Practice Guidelines are consistently cited models. They have produced sixteen guidelines ranging from coronary artery bypass graft (CABG) to management of chronic angina.[27]

Pharmacy has also devoted significant attention to patient safety. The American Society of Health-System Pharmacists (ASHP) has published extensively on safe medication practices. Reduction of medication errors has been an identified priority for a decade and is reflected through publications in professional and scientific journals, educational programming, and advocacy. Included among the standards and guidelines is a widely disseminated list of the top priority actions for preventing adverse drug events in hospitals.

Practice guidelines can also be written through a more interdisciplinary approach, such as the perinatal guidelines published jointly by the American

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College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics. There is now a fourth edition of these guidelines. As recognition has grown that errors are caused by failures in systems, interdisciplinary collaboration may become increasingly necessary for redesigning complex systems of care. Participants at the workshop suggested that professional societies develop guidelines devoted specifically to patient safety and the incorporation of patient safety considerations into other guidelines.

One of the most visible activities of professional groups is their convening function. Through annual conferences and specialty meetings, professional groups can develop and communicate standards, values, and policy statements to membership and key opinion leaders. Meeting conclusions may also be disseminated through their own and other journal publications. There are few examples of specialty meetings or conferences where patient safety has been explicitly included on the agenda. Additionally, there are few interdisciplinary conferences devoted to issues of patient safety. Participants at the workshop proposed a national conference that would bring together all health professions and professionals from other disciplines (e.g., industrial engineering, human factors analysis) and other industries (e.g., airline pilots).

Clinical training and education is a key mechanism for cultural change. Colleges of medicine, nursing, pharmacy, health care administration, and their related associations should build more instruction into their curriculum on patient safety and its relationship to quality improvement. One of the challenges in accomplishing this is the pressure on clinical education programs to incorporate a broadening array of topics. Many believe that initial exposure to patient safety should occur early in undergraduate and graduate training programs, as well as through continuing education. Clinical training programs also need to ensure that teaching opportunities are safe for patients. One workshop participant told of a monitoring device used to alert staff to possible problems with the patient that was turned off because it was seen as interfering with the teaching experience.

The need for more opportunities for interdisciplinary training was also identified. Most care delivered today is done by teams of people, yet training often remains focused on individual responsibilities leaving practitioners inadequately prepared to enter complex settings. Improving patient safety also requires some understanding of systems theory in order to effectively analyze the many contributing factors that influence errors. Again, the "silos" created through training and organization of care impede safety improvements. Instruction in safety improvement requires knowledge about work-

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ing in teams, using information and information technology, quality measurement, and communicating with patients about errors. A background in other disciplines is also relevant, such as cognitive psychology, systems theory, and statistics.[28] Principles of crew resource management used to train personnel who work together in airline cockpits might also be applicable to health care. Training should also emphasize better communications across disciplines. This is important when the members of a care team are in one physical location, such as a hospital or office setting, but becomes even more important when the care team may not be in one place, such as a team providing home care.

Few professional groups have sufficient resources to devote to research support, although many have established research and education foundations. The need for greater collaboration in developing regional databases was noted. A key advantage of establishing these at the regional level is the ability to obtain a sufficient number of cases for meaningful analysis. The number of cases of any particular event in a single hospital or clinical setting is usually too small to be able to generalize across cases and identify a way to make system improvements. Regional data systems can increase numbers to improve analytic power and can facilitate collaboration to understand the extent and nature of errors in health care. Professional societies and groups could participate in efforts to coordinate a research agenda and the development of databases to provide information on the extent and nature of errors in health care.

Professional groups can also serve as advocates for change. Professional groups have been able to call attention to a health risk and create awareness. For example, pediatricians have been active in promoting increased immunization rates, the American Heart Association has promoted diet and exercise to prevent heart disease, and the American Medical Association (AMA) has been an outspoken opponent against smoking. Professional groups have not been as visible in advocating for patient safety and communicating such concerns to the general public and policy makers. A notable exception has been the formation of the National Patient Safety Foundation (NPSF) by the AMA in 1997 (see Chapter 4). The NSPF has taken a visible role in advocating for improvements in patient safety and communicating with a broad array of audiences. Professional societies can play a role not only in informing their members about patient safety, but also in calling attention to the issue among the general public.

Implementation of activities to increase the role of health professionals in patient safety must occur at multiple levels. Although some professional

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groups influence and communicate with just their own members, other groups have the potential to influence many audiences. For example, the American Board of Medical Specialties has the potential to influence 24 professional medical societies. The Accreditation Council for Graduate Medical Education and the American Association of Colleges of Nursing have the potential to influence numerous training programs. The Association of American Medical Colleges can influence multiple medical schools and academic medical centers. There are many other similar groups that coordinate across multiple organizations. These "high leverage" groups are critical players in encouraging action among their constituent organizations. They should use their influence to promote greater awareness of patient safety and to consistently reinforce its importance.

STANDARDS FOR DRUGS AND DEVICES

The Food and Drug Administration is a major force in setting standards for medical products and monitoring their safety. FDA regulates prescription and over-the-counter drugs, medical and radiation-emitting devices, and biologics, among other things. This discussion focuses on its activities related to drugs and devices. It should be noted, however, that the FDA regulates manufacturers, not health care organizations or professionals. There are two opportunities for FDA to ensure and enhance patient safety: during its approval process for drugs and devices, and through postmarketing surveillance.

FDA has regulatory authority over the naming, labeling, and packaging of drugs and medical devices. FDA approves a product when it judges that the benefits of using the product outweigh the risks for the intended population and use.[29] For drugs, the approval process examines evidence of the effectiveness of the drug and the safety of the drug when used as intended. For devices, FDA looks at the safety and effectiveness of the device compared to devices already on the market or else looks for reasonable assurance of safety and effectiveness.

A major component of postmarketing surveillance is conducted through adverse event reporting.[30] Reports may be submitted directly to the FDA or through MedWatch, FDA's reporting program. For medical devices, manufacturers are required to report deaths, serious injures, and malfunctions to FDA. User facilities (hospitals, nursing homes) are required to report deaths to both the manufacturer and FDA, and to report serious injuries to the manufacturer. For suspected adverse events associated with drugs, report-

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ing is mandatory for manufacturers and voluntary for physicians, consumers, and others. All reports are entered into the Adverse Event Reporting System (AERS) or another database, which is used to identify problem areas or increased incidence of an event.

FDA receives approximately 235,000 reports annually for adverse drug events and approximately 80,000–85,000 reports on device problems. Despite the extensive testing that FDA requires before drugs and devices are approved, side effects or other problems invariably show up after they have been released and used widely. Not all risks are identified premarketing because study populations in premarketing trials are often too small to detect rare events, studies may not last long enough to detect some events, and study populations may be dissimilar from the general population.[31] Some of these initially unknown risks can be serious or even fatal. The problem is likely to continue and possibly worsen in the future because of the number of new drugs being introduced. In 1998 alone, FDA approved 90 new drugs, 30 new molecular entities (drugs that have never been marketed in this country before), 124 new or expanded uses of already approved drugs, 344 generic drugs, 8 over-the-counter drugs, and 9 orphan drugs, or almost two actions every day of the year.[32] Approximately 48 percent of the prescription drugs on the market today have become available only since 1990.[33] Medications are also the most frequent medical intervention, with an average of 11 prescriptions per person in the United States.[34]

FDA has three general strategies it pursues for corrective action. The first (and most commonly pursued) is negotiation with the manufacturer to make the desired changes. The extent of cooperation from the manufacturers can vary. In terms of drugs, names are the most difficult to change, particularly once a name has been trademarked by the company (Jerry Phillips, OPDRA, personal communication, May 4, 1999). Second, FDA may take regulatory action against manufacturers to require changes. This could include name changes or withdrawal of a product from the market. The final type of action that FDA can take is communication about risks, including letters to physicians, pharmacists, and other health professionals, postings on the Internet, and publication of clinical and consumer journals. FDA decisions about corrective action are made on a case-by-case basis, by considering the unexpectedness and seriousness of the event, the vulnerability of the population affected, and the preventability of the event.[35]

Some concerns have been expressed over the responsiveness of FDA to reported problems. Concerns have related to the timeliness and effectiveness of the agency's response or that the response to a given problem may

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not be strong enough given its seriousness. For example, five drugs were removed from the market in between September 1997 and September 1998, but almost 20 million people had been exposed to their risks before they were removed.[36] Terfenadine was on the market for 12 years, even though researchers earlier identified it as causing deaths; it was removed from the market by the manufacturer only after a substitute was developed.[37]

There have been calls for better methods for obtaining more information about the harm caused by drugs (e.g., greater use of active surveillance systems that look for indicators of problems rather than waiting for reports to be submitted) or for the establishment of an independent drug safety review board.[38] In the fall of 1998, FDA changed the process for follow-up on reported drug problems with the creation of a new Office of Post-Marketing Drug Risk Assessment (OPDRA). Before, incidents were reviewed by a committee, triaged, and sent back to the division that did the original review. This dispersed responsibility for review and follow-up led to variability in response. Now, OPDRA will conduct an analysis of all reported events and develop recommendations that are sent to the manufacturer and the director of the FDA division that conducted the original review. The division director must report to OPDRA in 60 days on the status of the recommendations. OPDRA estimates that approximately half of the causal factors that contribute to adverse events are issues to which it can respond (e.g., labeling problems); the remainder are outside its scope (e.g., bad handwriting) (Jerry Phillips, OPDRA, personal communication, May 4, 1999).

With regard to medical devices, in recent years, FDA has increased its requirements and guidance to manufacturers on designing devices to take into account human factors principles and user testing. Attention to human factors could improve simplicity of use, standardization of controls, and default to a safe setting during failure (e.g., loss of power). For example, intravenous infusion pumps vary markedly in their mode of operation and types of controls. Because they are expensive, hospitals do not replace old pumps when new ones become available, which results in different models being used. The lack of standardization among the models increases the likelihood of error when the pump is set up. Controls on defibrillators can also vary in position, appearance, and function on different machines, leading to errors when they are used rapidly in emergency situations. Although the increased attention to human factors principles does not affect devices already on the market, over time it is expected that manufacturers will become more accustomed to using human factors in the design of medical devices.

With the passage of the Safe Medical Device Act of 1990, FDA was

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granted the authority to require manufacturers of medical devices to establish and follow procedures for ensuring that device design addressed the intended use of the device and its users.[39] Final rules for this act became effective in June 1997. FDA has continued to emphasize to manufacturers the importance of human factors and is expected to issue a manual of engineering and design guidelines for manufacturers in 1999.

In terms of drugs, the use of human factors principles could reduce confusion of medications that occur because of brand names that look alike or sound alike, labels that are hard to read, and look-alike packaging. Wrong doses also occur frequently because of factors such as the lack of standardized terms in the display of contents. For example, contents displayed by concentration (e.g., 10 mg/mL) rather than total amount (e.g., 100 mg) can result in an overdose. There may also be inconsistent placement of warnings on a label or inconsistent use of abbreviations. Most recently, more than 100 errors have been reported in the use of Celebrex (prescribed for arthritis) and its confusion with Cerebyx (an antiseizure medication) and Celexa (an antidepressant).[40] FDA does not have guidance for using human factors principles in the packaging, labeling, or naming of drugs as exists relative to medical devices.

SUMMARY

The main sources of standards for health care organizations and professionals today are through licensing and accreditation processes. However, medical errors and patient safety are not an explicit focus of licensing and accreditation. Although licensing and accreditation standards do speak to the characteristics of quality improvement programs, and patient safety and error reduction may be part of these programs, many licensed and fully accredited organizations have yet to implement the most rudimentary systems and processes to ensure patient safety. Furthermore, the extent of variation in licensure within and across states suggests that there is no reliable assurance of safety to patients, even for those facilities and professionals covered under current rules.

Although current standard-setting authorities in health care are not devoting adequate attention to patient safety issues, the committee considered and rejected the option of recommending the creation of yet another regulatory authority. The recommendations contained in this chapter direct the existing regulatory structures to increase attention to patient safety issues. Licensing agencies and accrediting organizations have to hold health care

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organizations accountable for creating and maintaining safe environments. Professional licensing bodies should consider continuing qualifications over a lifetime of practice, not just at initial licensure. Standards for approving drugs and devices must consider safety for patients in actual use and real-life settings, not just safe production.

The actions of professional groups and group purchasers in setting standards and expectations are also critical. Professional groups shape professional behavior by developing practice guidelines and identifying best practices and through educational, convening and advocacy activities. All could be enhanced by a sharper focus on patient safety issues. Group purchasers have the ability to consider safety issues in their contracting decisions, and to reinforce the importance of safety by providing relevant information to employees and beneficiaries.

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8 Creating Safety Systems in Health Care Organizations

Unsafe acts are like mosquitoes. You can try to swat them one at a time, but there will always be others to take their place. The only effective remedy is to drain the swamps in which they breed. In the case of errors and violations, the "swamps" are equipment designs that promote operator error, bad communications, high workloads, budgetary and commercial pressures, procedures that necessitate their violation in order to get the job done, inadequate organization, missing barriers, and safeguards . . . the list is potentially long but all of these latent factors are, in theory, detectable and correctable before a mishap occurs.[1]

Safety systems in health care organizations seek to prevent harm to patients, their families and friends, health care professionals, contract-service workers, volunteers, and the many other individuals whose activities bring them into a health care setting. Safety is one aspect of quality, where quality includes not only avoiding preventable harm, but also making appropriate care available—providing effective services to those who could benefit from them and not providing ineffective or harmful services.[2]

As defined in Chapter 3, patient safety is *freedom from accidental injury*. This definition and this report intentionally view safety from the perspective of the patient. Accordingly, this chapter focuses specifically on patient safety. The committee believes, however, that a safer environment for patients would also be a safer environment for workers and vice versa, because both

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are tied to many of the same underlying cultural and systemic issues. As cases in point, hazards to health care workers because of lapses in infection control, fatigue, or faulty equipment may result in injury not only to workers but also to others in the institution.

This chapter introduces what has been learned from other high-risk industries about improving safety. It then discusses key concepts for designing systems and their application in health care. This is followed by a discussion of five principles to guide health care organizations in designing and implementing patient safety programs. Lastly, the chapter discusses a critical area of safety, namely medication safety and illustrates the principles with strategies that health care organizations can use to improve medication safety.

RECOMMENDATIONS

The committee is convinced that there are numerous actions based on both good evidence and principles of safe design that health care organizations can take now or as soon as possible to substantially improve patient safety. Specifically, the committee makes two overarching recommendations: the first concerns leadership and the creation of safety systems in health care settings; the second concerns the implementation of known medication safety practices.

RECOMMENDATION 8.1 Health care organizations and the professionals affiliated with them should make continually improved patient safety a declared and serious aim by establishing patient safety programs with a defined executive responsibility. Patient safety programs should: (1) provide strong, clear, and visible attention to safety; implement nonpunitive systems for reporting and analyzing errors within their organizations; (2) incorporate well-understood safety principles, such as, standardizing and simplifying equipment, supplies, and processes; and (3) establish interdisciplinary team training programs, such as simulation, that incorporate proven methods of team management.

Chief executive officers and boards of trustees must make a serious and ongoing commitment to creating safe systems of care. Other high-risk industries have found that improvements in safety do not occur unless there is commitment by top management and an overt, clearly defined, and continuing effort on the part of all personnel and managers. Like any other program, a meaningful safety program should include senior-level leadership,

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defined program objectives, plans, personnel, and budget, and should be monitored by regular progress reports to the executive committee and board of directors.

According to Cook,[3] *Safety is a characteristic of systems and not of their components. Safety is an emergent property of systems.* In order for this property to arise, health care organizations must develop a systems orientation to patient safety, rather than an orientation that finds and attaches blame to individuals. It would be hard to overestimate the underlying, critical importance of developing such a culture of safety to any efforts that are made to reduce error. The most important barrier to improving patient safety is lack of awareness of the extent to which errors occur daily in all health care settings and organizations. This lack of awareness exists because the vast majority of errors are not reported, and they are not reported because personnel fear they will be punished.

Health care organizations should establish nonpunitive environments and systems for reporting errors and accidents within their organizations. Just as important, they should develop and maintain an ongoing process for the discovery, clarification, and incorporation of basic principles and innovations for safe design and should use this knowledge in understanding the reasons for hazardous conditions and ways to reduce these vulnerabilities. To accomplish these tasks requires that health care organizations provide resources to monitor and evaluate errors and to implement methods to reduce them.

Organizations should incorporate well-known design principles in their work environment. For example, standardization and simplification are two fundamental human factors principles that are widely used in safe industries and widely ignored in health care.

They should also establish interdisciplinary team training programs—including the use of simulation for trainees and experienced practitioners for personnel in areas such as the emergency department, intensive care unit, and operating room; and incorporating proven methods of managing work in teams as exemplified in aviation (where it is known as crew resource management).

RECOMMENDATION 8.2 Health care organizations should implement proven medication safety practices.

A number of practices have been shown to reduce errors in the medication process and to exemplify known methods for improving safety. The committee believes they warrant strong consideration by health care organi-

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zations including hospitals, long-term-care facilities, ambulatory settings, and other health care delivery sites, as well as outpatient and community pharmacies. These methods include: reducing reliance on memory; simplification; standardization; use of constraints and forcing functions; the wise use of protocols and checklists; decreasing reliance on vigilance, handoffs, and multiple data entry; and differentiating among products to eliminate look-alike and sound-alike products.

INTRODUCTION

Errors occur in all industries. Some industrial accidents involve one or a few workers. Others affect entire local populations or ecosystems. In health care, events are well publicized when they appear to be particularly egregious—for example, wrong-site surgery or the death of a patient during what is thought to be a routine, low-risk procedure. Generally, however, accidents are not well publicized; indeed, they may not be known even to the patient or to the family. Because the adverse effects may be separated in time or space from the occurrence, they may not even be recognized by the health care workers involved in the patient's care.

Nevertheless, we know that errors are ubiquitous in all health care settings.[4] Harms range from high-visibility cases to those that are minimal but require additional treatment and time for the patient to recuperate or result in a patient's failure to receive the benefit of appropriate therapy. In aggregate, they represent a huge burden of harm and cost to the American people as described in Chapter 2.

To date, however, those involved in health care management and delivery have not had specific, clear, high-level incentives to apply what has been learned in other industries about ways to prevent error and reduce harm. Consequently, the development of safety systems, broadly understood, has not been a serious and widely adopted priority within health care organizations. This report calls on organizations and on individual practitioners to address patient safety.

Health care is composed of a large set of interacting systems—paramedic, emergency, ambulatory, inpatient care, and home health care; testing and imaging laboratories; pharmacies; and so forth—that are connected in loosely coupled but intricate networks of individuals, teams, procedures, regulations, communications, equipment, and devices that function with diffused management in a variable and uncertain environment.[5] Physicians in community practice may be so tenuously connected that they do not even

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view themselves as part of a system of care. They may see the hospitals in which they are attendings as platforms for their work. In these and many other ways, the distinct cultures of medicine (and other health professions) add to the idiosyncrasy of health care among high-risk industries.

Nevertheless, experience in other high-risk industries has provided well-understood illustrations that can be used in improving health care safety. Studies of actual accidents, incident-reporting systems, and research on human factors (i.e., the interface of human beings and machines and their performance in complex working environments) have contributed to our growing understanding about how to prevent, detect, and recover from accidents. This has occurred because, despite their differences from health care, all systems have common characteristics that include the use of technologies, the users of these technologies, and an interface between the users and the technologies.[6] The users of technology bring certain characteristics to a task such as the quality of their knowledge and training, level of fatigue, and careful or careless habits. They also bring characteristics that are common to everyone, including difficulty recalling material and making occasional errors.

Safety Systems in High-Risk Industries

The experience in three high-risk industries—chemical and material manufacturing and defense—provides examples of the information and systems that can contribute to improved safety and of the safety achievements that are possible. Claims that health care is unique and therefore not susceptible to a transfer of learning from other industries are not supportable. Rather, the experiences of other industries provide invaluable insight about how to begin the process of improving the safety of health care by learning how to prevent, detect, recover, and learn from accidents.

E.I. du Pont de Nemours and Company

E.I. du Pont de Nemours and Company has one of the lowest rates of occupational injury of any company, substantiation of an 11-point safety philosophy that includes the tenets that all injuries are preventable; that management is responsible and accountable for preventing injury; that safety must be integrated as a core business and personal value; and that deficiencies must be corrected promptly. In 1994, Conoco Refining, a subsidiary, reported only 1.92 work-loss days per 200,000 hours of exposure. In 1998,

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this rate was further reduced to 0.39. Some of DuPont's plants with more than 2,000 employees have operated for more than 10 years without a lost-time injury, and one plant producing glycolic acid celebrated 50 years without a lost workday.[7] DuPont credits its safety record, at least in part, to its implementation of a nonpunitive system to encourage employees to report near-miss incidents without fear of sanctions or disciplinary measures and its objective to create an *all-pervasive, ever-present awareness of the need to do things safely*.[8,9]

Alcoa, Inc.

Another industry example is Alcoa, which is involved in mining, refining, smelting, fabricating, and recycling aluminum and other materials. Alcoa uses a worldwide on-line safety data system to track incidents, analyze their causes, and share preventive actions throughout all of its holdings. One of its principles is that all incidents, including illnesses, injuries, spills, and excursions, can be prevented whether they are immediate, latent, or cumulative. Although Alcoa reduced its international lost work day rate per 200,000 hours worked from 1.87 in 1987 to 0.42 in 1997, it has recently gone even further and announced a plan to eliminate fatalities and reduce the average injury rate by 50 percent by the end of the year 2000.[10]

Several aspects of these two examples are striking. In comparison to the health care industry, DuPont, Alcoa, and others systematically collect and analyze data about accidents. They have been tracking their own performance over time and are able to compare themselves to others in their industries. They are willing to publish their results as information to which stockholders and employees are entitled and as a source of pride, and their efforts have achieved extremely low and continuously decreasing levels of injury. The importance of a strong culture of safety, as nurtured by both DuPont and Alcoa, is viewed by many in the safety field as being the most critical underlying feature of their accomplishments.

U.S. Navy: Aircraft Carriers

People are quick to point out that health care is very different from a manufacturing process, mostly because of the huge variability in patients and circumstances, the need to adapt processes quickly, the rapidly changing knowledge base, and the importance of highly trained professionals who must use expert judgment in dynamic settings. Though not a biological sys-

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tem, the performance of crews and flight personnel on aircraft carriers provides an example that has features that are closer to those in health care environments than manufacturing.

On an aircraft carrier, fueling aircraft and loading munitions are examples of the risks posed when performing incompatible activities in close proximity. On the flight deck, 100 to 200 people fuel, load munitions, and maintain aircraft that take off and are recovered at 48- to 60-second intervals. The ability to keep these activities separate requires considerable organizational skill and extensive ongoing training to avoid serious injury to flight and nonflight personnel, the aircraft, and the ship. Despite extremely dangerous working conditions and restricted space, the Navy's "crunch rate" aboard aircraft carriers in 1989 was only 1 per 8,000 moves which makes it a very highly reliable, but complex, social organization.*

Students of accident theory emphasize how the interactive complexity of an organization using hazardous technologies seems to defy efforts of system designers and operators to prevent accidents and ensure reliability. In part, this is because individuals are fallible and in part because unlikely and rare (and thus unanticipated) failures in one area are linked in complex systems and may have surprising effects in other systems—the tighter the "coupling," generally, the more likely that failure in one part will affect the reliability of the whole system. Nevertheless, even in such systems, great consistency is achievable using four strategies in particular: the prioritization of safety as a goal; high levels of redundancy, the development of a safety culture that involves continuous operational training, and high-level organizational learning.[11]

Weick and Roberts[12] have studied peacetime flight operations on aircraft carriers as an example of organizational performance requiring nearly continuous operational reliability despite complex patterns of interrelated activities among many people. These activities cannot be fully mapped out beforehand because of changes in weather (e.g., wind direction and strength), sea conditions, time of day and visibility, returning aircraft arrivals, and so forth. Yet, surprisingly, generally mapped out sequences can be carried out with very high reliability in novel situations using improvisation and adaptation and personnel who are highly trained but not highly educated.

*A crunch occurs when two aircraft touch while being moved, either on the flight or hangar deck, even if damage is averted.

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Naval commanders stress the high priority of safety. They understand the importance of a safety culture and use redundancy (both technical and personnel) and continuous training to prepare for the unexpected. The Navy also understands the need for direct communication and adaptability. Because errors can arise from a lack of direct communication, the ship's control tower communicates directly with each division over multiple channels.

As in health care, it is not possible in such dynamic settings to anticipate and write a rule for every circumstance. Once-rigid orders that prescribed how to perform each operation have been replaced by more flexible, less hierarchical methods. For example, although the captain's commands usually take precedence, junior officers can, and do, change these priorities when they believe that following an order will risk the crew's safety. Such an example demonstrates that even in technologically sophisticated, hazardous, and unpredictable environments it is possible to foster real-time problem solving and to institute safety systems that incorporate a knowledge of human factors.

In summary, efforts such as those described in the three examples have resulted neither in stifled innovation nor loss of competitive benefit; nor have they resulted in unmanageable legal consequences. Rather, they are a source of corporate and employee pride. Characteristics that distinguish successful efforts in other industries include the ability to collect data on errors and incidents within the organization in order to identify opportunities for improvement and to track progress. The companies make these data available to outsiders. Other notable features of these efforts include the importance of leadership and the development of a safety culture, the use of sophisticated methods for the analysis of complex processes, and a striving for balance among standardization where appropriate, yet giving individuals the freedom to solve problems creatively.

KEY SAFETY DESIGN CONCEPTS

Designing safe systems requires an understanding of the sources of errors and how to use safety design concepts to minimize these errors or allow detection before harm occurs. This field is described in greater detail in Chapter 3 which includes an error taxonomy first proposed by Rasmussen[13] and elaborated by Reason[14] to distinguish among errors arising from (1) skill-based slips and lapses; (2) rule-based errors; and (3) knowledge-based mistakes.

Leape has simplified this taxonomy to describe what he calls "the pathophysiology of error." He differentiates between the cognitive mechanisms

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used when people are engaging in well-known, oft-repeated processes and their cognitive processes when problem solving. The former are handled rapidly, effortlessly, in parallel with other tasks, and with little direct attention. Errors may occur because of interruptions, fatigue, time pressure, anger, anxiety, fear, or boredom. Errors of this sort are expectable, but conditions of work can make them less likely. For example, work activities should not rely on weak aspects of human cognition such as short-term memory. Safe design, therefore, avoids reliance on memory.

Problem-solving processes, by contrast, are slower, are done sequentially (rather than in parallel with other tasks), are perceived as more difficult, and require conscious attention. Errors are due to misinterpretation of the problem that must be solved, lack of knowledge to bring to bear, and habits of thought that cause us to see what we expect to see. Attention to safe design includes simplification of processes so that users who are unfamiliar with them can understand quickly how to proceed, training that simulates problems, and practice in recovery from these problems.

As described in Chapter 3, instances of patient harm are usually attributed to individuals "at the sharp end" who make the visible error. Their prevention, however, requires systems that are designed for safety—that is, systems in which the sources of human error have been systematically recognized and minimized.[15,16]

In recent years, students of system design have looked for ways to avoid error using what has been called by Donald Norman[17] "user-centered design." This chapter draws on six strategies that Norman outlines. They are directed at the design of individual devices so that they can be used reliably and safely for their intended purposes. Although these strategies are aimed at the human–machine interface, they can also be usefully applied to processes of care.

The first strategy is to make things visible—including the conceptual model of the system—so that the user can determine what actions are possible at any moment—for example, how to turn off a piece of equipment, how to change settings, and what is likely to happen if a step in a process is skipped. The second strategy is to simplify the structure of tasks so as to minimize the load on working memory, planning, or problem solving.

A third strategy is what Norman calls the use of *affordances* and *natural mappings*. An affordance is a characteristic of equipment or workspace that communicates how it is to be used, such as a push bar on an outward opening door that indicates where to push. Another example is a telephone handset that is uncomfortable to hold in any position but the correct one.

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Natural mapping refers to the relationship between a control and its movement; for example, in steering a car to the right, one turns the wheel right. Natural mapping takes advantage of physical analogies and cultural knowledge to help users understand how to control devices. Other examples of natural mapping are arranging light switches in the same pattern as lights in a lecture room; arranging knobs to match the arrangement of burners on a stove; or using louder sound, an increasingly brighter indicator light, or a wedge shape to indicate a greater amount.

A fourth important strategy is the use of constraints or "forcing functions" to guide the user to the next appropriate action or decision. A constraint makes it hard to do the wrong thing; a forcing function makes it impossible. A classic example of a forcing function is that one cannot start a car that is in gear.

Norman's fifth strategy is to assume that errors will occur and to design and plan for recovery by making it easy to reverse operations and hard to carry out nonreversible ones. An example is the Windows® computer operating system that asks if the user really intends to delete a file, and if so, puts it in a "recycle" folder so that it can still be retrieved.

Finally, Norman advises that if applying the earlier strategies does not achieve the desired results, designers should standardize actions, outcomes, layouts, and displays. An example of standardization is the use of protocols for chemotherapy. An example of simplification is reducing the number of dose strengths of morphine in stock.

Safety systems can be both local and organization wide. Local systems are implemented at the level of a small work group—a department, a unit, or a team of health care practitioners. Such local safety systems should be supported by, and consistent with, organization-wide safety systems.

Anesthesiology is an example of a local, but complex, high-risk, dynamic patient care system in which there has been notably reduced error. Responding to rising malpractice premiums in the mid-1980s, anesthesiologists confronted the safety issues presented by the need for continuing vigilance during long operations but punctuated by the need for rapid problem evaluation and action. They were faced with a heterogeneity of design in anesthesia devices; fatigue and sleep deprivation; and competing institutional, professional, and patient care priorities. By a combination of technological advances (most notably the pulse oximeter), standardization of equipment, and changes in training, they were able to bring about major, sustained, widespread reduction in morbidity and mortality attributable to the administration of anesthesia.[18]

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Organization-wide systems, on the other hand, are implemented and monitored at the level of a health care organization. These include programs and processes that cross departmental lines and units. In hospitals, infection control and medication administration are examples of organization-wide systems that encompass externally imposed regulations, institutional policies and procedures, and the actions of individuals who must provide potentially toxic materials at the right time to the right patient.

PRINCIPLES FOR THE DESIGN OF SAFETY SYSTEMS IN HEALTH CARE ORGANIZATIONS

Hospitals and other institutions have long-standing efforts to ensure patient safety in a variety of areas. Appendix E provides an overview of some of these efforts in hospitals. Some have been very effective in certain units or certain hospitals. These activities have not, however, succeeded in eliminating error or injury, and they have not been part of national or even institution-wide, high-priority efforts.

Compared to hospital care, out-of-hospital care—whether in institutions, homes, medical offices or other settings, both the knowledge of the kind and magnitude of errors and the development of safety systems are rudimentary. Safety tends to be addressed narrowly by reliance on education and training, policies, and procedures. There are undoubtedly many reasons for the lack of attention to safety including: small staff size, lack of technical knowledge of effective ways to improve quality or an infrastructure to support deploying this knowledge; lack of recognition of error (because the harm is removed in time or space from the error and because individuals are unharmed); lack of data systems to track and learn from error (most of the adverse drug events studies use emergency visits or hospital admissions to establish a denominator); the speed of change and the introduction of new technologies; and clearly, the same cultural barriers that exist in hospitals—namely, the high premium placed on medical autonomy and perfection and a historical lack of interprofessional cooperation and effective communication.

With the rise in outpatient and office-based surgery, attention is turning to anesthesia safety in settings such as private physician offices, dental, and podiatry offices. For example, guidelines for patient assessment, sedation, monitoring, personnel, emergency care, discharge evaluation, maintenance of equipment, infection control, and the like have been developed by an ad hoc committee for New York State practitioners.[19]

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After reviewing what has been learned from other high-risk industries as well as the evidence of practices that can improve health care safety, the committee has identified a set of five principles that it believes can be usefully applied to the design of safe health care, whether in a small group practice, a hospital, or a large health care system. These principles include: (1) providing leadership; (2) respect for human limits in the design process; (3) promoting effective team functioning; (4) anticipating the unexpected; and (5) creating a learning environment.

Principle 1. Provide Leadership

- Make patient safety a priority corporate objective.
- Make patient safety everyone's responsibility.
- Make clear assignments for and expectation of safety oversight.
- Provide human and financial resources for error analysis and systems redesign.
- Develop effective mechanisms for identifying and dealing with unsafe practitioners.

Make Patient Safety a Priority Corporate Objective

The health care organization must develop a culture of safety such that an organization's design processes and workforce are focused on a clear goal—dramatic improvement in the reliability and safety of the care process. The committee believes safety must be an explicit organizational goal that is demonstrated by clear organizational leadership and professional support as seen by the involvement of governing boards, management, and clinical leadership. This process begins when boards of directors demonstrate their commitment to this objective by regular, close oversight of the safety of the institutions they shepherd.

Reviews of progress in reaching goals and system design should be repeated, detailed, quantitative, and demanding. Ways to implement this at the executive level include frequent reports highlighting safety improvement and staff involvement, regular reviews of safety systems, "walk-throughs" to evaluate hazardous areas and designs, incorporation of safety improvement goals into annual business plans, and providing support for sensible forms of simplification.

Recommendations 5.1 and 7.1 also address institutional accountability for safety. Recommendation 5.1 calls for mandatory reporting of serious adverse events by health care organizations. Recommendation 7.1 urges regu-

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lators to focus greater attention on patient safety by requiring health care organizations to implement meaningful patient safety programs with defined executive responsibility and for public and private purchasers to provide incentives to health care organizations to demonstrate continuous improvement in patient safety.

Make Patient Safety Everyone's Responsibility

Messages about safety must signal that it is a serious priority of the institution, that there will be increased analysis of system issues with awareness of their complexity, and that they are endorsed by nonpunitive solutions encouraging the involvement of the entire staff. The messages must be well conceived, repeated, and consistent across health care systems, and should stress that safety problems are quality problems. Establishing and clearly conveying such aims are essential in creating safety systems.

All organizations must allocate resources to both production and safety. Although compatible in the long run, they may not be in the short run, which often results in considerable short-run tension. Health care institutions must be both accountable to the public for safety and able to address error and improve their performance without unreasonable fear of the threat of civil liability. This, too, creates tension between ensuring the transparency that allows institutions to be viewed publicly as trustworthy and the confidence that their workers have in identifying and addressing error without fear of formal or informal reprisal.

The committee recommends that health care professionals as well as health care organizations make safety a specific aim. Many, if not most, physicians in community practice view organizations such as hospitals primarily as platforms for their work and do not see themselves as being part of these larger organizations. Nevertheless, their participation in the safety efforts of these organizations is crucial. Health care practitioners should seek to affiliate themselves with organizations that embrace such aims, whether the organizations are hospitals, managed care organizations, medical societies, medical practice groups, or other entities**.** Rather than treating each error and hazard as a unique, surprising, separate, and sometimes tragic event, they should view the entire organization as a safety system and the search for improved safety and its associated design principles as a lifelong, shared journey.[20] Health professionals should also participate in new efforts that may be undertaken by groups such as a medical practice and the professional groups to which they belong.

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Make Clear Assignments and Set Expectations for Safety

Health care organizations should establish meaningful patient safety programs with defined executive responsibility that supports strong, clear, visible attention to safety. Most hospitals have safety programs for workers as required by Occupational Safety and Health Administration (OSHA), but few have patient safety programs. The committee emphasizes that by health care organizations, it intends such safety programs to be established not only by hospitals, but also by other organizations, including managed care organizations and the delivery sites with which they contract. Other industries have found that improvements in safety do not occur unless there are both a commitment by top management and an overt, clearly defined, and continuing effort on the part of all personnel, workers, and managers. As with any other program, a meaningful safety program should include senior-level leadership, defined program objectives, and plans; personnel; budget; collecting and analyzing data; and monitoring by regular progress reports to the executive committee and board of directors. Although safety can never be delegated, there should be clear accountability for safety, a budget, a defined program, and regular reporting to the board.

Provide Human and Financial Resources for Error Analysis and Systems Redesign

Responsibility for management and improvement in risky systems (e.g., medication) as a whole should be clearly located in individuals or cross-functional, cross-departmental teams given the time to discharge this duty. For example, individuals or departments "own" pieces of the medication system, but as a rule, no one manages the medication system as a whole. Oversight of a hospital's medication system as a whole, including its safety and improvement, might be placed under a single clinician, with 50 percent or more of his or her time devoted to this role.

In managed care organizations, quality improvement activities, whether or not developed by accreditation bodies, should focus on patient safety activities and an expectation of major improvements in safety. Although data from ambulatory settings are very limited, the committee believes that such improvement could be on the order of a 50 percent reduction in errors in hospital environments and could be greatly reduced in outpatient settings.

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Develop Effective Mechanisms for Identifying and Dealing with Unsafe Practitioners

Although almost all accidents result from human error, it is now recognized that these errors are usually induced by faulty systems that "set people up" to fail. Correction of these systems failures is the key to safe performance of individuals. Systems design—how an organization works, its processes and procedures—is an institutional responsibility. Only the institution can redesign its systems for safety; the great majority of effort in improving safety should focus on safe systems, and the health care organization itself should be held responsible for safety.

The committee recognizes, however, that some individuals may be incompetent, impaired, uncaring, or may even have criminal intent. The public needs dependable assurance that such individuals will be dealt with effectively and prevented from harming patients. Although these represent a small proportion of health care workers, they are unlikely to be amenable to the kinds of approaches described in detail in this chapter. Registration boards and licensure discipline is appropriately reserved for those rare individuals identified by organizations as a threat to patient safety, whom organizations are already required by state law to report.

Historically, the health system has not had effective ways of dealing with dangerous, reckless, or incompetent individuals and ensuring they do not harm patients. Although the health professions have a long history of work in this area, current systems do not, as a whole, work reliably or promptly. The lack of timeliness has been a special problem. Numerous reasons have been advanced for the lack of more timely and effective response by professions and institutions. Requirements posed by legal due process can be very slow and uncertain; the need for, but difficulty in arranging, excellent supervision has stymied efforts at retraining; and matching individual needs to adult learning principles and retraining that is tailored to specific deficits has been problematic. With this acknowledged, the committee believes that health care organizations should use and rely on proficiency-based credentialing and privileging to identify, retrain, remove, or redirect physicians, nurses, pharmacists, or others who cannot competently perform their responsibilities. With effective safety systems in place, the committee believes it will be easier for those within organizations to identify and act on information about such individuals. If these systems are working properly, unsafe professionals will be identified and dealt with *before* they cause serious patient injury.

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Principle 2. Respect Human Limits in Process Design

- Design jobs for safety.
- Avoid reliance on memory.
- Use constraints and forcing functions.
- Avoid reliance on vigilance.
- Simplify key processes.
- Standardize work processes.

Human beings have many intellectual strengths, such as their large memory capacity; a large repertory of responses; flexibility in applying these responses to information inputs; and an ability to react creatively and effectively to the unexpected. However, human beings also have well-known limitations, including difficulty in attending carefully to several things at once, difficulty in recalling detailed information quickly, and generally poor computational ability.[21] Respecting human abilities involves recognizing the strengths of human beings as problem solvers, but minimizing reliance on weaker traits. Several strategies are particularly important when considering such human factors: designing jobs for safety; avoiding reliance on memory and vigilance; using constraints and forcing functions; and simplifying and standardizing key processes.

Design Jobs for Safety

Designing jobs with attention to human factors means attending to the effect of work hours, workloads, staffing ratios, sources of distraction, and an inversion in assigned shifts (which affects worker's circadian rhythms) and their relationship to fatigue, alertness, and sleep deprivation. Designing jobs to minimize distraction may, for example, mean setting aside times, places, or personnel for specific tasks such as calculating doses or mixing intravenous solutions. Designing jobs for safety also means addressing staff training needs and anticipating harm that may accompany downsizing, staff turnover, and the use of part-time workers and "floats" who may be unfamiliar with equipment and processes in a given patient care unit. To the extent that these barriers presented by departmental affiliation and disciplinary training prevent caregivers from working cooperatively and developing new safety systems, job design requires attention not only to the work of the individual but also to the work and training of multidisciplinary teams.

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Avoid Reliance on Memory

Health care organizations should use protocols and checklists wisely and whenever appropriate. Examples of the sensible design and use of protocols and checklists are to ensure their routine updating and constructing checklists so that the usual state is answered as yes. Protocols for the use of heparin and insulin, for example, have been developed by many hospitals.[22] An Institute of Medicine report on the development of clinical guidelines suggests features for assessing guidelines that address their substance and process of development. Examples of attributes concerning the substance of guidelines are their validity and clinical applicability. Examples of the process of development include its clarity and documentation of the strength of the evidence.[23]

For medications, ways to reduce reliance on memory are the use of drug–drug interaction checking software and dosing cards (e.g., laminated cards that can be posted at nursing stations or carried in the pocket) that include standard order times, doses of antibiotics, formulas for calculating pediatric doses, and common chemotherapy protocols.[24]

Caution about using protocols wisely derives from the need to generalize and simplify, but to recognize that not all steps of a protocol may be appropriate. Rapid increases in knowledge and changing technology mean that a system for regular updating of protocols should be built into their production.

Use Constraints and Forcing Functions

Constraints and forcing functions are employed to guide the user to the next appropriate action or decision and to structure critical tasks so that errors cannot be made. They are important in designing defaults for devices and for processes such as diagnostic and therapeutic ordering. When a device fails, it should always default to the safest mode; for example, an infusion pump should default to shutoff, rather than free flow.

Examples of the use of constraints in ordering medications are pharmacy computers that will not fill an order unless allergy information, patient weight, and patient height are entered. Another forcing function is the use of special luer locks for syringes and indwelling lines that have to be matched before fluid can be infused. Removal of concentrated potassium chloride from patient floor stock is a (negative) forcing function.[25] Less restrictive, but user-oriented approaches to design are the use of affordances and natural mappings.

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Avoid Reliance on Vigilance

Human factors research has taught us that individuals cannot remain vigilant for long periods during which little happens that requires their action, and it is unreasonable to expect them to do so. Health care has many examples of automation used to reduce reliance on vigilance: using robotic dispensing systems in the pharmacy and infusion pumps that regulate the flow of intravenous fluids. Although automation is intended to reduce the need for vigilance, there are also pitfalls in relying on automation if a user learns to ignore alarms that are often wrong or becomes inattentive or inexpert in a given process, or if the effects of errors remain invisible until it is too late to correct them. Well-designed pumps give information about the reason for an alarm, have moderate sensitivity, and prevent free flow when the unit is turned off or fails.

Other approaches for accommodating the need for vigilance have been developed. These include providing checklists and requiring their use at regular intervals, limiting long shifts, and rotating staff who must perform repetitive functions.[26]

Simplify Key Processes

Simplifying key processes can minimize problem solving and greatly reduce the likelihood of error. Simplifying includes reducing the number of handoffs required for a process to be completed (e.g., decreasing multiple order and data entry). Examples of processes that can usually be simplified are: writing an order, then transcribing and entering it in a computer, or having several people record and enter the same data in different databases. Other examples of simplification include limiting the choice of drugs available in the pharmacy, limiting the number of dose strengths, maintaining an inventory of frequently prepared drugs, reducing the number of times per day a drug is administered, keeping a single medication administration record, automating dispensing, and purchasing easy-to-use and maintain equipment.[27]

Standardize Work Processes

Standardization reduces reliance on memory. It also allows newcomers who are unfamiliar with a given process or device to use it safely. In general, standardizing device displays (e.g., readout units), operations (e.g., location of the on–off switch), and doses is important to reduce the likelihood of

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error. Examples of standardizing include not stocking look-alike products; the use of standard order forms, administration times, prescribing conventions; protocols for complex medication administration; reducing the numbers of available dose strengths and the times of drug administration, placement of supplies and medications; and types of equipment.[28]

Sometimes devices or medications cannot be standardized. When variation is unavoidable, the principle followed should be to differentiate clearly. An example is to identify look-alike, but different, strengths of a narcotic by labeling the higher concentration with bright orange tape.

Principle 3. Promote Effective Team Functioning

- Train in teams those who are expected to work in teams.
- Include the patient in safety design and the process of care.

Train in Teams Those Who Are Expected to Work in Teams

People work together in small groups throughout health care, whether in a multispecialty group practice, in interdisciplinary teams assembled for the care of a specific clinical condition (e.g., teams that care for children with congenital problems, oncology teams, end-of-life care), in operating rooms, and in ICUs. However, members of the team are typically trained in separate disciplines and educational programs. They may not appreciate each other's strengths or recognize weaknesses except in crises, and they may not have been trained together to use new or well-established technologies.

The committee believes that health care organizations should establish team training programs for personnel in critical care areas (e.g., the emergency department, intensive care unit, operating room) using proven methods such as the crew resource management techniques employed in aviation, including simulation. People make fewer errors when they work in teams. When processes are planned and standardized, each member knows his or her responsibilities as well as those of teammates, and members "look out" for one another, noticing errors before they cause an accident. In an effective interdisciplinary team, members come to trust one another's judgments and attend to one another's safety concerns.

The risk associated with a move to adopt such training from fields such as aviation is in borrowing these training technologies too literally. Although the team issues associated with performance in aviation and medicine have

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strong parallels in medical settings, effective training must be based not on adopting the training technologies too literally but on adapting them to the practices and personnel in the new setting.

Include the Patient in Safety Design and the Process of Care

The members of a team are more than the health care practitioners. A team includes the practitioners, patients, and technologies used for the care of these patients. Whenever possible, patients should be a part of the care process. This includes attention to their preferences and values, their own knowledge of their condition, and the kinds of treatments (including medications) they are receiving. Patients should also have information about the technologies that are used in their care, whether for testing, as an adjunct to therapy, or to provide patient information. Examples of ways to share such information with patients include reviewing with patients a list of their medications, doses, and times to take them; how long to take them; and precautions about interactions with alternative therapies or with alcohol, possible side effects, and any activities that should be avoided such as driving or the use of machinery. Patients should also receive a clearly written list of their medications and instructions for use that they can keep and share with other clinicians.[29]

Principle 4. Anticipate the Unexpected

- Adopt a proactive approach: examine processes of care for threats to safety and redesign them before accidents occur.
- Design for recovery.
- Improve access to accurate, timely information.

Adopt a Proactive Approach: Examine Processes of Care for Threats to Safety and Redesign Them Before Accidents Occur

Technology is ubiquitous in acute care, long-term care, ambulatory surgical centers, and home care. The value of automating repetitive, time-consuming, and error-prone tasks has long been understood and embraced in health care. The increasing use of technologies goes well beyond bedside or operating room devices. It includes emerging technologies that range from molecular, cellular, genetic, and pharmaceutical interventions; to patient-administered technologies (e.g., prescribed medications, monitors, patient-

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controlled analgesia); to robotic and remote technologies such as remote ICU and telemedicine, Internet-based systems, and expert systems.[30–33]

At the same time, the human–machine interface is a focus of much preventive effort. Indeed, many technologies are engineered not only for safe operation in the care process, but specifically for the purpose of preventing error. Such technologies include automated order entry systems; pharmacy software to alert about drug interactions; and decision support systems such as reminders, alerts, and expert systems.

Health care organizations should expect any new technology to introduce new sources of error and should adopt the custom of automating cautiously, alert to the possibility of unintended harm. Despite the best intentions of designers, the committee emphasizes that *ALL technology introduces new errors, even when its sole purpose is to prevent errors.* Therefore as change occurs, health systems should anticipate trouble**.** Indeed, Cook emphasizes that future failures cannot be forestalled by providing simply another layer of defense against failure.[34] Rather, safe equipment design and use depend on a chain of involvement and commitment that begins with the manufacturer and continues with careful attention to the vulnerabilities of a new device or system. Prevention requires the continuous redesign and implementation of safe systems to make error increasingly less likely, for example:

- using order entry systems that provide real-time alerts if a medication order is out of range for weight or age, or is contraindicated;
- using bar coding for positive identification and detection of misidentified patients, records, and so forth;
- using "hear back" for oral orders and instructions—for example, having a pharmacist repeat a phoned-in prescription to the caller; and
- monitoring vital signs, blood levels, and other laboratory values for patients receiving hazardous drugs.

Double-checking for particularly vulnerable parts of the system is another approach to preventing patient injury. One approach could be the use of tiger teams. The military phrase *tiger team* originated with a group whose purpose is to penetrate security and test security measures. Professional tiger teams are now used to test corporate systems for vulnerability, particularly to hackers. The idea of using teams with sophisticated knowledge of technical systems to test and anticipate the ways health systems can go wrong could well be adopted by health care organizations.

Patient safety, as well as business outcomes, should be anticipated when

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reorganization, mergers, and other organization-wide changes in staffing, responsibilities, work loads, and relationship among caregivers result in new patterns of care. Such major changes often have safety implications that can be anticipated and tracked.

Design for Recovery

Prevention is one way to reduce error, but once the error rate and the transmission of the error to patients become very small, incremental gains are increasingly difficult to achieve. Another approach is to work on the processes of recovery when an error occurs. Designing for recovery means making errors visible, making it easy to reverse operations and hard to carry out nonreversible ones, duplicating critical functions or equipment as necessary to detect error, and intercepting error before harm occurs. Although errors cannot be reduced to zero, we should strive to reduce to zero the instances in which error harms a patient. A reliable system has procedures and attributes that make errors visible to those working in the system so that they can be corrected before causing harm.

Examples of procedures to mitigate injury are

- keeping antidotes for high-risk drugs up-to-date and easily accessible;
- having procedures in place for responding quickly to adverse events, such that these processes are standardized across units and personnel are provided with drills to familiarize them with the procedures and the actions each person should take;
- equipment that defaults to the least harmful mode in a crisis; and
- simulation training.

Another example of ways to prevent and to mitigate harm is simulation training. Simulation is a training and feedback method in which learners practice tasks and processes in lifelike circumstances using models or virtual reality, with feedback from observers, other team members, and video cameras to assist improvement of skills.[35] Simulation for modeling crisis management (e.g., when a patient goes into anaphylactic shock or a piece of equipment fails) is sometimes called "crew resource management," an analogy with airline cockpit crew simulation.[36–41] Such an approach carries forward the tradition of disaster drills in which organizations have long participated. In such simulation, small groups that work together—whether in the

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operating room, intensive care unit, or emergency department—learn to respond to a crisis in an efficient, effective, and coordinated manner.

In the case of the operating room (OR) this means attempting to develop simulation that involves all key players (e.g., anesthesia, surgery, nursing) because many problems occur at the interface between disciplines.[42] Although a full OR simulator has been in operation for some years at the University of Basel (Switzerland), the range of surgical procedures that can be simulated is limited. It will be a great challenge to develop simulation technology and simulators that will allow full, interdisciplinary teams to practice interpersonal and technical skills in a non-jeopardy environment where they can receive meaningful feedback and reinforcement.

Improve Access to Accurate, Timely Information

Information about the patient, medications, and other therapies should be available at the point of patient care, whether they are routinely or rarely used. Examples of ways to make such information available are the following

- Have a pharmacist available on nursing units and on rounds.
- Use computerized lab data that alert clinicians to abnormal lab values.
- Place lab reports and medication administration records at the patient's bedside.
- Place protocols in the patient's chart.
- Color-code wristbands to alert of allergies.
- Track errors and near misses and report them regularly.
- Accelerate laboratory turn around time.

Organizations can improve up-to-date access to information about infrequently used drugs by distributing newsletters and drug summary sheets; and ensuring access to Internet-based web sites, the *Physicians Desk Reference*, formularies, and other resources for ordering, dispensing, and administering medications.

Clearly, any discussion of the availability of accurate, timely information for patient care must stress the need for electronic databases and interfaces to allow them to be fully integrated, and the committee underscores the need for data standards and the development of integrated computer-based databases and knowledge servers.

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Health care organizations should join other groups in contributing to the development of standardized data sets for patient records. Uniform standards for connectivity, terminology, and data sharing are critical if the creation and maintenance of health care databases are to be efficient and their information is to be accurate and complete. National standards for the protection of data confidentiality are also needed. The committee urges that health care organizations join payers, vendors, quasi-public standard-setting bodies (such as the National Institute of Standards and Technology (NIST) and American National Standards Institute (ANSI)), federal agencies, and advisory groups in working to facilitate standards-setting efforts and otherwise become full participants in the multidisciplinary effort that is now under way.

Despite the computer-based patient record being "almost here" for 45 years, it has still not arrived. Its advantages are clear: computer-based patient records and other systems give physicians and other authorized personnel the ability to access patient data without delay at any time in any place (e.g., in an emergency or when the patient is away from home); ensure that services are obtained and track outcomes of treatment; and aggregate data from large numbers of patients, both to measure outcomes of treatment; and to promptly recognize complications of new drugs, devices, and treatments.[43]

The committee also believes that organizations, individually and in collaboration, must commit to using information technology to manage their knowledge bases and processes of care. Doing so will require the integration of systems that are patient specific, allow population-based analyses, and systems that manage the case process through reminder, decision support, and guidance grounded in evidence-based knowledge.

Principle 5. Create a Learning Environment

- Use simulations whenever possible.
- Encourage reporting of errors and hazardous conditions.
- Ensure no reprisals for reporting of errors.
- Develop a working culture in which communication flows freely regardless of authority gradient.
- Implement mechanisms of feedback and learning from error.

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Use Simulations Whenever Possible

As described under Principle 4, health care organizations and teaching institutions should participate in the development and use of simulation for training novice practitioners, problem solving, and crisis management, especially when new and potentially hazardous procedures and equipment are introduced. Crew resource management techniques, combined with simulation, have substantially improved aviation safety and can be modified for health care use. Early successful experience in emergency department and operating room use indicates they should be more widely applied.[44]

As noted, health care—particularly in dynamic setting such as operating rooms and emergency departments—involves tightly coupled systems. For this reason, crew resource management can be very valuable in reducing (though probably not eliminating) error. For such programs to achieve their potential, however, requires a thorough understanding of the nature of team interactions, the etiology and frequency of errors, and the cultures of each organization into which they are introduced.

Encourage Reporting of Errors and Hazardous Conditions

The culture of a health care organization plays a critical role in how well errors are detected and handled. Medical training and the culture instilled during this training have considerable strengths—emphasizing autonomy of action and personal responsibility. It has also led to a culture of hierarchy and authority in decision making and to a belief that mistakes should not be made. If they do occur, mistakes are typically treated as a personal and professional failure.[45] Because medical training is typically isolated from the training of other health professionals, people have not learned to work together to share authority and collaborate in problem solving. Attempting to change such a culture to accept error as normal is difficult, and accepting the occurrence of error as an opportunity to learn and improve safety is perhaps even more difficult. As noted at the beginning of this chapter, it requires at a minimum that members of the organization believe that safety is really a priority in their organization, that reporting will really be nonpunitive, and that improving patient safety requires fixing the system, not fixing blame. It will almost surely require changes in the way health care professionals are trained in terms not only of their own professional work, but also of how they learn to work together.

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Ensure No Reprisals for Reporting of Errors

Health care organizations should establish nonpunitive environments and systems for reporting errors and accidents. The most important barrier to improving patient safety is lack of awareness of the extent to which errors occur daily in all health care organizations. It is difficult to remedy problems that you do not know exist. This lack of awareness occurs because in most cases, errors are not reported.

Studies have shown that typically less than five percent of known errors are reported, and many are unknown.[46] When punishment is eliminated, reporting soars.

Important characteristics of reporting systems within organizations include that they be voluntary, have minimal restrictions on acceptable content, include descriptive accounts and stories (i.e., not be a simple checklist), be confidential, and be accessible for contributions from all clinical and administrative staff. Once submitted, they should be de-identified by reporter and analyzed by experts. Finally, staff should be given timely feedback on the results and how problems will be addressed.[47]

Develop a Working Culture in Which Communication Flows Freely Regardless of Authority Gradient

Organizations also have to foster a management style in dealing with error that supports voluntary reporting and analysis of errors so there are no reprisals and no impediments to information flowing freely against a power gradient.

Techniques for such communication can be taught. Military and civilian aviation has taught senior pilots to respect and listen to junior colleagues, and that copilots and junior officers have the responsibility to communicate clearly their concerns about safety. Superiors have the responsibility to reply to these concerns according to the "two-challenge rule." This rule states that if a pilot is clearly challenged twice about an unsafe situation during a flight without a satisfactory reply, the subordinate is empowered to take over the controls. During military briefings and debriefings, attendees are also expected to express their concerns about safety aspects of an operation.

Bringing about such change in communication patterns within the health care environment, particularly in teaching environments, is without question a major undertaking that begins at least with medical residency training and nursing training. For the leaders of health care teams, it requires learning leadership behavior that encourages and expects all mem-

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bers of the team to internalize the need to be alert to threats to patient safety and to feel that their contributions and concerns are respected.

Implement Mechanisms of Feedback and Learning from Error

In order to learn from error, health care organizations will have to establish and maintain environments and systems for analyzing errors and accidents so that the redesign of processes is informed rather than an act of tampering. There are five important phases to improving safety. The first is the reporting of events in sufficiently rich detail to create a "story" about what occurred. The second is understanding the story in order to make its meaning clear. The third is to develop recommendations for improvement. The fourth is implementation, and the fifth is tracking the changes to learn what new safety problems may have been introduced.

Organizations should develop and maintain an ongoing process for the discovery, clarification, and incorporation of basic principles and innovations for safe design, and should use this knowledge to understand the reasons for hazardous conditions and ways to reduce these vulnerabilities. Organizations require sound, scientifically grounded theories about error and safety. They should draw on the health care industry, other industries, and research on human factors and engineering, organizational and social psychology, and cognitive psychology for useful ideas. Analysis of events leading to error should draw on this knowledge base. Organizational expertise may have to be augmented by external technical assistance, especially in small institutions without the resources to support such activities and expertise internally. Such assistance might come from academically based research centers, trade associations, and professional groups.

Research and analysis are not luxuries in the operation of safety systems. They are essential steps in the effective redesign of systems because analysis provides the information needed for effective prevention. As safety research in other fields has taught us, when a major event occurs that results in patient harm or death, both active and latent errors were present. Investigation of active errors has focused on the individuals present and the circumstances immediately surrounding the event. However, such an explanation is often not only premature and uninformed, but it is usually unhelpful in preventing future events. Understanding the latent errors whose adverse consequences may lie dormant within the system requires considerable technical and systems knowledge about technical work and the way organizational

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factors play out in this technical work. It also requires understanding the roles of resource limitations, conflicts, uncertainty, and complexity.

Two other ways in which organizations can improve their performance through shared learning are by benchmarking and collaboration. Benchmarking is a way to compare oneself or one's organization against the "best in class." While learning about and finding ways to implement the best practices they can identify, organizations can implement sets of practical, time-series measures that can help them learn whether the steps they have taken are improving safety.[48] Organizations can also collaborate with other facilities, even within their market areas, to understand patterns of error and new approaches to prevention. For example, the New England Cardiovascular Project, the Vermont-Oxford Neonatal Network, and multisite research on the organization and delivery of care in intensive care units have demonstrated the gains that are possible from such collaborative work.[49,50]

The committee strongly encourages organizations to participate in voluntary reporting systems. Chapter 5 provides descriptions of some voluntary reporting systems available in the health care industry, and the committee has recommended that voluntary reporting initiatives be encouraged and expanded.

MEDICATION SAFETY

As described in Chapter 2, a good deal of research has identified medication error as a substantial source of preventable error in hospitals. In addition, organizations and researchers have paid considerable attention to methods of preventing such errors, and there is reasonable agreement about useful approaches. For this reason, the remainder of this chapter focuses on medication administration to illustrate how the principles for creating safety systems might be applied, including the need for a systems approach. It focuses on hospitals because most of the research in this area and virtually all the data are hospital-based but recognizes that many of the strategies apply to ambulatory and other settings as well.

Errors increase with complexity. Complexity in the medication system arises from several sources; including the extensive knowledge and information that are necessary to correctly prescribe a medication regimen for a particular patient; the intermingling of medications of varying hazard in the pharmacy, during transport, and on the patient care units; and the multiple tasks performed by nurses, of which medication preparation and administration are but a few. Because the burden of harm to patients is great, the

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cost to society is large, and knowledge of how to prevent the most common kinds of errors is well known, the committee singles out medication safety as a high priority area for all health care organizations.

A number of practices have been shown to reduce errors in the medication process and should be in place in all hospitals and other health care organizations in which they are appropriate.[51–53]

Selected Strategies to Improve Medication Safety

- Adopt a system-oriented approach to medication error reduction.
- Implement standard processes for medication doses, dose timing, and dose scales in a given patient care unit.
- Standardize prescription writing and prescribing rules.
- Limit the number of different kinds of common equipment.
- Implement physician order entry.
- Use pharmaceutical software.
- Implement unit dosing.
- Have the central pharmacy supply high-risk intravenous medications.
- Use special procedures and written protocols for the use of high-risk medications.
- Do not store concentrated solutions of hazardous medications on patient care units.
- Ensure the availability of pharmaceutical decision support.
- Include a pharmacist during rounds of patient care units.
- Make relevant patient information available at the point of patient care.
- Improve patients' knowledge about their treatment.

Several organizations have recently focused attention on medication safety, and a number have compiled recommendations for safe medication practices, particularly in the inpatient environment. Most recently, these include the National Patient Safety Partnership,[54] the Massachusetts Coalition for the Prevention of Medical Errors (1999),[55] the Institute for Healthcare Improvement (1998),[56] the National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP); and the American Society for Health-System Pharmacists.[57]

As illustrated in Table 8.1, most of the groups' recommendations are consistent with one another. Although each has been implemented by a large number of hospitals, none has been universally adopted, and some are not in

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TABLE 8-1 Comparison of Institute of Medicine (IOM) Strategies Regarding Medication Practices and Recommendations from Other Organizations

IOM Strategy	American Society of Health-System Pharmacists	National Coordinating Council for Medication Error Reporting and Prevention
Implement standard processes for medication doses, dose timing, and dose scales in a given patient care unit		
Standardize prescription writing and prescribing rules		All prescription orders should be written using the metric system except for therapies that use standard units. The term "units" should be spelled out. A leading zero should always precede a decimal expression of less than one. Prescribers should avoid use of abbreviations
Limit the number of different kinds of common equipment		
Implement physician order entry	Establish processes in which prescribers enter medication orders directly into computer systems	Prescribers should move to a direct, computerized order entry system
Use pharmaceutical software		
Implement unit dosing	Use unit dose medication distribution and pharmacy-based intravenous medication admixture systems	The medication order should include drug name, exact metric weight or concentration, and dosage form

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Institute for Healthcare Improvement	National Patient Safety Partnership	Massachusetts Coalition for the Prevention of Medical Errors
Reduce reliance on memory; simplify; standardize	Standardize drug packaging, labeling, storage	
Differentiate: eliminate look-alikes and sound-alikes	Avoid abbreviations	
Decrease multiple entry	Computerize drug order entry	Implement computerized prescriber order entry systems when technically and financially feasible in light of a hospital's existing resources and technological development.
		Encourage pharmacy system software vendors to incorporate an adequate set of checks into computerized hospital pharmacy systems
	Use "unit dose" drug systems (packaged and labeled in standard patient doses)	Maintain unit-dose distribution systems (either manufacturer prepared or repackaged by pharmacy) for all non-emergency medications.

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TABLE 8-1 Continued

IOM Strategy	American Society of Health-System Pharmacists	National Coordinating Council for Medication Error Reporting and Prevention
Central pharmacy should supply high-risk intravenous medications		
Use special procedures and written protocols for the use of high-risk medications		
Do not store concentrated solutions of hazardous medications on patient care units		
Ensure the availability of pharmaceutical decision support	All medication orders before a first dose should be routinely reviewed by a pharmacist and all staff should seek resolution whenever there is a question of safety	
Include a pharmacist during rounds of patient care units	Assign pharmacists to work in patient care areas in direct collaboration with prescribers and those administering medications	

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Institute for Healthcare Improvement	National Patient Safety Partnership	Massachusetts Coalition for the Prevention of Medical Errors
	Use pharmacy-based IV and drug mixing programs	Institute pharmacy-based IV admixture systems
Use protocols and checklists wisely	Limit access to high hazard drugs and use protocols for high hazard drugs.	Develop special procedures for high-risk drugs using a multi-disciplinary approach. Including written guidelines, checklists, pre-printed orders, double-checks, special packaging, special labeling, and education
		Remove concentrated potassium chloride (KCl) vials from nursing units and patient care areas. Stock only diluted premixed IV solutions on units.
		Have a pharmacist available on-call after hours of pharmacy operation.
		Information on new drugs, infrequently used drugs, and non-formulary drugs should be made easily accessible to clinicians prior to ordering, dispensing, and administering medications

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TABLE 8-1 Continued

IOM Strategy	American Society of Health-System Pharmacists	National Coordinating Council for Medication Error Reporting and Prevention
Make relevant patient information available at the point of patient care	Evaluate the use of machine-readable coding (e.g., bar coding) in their medication-use processes	Prescribers should include the age and when appropriate, the weight of the patient on the prescription or medication order
Adopt a system-oriented approach to medication error reduction	Approach medication errors as system failures and seek system solutions to preventing them	
Improve patient's knowledge about their treatment		Prescription orders should include a brief notation of purpose unless considered inappropriate Prescribers should not use vague instructions such as "Take as directed" as the sole direction for use
	Develop better systems for monitoring and reporting adverse drug events	

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Institute for Healthcare Improvement	National Patient Safety Partnership	Massachusetts Coalition for the Prevention of Medical Errors
Improve access to information	Put allergies and medications on patient records Require machine-readable labeling (bar coding)	Consider the use of machine-readable coding (i.e., bar coding) in the medication administration process Encourage the use of computer-generated or electronic medication administration records (MAR)
Increase feedback; train for teamwork; drive out fear; obtain leadership commitment; improve direct communication		Adopt a systems-oriented approach to medication error reduction; promote a non-punitive atmosphere for reporting of errors which values the sharing of information
Improve access to information	Educate patients Patients should tell physicians about all medications they are taking and ask for information in terms they understand before accepting medications	Educate patients in the hospital, at discharge, and in ambulatory settings about the safe and accurate use of their medications
Organize the work environment for safety		

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place in even a majority of hospitals. Based on evidence and drawing on the principles described in this chapter, this IOM committee joins other groups in calling for implementation of proven medication safety practices as described below.

Adopt a System-Oriented Approach to Medication Error Reduction

Throughout this chapter, emphasis is put on the development of a system-oriented approach that prevents and identifies errors and minimizes patient harm from errors that do occur. It involves a cycle of anticipating problems, for example with changes in staffing or the introduction of new technologies, adopting the five principles described, tracking and analyzing data as errors and near misses occur, and using those data to modify processes to prevent further occurrences. None of these steps is useful alone. When taken together with strong executive leadership in a nonpunitive environment and with appropriate resources, they become extremely powerful in improving safety.

Implement Standard Processes for Medication Doses, Dose Timing, and Dose Scales in a Given Patient Care Unit

One of the most powerful means of preventing errors of all kinds is to standardize processes. If doses, times, and scales are standardized, it is easier for personnel to remember them, check them, and cross-check teammates who are administering the medications.

Standardize Prescription Writing and Prescribing Rules

A host of common shortcuts in prescribing have frequently been found to cause errors. Abbreviations are the major offender because they can have more than one meaning. Other "traps" include the use of "q" (as in qid, qod, qd, qh), which is easily misread, and the use of the letter "u" for "unit." Failure to specify all of the elements of an order (form, dose, frequency, route) also leads to errors. Putting such information in computerized order entry forms can help eliminate such errors.

Limit the Number of Different Kinds of Common Equipment

Simplification—reducing the number of options—is almost as effective as standardization in reducing medication errors. Just as with limiting

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medications to one dose decreases the chance of error, limiting the types of equipment (e.g., infusion pumps) available on a single patient care unit will improve safety. Unless all such equipment has the same method of setup and operation, having several different types of infusion pumps and defibrillators increases the likelihood of misuse, sometimes with disastrous consequences.

Implement Physician Order Entry

Having physicians enter and transmit medication orders on-line (computerized physician order entry) is a powerful method for preventing medication errors due to misinterpretation of hand-written orders. It can ensure that the dose, form, and timing are correct and can also check for potential drug–drug or drug–allergy interactions and patient conditions such as renal function. In one before-and-after comparison,[58] nonintercepted serious medication errors decreased by more than half (from 10.7 to 4.86 events per 1,000 patient-days).

Direct order entry reduces errors at all stages of the medication process, not just in prescribing[60] and it has been recommended by National Patient Safety Partnership, a coalition of health care organizations.*

One study estimated cost savings attributable to preventable adverse drug events (ADEs) at more than $4,000 per event. Direct savings from reduction of ADEs were estimated to be more than $500,000 annually at one teaching hospital, with an overall savings from all decision support interventions related to order entry of between $5 to 10 million per year.[61] A computerized system costing $1 to 2 million could pay for itself in three to five years, while preventing injury to hundreds of patients each year.

Until computerized order entry is implemented, much of the safety benefit may be realized by manual systems that use standard order forms for highly prevalent circumstances, (e.g., myocardial infarction, use of heparin) if the forms are used as completed by clinicians and not transcribed.

Computerized order entry can be a valuable safety adjunct for laboratory and radiology ordering as well as for medication and to achieve the

*Member organizations include the American Hospital Association, American Medical Association, American Nurses Association, Association of American Medical Colleges, Agency for Healthcare Research and Quality, Food and Drug Administration, Health Care Financing Administration, Joint Commission on the Accreditation of Healthcare Organizations, Institute for Healthcare Improvement, National Institute for Occupational Safety and Health, National Patient Safety Foundation, Department of Defense (Health Affairs), and Department of Veterans Affairs.

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most benefit, should be linked with these databases. Such systems should provide relevant information about the patient and his or her medications to anyone who needs them. Bates et al.[62] report on the ability of computerized information systems to identify and prevent adverse events using three hierarchical levels of clinical information. Using only what they call Level 1 information (demographic information, results of diagnostic tests, and current medications), 53 percent of adverse events were judged identifiable. Using Level 2 (as well as Level 1) information (physician order entry), 58 percent were judged identifiable. Using Level 3 (as well as Levels 1 and 2) information that included additional clinical data such as automated problem lists, the authors judged that 89 percent of adverse events were identifiable. In this study a small but significant number of adverse events (5, 13, and 23 percent, respectively) were judged preventable by using such techniques as guided-dose, drug–laboratory, and drug–patient characteristic software algorithms.

As with any new technology, implementing any of these practices requires attention to the user–system interface to minimize the introduction of new problems. It is helpful if these systems have a clearly designated "process manager." It is also important to remember that on-line computer entry does not eliminate all errors associated with prescribing drugs. For example, if allergic reactions to a medication are not entered in the database for a given patient, the order entry system cannot alert the prescriber when the same medication (or one in the same class) is prescribed. Other errors such as transcription errors can remain if they are within an expected range.

Use Pharmaceutical Software

Pharmacies in health care organizations should routinely use reliable computer software programs designed to check all prescriptions for duplicate drug therapies; potential drug–drug and drug–allergy interactions; and out-of-range doses, timing, and routes of administration.

Software is available that permits pharmacists to check each new prescription at a minimum for dose, interactions with other medications the patient is taking, and allergies. Although not as sophisticated as computerized physician order entry, until the latter is in place, pharmacy computerized checking can be an efficient way to intercept prescribing errors. The committee cautions, however, that many pharmacy computer systems today are of limited reliability when used to detect and correct prescription errors, most notably serious drug interactions.[63] At a minimum, such systems should screen for duplicate prescriptions, patient allergies, potential drug–

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drug interactions, out-of-range doses for patient weight or age, and drug–lab interactions. Because such pharmacy software may not be programmed to detect all, or even most, dangers, pharmacists and other personnel should not rely on these systems exclusively nor, on the other hand, habitually override alerts.

Implement Unit Dosing

If medications are not packaged in single doses by the manufacturer, they should be prepared in unit doses by the central pharmacy. Unit dosing—the preparation of each dose of each medication by the pharmacy—reduces handling as well as the chance of calculation and mixing errors. Unit dosing can reduce errors by eliminating the need for calculation, measurement, preparation, and handling on the nursing unit and by providing a fully labeled package that stays with the medication up to its point of use.

Unit dosing was a major systems change that significantly reduced dosing errors when it was introduced nearly 20 years ago. Unit dosing has been recommended by the American Society of Health-System Pharmacists, JCAHO, NPSF, and the MHA in their "Best Practice Recommendations." As a cost-cutting measure, unfortunately some hospitals have recently returned to bulk dosing, which means that an increase in dosing errors is bound to occur.

Have the Central Pharmacy Supply High-Risk Intravenous Medications

Having the pharmacy place additives in IV solutions or purchasing them already mixed, rather than having nurses prepare IV solutions on patient care units, reduces the chance of calculation and mixing errors. For example, one study showed that the error rate in mixing of IV drugs is 20 percent by nurses; 9 percent by pharmacies, and 0.3 percent by manufacturers. This recommendation is supported by the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, and the experience reported by Bates et al.[64]

Use Special Procedures and Written Protocols for the Use of High-Risk Medications

A relatively small number of medications carry a risk of death or serious injury when given in excessive dose. However, these include several of the

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most powerful and useful medications in the therapeutic armamentarium. Examples are heparin, warfarin, insulin, lidocaine, magnesium, muscle relaxants, chemotherapeutic agents, and potassium chloride (see below), dextrose injections, narcotics, adrenergic agents, theophylline, and immunoglobin.[65,66] Both to alert personnel to be especially careful and to ensure that dosing is appropriate, special protocols and processes should be used for these "high-alert" drugs. Such protocols might include written and computerized guidelines, checklists, preprinted orders, double-checks, special packaging, and labeling.

Do Not Store Concentrated Potassium Chloride Solutions on Patient Care Units

Concentrated potassium chloride (KCl) is the most potentially lethal chemical used in medicine. It is widely used as an additive to intravenous solutions to replace potassium loss in critically ill patients. Each year, fatal accidents occur when concentrated KCl is injected because it is confused with another medication. Because KCl is never intentionally used undiluted, there is no need to have the concentrated form stocked on the patient care unit. Appropriately diluted solutions of KCl can be prepared by the pharmacy and stored on the unit for use.

After enacting its sentinel event reporting system, JCAHO found that eight of ten incidents of patient death resulting from administration of KCl were the result of the infusion of KCl that was available as a floor stock item.[67] This has also been reported as a frequent cause of adverse events by the U.S. Pharmacopoeia (USP) Medication Errors Reporting Program.[68]

Ensure the Availability of Pharmaceutical Decision Support

Because of the immense variety and complexity of medications now available, it is impossible for nurses or doctors to keep up with all of the information required for safe medication use. The pharmacist has become an essential resource in modern hospital practice. Thus, access to his or her expertise must be possible at all times.[69,70] Health care organizations would greatly benefit from pharmaceutical decision support. When possible, medications should be dispensed by pharmacists or with the assistance of pharmacists. In addition, a substantial number of errors are made when nurses or other nonpharmacist personnel enter pharmacies during off hours to obtain drugs. Although small hospitals cannot afford and do not need to have a

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pharmacist physically present at all times, all hospitals must have access to pharmaceutical decision support, and systems for dispensing medications should be designed and approved by pharmacists.

Include a Pharmacist During Rounds of Patient Care Units

As the major resource for drug information, pharmacists are much more valuable to the patient care team if they are physically present at the time decisions are being made and orders are being written. For example, in teaching hospitals, medical staff may conduct "rounds" with residents and other staff. Pharmacists should actively participate in this process and be present on the patient care unit when appropriate. Such participation is usually well received by nurses and doctors, and it has been shown to significantly reduce serious medication errors. Leape et al.[71] measured the effect of pharmacist participation on medical rounds in the intensive care unit. They found that in one large, urban, teaching hospital the rate of preventable adverse drug events related to prescribing decreased significantly—66 percent—from 10.4 per 1,000 patient-days before the intervention to 3.5 after the intervention; the rate in the control group was unchanged.

Make Relevant Patient Information Available at the Point of Patient Care

Many organizations have implemented ways to make information about patients available at the point of patient care as well as ways to ensure that patients are correctly identified and treated. With medication administration, some inexpensive but useful strategies include the use of colored wristbands (or their equivalent) as a way to alert medical staff of medication allergies. Colored wristbands or their functional equivalent can alert personnel who encounter a patient anywhere in a hospital to check for an allergy before administering a medication. Using computer-generated MARs, can minimize transcription errors and legibility problems as well as provide flow charts for patient care.

Improper doses, mix-ups of drugs or patients, and inaccurate records are common causes of medication errors in daily hospital practice. Bar coding (or an electronic equivalent) is an effective remedy.[72] It is a simple way to ensure that the identity and dose of the drug are as prescribed, that it is being given to the right patient, and that all of the steps in the dispensing and administration processes are checked for timeliness and accuracy. Bar

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coding can be used not only by drug manufacturers, but also by hospitals to ensure that patients and their records match. The Colmercy-O'Neil VA Medical Center in Topeka, Kansas, reports, for example, a 70 percent reduction in medication error rates between September, 1995 and April, 1998 by using a system that included bar coding of each does, use of a hand-held laser bar code scanner, and a radio computer link.[73]

Improve Patients' Knowledge About Their Treatment

A major unused resource in most hospitals, clinics, and practices is the patient. Not only do patients have a right to know the medications they are receiving, the reasons for them, their expected effects and possible complications, they also should know what the pills or injections look like and how often they are to receive them. Patients should be involved in reviewing and confirming allergy information in their records.

Practitioners and staff in health care organizations should take steps to ensure that, whenever possible, patients know which medications they are receiving, the appearance of these medications, and their possible side effects.[74] They should be encouraged to notify their doctors or staff of discrepancies in medication administration or the occurrence of side effects. If they are encouraged to take this responsibility, they can be a final "fail-safe" step.

At the time of hospital discharge, patients should also be given both verbal and written information about the safe and effective use of their medications in terms and in a language they can understand.

Patient partnering is not a substitute for nursing responsibility to give the proper medication properly or for physicians to inform their patients, but because no one is perfect, it provides an opportunity to intercept the rare but predictable error. In addition to patients' informing their health care practitioner about their current medications, allergies, and previous adverse drug experiences, the National Patient Safety Partnership has recommended that patients ask the following questions before accepting a newly prescribed medication:[75]

- Is this the drug my doctor (or other health care provider) ordered? What are the trade and generic names of the medication?
- What is the drug for? What is it supposed to do?
- How and when am I supposed to take it and for how long?
- What are the likely side effects? What do I do if they occur?

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- Is this new medication safe to take with other over-the-counter or prescription medication or with dietary supplements that I am already taking? What food, drink, activities, dietary supplements, or other medication should be avoided while taking this medication?

SUMMARY

This chapter has proposed numerous actions based on both good evidence and principles of safe design that health care organizations could take now or as soon as possible to substantially improve patient safety. These principles include (1) providing leadership; (2) respecting human limits in process design; (3) promoting effective team functioning; (4) anticipating the unexpected; and (5) creating a learning environment.

The committee's recommendations call for health care organizations and health care professionals to make continually improved patient safety a specific, declared, and serious aim by establishing patient safety programs with defined executive responsibility. The committee also calls for the immediate creation of safety systems that incorporate principles such as (1) standardizing and simplifying equipment, supplies, and processes; (2) establishing team training programs; and (3) implementing nonpunitive systems for reporting and analyzing errors and accidents within organizations. Finally, drawing on these principles and on strong evidence, the committee calls on health care organizations to implement proven medication safety practices.

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Appendixes

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A Background and Methodology

This report on patient safety is part of a larger study examining the quality of health care in America. The Quality of Health Care in America project was initiated by the Institute of Medicine in June 1998, with the charge of developing a strategy that will result in a *threshold improvement* in quality over the next ten years. Specifically, the committee is charged with the following tasks:

- review and synthesis of findings in the literature pertaining to the quality of care provided in the health care system;
- development of a communications strategy for raising the awareness of the general public and key stakeholders of quality-of-care concerns and opportunities for improvement;
- articulation of a policy framework that will provide positive incentives to improve quality and foster accountability;
- identification of key characteristics and factors that enable or encourage providers, health care organizations, health plans, and communities to continuously improve the quality of care; and
- development of a research agenda in areas of continued uncertainty.

A growing body of rigorous research has documented serious and widespread quality problems in American medicine. The burden of harm con-

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veyed by the collective impact of all of our health care quality problems requires the urgent attention of all stakeholders—the health professions, health policy makers, consumer advocates, and purchasers of care. The challenge is to bring the full potential benefit of effective health care to all Americans while avoiding unnecessary and harmful interventions and eliminating preventable complications of care. Meeting this challenge demands a readiness to think in radically new ways about how to deliver health care services and how to assess and improve their quality. Yet neither business leaders, medical leaders, policy makers, nor the public has a clear picture about whether different forms of financing and delivery of care have affected the quality of care and how best to structure financing, oversight, and delivery of care to improve quality.

The methods used for this study included a review of available literature, a commissioned paper, public testimony, a telephone survey, and input from targeted groups on specific issues. A review of the literature relied on published articles focusing on areas of quality, medical errors, patient safety, aviation safety, worker safety, and pharmaceutical safety. Working papers and web sites were also consulted, generally provided by organizations involved in patient safety, accreditation, and existing error reporting systems.

A paper was commissioned on the legal issues raised in protecting data and reporters in error reporting systems that are external to a health care organization. This paper was completed for the committee by Randall Bovbjerg, J.D., and David Shapiro, M.D., J.D. It formed the basis for Chapter 6 of this report.

The content of this report was discussed at seven meetings of two different subcommittees. It was on the agenda at four meetings of the Subcommittee on Creating an External Environment for Quality and three meetings of the Subcommittee on Creating the 21st Century Health System. It was also on the agenda at three meetings of the Committee on Quality of Health Care in America. The public testimony provided follows:

Subcommittee on Creating an External Environment for Quality

November 2, 1998	Martin Hatlie, National Patient Safety Foundation
	Michael Cohen, Institute for Safe Medication Practices
	Ronald Goldman, Veterans Health Administration

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January 29, 1999	Charles Billings, M.D., Ohio State University (designer of the Aviation Safety Reporting System)
June 15, 1999	Tim Cuerdon, Health Care Financing Administration
	Margaret VanAmringe, Joint Commission on Accreditation of Health Care Organizations
	Marge Keyes, Agency for Healthcare Research and Quality

Joint Meeting of Both Subcommittees

June 16, 1999	Kenneth Kizer, M.D., Undersecretary of Health, Veterans Health Administration

A short telephone survey was conducted between February 24 and May 5, 1999 of a number of states having error reporting systems that affect hospitals. The list of states was obtained from the Joint Commission on Accreditation of Healthcare Organizations. A nonrepresentative sample was chosen to obtain additional information on their programs, focusing mainly on the largest states. The respondent was the individual at the state health department with administrative responsibility over the reporting program. Information was collected on the definition of a reportable event, which organizations submit reports, the number of reports submitted in the most recent year available, the year the reporting program was implemented, who has access to the information reported, and what is done with the information obtained (e.g., organization follow-up on specific events, compilation of data and trending over time). All respondents were given an opportunity to review the information on their states and make any corrections or clarifications.

Finally, input was obtained through two group meetings with specific key audiences. The first meeting was a 90-minute discussion held on August 2, 1999, at the 12th Annual Conference of the National Academy for State Health Policy in Cincinnati, Ohio. This meeting was attended by 19 people, all of whom had responsibilities associated with quality-of-care issues, some related to state error reporting programs. Open discussion was held on roles that states can play in ensuring adequate oversight of quality-of-care and patient safety, and what would be helpful to the states to increase their efforts in safety oversight.

The second meeting was a one-day roundtable discussion held on Sep-

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tember 9, 1999, with health professionals active in their professional societies and associations through support from The Commonwealth Fund. This meeting was attended by 14 people representing medicine, nursing, and pharmacy. This open discussion covered issues related to the extent to which the health and medical community is aware of quality and safety concerns, specific actions that professional societies and groups can take to improve patient safety, and barriers that impede these actions from moving forward.

OTHER IOM WORK ON QUALITY

This quality initiative represents a continuing IOM interest in quality of health care. Several other quality-of-care projects have been undertaken in recent years.

America's Health in Transition: Protecting and Improving the Quality of Health and Health Care (IOM-wide special initiative)

The Special Initiative on Health Care Quality was created in 1996 to examine how to maintain and improve the health and well-being of the population and the quality of care that the public receives as the health care system restructures. This special initiative is evaluating quality assessment and improvement tools and their uses, and promoting the application of appropriate tools at all levels of health care, in all organizations, for the entire population. The initiative will also inform consumers, policy makers, providers, and others of key opportunities and obstacles to achieving better health outcomes for individuals and populations, and will provide them with information and tools to enable them to make better decisions and choices about health and health care.

National Roundtable on Health Care Quality

The National Roundtable on Health Care Quality was created to examine continual changes in health care and the implications of these changes for the quality of health and health care in this nation. The Roundtable convened nationally prominent representatives of the private and public sectors (regional, state, and federal); academia; patients; and the health media to analyze unfolding issues concerning health care quality. This initiative produced three reports: *The Urgent Need to Improve Health Care Quality, Mea-*

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suring the Quality of Health Care, and *Collaboration Among Competing Managed Care Organizations for Quality Improvement.*

Ensuring the Quality of Cancer Care

The National Cancer Policy Board undertook a comprehensive review of the quality of cancer care provided in the United States. The report, published in June 1999, delineates essential elements needed to improve quality in cancer care. The report provides an overview of the present cancer care system, moving from detection and early treatment to care at the end of life. Major obstacles impeding patient access to quality cancer care are identified. The report offers a model of an ideal cancer care delivery system and provides examples of the problems that limit early detection, accurate diagnosis, optimal treatment, and responsive supportive care. Recommendations to improve the quality of cancer care are offered for consideration by Congress, public and private health care purchasers, individual consumers, providers and researchers.

Improving Quality in Long-Term Care

The Committee on Improving Quality in Long-Term Care was convened to examine the means for assessing, overseeing, and improving the quality of long-term care in different settings and the practical and policy challenges of achieving a consistent quality of care regardless of where care is received. This study built on a 1986 report, *Improving the Quality of Care in Nursing Homes*, which initiated changes that significantly altered where long-term care is received and by whom. The most recent study examines the full range of long-term care settings and services, including nursing homes, assisted living facilities, and community-based home health care.

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B
Glossary and Acronyms

GLOSSARY

Accident—An event that involves damage to a defined system that disrupts the ongoing or future output of the system.[1]

Active error—An error that occurs at the level of the frontline operator and whose effects are felt almost immediately.[2]

Adverse event—An injury resulting from a medical intervention.[3]

Bad outcome—Failure to achieve a desired outcome of care.

Error—Failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim; the accumulation of errors results in accidents.

Health care organization—Entity that provides, coordinates, and/or insures health and medical services for people.

Human factors—Study of the interrelationships between humans, the tools they use, and the environment in which they live and work.[4]

Latent error—Errors in the design, organization, training, or maintenance that lead to operator errors and whose effects typically lie dormant in the system for lengthy periods of time.

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Medical technology—Techniques, drugs, equipment, and procedures used by health care professionals in delivering medical care to individuals and the systems within which such care is delivered.[5]

Micro-system—Organizational unit built around the definition of repeatable core service competencies. Elements of a micro-system include (1) a core team of health care professionals, (2) a defined population of patients, (3) carefully designed work processes, and (4) an environment capable of linking information on all aspects of work and patient or population outcomes to support ongoing evaluation of performance.

Patient safety—Freedom from accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximizes the likelihood of intercepting them when they occur.

Quality of care—Degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[6]

Standard—A minimum level of acceptable performance or results *or* excellent levels of performance *or* the range of acceptable performance or results.[7] The American Society for Testing and Materials (ASTM) defines six types of standards:

1. Standard test methods—a procedure for identifying, measuring, and evaluating a material, product or system.
2. Standard specification—a statement of a set of requirements to be satisfied and the procedures for determining whether each of the requirements is satisfied.
3. Standard practice—a procedure for performing one or more specific operations or functions.
4. Standard terminology—a document comprising terms, definitions, descriptions, explanations, abbreviations, or acronyms.
5. Standard guide—a series of options or instructions that do not recommend a specific course of action.
6. Standard classification—a systematic arrangement or division of products, systems, or services into groups based on similar characteristics.[8]

System—Set of interdependent elements interacting to achieve a common aim. These elements may be both human and nonhuman (equipment, technologies, etc.).

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ACRONYMS

ABMS	American Board of Medical Specialties
ADE	adverse drug event
AERS	Adverse Event Reporting System
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
AMAP	American Medical Accreditation Program
ASHP	American Society of Health-System Pharmacists
ASRS	Aviation Safety Reporting System
ASTM	American Society for Testing and Materials
CABG	coronary artery bypass graft
CAHPS	Consumer Assessment of Health Plans
CDC	Centers for Disease Control
CEO	chief executive officer
CERT	Centers for Education and Research in Therapeutics
DRG	diagnosis-related group
FAA	Federal Aviation Administration
FDA	Food and Drug Administration
HCFA	Health Care Financing Administration
HEDIS	Health Plan Employer Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
ICU	intensive care unit
ISMP	Institute for Safe Medication Practices
IV	intravenous
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MAR	Medical Administration Record
MER	Medical Error Reporting (system)
MERS-TM	Medical Event-Reporting System for Transfusion Medicine
M&M	morbidity and mortality
NASA	National Aeronautics and Space Administration

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NCC-MERP	National Coordinating Council for Medication Error Reporting and Prevention
NCQA	National Committee for Quality Assurance
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NORA	National Occupational Research Agenda
NPSF	National Patient Safety Foundation
NTSB	National Transportation Safety Board
OPDRA	Office of Post-Marketing Drug Risk Assessment
OSHA	Occupational Safety and Health Administration
PICU	pediatric intensive care unit
POS	point of service
PPO	preferred provider organization
PRO	peer review organization
QIO	Quality Improvement Organization
QuIC	Quality Interagency Coordinating Committee
USP	U.S. Pharmacopeia
VHA	Veterans Health Administration

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C
Literature Summary

This Appendix summarizes the literature described in Chapter 2. The references cited are at the end of Chapter 2.

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TABLE C-1 Literature Summary

Reference	Sample Description	Data Source
General studies of errors and adverse events		
Thomas et al., forthcoming 2000	Randomly sampled 15,000 nonpsychiatric 1992 discharges from a representative sample of hospitals in Utah and Colorado.	Chart review by trained nurses and board-certified family practitioners and internists.
Bhasale et al., 1998 Analysing potential harm in Australian general practice	A non-random sample of 324 general practitioners reporting incidents between October 1993 and June 1995.	General practitioner-reported free-text descriptions of incidents and answered fixed-response questions.

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Results	Definition(s)	Causes/Types of Error
Adverse events occurred in 2.9% ± 0.2 of hospitalizations in each state. 32.6% ± 4 of adverse events were due to negligence in Utah and 27.4 ± 2.4 were due to negligence in Colorado. Death occurred in 6.6% ± 1.2 of adverse events and 8.8% ± 2.5 of negligent adverse events. The leading cause of nonoperative adverse events were adverse drug events (19.3% of all adverse events; 35.1% were negligent). Operative events comprised 44.9% of all adverse events and 16.9% were negligent.	Adverse event—"an injury caused by medical management (rather than the disease process) that resulted in either a prolonged hospital stay or disability at discharge." Negligence was defined as "care that fell below the standard expected of physicians in their community."	46.1% of adverse events (22.3% negligent) were attributable to surgeons and 23.2% (44.9% negligent) were attributable to internists.
805 incidents were reported. 76% were preventable and 27% had potential for severe harm.	Incident—"an unintended event, no matter how seemingly trivial or commonplace, that could have harmed or did harm a patient."	Pharmacological management related to 51 per 100 incidents. Poor communication between patients and healthcare professionals and actions of others contributed to 23 per 100 incidents each. Errors in judgment contributed to 22 per 100 incidents.

Continued

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
General studies of errors and adverse events *(continued)*		
Leape et al., 1993 Preventing medical injury	Record review of 1,133 patients who suffered from an adverse event (AE).	Harvard Medical Practice Study.
McGuire et al., 1992 Measuring and managing quality of surgery	44,603 consecutive major operations performed at a large medical center from 1977 to 1990.	Resident reports giving name and procedure of each patient who suffered any complication. In a monthly conference, representatives of all specialties determined by consensus the category of each complication (inevitable, inherent risk, error, hospital deficit, coincidence, unknown).

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Results	Definition(s)	Causes/Types of Error
70% of adverse events were found to be preventable, 24% unpreventable, and 6% potentially preventable.	AE—per Leape (1991), AE is defined as "an unintended injury that was caused by medical management and that resulted in measurable disability." Preventable AE—an AE resulting from an error. Unpreventable AE—an AE resulting from a complication that cannot be prevented at the current state of knowledge. Potentially preventable AE—an AE where no error was identified but it is widely recognized that a high incidence of this type of complication reflects low standards of care or technical expertise.	The most common types of preventable errors were technical errors (44%), errors in diagnosis (17%), failures to prevent injury (12%), and errors in the use of a drug (10%). Approximately 20% of technical errors, 71% of diagnostic errors, 50% of preventative errors, and 37% of errors in the use of a drug were judged to be negligent.
2,428 patients (5.4%) suffered 2,797 complications (6.3%). 49% of these complications were attributable to error. 749 patients (1.7%) died during the same hospitalization. 7.5% of these deaths were attributable to error.		

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
General studies of errors and adverse events *(continued)*		
Bedell et al., 1991 Incidence and characteristics of preventable iatrogenic cardiac arrests	203 patients who suffered from cardiac arrest at a teaching hospital during 1981.	At least one of the authors evaluated patients who underwent CPR within 24 hours of arrest. Information from the medical record was also used.
Leape et al., 1991 The nature of adverse events in hospitalized patients	30,195 randomly selected records in 51 hospitals in New York state (1984).	Hospital records.
DuBois et al., 1988 Preventable Deaths	182 deaths from 12 hospitals for 3 conditions (cerebrovascular accident, pneumonia, or myocardial infarction)	Investigators prepared a dictated summary of each patient's hospital course. Panels of 3 physicians for each condition then independently reviewed each summary and independently judged whether the death was preventable.

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Results	Definition(s)	Causes/Types of Error
28 (14%) of arrests followed an iatrogenic complication. 17 (61%) of the 28 patients died. All 4 reviewers considered 18 (64%) of the iatrogenic arrests to have been preventable.	Iatrogenic cardiac arrest—"an arrest that resulted from a therapy or procedure or from a clearly identified error of omission."	The most common causes of potentially preventable arrest were medication errors and toxic effects (44%), and suboptimal response by physicians to clinical signs and symptoms (28%).
1,133 adverse events (AEs) occurred in 30,195 patients.	AE—"an unintended injury that was caused by medical management and that resulted in measurable disability."	Drug complications were the most common type of adverse event (19%), followed by wound infections (14%) and technical complications (13%). 58% of the adverse advents were errors in management, among which nearly half were attributable to negligence.
The physicians unanimously agreed that 14% of the deaths could have been prevented. 2 out of the 3 physicians found that 27% might have been prevented.		Preventable deaths from myocardial infarction reflected errors in management, from cerebrovascular accident reflected errors in diagnosis, and from pneumonia reflected errors in management and diagnosis.

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
General studies of errors and adverse events *(continued)*		
Steel et al., 1981 Iatrogenic illness on a general medical service at a university hospital	815 consecutive patients on a university hospital's general medical service during a 5-month period in 1979.	Record review, clinical personnel interviews, and information from utilization-review coordinators.
Cooper et al., 1978 Preventable anesthesia mishaps	47 interviews regarding preventable mishaps between September 1975 and April 1977 including staff and resident anesthesiologists from a large urban teaching hospital.	Interviewees selected at random from a list of departmental members.
Dripps et al., 1961 The role of anesthesia in surgical mortality	Records of 33,224 patients anesthetized in a 10-year period.	Patient records

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Results	Definition(s)	Causes/Types of Error
36% of patients had an iatrogenic illness. 9% of the patients had an iatrogenic illness that threatened life or produced considerable disability while, in another 2%, the illness was believed to contribute to the death of the patient.	Iatrogenic illness—"any illness that resulted from a diagnostic procedure or from any form of therapy." In addition, the authors included harmful occurrences (e.g., injuries from a fall or decubitus ulcers) that were not natural consequences of the patient's disease.	
359 preventable critical incidents were identified and coded.	Critical incident—a mishap that "was clearly an occurrence that could have led (if not discovered or corrected in time) or did lead to an undesirable outcome, ranging from increased length of hospital stay to death or permanent disability."	82% of the preventable incidents reported involved human error and 14% involved equipment error.
12 of the 18,737 patients who received spinal anesthesia died from causes definitely related to the anesthetic (1:1,560). 27 of the 14,487 patients who received general anesthesia supplemented with a muscle relaxant died from causes directly related to the anesthetic (1:536).		

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
General studies of errors and adverse events *(continued)*		
Beecher and Todd, 1954 A study of the deaths associated with anesthesia and surgery based on a study of 599,548 anesthesias in ten institutions	All deaths from January 1, 1948, through December 31, 1952, occurring on the surgical services of 10 university hospitals.	1 team, consisting of an anesthesiologist, a surgeon, and a secretary, worked in each of the 10 hospitals and appraised the causes of all deaths on the surgical services.
Medication-related studies		
Knox, 1999 Prescription errors tied to lack of advice *Globe* article	Analysis of medication errors by 51 Massachusetts pharmacists.	
Leape, 1999 Pharmacist participation on physician rounds and adverse drug events in the intensive care unit	75 patients randomly selected from each of 3 groups: all admissions to the study unit (2 medical ICUs at Massachusetts General Hospital) from February 1, 1993, through July 31, 1993 (baseline), and all admissions to the study unit (postintervention) and control unit from October 1, 1994, through July 7, 1995. 50 patients were also selected at random from the control unit during the baseline period.	Review of medical records and pharmacist recommendations.

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Results	Definition(s)	Causes/Types of Error
7,977 of the 599,548 patients who received anesthesia died. Gross errors in anesthetic management occurred in 29 of the 384 (7.6%) deaths caused by anesthesia.		
88% of medication errors involved the wrong drug or the wrong dose and 63% involved first-time prescriptions rather than refills.		Pharmacists cited factors that led to mistakes. 62% cited "too many telephone calls," 59% "unusually busy day," 53% "too many customers," 41% "lack of concentration," and 32% "staff shortage."
The rate of preventable adverse drug events (ADEs) due to ordering decreased by 66% from 10.4 per 1,000 patient days before the intervention to 3.5 per 1,000 patient days after the intervention. The rate was essentially unchanged during the same time periods in the control unit: 10.9 and 12.4 per 1,000 patient days.	ADE—per Bates (1993), ADE is defined as "an injury resulting from the administration of a drug."	

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Lazarou, 1998 Incidence of adverse drug reactions in hospitalized patients	39 prospective studies from U.S. hospitals.	4 electronic databases were searched for articles between 1966 and 1996.
Wilson et al., 1998 Medication errors in paediatric practice	682 children admitted to a Congenital Heart Disease Center at a teaching hospital in the United Kingdom.	Standardized incident report forms filled out by doctors, nurses, and pharmacists.
Andrews et al., 1997 An alternative strategy for studying adverse drug events	1,047 patients admitted to 3 units at a large, tertiary care, urban teaching hospital affiliated with a university medical school.	Ethnographers trained in qualitative observational research recorded all adverse events discussed while attending day-shift, weekday, regularly scheduled attending rounds, residents' work rounds, nursing shift changes, case conferences, and other scheduled meetings.

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Results	Definition(s)	Causes/Types of Error
The overall incidence of serious adverse drug reactions (ADRs) in hospitalized patients was 6.7% and of fatal ADRs was 0.32%. In 1994, an estimated 2,216,000 hospitalized patients experienced serious ADRs and 106,000 had fatal ADRs, making these reactions the fourth and sixth leading causes of death.	ADR—"According to the World Health Organization definition, this is any noxious, unintended, and undesired effect of a drug, which occurs at doses in humans for prophylaxis, diagnosis, or therapy. This definition excludes therapeutic failures, intentional and accidental poisonings (i.e., overdose), and drug abuse. Also, this does not include adverse events due to errors in drug administration or noncompliance (taking more or less of a drug than the prescribed amount)."	
441 medical errors were reported. Prescription errors accounted for 68% of all reported errors, administration errors for 25%, and supply errors for 7%.	Medication error—"a mistake made at any stage in the provision of a pharmaceutical product to a patient."	Doctors accounted for 72% of the errors, nurses for 22%, pharmacy staff for 5%, and doctor/nurse combination for 1%
An adverse event occurred in 480 of the 1,047 patients (45.8%). 185 of the patients (17.7%) had at least one serious event. The likelihood of experiencing an adverse event increased approximately 6% for each day of a hospital stay. Only 1.2% of the patients experiencing serious events made claims to compensation.	Adverse event—a situation "in which an inappropriate decision was made when, at the time, an appropriate alternative could have been chosen."	Individuals caused 37.8% of adverse events while 15.6% of the events had interactive causes and 9.8% were due to administrative decisions.

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Classen et al., 1997 Adverse drug events in hospitalized patients	Matched case-control study of all patients admitted to LDS Hospital (a tertiary care institution) from January 1, 1990, to December 31, 1993, and who had confirmed adverse drug events (ADEs). Controls and cases were matched on age, sex, acuity, year of admission, and primary discharge diagnosis related group (DRG).	Nursing acuity system and primary discharge DRG.
Cullen et al., 1997 Preventable adverse drug events in hospitalized patients	Prospective cohort study of 4,031 adult admissions to a stratified, random sample of 11 medical and surgical units (including 2 medical and 3 surgical ICUs and 4 medical and 2 surgical general care units) in 2 tertiary care hospitals over a 6-month period.	Stimulated self-report by nurses and pharmacists and daily review of all charts by nurse investigators. 2 independent reviewers classified the incidents.

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Results	Definition(s)	Causes/Types of Error
ADEs complicated 2.43 per 100 admissions. The occurrence of an ADE was associated with an increased length of stay of 1.91 days and an increased cost of $2,262. The increased risk of death among patients experiencing an ADE was 1.88. Almost 50% of all ADEs are potentially preventable.	ADE—an event that is "noxious and unintended and occurs at doses used in humans for prophylaxis, diagnosis, therapy, or modification of physiologic functions."	
The rate of preventable adverse drug events (ADEs) and potential ADEs in ICUs was 19 events per 1,000 patient days. This was nearly twice the rate of non-ICUs, but, when adjusted for the number of drugs used in the previous 24 hours or ordered since admission, there were no differences in rates between ICUs and non-ICUs.	ADE—"an injury resulting from medical intervention related to a drug." Potential adverse drug event—an incident "with potential for injury related to the use of a drug."	

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Lesar et al., 1997 Factors related to errors in medication prescribing	Every third prescribing error detected and averted by pharmacists in a 631-bed tertiary care teaching hospital between July 1, 1994, and June 30, 1995.	Retrospective evaluation by a physician and 2 pharmacists.
Schneitman-McIntire et al., 1996 Medication misadventures resulting in emergency department visits at an HMO medical center	Records of 62,216 patients who visited the emergency department of a California HMO between August 1992 and August 1993 .	Patient records and pharmacist interviews with patients.

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Results	Definition(s)	Causes/Types of Error
2,103 errors thought to have potential clinical importance were detected, and the overall rate of errors was 3.99 errors per 1,000 medication orders.		The most common factors associated with errors were decline in renal or hepatic function requiring alteration of drug therapy (13.9%), patient history of allergy to the same medication class (12.1%), using the wrong drug name, dosage, form, or abbreviation (11.4% for both brand and generic name orders), incorrect dosage calculations (11.1%), and atypical or unusual and critical dosage frequency considerations (10.8%). The most common group factors associated with errors were those related to knowledge and the application of knowledge regarding drug therapy (30%); knowledge and use of knowledge regarding patient factors that affect drug therapy (29.2%); use of calculations, decimal points, or unit and rate expression factors (17.5%); and nomenclature factors, such as incorrect drug name, dosage form, or abbreviation (13.4%).
1,074 or 1.7% of the emergency department visits were due to medication misadventures. Of the 1,074 misadventures, 152 (14.1%) resulted in hospital admissions.	Misadventures "included noncompliance and inappropriate prescribing but excluded intentional overdoses and substance abuse."	

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Bates et al., *J Gen Intern Med*, 1995 Relationship between medication errors and adverse drug events	A cohort of 379 consecutive admissions during a 51-day period in three medical units of an urban tertiary care hospital.	Self-report by pharmacists, nurse review of all patient charts, and review of all medication sheets. 2 independent reviewers classified the incidents.
Bates et al., *JAMA*, 1995 Incidence of adverse drug events and potential adverse drug events	4,031 adult admissions to a stratified random sample of 11 medical and surgical units in Brigham and Women's Hospital (726 beds) and Massachusetts General Hospital (846 beds) in Boston over a 6-month period between February and July 1993.	Stimulated self-reports by nurses and pharmacists and daily chart review. 2 independent reviewers classified the incidents.

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Results	Definition(s)	Causes/Types of Error
10,070 medication orders were written, and 530 medication errors were identified (5.3 errors/100 orders). 25 adverse drug events (ADEs) and 35 potential ADEs were found. 20% of the ADEs were associated with medication errors; all were judged preventable. 5 of 530 (0.9%) medication errors resulted in ADEs. Physician computer order entry could have prevented 86% of potential ADEs, 84% of non-missing dose medication errors, and 60% of preventable ADEs.	ADE—an injury "resulting from medical interventions related to a drug." Potential ADE—a medication error "with potential for injury but in which no injury occur-red." Medication error—an error "in the process of ordering or delivering a medication, regardless of whether an injury occurred or the potential for injury was present."	
247 adverse drug events (ADEs) and 194 potential ADEs were identified. Extrapolated event rates were 6.5 ADEs and 5.5 potential ADEs per 1,000 nonobstetrical admissions, for mean numbers per hospital per year of approximately 1,900 ADEs and 1,600 potential ADEs. 1% of all ADEs were fatal, 12% life-threatening, 30% serious, and 57% significant. 28% of all ADEs were judged preventable.	ADE—"an injury resulting from medical intervention related to a drug." Potential ADE—an incident "with potential for injury related to a drug."	56% of preventable ADEs occurred at the ordering stage, 34% at administration, 6% during transcription, and 4% during dispensing.

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Cullen et al., 1995 The incident reporting system does not detect adverse drug events	All patients admitted to five patient care units in an academic tertiary care hospital between February and July 1993.	Consensus voting by senior hospital administrators, nursing leaders, and staff nurses.
Leape et al., 1995 Systems analysis of adverse drug events	All nonobstetric adult admissions to 11 medical and surgical units in 2 tertiary care hospitals in the period between February and July 1993.	Reports from each unit solicited daily by trained nurse investigators and peer interviews. 2 independent reviewers classified the incidents.
Willcox et al., 1994 Inappropriate drug prescribing for the community dwelling elderly	6,171 adults from a cross-sectional survey of a national probability sample of individuals aged 65 or older.	1987 National Medical Expenditure Survey.

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Results	Definition(S)	Causes/Types of Error
Incident reports were submitted to the hospital's quality assurance program or called into the pharmacy hotline for 3 of the 54 people experiencing adverse drug events (ADEs). 15 (28%) of the ADEs were preventable and 26 (48%) were serious or life-threatening.	ADE—"an injury resulting from the use of a drug."	
334 errors were detected as the causes of 264 preventable adverse drug events (ADEs) and potential ADEs.	Potential ADEs—"errors that have the capacity to cause injury, but fail to do so, either by chance or because they are intercepted."	16 major system failures were identified as the causes of the errors, of which the most common was dissemination of drug knowledge (29% of 334 errors). 7 systems failures accounted for 78% of errors.
23.5% of people aged 65 years or older, or 6.64 million Americans, received at least 1 of the 20 contra-indicated drugs in 1987. 20.4% received two or more such drugs.	Contraindicated drugs include: 1) chlordiazepoxide 2) diazepam 3) flurazepam 4) meprobamate 5) pentobarbital 6) secobarbital 7) amitriptyline 8) indomethacin 9) phenylbutazone 10) chlorpropamide 11) propoxyphene 12) pentazocine 13) cyclandelate 14) isoxsuprine 15) dipyridamole 16) cyclobenzaprine 17) orphenidrat 18) methocarbamol 19) carisoprodol 20) trimethobenzamide	

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Bates et al., 1993 Incidence and preventability of adverse drug events in hospitalized adults	All patients admitted to 2 medical, 2 surgical, and 2 obstetric general care units and 1 coronary intensive care unit over a 37-day period in an urban tertiary care hospital.	Records entered into logs in each unit and satellite pharmacies by nurses and pharmacists, reports solicited by a research nurse twice daily on each unit, and chart review by the nurse.
Einarson, 1993 Drug-related hospital admissions	English–language studies of humans admitted to the hospital because of adverse drug reactions (ADRs) resulting from a patient's noncompliance or unintentionally inappropriate drug use.	Manual and computerized literature searches using MEDLINE, *Index Medicus*, and *International Pharmaceutical Abstracts* as databases

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Results	Definition(s)	Causes/Types of Error
73 drug-related incidents occurred in 2,967 patient days. 27 incidents were judged adverse drug events (ADEs), 34 potential ADEs, and 12 problem orders. 5 of the 27 ADEs were life-threatening, 9 were serious, and 13 were significant. 15 of the 27 ADEs (57%) were judged definitely or probably preventable.	ADE—"an injury resulting from the administration of a drug." Potential ADE—an incident "with a potential for injury related to a drug . . . [and an incident] in which a potentially harmful order was written but intercepted before the patient actually received the drug." Problem order—"an incident in which a drug-related error was made, but was judged not to have the potential for injury."	Physicians caused 72% of the incidents, with the remainder divided evenly between nursing, pharmacy, and clerical personnel.
Between 1996 and 1989, adverse drug reaction (ADR) rates from 49 hospitals or groups of hospitals in international settings were published in 37 articles. Drug-induced hospitalizations account for approximately 5% of all admissions. Reported admissions caused by ADRs ranged from 0.2% to 21.7%, with a median of 4.9% and a mean of 5.5%. 3.7% of patients admitted for ADRs died.	ADR—"any unintended or undesired consequence of drug therapy." Noncompliance—"any deviation from the regimen written (and intended) by the prescriber."	11 reports indicated that noncompliance induced 22.7% of ADR hospitalizations.

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Brennan et al., 1991 Incidence of adverse events and negligence in hospitalized patients	30,195 randomly selected records in 51 hospitals in New York state (1984).	Hospital records.
Classen et al., 1991 Computerized surveillance of adverse drug events in hospital patients	36,653 hospitalized patients in the LDS Hospital, Salt Lake City between May 1, 1989, and October 31, 1990.	Integrated hospital information system and pharmacist review of medical records.
Beers et al., 1990 Potential adverse drug interactions in the emergency room	424 randomly selected adults who visited the emergency room at a university-affiliated hospital. All subjects were discharged without hospital admission.	Complete emergency department record on every patient.

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Results	Definition(s)	Causes/Types of Error
Adverse events (AEs) occurred in 3.7% of the hospitalizations. Although 70.5% gave rise to disabilities lasting less than 6 months, 2.6% of the adverse events caused permanently disabling injuries and 13.6% resulted in death.	AE—"an injury that was caused by medical mismanagement (rather than the underlying disease) and that prolonged the hospitalization, produced a disability at the time of discharge, or both."	
731 verified adverse drug events (ADEs) occurred in 648 patients. 701 ADEs were classified as moderate or severe. Physicians, pharmacists, and nurses voluntarily reported 92 of the 731 ADEs detected using the automated system. The remaining 631 were detected from automated signals, the most common of which were diphenhydramine hydrochloride and naloxone hydrochloride use, high serum drug levels, leukopenia, and the use of phytonadione and antidiarrheals.	ADE—an event that is "noxious and unintended and occurs at doses used in man for prophylaxis, diagnosis, therapy, or modification of physiologic functions." "Therapeutic failures, poisonings, and intentional overdoses" were excluded.	
47% of visits led to added medication. In 10% of the visits in which at least one medication was added, a new medication added a potential adverse interaction.	"Drug interactions are an aspect of the inappropriate use of medication that may endanger patients and that may be avoided by more careful prescribing."	

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Hallas et al., 1990 Drug related admissions to a cardiology department	366 consecutive patients admitted to the cardiology department at Odense University Hospital, Denmark, during a 2-month period (May–June 1988).	Written and verbal histories and blood samples.
Lesar et al., 1990 Medication prescribing errors in a teaching hospital	289,411 medication orders written between January 1, 1987, and December 31, 1987, in a tertiary care teaching hospital.	Medication orders reviewed by a centralized staff of pharmacists and the prescribing physicians.
Sullivan et al., 1990 Noncompliance with medication regimens and subsequent hospitalizations	7 studies and 2,942 admissions with comparable methodologies and evaluation regarding the extent and direct cost of hospital admissions related to drug therapy noncompliance.	Meta-analytic literature review.

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Results	Definition(s)	Causes/Types of Error
"Definite" or "probable" drug events accounted for 15 admissions, or a 4.1% drug-related hospitalization rate. 11 were due to adverse drug reactions (ADRs) and 4 to dose-related therapeutic failures (DTFs). Of these 15 admissions, 5 cases were judged to have been "definitely avoidable."	ADR—"any unintended and undesirable effect of a drug." DTF—"lack of therapeutic effect that could be linked causally to either too low a prescribed dose, noncompliance, recent dose reduction/discontinuation, interaction or inadequate monitoring."	Of the 15 admissions, 5 were considered to be due to a prescription error.
905 prescribing errors were detected and averted, of which 57.7% had a potential for adverse consequences. The overall error rate was 3.13 errors for each 1,000 orders written and the rate of significant errors was 1.81 per 1,000 orders.	Medication errors—"medication orders for the wrong drug, inappropriate dosage, inappropriate frequency, inappropriate dosage form, inappropriate route, inappropriate indication, ordering of unnecessary duplicate/ redundant therapy, contraindicated therapy, medications to which the patient was allergic, orders for the wrong patient, or orders missing information required for the dispensing and administration of the drug."	
5.5% of admissions can be attributed to drug therapy noncompliance, amounting to 1.94 million admissions. This represents $8.5 billion in unnecessary hospital expenditures in 1986, an estimated 1.7% of all health care expenditures that year.	Drug therapy noncompliance—includes overuse, underuse, and erratic use of drugs.	

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Raju et al., 1989 Medication errors in neonatal and paediatric intensive-care units	2,147 patients admitted to a 17-bed NICU and 7-bed PICU (1,224 to NICU [57%] and 923 to PICU [43%]) at the University of Illinois Hospital from January 1985 to December 1988.	Written incident reports submitted by the individual who noticed the error.
Blum et al., 1988 Medication error prevention by pharmacists	Orders written between November 1986 and February 1987 at Indiana University Hospitals that contained potential medication errors about which the physician had been contacted.	Carbon copies of orders saved by pharmacists in the pediatric and adult facilities and reviewed by the four co-authors that served as the study monitors.

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Results	Definition(s)	Causes/Types of Error
315 iatrogenic medication errors were reported among the 2,147 neonatal and pediatric care admissions, an error rate of 1 per 6.8 admissions (14.7%). The frequency of iatrogenic injury of any sort due to a medication error was 3.1%, or 1 for each 33 intensive care admissions. 66 errors resulted in injury, 33 were potentially serious, 32 caused mild injuries, and 1 patient suffered acute aminophylline poisoning.	Medication error—"a dose of medication that deviates from the physicians' order as written in the medical record. . . . Except for error of omission, the medication dose must actually reach the patient . . . a wrong dose (or other type of error) that is detected and corrected before administration will not constitute a medication error. . . . Prescription errors (not dispensed and administered to the patient) . . . are excluded from this definition . . ."	60.3% of the 315 errors were attributable to nurses and 29.6% to pharmacists. Only 2.9% were attributable to physicians (because prescription errors detected before drug administration were not counted).
123,367 medication orders were written. Riley Hospital for Children had 1,277 errors out of the 48,034 (2.7%) orders written and University Hospital had 1,012 errors out of 75,333 (1.3%) orders written. 90.4% of the overall orders questioned by pharmacists were confirmed by the physician as being in error. 0.2% of the 2289 errors were classified as potentially lethal, 13.7% were serious, 34.2% were significant, and 51.9% were minor. The number of errors that pharmacists prevent each year approaches 9,000.	Order with a potential medication error—"if any aspect of the order was not in accordance with information in standard reference text, an approved protocol, or dosing guidelines approved by the pharmacy and therapeutics committee of the hospitals."	

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Nolan and O'Malley, 1988 Prescribing for the elderly, part I	21 hospital inpatient studies conducted in the United States, United Kingdom, Israel, New Zealand, Switzerland, Canada, and India published between 1964 and 1981.	Review of published studies on adverse drug reactions (ADRs).
Folli et al., 1987 Medication error prevention by clinical pharmacists in two children's hospitals	101,022 medication orders prescribed in two children's teaching hospitals (Miller Children's Hospital of Memorial Medical Center [MMC] and Stanford University Medical Center [SUMC]) during a six-month period (February through July 1985).	Copies of errant chart orders reviewed by a member of the pediatric faculty or attending physician and by two pediatric clinical pharmacist practitioners.
Perlstein et al., 1979 Errors in drug computations during newborn intensive care	43 nursing, pharmacy, and medical personnel tested for accuracy in calculating drug doses to be administered to newborn infants. (27 registered nurses, 5 registered pharmacists, and 11 pediatricians.)	

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Results	Definition(s)	Causes/Types of Error
Rates of patients experiencing ADRs ranged from 1.5% to 43.5%. A majority of the studies documented ADR rates between 10% and 25%.		
A combined total of 479 errant medication orders were identified at the two institutions. MMC and SUMC had similar frequency of error, 4.9 and 4.5 errors per 1,000 medication orders, or 1.37 and 1.79 per 100-patient days, respectively. Involving pharmacists in the reviewing of drug orders reduced the potential harm resulting from errant medication orders significantly.	Errant medication order—"An order was considered to be potentially in error if it was not in accordance with standard pediatric references, current published literature, or dosing guidelines approved by the pharmacy and therapeutics committees of each hospital."	The most common type of error was incorrect dosage. The most prevalent type of error was overdosage.
The mean test score for nurses was 75.6%. 56% of the errors would have resulted in administered doses ten times greater or less than the ordered dose. The mean test score was 96% for pharmacists and none of the errors would have resulted in the administration of doses over 1% greater or less than the dose ordered. Pediatricians averaged a score of 89.1%. 38.5% of the errors would have resulted in the administration of doses ten times higher or lower than the dose ordered.		

Continued

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Miller, 1977 Interpretation of studies on adverse drug reactions		Boston Collaborative Drug Surveillance Program
Burnum, 1976 Preventability of adverse drug reactions	1,000 adult medical patients drawn from a community, office-based practice of general internal medicine.	Physician observation.
Jick, 1974 Drugs: remarkably nontoxic	19,000 inpatients admitted to medical wards.	Boston Collaborative Drug Surveillance Program

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Results	Definition(s)	Causes/Types of Error
Adverse drug reactions (ADRs) occur in approximately 30% of hospitalized patients and after about 5% of drug exposures. The rate per patient of life-threatening ADRs in 3% and the rate per course of drug therapy is 0.4%.		
Adverse drug reactions (ADRs) occurred in 42 of the individual patients. 23 (55%) were judged unnecessary and potentially preventable.		23% of the 42 ADRs were attributable to physician error (10 out of 42; 6 because of giving a drug that was not indicated and 4 because of improper drug administration), 17% to patient or pharmacist error, and 14% to errors shared by the physician, patient and pharmacist.
30% of hospitalized medical patients have at least 1 adverse drug reaction (ADR) while hospitalized. An estimated 3 million hospital patients have an ADR in medical units each year.		

Continued

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Medication-related studies *(continued)*		
Phillips et al., 1974 Increase in U.S. Medication-error deaths between 1983 and 1993		All United States death certificates between 1983 and 1993.
Talley and Laventurier, 1974 Drug-induced illness		Boston Collaborative Drug Surveillance Program and an Israeli study.
Cost		
Thomas et al., 1999	Medical records of 14,732 randomly selected 1992 discharges from 28 hospitals in Utah and Colorado	Two-stage chart review by trained nurses and board-certified family practitioners and internists.

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Results	Definition(s)	Causes/Types of Error
In 1983, 2,876 people died from medication errors. By 1993, this number had risen to 7,391, a 2.57-fold increase. Between 1983 and 1993, outpatient medication error deaths rose 8.48-fold (from 172 to 1,459) and inpatient medical error deaths rose 2.37-fold (504 to 1,195).	Medication errors—"'accidental poisoning by drugs, medicaments, and biologicals' and have resulted from acknowledged errors, by patients or medical personnel."	
An estimated incidence of lethal adverse drug reactions ranges from a low of 60,000 (.18% incidence) to a high of 140,000 (.44% incidence) for hospitalized patients in the U.S.		
459 adverse events were detected, of which 265 were preventable. Death occurred in 6.6% of adverse events and 6.9% of preventable adverse events. The total costs were $661,889,000 for adverse events and $308,382,000 for preventable adverse events. Health care costs were $348,081,000 for all adverse events and $159,245,000 for preventable adverse events. 57% of the adverse event health care costs and 46% of the preventable adverse event costs were attributable to outpatient medical care.	Adverse event—"an injury caused by medical management (rather than the disease process) that resulted in either prolonged hospital stay or disability at time of discharge."	

Continued

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Cost (continued)		
Bates et al., 1997 The costs of adverse drug events in hospitalized patients	4,108 admissions to a stratified random sample of 11 medical and surgical units in Brigham and Women's Hospital (726 beds) and Massachusetts General Hospital (846 beds) in Boston over a 6-month period between February and July 1993. Cases were patients with an adverse drug event (ADE), and the control for each case was a patient on the same unit as the case with the most similar pre-event length of stay.	Stimulated self-reports by nurses and pharmacists and daily chart review. 2 independent reviewers classified the incidents.
Bootman et al., 1997 The health care cost of drug-related morbidity and mortality in nursing facilities	To estimate the cost of drug-related problems (DRPs) within nursing facilities, a decision analysis technique was used to develop a probability pathway model.	Survey of an expert panel consisting of consultant pharmacists and physicians with practice experience in nursing facilities and geriatric care.

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Results	Definition(s)	Causes/Types of Error
247 ADEs occurred among 207 admissions and 60 were preventable. The additional length of stay was 2.2 days with an ADE and 4.6 days with a preventable ADE. The estimated post-event costs attributable to an ADE were $2,595 for all ADEs and $4,685 for preventable ADEs. The estimated annual costs for a 700-bed teaching hospital attributable to all ADEs are $5.6 million and to preventable ADEs are $2.8 million. The national hospital costs of ADEs was estimated at $4 billion; preventable ADEs alone would cost $2 billion.	ADE—"an injury resulting from medical intervention related to a drug." Potential ADE—"incidents in which an error was made but no harm occurred."	
The cost of drug-related morbidity and mortality with the services of consultant pharmacists was $4 billion compared with $7.6 billion without services of consultant pharmacists. For every dollar spent on drugs in nursing facilities, $1.33 is consumed in the treatment of DRPs.	DRPs—"an event of circumstance involving a patient's drug treatment that actually or potentially interferes with the achievement of an optimal outcome."	

Continued

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TABLE C-1 *Continued*

Reference	Sample Description	Data Source
Cost (continued)		
Johnson and Bootman, 1995 Drug-related morbidity and mortality	A probability pathway model was developed for drug-related morbidity and mortality based primarily on drug-related problems (DRPs). A panel of experts gave estimates on the numbers of patients affected by DRPs and monetary value data were taken from published reports and statistical reports.	Telephone survey of 15 expert practicing pharmacists.
Schneider et al., 1995 Cost of medication-related problems at a university hospital	109 patients at a university-affiliated medical center hospital who were known to have had clinical consequences from an adverse drug reaction (ADR) or medication error.	Retrospective chart review.
Bloom, 1988 Cost of treating arthritis and NSAID-related gastrointestinal side-effects	Retrospective analysis of all direct costs related to the care of 527 Medicaid recipients treated for arthritis with non-steroidal anti-inflammatory drugs (NSAIDs) between December 1, 1981 and November 30, 1983.	Medicaid Management Information System of Washington, D.C.

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Results	Definition(s)	Causes/Types of Error
Drug-related morbidity and mortality costs an estimated $76.6 billion in the ambulatory setting in the United States. The panel members estimated that 40% of patients who receive drug therapy would have some form of DRP.	Drug-related problem—"an event or circumstance that involves a patient's drug treatment that actually, or potentially, interferes with the achievement of an optimal outcome."	
349 clinical outcomes associated with medical related problems (MRPs) (average of approximately 3 outcomes per patient) were detected. For the 1,911 ADRs and medication errors reported through the voluntary reporting system in 1994, the estimated annual cost was just under $1.5 million.		
In 1983, an estimated $3.9 million was spent on treating preventable gastrointestinal adverse drug reactions to NSAIDs.	Gastrointestinal adverse drug reaction—"any claim for payment accompanied by a diagnosis of peptic ulcer, gastritis/duodenitis, other disorders of the stomach or duodenum, gastrointestinal symptoms, or a pharmacy claim for an H2-recepter antagonist, sucralfate or antacid, which occurred during the arthritis treatment study period.	

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D
Characteristics of State Adverse Event Reporting Systems

CALIFORNIA

Reportable event

Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes, or other catastrophes and unusual occurrences that threaten the welfare, safety, or health of patients, personnel, or visitors. Other occurrences include, but are not limited to, prevalence of communicable disease; infestation by parasites or vectors; disappearance or loss of a patient or inmate-patient; sexual acts involving patients who are minors; nonconsenting adults, or persons incapable of consent; physical assaults on inmate-patients, employees, or visitors; and all suspected criminal activity involving inmate-patients, employees, or visitors.

Who submits reports

General acute care hospitals, acute psychiatric hospitals, skilled nursing facilities, immediate care facilities, home health agencies, pri-

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	mary care clinics, psychology clinics, psychiatric health facilities, adult day health centers, chemical dependency recovery hospitals, and correctional treatment centers.
Number of reports	4,337 (1998)
Year initiated	1972 (approximately)
Mandatory or voluntary	Mandatory; must be submitted within 24 hours of the incident.
Access to information	Reports that do not contain confidential information are accessible to the public. Reports that do contain confidential information can be obtained only by subpoena. The local licensing and certification office handles all requests for copies of reports.
Use of information	The state reviews the reported event and determines if an onsite visit is warranted. If violations of the regulations are suspected an onsite visit is conducted. If deficiencies are noted the facility must submit an acceptable plan of correction. Violation of regulations can also result in state or federal citations. Civil penalties of up to $50 per day or enforcement actions can be imposed.

COLORADO

Reportable event	All deaths arising from unexplained causes or under suspicious circumstances. Brain and spinal cord injuries. Life-threatening complications of anesthesia. Life-threatening transfusion errors or reactions. Burns; missing persons; physical, sexual, and verbal abuse; neglect, misappropriation of property; diverted drugs; malfunction or misuse of equipment.
Who submits reports	All state-licensed health care facilities.
Number of reports	1,233 (1998)
Year initiated	1989

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Mandatory or voluntary	Mandatory under Colorado State Statute 25-1-124(2).
Access to information	The name of the facility is disclosed. Patient and personnel information is kept confidential. Report summaries are posted on the Internet once the facility investigation is complete.
Use of information	An advisory committee meets monthly to identify patterns and issues. Summaries of the reviewed reports are sent out to the facilities and they have seven days to comment. The state will issue deficiencies if deemed necessary. All information is entered into a computer program for tracking. Surveyors and investigators review the information in the institution-specific database prior to conducting the regular survey and complaint investigations.

CONNECTICUT

Reportable event	All accidents or incidents that resulted in serious injury, death, or disruption of facility services.
Who submits reports	Nursing homes and hospitals.
Number of reports	14,783 (1996)—approximately 14,000 from nursing homes.
Year initiated	1987
Mandatory or voluntary	Mandatory for nursing homes; voluntary for hospitals.
Access to information	Reports disclose the name of the facility, but no information on patients or personnel. To obtain a report, one must fill out a Freedom of Information Act form and submit the request to the health department.
Use of information	Information is reviewed by a nurse consultant who determines if there needs to be an investigation by the health department.

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FLORIDA

Reportable event	Urgent issue: life-threatening situation, epidemic outbreak. Code 15: serious adverse event (i.e., wrongful death, brain injury, wrong limb removal, incorrect surgery).
Who submits reports	Hospitals and ambulatory surgical centers.
Number of reports	Approximately 5,000 a year; 4,000 are urgent issue and 1,000 are Code 15.
Year initiated	1985
Mandatory or voluntary	Mandatory
Access to information	A summary of the aggregate data collected from reports is issued once a year. All other information is confidential and cannot be released without a subpoena.
Use of information	Urgent-issue situations are considered to be outside the facility's control; and thus no facility follow-up is required. When reporting a Code 15, an analysis of the injury and a plan of correction must be submitted by the facility within 15 days. The state's risk management program tracks trends in the reporting.

KANSAS

Reportable event	An act by a health care provider that (1) is or may be below the applicable standard of care and has a reasonable probability of causing injury to a patient or (2) may be grounds for disciplinary action by the appropriate licensing agency.
Who submits reports	All licensed medical care facilities.
Number of reports	488 (1997)
Year initiated	1986
Mandatory or voluntary	Mandatory
Access to information	All reports are confidential. All peer review information and standard of care determinations are protected under the risk management statutes. Only the facts of the case

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	have been subpoenaed. The name of the reporter is protected.
Use of information	Each facility must establish a written plan for risk management and patient care quality assessment on a facility-wide basis. This initial plan must be submitted to the health department at least 60 days prior to the licensure date. The plan will be reviewed and the facility will be notified in writing concerning plan approval. The facility's governing board must review and approve the risk management plan on an annual basis. All changes must be approved by the department. Following an incident, the department will review the facility's plan to ensure that it is adequate. Depending on the severity of the incident, the department will then possibly conduct an investigation.

MASSACHUSETTS

Reportable event	Injury that is life-threatening, results in death, or requires a patient to undergo significant additional diagnostic or treatment measures. Medication errors. Major biomedical device or other equipment failure resulting in serious injury or having potential for serious injury. Surgical errors involving the wrong patient, the wrong side of the body, the wrong organ, or the retention of a foreign object. Blood transfusion errors. Any maternal death within 90 days of delivery or termination of a pregnancy. Death of a patient by suicide.
Who submits reports	All licensed health care facilities.
Number of reports	10,500 (1997); 390 were from hospitals
Year initiated	1986
Mandatory or voluntary	Mandatory

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Access to information	Copies of reports submitted by facilities are available to the public after official action has been taken by the health department. The identity of the patient is removed. Reports relating to abuse, neglect, or misappropriation are confidential and are not released.
Use of information	All reports are entered into a Massachusetts Health Department database and are reviewed. This database is used to retain information on the individual case and look for general patterns across cases. Depending on the incident, the department can decide to contact the facility for more information or conduct a site visit. Deficiencies are cited if the facility is found to have not reported all relevant information.

MISSISSIPPI

Reportable event	Suicide or attempted suicide, wrongful death, unexplained injuries, abuse, and interruptions of service at the facility.
Who submits reports	All licensed health care facilities.
Number of reports	Not provided
Year initiated	1993
Mandatory or voluntary	Mandatory
Access to information	Actual reports are not accessible to the public; however statements of deficiencies and plans of correction are available by request. The health department does spend a great deal of time in litigation with malpractice attorneys who are attempting to subpoena its records.
Use of information	Attempts are made to identify trends in the data received, and the department's findings are discussed with the facility.

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NEW JERSEY

Reportable event	Any incident that endangers the health and safety of a patient or employee and any death or injury associated with anesthetics.
Who submits reports	All state licensed health certificates.
Number of reports	Not provided
Year initiated	1986
Mandatory or voluntary	Mandatory
Access to information	Information is disclosed only in the event that the facility receives a citation from the state. Penalty letters revealing the name of the facility and describing the incident that led to the citation are posted on the Internet. Patient and personnel information is kept confidential.
Use of information	If deemed necessary, a state inspection team is sent to investigate the facility. The team's findings are shared with the facility, which must comply with the report's recommendations or be cited with deficiencies. Then the facility must submit a plan of correction for each deficiency. The health department can impose fines, curtail admissions, appoint a temporary manager, issue a provisional license, suspend a facility's license, or close the facility.

NEW YORK

Reportable event	An unintended adverse and undesirable development in an individual patient's condition occurring in a hospital. A list of 47 occurrences is included on a specification of reportable events.
Who submits reports	Hospitals
Number of reports	15,000–20,000 reports each year
Year initiated	1986
Mandatory or voluntary	Mandatory

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Access to information	Narrative reports on incidents and the investigations conducted are protected by law, but the state can release aggregate data by hospital, including the number of reports submitted. State actions against a facility are posted on the Internet (whether the source was the reporting system, patient complaint, or other).
Use of information	The state may investigate specific incidents. If the hospital has taken action acceptable to the department, the case is closed. If the violation persists, the state may issue deficiencies or fines. The state also intends to develop regional error rates for benchmarking and dissemination to regional councils that are being formed.

OHIO

Reportable event	Death or injury resulting from equipment malfunction or treatment of the wrong subject or wrong modality.
Who submits reports	Free-standing therapy, imaging, and chemotherapy centers
Number of reports	Not provided
Year initiated	1997
Mandatory or voluntary	Mandatory
Access to information	Governed under Ohio's public record law. This law prohibits the collection of patient-specific information. The state will only be releasing aggregate data on the incidents reported. Facilities will have access only to their own information. The state plans to compile an annual report on incidents that will be available to the public.
Use of information	A database is being developed to track the number of reports received and provide an indicator of which facilities should be inves-

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tigated. The goal is to identify noticeable trends in types of errors. The director of health monitors compliance and can inspect any health care provider. Health care providers may be required to regularly issue reports and undergo independent audits.

PENNSYLVANIA

Reportable event	An event that seriously compromises quality assurance or patient safety, including: deaths due to injuries, suicide, or unusual circumstances; deaths due to medication error; deaths due to malnutrition, dehydration, or sepsis; elopements; patient abuse; rape; surgery on the wrong patient or modality; hemolytic transfusion reaction; infant abduction or discharge to wrong family; fire or structural damage; unlicensed practice of a regulated profession.
Who submits reports	Hospitals, nursing homes, home health agencies, ambulatory surgical facilities, intermediate care facilities for persons with developmental disabilities.
Number of reports	Not provided
Year initiated	1990
Mandatory or voluntary	Mandatory
Access to information	All collected information is confidential. Reports are often shared only with another state agency. They are not considered public material and were not intended to provide information to the public. The department usually requests that courts overrule subpoenas, and in the majority of cases its request is granted.
Use of information	On some occasions, the department will request more information from a facility and conduct investigations. This is usually done when there is a recurrence of incidents or

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drug misappropriation. Very few cases have resulted in a fine to a facility following an adverse event.

RHODE ISLAND

Reportable event	Any incident causing or involving the following: brain injury; mental impairment; paraplegia; quadriplegia; paralysis; loss of use of limb or organ; birth injury; impairment of sight or hearing; surgery on the wrong patient; subjecting a patient to any procedure that was not ordered or intended by the physician.
Who submits reports	Hospitals
Number of reports	134 (1998) from 15 facilities
Year initiated	1994
Mandatory or voluntary	Mandatory
Access to information	The names of personnel and patients are not disclosed in submitted reports. All reports are confidential and are protected by law. The hospital involved is contacted whenever the health department receives a subpoena from an attorney. The hospital may initiate proceedings to quash the subpoena. However, if the state takes action against the facility—for example, following a site investigation—then this information may be disclosed to the public.
Use of information	Reports are reviewed by department staff and filed. If deemed warranted, an investigation of the incident will be conducted. After submitting a report the hospital must conduct a peer review process to determine whether the incident falls within the normal range of outcomes, given the patient's condition. If the hospital's findings conclude that the in-

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cident was outside the normal range, the hospital must provide the health department with the following information: an explanation of the circumstances surrounding the incident; an updated assessment of the effect of the incident on the patient; a summary of current patient status including follow-up care provided and post-incident diagnosis; and a summary of all actions taken to correct the problems identified to prevent recurrence and/or improve overall patient care. Incidents that are determined to have fallen within a normal range of outcomes by the hospital are reviewed by the health department. In the event that the health department disagrees with the hospital's findings, a separate investigation is conducted and peer review documents are examined.

SOUTH DAKOTA

Reportable event	Unnatural deaths; missing patients or residents; incidents of abuse, neglect, or misappropriation.
Who submits reports	All licensed health care facilities.
Number of reports	The health department has not kept track of the exact number of reports received. The majority are submitted by nursing homes.
Year initiated	1994
Mandatory or voluntary	Mandatory
Access to information	Reports are completely confidential, unless a deficient practice is identified at the facility. A summary of the cited deficiency is releasable information. As required by state law, a judicial court order must be issued before the health department will release any other information.

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Use of information	Each incident report is analyzed to assess whether the facility did everything possible to avert the incident. If it did not, the facility will be cited and then they must develop a plan of correction.

SOURCE: Information for this table was collected from each state health department by telephone between February 24 and May 5, 1999. Each respondent was given the opportunity to review the draft and correct any errors.

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E
Safety Activities in Health Care Organizations

Numerous programs intended to promote patient safety can be found in hospitals, nursing homes, and other health care organizations. Hospitals, home health agencies, nursing homes, clinical laboratories, ambulatory surgery centers, and other health care facilities are licensed by state departments of health, which establish the terms under which they may operate.

One way in which federal and state quality oversight requirements have historically been met is through reliance on private-sector accrediting bodies, termed *deemed status.* In most circumstances, deemed status arrangements allow a facility to meet government standards either through accreditation or directly through the government agency or through accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association.

A brief review of widely implemented safety programs in health care facilities, then, is grounded in the state licensing or, more likely, the voluntary accreditation standards of accrediting bodies such as the JCAHO. The JCAHO's standards for hospital accreditation,[1] for example, include several facility-wide safety systems intended to ensure patients' physical safety and protection from environmental hazards and risks, accidents, and injuries including, for example, life safety; infectious disease surveillance, prevention,

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and control; and the handling and use of blood and blood products. Other traditional approaches to learning about error and how it might be prevented include morbidity and mortality conferences and autopsy.

LIFE SAFETY

Life safety refers to a set of standards for the construction and operation of buildings and the protection of patients from fire and smoke. These standards are based on the Life Safety Code, promulgated by the National Fire Prevention Association. Life safety standards that require fire alarm and detection systems are monitored and serviced routinely, that fire and smoke containment systems are in place, and that systems for transmitting alarms to the local fire department are functional. Facilities typically participate in fire and other disaster drills that help them identify weaknesses in their systems. By analogy, many other kinds of delivery-related simulations can probably help groups with differing disciplinary backgrounds learn to work cooperatively and effectively in, for example, the intensive care unit, emergency department, or operating room. The recent development of highly sophisticated operating room simulators has demonstrated their value both in teaching and for practitioners to practice recovering from crises.

INFECTIOUS DISEASE SURVEILLANCE, PREVENTION, AND CONTROL

Today, infection control covers a broad range of processes throughout the hospital. It requires epidemiological expertise and includes attention to medical devices (e.g., intravascular and alimentation devices, ventilators, equipment used for examination); the physical environment (e.g., air ducts, surfaces); surgical wound management; and carriage by employees and other health professionals.

Such infection control processes are managed by individuals who are assigned the responsibility of surveillance, reporting, and investigating outbreaks of nosocomial infections (infections acquired while in health care that are unrelated to the original condition), and putting in place and monitoring the results of processes to prevent or reduce the risk of infectious transmission. In the best systems, data from many sources within the hospital—infection control committee surveillance, length-of-stay outlier reports, operating room logs, bacteriology and pathology reports, morbidity and

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mortality (M&M) conferences and so forth—can be brought to bear to identify trends and sources of infectious disease.

Despite major efforts to decrease transmission, infection control remains a challenge to health care facilities. Indeed, in some ways it is more difficult now than in the past. Like other advances in patient care, the advent of antibiotics has dramatically improved patient care, but the emergence of antibiotic resistance means that new efforts of surveillance and prevention must be implemented in order to make progress against infection, and continuing efforts are needed to maintain earlier achievements.

According to the Centers for Disease Control (CDC), nosocomial infections affect approximately 2 million patients annually in acute care facilities in the United States at an estimated direct patient care cost of approximately $3.5 billion per year (NCID/CDC&P). In long-term care facilities including nursing homes, CDC estimates that more than 1.5 million cases of nosocomial infection occur each year, an average of one infection per patient per year.[2] Epidemiological studies have estimated that one-third of nosocomial infections can be prevented by well-organized infection control programs, yet only six to nine percent are actually prevented.

Recognition of the danger of transmission of infection in the health care setting is credited to the insight of a Viennese obstetrician Ignaz Phillip Semmelweis in 1847. Semmelweis correctly identified the cause of an epidemic of childbed fever (puerperal sepsis) among maternity patients as originating from physicians who had previously done autopsies and then transferred bacteria (later found to be *Streptococcus pyogenes*) on their hands when they examined their patients. After Semmelweis introduced the practice of hand washing with a solution of chloride of lime (an antiseptic) before examination, maternal mortality decreased from 18 percent to 2.4 percent in the first month.[3,4] According to CDC, even today, "handwashing is the single most important means of preventing the spread of infection." Yet, repeated studies indicate that after more than 150 years of experience, lack of or improper handwashing still contributes significantly to disease transmission in health care settings[5–11] Exhortations to personnel have not been effective, and some organizations have begun to look at system barriers to handwashing (e.g., the time required as well as the chapping and irritation caused by frequent handwashing) and ways to eliminate these problems by designing better hand hygiene processes.

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MORBIDITY AND MORTALITY CONFERENCES

Morbidity and mortality (M&M) conferences began early in the twentieth century (1917) as a standardized case report system to investigate the reasons and responsibility for adverse outcomes of care. Mandated in 1983 by the Accreditation Council for Graduate Medical Education, M&M is a weekly conference at which, under the moderation of a faculty member, medical and surgical residents and attendings present cases of all complications and deaths. The value of the M&M conference is highly dependent on how the department chair uses it, but a recent national survey on attitudes and opinions of the value of M&M conferences found that 43 percent of residents and 47 percent of surgical faculty believed that the conference was an important and powerful educational tool.[12] Lower rankings were given to its value in reducing error and improving care.

M&M conferences are case-by-case reviews, with an emphasis on learning what might have been done differently in a given case rather than punishment, but they stress the value of knowledge, skill, and alertness to anticipate problems.[13] They tend not to address systemic issues. Their value in improving the quality of care could be substantially increased if ongoing data are kept to identify repeated complications and time trends and if information from the M&M conferences is integrated with information from other available sources within the hospital.

AUTOPSY

Unexpected findings at autopsy are an excellent way to refine clinical judgment and identify misdiagnosis. Lundberg cites a 40 percent discrepancy between antemortem and postmortem diagnoses.[14] Nevertheless, autopsy rates have declined greatly in recent years from 50 percent in the 1940s to only 14 percent in 1985.[15,16] Autopsy rates in nonteaching hospitals are now less than 9 percent.

When autopsies are completed, their value in improving care depends on reports reaching clinicians in a timely manner. Yet, many hospitals report long delays (several weeks or more) before clinicians receive autopsy reports. In general, rapid improvement requires shortening the cycle time between investigation and feedback to caregivers and managers, and timeliness in autopsy reporting is representative of all data gathering activities intended for quality improvement and reduction of errors.

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RISK MANAGEMENT PROGRAMS

Originating with the increase in liability risk in the mid-1970s, hospital risk management programs have long been associated with the reduction of institutional liability and financial loss control.[17,18] Controlling loss has focused historically on preserving the institution's financial (and human) resources. Risk management includes identification of risk and education of staff, identifying and containing risk after an event, education of staff and patients, and risk transfer. Educational efforts tend to focus on such topics as review of state statutes on informed consent, presentations by the hospital's defense counsel, and programs on medical and legal topics for physicians.

Although effort has been made to move toward "primary" risk management that would focus on preventing adverse events from occurring, risk management is still focused largely on loss control. Although incident reporting systems are intended to include major events such as surgical mishaps, incidents have traditionally been greatly underreported and the reports that are filed have involved largely slips, falls, and medication errors that may have little consequence.[19,20] The American College of Surgeons estimated in 1985 that only 5–30 percent of major mishaps are reported on traditional incident forms.[21] Cullen et al. (1995) found that of 54 adverse drug events identified in their study, only six percent had a corresponding incident report submitted to the hospital's quality assurance program or the pharmacy hotline.

Although risk management committees include a member of the medical staff, risk management has not been embraced at the organizational leadership level in its broadest sense of patient safety—protecting patients from any accidental injury. Risk managers interact when necessary with the administrator or chief executive officer, medical director or chief of staff, nursing director, medical records director, and chief financial officer, but the function of improved patient safety is not, typically, represented through risk managers on the governing board's executive committee or at corporate headquarters.

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Exhibit 32

An organisation with a memory

Department of Health

An organisation with a memory

Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer

Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer

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Report of an expert group on learning from adverse events in the NHS

Chaired by the Chief Medical Officer

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FOREWORD

by the Secretary of State for Health

The Government is committed to building a new NHS that offers faster, fairer and higher-quality services to patients. The modern NHS we are creating must be constantly alert to opportunities to review and improve its performance.

Advances in knowledge and technology have in recent decades immeasurably increased the power of health care to do good, to prevent or treat illnesses against which there was previously no defence. Yet they have also immeasurably increased the complexity of health care systems. Their unique combination of processes, technologies and human interactions means that modern health care systems are among the most complex in the world.

With that complexity comes an inevitable risk that at times things will go wrong. And in health care when things go wrong the stakes are higher than in almost any other sphere of human activity.

No-one pretends that adverse health care events, as this report has termed them, can be eliminated from modern health care. Health care interventions usually bring great benefits, but they can sometimes cause harm if things go wrong. The challenge is to ensure that the modern NHS is as safe a place as possible for patients, and that the outcomes of its care are skewed even more overwhelmingly to the positive. That is a challenge this Government is determined to meet.

Too often in the past we have witnessed tragedies which could have been avoided had the lessons of past experience been properly learned. The task of the Expert Group was to advise the Government on the steps that can be taken to ensure that the NHS learns from its experiences, so that the risk of avoidable harm to patients is minimised.

This report examines the key factors at work in organisational failure and learning, a range of practical experience from other sectors and the present state of learning mechanisms in the NHS before drawing conclusions and making recommendations. Its recommendations include the creation of a new national system for reporting and analysing adverse health care events, to make

sure that key lessons are identified and learned, along with other measures to support work at local level to analyse events and learn the lessons when things go wrong.

I welcome this report and will be studying its findings very closely. My fellow Ministers and I will be working with the Chief Medical Officer over the next few months to decide how best to take forward the necessary action.

Alan Milburn
Secretary of State for Health

EXECUTIVE SUMMARY

1 The great majority of NHS care is of a very high clinical standard, and serious failures are uncommon in relation to the high volume of care provided every day in hospitals and in the community. Yet where serious failures in care do occur they can have devastating consequences for individual patients and their families, cause distress to the usually very committed health care staff involved and undermine public confidence in the services the NHS provides. In addition, the cumulative financial cost of adverse events to the NHS and to the economy is huge. Most distressing of all, such failures often have a familiar ring, displaying strong similarities to incidents which have occurred before and in some cases almost exactly replicating them. Many could be avoided if only the lessons of experience were properly learned.

2 The introduction of clinical governance provides NHS organisations with a powerful imperative to focus on tackling adverse health care events. This report, commissioned by Health Ministers from an expert group under the chairmanship of the Chief Medical Officer, sets out to review what we know about the scale and nature of serious failures in NHS health care, to examine the extent to which the NHS has the capacity to learn from such failures when they do occur and to recommend measures which could help to ensure that the likelihood of repeated failures is minimised in the future. The work of the group was informed by evidence and experience from a range of sectors other than health, including industry, aviation and academic research.

The problem

3 Currently, NHS reporting and information systems provide us with a patchy and incomplete picture of the scale and nature of the problem of serious failures in health care. We know, for example, that every year:

- 400 people die or are seriously injured in adverse events involving medical devices;
- nearly 10,000 people are reported to have experienced serious adverse reactions to drugs;
- around 1,150 people who have been in recent contact with mental health services commit suicide;

- nearly 28,000 written complaints are made about aspects of clinical treatment in hospitals;
- the NHS pays out around £400 million a year settlement of clinical negligence claims, and has a potential liability of around £2.4 billion for existing and expected claims;
- hospital acquired infections – around 15% of which may be avoidable – are estimated to cost the NHS nearly £1 billion.

4 Just as none of these statistics can be attributed wholly to service failures, research in this country and abroad suggests that they give no indication of the potential true scale of the problem. This issue has been the subject of major pieces of academic research in Australia and the USA, but work in the UK is in its infancy. Yet the best research-based estimates we have reveal enough to suggest that in NHS hospitals alone adverse events in which harm is caused to patients:

- occur in around 10% of admissions – or at a rate in excess of 850,000 a year;
- cost the service an estimated £2 billion a year in additional hospital stays alone, without taking any account of human or wider economic costs.

5 In addition, there is evidence that some specific types of relatively infrequent but very serious adverse events happen time and again over a period of years. Inquiries and incident investigations determine that 'the lessons must be learned', but the evidence suggests that the NHS as a whole is not good at doing so. Still less is known about the situation in primary care, despite the fact that it accounts for the great majority of NHS patient contacts and can still experience service failures which have serious consequences for individual patients.

Evidence and experience

6 Research on learning from failures in health care is relatively sparse, yet the evidence from other areas of activity – and in particular from industry – reveals a rich seam of valuable knowledge about the nature of failure and of learning which is as relevant to health care as to any other area of human activity.

7 When things go wrong, whether in health care or in another environment, the response has often been an attempt to identify an individual or individuals who must carry the blame. The focus of incident analysis has tended to be on the events immediately surrounding an adverse event, and in particular on the human acts or omissions immediately preceding the event itself.

8 It is of course right, in health care as in any other field, that individuals must sometimes be held to account for their actions – in particular if there is evidence of gross negligence or recklessness, or of criminal behaviour. Yet in

the great majority of cases, the causes of serious failures stretch far beyond the actions of the individuals immediately involved. Safety is a dynamic, not a static situation. In a socially and technically complex field such as health care, a huge number of factors are at work at any one time which influence the likelihood of failure. These factors are a combination of:

- active failures: 'unsafe acts' committed by those working at the sharp end of a system, which are usually short-lived and often unpredictable; and
- latent conditions: that can develop over time and lie dormant before combining with other factors or active failures to breach a system's safety defences. They are long-lived and, unlike many active failures, can be identified and removed before they cause an adverse event.

9 Human error may sometimes be the factor that immediately precipitates a serious failure, but there are usually deeper, systemic factors at work which if addressed would have prevented the error or acted as a safety-net to mitigate its consequences. We illustrate this point with case studies from the NHS and from many other sectors, including the aviation industry.

10 Activity to learn from and prevent failures therefore needs to address their wider causes. It also needs to stretch beyond simply diagnosing and publicising the lessons from incidents, to ensure that these lessons are embedded in practice. The distinction between passive learning (where lessons are identified but not put into practice) and active learning (where those lessons are embedded into an organisation's culture and practices) is crucial in understanding why truly effective learning so often fails to take place.

11 It is possible to identify a number of barriers that can prevent active learning from taking place, but there are two areas in particular where the NHS can draw valuable lessons from the experience of other sectors.

- Organisational culture is central to every stage of the learning process – from ensuring that incidents are identified and reported through to embedding the necessary changes deeply into practice. There is evidence that 'safety cultures', where open reporting and balanced analysis are encouraged in principle and by example, can have a positive and quantifiable impact on the performance of organisations. 'Blame cultures' on the other hand can encourage people to cover up errors for fear of retribution and act against the identification of the true causes of failure, because they focus heavily on individual actions and largely ignore the role of underlying systems. The culture of the NHS still errs too much towards the latter;
- Reporting systems are vital in providing a core of sound, representative information on which to base analysis and recommendations. Experience in other sectors demonstrates the value of systematic approaches to recording and reporting adverse events and the merits of quarrying information on 'near misses' as well as events which actually result in harm. The NHS does not compare well with best practice in either of these areas.

12 Despite the particular characteristics and complexities of health care systems, there is much of value that can be gleaned from research and wider experience about the nature of both failure and learning. The experience of other sectors provides valuable pointers towards ways in which NHS systems might be developed.

NHS systems for learning from failure

13 A number of systems already exist in the NHS which can, to varying extents, be seen as mechanisms for learning from adverse health care events, but collectively they have serious limitations. These NHS systems include:

- a number of local, regional and national incident reporting schemes;
- ongoing national studies in specific areas of care, such as the four Confidential Inquiries;
- systems, such as those for complaints and litigation, which are designed to investigate or respond to specific instances of poor quality care;
- periodic external studies and reviews (e.g. the Audit Commission's Value for Money studies);
- health and public health statistics; and
- a range of internal and external incident inquiries.

14 Some of these systems (such as the Confidential Inquiries and the national reporting system for incidents involving medical devices) achieve good coverage of very specific categories of event, and produce high-quality recommendations based on analysis of the information collected. Overall though coverage is patchy and there are many gaps. Guidance on the reporting of adverse incidents in the NHS stretches back over 40 years, but there is still no standardised reporting system, nor indeed a standard definition of what should be reported.

15 Local risk reporting systems, which should provide a bedrock for onward reporting to regional or national systems, are developing but similarly variable. Incident reporting systems appear to be particularly poorly-developed in primary care, and systematic reporting of 'near misses' (seen as an important early warning of serious problems) is almost non-existent across the NHS.

16 Systems vary too in the degree to which the information collected is subject to analysis with the aim of promoting learning. Information from the complaints system and from health care litigation in particular appear to be greatly underexploited as a learning resource. The NHS also secures variable value, both financially and in useful learning extracted, from the range of ad hoc incident investigations and inquiries undertaken every year. There is no single focal point for NHS information on adverse events, and at present it is spread across nearly 1.000 different organisations.

17 The NHS record in implementing the recommendations that emerge from these various systems is patchy. Too often lessons are identified but true 'active' learning does not take place because the necessary changes are not properly embedded in practice. Though there is some good evidence of meaningful medium and long-term change as a result of Confidential Inquiry recommendations, for example, these are rarely driven through into practice and the onus for implementation and prioritisation is very much on local services. Takeup can tend to 'plateau' once changes have been implemented by those who are most naturally receptive to them, and there is some evidence that progress nationally can slip back if efforts are not sustained.

18 The renewed focus on quality as a core component of the Government's NHS modernisation programme provides an opportunity to address some of these shortcomings. The reporting and analysis of adverse health care events should be a specific focus for action, over and above the general drive for improved risk management and better risk reporting.

The Way Forward

19 The time is right for a fundamental re-thinking of the way that the NHS approaches the challenge of learning from adverse health care events. The NHS often fails to learn the lessons when things go wrong, and has an old-fashioned approach in this area compared to some other sectors. Yet the potential benefits of modernisation are tremendous – in terms of lives saved, harm prevented and resources freed up for the delivery of more and better care.

20 We believe that, if the NHS is successfully to modernise its approach to learning from failure, there are four key areas that must be addressed. In summary, the NHS needs to develop:

- unified mechanisms for reporting and analysis when things go wrong;
- a more open culture, in which errors or service failures can be reported and discussed;
- mechanisms for ensuring that, where lessons are identified, the necessary changes are put into practice;
- a much wider appreciation of the value of the system approach in preventing, analysing and learning from errors.

21 Only if these four conditions are met can the NHS hope to develop the modern and effective approach to learning from failures that it so badly needs. It is the specific action needed to create these conditions that our conclusions and recommendations seek to address in detail.

GLOSSARY

Throughout this report we use a number of terms the definition of which has been the subject of much debate. An accurate appreciation of the meaning attached to these terms is important in understanding fully our report and its conclusions. This brief glossary sets out the meanings we have attributed to these key terms in our report.

Adverse health care event
An event or omission arising during clinical care and causing physical or psychological injury to a patient

Error
The failure to complete a planned action as intended, or the use of an incorrect plan of action to achieve a given aim[1]

Hazard
Anything that can cause harm[2]

Health care near miss
A situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury to a patient

Risk
The likelihood, high or low, that somebody or something will be harmed by a hazard, multiplied by the severity of the potential harm

System
A set of interdependent elements interacting to achieve a common aim. These elements may be both human and non-human (equipment, technologies etc.).[3]

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CHAPTER 1

Introduction

In this chapter we set out the rationale for the group's task. Serious incidents and failures of services are uncommon in relation to the high volume of care provided throughout the NHS every day. Yet when they do occur they can have disastrous implications for patients and their families. When we read about serious problems they often have a familiar ring, displaying similarities to incidents which have occurred before. The expert group was set up to examine the extent to which the NHS currently has the capacity to learn from incidents and service failures, and to recommend steps which might be taken to help ensure that similar events can be avoided in the future.

1.1 In December 1997, the Government published a White Paper *The New NHS: Modern, Dependable* [4], which set out a ten year modernisation strategy for the NHS. One of the main aims of the proposals set out in the White Paper is to bring about a major improvement in the quality of clinical care delivered to patients in the NHS.

A programme to improve quality in the NHS

1.2 As part of these changes, a formal responsibility for quality has been placed on every health organisation in the country through arrangements for clinical governance at local level. This responsibility is underpinned by a new statutory duty of quality on NHS providers.

Clinical Governance

"A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" [5]

1.3 Clinical governance is thus an organisational concept. It requires the creation of a culture as well as systems and methods of working which will ensure that opportunities for quality improvement are identified in all the organisation's services and that over time there is a major step up in the quality of care provided throughout the NHS.

1.4 Under these new policies local clinical governance is reinforced by new national structures: National Service Frameworks and the National Institute for Clinical Excellence (NICE) will set standards, a new NHS Performance Assessment Framework will provide a better-balanced means of gauging NHS performance and the Commission for Health Improvement (CHI) will review local clinical governance arrangements. The Commission will also have a 'trouble-shooting' role to help individual NHS organisations identify the root causes of serious difficulties and advise on the measures needed to resolve them.

Shifting the quality curve

1.5 If a simple summary measure were available of the quality of care produced by each NHS organisation and each clinical team within that organisation, we might expect that the majority would tend to cluster near the middle of the range. Outlying values, whether representing very good quality or very poor, would be much less common than more 'average' performance. One such pattern is shown in Figure 1.1. The exact form of the curve is not important, only that values towards the middle of the curve are common in comparison with those at the two extremes. This form of central tendency is generally found in complex and biological systems such as those underlying health care delivery.

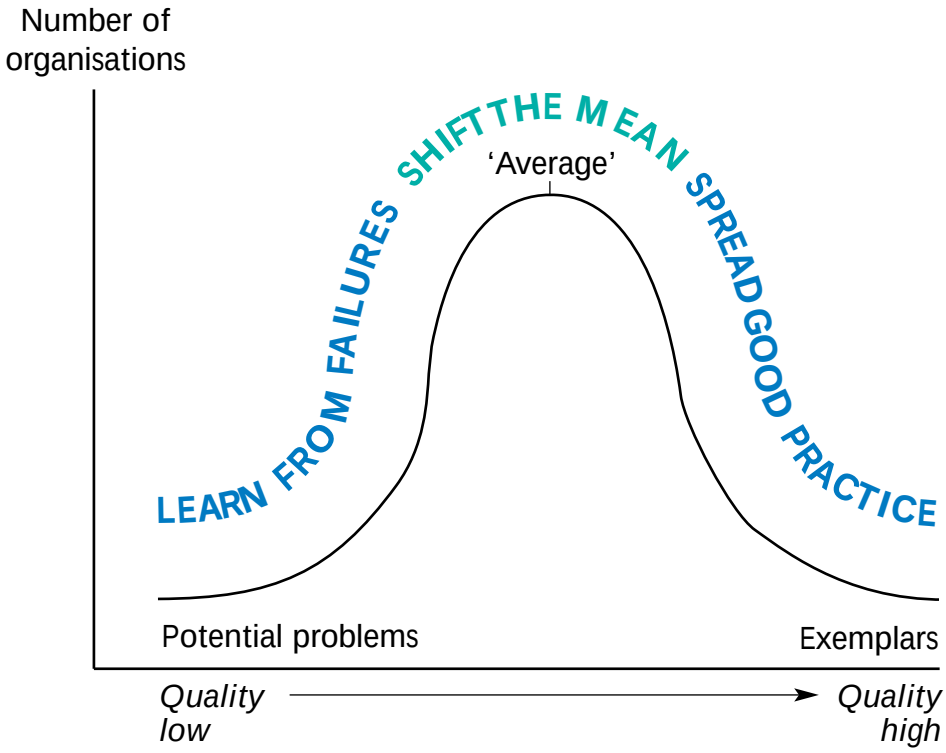

Figure 1.1: Variation in the Quality of Organisations

Source: Scally and Donaldson 1998[6]

"quality must be 'everybody's business', and not simply an issue for the very best and the very worst"

1.6 The Government's policies for the NHS aim to address all aspects of this quality curve. By doing so, and shifting the curve in Fig. 1.1 to the right in the direction of higher quality, the major benefits will come from improving the position of the 'average', where the bulk of health care organisations and clinical teams lie. This underlies the philosophy that quality must be 'everybody's business', and not simply an issue for the very best and the very worst. This is a key principle of current policy to improve clinical quality within the framework of clinical governance.

1.7 It is also important, though, that we do not lose sight of the left-hand tail of the curve in Fig. 1.1. Organisational performance in the NHS will never be homogenised to the extent that this 'tail' will be altogether eliminated, and it is inevitable that whatever the position of the curve itself there will always be organisations whose performance is worse (or better) than the average. The adverse events and failures which lie behind this part of the curve, however infrequently they may occur, can be a source of valuable learning. They need to be studied so that valid lessons can be drawn, communicated and learned for the benefit of the NHS and its future patients. That process provides the focus for the rest of our report. As a result our report is bound to concentrate disproportionately on instances of poor outcome and failure.

Addressing serious quality problems

1.8 The 'problem' tail of the quality curve has caused greatest concern in recent years. This is for two reasons. Firstly, although serious problems in the quality of health care are uncommon in proportion to the high volume of very good care provided, when they do occur they can have devastating consequences for individuals and their families. Secondly, stories about very poor care regularly hit the headlines and they worry people. They give the impression that the NHS is powerless to prevent such disasters and they generally undermine public confidence in services. Rightly or wrongly, accounts of particular health service failures lead to the perception that they may be only the tip of an iceberg beneath which much more poor quality lies.

1.9 This is an area where the NHS has not had a strong track record over its 52 years of existence. The Government has recently acted to address the problem of unacceptable quality of care arising from the poor clinical performance of doctors. A consultation paper[7] has been published setting out proposals to completely modernise the approach to poor clinical performance, with a much greater emphasis on its prevention and early recognition and on fast, fair and effective resolution of problems when they do occur.

1.10 Not all serious failures in quality of care will be due either wholly or in part to poor performance by a doctor or other health professional. Poor professional performance may occur in conjunction with other problems within the organisation. Alternatively, the service failures may result from human error rather

than being the end result of a pattern of poor practitioner performance. Invariably though, human error will be combined with wider organisational factors which contributed to the failure. This, as will become apparent, is one of the major themes of this report.

1.11 Over time, we would expect the development of clinical governance in all health care organisations within the NHS to reduce the likelihood of service failure. An important part of this local process will be the further development of risk management programmes, an approach which is already well underway as part of the overall NHS approach to controls assurance. The work of the Commission for Health Improvement will assist and reinforce these local developments in quality improvement.

An absence of learning from failure

"the NHS is behind some other sectors where there are risks in service delivery and where human safety is at stake"

1.12 Amidst this major and comprehensive range of measures to assure and improve quality in the NHS, there is one remaining weak link. The NHS has no reliable way of identifying serious lapses of standards of care, analysing them systematically, learning from them and introducing change which sticks so as to prevent similar events from recurring. In this respect the NHS is behind some other sectors where there are risks in service delivery and where human safety is at stake.

1.13 There are a number of things we should expect to see if, overall, systems for minimising and learning from failures are working well.

A service working well should expect that:

- Serious failures of standards of care are uncommon.
- Serious failures of a similar kind do not recur on a future occasion.
- Incidents where services have failed in one part of the country are not repeated elsewhere.
- Systems are in place which reduce to a minimum the likelihood of serious failure in standards of care happening.
- Attention is also paid to monitoring and reducing levels of less serious incidents.

1.14 The starting point for this report was that these conditions are by and large not fulfilled at present. Experience suggests that the NHS as a service is not expert at preventing serious incidents or occurrences in which patients are harmed or experience very poor outcomes of care. Nor does it always learn efficiently or effectively from such failures when they do occur.

The present NHS position on adverse incidents

- Some failures occur which are avoidable.
- Untoward events which could be prevented recur, sometimes with devastating consequences.
- Incidents which result in lapses in standards of care in one or more health organisations do not reliably lead to corrections throughout the NHS.
- Circumstances that predispose to failure, and which if addressed could allow risks to be minimised, are not well recognised.

The price of failure

1.15 The importance of addressing this deficit – the failure to learn reliably from adverse events – is illustrated by seven simple facts:

- Research suggests that an estimated 850,000 (range 300,000 to 1.4 million) adverse events might occur each year in the NHS hospital sector, resulting in a £2 billion direct cost in additional hospital days alone; some adverse events will be inevitable complications of treatment but around half might be avoidable.
- The NHS paid out around £400 million[8] in clinical litigation settlements in the financial year 1998/99 and has a potential liability of around £2.4 billion from existing and expected claims; when analysed many cases of litigation show potentially avoidable causes.
- There were over 38,000 complaints about all aspects of Family Health Services during 1998–99, and nearly 28,000 written complaints about aspects of clinical treatment in hospitals alone[9].
- At least 13 patients have died or been paralysed since 1985 because a drug has been wrongly administered by spinal injection.
- Over 6,600 adverse incidents involving medical devices were reported to the Medical Devices Agency in 1999, including 87 deaths and 345 serious injuries[10].
- Experience from the serious incident reporting system run by one of the NHS Executive's Regional Offices suggests that nationally at least 2,500 adverse events a year occur which should be serious enough to register on such systems.
- The costs to the NHS of hospital acquired infections have been estimated at nearly £1 billion a year, and around 15% of cases are regarded as preventable[11].

The Committee's task

1.16 The present Expert Committee comprised (Annex A) members from within

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the NHS and from some of the specialist agencies that see the results of poor quality care in the NHS, as well as consumer representation. Committee members from fields other than health care brought important experience and expertise on organisational failure, incidents and disasters from other sectors. In addition, we drew on the particular expertise of a number of external presenters and contributors. The Committee was established in February 1999 by the then Health Minister Baroness Hayman, under the Chairmanship of the Chief Medical Officer, Professor Liam Donaldson.

Terms of Reference

"To examine the extent to which the National Health Service and its constituent organisations have the capability to learn from untoward incidents and service failures so that similar occurrences are avoided in the future. To draw conclusions and make recommendations."

1.17 The Expert Committee explored fully the context and issues which underlay its terms of reference.

The Expert Committee's tasks

- Clarify the size and nature of the problem of avoidable service failure in the NHS.
- Identify the issues underlying service failure in the NHS.
- Draw on experience, research and good practice from other fields in which organisational failure and disasters have been addressed.
- Establish the best ways to identify problems, collect data and analyse them.
- Set out an approach to achieve major improvement in the way the NHS approaches this problem.

1.18 Extensive use was made of case studies and examples drawn from both health care and non-health care experience. The majority were already in the public domain, but all have been anonymised to protect individual patients and their relatives.

1.19 Experience of adverse incidents is almost entirely based on their occurrence in secondary care. It could be argued that they are more likely to happen in the organisationally complex, high technology environment of a hospital. The truth is that we simply do not know the frequency and nature of such

problems occurring in primary care. The examples in this report therefore mainly concern secondary care, but its core themes and recommendations are also intended to encompass primary care. They will apply in particular to Primary Care Groups and Primary Care Trusts as they develop as organisations. In the context of the conviction of the General Practitioner Dr Harold Shipman for murdering 15 of his patients, Health Ministers also asked that our recommendations specifically addressed the situation in this sector, with particular regard to incident reporting arrangements.

CHAPTER 2

The scale and nature of the problem

In this chapter we assess what we know about the scale of the problem of adverse events in the NHS, in both human and financial terms, and illustrate briefly some of the kinds of events which occur. In fact we have relatively little reliable information to help us quantify the scale of the problem, but what there is gives at least some indication of the significance of this issue for the NHS.

Information on the scale of the problem

2.1 Table 2.1 captures, in summary form, information from a selection of the existing incident reporting and recording systems which we describe in more detail in chapter 3. It does not provide a complete or accurate picture of the scale or nature of service failures in the NHS, and indeed not all the figures cited will necessarily reflect 'adverse incidents' as opposed, for example, to unavoidable deaths. It provides some insight but must be regarded as a serious underestimate of the size of the problem. Specifically, there are no incident reporting systems which properly take account of adverse events in primary care.

2.2 Some of these statistics provide a more reliable and complete picture than others. For example coverage of statistics on suicides and homicides by mentally ill people is virtually 100%, whereas the figures from Regional incident reporting systems are unlikely to reflect anything approaching true frequency.

2.3 In the past, very little research has been undertaken to assess comprehensively the proportion of episodes of health care that result in adverse events. However, relatively recently major studies from the United States of America and Australia have yielded important data. If these are extrapolated to the NHS in England, even allowing for differences in health care systems, the estimated number of patients involved is worryingly high (Table 2.2).

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Table 2.1 Information from NHS incident reporting and recording systems

Source	*Event*	*Estimated annual number*
Confidential Inquiry – Suicides and homicides	Suicides by people in recent contact with mental health services in the 12 months prior to the event	1150*
	Homicides by people in contact with mental health services in the 12 months prior to the event	40*
Confidential Enquiry - Maternal deaths	Deaths of women during pregnancy or within one year of giving birth	125#
Confidential Enquiry - Peri-operative deaths	Deaths within 30 days of surgery	20,000
Confidential Enquiry - Stillbirths and deaths in infancy	Stillbirths and infant deaths	7,800#
Complaints data	Written complaints about aspects of clinical treatment in hospitals	27,949*
	Written complaints about all aspects of treatment in primary care	38,857*
NHS Litigation Authority claims data	Clinical negligence claims settled by the Authority above local excess levels	810#
Regional Serious Untoward Incident Reporting Systems	Serious Untoward Incidents (as variously defined)	2,500 +
Medical Devices Agency medical devices	Adverse incidents involving (Including 87 deaths and 345 serious injuries)	6,610
Medicines Control Agency	Reported Adverse Drug Reactions (ADRs)	18,196* (9,819 serious)

***** Most recent year for which information is available.

Average of several years

+ Extrapolated from the best-developed Regional system

Table 2.2 United States and Australian research into adverse events in hospitals

	Harvard Medical Practice Study, 1991	*Quality in Australian Health Care Study, 1995*
Proportion of inpatient episodes leading to harmful adverse events	3.7%	16.6% (half preventable)
Proportion of inpatient episodes resulting in permanent disability or death in which harm was also caused*	0.7%	3%
Broad extrapolation of findings to the NHS based on 8.5 million inpatient episodes a year+	314,000 potential adverse events 60,000 potential instances of permanent disability or death in cases where adverse events occurred*	1,414,000 potential adverse events 255,000 potential instances of permanent disability or death in cases where adverse events occurred*

* It is important to emphasise that adverse events will not always be a causal or contributory factor in these cases. Many of the patients involved will have been terminally ill, and adverse events may not have played a part in causing their disability or death.
\+ Extrapolated by the expert group for the purposes of the present report, not in association with the original studies.
Source: Brennan et. al.1991[12], Leape et. al. 1991[13], Wilson et. al. 1995[14]

2.4 These 'ballpark' extrapolations to the NHS in England seem to be supported by the results of a recent small-scale pilot study of hospital inpatients in London (Table 2.3).

2.5 Whilst the primary concern must of course be the human cost of service failures, there is also some information available which can help to quantify some of the financial costs of adverse events. Paid litigation claims are one example: they cost the NHS around £400 million in 1998/99, in addition to an estimated potential liability of £2.4 billion for existing and expected claims. The results of the UK pilot study on adverse events suggest that nationally the costs to the NHS of extended hospital stays as a result of adverse events could

Table 2.3 Results of a United Kingdom pilot study of adverse events in hospitalised patients

Proportion of inpatient episodes leading to harmful adverse events	10% (around half preventable)
Direct cost of additional days in hospital as a consequence of adverse events	£250,000 for 1,011 admissions
Broad extrapolation to the NHS in England based on 8.5 million inpatient episodes a year	850,000 admissions lead to adverse events Up to £2 billion direct cost of additional bed-days

Source: Vincent[15]

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be as high as a further £2 billion a year – five times the costs of clinical negligence litigation.

Case studies

2.6 Throughout the report we draw attention to particular problems through the use of case studies which serve to illustrate the nature of the issues underlying adverse events in the NHS. In the rest of this chapter we provide examples of the kinds of adverse events which can occur and their potential consequences.

Incidents involving incorrect medication dosage

- A hospital patient collapsed after a nurse gave her antibiotic tablets crushed in water via an intravenous drip. Only special fluids can be given via an intravenous drip. Similarly, antibiotics and other drugs can only be given in specially-prepared solutions and not through the impromptu crushing of tablets. The patient was rushed to intensive care and subsequently recovered.

Source: NHS Executive

- In a three-week period two young children received double the proper dose of medication in a hospital X-ray department, prior to having a scan. In both cases their weight had been recorded in pounds, rather than kilograms. Fortunately the children suffered no ill-effects.

Source: NHS Executive

- A premature baby girl died after being given an excessive dose of morphine – 15mg instead of 0.15mg – due to miscalculation of the dosage. The dose was calculated by the Senior House Officer, checked by a nurse and administered by the Senior Registrar.

Source: NHS Executive

Incidents involving the use of technical procedures

- A number of women became pregnant following failure of earlier sterilisations which had been carried out by laparoscope (keyhole surgery). The surgeon had attached the sterilisation clips to the wrong part of the Fallopian tube.

Source: NHS Executive

- A patient had a Hickman line (plastic tube) in one of his veins to allow drugs to be administered over a long period of time. When it came for the line to be removed it was accidentally cut through and broke loose into his venous system, placing him at serious risk. He had it removed and recovered.

Source: NHS Executive

Incidents involving failures in communication

- A man admitted to hospital for an arthroscopy (an exploratory operation) on his knees had a previous history of thrombosis (blood clots). This was noted by a nurse on his admission form, but was not entered on the operation form which had a section for risk factors and known allergies. The operation was carried out and the patient was discharged from hospital the same day. Given his history of thrombosis the patient should have been given anticoagulant drugs following his operation, but because his history had not been properly recorded none were given. Two days later he was admitted to the intensive care unit of another hospital with a blood clot in his lungs.

Source: Medical Protection Society Casebook No. 13, Summer 1999

- A patient with leukaemia was about to receive a transfusion of blood platelets. The experienced senior nurse on duty in the ward noticed that there were small clumps visible in the platelet pack, and had questioned whether the transfusion should proceed. She was advised that these were probably small platelet aggregates which would be removed by a filter in the equipment. Following transfusion, the patient developed severe septicaemia and subsequently died. The platelet pack was found to be contaminated with E.-coli, a bacterium that can sometimes be present in platelets through contamination from the donor's skin. It was found on inquiry that although non-harmful platelet aggregates used to be a common feature, new processing methods had eliminated this, so that an abnormal appearance in the platelet pack should not have been accepted as of no significance. Steps were taken nationally to communicate this change to all relevant staff.

Source: NHS Executive

2.7 A graphic example of the way in which specific serious errors can be repeated a number of times over a period of years is provided by an analysis of incidents involving erroneous administration of a certain category of anti-cancer drug.

History repeating itself: Errors in spinal injections proving catastrophic

- Since 1985 at least 13 cases have occurred of people (usually children) being killed or paralysed due to the maladministration of drugs by spinal injection. The circumstances have been very similar.

Source: Review of published medical research.

2.8 Intrathecal (spinal) maladministration of drugs which should instead have been administered by the intravenous route is a rare, but always very serious, medical accident. Since 1985, 13 such accidents have been reported in medical literature or to the Committee on Safety of Medicines, but it is not known whether there are more than this because no comprehensive central record is kept of such adverse events.

2.9 Of the 13 documented maladministration accidents, 12 involved injection into the spine of an anti-cancer (cytotoxic) drug, specifically one group of drugs called vinca alkaloids (vinblastine, vincristine, and vindesine). Ten of these accidents are known to have been fatal; the final outcome is unknown in the remaining two. The two published case reports that follow are typical of this kind of incident.

Case 1

"A 10 year old boy with acute lymphoblastic leukaemia was accidentally given vindesine 4.5 mg intrathecally. After two hours he became drowsy with diplopia, third nerve palsy, and leg weakness. Folinic acid and dexamethasone were given and he made a transient recovery; 24 hours later the symptoms recurred and he died on the third day from progressive ascending paralysis. Necropsy showed leukaemic infiltration of the parietal lobes and arachnoiditis of the lumbrosacral cord and twelfth nerve nucleus – similar to the changes induced by intrathecal vincristine."

Source: Robbins et al 1985[16]

Case 2

"A patient was prescribed methotrexate 10 mg intrathecally and vincristine 2 mg intravenously as part of their chemotherapy course. The drugs were prepared ready for administration by the pharmacy department. Both syringes were sent to the ward in the same clear plastic bag. The syringes were labelled with the patient's name, the drug name, and the dose. The senior house officer gave both drugs via the intrathecal route instead of administering the vincristine intravenously as prescribed. The patient subsequently died. The doctor, who admitted at the inquest to not reading the syringe labels, was assisted by a student nurse. The doctor had not checked the syringe labels against the prescription nor verified the administration details with the nurse."

Source: Cousins and Upton 1994[17]

2.10 The vinca alkaloids are not a recent clinical development; first isolated from the periwinkle plant (Vinca rosea) in the 1950s, they were introduced into

cancer chemotherapy in the 1960s. Since then, they have been widely used to treat the acute leukaemias, lymphomas, and some solid tumours. Used properly, these drugs can be very effective in the treatment of some leukaemias. However, they have long been recognised as strongly neurotoxic and can kill if incorrectly administered. They can be given safely only by the intravenous route, and should never be injected into the spine.

2.11 Product data sheets (summaries of product characteristics), package inserts, vial and pack labels, and the British National Formulary all carry prominent warnings of this hazard. For example, the data sheet for Oncovin (vincristine) carries prominent boxed warnings in three separate places, and repeats the message in the text. The pack contains an auxiliary warning sticker to be placed on syringes containing the drug, and pre-prepared syringes containing the product must be packaged in an overwrap warning label:

"Do not remove covering until the moment of injection.
Fatal if given intrathecally. For intravenous use only"

2.12 Despite the long-recognised neurotoxicity of vinca alkaloids, and the precautionary measures described above, disasters involving these drugs continue to occur. A case in London in 1997 led to manslaughter charges against the doctors concerned (eventually dropped by the Crown) and received widespread media attention[18,19] yet a further fatal case was reported to the Committee on Safety of Medicines the following year.

2.13 The circumstances in which vinca alkaloids are sometimes used are an important contributory factor in these accidents. In virtually all of the documented cases, the patient had been prescribed intrathecal methotrexate combined with intravenous vinca alkaloid. The two injections are then confused, or both are given by the intrathecal route. The consequences are entirely predictable. The patient may be in remission from their cancer at the time of the accident, which makes the event particularly tragic for the individual and their family. The staff concerned may face criminal proceedings, in addition to NHS and professional disciplinary processes.

2.14 The circumstances in which these incidents occur are well known. They should be entirely avoidable, but have not been eliminated. This example is taken further in section 3.13 of the next chapter to illustrate some of the underlying causal factors.

The impact of adverse events on individuals

2.15 Adverse events involve a huge personal cost to the people involved, both patients and staff. Many patients suffer increased pain, disability and psychological trauma. On occasions, when the incident is insensitively handled, patients and their families may be further traumatised when their experience is

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ignored, or where explanations or apologies are not forthcoming. The psychological impact of the event may be further compounded by a protracted, adversarial legal process. Staff may experience shame, guilt and depression after a serious adverse event, which may again be exacerbated by follow-up action.[20,21]

2.16 The effect of adverse events on patients, their families and staff is not sufficiently appreciated and more attention should be given to ways of minimising the impact of adverse events on all those involved. These issues, while of great importance, cannot be fully addressed within this report and may require separate attention, though we made some limited comment in the context of our discussion on litigation in chapter 4.

Chapter 2 – Conclusions

- Information on the frequency and nature of adverse events in the NHS is patchy and can do no more than give an impression of the problem. Information from primary care is particularly lacking;
- International research (including a recent UK pilot study) has thrown light on the potential scale of the problems, and suggests that these may be around 850,000 adverse events each year in the NHS (range 300,000 to 1.4 million);
- The financial costs of adverse events to the NHS are difficult to estimate but undoubtedly major – probably in excess of £2 billion a year;
- There is evidence of a range of different kinds of failure, and of the recurrence of identical incidents or incidents with similar root causes;
- Case studies highlight the consequences of weaknesses in the ability of the NHS as a system to learn from serious adverse events;
- There is a need for further work focusing specifically on how the impact of adverse events on patients, their families and staff can be minimised.

CHAPTER 3

Learning from failure: evidence and experience

In this chapter we draw upon the research evidence available concerning adverse events not just in health care but across all sectors. Extensive study in non-health care fields has shown that, within most unintentional failures, there is usually no single explanatory cause for the event. Rather there is a complex interaction between a varied set of elements, including human behaviour, technological aspects of the system, socio-cultural factors and a range of organisational and procedural weaknesses. Systematic study of these issues in the health care field is sparse, but the available evidence suggests a similarly complex pattern of cause and effect relationships. Learning from adverse events is also a complex phenomenon. Yet research suggests that it is possible to identify some of the barriers that prevent organisations from learning effectively from adverse events, and to put in place measures to help overcome them.

3.1 Every year around the world major catastrophes and disasters lead to loss of life and serious injury. The text below is a reminder of some of those that have occurred in Britain. Each gave rise to huge public concern and was the subject of a formal investigation or public inquiry.

Non-health care disasters resulting in death

- Hillsborough and Bradford football ground tragedies
- Sinking of the *Marchioness* pleasure boat on the river Thames
- Manchester and Kegworth air crashes
- Southall rail crash
- Capsizing of the Zeebrugge cross-channel ferry *Herald of Free Enterprise*

3.2 Each of these catastrophes was typified by the complex set of interactions that

occurred between factors which precipitated the event. In no case was there any single factor which could be deemed to have resulted in the failures, but rather an interaction between local conditions, human behaviours, social factors and organisational weaknesses. But what do we know about the factors that influence levels of hazard, the probability of failure and the ability of organisations to learn lessons when things go wrong?

3.3 Experience has been built up over many years in understanding the reasons for accidents, disasters and system failures in a number of fields. Academics have researched and written widely on the subjects of human error, risk, crisis and disaster management, as well as reliability engineering and safety management. Particular industries – for example aviation and nuclear power generation – have been conspicuous in implementing improvements based on systematic learning from accidents and incidents. Other experts have commented on the conduct of inquiries into disasters and identified the factors that appear to determine whether their findings will be implemented.

3.4 A detailed review of the research literature is beyond the scope of this report, though our references form a selected bibliography. In this chapter we highlight some of the main themes that emerge from both academic research and practical experience of preventing, analysing and managing failure of all kinds. We look first at the underlying causes of failure, and then at the factors influencing learning.

3.5 There is relatively little information to draw upon which deals specifically with the health field, though we do provide some examples. Much of the work that exists is based upon experience in the USA which bring with it a different socio-cultural and economic context in which the work is grounded. There is currently a great deal of interest in the health care sphere, following a number of well publicised serious incidents, so it is likely that research in this area will grow quickly.

Understanding the causes of failure

"Human error should be seen as a consequence, not a cause, of failure"

Human Error

3.6 There are two ways of viewing human error: the *person-centred approach* and the *system approach*. The former is still the most dominant tradition within the academic literature on failure, largely because it is more suited to the agenda of management. This approach focuses on the psychological precursors of error, such as inattention, forgetfulness and carelessness. Its associated counter-measures are aimed at individuals rather than situations and these invariably fall within the "control" paradigm of management. Such controls include disciplinary measures, writing more procedures to guide individual behaviour, or blaming, naming and shaming. Aside from treating errors as moral issues, it

isolates unsafe acts from their context, thus making it very hard to uncover and eliminate recurrent error traps within the system. Though attractive from a managerial and legal perspective, as the predominant approach it is ill-suited to the healthcare domain – or to any other sphere which has high-technology elements. It is important to emphasise that this does not mean that individuals should never be held accountable for their actions.

3.7 The system approach, in contrast, takes a holistic stance on the issues of failure. It recognises that many of the problems facing organisations are complex, ill-defined and result from the interaction of a number of factors. This approach starts from the premise that humans are fallible and that errors are inevitable, even in the best run organisations (a notion captured recently in the title of the US Institute of Medicine report "To Err is Human")[22]. Errors are seen as being shaped and provoked by 'upstream' systemic factors, which include the organisation's strategy, its culture and the approach of management towards risk and uncertainty. The associated counter-measures are based on the assumption that while we cannot change the human condition we can change the conditions under which people work so as to make them less error-provoking. When an adverse event occurs, the important issue is not who made the error but how and why did the defences fail and what factors helped to create the conditions in which the errors occurred. The system approach recognises the importance of resilience within organisations and also recognises the process of learning as enhancing such resilience[23, 24, 25]. During the course of its work, the Committee was repeatedly struck by the importance of the system approach, and we return to it later in the report.

3.8 Human error is commonly blamed for failures because it is often the most readily identifiable factor operating in the period just prior to an adverse event. Yet two important facts about human error are often overlooked. First, the best people can make the worst mistakes. Second, far from being random, errors fall into recurrent patterns. The same set of circumstances can provoke similar mistakes, regardless of the people involved. Any attempt at risk management that focuses primarily upon the supposed mental processes underlying error (forgetfulness, inattention, carelessness, negligence, and the like) and does not seek out and remove these situational 'error traps' is sure to fail. The local human errors are the last and probably the least manageable part of the causal sequence leading up to some adverse event.

"Human actions are a key element in many serious incidents but they are only part of the explanation for why disaster strikes"

3.9 All organisations operating in hazardous circumstances tend to develop barriers, defences and safeguards that become interposed between the source of the hazard and the potential victims or the losses that would occur should that risk become realised. These defences may be either 'hard' (physical containments, automation and engineered safety features) or 'soft' (the procedures, protocols, administrative controls and people at the 'sharp end'). The human elements of a system can weaken or create gaps in these defences in two ways: by *active failures* and *latent conditions* [26].

- Active failures are the 'unsafe acts' committed by those at the sharp end.

These can be slips, lapses, mistakes or procedural violations. They have an immediate and usually short-lived impact on the defensive layers. They also tend to occupy the spotlight in any subsequent investigation.

- Latent conditions are comparable to 'resident pathogens' in the body. By themselves, they often do no particular harm. They may lie dormant in the system for long periods before combining with local factors and active failures to penetrate or bypass the defences. Research has suggested that organisations can embed the preconditions for failure, and that this can take place over many years. Latent conditions arise from strategic decisions made by designers, builders, procedure-writers and top management. All such decisions have the potential for seeding 'pathogens' into the system, even good ones (hence the term 'latent condition' rather than 'latent failure'). For example, it is the business of senior management to allocate limited resources. But this is rarely done on an equitable basis. Some departments get more, others less – for what seem like sensible reasons at the time. For the latter, these shortfalls can translate into error-provoking conditions in the workplace – for example, time pressure, excessive fatigue, staff shortages, lack of experience and inadequate equipment. Unlike active failures, whose precise forms are hard to predict, latent conditions are always present. They can be identified and removed before they cause an adverse event. To use another analogy: errors and violations at the sharp end are like mosquitoes. Swat them one by one and they keep on coming. The long-lasting remedy is to drain the swamps in which they breed. The swamps are the ever-present latent conditions. However the process of addressing these latent conditions can strike at the heart of the organisation's culture or the dominant paradigm within management theory. Consequently, attempts to deal with such issues are often problematic as they require quite fundamental changes to the core beliefs and values of senior staff within the organisation.

"The evidence from a large number of accident inquiries indicates that bad events are more often the result of error-prone situations and error-prone activities than they are of error-prone people"

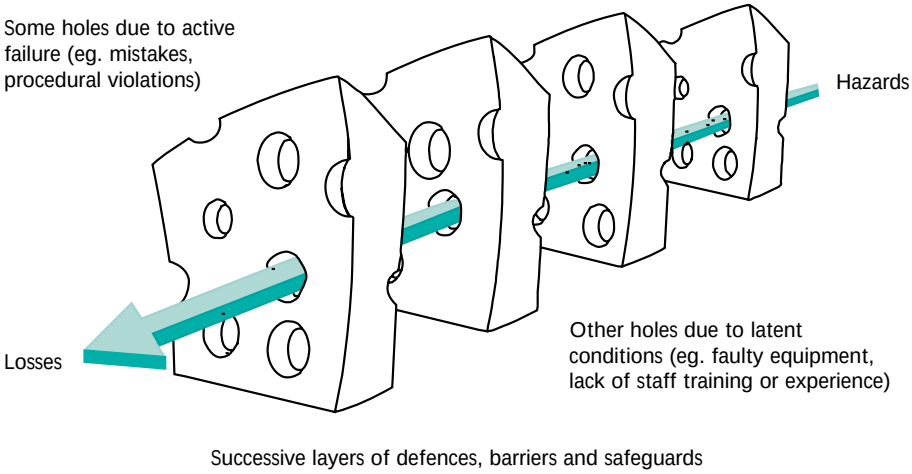
3.11 One view of accident causation that has wide currency in the fields of aviation and nuclear power generation is called the 'Swiss cheese' model. This is illustrated in Figure 3.1. Ideally, all the defences separating hazards from potential losses should be intact; but, in reality, they are more like slices of Swiss cheese – full of holes. Unlike the holes in Swiss cheese, however, the gaps in system defences are continuously opening, shutting and shifting position. They are created, as discussed above, by active failures and latent conditions. Serious danger arises when a set of holes lines up to allow a brief window of accident opportunity. In hi-tech, well-defended systems (e.g. modern airliners and nuclear power plants), with many layers of barriers and safeguards, such accident opportunities are rare, but they can have devastating consequences. In many fields of clinical practice, however, there can be relatively few protective 'slices' intervening between danger and harm. In surgery, for example, very little lies between the scalpel and some untargeted nerve or blood vessel other than the skill and training of the surgeon. In health care, the human elements of the system are often the last and most important defences.

"In health care, the human elements of the system are often the last and most important defences"

Figure 3.1

Source: Reason 1997[27]

The "Swiss cheese" model of accident causation



3.12 A good example of the need to put human error into perspective is provided by the 1989 Kegworth air crash.

Human error in perspective – the Kegworth air crash

In 1989, 47 people died when a British Midland Boeing 737-400 aircraft crashed onto the M1 motorway. The immediate act precipitating the crash was the shutdown by the crew of the wrong engine following an engine fire. The pilots were criticised for acting too quickly and for failing to assimilate information from their instruments. The official report made a number of recommendations concerning changes to the aircraft as well as pointing to the faults of the pilots and cabin staff. The media though used the shorthand of 'human error' to describe the event.

In fact the accident at Kegworth illustrated how system failure can occur at a number of levels. In the first instance there was a failure of the technical component itself which resulted from the fracture of the engine fan blades. The specific nature of this failure was not identified by the aircraft's warning system which failed to provide the pilots with unambiguous information concerning the nature of the event. There was also a failure in the decision making processes of the pilots which led to their incorrect diagnosis of the source of the engine failure and led them to close down the wrong engine. A series of communication failures compounded the problem. The pilots claimed that they were constantly distracted by communications from air traffic control and this impacted upon their reassessment of the decision to close down the right-hand engine. In addition, there was also a failure of the cabin staff and the passengers to communicate their observations of the smoke and flames from the left-hand engine.

Finally, there were a series of organisational and environmental factors

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that combined to create the climate in which the failure occurred. These included the design of the cockpit and its instrumentation, the protocols available for fault finding, the difficulties facing the pilots in reprogramming the automatic landing computer and the training given to the pilots to allow them to convert to a new type of aircraft.

Source: Smith 1999[28]

3.13 In the NHS too, adverse events are often the result of a series of errors or omissions leading up to the critical event itself. This is powerfully illustrated by the sequence of events leading to the death in 1997 of a young boy from maladministration of an anti-cancer drug – an issue we summarised in chapter 2. In this section we take the case study further by analysing the underlying events which led to the tragedy.

3.14 Researchers have identified a number of general factors that influence clinical practice, many of which can be related to incidents such as that illustrated in detail above. It is readily apparent that issues relating directly to the individual health care professional are only one small subset of the factors at work in clinical practice.

Factors that influence the delivery of health care

- Institutional context
- Organisational and management factors
- Work environment
- Team factors
- Individual (staff) factors
- Task factors
- Patient characteristics

Source: Vincent, Taylor-Adams and Stanhope 1998[29]

3.15 This is not to say that individuals can be absolved of their responsibilities, nor that disciplinary action is never appropriate – for example in cases involving malicious acts or gross negligence. Rather the system approach suggests that we should not automatically assume or seek out some serious, blameworthy individual failing as the principal cause of an adverse event. A focus solely on the failings of individual health care staff will miss important causes of adverse events and hamper effective learning.

The system approach to error management

3.16 Research specifically focused on health care systems suggests that as many as

An organisational accident chronology in health care: Death of a patient from maladministration of an anti-cancer drug

Sequence of events	*Failures*
A child was a patient in a district general hospital (DGH) and due to receive chemotherapy under general anaesthetic at a specialist centre. He should have been fasted for 6 hours before the anaesthetic, but was allowed to eat and drink before leaving the DGH.	*Fasting error. Communications problem between DGH and specialist centre.*
No beds were available for the patient on the oncology ward, so he was admitted to a mixed-specialty "outlier" ward.	*Lack of organisational resources. (i.e. beds for specialised treatments)* *Patient placed in an environment lacking oncology expertise.*
The patient's notes were lost and not available to ward staff on admission.	*Loss of patient information.*
The patient was due to receive intravenous vincristine, to be administered by a specialist oncology nurse on the ward, and intrathecal (spinal) methotrexate, to be administered in the operating theatre by an oncology Specialist Registrar. No oncology nurse specialist was available on the ward.	*Communication failure between oncology department and outlier ward.* *Absence of policy and resources to deal with the demands placed on the system by outlier wards, including shortage of specialist staff.*
Vincristine and methotrexate were transported together to the ward by a housekeeper instead of being kept separate at all times.	*Drug delivery error due to non-compliance with hospital policy, which was that the drugs must be kept separate at all times.* *Communication error. Outlier wards were not aware of this policy.*
The housekeeper who took the drugs to the ward informed staff that both drugs were to go to theatre with the patient.	*Communication error. Incorrect information communicated.* *Poor delivery practice. Allowing drugs to be delivered to outlier wards by inexperienced staff.*
The patient was consented only for intrathecal methotrexate and not for intravenous vincristine.	*Poor consenting practice. Junior doctor allowed to take consent.* *Consenting error.*
A junior doctor abbreviated the route of administration to IV and IT, instead of using the full term in capital letters.	*Poor prescribing practice.*
When the fasting error was discovered, the chemotherapy procedure was postponed from the morning to the afternoon list. The doctor who had been due to administer the intrathecal drug had booked the afternoon off and assumed that another doctor in charge of the wards that day would take over. No formal face-to-face handover was carried out between the two doctors.	*Communication failure. Poor handover of task responsibilities.* *Inappropriate task delegation.*

[continues on next page]

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Sequence of events	*Failures*
The patient arrived in the anaesthetic room and the oncology Senior Registrar was called to administer the chemotherapy. However the doctor was unable to leave his ward and assured the anaesthetist that he should go ahead as this was a straight-forward procedure. The oncology Senior Registrar was not aware that both drugs had been delivered to theatre. The anaesthetist had the expertise to administer drugs intrathecally but had never administered chemotherapy. He injected the methotrexate intravenously and the vincristine into the patient's spine. Intrathecal injection of vincristine is almost invariably fatal, and the patient died 5 days later.	*Inadequate protocols regulating the administration of high toxicity drugs.* *Goal conflict between ward and theatre duties. Poor practice of expecting the doctor to be in two places at the same time.* *Situational awareness error.* *Inappropriate task delegation and lack of training. Poor practice to allow chemotherapy drugs to be administered by someone with no oncology experience.* *Drug administration error.*

"Research specifically focused on health care systems suggests that as many as 70% of adverse incidents are preventable"

70% of adverse incidents are preventable. However, although errors can be minimised they will never be completely eliminated – particularly where high volumes of activity occur. It has been estimated, for example, that a 600 bed teaching hospital with 99.9% error free drug ordering, dispensing and administration will experience 4,000 drug errors a year[30]. So measures also need to be taken to limit the adverse consequences of those errors that still occur. This involves designing or modifying systems so that they are better able to tolerate inevitable human errors and contain their damaging consequences.

3.17 Whilst those committed to the person approach tend to allocate the bulk of their resources to trying to make individuals less fallible, the system approach aims for a comprehensive programme directed simultaneously at people, teams, tasks, workplaces and institutions. There is no single solution which can be applied in every circumstance.

3.18 Since serious adverse events rarely have a single, isolated cause, attempts to prevent or mitigate adverse events need to address not just single event chains, but systems as a whole. While details of some future failure can hardly ever be predicted, defences can be installed that will limit their bad effects. Well-designed systems can minimise the harmful effects of errors by anticipating their occurrence and detecting them at an early stage. A simple example is the word processing package. Its designers understood that people can exit files without saving them. So they built in reminders and 'forcing functions' to make this more difficult. Similar principles can be applied to eliminating error traps in hazardous systems, and indeed to the application of design solutions. One example of the latter in health care is the development of automatically retracting syringes, which expose the needle only at the moment of injection, as an aid to the prevention of needle-stick injuries.

High-technology, high-risk procedures

3.19 High-technology, high-risk procedures have been little researched for their

relevance to adverse events. However recent research suggests that particular factors can be at work in this field, and that it warrants consideration as a particularly important area of health care.

3.20 High-technology areas such as intensive care units, emergency rooms, operating theatres and high-risk medicine such as oncology, transplantation, neurosurgery, cardiac surgery and gene therapy share many similarities with other complex socio-technical systems in which people and complex technologies interact. It is logical to conclude that theories of organisation or system accidents, such as those we have discussed in this chapter, are applicable to adverse events occurring in these areas. Fatal actions in the operating theatre or in the ward are often the result of an accumulation of multiple minor and major failures, many of which may have their origins away from the immediate environment of care.

3.21 There is, however, a major difference between high-risk medicine and complex socio-technical systems such as the aviation industry. Technical advances in the latter have been such that major technical failures are rare compared to human failures. In high-risk medicine, failures may be attributable to poor patient risk (for example if a patient is in poor general health), inherent risk in some difficult treatments and/or poor performance of care providers.

"Even in cases of major human failures, appropriate compensating behaviour can prevent adverse events"

3.22 Recent research into these interactions has highlighted the role of human failures over and above the risks ascribable to particular conditions and to particular high-risk treatments. It also showed that even in cases of major human failures, appropriate compensating behaviour can prevent adverse events.[31]

3.23 The same study demonstrated that very little is done to eradicate the many small failures sometimes hardly noticed by the clinicians providing care. They were shown to have a multiplicative effect so that they became a significant risk factor. Dealing with these minor failures is one of the most challenging tasks of health care organisations. They are so subtle that most of them are not reported even in the most open incident reporting system. The employment of human factors experts as outside observers for research purposes has been extremely useful in detecting these minor failures, but whether such techniques are appropriate or feasible for more general application as a training and quality improvement tool is more questionable.

3.24 Other research has shown that for one high-risk procedure, coronary artery surgery, the rate of post-operative complications did not correlate strongly with post-operative death rates. There was however a correlation between death rates and success in rectifying complications when they did arise: the hospital with the highest mortality had a higher rate of failure to rescue from complication, rather than a higher rate of complication *per se*.[32]

3.25 What all this suggests is that to a great extent high-risk medicine is bound to

be eventful and that serious errors and complications will never be eradicated, simply because there is a level of risk for which no system can fully compensate. Focusing on correction, recovery or rescue from these complications and failures – on error management as well as on error prevention – is an important and under-recognised way to improve safety in these areas. Many medical and surgical teams, whilst being perfectly capable of dealing safely with 'straightforward' cases, may not have the capacity to cope with serious adverse events. This is one of the most fundamental differences between success and failure.

Factors influencing learning from failure

3.26 So far in this chapter we have set out some key principles on the nature of error and failure, illustrating some of the complexities in this area and highlighting the importance of systems in understanding why things go wrong. In the next section we consider some of the factors which influence the ability of organisations to learn from failures when they do occur.

The learning loop

3.27 Organisational learning is a cyclical process, the key components of which can be described with reference to an approach which we have adapted from a model used by British Petroleum in the context of its work on knowledge management (Fig 3.2). Of necessity this model greatly over-simplifies the process it depicts – omitting for example the important dimension of feedback 'short circuits' within the process – but it serves to illustrate the fundamental steps in a learning cycle.

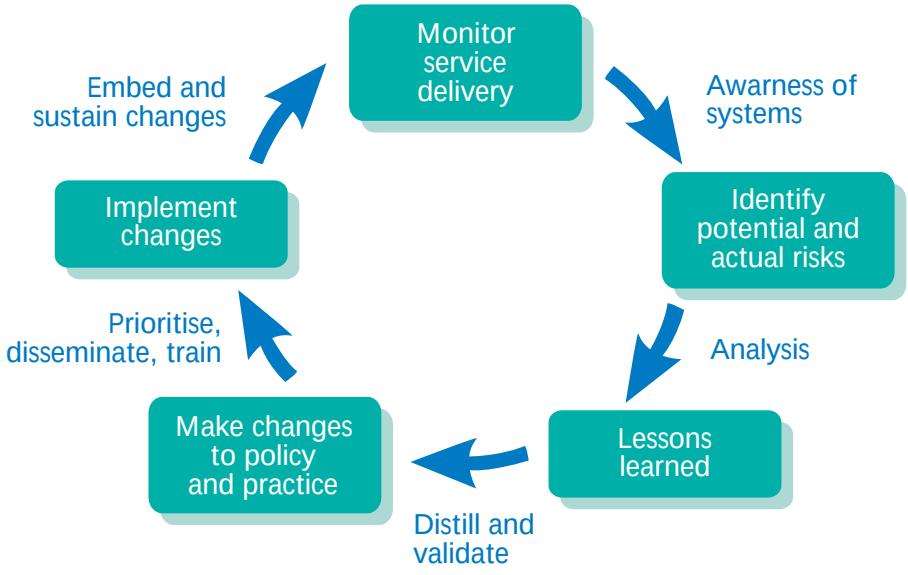

Figure 3.2
The Learning Circle

Source: Adapted to health care from a model developed by BP Amoco

3.28 The process does not differ regardless of whether learning takes place before, during or after the event. The first half of the learning cycle essentially concerns the identification of learning opportunities and the development of sound solutions. Monitoring of service delivery activity – including adverse events and the experiences of others – provides a basis for asking questions about how improvements can be brought about and errors avoided. Some commentators have suggested that a key part of this process is 'sensemaking'[33] – ensuring that individuals and organisations actually understand what the true nature of their experience is so that it provides a sound basis for learning. It is far more difficult for effective learning to take place if the initial understanding of what has occurred is seriously flawed. In particular, it is important to consider experiences in the context of the various systems in place and the way these interact, because only in this way is it possible to come to sound conclusions about the nature of potential and actual risks faced.

"It is difficult for effective learning to take place if the initial understanding of what has occurred is seriously flawed"

3.29 Once potential and actual risks have been identified, they must be properly analysed to identify lessons for policy and practice. Lessons can be extracted from the pool of available information through analysis, but then need to be distilled – to make sure that the essence of the learning points is properly captured – and their validity tested in theory or practice. Validation is important where ideas come from experience in other sector or organisations – transferability is often possible but cannot be assumed – but it is also a key step in learning from experience within a team or an organisation. It is all too easy to reach a conclusion or draw a lesson which appears obvious, but which does not in fact stand up to testing. The initial assessment of the experience or diagnosis of the problem may be flawed, or the solution identified may not in practice address the issue effectively.

3.30 The second part of the learning process, once sound solutions have been derived, is to make sure that they are put into practice. Learning points need to be translated into practical policies and actions that can be implemented at the appropriate level. These practical changes then need to be prioritised, to provide a clear agenda for action, and disseminated to the relevant audience. Training is a vital tool in ensuring that information on change is both disseminated and acted on.

3.31 Action to implement and apply improvements on the ground is an essential part of the learning process. Lessons can be 'learned' on one level, in that there is a strong awareness of what needs to change and why, but if there are barriers in place to the application of that learning in practice the active learning process will fail. However, to sustain long-term change solutions also need to be firmly embedded into the culture and routine practice of the organisation. Only if change is successfully embedded in an organisation will it survive once the "heat" is perceived to have gone out of a particular problem. If an organisation focuses intensively on a problem for a short period of time but forgets about it when new priorities emerge or key personnel move on, effective

learning has not taken place. As we have already observed, learning is not a one-off event, it is an ongoing dynamic.

3.32 Finally, continuous monitoring of changes and improvements in practice is an essential part of ongoing learning and improvement.

3.33 All the evidence suggests that the latter stages in this learning process are critical in ensuring that organisational behaviour is actually changed as a result of the lessons drawn from adverse incidents, and that true 'learning' requires more than just the identification of valid lessons. But it is at the stages of implementation and embedding that the learning loop often seems to fracture.

3.34 The literature is replete with examples from a range of different sectors where lessons had been clearly and correctly drawn from experience, but for one reason or another these lessons had not been translated into effective organisational learning. The text below outlines four such examples – two from the NHS and two from other spheres.

Four examples of failures to close the learning loop

Bradford football ground fire

On 11 May 1985, a fire started in the main stand during a match at Bradford City's Valley Parade ground. Rubbish which had been allowed to gather beneath the wooden stand was ignited by what is believed to have been a discarded cigarette, and within a matter of minutes the stand was ablaze. 56 people lost their lives, and another 200 were injured.

As early as August 1969, the Fire Prevention Association published an article entitled "Playing safe in sporting arenas" which gave details of several fires which had taken place in football stands like the one at Bradford, and warned that "Should a fire break out, particularly if a game is in progress, a major tragedy could result."

Source: Toft 1992[34]

Taunton train fire

In the early hours of 6 July 1978 at Taunton, Devon, bed linen stored against an electric heater in a railway sleeper car caught fire and set the rest of the car ablaze. Although staff and travellers reacted with commendable speed, 12 passengers died and a further 16 were injured.

British Rail had received a warning five years previously that bed linen left on the sleeping car heater was a source of danger, following an inquiry after linen caught fire on a Glasgow-Euston train. Apparently, the lessons of the fire on the Glasgow-Euston train were not passed on because at the time of that incident all the sleeping cars on the Western Region were

steam heated. Unfortunately, when the Western Region sleeping cars were converted to electric heating nobody thought to inform them of the previous incident.

Source: Toft & Reynolds 1997[35]

Suicides by mental health inpatients

For some years it has been recognised that a major means of suicide among inpatients in mental health units is hanging from curtain or shower rails. A paper drawing attention to this was first published in 1971[36]. These events can be prevented fairly simply by fitting collapsible rails which give way under the weight of a person. The 1999 report of the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness concluded that hanging, and in particular hanging from non-collapsible structures such as bed and shower and curtain rails, is still the commonest method of suicide among mental health inpatients. A total of 81 mental health inpatients committed suicide on the ward by hanging in the two years to April 1998 – two thirds of all suicides which took place on the ward.

On at least one occasion a collapsible curtain rail which had given way, preventing a hanging, was incorrectly repaired. When another patient later attempted to hang himself from the same rail it failed to collapse and the patient died.

Source (suicide statistics): Safer Services 1999[37]

Death due to incorrect urinary tract irrigation

A patient with urinary tract stones underwent a procedure, under anaesthetic, in which her upper urinary tract should have been washed out with a special fluid. In fact plain water was used by mistake. The water affected the patient's bloodstream, and she suffered a fatal heart attack in the operating theatre. Despite details of the incident being circulated to all relevant hospitals, a second similar incident almost occurred within a few months in a hospital only 30 miles away. Fortunately in this case the mistake was spotted before the fluid could be administered, and no harm came to the patient. The surgeon involved pointed out that, at a distance, the bags of different irrigating fluids looked identical.

Source: NHS Executive

"It is only through active learning that the benefits of experience are actually realised"

3.35 The NHS case studies in particular are good examples of the phenomenon of 'passive' learning: valid lessons have been drawn from experience, but they have not been fully implemented. By contrast, 'active' learning involves both drawing valid conclusions and putting them into practice[38]. It is only through active learning that the benefits of experience are actually realised.

3.36 Some NHS examples of 'active learning' – where effective changes in practice

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do appear to have been made to prevent particular problems recurring – are provided by the 'Back to Sleep' campaign to reduce cot deaths.

The Back to Sleep Campaign – active learning in the NHS saved the lives of 3,000 babies

In the 1970s and 1980s advice given to new parents by health care professionals was that babies should be placed in their cots on their fronts. It was reasoned that if a baby regurgitated milk choking was less likely than if the baby were lying on its back.

Research from several countries, confirmed by work from Bristol published in 1990, found that babies placed on their backs had a lower incidence of 'cot death'. An expert group convened by the then Chief Medical Officer in October 1991 reviewed this and further evidence from Bristol, where the cot death rate had fallen after health care professionals started encouraging mothers to avoid prone sleeping positions in 1989.

As a result from December 1991 the Department of Health and the media ran a campaign to educate parents (the Back to Sleep campaign). Cot deaths have halved in the years since the campaign. This is an example of rapid, active learning in the NHS which led to the saving of over 3,000 babies' lives in the six years up to 1998.

Source: NHS Executive

3.37 The position of the confidential inquiries conducted in the NHS (see also paragraphs 4.40–4.43) is a half-way house between active and passive learning. It is passive because recommendations do not often lead to mandatory and immediate procedural change but rather rely on the published report to have an impact. On the other hand, because it is targeted at specific professional practitioners, some of its recommendations are taken very seriously so that a momentum for change is induced. Examples are shown at the end of chapter 4, where we discuss in more detail the NHS's capacity to implement learning from existing information sources.

Barriers to learning

"Individuals may learn from their mistakes but those around them often fail to do so"

3.38 In general, experience in the NHS and in other organisations suggests that individuals may learn from their mistakes but those around them often fail to do so. Individuals may learn because mistakes cause them emotional pain, even if they go unnoticed by others. In some cases, of course, individuals may refrain from hearing key messages as a kind of personal 'defence mechanism' – this is partly a personality feature, though people can be taught to apportion responsibility more reasonably.

Barriers to learning – an NHS example

An NHS acute psychiatric unit had been regarded by staff and managers as a troubled unit for some years. Although it had not experienced a major adverse event as such, there were acknowledged problems of an unsuitable physical environment and poor standards of care. The perception of staff working in the unit was of "a catastrophe waiting to happen". Yet it was only after a critical Mental Health Act Commission report, which described the unit as one of the worst in the country, that any action was taken.

The management team brought in to turn the unit around was ultimately successful, and two years later the unit received a national risk management award. But it took the impact of a very critical external review to galvanise the organisation into action on what had for some time been widely recognised failings. Even once the change process had begun, a number of latent barriers to learning and change – at individual, team and organisational levels – still had to be overcome.

Specific barriers identified by those brought in to turn the unit around included:

- **misdiagnosis of the real problems within the unit**. Violence and aggression had become commonplace in the unit because the standard of care had completely broken down. Rather than seeing these issues as symptoms of underlying systemic problems, the organisation initially responded to the immediate difficulties by fitting more locks, tightening security and installing a new seclusion room. These "solutions" simply exacerbated the real problem of a poor environment of care and compounded existing system failures;
- **the "closed" system within which the unit had operated**. The unit was isolated from the wider care system and therefore not open to feedback from service users and other key stakeholders. A sustained effort had to be made to lower barriers to external feedback and keep them down;
- **the inability of management to engage with the human and emotional dynamics of change**. A "macho" approach to management and care meant that staff were either emotionally "burnt out" or they were emotionally blunted and appeared uncaring. The immediate emotional needs of staff had to be addressed, and sustained through the provision of supervision and support, to enable staff to separate their own issues from the needs of their patients;
- **the failure of senior managers to acknowledge and act on concerns which had been raised repeatedly by staff**. One senior manager involved later spoke of a situation approaching "organisational denial", and staff in the unit felt frustrated and angry that the organisation had failed even to register, let alone act on, concerns which they had repeatedly raised;

- **the distracting effects of constant organisational change**. The period in which the unit had deteriorated most markedly was characterised by major changes in management structures movement among senior personnel. Senior managers "took their eye off the ball" as they became preoccupied with organisational restructuring.

Source: Presentation to the Committee on the experience of the Seymour Clinic, East Wiltshire NHS Trust. Winner of Health Service Journal Management Awards Risk Management category, 1998.

3.39 Although individuals are more likely to learn from incidents, particularly if they accept a degree of responsibility for them and/or they experience the pain of a public accident, what they learn may not always be useful. For example, it may lead to more defensive practice – perhaps keeping patients in hospital longer than is warranted. A focus on the individual makes it harder for systems to learn, to spread the impact of events or accidents beyond their immediate environment. Researchers have identified a number of 'barriers to learning' which contribute to this.

Barriers to organisational learning

- An undue focus on the immediate event rather than on the root causes of problems;
- Latching onto one superficial cause or learning point to the exclusion of more fundamental but sometimes less obvious lessons;
- Rigidity of core beliefs, values and assumptions, which may develop over time – learning is resisted if it contradicts these;
- Lack of corporate responsibility – it may be difficult, for example, to put into practice solutions which are sufficiently far-reaching;
- Ineffective communication and other information difficulties – including failure to disseminate information which is already available;
- An incremental approach to issues of risk – attempting to resolve problems through tinkering rather than tackling more fundamental change;
- Pride in individual and organisational expertise can lead to denial and to a disregard of external sources of warning – particularly if a bearer of bad news lacks legitimacy in the eyes of the individuals, teams or organisations in question;
- A tendency towards scapegoating and finding individuals to blame – rather than acknowledging and addressing deep-rooted organisational problems;
- The difficulties faced by people in "making sense" of complex events is compounded by changes among key personnel within organisations and teams;
- Human alliances lead people to "forgive" other team members their

mistakes and act defensively against ideas from outside the team;
- People are often unwilling to learn from negative events, even when it would be to their advantage;
- Contradictory imperatives – for example communication versus confidentiality;
- High stress and low job-satisfaction can have adverse effects on quality and can also engender a resistance to change;
- Inability to recognise the financial costs of failure, thus losing a powerful incentive for organisations to change.

Source: Derived from Smith and Elliot 1999[39], Firth-Cozens 2000[40], Wason 1960[41]

The importance of organisational culture

3.40 A key issue in the institutional context of adverse events is that of culture. This is important for two reasons. First, people may come and go, but an effective safety culture must persist. Second, culture is perhaps the only aspect of an organisation that is as widespread as its various defences; as such, it can exert a consistent influence on these barriers and safeguards—for good or ill. Airlines operate globally with similar equipment, training and licensing, but that the risk to passengers among different carriers varies by a factor of 42[42]. A significant part of this variation can probably be attributed to differing 'safety cultures'.

"People may come and go, but an effective safety culture must persist"

3.41 It has been argued that safety cultures, far from being mysterious intangible entities, can be established by identifying and putting in place their key components. The process can essentially be seen as one of collective learning, or of a constant and active awareness of the potential for failure.

3.42 Experience and research studies suggest that safety is likely to be a strong feature of an informed culture, which has four critical sub-components[43]:

- a reporting culture: creating an organisational climate in which people are prepared to report their errors or near-misses. As part of this process data need to be properly analysed and fed back to staff making reports to show what action is being taken;
- a just culture: not a total absence of blame, but an atmosphere of trust in which people are encouraged to provide safety-related information – at the same time being clear about where the line is drawn between acceptable and unacceptable behaviours. An example is the airline safety system which we discuss later in this chapter;
- a flexible culture: which respects the skills and abilities of 'front line' staff and which allows control to pass to task experts on the spot; and
- a learning culture: the willingness and competence to draw the appropriate conclusions from its safety information system, and the will to implement major reforms where their need is indicated.

Absence of a safety culture

Non-NHS: In November 1996 an outbreak of E.-coli O157 (a serious gastro-intestinal infection sometimes carried on raw meat) occurred in Lanarkshire, Scotland, affecting around 500 people and causing at least 20 deaths. The outbreak was traced to a single butcher's shop and bakery which operated a substantial wholesale and retail trade in cooked and raw meat products. The infection had been spread from raw meat to cooked food because of inadequate food preparation, handling and hygiene standards. The business concerned had undergone considerable expansion during which insufficient attention had been paid to the maintenance of food safety.

Source: Report of the Pennington Group[44]

NHS: A young boy died in October 1998 after failing to recover from a general anaesthetic administered at a dental practice. A fatal accident inquiry concluded that the boy's death could have been prevented if a number of reasonable precautions had been in place. There was no agreement with the local hospital for rapid transfer of patients in emergencies, no heart monitor was attached when the anaesthetic was given and the anaesthetist lacked a specialist qualification. In addition, the risks of a general anaesthetic and possible treatment alternatives were not discussed with the boy's mother, the practice failed to employ a properly qualified anaesthetist's assistant and all staff lacked training in responding to medical emergencies.

Source: Fatal accident inquiry report, February 2000[45]

3.43 The potential of safety cultures to have a very positive and quantifiable impact on the performance of organisations is well-illustrated by the experience of part of the Shell oil company between 1981 and 1992.

Impact of a safety culture

In 1982, Shell Oil Tankers (UK) experienced a number of accidents in which a total of six employees lost their lives. These incidents forced the organisation to take a critical look at, for example, their safety policies, rules, regulations, operating procedures, training courses, mechanisms for learning from accidents, methods of disseminating information, methods of raising employee awareness of safety issues and their long-term strategy on safety. Thus what they actually, if unconsciously, did was to take a hard look at the safety culture of their organisation.

Following this review, the company instituted a new long-term safety

management philosophy encompassing everyone who worked for the company. Components of this new approach included a visible management commitment to safety, new safety management techniques and training, more research into safety, an emphasis on learning from mistakes within the organisation and elsewhere, mechanisms for disseminating safety information, ways of motivating personnel to be safe and the fostering of a "no blame culture" so employees would feel able to admit their mistakes.

One of the key success indicators for this programme was judged to be the lost time accident frequency – a measure of the time off work lost across the organisation as a result of accidents. By 1992, the company had reduced its loss time accident frequency to one sixteenth of its 1981 level.

Source: Toft 1998[46]

Overcoming barriers to learning and creating an informed culture.

3.44 A combination of research and experience also suggests a number of ways in which some of the barriers to active learning can be overcome or minimised, helping to create informed cultures which can learn from and respond to failures.

What can we do to create an informed culture?

- **Raise awareness of the costs of not taking risk seriously.** There is a need for more routinely available data on the human and financial costs of adverse events;
- **Focus on "near misses" as well as actual incidents.** This can remove the emotion from an incident and allow learning to take place more effectively. It is also easier to keep near miss data anonymous, itself a factor in encouraging reporting;
- **Ensure that concerns can be reported without fear.** Bearers of bad news may fear that they will be ostracised or silenced: clear rules about what must be reported, and regarding reporting as good behaviour rather than as disloyalty will all help;
- **Avoid simplistic counting.** Data must be analysed and synthesised to reveal their underlying lessons;
- **Develop effectively-led teams as mechanisms for culture change.** Teams need to be firmly linked into the wider management structure to ensure that alliances within them do not hamper learning. Team-based training can also be a useful tool here.
- **Use external input to stimulate learning.** External input can help teams to think outside established parameters and challenge assumptions about the way things are done. User involvement can be of particular value in encouraging learning;

- **Ensure effective communication and feedback to front-line staff.** Teams and organisations must operate on genuinely two-way communication, not just "top down". Communication systems need to be in place to allow people to see what has changed as a result of incident or near miss reporting;
- **Give a high-profile lead on the issue.** Make it clear both nationally and locally that safety and quality are key goals;
- **Recognise staff concerns.** Try hard to emphasise the personal and service benefits of change rather than just the threats.

Source: Derived from Firth-Cozens 2000 op. cit.

Safety information systems

3.45 Detecting and accurately recording errors is a fundamental step in learning from experience. It is common-sense that we need to know what is wrong before we can take steps to put it right, but this is not always just a question of monitoring adverse outcomes. Not all unsafe systems produce bad outcomes all the time. The potential for disasters may exist, but for any number of reasons those disasters might not occur at all, or occur very rarely – what has been termed 'a dynamic non-event'.

"Near misses can be seen as a free lesson; full-blown incidents have a high human and financial cost"

3.46 If there are no bad outcomes to monitor, safety information systems need to collect, analyse and disseminate information from incidents and near misses, as well as from regular proactive checks on the system's 'vital signs'. As far back as the 1940s, research in industry demonstrated that for each accident causing serious injury, there were a far greater number of accidents which resulted in minor injuries or no injury at all – 'near misses'[47]. This phenomenon can be graphically illustrated as in figure 3.3.

3.47 Most accidents have the potential to produce serious injury but do not do so in practice – either because of some intervention or compensation or simply through good fortune. By confining analysis and learning to events which

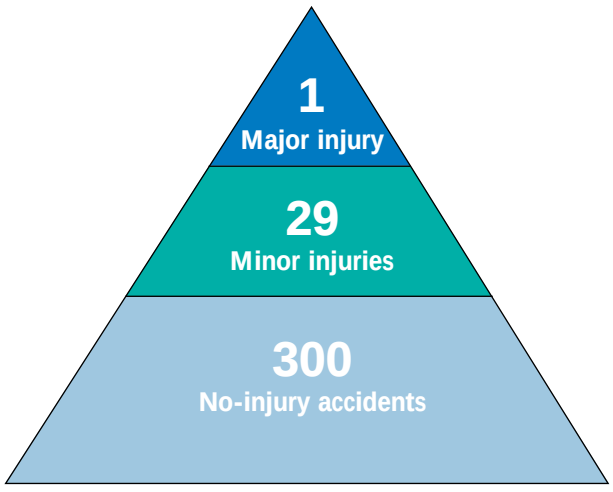

Figure 3.3: The Heinrich Ratio

After Heinrich, 1941

result in serious harm we risk skewing learning towards a very small cross-section of accidents, and may miss other important lessons for the future prevention of adverse events.

3.48 Heinrich estimated a ratio in industry of one major injury and 29 minor injuries to 300 no-injury accidents. To some extent the health of a reporting system can be judged by the proportion of minor incidents to more serious reported incidents and accidents: the greater the proportion of minor incidents reported, the better the reporting system is working.

3.49 There are practical examples of the use of 'near miss' reporting in other sectors, for example in the aviation industry which we discuss in more detail below. Some areas of activity – including the health service – may produce actual adverse outcomes on a more frequent basis, but monitoring of near misses can still highlight further issues which might not otherwise be detected.

Approaches to analysis

3.50 One of the challenges which many different sectors face is the task of both learning from and minimising the risk of so-called 'one-off' events. It is of course true to say that no specific disaster or serious incident occurs twice: each is in some way unique. However it is quite possible for an event which is on another level of analysis very similar to occur elsewhere – even in a completely different sector.

3.51 Learning from untoward events can be seen as taking place on three different levels.

Three levels of organisational learning

- individuals and organisations involved in a particular incident can each draw their own lessons from it;
- more general lessons can be drawn from an analysis of the factors surrounding an incident;
- some learning can take place simply as result of being made aware that a particular event has taken place.

Source: Toft 1992[48].

3.52 The second of these, the drawing of general lessons from individual complex, large-scale incidents (termed 'isomorphic learning' by researchers) can be a powerful tool for helping to prevent failures which, though not identical in every respect, are in some ways similar to those which have occurred previously. Researchers have suggested a number of different ways in which the task can be approached.

Types of transferable learning

Different events can create identical hazardous situations: two or more separate events may take place and manifest themselves in very different ways, but lead to the creation of what are on one level identical hazardous situations.

Different organisations can have similar experiences: different organisations operating in the same business may experience what are in essence very similar incidents.

Different kinds of organisation can have operational similarities: organisations in different lines of business may use identical or similar tools, techniques or procedures in their work, presenting similar or identical hazards.

Different parts of an organisation can have the same characteristics: where the organisation involved is very large it may have many operational sub-units which generate the same products or deliver the same services. Large companies such as Railtrack and General Motors provide examples, along with local government and – of course – the National Health Service.

Source: Toft 1992[49]

3.53 Of course there are some cautions. In particular, when looking for similarities, there is a need to guard against assuming that events which appear superficially similar are in fact similar. Just as apparently very different incidents can in fact share key common features, events which might at first look similar can in fact be very different on a more fundamental level. It is also important to guard against what has been termed 'decoy phenomenon', where attention and action is focused on a well-defined hazard while other potentially more serious problems are missed.[50]

"Organisations operating in completely different spheres can draw learning from each other's experiences of accidents or adverse events"

3.54 This approach does however suggest that, given an appropriate level of analysis, organisations operating in completely different spheres can draw learning from each other's experiences of accidents or adverse events. The following brief case studies illustrate how incidents which at first seem very different can in fact have remarkable similarities.

Misinterpretation of instruments

Non-NHS: Two airliners came close to colliding over London when an air traffic controller instructed the wrong pilot to descend. The two aircraft were circling waiting to land, but the aircraft were so close to each other

on the controller's radar screen that their identity tags were difficult to read. The controller wanted the lower of the two aircraft to descend but mistakenly instructed the higher aircraft to do so. The aircraft were within approximately four hundred feet of each other when the pilot of the higher aircraft spotted the danger and climbed to safety.

Source: Toft 1999[51]

NHS: Machines called cardiotocographs (CTGs) are used to monitor and display fetal heart rate during labour. They rely on ultrasonic detection of foetal heart movement. Reports to the Medical Devices Agency revealed that several incidents occurred where, despite the fact that the monitors were showing a heart trace and gave no indication that anything was wrong, babies were delivered stillborn. It is believed that in these cases the CTG was in fact recording the maternal heartbeat rather than that of the fetus. A safety notice issued in March 1998 advised users of CTG monitors to confirm that the CTG is displaying the fetal heat rate, to use monitors in accordance with the manufacturers' instructions and not to place reliance on a single monitoring system.

Source: Safety Notice MDA SN 9813

Rogue individual behaviour within a weak management framework

Non-NHS: On 26 February 1995 Barings Bank was forced into receivership owing £840 million. The collapse was caused by a rogue trader, Nick Leeson, who had deliberately circumvented established company rules and regulations to engage in high-risk trading activity. The board of the bank had been aware that such abuse was technically possible, but did not perceive the risk as being real because they did not believe that a member of their staff would behave in this way.

Source: Contemporary media reports

NHS: During the months February to April of 1991, Beverley Allitt, a nurse on the children's ward at Grantham and Kesteven General Hospital, killed four children in her care and harmed nine others by a variety of methods. The independent inquiry into these incidents identified shortcomings in the management and organisation of the hospital, citing lax operational procedures and failure to act quickly and decisively on suspicions of foul play. It concluded that these failings contributed to the vulnerability of the unit to this kind of rogue individual behaviour.

Source: The Allitt Inquiry, 1994[52]

Staff acting beyond their competence in critical situations

Non-NHS: A young student tenant died from carbon monoxide poisoning following the installation of an inappropriate type of boiler in the

bathroom of her flat. The actual installation of the boiler was also carried out to an unacceptable standard. During the subsequent trial the court was told that the gas fitter was not competent to install the boiler nor was he registered with the Council for Registered Gas Installers (CORGI) as required by law.

Source: Toft 1999[53]

NHS: An unaccredited perfusionist (technician) was allowed to work unsupervised following major heart surgery on a baby in 1998. A blood filter was inserted incorrectly into the heart bypass machine which he was supervising, and the machine failed. Although the Coroner concluded that the baby was already fatally ill before the machine failed, under other circumstances such a failure would almost certainly have been fatal.

Source: NHS Executive

Using equipment for a purpose which was not intended

Non-NHS: An engineer checking a high-pressure water pump indicator light on a control panel at a nuclear power plant in Japan left an aluminium rod, which he should not have been using, inside the computer he was working on. The rod caused a short-circuit which created a false signal leading the reactor's computer to conclude that one of the three pumps used for circulating water in the reactor was working when it was not. As a result the computer turned off the other two pumps. This action caused a large rise in temperature to occur forcing the automatic emergency core cooling system into operation and a rapid shutdown of the reactor.

Source: Toft 1999[54]

NHS: In 1996, four babies contracted the same type of serious infection at a neonatal unit in the West Midlands. Two died and one had to have part of a limb amputated. The organism causing the infection was traced to wooden tongue depressors which were being used as splints to immobilise limbs for the insertion of intravenous lines. This was ad hoc adaptation of a piece of equipment with disastrous consequences. The Medical Devices Agency (MDA) advised hospitals to stop using wooden tongue depressors as limb splints, to use proper splinting materials and to ensure that nursing procedures required skin under splints to be checked regularly.

Source: Hazard Notice MDA HN 9604

Warnings ignored

Non-NHS: 144 people, including 116 children, died at Aberfan, South Wales in October 1966 when a large amount of coal mining waste slipped down a hillside and engulfed part of the village. Over the years there had

been many warnings from the local population about the dangers the tip posed, especially after a number of previous slips. However, no remedial action was taken by those responsible to rectify the situation.

Source: Toft & Reynolds 1997[55]

NHS: In September 1994, a man suffering from paranoid schizophrenia ran over and killed a stranger. He was charged with murder but found unfit to plead and was detained in a high security hospital. The man had a history of severe mental illness stretching back over 10 years and had been admitted to hospital on a number of occasions. His condition deteriorated while his social worker was on leave, but despite the fact that a neighbour and drop-in centre workers raised concerns with social services nothing was done until the social worker returned. The social worker visited once more a few days later after a neighbour again raised concerns, but the subsequent inquiry commented that his "possible need for hospital treatment was not met". Shortly afterwards he ran over and killed a woman in a car park.

Source: Main et. al. 1996[56]

"With hindsight it is easy to see a disaster waiting to happen. We need to develop the capability to achieve the much more difficult – to spot one coming"

Dangerous omissions

Non-NHS: An aircraft of the Royal Flight was forced to make an emergency landing when the aircrew noticed that all four of the aircraft's engines were experiencing a significant drop in oil pressure. Before landing the pilot had to shut down two of the engines and a third as they taxied on the runway. Upon investigation, the cause of the problem was found to be that none of the engine oil seals had been replaced during routine maintenance and so when the engines were running they were all losing oil.

Source: Toft 1999[57]

NHS: Two patients died in separate incidents when partially-used containers of intravenous fluid were reconnected to administration sets. Both patients suffered fatal air embolisms (air bubbles in the bloodstream). A subsequent MDA safety notice emphasised that partially-used intravenous fluid containers should always be discarded because re-use increases the risk of both air embolism and infection.

Source: Hazard Notice MDA HN 9702

Systems for learning from experience – the example of the aviation industry

3.55 Some industries have invested significant resources in developing systems to gather and analyse information on service failures and to ensure that lessons

are systematically implemented. The best examples tend to occur in sectors where real-life experience has shown that the potential consequences of failures are high in human, environmental or financial terms – for example the oil, nuclear and airline industries. A comprehensive review of these systems is beyond the scope of this report, but some valuable insights can be gleaned from a brief review of what is probably the best-developed system, that operated by the airline industry.

3.56 The Aviation Safety System operates internationally, though reporting of lower-level incidents in particular is better-developed in some countries than in others. The system has five principal components, which combine to provide a means of detecting, analysing and acting on actual incidents and "near misses" or other errors, along with proactive identification of issues which have the potential to pose a safety risk if left unchecked.

Components of the aviation safety system

- **Accident and serious incident investigations,** governed by the International Convention on International Civil Aviation (ICAO) Accident/Incident Data Reporting Programme (ADREP). ADREP includes provision for the international dissemination of investigation reports.
- **The Mandatory Occurrence Reporting Scheme (MORS),** which provides a mechanism for notifying and reporting a range of adverse occurrences regardless of whether they result in an accident. MORS feeds into a database at national level for trend analysis and feedback to the industry.
- **The Confidential Human Factors Incident Reporting Programme (CHIRP),** which is administered by an independent body and which provides sensitive follow-up and feedback on reports of human errors that have been rendered anonymous.
- **Company safety information systems,** such as British Airways' BASIS system, which record all levels of safety-related incidents. Information is shared on a peer basis within systems, and staff report with an explicit reassurance that no individual will be pursued for an honest mistake.
- **Operational monitoring systems,** which proactively monitor crew competency through regular checks and review Flight Data Recorder information from every flight. There is management/union agreement on handling of any incidents or failures detected in this way.

3.57 The focus of the system is on detecting and learning from not only accidents and serious incidents, but also lower-level incidents or near misses, some of which might have the potential to lead to a more serious occurrence. The

aviation safety system receives reports of around 600 incidents, 30 serious incidents and 10 accidents for every one fatal accident. Thus in aviation the great majority of learning is extracted not from accidents themselves but from incidents which had the potential to result in accidents.

"In aviation the great majority of learning is extracted not from accidents themselves but from incidents which had the potential to result in accidents"

3.58 Yet the aviation safety information system has not always been so well-developed. Advances over the last ten years demonstrate the potential greatly to improve organisations' incident reporting systems in a relatively short space of time if the issue is given sufficient priority.

The situation which led to the establishment of the British Airways safety information system (BASIS)

"In 1989 British Airways possessed 47 four-drawer filing cabinets full of the results of past investigations. Most of this paperwork had only historic value. An army of personnel would have been required if the files were to be comprehensively examined for trends or to produce useful analyses."

Captain Mike Holton, Senior Manager Safety Services, British Airways Plc.

3.59 From research on the characteristics of effective safety information systems, together with experience from the aviation industry, we can draw a number of conclusions about the characteristics of effective incident reporting systems.

Characteristics of effective incident reporting systems

- separation of collection and analysis from disciplinary or regulatory bodies
- collection of information on "near misses" as well as actual incidents
- rapid, useful, accessible and intelligible feedback to the reporting community
- ease of making a report
- standardised reporting systems within organisations
- a working assumption that individuals should be thanked for reporting incidents, rather than automatically blamed for what has gone wrong
- mandatory reporting
- standardised risk assessment – i.e. a common understanding of what factors are important in determining risk
- the potential for confidential or de-identified reporting

Chapter 3 – Conclusions

- Awareness of the nature, causes and incidence of failures is a vital component of prevention – ("You can't know what you don't know");
- Analysis of failures needs to look at root causes, not just proximal events; human errors cannot sensibly be considered in isolation of wider processes and systems.
- Error reduction and error management systems can help to prevent or mitigate the effects of individual failures;
- Certain categories of high-risk, high-technology medicine might be regarded as special cases. In these areas the level of endemic risk is such that serious errors or complications will never be eradicated. The evidence suggests that here a focus on compensating for and recovering from adverse events might be an important part of the approach to improving safety and outcomes;
- Organisational learning is a cyclical process, and all the right components must be in place for effective, active learning to take place. Distilling appropriate lessons from failures is not enough: there is a need to embed this learning in practice, and it is at this stage that the "learning loop" often fails;
- It is possible to identify a number of important barriers to learning which must be overcome if the lessons of adverse incidents are to be translated into changes in practice;
- Culture is a crucial component in learning effectively from failures: cultural considerations are significant in all parts of the learning loop, from initial incident identification and reporting to embedding appropriate changes in practice. Safety cultures can have a positive and quantifiable impact on the performance of organisations;
- Sound safety information systems are a precondition for systematic learning from failures. They need to take account of the fact that low-level incidents or "near misses" can provide a useful barometer of more serious risks, and can allow lessons to be learned before a major incident occurs;
- Given appropriate approaches to analysis, it is possible to identify common themes or characteristics in failures which should be of use in helping to predict and prevent future adverse events;
- The NHS is not unique: other sectors have experience of learning from failures which is of relevance to the NHS.

CHAPTER 4

Strengths and weaknesses of NHS mechanisms for learning from adverse events

In this chapter we set out recently implemented arrangements for quality improvement in the NHS. We then review the approaches that are currently taken to learning from incidents and service failures in the NHS, which have not so far been a major part of the NHS modernisation programme. Some reporting systems are in place for major incidents, but they vary in their approach and operate with differing degrees of formality. There is no standardisation or definition of what constitutes an incident or adverse event for reporting purposes. There is no national system whatsoever for gathering information on serious incidents where a catastrophe or serious incident has been averted ('near misses').

Particular strengths of the present system are the development work which has been undertaken on risk management over the last few years and the professionally-led Confidential Inquiries which aim to identify avoidable factors which lead to poor outcomes of care in certain fields. Despite this there is little doubt that the lack of a comprehensive and purpose-designed system of information gathering, the absence of a 'reporting culture' and the patchiness of mechanisms for learning are weaknesses of the NHS at present.

The context: An NHS quality framework

4.1 Assuring and improving the quality and safety of NHS clinical services is a key theme of the current Government's health service modernisation strategy. Following on from *The new NHS* White Paper, the consultation document *A First Class Service: Quality in the new NHS* set out a three-pronged approach to NHS quality improvement, comprising:

- Clear national quality standards: set by a new National Institute for Clinical Excellence (NICE) and National Service Frameworks (NSFs);
- Dependable local delivery: through systems of clinical governance in NHS organisations;

- Strong monitoring mechanisms: a new statutory Commission for Health Improvement, an NHS Performance Assessment Framework and a national survey of NHS patient and user experience.

4.2 This new national approach to quality improvement should over time have a positive impact on the development of local capacity to detect, prevent and learn from service failures. The introduction of local systems of clinical governance is particularly relevant to the development of NHS organisations' predisposition to learn from failures. The three main components of local clinical governance arrangements are:

- clear arrangements for accountability and reporting, with ultimate Board level responsibility for arrangements to assure and improve quality;
- a coherent programme of quality improvement activity; and
- risk management processes, including mechanisms for detecting and dealing with poor professional performance.

4.3 NHS organisations are due to produce their first annual clinical governance reports later this year, but as has been explicitly recognised there is considerable variation in states of readiness for the development of clinical governance and it should be seen as a medium to long-term development objective. It is also very pertinent to ask how well current mechanisms for learning from experience appear to support NHS organisations in improving the quality and safety of the care they provide.

Risk management in the NHS

4.4 Further important context is provided by the development of risk management systems in the NHS. Adverse clinical events are of course one of the many risks which NHS organisations face, and must to some extent be seen in that wider context.

4.5 There has been a concerted drive during the 1990s to develop risk assessment and risk management systems within NHS organisations. This work was initially focused on reducing litigation risks and subsequently – with the broadening of the concept of Controls Assurance – on the reduction of financial risks and ensuring probity. More recently the NHS Executive has emphasised the importance of developing holistic approaches to risk management, not least in recognition of the fact that it can be difficult to differentiate between 'clinical' and 'non-clinical' risk management. There have also been moves to encourage a broader focus on adverse events, rather than simply on litigation.

4.6 In combination, the introduction of clinical governance and the expansion of controls assurance beyond purely financial risks provide a strong impetus for the further development of comprehensive local risk assessment and risk

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management systems, of which sound local incident reporting mechanisms are a particularly important part.

Poorly-performing clinicians

4.7 It is important to recognise that the great majority of adverse events are not indicative of or attributable to deep-seated problems of poor performance on the part of individual clinicians. As we have already discussed, the causes of errors are manifold and complex, and can rarely be attributed solely to the actions of one individual. But there are inevitably some links between sub-standard professional performance and adverse events. In particular, in health care, action to prevent recurrence may need to be directed at an individual or a team as well as at organisational systems.

4.8 The Government published last year a consultation document setting out proposals for new ways of preventing, recognising and dealing with poor performance among doctors specifically[58]. That document emphasised the importance of exploring thoroughly apparent poor performance problems to ensure that the root causes of any problems can be accurately identified and dealt with, and it specifically recognised the likelihood that a systematic examination of some professional performance issues may well reveal deeper and more complex problems within organisations. Similarly, it is possible that systems for detecting and analysing adverse events might provide indications of emerging problems with a particular clinician. Although poor professional performance and adverse clinical events are very distinct issues, it is therefore important that systems put in place for detecting and addressing each of these problems can link with and refer to the mechanisms for tackling the other.

Current NHS mechanisms for learning from adverse events

"There are no universally accepted criteria for identifying the occurrences or outcomes of health care that should constitute a basis for recording or reporting poor quality"

4.9 There are no universally accepted criteria for identifying the occurrences or outcomes of health care that should constitute a basis for recording or reporting poor quality. Neither does the NHS have a single comprehensive system of gathering data to enable service failure to be recognised, but information is available from different sources. Some are specifically set up to monitor adverse events, whilst others are designed to gather more general health information.

Current systems that can yield information on adverse incidents

- Incident reporting systems (e.g. local risk reporting systems in NHS Trusts and other bodies, untoward incident schemes run in NHS

regions, reporting of adverse reaction to medicines and medical devices).

- Data derived as a by-product of systems designed to investigate or respond to instances of poor quality care (e.g. litigation for alleged medical negligence, the NHS complaints procedure, cases referred to the Health Services Commissioner, Coroner's cases).
- Databases of on-going studies on a national basis which aim to identify poor outcomes and avoidable factors in certain specific fields of health care (in particular the confidential enquiries into peri-operative death, maternal mortality, stillbirth and infant deaths, homicides and suicides by mentally ill people).
- Periodic external studies and reviews (e.g. the national Value for Money studies conducted by the Audit Commission).
- Spontaneous reporting outside normal channels by individual members of staff (sometimes know as "whistleblowing").
- Health service and public health statistics.

4.10 In addition, the NHS makes a considerable investment in ad hoc inquiries of various kinds in its attempts to extract learning from specific incidents.

4.11 These sources of information give a very incomplete picture of the size and nature of the problem of service failure and adverse events in the NHS. Their strengths and weaknesses, as well as what can be derived from them, are considered in the next few sections.

Incident reporting systems

4.12 The concept of an untoward incident is one which has grown up within the NHS over the years. It is a loosely used term for which there is no standardised definition:

Some characteristics of untoward incidents in the NHS

- a serious event in which a patient or patients were harmed or could have been harmed;
- the event was unexpected;
- the event would be likely to give rise to serious public concern or criticism of the service involved.

"Some extant NHS guidance on untoward incident reporting dates from 1955"

4.13 Formal Department of Health guidance on untoward incident reporting was first issued in 1955. Somewhat surprisingly, this guidance is still current. Incident reporting has also been addressed in subsequent guidance and in the recommendations of major independent incident inquiries.

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Guidance and recommendations on incident reporting in the NHS

". . . a brief report should be prepared by the Secretary of the Board of Governors or Hospital Management Committee as soon as possible after any occurrence of the kind in question, giving the name of any person injured, the names of all witnesses, details of the injuries and the full facts of the occurrence and of the action taken at the time . . ."

[H.M.(55)66: National Health Service – Reporting of Accidents in Hospitals. Ministry of Health, July 1955]

- a procedure should be devised and implemented, covering the action to be taken by line managers in the event of an incident involving actual or potential loss, injury or damage
- all incidents involving actual or potential injury, loss or damage should be reported immediately
- a simple reporting procedure using no more than two forms should be introduced
- a designated individual should be responsible for initiating further communication or enquiries and ensuring that appropriate action is taken."

[Risk Management in the NHS. NHS Executive 1993 (reissued 1996)]

"reports of serious untoward incidents to District and Regional Health Authorities should be made in writing and through a single channel which is known to all involved."

[Sir Cecil Clothier (Chairman), The Allitt Inquiry, HMSO February 1994]

". . . there must be a quick route to ensure that serious matters . . . are reported in writing to the Chief Executive of the hospital, and in the case of directly managed units, to the District Health Authority. All District Health Authorities and NHS Trust Boards should take steps immediately to ensure that such arrangements are in place."

[EL(94)16 Report of the independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital during the period February to April 1991 ("the Allitt Inquiry") – NHS Executive, 1994]

"Now that Regional Offices are in place it is appropriate for them to be formally notified of serious untoward incidents, whether these occur in NHS Trusts or DMUs. I should therefore be grateful if you could discuss with Trust Chief Executives the best means of instituting arrangements whereby you are informed in writing of any such incidents."

[Letter to NHS Executive Regional Directors from J F Shaw, Director of Corporate Affairs, NHS Executive, 10 May 1995]

"explicit arrangements (or protocols) for the reporting of serious untoward incidents from the NHS to Regional Offices should be in place following

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NHS Executive guidance issued in May 1995 in the wake of the Beverley Allitt case."

[Sir William Wells (Chairman) – Kent & Canterbury screening report – October 1997]

"Criterion 13: Incidents, including ill health, are systematically identified, recorded and reported to management in accordance with an agreed policy of positive, non-punitive reporting.
Criterion 16: All reportable incidents are communicated to the relevant external body in accordance with relevant reporting requirements."

[Controls Assurance Standard: Risk Management System (Core Standard). NHS Executive, November 1999]

4.14 The Clinical Negligence Scheme for Trusts (CNST) was established in 1995 and almost all NHS Trusts are members. It requires, as a condition of discounted premiums, the development of clinical incident reporting systems for compliance with its risk management standards. NHS Trusts must have basic systems in place across some of the organisation to attain even the most basic level of CNST standards, and have to develop a comprehensive system to reach the highest level, level 3. The requirement as part of clinical governance for the development of clear clinical risk management policies provides further impetus for the development of local reporting systems.

4.15 The evidence suggests that historically incident reporting has been rather haphazard. Today, although the great majority of NHS Trusts have some form of incident reporting system in place, there is substantial variation in the coverage and sophistication of these systems.

Status of incident reporting in NHS Trusts

- a fifth do not have reporting systems covering the whole organisation
- less than half provide specific training on risk management or incident reporting
- less than a third provide guidance to staff on what to report
- a third do not require clinicians to report unexpected operational complications or unexpected events
- rates of reporting vary widely

Source: Dineen and Walsh 1999[59]

4.16 Experience of reporting systems at Regional level is also variable. The eight Regional Offices of the NHS Executive have approached the requirement to establish incident reporting in their regions in different ways. All have put in place protocols and mechanisms of some kind, but these vary considerably in

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their nature and sophistication. They have tended to focus primarily on the immediate handling issues around incidents, rather than on systematic recording. The longest-established system is that which has been operated since 1995 by the NHS Executive's Northern and Yorkshire Regional Office.

Regional incident reporting – good practice

In 1995, the Northern and Yorkshire Regional Office of the NHS Executive set up a standardised untoward incident reporting system. Examples of serious incidents are given and a serious untoward incident is defined. NHS Trusts and health authorities are asked to notify the Regional Office as soon as possible after a serious untoward incident. An electronic database was established in 1997 to facilitate the reporting and review of incidents. It can be interrogated for brief summary reports and is being further refined to include categorisation of incidents by care sector. There are explicit requirements set out for reporting, for conducting inquiries, for disseminating their findings and acting on the lessons learned.

4.17 The numbers of serious incidents reported to each region are shown in Table 4.1. They must be taken as a very crude reflection of all such occurrences especially in the regions which have less developed incident reporting systems. The Northern and Yorkshire database gives an indication of which sector the incidents fall into. Although not all regions can provide this level of analysis, most have informed us that incidents in mental health services account for about half the total each year. This is likely in part to be a reflection of higher reporting levels for incidents involving mental health services – for which there

Table 4.1 Numbers of incidents reported to NHS Executive Regional Offices in England (1998)

Region	*Number of Incidents*
Trent	82
South Eastern	150[1]
Eastern	150–200[1]
North West	110–120[2]
Northern and Yorkshire	361
London	180[1]
West Midlands	122[3]
South and West	120[1]

1 Region's estimate of number of reported incidents per annum. Boundary changes mean that figures are not available by current RO.

2 Mental health incidents only. No formal recording procedure for other incidents

3 Number of incident briefings provided June 1997 to February 1999

are specific reporting requirements – and cannot be taken as an accurate representation of the relative numbers of actual incidents.

Current regional incident reporting systems fulfil a number of purposes:

- creating an opportunity to make an intervention to resolve or handle a problem;
- gathering information to learn from the adverse event and prevent similar occurrences in the future;
- advising Health Ministers of the existence of the problem;
- alerting government and NHS Press Officers that there is likely to be media coverage and advising on how this should be handled.

4.18 From our review of incident reporting systems we concluded there were a number of serious weaknesses:

Weaknesses in current NHS incident reporting systems

- There is no standardised, operational definition of "adverse event" which would be easily understood by all NHS staff.
- The coverage and sophistication of local incident reporting systems, and the priority afforded to them by NHS Trusts, varies widely. Incident reporting in primary care is largely ignored.
- Regional Offices of the NHS Executive are charged with establishing and maintaining systems for reporting and monitoring incidents beyond the organisations immediately concerned, but there are major differences in the approach taken in the eight parts of the country.
- The regional incident reporting systems undoubtedly miss some serious incidents and take hardly any account of less serious incidents or those which do not harm patients but might have done.
- There is no standardised approach to investigating serious incidents at any level. Most involve internal enquiries, some involve external enquiries but the way in which a decision is taken or how they are carried out is inconsistent.
- Current systems do not facilitate learning across the NHS as a whole.

4.19 To some extent this situation may reflect both the culture of devolved responsibility and competition under the internal market of the early to mid 1990s and the major structural changes which occurred at Regional level during the same period.

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4.20 In addition to the local and regional incident reporting mechanisms described above, specific systems exist for the reporting of adverse reactions to drugs and errors involving medical devices.

Reporting of adverse reactions to drugs

4.21 Information is limited on the safety of medicine at the time of licensing, since clinical trials are generally carried out on relatively small numbers of subjects and in carefully defined populations. All drugs have the potential to cause adverse reactions and spontaneous reporting schemes are the only practical method of monitoring the safety of all drugs throughout their use in clinical practice. Therefore, encouraging spontaneous reporting of adverse drug reactions (ADRs) is an essential part of establishing the safety profile of a medicine in clinical use.

4.22 The Medicines Control Agency (MCA) administers a single system – the "Yellow Card" scheme- for reporting ADRs in England, Scotland and Wales. The principal purpose of spontaneous reporting is to identify previously unrecognised potential drug safety hazards. In this respect the Yellow Card Scheme has proved to be one of the most effective in the world.

The Yellow Card scheme

The Yellow Card scheme has been in operation since 1964. Reporters of suspected adverse drug reactions (ADRs) are doctors, dentists, coroners and hospital pharmacists. Reports are received directly from them and from pharmaceutical companies relating to the drugs for which they hold Marketing Authorisations. The scheme is voluntary for health professionals, whereas Marketing Authorisations holders are required to report serious ADRs to the MCA within 15 days of notification. Since 1964 more than 350,000 UK reports of suspected adverse reactions have been received. Reporting levels are quite consistent and there is good co-operation from health professionals. Facilities for electronic reporting are being introduced to improve the speed and ease of the process and help reduce under-reporting.

Marketing Authorisations are regularly updated as new information arises to ensure that prescribers and patients have sufficient information to allow the safe and effective use of medicines.

4.23 The limitations of the scheme are well recognised. In particular, there is a variable degree of under-reporting and there have been recent initiatives to try to combat this.

4.24 Spontaneous reporting data must be interpreted with care. Doctors are asked

to report suspected ADRs and a report of a suspected adverse reaction does not necessarily imply a causal relationship with the drug. Nor does an ADR necessarily imply an error in the drug's prescribing or administration.

Reporting of adverse incidents involving medical devices

4.25 Adverse incidents involving medical devices are reported to the Medical Devices Agency (MDA). Information is logged on a central database, containing details of over 48,000 incidents. Incidents are assigned to a level of investigation depending on the risks involved.

4.26 Outcomes of investigations are subject to a formal review. Patterns or clusters of incidents can then be identified, subjected to further risk assessment procedures and investigated where necessary.

4.27 When an incident reveals a device-related safety problem the MDA produces a Hazard or Safety Notice for distribution.

Medical Devices Agency notices and bulletins

Hazard Notices are used in the most serious cases, when either a patient's health (or life) has been put at risk, or staff safety has been compromised, either by a device fault or an operator error. They require immediate action when received by healthcare organisations.
Safety Notices are issued when it is clear that a potential safety problem exist with a medical device. They call for action to avoid the risk, often involving alerting staff, or altering procedures either for use or maintenance of the equipment.
Device Bulletins are longer publications produced when device management changes are needed for safe and effective device use, and **Pacemaker Technical Notes** are dedicated to advice relating to pacemakers and are distributed directly to pacing centres.

4.28 Each year the MDA reminds the whole of the health care sector how to report an adverse incident, through publication of a Safety Notice. The annual notice describes what an adverse incident is, what to report, how to report it and gives statistics for the previous year.

Reports to the Medical Devices Agency (1999)

- 6,610 reports of adverse incidents
- 37% manufacturing problems (design, quality control, packaging etc.)

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- 27% device faults which developed during use
- 12% user error
- 24% displayed no links to the device failure

Source: MDA

Complaints

4.29 A single NHS complaints system was introduced in 1996 for hospitals, community health services and family health services. Complaints to NHS organisations are first addressed by local services, with the aim of resolving the issue (often informally) as quickly as possible. Unresolved complaints are subject to a further review which may result in consideration by an Independent Review Panel. The panel will investigate the complaint and produce a written report, which may make comments and recommendations about the circumstances of the complaint and the need for service improvements.

4.30 If complainants are not satisfied with the response from the NHS, they may refer the matter to the Health Service Commissioner. The Commissioner's jurisdiction was extended in 1996 to cover complaints about clinical judgement and family health services, to enable him to look at complaints about all aspects of NHS care. The Health Service Commissioner publishes an annual overview and more detailed six-monthly reports on complaint investigations, which may contain recommendations for changes in practice.

4.31 National complaints statistics are published annually but have historically been used more to monitor how the system is working rather than to focus on the substance of the complaints themselves.

NHS complaints (1998–99)

- 86,013 written complaints made about hospital care
- 38, 857 written complaints made about family health services
- 27,949 hospital complaints concerned "aspects of clinical treatment"
- 285 hospital and 313 family health services complaints were referred for independent review
- there is no information nationally on the number of complaints which are "upheld"

Source: Department of Health 2000[60]

4.32 Complaints reviews are one source of qualitative information about service failures and may highlight the need for particular improvements. The system as a whole does not provide a reliable picture of the number or types of service

"Information from complaints is under-exploited as a learning resource"

failures experienced in the NHS. Nor, as presently organised, does it provide any basis for learning across the NHS as a whole. It is only the small number of complaints considered by the Health Service Commissioner that enable (through his publications) issues of relevance to the NHS as a whole to be identified. There is no evidence to show the extent to which individual NHS organisations learn from complaints though this is one of the requirements of clinical governance. Overall, we believe that information from complaints is under-exploited as a learning resource, particularly at national level. The NHS Executive's evaluation of the operation of the complaints system, which is due to report early in 2001, may provide one opportunity for addressing some of these concerns.

Learning from clinical litigation

4.33 It was not within the Committee's remit to focus in any major way on the issue of clinical negligence litigation. Inevitably, though, litigation did form part of our deliberations, for a number of reasons:

- It represents a very visible manifestation of adverse outcomes of care, which are damaging to patients and their families as well as costly to the NHS;
- Many of the injuries to patients that result in litigation are judged in retrospect to have been potentially avoidable;
- Data from litigation claims represent a potentially rich source of learning from failure;
- Only a small proportion of potential negligence claims are pursued through to court. There is a tremendous amount of unutilised data, beyond high-profile court cases, which provides a further potential source for learning;
- It is a very significant part of the resource costs of adverse incidents to the NHS, with a cash outlay of around £400 million a year in addition to an estimated potential liability of £2.4 billion – for existing claims and incidents which may result in claims – spread over a number of years;
- The processes of dealing with adverse events which lead to litigation are often themselves perceived by patients as a further element of poor care. Thus there are lessons to be learned and improvements to be made to procedures for dealing with the aftermath of adverse events. For example the NHS needs to move away from a position where the automatic response to complaints and claims is often very defensive, towards one which is much more open. A common criticism, though one which is beginning to be addressed, is that the NHS is bad at admitting its mistakes and offering patients an apology. The NHS Litigation Authority has addressed this point in guidance, but change in attitudes and practice is gradual;

4.34 The possible impact of creating an effective 'learning loop' to derive benefit from clinical litigation information is illustrated by an example from the field of obstetrics and midwifery. A substantial proportion of the money paid out in clinical litigation settlements by the NHS each year arises from obstetric

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problems which result in the birth of babies which result in significant brain damage and permanent serious disabilities, such that they are handicapped for life. The birth of a brain-damaged baby is not always due to clinical error, but a number of consistent factors contribute to those cases which do involve negligence.

Brain damage to babies at the time of birth – key facts

- The average sum awarded is around £1.5 million, with some awards as high as £4 million;
- Claims account for 50% of the NHS litigation bill every year;
- A 10% reduction in the number of adverse events causing brain damage to babies at birth would save the NHS at least an estimated £20 million a year;
- Evidence suggests that the following actions would substantially reduce risk in this area[61]:
  – improved staff supervision;
  – proper use of equipment to monitor labour;
  – better technique and diagnostic skills at delivery.

"The potential to learn from clinical negligence litigation is enormous"

4.35 A concerted effort to learn from this experience would surely prevent some future births of brain-damaged babies, reducing the misery and distress caused to children and their families and saving the NHS large amounts of money which could be diverted to other areas of patient care. This is only one example, and the potential to learn from the experience of litigation across other areas of health care is enormous.

4.36 Further evidence of the potential value of litigation information is provided by the results of a study of over 100 litigation claims paid on behalf of consultant anaesthetists working in the private sector. It found that every claim involved problems in at least one of four key areas.

Learning from litigation: Significant risk factors in anaesthesia claims

- Inadequate or no pre-operative assessment
- Failure to use essential equipment
- Medication issues, e.g. overdose of muscle relaxant
- Monitoring before, during or after the operation

Source: Medical Defence Union 1997[62]

4.37 There are currently no systematic analyses of the litigation data on hospital

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cases held by the NHS Litigation Authority. In primary care the medical defence organisations such as the Medical Defence Union and Medical Protection Society (which provide cover against negligence for individual practitioners in primary care and in private practice) maintain their own databases of claims and publish illustrative case-histories as an aid to learning among their members. This information can be used to identify specific trends in the nature of negligence claims in general medical practice.

Adverse incidents resulting in litgation claims in General Medical Practice

Delays in diagnosis, principally	55% of claims*
– missed malignancies	
– missed heart attacks	
– missed conditions requiring surgery	
– missed meningitis and pneumonia	
Medication errors	25% of claims
Management of pregnancy	10% of claims
Other procedures and interventions	20% of claims

* Approximate percentage of total indemnity paid out. Total value of payments in the latest 2 year period is £16.9 million.

Source: Medical Defence Union

4.38 From a more detailed examination of the area of medication errors, which account for around 25% of all litigation claims in general practice, it is possible to identify a number of recurrent problems or types of error.

Common medication errors resulting in litigation claims

- Incorrect or inappropriate dosage
- Wrong drug
- Administration error (correct medication wrongly administered)
- Contra-indicated medication (e.g. patient given medication which reacts badly with another drug or condition)
- Prescribing and dispensing errors (e.g. prescribing or dispensing an incorrect drug with a similar name to the intended medication)
- Failure to monitor progress
- Failure to warn of side-effects
- Repeat prescribing without proper checks
- Over-reliance on computerised prescribing
- Prescribing unlicensed drugs

Source: Derived from Medical Protection Society and Medical Defence Union

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4.39 In relation to those aspects of clinical litigation relevant to our work, we drew the following conclusions:

- Clinical data arising from negligence claims are not in general being used effectively to learn from failures in care:
- There is significant potential to extract valuable learning by focusing, specialty by specialty, on the main areas of practice which have resulted in litigation.

Wasted and lost opportunities for learning from litigation in the NHS

To date little or no systematic learning across the NHS has taken place from:

- A historical base of over 14,000 claims (relating to events stretching back many years) held by the NHS Litigation Authority
- An annual rate of around 800 new claims settled by the NHS Litigation Authority arising from incidents in NHS Trusts
- A historical base of tens of thousands of claims from primary and secondary care held by organisations such as the Medical Defence Union and the Medical Protection Society*
- An annual rate of around 700 new claims settled by the medical defence organisations arising mainly from incidents in primary care*

* The MDU and MPS publish analyses of their data for the benefit of their members and have made it clear that they are willing to share information and experience to maximise the opportunities for collective learning.

Confidential inquiries

4.40 Four National Confidential Inquiries operate in the NHS:

- the Confidential Enquiry into Maternal Deaths (deaths of women during pregnancy or within one year of childbirth)
- the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) (stillbirths and infant deaths)
- the Confidential Enquiry into Peri-Operative Deaths (NCEPOD) (hospital deaths within 30 days of surgery)
- the Confidential Inquiry into Suicides and Homicides by People with Mental Illness (suicides within one year of contact with mental health services and homicides involving people who have been in contact with mental health services at any time)

4.41 Each Inquiry takes anonymised information, on a comprehensive or sample basis, about deaths related to a particular condition or aspect of health care and analyses it to produce recommendations for improved practice. Because of the confidential nature of the data gathering process – information is anonymised on receipt – the Confidential Inquiries are only exceptionally able

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to give specific feedback to individual services. Rather they publish national reports drawing on the range of events they have examined.

Key features of the confidential enquiries

- Aim to identify all deaths in a specific category
- Confidential reporting (i.e. patient, staff and hospital not identified in reports)
- Multidisciplinary review of deaths to discover avoidable factors
- Results published in periodic reports
- Key themes identified and recommendations made for improvement
- No mandatory compliance with recommendations
- No systematic monitoring of uptake of recommendations

4.42 Anonymity is widely seen as a prerequisite both for high reporting rates and for honest reporting of information about individual cases, though the experience of the Confidential Inquiries in general suggests that there are limits to the coverage which can be achieved by voluntary reporting systems. For example, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness achieved reporting rates of only around 15% for suicide until it was redesigned to draw on other sources of information – District Directors of Public Health and Office for National Statistics (ONS) data – for the initial identification of relevant incidents. Clinical information is now collected on 92% of relevant suicides and 93% of relevant homicides. The participation rate in NCEPOD, the biggest Confidential Inquiry, varied between 71% and 86% (depending on specialty) in the most recent year of study.

"it is usually left to individual services to pick up and implement specific recommendations of the Confidential Inquiries"

4.43 As discussed in paragraph 3.37 it is usually left to individual services to pick up and implement specific recommendations of the Confidential Inquiries, and there is little by way of systematic monitoring of uptake. Some recommendations have resulted in service improvements but others are repeated from report to report without action being taken. The latter are not so much those which have resource implications as those which would involve marked changes in patterns of clinical practice, and those aimed at clinicians outside the normal readership of the report. For example, the Confidential Enquiry into Maternal Deaths makes recommendations which affect general practice, accident and emergency departments and general medicine, but the reports may not be widely read by health professionals in these areas of practice.

Other external reviews

4.44 A number of bodies are active in externally reviewing aspects of NHS service provision.

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Other external reviews

The Audit Commission conducts "Value for Money" studies in the NHS. These reviews are concerned with service quality, but they tend to focus on the generality – for example on "sub-optimal" care – rather than adverse incidents *per se*;

The professional regulatory bodies, such as the General Medical Council, deal with issues of individual professional performance. The drive towards proactive assessments or "revalidation" in medicine may ultimately provide a further mechanism for identifying actual or potential adverse events;

Medical Royal College visits can from time to time highlight concerns about the quality and safety of care provided in a particular unit;

The Commission for Health Improvement will have a key role both in the detection of poor quality systems, through its reviews of local clinical governance arrangements, and in the scrutiny of specific adverse incidents through its "troubleshooting" work. It also has a potentially valuable role to play in improving the conduct of NHS incident inquiries (see below) and in helping to make greater sense of the existing patchwork of external reviews.

Public Interest Disclosure

4.45 Organisational and team cultures which prevail in much of the NHS can act to discourage reporting of incidents or concerns, particularly when these relate to activities involving professional colleagues.

"The fear of being labelled a trouble-maker, the fear of appearing disloyal and the fear of victimisation by managers and colleagues are powerful disincentives against speaking up about genuine concerns staff have about criminal activity, failure to comply with a legal duty, miscarriages of justice, danger to health and safety of the environment, and the cover up of any of these in the workplace"

[HSC 1999/198 The Public Interest Disclosure Act 1998 – Whistleblowing in the NHS *NHS Executive, August 1999]*

4.46 Cultural barriers will take time to break down, but the Public Interest Disclosure Act 1998 (which became law in July 1999) represents an important step forward in encouraging and protecting appropriate reporting of incidents or concerns. The Act gives significant statutory protection to employees who disclose information reasonably and responsibly in the public interest and are

victimised as a result, and has prompted a renewed drive to encourage open reporting in the NHS.

NHS executive guidance on "whistleblowing"

"Every NHS trust and Health Authority should:-
Have in place local policies and procedures which comply with the provisions of the Public Interest Disclosure Act 1998. The minimum requirements of local policies should include:-

(i) the designation of a senior manager or non-Executive Director with specific responsibility for addressing concerns raised in confidence which need to be handled outside the usual line management chain;
(ii) guidance to help staff who have concerns about malpractice to do so reasonably and responsibly with the right people;
(iii) a clear commitment that staff concerns will be taken seriously, and investigated;
(iv) an unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation."

[HSC 1999/198 The Public Interest Disclosure Act 1998 – Whistleblowing in the NHS *NHS Executive, August 1999]*

4.47 It is too early to assess the impact of these developments. Legislative changes are not in themselves sufficient to bring about more open, learning cultures within NHS organisations, but they certainly have the potential to contribute to that process. In one sense, 'whistleblowing' can be seen as evidence of a failure to learn – people are far more likely to pursue channels outside their own organisation if there has been a failure to act on or even acknowledge concerns raised internally. To many a perceived need for external whistleblowing is in itself a sign that organisational culture is seriously awry.

Inquiries

4.48 Although they are not a mechanism for systematic information gathering, inquiries of one kind or another are an area in which the NHS invests considerable resources in an effort to learn from failures.

4.49 An inquiry can be established into a failure in the standards of care provided in a number of ways:

- An inquiry with statutory powers (e.g. to require information) ordered by the Secretary of State for Health under the powers set out in section 84 the NHS Act 1977. This tends to be for very serious issues. A recent example is

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the Bristol Royal Infirmary Inquiry into the deaths of a number of children following heart surgery.

- An external inquiry without statutory powers organised by the NHS locally, possibly at the request of and/or under the supervision of the NHS Executive Headquarters or one of its Regional Offices. The Secretary of State has statutory powers to set up such inquiries under his general powers in section 2(b) of the 1977 Act, as do Health Authorities to whom this power has been delegated. Two recent examples of inquiries instigated by the Secretary of State are the enquiry into the retention of children's organs after post-mortem at Alder Hey hospital and the enquiry into the case of Dr Harold Shipman, the general practitioner convicted of murdering 15 of his patients.
- A mental health inquiry established under the terms of the 1994 circular *Guidance on the discharge of mentally disordered people and their continuing care in the community (HSG(94)27/LASSL(94)4)*. These inquiries deal with serious incidents – in particular homicides – involving people in contact with mental health services.
- An internal inquiry (with or without external advisers) – this is used in the majority of serious incidents within the NHS.

"There has been little formal evaluation of these processes of inquiry"

4.50 There has been little formal evaluation of these processes of inquiry to see what impact they have. Anecdotally, there is an impression of variable focus, different levels of rigour, differences in methodology and in the way that recommendations are framed and adopted. There are no clear thresholds for determining when an inquiry should take place and what kind of inquiry is most appropriate.

NHS inquiries into adverse events: Key issues

- Thresholds for initiating an enquiry are unclear.
- Purely internal enquiries often do not reassure public.
- The NHS has variable expertise in conducting enquiries.
- There is often a long wait for the outcome.
- Written reports are of variable quality.
- Too often recommendations are not written in a format which is effective in helping to bring about the change required.
- A large amount of information is often presented, which may result in overload and act as a barrier to learning.

4.51 Experience from other fields demonstrates that the NHS experience of external incident inquiries, in particular, is not unique. Even large-scale, and apparently very thorough, inquiries in other fields sometimes fail adequately to address whole chains of critical events[63] and recommendations are often not specific

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enough to provide a sound basis for practical action. The sheer volume of information involved can act to inhibit effective analysis and learning. Research has also shown that there is a common core of 24 broadly similar recommendations, falling into five categories, which are made time and again by inquiries – regardless of the topic under investigation. Inquiries in the NHS often make recommendations on similar issues – for example communications among health professionals or between different agencies – but again these are sometimes not formed in such a way that people understand exactly what change they are expected to make.

Categories of core recommendations common to most enquiries

- Communication: recommendations designed to improve the communication of information between individuals, departments, other organisations and in some cases with the wider general public;
- Technical: recommending the installation of physical safety precautions where they appear to be required;
- Attempted foresight: recommendations designed to forestall different problems, not necessarily directly linked with the incident in question, which could arise in the future;
- Personnel : recommendations addressing issues such as staff training, staffing levels, lack of expertise or shortfalls in supervision;
- Authority: recommendations which attempt to produce safety by demanding it – for example through new rules, orders or legislation.

Source: Toft and Reynolds 1997[64]

4.52 Historically, inquiries and investigations have had to serve a range of different – and sometimes incompatible – purposes. Inquiries may be used to establish the facts of a case, provide an expert or independent perspective on an incident and help to extract learning so that services can be improved and further errors avoided. But they may also serve as vehicles for demonstrating to the public and to patients or relatives that incidents are being taken seriously, to provide a reassurance that lessons will be identified and learnt and to demonstrate accountability. Researchers have suggested that in practice the primary purposes of formal external inquiries have been 'discipline, learning, catharsis and reassurance'[65].

"In practice the primary purposes of formal external inquiries have been discipline, learning, catharsis and reassurance"

4.53 Each of these purposes is distinct and it is easy to see how they might come into conflict. For example, for a major incident an inquiry held in public might be more effective in assuaging public concerns and demonstrating openness, but it can be argued that public proceedings can encourage defensiveness and hamper efforts both to get at the true facts of a case and to extract learning. And a search for individuals to 'blame' as the central purpose of an

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enquiry can impede proper understanding of the true, often very complex, causes of failure. For ensuring that active learning takes place within organisations, formal external inquiries may be less effective than internal service reviews or audits, but the latter have tended to be of variable quality and rigour and are often not trusted by patients as sufficiently impartial or searching.

4.54 Within the NHS, there are proposals to give the new Commission for Health Improvement a remit for overseeing and improving the way inquiries are conducted. The Commission should have a major contribution to make to improving the way the NHS learns from investigations into serious adverse events, and also help to introduce some clarity into the relationships between the various existing external review mechanisms.

Health service and public health statistics

4.55 A large amount of regular statistical information is collected both by the NHS locally and by the Department of Health. The Hospital Episode Statistics (HES) capture information on 11 million hospital episodes annually in England alone, covering admission, diagnosis, resulting operations and basic outcomes (death, discharge home and other discharge). Historically, the uses of these data have concentrated on recording and assessing activity levels and on performance including technical efficiency. Much is of variable technical quality and equally variable relevance to the quality and outcomes of the care the NHS provides. It is revealing that statisticians commissioned by the Bristol Royal Infirmary inquiry into the deaths of children following heart surgery had to undertake special statistical work on HES data in order to use it to compare the performance of different cardiothoracic services around the country.

4.56 The launch of a new NHS Performance Assessment Framework, which explicitly balances efficiency with measures designed to reflect outcomes and effectiveness, has been complemented by a Clinical Indicators initiative which aims to focus on quality by exploiting HES data by linking successive episodes to produce information on post-operative mortality and re-admissions. However, whilst this information will over time help to provide a better picture of the general quality of care provided by the NHS, it is unlikely to tell us a great deal about adverse events in the short or medium term.

Analysis of information on adverse events

4.57 We have commented in our description of the various sources of information on adverse events about the extent to which the data collected are analysed to extract learning. In summary some mechanisms, such as the Confidential

Inquiries and the Medical Devices Agency and Medicines Control Agency systems have a strong focus on the rigorous analysis of information to distil lessons for practice. However, as we have made clear, little effort is made systematically to extract lessons from some potentially important streams of information, principally those arising from complaints and litigation, or to bring together the results of the various analysis systems that are in place. Regional incident reporting systems are also highly variable in the extent to which they analyse their data to distil learning.

Acting on lessons identified

4.58 It would be quite wrong to conclude that the NHS as an organisation is incapable of learning and improving, but the evidence suggests that learning generally takes a long time and that implementation of lessons can be very patchy. We have already highlighted in case studies specific kinds of problem or incident which have recurred time after time despite the fact that they have been identified as hazards.

"Where change does occur, it can take a long time to come about"

The pace of change – The example of the National Confidential Inquiries

4.59 Where change does occur, it can take a long time to come about. Even where there is good evidence from high quality systems such as the Confidential Inquiries, the evidence is that implementation of lessons and recommendations is often a very slow process, though meaningful changes can be brought about over a period of years. The Confidential Enquiry into Maternal Deaths has helped to bring about dramatic improvements in the safety of some aspects of maternity care, but an audit of specific recommendations reveals that there are still areas in which key findings have not been universally acted upon.

Examples of the pace of learning – the Confidential Enquiry into Maternal Deaths (CEMD)

Improvement occurs over a long period of time

- The rate of direct anaesthetic deaths fell from 12.8 per million births in 1970 to 0.5 per million births by 1996, though the rate of the fall was not steady during this period;

Improvement occurs patchily

- Local protocols for the management of massive haemorrhage were recommended in the CEMD report for 1985–87. In 1994, 11% of units in England still lacked such a protocol;
- Further long-standing recommendations concern the availability of on-site blood banks and Intensive Care units. In 1994, 21% of units in

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England had no on-site ITU and 12% had no on site blood bank;

Some recommended improvements are not implemented

- CEMD has repeatedly recommended the establishment of a system of regional advice and referral centres for pregnancy-induced hypertension. So far such a system has not been implemented, and hypertensive disorders remain the second most common cause of maternal deaths;
- A recurring theme of CEMD reports has been the dangers of inadequate senior supervision and problems with delegation. A report in 1995 concluded that both were still factors in a number of maternal deaths;

Improvement is not always sustained

- Deaths from haemorrhage reached their lowest point in history during 1985–87, when 10 deaths occurred. The number of deaths rose to 22 in 1988–90, partly because basic lessons were being forgotten;

Some long-standing problems remain

- In the three years 1991–93, 63 deaths occurred which involved sub-standard care. Sub-standard care was a factor in 16 of 20 deaths from hypertensive disorders, 16 of 18 early pregnancy deaths and 7 of 8 anaesthetic deaths.

Sources: Hibbard and Milner 1995[66], Drife 1997[67]

4.60 Further evidence of the ability of the Confidential Inquiries to bring about change, and of the variable pace with which that change comes about, is provided by the National Confidential Enquiry into Perioperative Deaths (NCEPOD). In its 1999 report[68], NCEPOD returned to a study of 1989 and assessed the degree of change in practice in relation to surgery and anaesthesia in children. The 1989 report stated that 'surgeons and anaesthetists should not undertake occasional paediatric practice'. Comparison between 1989 and 1997/98 data shows evidence of a number of changes in practice:

Examples of the pace of learning – The National Confidential Enquiry into Perioperative Deaths, 1989 – 1998

Meaningful improvements have occurred in paediatric surgery, but they have taken a number of years to come about and in some cases recommendations have not been universally adopted:

- The proportion of anaesthetists who did not anaesthetise infants of less than six months had increased from 16% (1989) to 58% (1997/98)

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- The proportion of orthopaedic surgeons dealing with small numbers (1–9 cases per year) of infants has fallen from 41% to 19% and those dealing with 10–19 cases per year has fallen from 9% to 3%
- The proportion of anaesthetists dealing with small numbers (1–9 cases per year) of infants has fallen from 40% to 26% and those dealing with 10–19 cases per year has fallen from 22% to 7%
- The proportion of orthopaedic surgeons who do not operate on infants has increased from 39% (1989) to 74% (1997/98)
- The figures for many of the other surgical specialties show similar trends, with more specialisation in children's surgery.

4.61 In neither of these examples was there a particularly strong national drive for implementation of the Confidential Inquiry recommendations, other than that coming from the professions and the Inquiries themselves.

4.62 There is far less evidence about the systematic implementation of lessons from other information sources, but the issues and examples cited in the preceding three chapters suggest that the situation with regard to most is likely to be less favourable than for the Confidential Inquiries. Aside from the Confidential Inquiries, only the Medical Devices Agency and Medicines Control Agency systems have the facility even to report on their findings in a systematic and comprehensive way. Most of the existing systems share the weakness of the Confidential Inquiries in that follow-up and implementation of lessons is left entirely to local services or even to individual practitioners.

The situation in primary care

4.63 We have already observed that the great majority of available information and evidence on adverse events in the NHS, and in the health care sector generally, relates to hospital-based care. We have also stressed that this report and its conclusions are nevertheless of equal relevance to primary care, in particular to Primary Care Groups and Primary Care Trusts as developing organisations. The case of Dr Harold Shipman, the Lancashire General Practitioner convicted earlier this year of murdering 15 of his patients, is fortunately exceptional, yet it serves as a powerful illustration of the implications of a major deficit in the reporting of serious adverse events at source.

4.64 Some of the information sources we have highlighted do encompass primary care: for example reporting of Adverse Drug Reactions and information from complaints and litigation. In particular the medical defence associations such as the Medical Defence Union and Medical Protection Society do systematically attempt to draw out and disseminate key lessons from the negligence claims they handle, providing a resource that the secondary care sector largely

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"Historically, guidance on incident reporting has been heavily focused on secondary care"

lacks. However some of the most valuable sources of information, such as the Confidential Inquiries, are by their nature and focus very much secondary care orientated. Historically, NHS Executive guidance on untoward incident reporting has also been heavily focused on secondary care – largely because of a perception that this is where most serious incidents occur. Yet far more patient contacts take place every year in a primary care setting and there is still the potential for patients to be seriously harmed by failures in care.

NHS activity: Adverse event reporting is least developed in sectors where the most patients are seen

Primary care

- 251 million GP consultations
- 26 million courses of dental treatment

Community health care

- 16 million new episodes

Hospital care

- 8.6 million hospital admissions
- 11.8 million new outpatients
- 12.8 million attendances at Accident and Emergency departments

Source: Department of Health Departmental Report 2000–2001. Figures quoted are for 1998–99[69]

4.65 In addition, local risk and incident reporting systems are far less developed in primary care, though there are instances of good practice in primary care risk management. Primary care faces particular challenges in developing and maintaining effective local incident risk reporting systems, not least because it has lacked some of the organisational structures to support such systems. The development of Primary Care Groups and Primary Care Trusts provides an opportunity to effect further improvements in this area, in general medical practice at least.

4.66 There is very little evidence about the capacity of primary care organisations, down to the level of individual practices, to learn actively from failures, but the general caveats we have highlighted about lack of systematic dissemination and follow-up of lessons apply at least as strongly in primary care as they do in the hospital sector.

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Chapter 4 – Conclusions

- Learning from adverse clinical events is a key component of clinical governance and will be important in delivering the Government's quality strategy for the NHS. It warrants specific attention over and above wider work to improve overall risk management in the NHS;
- Although most adverse events are not related to serious problems of poor professional performance, there must be appropriate links between systems for learning from failure and those for detecting and addressing poor performance;
- The existing mechanisms for detecting and analysing serious untoward incidents and service failures in the NHS are a patchwork of systems which, in various ways and to different extents, support NHS efforts to learn from experience. NHS systems for reporting and learning from adverse events could be greatly improved, in their coverage, consistency and immediacy;
- Mechanisms for learning from adverse events in primary care are generally less well-developed than those in the hospital sector;
- There are no generally accepted definitions to guide incident reporting;
- Levels of reporting to the different existing systems vary greatly and, outside a few specific areas, are very patchy. “Near miss” reporting is almost non-existent;
- The NHS culture is not – by and large – one which encourages reporting and analysis;
- Some sources of information which might yield valuable lessons – such as complaints and litigation data – are not systematically analysed with that end in mind. The way in which complaints and litigation are handled can also hamper effective learning;
- The conduct and added value of incident inquiries is highly variable;
- Recommendations from the Confidential Inquiries, Health Service Commissioner's reports and other sources of information and analysis are often not reliably translated into practice: the onus is on individual NHS organisations to take them up and act on them;
- In general, the NHS does not appear to learn lessons consistently or quickly from the systems that are currently available to it, though there is some good practice on which to build.

CHAPTER 5

The need for action: conclusions and recommendations

In this chapter we draw together conclusions from what we have learned from an extensive review of the adequacy of present NHS information systems to detect, report, analyse and learn from adverse events in health care service, in this country. We also distil the important lessons from our review of research and experience of this field both in the health and non-health care sectors. The present situation is far from satisfactory. The NHS is failing to learn from the things that go wrong and has no system to put this right. In the context of a major programme of modernisation now being implemented in the NHS's approach to quality assurance and quality improvement, this is a gap that needs to be closed. The NHS has an old-fashioned approach in this area compared to some other sectors. Yet the opportunity for transformation is enormous with huge resulting benefits – lives can be saved, serious harm to patients can be avoided, health organisations can become much safer places for patients and staff and in the long-term large sums of money could be released which could then be used to provide more patient care.

5.1 There are at present some major shortcomings in the ways the NHS learns from its failures. Yet there are also tremendous opportunities to bring about real improvements in care, not least the beginnings of a powerful cultural shift brought about by a renewed and sustained focus on quality. There are a number of pointers from research and from other sectors that suggest how these improvements might be brought about.

5.2 For the NHS to become an organisation that can learn effectively from failure some straightforward conditions must be fulfilled.

- First, unified mechanisms are needed for reporting and analysing examples of when things have gone wrong, with clear lines of accountability. This involves both:
  – reporting of adverse events; and
  – the monitoring and analysis of a full range of adverse event data.

- Second, a more open culture must be developed, in which errors or service failures can be admitted, reported and discussed without fear of reprisal (though this does not mean that individuals should never be held to account for their actions).
- Third, lessons must be identified, whether from adverse events or from other sources of data, active learning must take place and necessary changes must be put into practice. This process needs to be actively managed.
- Fourth, the NHS must develop a much wider appreciation of the need to 'think systems' in analysing and learning from errors, as well as in prevention (through risk management).

Key problems

5.3 Within the body of our report we have drawn a number of conclusions about the weaknesses and shortcomings of the current NHS arrangements for detecting, reporting, analysing and learning from adverse events in health care, and highlighted a number of important lessons which can be drawn from research and from experience in health care and in other sectors.

Data gathering

5.4 Whilst a number of mechanisms are in operation to gather data on things that go wrong in health care, there are several systematic weaknesses.

There is no consensus on what to report. Few of the systems are based on a simple, easily communicated definition of what it is that should be reported. Few are governed by any clear reporting protocol that all staff are aware of, understand and are trained to use.

There are different, and potentially conflicting, views on the purpose of adverse event reporting systems. Functions attributed to reporting systems include:
– spotting potential clinical negligence claims;
– identifying trends in different kinds of adverse event;
– handling media coverage;
– acting as the first stage in organisational learning.

There are no proper linkages between reporting systems. Such reporting mechanisms as do exist are not integrated and seldom interrelate to each other. The usefulness of adverse event reporting systems would be improved further if a formal mechanism to consider near misses were also integrated.

Analysis

5.5 Not only do the systems for collecting information on adverse events leave room for improvement, but there are also shortcomings in the way information is analysed and translated into advice and recommendations for action.

Best use is not made of available information. With the exception of the more specialised systems (e.g. confidential clinical enquiries, adverse drug and device reporting systems) data are not analysed or synthesised in a way that patterns or trends can be identified. In some cases little or no analysis is attempted beyond local level. It is a great irony, for example, that in the past individual health care workers have been urged to see complaints as a resource to learn from but no systematic attempt has been made to realise the huge potential of learning from complaints to benefit the NHS as a whole.

Analysis does not reliably take place across different systems. There is no reliable mechanism for analysing information collected through different reporting channels to distil common themes or lessons. At present, NHS information on adverse events is spread across nearly 1000 different organisations. This can mean that the NHS misses out on some of the more creative approaches to analysis which we highlight in chapter 3, and that common root causes of different kinds of adverse event go unrecognised.

Inquiries and investigations

5.6 As we have noted, there are a number of different provisions and mechanisms for holding internal or external inquiries into individual adverse events or into clusters of events. Yet on the evidence we have considered such inquiries, and in particular external inquiries, are not always effective learning tools for the NHS.

The threshold for inquiries or investigations is unclear. There is very little clarity about the circumstances under which some form of external investigation or inquiry is appropriate following an adverse event. The need for specific work to address this issue for mental health inquiries has already been recognised and specific work undertaken.

There is no clear framework or source of advice on the conduct of investigations. Even after a decision has been taken to conduct some form of inquiry or investigation, there is often little by way of consistent support of expertise available to NHS organisations or to inquiry teams in the conduct of the process. It is reasonable to suggest that this could result in a more protracted and costlier inquiry process, and may mean that an inquiry is less thorough or effective than might otherwise have been the case.

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Inquiry recommendations are not always sufficiently helpful or focused. No doubt partly as a consequence of the lack of advice and expertise in their conduct, the products of inquiries in the NHS – in common with those in other fields – are not always focused in a way which facilitates learning and implementation. For example, a recommendation which states that communications among professionals, or between professionals and patients, are poor (a fairly frequent theme in adverse events) and must be improved might not be very helpful because it does not provide the organisation(s) concerned with an operational change to implement.

Implementation and follow-up of recommendations is patchy. In common with other sources of learning on adverse events, follow-up work to implement the recommendations of inquiries is inconsistent. Often, inquiry recommendations have no clear status, or the quality and relevance of recommendations themselves may be in doubt.

There is no systematic mechanism for sharing more widely the learning from individual local adverse event investigations. There is powerful evidence that, time after time, inquiries and investigations identify similar or identical problems and make the same sorts of recommendations. Yet there is no system for drawing together these findings to draw out general trends or to emphasise wider priorities for action. The potential implications of inquiry reports beyond the immediate circumstances of the event in question may, therefore, not always be recognised.

Understanding adverse events

5.7 The level of understanding of the nature, causes and prevention of adverse events in the health care sector is poorly developed in comparison to many fields, for example industry and air transport.

There is little basic research into the nature, causes and prevention of adverse events in health care. Most of the scientific work has been done in contexts outside the health service. Whilst much of it is likely to be extendable to the health sector, this needs to be confirmed. Equally, where exceptions occur that are particular to the NHS, these must be identified and investigated specifically.

The concept of the 'system approach' is poorly developed. There has been rapid progress in many fields in identifying the place for 'whole system' response to adverse events. Inappropriate systems are commonly a more important contributory factor than individual failings or errors. Appropriate systems can do much to reduce the burden on individuals and the resulting risk of adverse events, and to mitigate the consequences. This approach needs to be better developed in the NHS.

Information is difficult for staff to access. NHS clinicians and other staff need to access information rapidly and conveniently in the context of busy schedules. This includes both general information on the causes of adverse events and approaches to risk minimisation, and specific information on particular hazards and pitfalls. Information systems are not yet uniformly well developed enough to deliver these requirements, inhibiting the ability of the NHS to respond positively.

Learning culture

5.8 Our review of the current position confirms that there are several key areas in which the NHS falls short of being a learning organisation at the outset.

There is too often a 'blame' culture. When things go wrong, the response is often to seek one or two individuals to blame, who may then be subject to disciplinary measures or professional censure. That is not to say that in some circumstances individuals should not be held to account, but as the predominant approach this acts as a significant deterrent to the reporting of adverse events and near misses. It also encourages serious underestimation of the extent to which problems are due not to individuals but to the systems in which they operate.

No account is taken of 'near misses'. Apart from the reporting systems run by the Medical Devices Agency and Medicines Control Agency, there is no mechanism to learn from adverse events which do not result in significant harm. The 'near miss' can provide valuable information to help prevent adverse events, and is regarded in many other sectors as an important free lesson. Moreover, research suggests that for every full-blown incident there are likely to be several hundred near-misses.

There is little culture of individual self-appraisal. The education of NHS professionals depends to a variable, but generally significant, extent on clinical apprenticeship – that is, on learning by example. This process rarely counteracts a burden of public expectation of infallibility, and may often reinforce it. Yet for the NHS to learn effectively from experience, these individuals must be able to admit that perfection is not always attained: firstly and most importantly, to themselves, and then to their fellows. Where the ability to self-appraise openly and frankly is absent, the negative effects of a 'blame culture' will be reinforced

Active learning

5.9 The NHS does not, in our experience, learn effectively and actively from failures. Too often, valid lessons are drawn from adverse events but their implementation throughout the NHS is very patchy. Active learning is mostly confined to the individual organisation in which an adverse event occurs. The

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"The NHS is *par excellence* a passive learning organisation"

NHS is *par excellence* a passive learning organisation. A number of specific weaknesses are apparent.

Some existing systems take a long time to report. The Confidential Enquiries, for example, operate to fixed timetables and produce periodic reports based on analysis of historic data. Depending on the Inquiry concerned, it can take between one and four years for the learning from an adverse event to be reflected in an inquiry report. Arrangements for giving interim feedback are not well-developed.

Implementation of recommendations takes a long time. What evidence we have on the implementation of Confidential Inquiry recommendations shows that it can take ten or fifteen years to bring about meaningful change once an inquiry has reported. We have cited one example, of suicide by hanging among mental health inpatients, of an issue which was first highlighted nearly 30 years ago but which is still a prominent problem in the NHS.

There is little or no systematic follow-up of recommendations. The recommendations arising from most reporting systems are left to individual bodies to follow up. Often it is left to future inquiry reports to comment on failures to implement earlier recommendations.

There is a lack of clarity about priorities for improvement. NHS organisations face a range of competing priorities for action from all sorts of sources. Often there is no authoritative indication of the relative priority which should be attached to particular issues.

Insufficient effort is made to target high-risk clinical procedures or to prevent the recurrence of specific catastrophic events. Research suggests that there are some procedures or areas of activity in which the likelihood of serious errors is relatively high and/or the consequences of errors are particularly serious. For example the potential consequences of obstetric and midwifery errors are very serious in human terms, and this is reflected in their prominence in litigation. There are also any number of highly complex technical procedures in which the inherent risk of error is relatively high simply because of the number of factors at work and the physical difficulty of the procedure. Similarly, there are certain very specific kinds of adverse clinical event which have recurred on a number of occasions with devastating consequences (for example the misadministration of anti-cancer drugs by spinal injection).

The possibility of developing design solutions to specific hazards is under-explored in health care. In other sectors significant efforts are being made to design equipment and products in a way which helps to minimise potential hazards, yet despite one or two examples of good practice which demonstrate its applicability to health care this approach has not yet been applied extensively or systematically in the NHS.

5.10 Table 5.1 summarises some of the key negative characteristics of the NHS's approach to adverse events, and juxtaposes the positive characteristics we believe it needs to develop in the future.

Table 5.1 A new approach to responding to adverse events in the NHS.

Past	*Future*
Fear of reprisals common	Generally blame-free reporting policy
Individuals scapegoated	Individuals held to account where justified
Disparate adverse event databases	All databases co-ordinated
Staff do not always hear the outcome of an investigation	Regular feedback to front-line staff
Individual training dominant	Team-based training common
Attention focuses on individual error	Systems approach to identifying hazards and prevention
Lack of awareness of risk management	General risk management awareness training provided
Short-term fixing of problems	Emphasis on sustaining risk reduction
Manipulative use of data	Conscientious use of data
Many adverse events regarded as isolated "one-offs"	Potential for replication of similar adverse events recognised
Lessons from adverse events seen as primarily for the service or team concerned	Recognition that lessons learned may be relevant to others
Passive learning	Active learning

5.11 Figure 5.2 further illustrates what we believe are some of the crucial steps in learning from adverse events. If any one of these is fundamentally flawed, the process as a whole will not perform effectively. Our recommendations, taken as a whole, are therefore aimed at achieving sustained improvements in each of the steps in this process.

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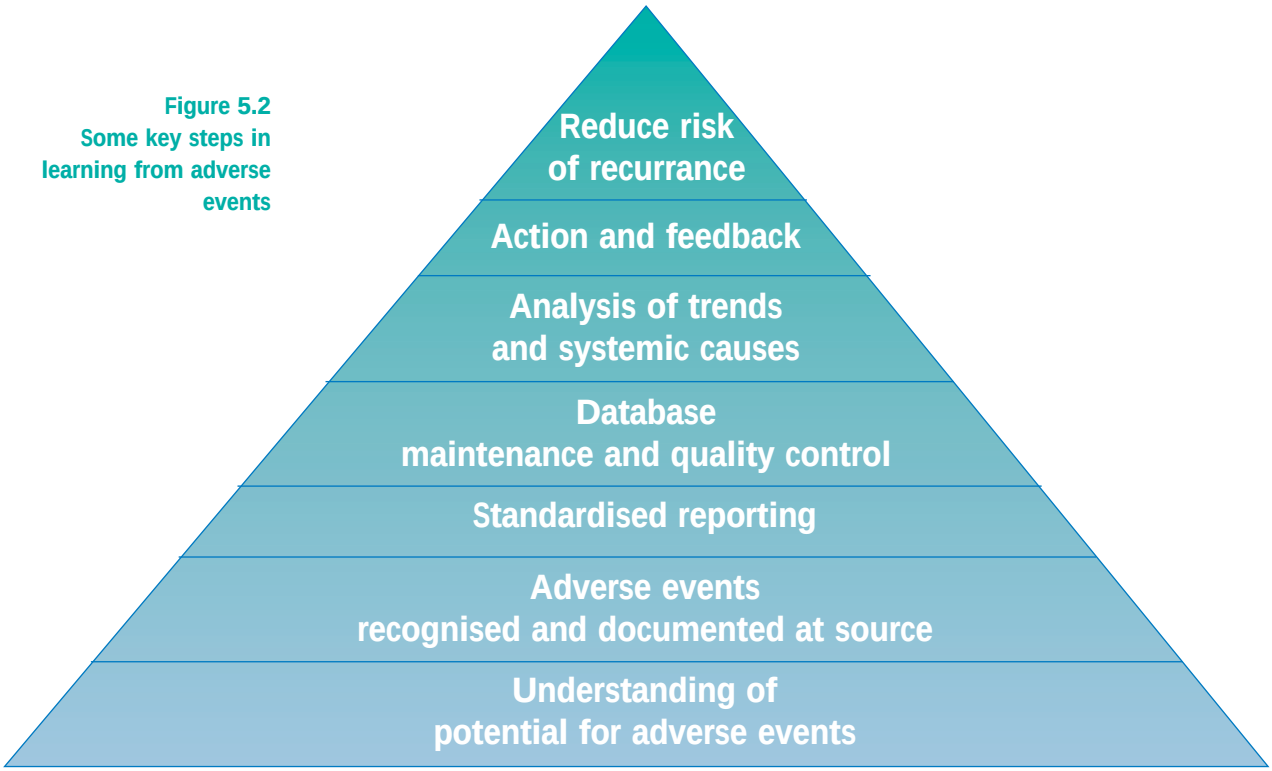

Figure 5.2
Some key steps in learning from adverse events

Recommendations

5.12 Drawing on the wide range of evidence and opinion we have considered in the course of our work, we make a number of recommendations aimed at addressing the problems and weaknesses identified.

Recommendation 1: Introduce a mandatory reporting scheme for adverse health care events and specified near misses

We recommend that a scheme should be introduced by the NHS Executive to ensure comprehensive reporting of adverse events and near-misses in NHS health care settings. We recommend that this scheme should:

- be rooted in sound, standardised local reporting systems, building on and developing the current local adverse event reporting system as recommended in the NHS Executive controls assurance standard 'Risk Management System';
- adopt as the basis for reporting the concepts of an adverse health care event (AHCE) and a health care near miss (HCNM), and that these are clearly defined. As a starting point for the development of agreed definitions, we suggest;

  'an adverse health care event (AHCE) is an event or omission arising during clinical care and causing physical or psychological injury to a patient';

  'a health care near miss (HCNM) is a situation in which an event or omission, or a sequence of events or omissions, arising during clinical

care fails to develop further, whether or not as the result of compensating action, thus preventing injury to a patient';

- operationalise these high-level definitions by developing, maintaining and making use of a set of detailed standardised categorisations of different types of adverse health care event and reportable near miss. These should be published in a standard manual detailing specific kinds of adverse event and near miss which must be reported (a) locally and (b) beyond the organisation concerned. We envisage that a 'filter' will operate so that only certain categories of event and near miss will be reported nationally or regionally. The coverage and sophistication of the categorisations should be improved over time;
- specify clearly in the manual the format in which adverse events and near misses should be reported. The reporting format and precise information to be collected should be determined only after thorough consideration of the analytical purposes to which it is to be put;
- adopt standardised computer software for adverse event and near miss reporting;
- set out clearly both the channels for reporting and the locus of responsibility for ensuring that reports are made, both within and where necessary beyond local organisations;
- be comprehensive in its coverage, incorporating all NHS organisations which deliver health care along with general practitioners and dentists treating NHS patients in primary care. The system should incorporate the arrangements for mandatory reporting of deaths in general practice announced by Health Ministers in the wake of the conviction of Dr Harold Shipman. It should also cover care provided on behalf of the NHS in private hospitals and clinics;
- be mandatory for both organisations and individuals;
- be run by an independent body which is perceived as neutral by health care staff.

Recommendation 2: Introduce a scheme for confidential reporting by staff of adverse events and near misses

We recommend that, until local reporting systems and cultures are sufficiently developed to allow all staff to feel that they can report all adverse events and near misses without fear of retribution, the national system described in Recommendation 1 should include provision for direct, confidential (but not anonymous) reporting of adverse events and near misses to regional or national level. This has been found to be of great importance in other sectors. The system should:

- be widely publicised and available to all NHS staff, as well as to family health services contractors and their employees. The viability of extending the scheme to staff in independent hospitals and clinics treating patients on behalf of the NHS should also be explored;

- have the capacity to follow-up near misses without revealing the identity of the reporter if he or she wishes. We recognise that in some circumstances it may be impossible or inappropriate to preserve anonymity – for example where there is evidence of gross negligence, criminal activity and/or a threat to patient safety and this cannot be addressed without disclosing the identity of the reporter – and this should be openly acknowledged;
- be regarded as a mechanism to be used in exceptional circumstances, with reporting channelled wherever possible through the new system described in R.1.;
- be kept under regular review as local systems and cultures develop, to determine whether continued provision of a direct confidential reporting facility, as an adjunct to the main mandatory reporting systyem (see R.1.), is both necessary and desirable.

Recommendation 3: Encourage a reporting and questioning culture in the NHS

We recommend that the NHS should encourage a reporting culture amongst its staff which is generally free of blame for the individual reporting error or mistakes, and encourage staff to look critically at their own actions and those of their teams. We acknowledge that significant progress has been made in this area in recent months and years, but believe that there is scope for further action in a number of key areas:

- NHS Trusts, Health Authorities, Primary Care Trusts and Primary Care Groups should use the implementation of clinical governance as an opportunity specifically to reinforce their procedures for adverse health care events, stressing in particular the responsibilities of all staff for reporting events and the duty of the organisation to treat individual members of staff justly, with no prior assumption of blame. General risk management awareness training for staff should be part of this process;
- local annual clinical governance reports should include explicit statements of the organisation's adverse event reporting policy, and where possible should display evidence both of real changes effected as a result of reporting and of a just approach to individuals who report their own errors;
- the provision for confidential reporting recommended in R.2. should help to give staff the confidence to report information which might otherwise go undetected;
- the NHS Executive nationally and regionally, and NHS organisations locally, should work proactively to ensure accurate media reporting of adverse events and to foster a greater public understanding of the issues involved.
- all those responsible for the initial and continuing training and education of doctors, nurses and other clinicians should address the development of an approach to frank self-appraisal. This will involve exposing clinicians to the appropriate culture of blame-free assessment and learning at every level, from undergraduate through postgraduate training to life-long learning.

Recommendation 4: Introduce a single overall system for analysing and disseminating lessons from adverse health care events and near misses

We recommend that a single overall system should be devised for analysing and disseminating lessons from adverse health care events and near misses. This system should:

- receive reports of agreed categories of events notified through the mechanisms described in R.1. and R.2.;
- analyse them in such a way that common factors and causes can be identified;
- consider and specify the action necessary to reduce risks to future patients throughout the NHS;
- ensure that feedback is provided in a way which encourages continued reporting;
- be managed or overseen by a single organisation.

Recommendation 5: Make better use of existing sources of information on adverse events

We recommend that, to facilitate fuller and more effective use of information from existing sources of information on adverse health care events:

- the new analysis and dissemination system recommended in R.4. should incorporate information and identified trends from the NHS complaints system, from litigation activity and from other reporting and analysis systems to ensure that maximum cumulative learning is extracted from these resources;
- the NHS Executive should use the opportunity provided by the forthcoming report of its complaints system evaluation to examine ways in which greater use of patient complaints as a learning resource could be encouraged and facilitated, both locally and nationally;
- the NHS Litigation Authority should work with the medical defence organisations to ensure that maximum learning is drawn from analyses of the extensive information available on clinical negligence litigation. This learning should in turn be fed into the new overall analysis and dissemination proposed at R.4.;
- patient and carer input, which can be of tremendous value in learning from adverse events, should be actively sought at each stage of the process. Systematic efforts should be made to involve patients and carers in work to implement the recommendations of this report.

Recommendation 6: Improve the quality and relevance of NHS adverse event investigations and inquiries

We recommend that the NHS Executive should work with the Commission for Health Improvement to improve the quality and relevance of adverse event

investigations and inquiries in the NHS. In particular, the NHS Executive should:

- clarify the arrangements for local adverse event handling (including reporting – see R.2.), and offer further guidance to the NHS on the thresholds for different types of response, including inquiries;
- ensure that the Commission for Health Improvement as an early priority in its work programme, develops a national role in advising on process and conduct issues with the aim of ensuring higher quality and greater standardisation of inquiry conduct. Its advice should cover the framing of recommendations so that they are of maximum help to the organisation(s) concerned, and where appropriate to the NHS as a whole, in effecting practical change;
- ensure that inquiry recommendations and findings are wherever possible fed into to the proposed national adverse event reporting scheme and the associated database.

Recommendation 7: Undertake a programme of basic research into adverse health care events in the NHS

We recommend that a programme of basic research into adverse events in the NHS be commissioned by the Research Council and the NHS R&D programme. Specific foci of this programme should include:

- the incidence, nature and causation of health care adverse events;
- the extent to which knowledge from other fields is transferable to the health sector;
- practical approaches to risk minimisation and the takeup of learning; and
- the contribution of system approaches in health care;
- the use of automated methods to monitor and evaluate the performance of clinical interventions (the creation of a clinical 'black box').

Recommendation 8: Make full use of new NHS information systems to help staff access learning from adverse health care events and near misses

As NHS information systems, such as the new National Electronic Library for health, are developed to bring more rapid and convenient access to clinical and other staff, we recommend that priority is given to including access to information needed in this area. The aim should be to:

- increase knowledge on the processes of learning from experience and risk minimisation;
- include systematic information on particular causes of adverse events and how to avoid their repetition;
- present information in ways which are accessible to busy health professionals and managers;

- tailor messages and routes of communication to the needs of specific audiences; and
- maximise the contribution that improvements in information systems (such as the introduction of the Electronic Patient Record, the development of electronic prescribing systems and easy access to up to date guidelines and protocols) can make to active learning and the prevention of adverse events.

Recommendation 9: Act to ensure that important lessons are implemented quickly and consistently

We recommend that specific action is taken by the NHS Executive, the National Institute for Clinical Excellence and the Commission for Health Improvement to ensure that that important lessons from failures are quickly and reliably acted on in the NHS and that improvement is sustained. In particular, we recommend that:

- the NHS Executive should offer greater support to the NHS in prioritising actions arising from learning on adverse events. There should be a single focus within the NHS Executive for making these decisions and for ensuring that implementation is driven forward. Where appropriate, resource considerations should be taken into account when determining implementation priorities;
- the importance of implementing key lessons from adverse events, including specifically the recommendations of the Confidential Inquiries, should be given greater weight nationally by the NHS Executive as a core component of clinical governance;
- the NHS Executive should give urgent consideration to the role which routine performance management should play in ensuring that key findings from adverse event analysis are disseminated and acted upon by NHS bodies as a part of their wider clinical governance responsibilities;
- the National Institute for Clinical Excellence (NICE), as the body which now has responsibility for the operation of the Confidential Inquiries, should explore with the Chairmen and Directors of those Inquiries the possibility of developing ‘fast track’ processes to allow them to generate specific recommendations outside the normal reporting cycle if sufficiently serious issues emerge. We recommend that NICE should also explore with the Inquiries the options for enabling them to give more systematic feedback to individual units if a serious ongoing threat to patient safety is identified, provided this does not compromise the confidential nature of the process;
- in developing its review and reporting process for clinical governance, the Commission for Health Improvement should make provision to comment specifically on the uptake of recommendations arising from adverse event analysis and provide feedback to the relevant reporting and analysis systems to inform future work;
- both the NHS Executive and the Commission for Health Improvement

should remain alert for evidence that improvement is not being sustained or that progress is slipping back, so that interventions can be planned if necessary.

Recommendation 10: Identify and address specific categories of serious recurring adverse health care event.

We recommend that there should be an explicit focus on identifying and addressing very specific serious categories of recurring serious adverse event. We recommend that as part of this work:

- the NHS Litigation Authority should be given a stronger educational remit, to work with professional bodies and the medical defence organisations to publicise high-risk areas and risk-reduction activities among managers and clinicians;
- steps should be taken to ensure better use of existing information on areas of practice and individual procedures which pose relatively high risks, in frequency of error and / or the consequences of error. Consideration should be given to the production and piloting of standardised procedural manuals and safety bulletins which it is obligatory to use when embarking on specific high-risk procedures. This work might be co-ordinated by the National Institute for Clinical Excellence;
- the NHS Executive and the Medical Devices Agency should consider how the more systematic application of design solutions could be encouraged as one means of minimising specific hazards;
- the Department of Health should establish groups to work urgently to achieve four specific aims:
  - by 2001, reduce to zero the number of patients dying or being paralysed by maladministered spinal injections (at least 13 such cases have occurred in the last 15 years);
  - by 2005, reduce by 25% the number of instances of negligent harm in the field of obstetrics and gynaecology which result in litigation (currently these account for over 50% of the annual NHS litigation bill);
  - by 2005, reduce by 40% the number of serious errors in the use of prescribed drugs (currently these account for 20% of all clinical negligence litigation);
  - by 2005, reduce to zero the number of suicides by mental health inpatients as a result of hanging from non-collapsible bed or shower curtain rails on wards (currently hanging from these structures is the commonest method of suicide on mental health inpatient wards).

Sound baselines will first need to be established for the second and third of these areas in particular, and it is important to recognise that in the short-term the number of recorded events may rise as reporting and recording systems improve.

ANNEX A

Membership of the Expert Committee on Learning from Experience in the NHS

Professor Liam Donaldson	Chief Medical Officer (Chairman)
Professor Louis Appleby	Professor of Psychiatry, School of Psychiatry and Behavioural Science, University of Manchester
Dr Jonathan Boyce	Director of Health Studies, Audit Commission
Mr Michael Buckley	Health Service Commissioner
Professor James Drife	Professor of Obstetrics and Gynaecology, University of Leeds
Professor Jenny Firth-Cozens	Director for the Centre of Clinical Psychology Research, University of Northumbria
Mrs Patricia Hart	Director of Nursing and Patient Services, Oxford Radcliffe Hospital
Dr Bill Kirkup	Regional Director for Public Health, NHS Executive Northern and Yorkshire Region
Professor Marc de Leval	Professor of Cardiothoracic Surgery, Great Ormond Street Hospital for Children
Dr Nick Naftalin	Medical Director, Leicester Royal Infirmary NHS Trust
Professor James Reason	University of Manchester Department of Psychology
Ms Marianne Rigge	College of Health
Mr Ken Smart	Chief Inspector of Air Accidents, Air Accident Investigation Branch, Department of Environment, Transport and the Regions
Professor Denis Smith	Professor of Management and Head of the Centre for Risk and Crisis Management, University of Sheffield
Professor Brian Toft	Director, Marsh Risk Consulting, Marsh UK Ltd.
Dr Charles Vincent	Reader in Psychology, University College London
Mr Steve Walker	Chief Executive, NHS Litigation Authority
Mr John Llewellyn Williams	Chairman, National Confidential Enquiry into Peri-Operative Deaths
Mr Bill Worth	Chief Executive, North Durham Healthcare NHS Trust

Secretary to the Expert Committee: Mr Simon Reeve, NHS Executive Quality Management Team

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Room D4.17
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Stormont
BELFAST
BT4 3SJ
Tel No: (01232) 522795
FAX No: (01232) 528126
E-Mail: john.mcgrath@dhsspsni.gov.uk

Chief Executives, HSS Boards
Chief Executives, HSS Trusts and Special Agencies;
Chairs, Local Health and Social Care Groups
Chief Officers, HSS Councils

13 January 2003

Dear Colleague

GOVERNANCE IN THE HPSS –
Clinical and Social Care Governance: Guidelines for Implementation

Summary

1. This guidance is intended to enable you to formally begin the process of developing and implementing clinical and social care governance arrangements within your organisation or area of responsibility with effect from the date of receipt of this circular. It should be read in conjunction with guidance already issued on the implementation of a common system of risk management across the HPSS and the development of controls assurance standards for financial and organisational aspects of governance.

Background

2. The consultation document "Best Practice – Best Care" set out proposals for a framework to improve the quality of services delivered by the Health and Personal Social Services (HPSS). Decisions on the way forward with implementing these proposals were announced in July 2002 focusing on three main areas:

   (i) arrangements for setting clear standards for services;

   (ii) mechanisms for promoting local delivery of high quality health and social care services through clinical and social care governance arrangements, reinforced with a statutory duty of quality. These arrangements will be supported by programmes of continuous professional development and lifelong learning and strengthened by enhanced arrangements for professional regulation; and

(iii) effective systems for regulating services and monitoring the delivery of services.

3. In July 2002 the Department wrote to Chief Executives of HSS Boards, Trusts, Special Agencies and Chairs of Local Health and Social Care Groups setting out these new arrangements in more detail and enclosing a draft circular on clinical and social care governance for comment. The attached circular has been revised to take account, as far as is possible, of comments received from the HPSS.

4. The requirements set out in this circular have been kept to a minimum for this stage. The detailed requirements arising from clinical and social care governance will be developed in conjunction with the HPSS starting with a series of workshops across Board areas in January/February 2003. Further guidance will be issued as necessary.

Action Needed

5 While it is recognised that there has been some progress in developing clinical and social care governance arrangements, what has been lacking is a consistent approach throughout the region. This guidance builds on the work of the past and maps out the way ahead, providing a management framework for clinical and social care governance. The following is the minimum list of actions, covered in greater detail in the circular, which need to be taken by each organisation.

- The appointment of a senior professional at board level to provide leadership in relation to clinical and social care governance arrangements and processes.

- The designation of a committee to be responsible for the clinical and social care governance of the organisation. This may be an entirely new committee or the function could be taken on by an existing committee e.g. the Risk Management Committee.

- An evaluation of the current clinical and social care governance arrangements in the organisation to establish the baseline from which developments must begin.

- The formulation of a plan for the development and maintenance of clinical and social care governance arrangements.

- A system to deliver routine progress reports to the board and a formal progress report within the organisation's Annual Report.

6. The structure of this circular is as follows:

- Introduction
- Key Policy Objectives
- The Challenge
- Tailoring Guidance to Individual Organisations
- Monitoring Performance
- Next Steps
- Resources
- Further Guidance

For ease of reference the following paragraphs summarise what is covered by each section.

INTRODUCTION (Paragraphs 1-3) **Page 5**

This section explains the purpose of the circular, acknowledges what some HPSS organisations are already doing and points to the need for all to follow this guidance.

KEY POLICY OBJECTIVES (Paragraphs 4-19) **Pages 5-8**

This section identifies the key elements of the strategy for improving quality in the HPSS and sets clinical and social care governance in the context of the wider quality agenda. It covers the statutory duty of quality, defines clinical and social care governance and deals with the culture change that will flow from these new arrangements.

THE CHALLENGE (Paragraphs 20-38) **Pages 8-13**

This section sets out the challenge to HPSS organisations to ensure that implementation of clinical and social care governance is successful. It identifies the key steps which all HPSS organisations will need to take in the first year and focuses on establishing accountability and leadership arrangements; assessing the organisation's baseline position; agreeing a development plan and implementing that plan.

TAILORING GUIDANCE TO INDIVIDUAL ORGANISATION'S NEEDS (Paragraphs 39-48) **Pages 13-15**

This section provides guidance on how organisations may tailor the guidance to meet their particular organisational needs while adhering to the underlying principles of clinical and social care governance and the statutory duty of quality.

MONITORING PERFORMANCE (Paragraphs 49-54) **Pages 15-16**

This section refers to arrangements for monitoring clinical and social care governance and sets out the core functions of the new Health and Social Services Regulation and Improvement Authority.

NEXT STEPS (Paragraph 55) **Pages 16-17**

This section lists the actions (with effective dates) that must be taken by the Department and HPSS organisations.

RESOURCES (Paragraph 56) Page 17

FURTHER GUIDANCE (Paragraph 57) Page 17

INTRODUCTION

1. The purpose of this circular is to provide guidance specific to clinical and social care governance. The Department recognises that many HPSS organisations have already begun to develop their own systems for clinical and social care governance based on guidance issued in England Scotland and Wales. While there are many parallels in approach, our arrangements for clinical and social care governance must take account of the organisational structures and manner of delivery of services currently in place here. This guidance must be read in the context of guidance already issued on the implementation of a common system of risk management across the HPSS and the development of controls assurance standards for financial and organisational aspects of governance.

2. It is important, therefore, that while much good work has already been done in relation to the development of clinical and social care governance, from now on all organisations must apply the principles set out in this guidance.

3. It is not intended to be prescriptive on an exact model to be used. It is for your organisation or group, together with your co-workers, staff, users and local communities to determine how best to implement arrangements which take account of the services delivered by you and your organisation at every level. This circular does, however, set a framework for action which highlights the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure delivery of high quality health and social care.

KEY POLICY OBJECTIVES

4 The key elements of the strategy for improving quality in the HPSS are:

(i) arrangements for setting clear standards for services;

(ii) mechanisms for promoting local delivery of high quality health and social care services through clinical and social care governance arrangements, reinforced with a statutory duty of quality. These arrangements will be supported by programmes of continuous professional development and lifelong learning and strengthened by enhanced arrangements for professional regulation; and

(iii) effective systems for regulating services and monitoring the delivery of services.

Statutory Duty of Quality

5. Clinical and social care governance arrangements within organisations which provide or commission services will be underpinned by a statutory duty of quality. The introduction of this duty will mean that accountability for the quality of services provided, including commissioning, is comparable with the statutory duty that exists on HPSS bodies in relation to the financial management of their organisations.

6. The statutory duty of quality will apply to Health and Social Services Boards (HSS Boards), Health and Social Services Trusts (HSS Trusts), and some Special Agencies

(the Regional Medical Physics Agency, the Northern Ireland Blood Transfusion Agency and the NI Guardian ad Litem Agency) for the services they commission and provide to the public. While the statutory duty of quality will not, for now, directly apply to the management boards of Local Health and Social Care Groups (LHSCGs), the Central Services Agency (CSA) and the remaining Special Agencies, they too must put in place effective clinical and social care governance arrangements which will also be subject to monitoring.

7. Everyone employed in the organisation, individuals, teams and corporate board members, have a role to play in ensuring effective clinical and social care governance arrangements work throughout their organisation and must be aware of their role and responsibilities.

What is clinical and social care governance?

8. "Best Practice – Best Care" defines clinical and social care governance as a framework within which HPSS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment. Clinical and social care governance is about organisations taking corporate responsibility for performance and providing the highest possible standard of clinical and social care.

9. The clinical and social care governance framework is intended to build on and strengthen existing activity relating to the delivery of high quality care and treatment. This includes activity on:

- audit;
- identifying, promoting and sharing good practice, learning lessons from best practice as well as poor performance.
- risk assessment and risk management;
- adverse incident management;
- quality standards;
- complaints management;
- clinical and social care effectiveness;
- evidence-based practice;
- research and education;
- effective leadership and management;
- a clear policy aimed at improving communication between management, users, staff and local communities;
- policies aimed at securing effective user involvement, and which enable local communities to engage in all aspects of clinical and social care governance;
- effective recruitment and selection procedures;
- continuing professional and personal development; and
- professional regulation.

10. The framework is designed to bring all of these components together to secure a co-ordinated approach to the provision of high quality care and treatment, while ensuring a greater focus on the standard of clinical and social care practice. This will ensure that high quality, effective treatment and care is delivered and that where things do go

wrong, they are quickly addressed and lessons are learnt to help prevent re-occurrence.

11. Clinical and social care governance is central to achieving improvements in the quality of services provided in the HPSS. Its successful development and delivery is crucial to the overall success of the framework for quality improvement.

12. The integration of health and social services means that governance arrangements must include social care in addition to clinical care, where operationally appropriate, within HSS Boards, LHSCGs, HSS Trusts, the CSA and Special Agencies. In addition, local arrangements for clinical and social care governance must complement the existing roles and management and executive professional responsibilities in place within HSS Boards and HSS Trusts.

Changing Culture

13. The introduction of clinical and social care governance arrangements will bring about a fundamental change in the culture of HPSS organisations. Clinical and social care governance is about developing a culture that safeguards high standards, promotes and supports improvements in practice and in the treatment and care delivered. This culture needs to be one of openness, transparency, listening to the views of users, staff and local communities, learning, sharing information and developing partnerships.

14. A culture that encourages open discussion and reflection on practice allows staff to learn from their experiences. This includes both celebrating what is done well and learning from what is done less well. If an organisation is to encourage staff to report incidents and learn from mistakes, it must develop an open and honest culture, rather than one of blame and shame and a reliance solely on disciplinary procedures. Developing the right culture is perhaps one of the biggest challenges in establishing clinical and social care governance processes. It will take dynamic leadership, time and commitment from all levels of the organisation.

Effective User and Community Involvement

15. Effective user and community involvement is crucial to the delivery of high quality treatment and care. Clinical and social care governance arrangements must involve users in ways that are meaningful, appropriate and acceptable to them. Each organisation needs to have a clear policy about and strategy for securing user and local community involvement. Involving users will provide a means whereby organisations can show that they are accountable to the population they serve. It can also help to improve staff/user communication and understanding as well as make use of the specific expertise that users have to offer. Similarly, HPSS organisations need to have regard to the relationship they have with their local communities and to consider how best these communities can be empowered to participate in the arrangements for clinical and social care governance.

16. "Token involvement syndrome" must be avoided. Users and local communities can and should play a much more meaningful role in the planning and delivery of services. They could for example identify issues that may inform the way in which information is gathered or through a partnership approach with professionals, they

could help determine the scope, focus and outcome of a service initiative. Organisations will wish to take account of the work and expertise developed by Health and Social Services Councils

17. Ultimately the effective involvement of users and local communities within clinical and social care governance arrangements will be determined by the approach taken by individual organisations

Development of Clinical and Social Care Governance

18. While those HPSS organisations which have already begun developing arrangements are to be commended for the work they have already done, clinical and social care governance is a dynamic and continuous process and full implementation will be an evolving process. There are however some practical steps that all HPSS organisations should address.

19. These involve setting up local structures to ensure clinical and social care governance arrangements are in place. Whilst the range of local structures will be dependent on the size and complexity of each organisation, there are some core arrangements which should always be put in place. These are establishing and maintaining:

- clear lines of responsibility and accountability for the overall quality of treatment and care;
- effective systems to identify, value, promote and share good practice within the organisation and where appropriate outwith the organisation particularly in circumstances where services are commissioned from an external provider;
- a comprehensive programme of quality improvement activities, including arrangements for ensuring users and local communities will be fully involved in securing high quality services;
- clear policies aimed at assessing and managing risk; and
- an open, honest and proactive system where people can report poor performance, near-misses and adverse events to allow them to be appropriately dealt with, lessons learnt and shared within and where appropriate outwith the organisation.

THE CHALLENGE

20. Clinical and social care governance has significant implications for the way in which HPSS organisations will conduct their business. Issues relating to the quality of clinical and social care provision will feature highly on their agenda and will form an equal and complementary strand with financial and organisational governance issues in their accountability.

21. The leadership provided within HPSS organisations will be the key to creating a culture and environment where the delivery of the best possible standards of care and treatment is seen to be the responsibility of everyone in the organisation.

Where are we now and what do we need to do?

22. Whilst it is recognised that HPSS organisations may already have made varying degrees of progress in developing governance arrangements, there are key steps which all HPSS organisations will need to take in the first year. These are:

Step 1: establishing leadership, accountability and working arrangements;

Step 2: depending on how advanced clinical and social care governance arrangements are within an organisation either:

(a) review their current arrangements and progress towards complying with the principles set out in this guidance;

or

(b) carry out an initial baseline assessment of capacity and capability;

Step 3: formulate a development plan, in the light of this review or assessment securing agreement and support for this plan across the organisation; and

Step 4: clarify reporting arrangements for clinical and social care governance as part of the management of the organisation and arrange for the preparation of an annual report on what has been achieved and what is planned for subsequent years.

Taking these steps is the key requirement arising from this circular. The following paragraphs set out guidance in relation to each of the four steps.

Step 1: Establish leadership, accountability and working arrangements

23. The Chief Executive of each organisation will be accountable to his/her board for the delivery of quality, treatment and care by the organisation in the same way as he/she is already responsible for financial and organisational matters.

24. The following paragraphs set out the suggested leadership arrangements within HPSS organisations that commission or provide services directly to the public. It is important to remember, however, that whatever leadership arrangements are decided upon it is essential that all organisations demonstrate:

- **inclusivity:** ensuring that all staff in the organisation are involved and kept fully informed about the purpose and progress of the clinical and social care governance programme;

- **commitment from the top:** reporting and having access to the Chief Executive and the board, particularly when problems need to be resolved or barriers to progress have been identified;

- **good external relationships:** forging strong open working partnerships with users, local communities, health and social care organisations and other agencies in the locality;

- **good internal relationships:** forging ownership of clinical and social care governance by the employees of an organisation;

- **continuing focus:** keeping the arrangements on course and not being deflected from the goals that the organisation has set itself;

- **accounting for progress:** being able, on request, to provide a comprehensive overview of progress with the clinical and social care governance arrangements programme throughout the organisation; and

- **communication:** with all staff in the organisation and with external partners, users and local communities on a regular basis.

Leadership arrangements within all organisations

25. The Chief Executive of each organisation (or in the case of LHSCGs the management board) will designate a senior professional at board level to support him or her in the discharge of his or her role as accountable officer for the delivery of quality care and treatment within the organisation. The leadership arrangements will differ according to local circumstances but it is likely that the senior professional will wish to assemble a multi-disciplinary team, with each member having responsibility for different aspects of the arrangements. It may well be that such a multi-disciplinary team has already been established as part of the organisation's overall approach to risk management.

26. It is proposed that this senior professional will provide leadership in relation to clinical and social care governance arrangements and processes. He/she will support and encourage good practice, while ensuring that where problems are identified, appropriate remedial action is taken.

27. The senior professional will also develop local systems for engaging the views of users and staff and mechanisms that will support the dissemination of clinical and social care standards, best practice and innovation. In addition the senior professional will be expected to put in place mechanisms for ensuring the production of clinical and social care governance reports. The senior professional will look to other key professional and staff groups to provide support. They will need to meet as often as necessary to promote and maintain a culture of quality and will be monitored on behalf of the organisation by the committee with responsibility for clinical and social care governance.

Leadership arrangements – Committee of the board with responsibility for clinical and social care governance

28. HPSS organisations to which the statutory duty of quality applies, must designate a Committee to be responsible for the oversight of the clinical and social care governance of the organisation. This may be an entirely new committee or the function could be taken on by an existing committee e.g. the Risk Management Committee.

29. The Committee with responsibility for clinical and social care governance should represent an appropriate balance of skills and interests and organisations should give consideration to how they can best ensure user and local community input into discussions about the development and maintenance of clinical and social care governance at the various levels of the organisation.

30. The Committee will be responsible for assuring the organisation's board that effective and regularly reviewed structures are in place to support the implementation and development of clinical and social care governance. The Committee must ensure:

- that where problems are identified, appropriate remedial action is taken;
- local community and user input into the development and maintenance of clinical and social care governance arrangements;
- effective mechanisms for engaging the views of users and staff are developed; and
- the provision of a report, to the board, which includes recommendations and any remedial action taken or proposed if there is an internal failing in systems or services.

31. The Committee should appoint a chair. In most organisations this should be a Non-Executive Director. The organisation's Chief Executive and other Executive Directors may be invited to attend meetings. The Committee should meet as often as required to discharge its role effectively and efficiently but not less than three times a year.

Step 2(a): Review current arrangements or progress towards complying with the principles set out in this guidance

32. For those organisations, which have begun to develop their own systems for clinical and social care governance, a review of current clinical and social care governance arrangements should be undertaken in light of this guidance. The review should include a report on the progress made towards complying with the components and features set out in paragraph 9 above as well as an assessment of the extent to which the criteria in Step 1 have been applied in relation to leadership and management.

or

Step 2(b): Carry out a baseline assessment of capacity and capability

33. For those organisations, which have not begun to develop a system of clinical and social care governance, implementation should start with a baseline assessment of the organisation's position. The baseline assessment should include:

- an analysis of the organisation's strengths and weaknesses in relation to current performance on quality;
- identification of any particularly problematic services;
- assessment of the extent to which data is in place for quality surveillance;
- establishing whether there are deficiencies in existing key mechanisms;
- ensuring integration of quality activities and systems;
- making clear the links with health and wellbeing investment programmes, delivery plans and local priorities; and
- designing ways in which underpinning strategies such as information management and technology, human resources, continuing professional development and research and development will support clinical and social care governance.

34. The review/baseline assessment (whichever is appropriate) should let the whole organisation see what it is good at, what it is less good at, and the areas needing to be developed. It should provide the basis for a development plan that includes clear milestones. When a quality initiative has significant resource consequences, discussions should take place within the context of the health and wellbeing investment plans, taking account of planned service development frameworks (when in place) and the available resources. Decisions will have to be made about which improvements are feasible and at what pace.

Step 3: Formulate a development plan and secure agreement across the organisation in the light of this review/assessment

35. On the basis of the review/baseline assessment, organisations can then establish a plan for developing and maintaining clinical and social care governance arrangements. This should address issues such as reducing any gaps in current performance, developing infrastructure (ie reporting structures, information management and technology, human resources etc), identifying and responding to staff development and organisational developmental needs and resource implications. The aim should be to build on existing best practice.

Step 4: Clarifying reporting arrangements

36. Organisations will be expected to include an up-date on progress in the development of clinical and social care governance arrangements in their Annual Reports for 2002-2003. Thereafter they will be expected to devote a specific section in subsequent

Annual Reports, giving a full account of their activities related to clinical and social care governance, what has been achieved and what is planned for subsequent years. In addition, organisations should ensure that they have appropriate mechanisms in place to deliver routine reports to the board on progress made in implementation, building on current best practice arrangements.

37. Clinical and social care governance reports for all organisations should attempt to answer three broad sets of questions about implementation

- *Where did we start?* – the review/baseline position;
- *What progress have we made?* - the development plan for the year and the monitoring and evaluation undertaken; and
- *Where are we going?* – the development plan for the coming year.

38. It is important to remember that each organisation will have to develop systems in accordance with its structure and responsibilities.

TAILORING GUIDANCE TO SUIT INDIVIDUAL ORGANISATION'S NEEDS

Health and Social Services Boards (HSS Boards)

39. HSS Boards will be expected to adopt the principles of clinical and social care governance in relation to all services they provide or commission. The principles will guide the planning of services and the development of Health and Wellbeing Investment Plans.

40. HSS Boards will be responsible for developing a culture that encourages high quality treatment and care. They will also be responsible for ensuring a high quality public health function and that the local health and social care infrastructure encourages open, confident, and responsive quality treatment and care provision.

41. As outlined at paragraph 23, the Chief Executive of each HSS Board will be responsible and accountable to his/her organisation's board for ensuring the HSS Board's responsibilities with regard to clinical and social care governance are discharged. The Chief Executive will be expected to look to his/her Professional Directors to provide support.

42. In addition to the steps outlined at paragraph 22, the HSS Boards should:

- identify the priorities for quality improvement in the HSS Board area through mechanisms such as needs assessment processes and as identified in local and regional action plans and other sources of information;
- base decisions on investment and action on the basis of these priorities;
- recognise and promote good practice within their own organisation and those organisations from which they commission services;

- ensure good clinical and social care governance of the HSS Board's own internal processes and functions such as public health, communicable disease control, and clinical and social care advice on commissioning;

- support, facilitate and ensure the development of clinical and social care governance amongst all local HPSS organisations, including LHSCGs.

Health and Social Services Trusts (HSS Trusts)

43. HSS Trusts will be expected to adopt the principles of clinical and social care governance in relation to all services they provide directly or commissioned by the Trust. The principles will guide the provision of services and the development of Trust Delivery Plans. Chief Executives in line with the statutory duty of quality must make sure that their organisations have in place effective clinical and social care governance arrangements.

44. In addition to the steps outlined in paragraph 22, HSS Trusts should:

- recognise and promote good practice within their own organisation and those organisations from which they commission services;

- reflect the pursuit of quality in Trust Delivery Plans; and

- have regard to/support the clinical and social care governance arrangements within other organisations locally.

Central Services Agency and the Special Agencies

45. Central Services Agency and the four Special Agencies, the Regional Medical Physics Agency, the Northern Ireland Blood Transfusion Agency, the Health Promotion Agency and the Guardian ad Litem Agency will be expected to adopt the principles of this guidance in relation to the services they provide and commission. In addition the Chief Executives of the Regional Medical Physics Agency, the Northern Ireland Blood Transfusion Agency and the Guardian ad Litem Agency will be responsible and accountable to their respective boards for the quality of care (as they will have a statutory duty of quality for the services provided directly to the public) provided by that agency in the same way as they are already responsible for financial matters. It will be for each Agency's board to develop the framework appropriate to discharge their relevant responsibilities, in line with general principles set out in this guidance.

Local Health and Social Care Groups (LHSCGs)

46. The establishment of LHSCGs provides an organisational platform around which a system of clinical and social care governance can be developed. The principles of clinical and social care governance apply to all LHSCGs including independent contractors. (Further guidance will be issued on this). Therefore the steps outlined in paragraph 22 and subsequent paragraphs, apply equally to LHSCGs. The leadership structure may differ according to the size and complexity of the LHSCG. The following paragraphs are intended to give an example of a structure for clinical and social care governance within LHSCGs.

Deleted: and subsequent aragraphs - ??

47. Each LHSCG should appoint a professional at management board level (a clinical and social care governance lead) to co-ordinate clinical and social care governance activities. This professional, who will need to be supported by a local sub-group or task group will:

- review current arrangements, carry out a baseline assessment and formulate a development plan;
- ensure that clinical and social care governance activity takes place across the whole of the LHSCG in a planned way;
- provide leadership in relation to clinical and social care governance arrangements within the LHSCG;
- co-ordinate the efforts of the LHSCG in the pursuit of the provision of high quality services;
- support and encourage good practice, while ensuring that where problems are identified appropriate remedial action is taken;
- develop mechanisms for engaging the views of users, local communities and staff;
- identify a development programme to meet the individual and organisational needs of all staff who work within the LHSCG, and work collaboratively with other organisations to meet these needs;
- have regard to the clinical and social care governance arrangements within other organisations; and
- ensure that there is an agreed mechanism in place for reporting progress on clinical and social care governance.

48 The clinical and social care governance lead will account to the management board of the LHSCG, which in turn will account to the HSS Board for the implementation of clinical and social care governance activities at LHSCG level.

MONITORING PERFORMANCE

Monitoring of Clinical and Social Care Governance Arrangements

49. Monitoring of clinical and social care governance will take several forms. The Department through its accountability arrangements will monitor implementation in HSS Boards, HSS Trusts, the Central Service Agency and Special Agencies. HSS Boards will provide the first line of external monitoring for its development within LHSCGs.

50. In addition, the new Health and Social Services Regulation and Improvement Authority (HSSRIA) will provide the independent monitoring of clinical and social care governance. The HSSRIA will have the following core functions:

- regulate services;
- inspect services;
- provide advice;
- conduct reviews of clinical and social care governance arrangements;
- carry out systematic service reviews; and
- undertake investigations.

51. It is intended that the powers of HSSRIA will be wide ranging. In addition to the regulatory function, it will take the lead in conducting reviews of clinical and social care governance arrangements. It will, through a rolling programme of local reviews of HPSS organisations, independently scrutinise the arrangements developed to support, promote and deliver high quality services. It will also help organisations identify and tackle serious or persistent shortcomings in clinical or social care service delivery. The ultimate aim of HSSRIA will be to support HPSS organisations in the delivery of high quality, safe services for the user.

52. As well as the HSSRIA, the Department, subject to the Minister's approval, can call on the Commission for Health Improvement (CHI) to undertake specific service reviews and in exceptional cases, where it is considered that expertise in clinical issues from elsewhere is required, to assist in other investigations.

53. Over time the HSSRIA will have a key role in providing users, the public and the Minister with the assurance that systems are in place to ensure that the best possible standards are being adhered to and the risk of something going wrong is greatly reduced.

54. HSSRIA will have to work collaboratively with other organisations involved in review or inspection such as the Northern Ireland Audit Office, the Health and Safety Inspectorate, the Social Services Inspectorate and the Pharmacy Inspectorate.

NEXT STEPS
Action by all HPSS organisations

55. The following actions must be taken by all organisations:

From the date of receipt of this circular

- formally begin the process of developing and implementing arrangements for effective clinical and social care governance;

By 28 February 2003

- identify the senior professional at board level to provide leadership in relation to clinical and social care governance;

By 31 March 2003

- designate a Committee with responsibility for clinical and social care governance (or in the case of LHSCGs, a sub-group or team), and appropriate supporting structures; and

- complete a review/baseline assessment or arrangements within the organisation that identifies current systems that support clinical and social care governance and identifies systems that require further development;

By 1 May 2003

- formulate and agree the organisation's plan for developing and maintaining effective clinical and social care governance arrangements;

By 1 June 2003

- incorporate a requirement to comply with the principles of clinical and social care governance into service agreements with provider organisations to take effect from 1 April 2004;

By 30 November 2003

- provide update on progress in the development of clinical and social care governance arrangements in Annual Report for 2002/03.

RESOURCES

56. The Department wishes to engage with HPSS organisations on the development of clinical and social care governance and to that end a series of workshops has been arranged for January and February 2003, across the four HSS Board areas, to discuss the way forward including the establishment of a Clinical and Social Care Governance Support Team (CSCGST). It is envisaged that the CSCGST will be multi-disciplinary and will consist of staff experienced in management, clinical and social care practice and family health services. It could provide support and training for HPSS organisations and develop further implementation guidance. In November 2002 an additional £0.25m (rising to £0.4m from 1 April 2003) was allocated to the HPSS to support governance and in recognition of the additional costs of implementing risk management arrangements, including clinical and social care governance arrangements.

FURTHER GUIDANCE

57. This circular will be supplemented by further guidance as necessary.

Yours sincerely

JOHN McGRATH

Director

Exhibit 34

HSC Safety Forum

Promoting shared learning and leadership

HSC SAFETY FORUM

ANNUAL REPORT

2009-2010

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1. INTRODUCTION

This is the first HSC Safety Forum Annual Report, outlining a brief summary of the work and main achievements that have taken place during the year 1 April 2009 – 31 March 2010.

During 2009-2010 the HSC Safety Forum continued to be a reliable source of energy, knowledge and support in the drive to continually improve health and social care across N Ireland. It still retains its key aim to be a recognised and respected support not only to providers of care but also to key stakeholders such as the DHSSPS Safety, Standards and Quality (SQS)Directorate, the HSC Board (HSCB), the Public Health Agency (PHA) and both Universities.

The year 2009-2010 has seen the Forum facilitate a total of 6 collaboratives; deteriorating patients, medication safety, mental health, perinatal, SSI (C-Section) and VTE prevention. It supported 2 Trusts for improvement work in prototypes in Clinical Microsystems and Transforming Care at the Bedside.

Other work has included the provision of support to Trusts in their work on implementing the WHO Surgical Site Checklist, provision of improvement science training to HSC staff and hosting a number of breakfast seminars.

The Forum has continued to work closely with key stakeholders such as the Performance Management and Service Improvement Directorate (PMSID) of the HSC Board. This work outlined in Section 3 (page 6) has fostered the building of relationships between the HSCB and the Forum and generated greater awareness of improvement science methodology.

A new Assistant Director took up post within the Forum in July 2009 further strengthening its commitment to supporting HSC organisations to continually improve safety and quality.

It is also important to acknowledge the continued commitment and support that HSC organisations, in particular HSC Trusts, have given in driving forward the safety and quality agenda. The Safety Forum looks forward to building on this work in partnership with all HSC organisations in 2010-2011.

In the spirit of sharing the work undertaken in patient safety with others on both a nationally and international stage, an article was accepted and published in Healthcare Risk Report (December 2009/January 2010) entitled “Safety Improvement in Northern Ireland’s Health and Social Care Services”, a presentation was given on the work ongoing in Transforming Care at the Bedside at the National Forum in Quality and Safety in Orlando (December 2009), and a poster on the

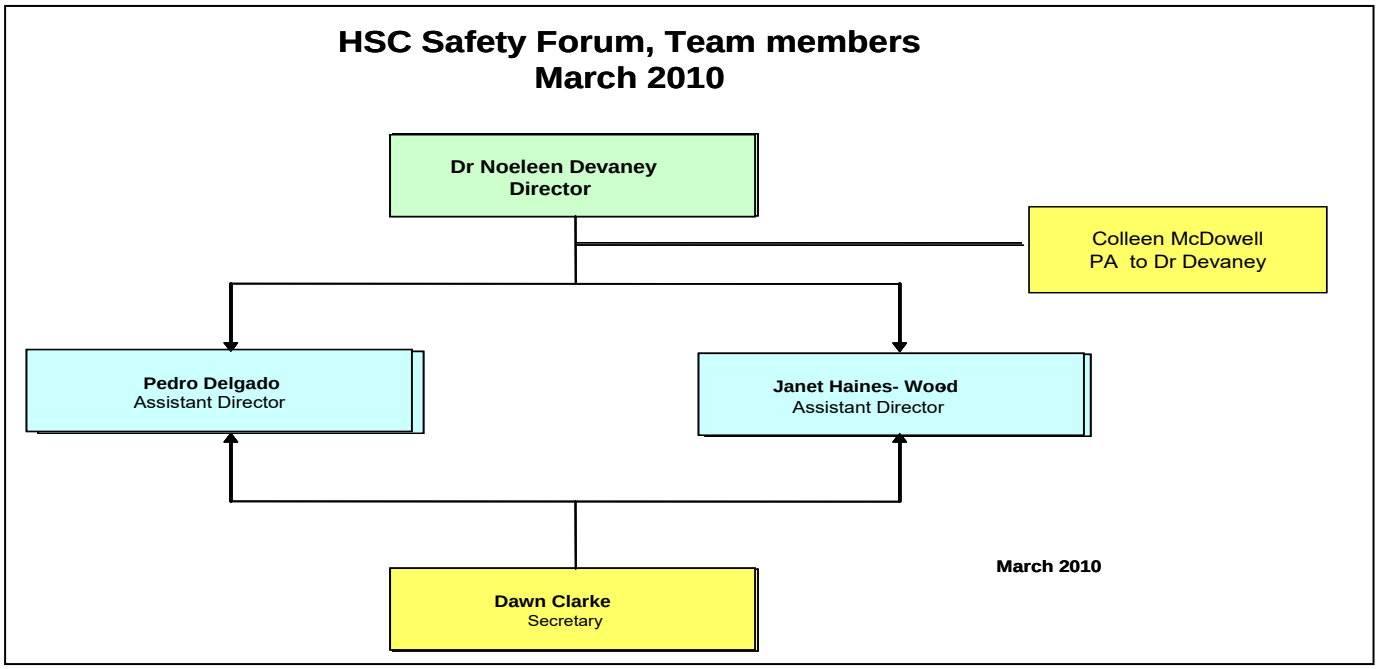
Journey of Patient Safety in Northern Ireland was presented at the International Forum for Quality and Safety in Healthcare, April 2010 (in Nice).

2. HSC SAFETY FORUM WORKING ARRANGEMENTS

This section briefly outlines the working arrangements of the Safety Forum (referred to as the Forum from this point) during the year 2009-2010.

During 2009-2010 the Forum expanded with the appointment of a 2nd Assistant Director and a permanent Band 3 secretary to support the 2 Assistant Directors. The appointment of the 2nd Assistant Director was in line with the plan outlined in the Operating Framework 2008-2009 to ensure that the full spectrum of Health and Social Care is encompassed in the work of the Forum (Fig. 1)

Figure 1 Members of the HSC Safety Forum



Whilst accountability lies with the DHISSPSNI, a Safety Forum Steering Group was formed (See Fig. 2) to oversee the work of the Forum. It held its inaugural meeting in August 2009. It was agreed that this Committee will:

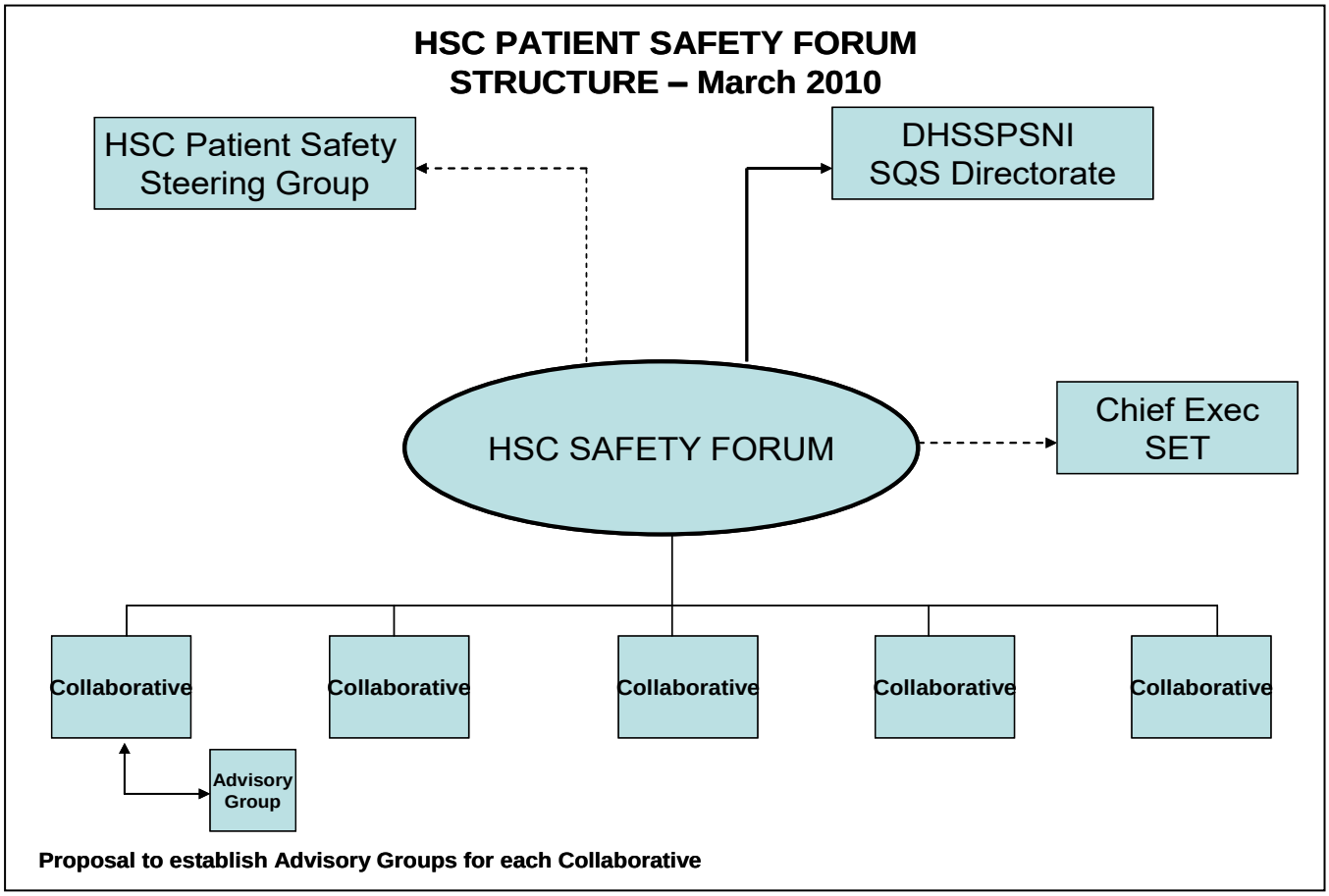
- Discuss the general direction the Forum takes;
- Agree a programme of work taking account of regional HSC priorities (eg. Programme for Government, Priorities for Action, etc);
- Submit a business plan to the Deputy Chief Medical Officer via the Safety, Quality & Standards Directorate for agreement on an annual basis at the beginning of each financial year
- Review progress against its objectives and aims

- Provide quarterly feedback to the Safety, Quality and Standards Directorate, DHSSPSNI and the Health Foundation (who had provided a non-recurrent grant to the Forum) on progress against the business plan.

The membership of the Committee reflects the multidisciplinary nature of HSC encompassing all key stakeholders of the Forum (See **Appendix A** for list of members). The Committee met quarterly and copies of the minutes can be accessed through the HSC Safety Forum website (www.hscsafetyforum.com).

Figure 2 (page 5) outlines the HSC Safety Forum structure and accountability.

Figure 2. Structure of HSC Safety Forum as a Regional Organisation



Below are the **Key Objectives** for the Forum providing direction for the work undertaken:

- Assist HSC organisations as they strive to deliver safe, high quality health and social care within an open learning culture
- Build and develop quality improvement capability in line with internationally recognised theory and practice across the health and social care spectrum including primary care
- Act collaboratively with key stakeholders to progress the safety and quality agenda regionally
- Proactively raise awareness of the importance of public and individual involvement in improving the safety of health and social care and support commissioners and providers of services in engaging with patients and clients to improve safety and quality

- Build and strengthen expertise, knowledge and skills of the HSC Safety Forum Team

The remainder of this Report will summarise the work undertaken during the year 2009-2010 to achieve the key objectives.

3. Assist HSC organisations as they strive to deliver safe, high quality health and social care within an open learning culture

The Forum continued its collaborative work to support Trusts in working towards achievement of the PfA 2009-2010 Safe and effective care targets for:

- Surgical Site Infection, C-Section and orthopaedics
- Deteriorating patients/Crash Calls
- Mental Health
- VTE

The collaboratives were well attended, there being an average of 30 people in attendance at each Learning Set with all Trusts being represented.

Feedback from these collaboratives was positive and some comments from those who attended:

> *"Collaborative useful to give opportunity to meet with other teams and share experiences and hear how other teams have overcome problems",*
>
> *"Useful to find that at the workshops everyone has similar problems"*
>
> *"Useful to review our own progress against information presented by Forum and other teams".*

The Surgical Site Infection, Deteriorating Patients (crash calls), and Mental Health collaboratives all reached the Learning Set 5 stage by January 2010.

Learning Set 2 of the prevention of VTE collaborative was also held in January 2010.

Work has been ongoing throughout the year on a Performance Management template. The Forum has worked closely with both the PMSID and Trusts with regard to this and the template now includes run charts. This is the template that Trusts use to report on a monthly basis to the PMSID on their progress with the safe and effective care targets as outlined in Priorities for Action (PfA). An example of the reporting ranges used in this Template is outline on Page 7, Figure 3.

The Forum was also invited to report on Trusts' progress against these targets from an improvement methodology perspective. This has fostered the building of relationships between the HISCB and the Forum and generated greater awareness of improvement science methodology.

Across the region compliance against the targets has been good. This reflects the significant amount of work that has been undertaken by all Trusts towards meeting these targets.

Figure 3

Colour description	Process measure standard	
Green - target fully achieved	95% or above (reliable)	
Green / Amber - target substantially achieved / missed only by a narrow margin	More than 85%	Green / amber
Amber - target partly achieved	Between 50% and 85%	
Amber / red – work done but limited progress	Between 35% and 50%	Amber / red
Red - target not achieved	Lower than 35%	

The aim of the work being undertaken is to ensure the implementation of safe and reliable systems that will support the achievement of the targets outlined in PfA. Significant work has been undertaken by all Trusts to meet these targets. All improvement methodology begins with testing in pilot areas and only when Teams are satisfied that they have achieved reliability in this pilot area, will then fully implement in this area and look to spreading across the organisation. It should be noted that this can take time but will ultimately result in both consistency and reliability. Implementation and spread remain challenging areas in all improvement work.

A summary of the progress is outlined below.

3.1 SSI, Orthopaedics and C-Section

The bundle, within orthopaedics has been reliably implemented. Within C-Section, compliance with the surgical site bundle sits in the green/amber range. There is currently work ongoing in collaboration with HISC to validate Surgical Site C-Section infection rates.

3.2 Critical Care

A regional definitions document was agreed, produced and shared at the learning sessions. This included an agreement with HISC and CCaNNI to take a lead on ICU related safety and quality initiatives including a surveillance implementation strategy.

3.3 WHO Surgical Site Checklist

Work on the WHO Surgical Site Checklist began following a regional agreement to have 50% theatres reliably implement this checklist.

A collaborative was not held for this work, with Trusts agreeing to include work on the Checklist into their local Quality Improvement Plans and carry out work internally.

The Forum has provided support when required and held a meeting in March 2010 with all trusts to report their progress. Whereas all Trusts are working on implementing the Checklist, there is variation as regards progress and the 50% target has not been achieved. At this meeting, the importance of measuring compliance was highlighted and Trusts agreed to measure and report this on the Northern Ireland Extranet.

3.4 VTE

Trusts began posting baseline measures from October 2009 and are demonstrating 65-100% compliance with appropriate prophylaxis (by March 2010), but encountering significant challenges with ensuring that risk assessment is being undertaken.

The collaborative made a decision to develop a regional patient information and regional poster.

Following discussion at Learning Set 2, the Belfast Trust agreed to undertake pilot work on relevant and useful outcome measures regarding VTE.

A VTE workshop was also planned for June 2010, to be facilitated by speakers from King's College and the Lifeblood Thrombosis Charity.

3.5 Mental Health

Learning Set 5 was reached in January 2010. The measures being reported on in Risk Assessment and Multidisciplinary Team reviews demonstrated 95% compliance and above. The measure on Multidisciplinary Care Planning shows 83% compliance but again demonstrating a clear trend of improvement since the collaborative began. A decision will be made over the summer on the future of this collaborative and agreement sought in taking forward other areas of work in Mental Health.

3.6 Perinatal

Learning Sets 3-5 were held for the Perinatal collaborative during the year. Trusts initial work focused on compliance with the Electronic Foetal Monitoring bundle and by end of March, results demonstrated varied compliance with this bundle ranging from amber – amber/green. This is a large bundle and Trusts are struggling to ensure compliance with all elements.

Additional work is planned for inclusion into this Collaborative in relation to Induction of Labour. This will begin in September 2009.

3.7 Medication Safety

A primary/secondary care interface medication safety collaborative was commenced, following an initial meeting in June 2009 to seek agreement on this topic. Measures focused on medicines reconciliation on admission and discharge.

Learning sets 1 and 2 were held during the year and reporting began on the Extranet in January 2010. Trusts, involved in waves 1 and 2 of the Safer Patients' Initiative had already begun work in this area and their learning to date proved vital to taking this work forward.

From early on in the work, a need for an electronic system was identified to ensure timely and accurate medicines reconciliation. Work will continue throughout 2010-2011.

3.8 Stroke

Work began in October 2010 within the Belfast HSC Trust as a pilot site to support the PfA 2009/2010/201 thrombolysis stroke target.

An agreement was reached to commence a regional Stroke Collaborative focusing on thrombolysis; Learning Set 1 scheduled to begin in June 2010. Links were also forged with the Regional Stroke Strategy Group and ongoing work in relation to the development of the regional Stroke Dataset.

3.9 Social Care

Preliminary discussion took place with Board and Trusts in regards to the identification of a topic for a social care collaborative. It was suggested that the topic be chosen from the regional Project to improve the interface between Mental Health and Children's Services.

This will be further progressed during 2010-2011.

3.10 Frameworks for continuous improvement

(a) Transforming care at the bedside (TCAB)

During the year TCAB prototype work was commenced in one ward in the South Eastern Trust. This demonstrated positive results; a 48% reduction of in-patient falls. The Trust has put a plan in place to spread TCAB to additional wards.

A poster describing this work was accepted for the International Forum for Quality and Safety in Healthcare, April 2010 (in Nice).

A regional TCAB collaborative was proposed and discussed at the HSC Safety Steering Group in November 2009. Initial

agreement was secured that this could begin in the autumn of 2010 and will be included in the 2010-2011 HSC Safety Forum Business Plan.

(b) Clinical Microsystems

A prototype for Clinical Microsystems commenced at the Belfast HSC Trust, RVH Emergency Department. This was led by the Clinical Director. The global theme chosen by the Team was flow through the Emergency Department. Work continued to show positive results on focused interventions.

A poster describing the work was also accepted for the International Forum for Quality and Safety in Healthcare, April 2010 (in Nice).

3.11 Primary Care

Preliminary meetings took place with NIMDTA and general practitioners (GPs) regarding improvement methodology. This included an evening session for GPs, in partnership with NIMDTA, to explore implementing clinical Microsystems within practices. Initial interest was expressed and this will be progress during 2010-2011.

A half day training event, in the use of the Primary Care Trigger Tool was organised, for May 2010, by the Forum, in conjunction with NIMDTA and the NHS Institute for Innovation and Improvement.

4. Build and develop quality improvement capability in line with internationally recognised theory and practice across the health and social care spectrum including primary care.

4.1 Improvement Science Training

(a) Initially, bespoke training had been offered, by the Forum, to each Trust, however due to specific winter pressures in 2009, this was deferred and agreement was made that sessions on generic improvement science would be offered to all HSC organisations.

Over the year, 5 training sessions, were therefore, were held with a further one planned for June 2010.

Overall a total of over 100 staff attended these sessions drawn from Trusts, Public Health Agency, HSC Board, DHSSPSNI, Business Services Organisation, RQIA and NI Ambulance Service.

A half day training session on the Global Trigger Tool was provided for Trust staff in March 2010. Three out 5 Trusts attended this training.

4.2 Patient Safety Officer Executive Programme

Utilising the Health Foundation resource as agreed, one place per Trust was offered for at attendee at the IHI's Patient Safety Officer Executive Development Programme. All Trusts availed of this opportunity (one Trust deferred attendance to the autumn of 2010) including the Ambulance Service.

Since 2008 at total of 13 representatives have attended this Programme across all Trusts within NI providing a body of expertise to further drive patient safety and quality within the organisations.

4.3 Scottish Patient Safety Fellowship (SPSF)

Over the year 2009-2010, 2 applicants, nurse and doctor, were awarded a place on the SPS Fellowship

Both reported that the attendance on this Programme enhanced their capacity to drive the patient safety agenda within their own organisation and provided excellent international networking opportunities.

4.4 Breakfast Seminars

Educational breakfast seminars continued throughout 2009-2010 and were well attended.

Speakers were:

- Jason Leitch, Scottish Patient Safety Programme (May 2009),
- Marjorie Godfrey (June 2009); Quality by Design: Achieving strategic outcomes in healthcare through Clinical Microsystem development",
- Steven Allder, (September 2009), Clinical System Improvement,
- Anthony Staines (March 2010), Strategies for holistic improvement: learning from high performance organisations.

A further evening seminar was also scheduled for June 2010 with Jim Easton, NHS Director for Improvement and Efficiency.

5. Act Collaboratively with key stakeholders to progress the safety and quality agenda regionally

Implicit in the work of the Forum is that of working collaboratively with all key stakeholders. This can be evidenced through the HSC Safety Steering Group meetings, via collaboratives, specific meetings with bodies such as DHSSPSNI, HSC Board, Public Health Agency, NIPEC, RQIA and GAIN in order to identify key priorities and opportunities to work together.

Some of this collaborative work has been outlined in section 3.1 in regards to the work that took place between the Forum and Performance Management/Service Improvement Directorate of the HSC Board regarding a Performance Management Template for the Safe and Effective Care Targets.

Other examples of collaborative working include:

- Bi-monthly meetings held between the Forum and Trust Patient Safety Officers
- Establishment of a QUB IHI Open School Chapter
- As part of the QUB Medical School, a Patient Safety Module is offered as a Student Selected Component. This was the 2nd year that this has been available
- Visit to Bombardier, a high performing manufacturing company, to learn from another industry. This was well received by those who attended. A further visit was set up for Copeland Emerson, but unfortunately had to be cancelled
- Establishment of Collaborative specific Advisory Groups (to include doctors, nurses, pharmacists) to support the work of each collaborative and drive for improvement
- Involvement in a National Learning Set ……..
- Links have been established with the Health Foundation's Safer Patients' Network which was set up to take forward the work of the Foundation's Safer Patients Initiative (SPI)

Evaluation of Forum

As part of the evaluation of the work of the Forum, a questionnaire

Survey was carried out in May for the period 2009-2010. Via Survey Monkey a link was sent to key stakeholders.

Results showed that:

- 90% stakeholders believed that the HSC Safety Forum has been effective in its role
- 90% stakeholders were either satisfied or very satisfied with the support provided by the Safety Forum.

When asked if there was anything that the Forum could do differently responses included:

- Identification of key issues which should be prioritised in education and training courses for health professionals and students
- An annual workshop event to agree priorities for the year
- Ongoing programme of training and development for key personnel
- Regular summary of ongoing work and progress
- To be inclusive of other areas outside acute

Positive comments were also received:

- I am a strong supporter of the Forum as a force for good care
- We have very much appreciated the help, support and advice, particularly in relation to training of key personnel regarding patient safety issues and techniques. The networking opportunities have also been beneficial and the contact with the Forum has greatly assisted in focussing us on patient safety

As the Forum further develops, all the feedback received from both this Evaluation and from regular feedback through each of the Collaboratives, will be taken into account to plan for the future.

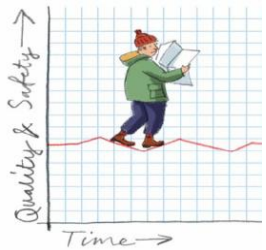
6. Proactively raise awareness of the importance of public and individual involvement (PPI) in improving the safety of health and social care and support commissioners and providers of services in engaging with patients and clients to improve safety and quality

In recognition of the importance of involving patients in improving patient safety, meetings were held between the Forum and the Patient Client Council. A patient representative was identified and now is a full member of the HSC Safety Forum Steering Group.

In addition, a Conference on the theme, Patient Involvement in Ir Patient Safety, was originally scheduled to be held on 19 November 2009. Due to significant pressures on Trusts at that time, this was rescheduled for May 2010.

This work will continue to be progressed throughout 2010-2011.

Trusts are continuing to work on the PPI standards and the importance of patient involvement is reinforced within each collaborative.



7. Conclusion

As stated in the introduction, this is the first Annual Report of the HSC Safety Forum. It outlines the key work undertaken by the Forum during 2009-2010 against its key objectives. It is not all encompassing of the patient safety work in Northern Ireland. There are Trust and many regional networks undertaking improvement work in many areas.

The Forum, however, provides a vehicle for organisations throughout the HSC to share their views and shape the patient safety agenda.

There are encouraging signs of improvement and sustainability in a number of areas described in this Report and work still required on others.

This is a journey and, as such, will develop and progress. Priorities will be identified for patient safety work and it is important that areas other than acute become involved in this work. Early links have been made with both social and primary care and these must be built on over the coming year.

The Forum, itself, will be undergoing changes during the coming year with proposals that it transfers to the Public Health Agency. This should enable further linkages with health and social care and support co-ordination of initiatives.

Importantly, all this work has been led by front-line staff and thanks should go to them for their continued commitment.

HSC Safety Forum Steering Committee Members
(as of March 2010)

Dr Eddie Rooney (Chair)	Chief Executive	Public Health Agency
Ms Simona Arena	Programme Manager	The Health Foundation
Mrs Hazel Baird	Head of Governance and Patient Safety	Northern HSC Trust
Mr Gerry Bond	Patient Representative	
Dr Noeleen Devaney	Director	HSC Safety Forum
Mr Shane Devlin	Director of Customer Care and Performance	Business Services Organisation
Miss Janet Haines-Wood	Assistant Director	HSC Safety Forum
Dr Carolyn Harper	Director of Public Health/Medical Director	Public Health Agency
Mrs Mary Hinds	Director of Nursing & Allied Health Professions	Public Health Agency
Mrs Maeve Hully	Chief Executive	Patient & Client Council
Dr Jim Livingstone	Director of Safety, Quality and Standards	DHSSPS
Dr Patrick Loughran	Medical Director	Southern HSC Trust
Mr Tom McGarey	Risk Manager	NI Ambulance Service
Dr David McManus	Medical Director	NI Ambulance Service
Dr Charlie Martyn	Medical Director	South Eastern HSC Trust
Mr Hugh Mullen	Director of Performance Management and Service Improvement	HSC Board
Dr Tony Stevens	Medical Director	Belfast HSC Trust
Dr David Stewart	Medical Director & Director of Service Improvement	RQIA
Mr Richard Wray	Consultant & Divisional Clinical Director	Western HSC Trust

Noel McCann
Director of Planning & Performance Management

Department of
Health, Social Services and Public Safety
An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
www.dhsspsni.gov.uk

Room D4.13, Castle Buildings
Stormont Estate
Belfast, BT4 3SQ

Tel: 028 9052 2795
Fax: 028 9052 8126
Email:
noel.mccann@dhsspsni.gov.uk

Your Ref:
Our Ref: HSS (PPM) 05/05

Date: 10 June 2005

For Action (with enclosures):

Chief Executives of HSS Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies

For information (without enclosure):

Chief Executive, HPSS Regulation & Improvement Authority
Chief Officers, HSS Councils
Directors of Public Health in HSS Boards
Directors of Social Services/Social Work in HSS Boards and Trusts
Directors of Dentistry in HSS Boards and Trusts
Directors of Pharmacy in HSS Boards and Trusts
Directors of Nursing in HSS Boards and Trusts
Directors of Primary Care in HSS Boards
Medical Directors in HSS Trusts
Chairs, Local Health and Social Care Groups
General Medical, Community Pharmacy,
General Dental & Ophthalmic Practices

Dear Colleague

REPORTING OF SERIOUS ADVERSE INCIDENTS WITHIN THE HPSS

Introduction

1. Circular PPM 06/04, issued in July 2004, provided interim advice for HPSS organisations and Special Agencies on the reporting and management of serious adverse incidents and near misses.

2. The purpose of this Circular is to provide an update on safety issues; to underline the need for HPSS organisations to report serious adverse incidents and near misses to the Department in line with Circular PPM 06/04; and to request details of senior managers who have been assigned overall responsibility for the reporting and management of adverse incidents.

Update on Safety Issues

Safety Group

3. The Department established a Safety in Health and Social Care Steering Group initially to advise on the future role and function of the Northern Ireland Adverse Incident Centre (NIAIC), with particular emphasis on the establishment of NIAIC accountability boundaries. However, the Steering Group considered that there was a need for the Department to take a broader, more systematic approach to safety within the HPSS and to provide greater strategic direction on the recording, reporting and investigation of all adverse incidents and near misses.

4. As part of this work, the Steering Group commissioned Deloitte to carry out a scoping exercise on adverse incidents and near miss reporting in the HPSS and special agencies; and to evaluate the Northern Ireland Adverse Incident Centre.

Key Findings of Deloitte Report

5. The Deloitte report acknowledged that, within HPSS organisations, there is a consistent drive to improve the reporting and management of adverse incidents, based on a common belief and understanding of the benefits it can bring to patient and client safety and care. However, the report also noted inconsistencies in approach, including incident reporting systems, monitoring, collation, analysis and follow-up.

6. The report's key recommendations included the need for:

- a consistent approach to the definition and coding of adverse incidents and near misses;
- more Departmental guidance on risk assessment, reporting structures and links to other organisations;
- the development of improved reporting systems to support the analysis and audit of incidents and the development of mechanisms to improve learning and knowledge;
- links between local reporting arrangements and national, statutory, and confidential reporting mechanisms;
- the development of guidance on local investigations and reviews; and
- improved training and development of staff in the use of risk assessment tools, such as root cause analysis.

Further Work

7. In line with these proposals, a number of projects are now being taken forward by the Department. These include:

- work to standardise definitions and coding;
- the development of formal links with the National Patient Safety Agency; and
- the development of a safety framework for the HPSS.

8. Further information about progress with each of these projects will be issued at a later date.

Reporting Incidents

9. Circular HSS (PPM) 06/04 indicated that the Department, in collating information on serious adverse incidents and near misses, would feed back relevant analysis to the HPSS. In line with this undertaking, a small group has been established in the Department, which reviews all incidents that are notified. It is planned that regular feedback will be issued to the HPSS, including an annual report.

10. As the first step in this process, a briefing session has been arranged for safety managers on 15 June, when the Department will be providing feedback on the operation of the reporting and management arrangements established by Circular PPM 06/04.

11. In the meantime, it is important that notifications required under the interim guidance should continue to be provided to the Department. Safety managers should review the operation of local procedures on a regular basis to ensure that all serious adverse incidents are being reported to the Department.

12. All HPSS organisations are reminded that incidents which are regarded as falling in any of the categories below should be notified to the Department in accordance with the procedures outlined in the guidance:

- **incidents regarded as serious enough to warrant regional action to improve safety or care within the broader HPSS;**
- **incidents which are likely to be of public concern;**
- **incidents which are likely to require an independent review.**

13. All other existing systems should continue to be used. In particular, HPSS organisations should continue to report incidents involving medical devices and equipment to the NIAIC.

Management Arrangements

14. Circular PPM 06/04 indicated that HPSS organisations and Special Agencies should be developing a culture of openness. In that context, it requested all HPSS organisations and Special Agencies to nominate a senior manager at board level who would have overall responsibility for safety and the reporting and management of adverse incidents within the organisation. To assist with future communications on safety issues, the Department has decided to establish a central list of these safety managers.

Action

15. A copy of the Deloitte Report is enclosed for your information; also enclosed is a specific section relating to your Trust, Board or Special Agency as appropriate. Taken together, these should be used to inform the safety agenda within your organisation.

16. Chief Executives of Boards, Trusts and Special Agencies should ensure that copies of the Deloitte Report are available for distribution as appropriate.

17. In line with paragraph 14 above, I should be grateful if you would let Jonathan Bill (jonathan.bill@dhsspsni.gov.uk) have details of your safety manager – their name, position and contact details, **by 30 June 2005**.

Yours Sincerely

NOEL McCANN

Department of Health, Social Services and Public Safety
An Roinn Sálinte, Serbhísí Sóisialta augus Sábháilteacht Phioblí

Subject:
Reporting and follow-up on serious adverse incidents

Circular Reference: HSS (PPM) 02/2006

Date of Issue: 20 March 2006

For action by:

- Chief Executives of HSS Trusts
- Chief Executives of HSS Boards
- Chief Executives of Special Agencies
- Chief Executive of Central Services Agency
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Officers, HSS Councils
- Directors of Public Health in HSS Boards
- Directors of Social Services in HSS Boards and Trusts
- Directors of Dentistry in HSS Boards and Trusts
- Directors of Pharmacy in HSS Boards and Trusts
- Directors of Nursing in HSS Boards and Trusts
- Directors of Primary Care in HSS Boards
- Medical Directors in HSS Trusts
- Chairs, Local Health and Social Care Groups
- Chairs, Area Child Protection Committees
- Chief Executive, Regulation & Quality Improvement Authority
- Chief Executive, Mental Health Commission

Summary of Contents:

The purpose of this Circular is to notify a number of important points about the reporting and management of Serious Adverse Incidents (SAIs)

Enquiries:

Any enquiries about the content of this Circular should be addressed to:

Quality & Performance Improvement Unit
DHSSPS
Room D2.4
Castle Buildings
Stormont
BELFAST
BT4 3SQ

Tel: 028 9052 2239
elaine.lawson@dhsspsni.gov.uk

Related documents

HSS (PPM) 06/2004
HSS (PPM) 05/2005

Superseded documents

Circular HSS4 (OS) 1/73 - Notification of Untoward Events in Psychiatric and Special Care Hospitals

HSS (THRD) 1/97 - Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability

Annexes A and B to Circular HSS (PPM) 06/04

Status of Contents:

Action

Implementation:

Immediate

Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Noel McCann
Director of Planning & Performance Management

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

For action:

Chief Executives of HSS Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies
Chief Executive of Central Services Agency
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Directors of Primary Care in HSS Boards
Medical Directors in HSS Trusts
Chairs, Local Health and Social Care Groups
Chairs, Area Child Protection Committees
Chief Executive, Regulation & Quality Improvement Authority
Chief Executive, Mental Health Commission

Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Tel: 028 9052 2795

Fax: 028 9052 8126

Email:
noel.mccann@dhsspsni.gov.uk

Circular HSS (PPM) 02/2006

20 March 2006

Dear Colleague

REPORTING AND FOLLOW-UP ON SERIOUS ADVERSE INCIDENTS

Introduction

1. Circular HSS (PPM) 06/2004, issued in July 2004, introduced new interim reporting procedures for serious adverse incidents (SAIs) and near misses for HSS Boards, Trusts, Agencies and Family Practitioner Services. Since then, the Department has been monitoring the operation of the system and the purpose of this circular is to notify a number of important points about the reporting and management of SAIs.

2. In particular, this guidance:

   - draws your attention to certain aspects of the process which need to be managed more effectively;
   - notifies important changes in the way that SAIs should be reported in future; and
   - provides a revised report pro forma which should be used in all future reports.

INVESTOR IN PEOPLE

3. This guidance also clarifies the processes that the Department has put in place to consider SAIs notified to it and outlines the feedback that will be made available to the HPSS.

Areas for improvement

4. On the basis of the review that the Department has undertaken, it is clear that a number of areas need to be improved:

Nominated Reporting Officers - for an HPSS organisation to comply with the current risk management controls assurance standard, the senior manager at board level with overall responsibility for the reporting and management of adverse incidents should consider the incident against the criteria set out in HSS(PPM) 6/2004. Having a nominated officer at board level provides assurance that incidents are being dealt with appropriately. However, the Department is concerned to note that incidents continue to be reported from a variety of sources within some organisations (in some cases, causing duplicate reporting). This potentially undermines the development of a coherent, co-ordinated and effective approach to incident management within organisations.

It is recognised that circumstances differ in the primary care environment. However, the principles of having a nominated lead to co-ordinate the reporting of incidents is just as relevant. As part of having effective governance arrangements, practices should report SAIs to their area HSS Board. Therefore it is important that both HSS Boards and practices have a nominated lead. It is recognised that different terms are used to mean the same thing in primary care, such as significant events, critical incidents or untoward events. Those events or incidents which occur at practice level and which can be classified as SAIs, should be communicated, within the specified timeframe, by the practice to the relevant HSS Board in the first instance. The HSS Board is responsible for the onward report to the Department of those events or incidents which meet the definition of an SAI. This will include specifying which criteria in HSS (PPM) 06/2004 is relevant in the context of the incident.

The arrangements in place within your organisation should be reviewed to ensure that incident management is co-ordinated and working effectively and that your designated senior manager is aware of those incidents reported to the Department as SAIs and that each meets the criteria set out below.

Appropriate reporting – whilst this circular relates to the reporting of SAIs to the Department, it should be noted that organisations should continue to follow existing reporting mechanisms in order to fulfil their statutory obligations (for example to RQIA or MHC(NI)) and national or local reporting commitments (such as National Confidential Enquiries or under *Co-operating to Safeguard Children*).

HSS (PPM) 06/2004 outlined the steps to be taken by the designated senior manager when alerted to an SAI. The manager has to consider whether the incident should be reported to the Department where it is likely to:

- be serious enough to warrant regional action to improve safety or care;
- be of public concern (such as serious media interest); or
- require an independent review.

A number of incidents reported do not fall into these categories. Although the Department continues to encourage organisations to use the SAI reporting system - and would advise organisations to report if in any doubt – there is a need to ensure that reports made to the Department are serious **and** fall within one or more of the categories set out above.

Children's Homes - in particular, the Department is receiving a substantial number of reports about children who go missing without permission from children's homes. A follow-up report usually arrives (within 24 hours) confirming that the child has been located. Schedule 5 to the Children's Homes Regulations sets out the statutory requirements for notification of such cases. **The Department should only be notified if the criteria set out above apply**. In particular, if an organisation intends to contact the media to assist it in locating a child or if a felony is suspected, the Department should be informed under the SAI reporting system, prior to notification being made to the media. In all other cases, unless they fulfil the SAI reporting criteria, incidents about children who go missing without permission should not normally be reported to the Department.

Confidentiality - incident reports sometimes include details about patients' or clients' names. This practice should be discontinued. All incident reports should be anonymised – generally the gender and age of the patient or client is sufficient detail. To aid any follow-up enquiries, however, you should provide the organisation's incident identifier number.

Delay in Reports - unless there is reasonable justification, a report to the Department should be submitted within 72 hours of the incident being discovered. Where an incident involves the death of a person every effort should be made to submit a report within 24 hours. There has been a number of incidents where the time delay in reporting has been considerable; in some cases, these have been accompanied by an explanation for the delay. Some, however, have failed to provide any explanation.

Electronic Reporting - some organisations have indicated concerns about reporting SAIs by e-mail, chiefly on the basis of uncertainty as to whether the information has been received by the Department. The SAI electronic system has a dedicated e-mail address which is regularly checked. However, in order to provide an additional assurance to the reporting organisation, a response acknowledging receipt of an incident report will in future be issued to the sender's e-mail address. If an organisation fails to receive such a response within 24 hours, it should contact the Department to ensure that the incident report has been received.

Revised Notification Arrangements

5. Previous guidance indicated that, until further notice, HPSS organisations should continue to use existing reporting systems alongside the SAI procedures introduced in 2004. In order to reduce duplication, however, it has been decided to discontinue the requirement to submit separate notifications to the Department in the case of untoward events in mental health, learning disability, nursing and residential homes and child care. When an SAI report is received on these issues, it will be forwarded to the relevant point within the Department. Existing guidance, contained in Circulars HSS4 (OS) 1/1973 (Notification of Untoward Events in Psychiatric and Special Care Hospitals) and HSS (THRD) 1/1997 (Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability) is now discontinued.

6. All other existing reporting systems should continue to be used.

Amendments to the SAI Report Proforma

7. The SAI Report proforma (formerly attached as Annex B to Circular HSS (PPM) 06/04) has been revised and is set out in the Annex to this letter. The additional elements are:

- Box 1 - provision for the organisation's own incident identifier number – this will facilitate easier tracing should the Department need to seek further information about the incident.
- Box 2 – in completing this section, reference should be made to any previous SAIs reported which are connected to this particular incident.
- Box 3 – now displays the SAI criteria for reporting to the Department and asks for an explanation as to why the incident meets the criteria.
- Box 4 – extended to include the incident classification as initially assessed by the organisation.
- Box 5 – extended to include the question "Are there any aspects of this incident which could contribute to learning on a regional basis?".
- Box 7 – inclusion of RQIA and facility to record the date on which other organisations are notified. ***Trusts and practices should note that all SAIs should be reported to their commissioning HSS Board as a matter of course***. These reports will help inform HSS Boards with regard to meeting their statutory duty of quality on the services they commission by providing an overview of the quality of service provision and, where appropriate, will facilitate regional learning. In the case of primary care practices, HSS Boards should report to the Department those 'significant events' which are SAIs and fall within the criteria of HSS (PPM) 6/2004.
- Box 8 – as outlined above, it is important that the Chief Executive and the designated senior manager is aware of the incident before the report is submitted to the Department.

Learning from Adverse Incidents

8. The Serious Adverse Incident process is not a performance management tool. However, a key objective in the process is to ensure, where possible, that lessons are learned from adverse incidents and that the quality of services is improved. The Department has, therefore, put in place arrangements to review incidents reported to it on a regular basis and to feed back relevant analysis to the HPSS. In this context, the Serious Adverse Incident Group in the Department meets on a monthly basis to consider reports submitted. It may seek clarification from organisations on the outcome of incidents to determine whether regional guidance is needed. In the case of independent reviews, the Department may also provide guidance as to specialist input into such reviews.

9. In June 2005, the Department provided a first regional briefing on SAIs, focusing on the key issues emerging from incidents reported until then. A further briefing event will take place later this year. Additionally, the Department intends to publish a report later this year which will summarise the key issues emerging and recurrent problems being encountered across the region. It is intended that this will assist organisations to review their clinical and social care governance processes, strengthen their incident reporting arrangements and improve the quality of services.

Action

10. All HPSS organisations are requested to:

- note the areas for improvement identified at paragraph 4 above and ensure that action is taken to address these;
- review the arrangements in place within organisations to ensure that incident management is co-ordinated and working effectively, that designated senior managers are aware of those incidents reported to the Department as SAIs and that such incidents meet the criteria set out in paragraph 16 of HSS (PPM) 06/2004;
- note that existing procedures (under 1973 and 1997 guidance) for the notification of untoward events in mental health services and learning disability are now discontinued;
- cancel Circulars HSS4 (OS) 1/73 (Notification of Untoward Events in Psychiatric and Special Care Hospitals) and HSS (THRD) 1/97 (Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability);
- note the amendments that have been made to the SAI Report Pro-forma; and
- ensure that the revised Pro-forma is brought into use immediately.

11. This Circular will be reviewed in 2007.

12. A copy of this Circular is being sent to designated senior managers responsible for incident reporting in HSS Boards, Trusts and Agencies.

Yours sincerely

NOEL McCANN

ANNEX

SERIOUS ADVERSE INCIDENT REPORT			
1. Organisation: **Incident Identifier No.**			
2. Date and brief summary of incident:			
3. Why incident considered serious: (i) warrants regional action to improve safety or care within the broader HPSS; (ii) is of public concern; or (iii) requires an independent review.	**Briefly, explain why this SAI meets the criteria:**		
4. Immediate action taken: **Classification of incident as initially assessed by organisation: Catastrophic / Major / Moderate / Minor / Insignificant**			
5. Is any regional action recommended? Y/N (if 'Yes', full details should be submitted): **Are there any aspects of this incident which could contribute to learning on a regional basis?**			
6. Is an Independent Review being considered? Y/N (if 'Yes', full details should be submitted):			
7. Other Organisations informed:		**Date informed**	Other (please specify) Y/N
HSS Board	Y/N		
HM Coroner	Y/N		
Mental Health Commission	Y/N		
NIHSE	Y/N		
PSNI	Y/N		**Date informed:**
RQIA	Y/N		
8. 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 Department. (*delete as appropriate*) **Report submitted by:** (name and contact details of reporting officer) **Date:**			

Completed proforma should be sent, by email, to:

adverse.incidents@dhsspsni.gov.uk
If e-mail cannot be used, fax to (028) 9052 8126

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Exhibit 37

SAFETY FIRST:
A Framework for Sustainable Improvement in the HPSS

March 2006

Produced by:
Department of Health, Social Services and Public Safety
Castle Buildings
Belfast
BT4 3SQ

Telephone: 028 9052 8332
Textphone: 028 9052 7668

This document is also available
on the Department's website:
www.dhsspsni.gov.uk

March 2006

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POLICY STATEMENT ON SAFETY

The Department of Health, Social Services and Public Safety, together with the Health and Personal Social Services (HPSS), is committed to the ongoing development of a safer service, as part of its drive to improve clinical and social care, service user experience and outcomes.

No health and social care environment will ever be absolutely safe and without risk; however, more can always be done to improve the safety and quality of care provided.

High safety standards are key indicators of a high quality service. Over the next few years, the policy focus will be on linking quality and safety. Particular attention will be on:

- Creating an informed, open and fair safety culture within the HPSS;
- Raising awareness of risk and promoting timely reporting of adverse incidents;
- Investigating serious incidents;
- Sharing the learning across HPSS environments;
- Implementing change;
- Developing skills, knowledge and expertise; and
- Involving and communicating with the public.

In support of the policy, an action plan has been developed, which places “Safety First” as the philosophy which all organisations, practitioners and staff should promote and adopt.

The action plan will be reviewed in 2007.

SECTION 1 – AIM OF FRAMEWORK

1.1 INTRODUCTION

Safety has to be the first concern of everyone who works in or manages the Health and Personal Social Services (HPSS) in Northern Ireland. It is an integral part of quality in health and social care - diminished standards of safety reflect poor quality of service for people. Effective care, therefore, has to place an emphasis on efforts to improve safety processes in order to prevent adverse outcomes, and to improve the service user and carer experience. Safety is, therefore, an integral part of clinical and social care governance.

This document aims to draw together key themes to promote service user safety in the HPSS. It intends to build on existing systems and good practice, to bring about a clear and consistent DHSSPS policy and action plan, which can be reviewed in light of advances and developments. It does not aim to identify or replace existing policies and procedures, particularly those relating to statutory health and safety functions, or staff or visitor safety, but rather focuses on safety in terms of improvement of quality of care through enhanced clinical and social care governance.

The major policy focus and action will be on:

- creating an informed, open and fair safety culture across HPSS organisations;
- raising awareness of risk and promoting timely reporting of adverse incidents;
- sharing the learning across HPSS environments;
- implementing change;
- investigating serious incidents; and
- involving and communicating with the public.

Appendix A sets out the Terms of Reference and scope of this safety document. The action plan (section 5) will be reviewed in 2007, to determine progress and map future priorities.

1.2 ERROR – A PART OF THE HUMAN CONDITION

No health and social care environment is one hundred percent safe. Some adverse incidents which occur may be the inevitable complication of treatment or care. Many treatment decisions are made in a busy working day, using a range of technologies and

activities (e.g. medicines, medical devices, equipment, procedures) and in different environments, which can, in themselves, be the subject of error. The factors which influence quality and safety of care, include:

- the context, e.g. HPSS, regulatory frameworks;
- the organisation and its management e.g. financial resources, priorities, policies, safety culture;
- the work environment e.g. staffing levels, skill mix, workload;
- the team e.g. structure, communication, supervision arrangements;
- the individual (staff) e.g. knowledge and skills, motivation, health;
- the task e.g. task design, use of protocols, accuracy of test results; and
- patient characteristics e.g. complexity of condition, language and communication, personality and social factors.[1]

Given the multiplicity of factors which influence the care of an individual, health and social services will never be totally error-free. But what can be achieved is the minimisation of risk, a greater knowledge and understanding of why human error and systems failures occur and the fostering of a culture which supports learning in order to prevent reoccurrence.

1.3 DEFINITION OF AN ERROR OR INCIDENT

It is important to have a common understanding of what constitutes an error or incident, regardless of the source. Errors can occur at all stages of the process of care, from diagnosis to treatment, to preventive care. Not all errors result in harm; these errors are often described as “near misses”. These too, represent an opportunity to identify systems improvements and have the potential to prevent adverse incidents in the future. All types of errors and incidents should be included in a common definition - social care, clinical, health and safety, fire, infection control etc., as they could potentially impact on the health and social care of service users, staff and visitors.

For the purposes of the Department and the HPSS, the regional definition of an error or incident is as follows:

[1] Adapted from; Vincent, Taylor-Adams and Stanhope 1998

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation".

The definition acts as a common working definition for HPSS organisations. It acknowledges that not all errors result in harm to patients and service users, but some do. Where the potential for harm/loss/damage is detected and the incident is prevented thus resulting in no harm to the individual, it is considered a "near miss" and can yield valuable learning.

The definition also supports the view that damage to property, environment or reputation can have both a direct and indirect impact and cost on health and social care. For example, faulty equipment may require tests to be repeated, potential for mis-diagnosis and concern for service users and staff. In addition, an incident may lead to loss of trust on behalf of the public and reduced satisfaction and morale among staff, with consequent negative impact on workforce recruitment and retention. More generally, employers and society may pay because of loss of worker productivity, school attendance, and a reduction in population health status. So, the human, social and economic costs resulting from adverse incidents are potentially high, but especially when a death occurs which may have been preventable.

1.4 THE HUMAN, SOCIAL AND ECONOMIC COSTS

The National Patient Safety Agency in England and Wales has produced its first report based on findings of the National Reporting and Learning System from November 2003 to March 2005. It shows a rate of five adverse incidents reported per 100 admissions in acute hospitals. In acute hospital settings, about three in every 1,000 reported incidents resulted in death[2].

Although many HSS Trusts and Boards have local incident reporting systems, the health and social services in Northern Ireland do not have a common reporting or data analysis system for adverse incidents; therefore, neither the number of adverse incidents in health and social care environments is known nor can the order of magnitude of untoward deaths be estimated. However, as with other developed healthcare systems, it can be reasonably assumed that the problem exists in our health and social care environment.

[2] Building a Memory: preventing harm, reducing risks and improving patient safety – The first report of the National Reporting and Learning System and the Patient Safety Observatory – July 2005 – www.npsa.nhs.uk

What is known is the fact that any adverse incident, whether or not it results in injury, harm or death, has the potential to cause considerable distress not just to service users and carers but also to health and social care staff. For the families of those who have suffered the loss of a loved one, that loss can be made worse by the knowledge that death may have been preventable and that past lessons may not have been learnt.

The human, social and economic costs to individuals and families, the Health and Social Services and society are enormous. For example, in the HPSS:

- in 2004, via the Northern Ireland Adverse Incident Centre[3], 166 adverse incidents reports were received with 4 relating to circumstances involving fatalities;

- in 2004/05, a total of 10,107 medication-related patient safety incidents[4] were reported by staff in eight of Northern Ireland hospitals alone, although 89% of these were considered not to have caused harm (i.e. a near miss);

- in 2004/05, the frequency of MRSA[5] among hospital patients has shown a first and significant annual downturn during four years of monitoring, 242 patients were recorded as having MRSA in 2004/05 a decrease of 21% when compared to the same period in 2003/04;

- 15 suspected suicides and 3 suspected homicides occurred involving people in or who had just been discharged from mental health settings in the HPSS and were reported to the Department in 2004/05[6]; and

- in 2003/04, £15 million was paid in settlement of clinical negligence claims (HSS Boards and Trusts) with a future potential liability of around £100 million for current claims[7].

[3] Northern Ireland Adverse Incident Centre records and investigates, as appropriate, reported adverse incidents involving medical devices, non medical equipment, plant and building items used in the HPSS

[4] Source – Northern Ireland Medicines Governance Team

[5] Source - Communicable Disease Surveillance Centre – Northern Ireland – www.cdscni.org.uk

[6] Source – DHSSPS – Circular HSS (PPM) 06/2004. Reporting and follow-up of serious adverse incidents

[7] Source - DHSSPS

1.5 LEADERSHIP AND ORGANISATIONAL CULTURE

The culture of an organisation is about "how we do things around here" and this is significantly influenced by the leadership of senior management. But for senior management to demonstrate leadership, it has to have the knowledge, skills and information to promote a safety culture.

An informed safety culture has four major sub-components[8]:

- *a reporting culture* - in which people are prepared to report their errors and near misses;
- *a just culture* – where an atmosphere of trust and fairness is created in which staff are encouraged to engage in safety related activities;
- *a flexible culture* - which respects the skills, abilities and limitations of frontline staff; and
- *a learning culture* – the willingness and competence to draw the appropriate conclusions from its safety information systems and to implement major reforms.

The DHSSPS endorses the approach that all organizations should have an informed safety culture, which should be given the highest priority at senior management level and promoted throughout as "everyone's business".

1.6 AN INFORMED SAFETY CULTURE

At present, there is no internationally accepted definition of patient safety incidents. Different definitions, information sources and methods of collection and analysis will affect findings. Appendix B provides examples of potential sources of information about the frequency of patient safety incidents and some of the strengths and weaknesses of each system. These include incident reporting systems, medical records review, surveys of patients and staff, and routine data collection. These illustrate the potential breadth of information sources, which contribute to knowledge of safety incident rates. However, for health and social care, the sources of reporting and data collection are even wider. What is needed is the systematic approach to data analysis and intelligence gathering from a range of sources, building on local, national and international capacity and capability, for example:

[8] Reason, J. Managing the risks of organisational accidents. Ashgate. Aldershot 1997

- published literature for health and social care environments e.g. NICE, SCIE and NPSA;
- National Inquiries - e.g. Confidential Inquiries: CEMACH, NCISH, NCEPOD;
- statutory and voluntary reporting systems - e.g. local medicines and devices reporting, MHRA, child protection, Mental Health Commission;
- hospital and social care episode statistics;
- health and social care complaints;
- local and national Inquiries, e.g., Lewis, Ombudsman, Hyponatraemia, Climbié, Shipman and Bristol Inquiry Reports;
- regional and local audit findings;
- Regulation and Quality Improvement Authority (RQIA) reviews and reports;
- Social Services Inspectorate reports;
- claims and litigation findings;
- coroner's findings; and
- death certification data.

Building a comprehensive picture on safety as part of improved quality of care can be complex. However, given the relatively small population size in Northern Ireland and the integrated nature of health and social care services, this provides us with a unique opportunity to draw together the different strands of learning and disseminate it in a positive way - to improve quality of health and social care, rather than in a punitive way to blame and shame individuals or organisations.

Yet being a small region also has its disadvantages in that incidents may occur relatively infrequently here to make their detection and monitoring meaningful. We must also learn from errors detected nationally; we cannot "reinvent the wheel" in terms of national and international expertise and resources when trying to draw together all the variety of sources of information to enhance learning. So, a balance has to be struck between the need for local intelligence mechanisms and expertise, and building on national and international capacity and capability. Hence the need for links with national organisations such as the National Patient Safety Agency (NPSA), Social Care Institute For Excellence (SCIE) and the National Institute for health and Clinical Excellence (NICE) - to enhance both quality and safety in health and social care.

KEY POINTS

- No health and social care service will ever be 100% error-free but what we can do is reduce the risk, enhance systems and expertise, and learn from adverse incidents and near misses.
- Strong leadership, a focus on systems and on organisational safety culture will reduce error.
- A regional definition of an adverse incident is identified covering health, social care, people, property, environment and reputation.
- A systematic approach to information gathering and data analysis is needed locally, which builds on national and international capacity and capability.
- No single source of information will provide all the data that is needed for safety analysis. For example, complaints, litigation, and death certification, together with adverse incidents reporting systems, audit and performance data need to be linked to enhance quality of care and be linked to evidence of effectiveness.

SECTION 2 – CURRENT SYSTEMS TO PROMOTE SUSTAINABLE IMPROVEMENT IN THE HPSS

2.1 INTRODUCTION

Sustainable improvement is at the forefront of the development of health and social care services in Northern Ireland. This is being undertaken through a multi-faceted approach to modernising and reforming organisational structures and delivery of care, together with a greater emphasis on quality, safety and accountability for the commissioning and delivery of that care.

Although healthcare systems from around the world vary considerably, many developed countries, such as the United States of America, Australia and the United Kingdom are leaders in the field of patient safety initiatives. Last year the UK European Union Presidency had a major focus on patient safety.

This section of the Safety Framework recognises that quality and safety are part of the continuum of local service improvement and are integral to good governance of an organisation. It sets out:

- the local commitment to quality and service improvement;
- safety and risk management systems underpinning good governance;
- local examples of organisational cultural change;
- links to national standard-setting bodies;
- examples of learning from local serious adverse incidents;
- changes to HPSS complaints procedures;
- serious adverse incident interim reporting arrangements; and
- the need for education, workforce development and regulation.

2.2 A COMMITMENT TO QUALITY AND SERVICE IMPROVEMENT

In 2001 the Northern Ireland Executive gave a commitment in the first Programme for Government to put in place a framework for raising the quality of services delivered and for tackling poor performance in the HPSS. Since then, much work has been undertaken to bring forward this programme.

The consultation document "Best Practice – Best Care"[9], issued in April 2001, was the first step towards fulfilling this commitment. It set out proposals to put in place a framework to raise the quality of services provided to the community and tackle issues of poor performance across the HPSS. The aim was to provide a high quality system of health and social care, which was easy and convenient to use, was responsive to people's needs and provided a service that instilled confidence in those who used it.

The quality improvements in "Best Practice – Best Care" are centred on five main areas:

- setting of standards: to improve services and practice;
- improving governance in the HPSS: in other words, the way in which organisations manage their business;
- improving the regulation of the workforce, and promoting staff development through life-long learning and continuous professional development;
- changing the way HPSS organisations are held to account for the services they commission and/or provide: the Duty of Quality; and
- establishing a new, independent body to assess the quality of health and social care - the Regulation and Quality Improvement Authority (RQIA).

From 1 April 2003, a statutory duty of quality was placed on HSS Boards and Trusts. Under this duty, each Board/Trust is required to[10] "*put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals and the environment in which it provides them*". This requirement to deliver on the quality of services is similar to the requirements already placed on the HPSS to ensure financial probity.

RQIA came into operation from April 2005. RQIA's principal role includes the registration, regulation and inspection of a wide range of services delivered by the independent sector and the HPSS, and to report to the Department on the quality of care provided by the HPSS. In addition, it has a general role to promote and facilitate quality improvement in health and social care.

[9] Best Practice – Best Care: a framework for setting standards, delivering services and improving monitoring and regulation in the HPSS

[10] Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (S.I. 2003 No.431 (N.I.9))

In order to provide greater consistency and accountability in the quality of care provided, and to facilitate the RQIA in its role, a range of standards have been developed, including:

- controls assurance standards[11], to assist HPSS organisations to demonstrate that they are doing their reasonable best to manage risk effectively;
- minimum care standards[12], applicable to agencies and establishments in the independent, voluntary and statutory sectors and to certain HPSS services; and
- generic quality standards[13], applicable to primary, secondary and tertiary care in the HPSS.

The above developments all contribute to good governance within the HPSS.

2.3 SAFETY AND RISK MANAGEMENT AS PART OF GOOD GOVERNANCE

All HPSS organisations are required to have a system of internal control to help facilitate the flow of information about risk both up and down and across the organisation. Part of this system is the recording of risks on risk registers. These are held at key points within the organisation depending on its size and structure. When most effective, a system of risk management involves every member of staff, and the organisation as a whole being aware of the key risks that affect them.

The function of risk registers is to inform key decision-makers of the risks they need to know about in order to fulfill their role in the commissioning and delivery of care. The recently-produced "Establishing an Assurance Framework: a practical guide for management boards of HPSS organisations[14]" is written to help HPSS board members, directors and senior managers within the HPSS to further improve their systems of internal control and to embed the principles of whole-organisation risk management as an integral part of quality health and social care. It acknowledges

[11] Controls assurance standards available on: http://www.dhsspsni.gov.uk/index/health_and_social_services/governance/governance-controls.htm
[12] Draft care standards available on: http://www.dhsspsni.gov.uk/index/consultations/previous_consultations.htm
[13] The Quality Standards for Health and Social Care: supporting good governance and best practice in the HPSS available on: http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health_social_care.pdf
[14] Establishing an Assurance Framework: a practical guide for management boards of HPSS organisations – http://www.dhsspsni.gov.uk/publications/2006/assurance_framework.pdf

that decisions by individuals, managers and directors can positively or negatively affect the delivery of care to the individual.

Knowledge and skills in the assessment and appropriate management of risk in an often rapidly changing environment of care are essential to organisational health, to ensure safety and to improve outcomes in clinical and social care. Clear roles, policies, procedures and systems will help facilitate appropriate risk decisions and minimise inappropriate and potentially damaging decisions. This includes a system for assuring that each organisation has available information about key elements of risk:

- at the right time;
- in the right way; and
- to the right person(s).

This enables the most appropriate decisions to be made and facilitates the promotion and delivery of improvements in care.

2.4 SUPPORTING CULTURAL CHANGE

Having appropriate procedures to identify, assess and manage risk is central to organisational health, but this has to be complemented by cultural change in order to demonstrate a commitment to good practice, drive quality and enhance organisational performance. The following four initiatives are all examples which support cultural change:

The Clinical and Social Care Governance Support Team (CSCG) was established by the DHSSPS in 2004. In establishing the CSCG Support Team, the Department's aim was to promote the longer-term cultural change and organisational development that it considered necessary to ensure that the statutory duty of quality could be implemented successfully and consistently in the HPSS. In turn, this would lead to a continuous improvement in health and social care services in Northern Ireland. A decision to link with the NHS Clinical Governance Support Team in developing these local arrangements was taken on the basis that the HPSS would have access to the experience, knowledge and tools already developed in the NHS. The CSCG Team has developed an extensive work programme across primary, community and secondary care. This programme has included specific training initiatives and topic specific programmes, such as in elderly care, to facilitate a multidisciplinary approach to learning and to champion

quality improvement. It complements the many other local initiatives, some of which have been ongoing for a number of years, such as the Clinical Resource Efficiency Support Team (CREST) which aims to drive up standards in clinical practice by the production of specific guidance.

Regional Governance and Risk Management Adviser - The post of Regional Governance and Risk Management Adviser, sponsored by the Department from October 2003, was initially focused on supporting the HPSS in embedding the fundamental structures and processes of risk management. The post promotes a joined-up approach to governance arrangements in HPSS organisations. Integral to this is the involvement of the adviser in a range of safety, quality and risk management initiatives. A major project is underway relating to the standardisation of definitions and coding to enhance incident management (see Appendix D).

The Northern Ireland Medicines Governance Team aims to improve medication-related patient safety by a systematic regional approach to medication risk management through the deployment of six senior pharmacists dedicated to medicines risk management in Northern Ireland hospitals. Beginning in August 2002, the team has addressed three main areas: the development of the risk management process itself, including identification, analysis and evaluation of risk, the development of 'good practice' initiatives and risk education. In November 2004, the Team was awarded the Health Service Journal Award for Patient Safety. As part of the Pharmaceutical Services Improvement Projects currently underway, funding has been secured to extend the Medicines Governance Team, with the aim of enhancing medicines governance arrangements in the primary care sector of the HPSS.

The Safer Patient Initiative, promoted and funded by The Health Foundation Trust, in collaboration with the Institute for Healthcare Improvement (IHI) in the USA, aims at making hospitals safer for patients in the UK. Following rigorous assessment of applications, Down Lisburn Trust was one of four UK Trusts selected to start work on the safety initiative in October 2004. This provides the Trust with an opportunity to work with an expert team from IHI and world experts to promote safety and quality. The four UK Trusts were selected for this prestigious project on the basis of their exceptionally high level of commitment to improving patient

safety. The project will last for two years; the selected trusts are expected to become exemplars in patient safety so that other hospitals can learn from their success.

2.5 LINKING WITH NATIONAL BEST PRACTICE

Whilst HSS Boards and Trusts in Northern Ireland have the capacity to be leaders in the field of quality and safety, given our relatively small size and limited resources, we must draw on the wide range of skills, knowledge and expertise that is available at national and international level. The establishment of appropriate links with national best practice and standard setting bodies is a key element in the framework for raising the quality of health and social services in Northern Ireland. These links are necessary to secure access to independent evidence-based guidance to promote safe, effective and efficient care.

It is recognised that guidance developed in Great Britain should generally have universal application and that local duplication is unnecessary.

Current progress on the Department's links with national bodies is outlined below.

- **National Patients Safety Agency (NPSA)** - A formal agreement with NPSA to extend its services to Northern Ireland is planned from April 2006. This will provide access to the whole range of NPSA's training material, tools and guidance to promote and facilitate safety in the HPSS. This will include access to the NPSA's *Seven Steps to Safety* programme for both primary and secondary care, adapted to meet the need of our integrated health and social care environment. In addition, the HPSS will eventually join with the National Reporting and Learning System, to facilitate an integrated approach to reporting and learning from adverse events (see section 3). The NPSA's Patient Safety Observatory will bring together many sources of information and facilitate benchmarking on safety across the HPSS with other regions.

- **National Clinical Assessment Service (now part of NPSA but previously the autonomous National Clinical Assessment Authority)** - Since October 2004, NCAS provides advice, support, and assessment for HPSS organisations where a doctor's or dentist's performance is called into question (see section 3). This was one of the key

recommendations in *Confidence in the Future for Patients, and for Doctors*[15]. This document set out proposals for the prevention, recognition and management of poor performance of doctors.

- **Social Care Institute for Excellence (SCIE)** – SCIE was developed to identify and promote dissemination of knowledge about what works in social care. A service level agreement was established with SCIE in June 2004 extending the Institute's remit to cover Northern Ireland. Local social care practitioners and academics are now actively involved in SCIE projects and the development of best practice guidelines.

- **National Institute for health and Clinical Excellence (NICE)** - Whilst NICE guidance has no formal status in Northern Ireland, many parts of the HPSS draw on the material produced by the Institute. The Department has had negotiations with NICE on formal links and is represented, in observer capacity, on the committee that provides advice on the selection of topics for NICE appraisal and guidance programmes. A process for reviewing the applicability of NICE guidance to Northern Ireland and, where appropriate, endorsing it for uptake in the HPSS is being put in place. In addition, the HPSS will link with NICE new interventional procedures programme to ensure that new procedures used for diagnosis and treatment are safe enough and work well enough for routine use in the HPSS.

2.6 LEARNING FROM LOCAL ADVERSE INCIDENTS

The provision of health and social care will never be error free due to the complexity of factors which contribute to that care. It is acknowledged that the majority of errors do not lead to any harm for patients, staff or service users, but unfortunately some will. Recent examples of adverse incidents which continue to receive much attention, because of potential severity of outcome are:

- **The Independent Review of Endoscope Decontamination,** was established in June 2004, following concerns about the effectiveness of decontamination of endoscopes in some locations in Northern Ireland. This was chaired by Dame Deirdre Hine. It examined the systems and processes in Trusts to ensure the effective cleaning and

[15] www.dhsspsni.gov.uk/publications/archived/2000/confuture.pdf

high-level disinfection of flexible endoscopes before and after their use on patients, and found a number of areas in which procedures could be improved. Implementation of the recommendations is currently underway.

- **Inquiry into Hyponatraemia – Related Deaths[16].** In November 2004, the Department appointed Mr John O'Hara QC to hold an Inquiry into the events surrounding and following the deaths of three young children, with particular reference to their care and treatment in relation to fluid balance, and the role that individuals and organisations played following their deaths.

- **The Management of Hyperkalaemia in Adults.** Following recent serious adverse incidents relating to blood electrolyte abnormalities involving potassium, the Clinical Resource Efficiency Support Team (CREST) produced guidelines and wall charts for every local organisation to provide clear and concise information to enable clinicians to safely and effectively manage patients presenting with hyperkalaemia.

- **Post operative care following laparoscopic abdominal surgery.** An independent review team produced a report on lessons arising from the death of Mrs Janine Murtagh. It contained a number of recommendations covering consent, patient care, leadership and communication, and the implementation of policies and procedures.

2.7 ARRANGEMENTS FOR MONITORING AND LEARNING FROM SERIOUS ADVERSE INCIDENTS

In July 2004, interim guidance was issued to the HPSS, including family practitioner services, on the circumstances where particular serious adverse incidents or near misses must be reported to the DHSSPS (Circular HSS (PPM) 06/04). These are where the episode is considered:

- to be serious enough for regional action to be taken to ensure improved care or safety for patients, clients or staff;
- to be of such seriousness that it is likely to be of public concern; or
- to require independent review.

[16] www.ihrdni.org

The guidance complements existing local and national reporting systems, both mandatory and voluntary, which have been established over the years. These provide for specific incidents relating to, for example, medical devices, equipment, medicines, mental illness, child protection, communicable disease and the safety of staff to be reported to various points in the DHSSPS.

The new interim reporting arrangements on serious adverse incidents (SAI) were developed to try and ensure that lessons are learned across the HPSS and that serious local incidents are not repeated. The DHSSPS plans to collate learning from reported SAIs and produce an annual report. DHSSPS will also hold SAI briefings for the HPSS at regular intervals. HPSS directors and senior officers responsible for safety and quality will attend these meetings in order to gain information on the emerging current picture of SAIs across the HPSS. This will present an opportunity for the service to share learning and discuss possible improvements to the current reporting mechanisms in order to facilitate further sharing and learning.

It is recognised that different sources and types of data on adverse incidents all contribute to our knowledge of adverse incidents. Examples include “near misses”, complaints, social care inspections, litigation, audit, records review, confidential inquiries etc., together with information about relatively infrequent incidents, which occurred in other health and social care systems. Through the NPSA’s National Learning and Reporting System, and Patient Safety Observatory, the triangulation of data sources and analysis will be facilitated. However, there will remain a need to have some local reporting arrangements to ensure timely dissemination of local adverse incidents and near misses. Work will be done to clarify arrangements and avoid duplication.

2.8 EDUCATION, WORKFORCE DEVELOPMENT AND REGULATION

Staff and HPSS organisations must be able to justify the trust that the public places in them. For this to happen, the DHSSPS and the HPSS need to be able to demonstrate that good standards of practice and care are being maintained and that respect for service users is being shown. It is recognised that when safety and quality are introduced early into educational programmes, this has a positive impact on the future delivery of safe and effective care. Consequently, the content of this framework will be of use to educational providers.

The maintenance of good standards of practice and care requires individuals and organisations to have a learning culture, and one which supports training and development of staff. Training and development needs analyses, linked to regional, local, organisational and individuals' priorities and objectives, are essential for the ongoing enhancement of quality and safety within the HPSS. The introduction of quality assured appraisal systems which facilitate review of performance and the identification of development needs have the capacity to improve treatment and care and reduce error.

The regulation of the workforce has a major part to play in the promotion of quality and safety. Regulation and responsibility should take place at different levels[17], for example:

Personal level – based on a commitment to quality of care that puts the safety and care of the patient and service user first;

Team level – based on the concept of the importance of team working and the requirement to take responsibility for the performance of the team, and to act if an individual's conduct, performance or health is placing the public at risk;

Workplace level – which reflects the responsibility that HPSS organisations have for ensuring that staff, equipment and facilities are fit for purpose in the commissioning and provision of care. This is expressed through the Duty of Quality, clinical and social care governance, performance management systems and compliance with legislation; and

Professional level – which is undertaken by statutory regulators, for example, working through the development of standards, education, registration and licensing, and fitness to practise procedures.

Examples of professional regulators include the General Medical Council, General Dental Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland, the Health Professions Council, General Optical Council and the Northern Ireland Social Care Council. All of these organisations have a major part to play in the promotion of quality of care and in the identification and management of fitness to practise. The Council for Healthcare Regulatory Excellence was formed in April 2003 to

[17] Adapted from Developing Medical Regulation: A Vision for the Future – April 2005 - GMC

ensure consistency of approach and good practice among nine "health" regulators. Several of the professional regulatory organisations identified above are undergoing development and change. Many of the drivers for change in the regulation of the workforce are as a consequence of national inquiries such as, the Bristol, Shipman, and Climbié Inquiry Reports.

Locally, a number of organisations also promote best practice and enhanced clinical and social care performance, including:

Northern Ireland Social Care Council (NISCC) – As part of the Northern Ireland Assembly's commitment to raising the status of the whole social care workforce, raising the standards of social care practice and ensuring proper protection of the public against persons who are unsuitable to carry out the work, NISCC was established in 2001 to regulate the social care workforce and to regulate the training of social workers.

Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) – In 2002, NIPEC was established to shape practice, education and performance within the professions of nursing and midwifery in Northern Ireland and to equip nurses and midwives in such a way as to enable them to provide better care for patients and service users.

KEY POINTS

- Sustainable improvement in health and social care requires a multifaceted approach, including service reorganisations and reform, and an emphasis on safety and quality as part of good governance.
- Systems and procedures for the identification, assessment and management of risk are important but have to be supported by organisational cultural change to promote sustainable quality improvements.
- Much work had already been undertaken locally to support quality and safety.
- National links are an important way of gaining access to knowledge, skills and best practice.
- Linkage with the National Patient Safety Agency, National Institute for health and Clinical Excellence, and the Social Care Institute for Excellence are pivotal to the promotion of quality and safety.
- Education, workforce development and regulation occur at individual, team, organisational, regional, and national levels; it is part of the drive to promote quality and protect the public.
- Recent local adverse incidents emphasise the need to put *safety first.*

SECTION 3 – PROMOTING SERVICE USER AND STAFF SAFETY

3.1 INTRODUCTION

Section 2 identified the progress that has been made to date to promote and embed quality and safety within HPSS environments. This section builds on this work and identifies other key elements to promote service user and staff safety. These include:

- creating an informed, open and fair safety culture across the HPSS;
- raising awareness of risk and promoting timely open reporting of adverse incidents;
- sharing the learning across HPSS environments and implementing solutions; and
- investigating serious incidents.

To facilitate implementation of these key elements requires co-ordinated action involving individuals, the HPSS including family practitioner services and the DHSSPS. Actions to promote and support a safer service are identified in section 5. This section is written for managers, educationalists and practitioners to clearly document high level work which needs to occur between 2006 and 2007. The action plan is outcome focused and attributes responsibilities.

3.2 CREATING AN INFORMED, OPEN AND FAIR SAFETY CULTURE ACROSS ORGANISATIONS

An informed organisational culture that promotes safety and quality should be at the centre of every stage of prevention, treatment and care. Section 1 identified four main components of an informed safety culture as:

- a reporting culture;
- a just culture;
- a flexible culture; and
- a learning culture.

A just culture is one that is seen to be open and fair to staff. Creating such a culture encourages the reporting of incidents, which is essential to the success of data collection and subsequent improvement in activity, systems, and care.

An “open and fair” organisation can be defined as a one where staff are not blamed, criticised or disciplined as a result of a

genuine slip or mistake that might have lead to an incident. Disciplinary action would, however, follow an incident that occurred as a result of misconduct, gross negligence or an act of deliberate harm. In determining 'blameworthiness', a 'fair' approach is one that separates the actions of individuals involved from the patient outcomes. A 'fair' culture advocates the systems approach, recognising that accidents may occur as a result of a series of system failures rather than through a deliberate malicious act on the part of an individual. Moving to the systems approach will be an important challenge. Research has shown that currently 85% of health care incidents are caused by systems failures yet, 98% of remedial action focuses on the person or people involved in the incident[18].

Organisations that operate a 'fair' culture are more likely to gather useful information about their organisation that can be used to further improve safe practice and pre-empt future incidents. In this way the organisation can acknowledge mistakes, learn from them and take action to put things right. This is an integral part of what the public wants the HPSS to achieve.

But being "open and fair" also means that the organisation should encourage staff to be open and fair when communicating with patients, service users and carers. This is a part of the redress that people can and should expect when things go wrong and where harm has been caused. This includes an organisational commitment to providing an explanation of what happened, an apology, a reassurance of speedy remedial treatment and, where appropriate, financial compensation.

Any change in culture requires sustained commitment at the most senior level in the organisation. Frank and open discussion needs to occur within senior management and agreement reached on what an open and fair culture will mean in practice for their organisation and this needs to be cascaded throughout the organisation as part of an overarching policy on safety. There are many tools which can assist HPSS organisations in assessing organisational safety culture in terms of underlying beliefs, attitudes and behaviours. In addition, tools such as root cause analysis and NPSA's Incident Decision Tree can assist in distinguishing between poor performance of the individual and a systems failure.

[18] Overveit J. Health Service Quality. Brunel University, 1998

3.3 RAISING AWARENESS OF RISK AND PROMOTING TIMELY REPORTING

Raising awareness of risk implies that all members of an organisation should have a good understanding of the factors that contribute to human and organisational error. In addition, there is a need for individuals to recognise that no-one is perfect; that there is always the capacity to reflect on one's work and to improve. Key tools to enhance this reflection are, for example, professional appraisal, audit and significant event analysis, and multidisciplinary team discussion and analysis.

Raising awareness of risk has to happen at all levels within an organisation. Whilst much work has been done to promote risk assessment and risk management within HPSS organisations within recent years, there remain opportunities which the HPSS will have, in the near future, including access to all NPSA material, tools and guidance.

Recent HPSS adverse incidents, highlighted through the coroner's service, have emphasised the need to pay particular attention to risk awareness and action within undergraduate and post graduate training programmes, newly appointed staff and at vulnerable interfaces such as the transfer of patients to different parts of the HPSS or at the interface between secondary, community and primary care. Specific action to raise awareness in these vulnerable areas needs to be undertaken. In particular, risk awareness should be incorporated into education and training programmes; there should be mandatory training for all newly recruited staff on basic organisational risk awareness, policies and procedures, risk within their specific areas of work, and on incident reporting systems. This should be seen by senior management as an integral part of a new recruit's induction into the organisation. In addition, all existing staff should have in-service education and training to support the continual awareness of risk. Appendix C provides an example of a training programme to promote risk awareness.

It must be explicit in all training and incident reporting and management policies that a staff member's responsibility for patient and service user safety comes before any responsibility to other staff, for example, in their own team or profession. This is supported by the codes of conduct for each profession and must be observed regardless of the severity of the incident(s) concerned.

Promoting a reporting culture is an important challenge for all sections of the HPSS and one which is essential if organisations and individuals are to learn from errors. Timely and open reporting is part of individual and organisational responsibility to quality improvement and learning. Whilst it is acknowledged that the majority of incidents do not lead to harm, valuable lessons can be learnt from these and "near misses" – where an error was detected and stopped before it resulted in harm. Research has shown that the more incidents and near misses that are reported then the more information there is about what is going wrong and the more action that can be taken to make health and social care safer both locally and nationally[19].

It is essential that commitment from senior management within the organisation is evident and that clear lines of accountability and communication are defined. It is equally important to ensure that policies and procedures are not simply 'for show' and that staff experiences reflect the ethos agreed by senior management. For example, the ways in which the reporting, investigation and subsequent management of medication incidents have been handled to date, indicates that cultural change is possible and, as a consequence, staff are willing to report incidents. But for staff, the benefits of reporting are not always made clear, particularly when there is a fear of blame, no noticeable change and no feedback. In addition, reporting can seem time-consuming and complicated.

The benefits of reporting need to be cascaded throughout the HPSS. These include:

- improvement in care of patients, clients, service users and staff;
- resources targeted more effectively;
- increased responsiveness;
- pre-empting complaints; and
- reducing costs.

3.4 REGIONAL REPORTING SYSTEMS PROJECT

In order to promote consistency of approach to reporting, in January 2005, the DHSSPS commissioned a project to be carried out across the HPSS to standardise definitions, reporting forms and the coding of incidents. A summary of the first phase of this project is included in Appendix D. This work should help facilitate

[19] Seven Steps to Patient Safety – NPSA - 2004

the sharing of learning between HPSS organisations as data can be shared and analysed more easily across Trusts, Boards and relevant Agencies that comprise Northern Ireland's HPSS. This project's remit encompasses all adverse incidents, inclusive of clinical incidents, social care, staff incidents and any other adverse event that may affect the operation of the HPSS, including the family practitioner services. The work will further facilitate a future link with the National Patient Safety Agency's National Reporting and Learning System.

Whilst local reporting mechanisms will always be important, there is some potential duplication in current reporting systems at local, regional and national level. This is because reporting systems serve different purposes and may have different specialist audiences. In order to provide a greater understanding of where the links are at local, regional and national level will require the Department to work with the HPSS and the NPSA to promote a consistent approach. Of particular importance is the incorporation of all health (both clinical and non clinical) and social care incidents.

The Regional Reporting Systems Project is part of the work to provide greater consistency of approach locally. This Project is part of the phased implementation plan to join with the NPSA's National Reporting and Learning System (NRLS). Joining the NRLS will mean that the HPSS will receive comprehensive reports on patient safety incidents, tailored to the needs of Northern Ireland, but it will also facilitate comparisons with other regions in England and Wales on the frequency of reporting and type of incident. In addition, through the Patient Safety Observatory, the Department and HPSS will have access to the learning that will emerge from other reporting systems and sources, such as, MHRA for medicines and medical devices, professional bodies and National Confidential Enquiries. Use of computerised data analysis tools will help identify potential clusters, patterns and trends across these reporting systems.

Comparisons between regions are important; however, there remains a need within each HPSS organisation to ensure that a reporting culture is fostered and that tools such as the Heinrich ratio are used to regularly assess the "health" of the organisation's reporting system and, where appropriate, ask area/sections which are not reporting for a "nil return" to confirm that incidents have not occurred.

3.5 SHARING THE LESSONS ACROSS THE HPSS

Section 1 provided examples of the many and varied data sources from which learning on safety and quality issues can occur - for example, audits reports, incidents reporting systems, complaints procedures and claims and litigation. When an incident occurs, a fundamental principle of a systems approach to error management is the understanding of how and why an incident occurred[19]. It is only then that learning can be shared and the lessons learnt used to prevent its reoccurrence. The sharing of learning can and should take place at different levels, for example:

- multidisciplinary team discussion within HPSS organisations;
- participation in personal and team education, training and development e.g. development of guidelines and solutions;
- training and participation in and use of investigative tools such as Root Cause Analysis;
- formal data collection and analysis procedures e.g. outcome statistics discussed at team, clinical and social care governance and senior management levels;
- formal communications pathways and networks e.g. urgent communications, newsletters, IT-based systems and discussion fora; and
- production and cascade of annual/ quarterly reports on adverse events.

Further consideration will be given to developing a single information gateway to bring together all departmental publications and guidance in an accessible format and on a monthly basis. In addition, the DHSSPS and the HPSS will consider how the extranet could be used to disseminate the results of all root cause analysis between organisations.

The accountability for patient, service user and staff safety rests with the Chief Executive of an organisation. To facilitate discussion, analysis and feedback, an integrated governance approach should be encouraged within HPSS organisations. There is a need to ensure that there are clearly delineated relationships and communication pathways within the organisation. This is necessary so that front line staff and, in particular, clinical and social care governance leads and risk managers have access to up to date information and that there is a feedback loop to ensure that safety information is received and acted upon within an appropriate timeframe.

The Safety Alert Broadcast System (SABS) is an electronic system developed by the Department of Health in England, with the MHRA, NHS Estates and the NPSA. The aim of this system is to bring different types of alerts together into one electronic system thus ensuring that all urgent communications are received and implemented. Nominated leads in each Trust and Primary Care Trust are asked to disseminate it to those who need to take action. This role is similar to the current MHRA medical device liaison officer role but with the additional responsibility of providing feedback on action to implement the alert using a simple electronic form. The development of a Service Level Agreement with NPSA will provide an opportunity for the Department to explore with the Department of Health in England if appropriate links to the SABS system can be established.

3.6 INVESTIGATING SERIOUS INCIDENTS

Obtaining incident reporting data is just the first step towards a comprehensive approach to safety. Significant investment has been made locally and nationally in root cause analysis training to promote proper understanding of the cause(s) of an adverse incident. There should be a consistent approach to deciding which incidents need to be followed up and further investigated; these should follow best practice in the use of tools for root cause analysis. There are two main criteria, which the HPSS should use in determining further investigation of an incident:

- ***the level of severity/grade of the incident*** - e.g. an untoward death or permanent injury; and
- ***the potential for learning*** e.g. frequency of incident or near miss.

The Chief Executive of the organisation is responsible for investigating the cause of a serious incident as part of his/her commitment to quality of care, which is underpinned by the Duty of Quality. The immediate priority in this case should be to take all the necessary steps to secure the safety of services users, staff and other people involved. All HPSS organisations should have clear policies on incident reporting including a standard approach to investigation of each level of severity of incident. This will be facilitated by the Regional Reporting Systems Project (see Appendix D) and links with the NPSA.

Incidents involving unexpected death or serious harm and requiring investigation by the police and/or the Health & Safety Executive (HSENI) are rare but have increased in number in the

past few years. There is a statutory duty placed on individuals and organisations to report such incidents. When they happen, incidents need to be handled correctly for public safety reasons as well as the maintenance of confidence in the HPSS, Police, Coroner and Health and Safety Executive. To achieve this, it is important that these four arms of the public sector communicate and work with one another in a consistent and ordered manner. The DHSSPS has finalised a Memorandum of Understanding[20] between these four organisations in order to better facilitate these complex interactions. The Memorandum complements existing joint procedures in relation to the protection of children and vulnerable adults.

Special action must be taken in the event of a public health hazard such as a major incident, chemical contamination, or biological, radiological or nuclear emergency. Specific regional guidance governs arrangements for dealing with major incidents.

Regional guidance should be followed where incidents involve suicides or other serious events involving people who have a mental disorder, child protection issues or when an incident fitting the criteria of a National Confidential Enquiry has occurred.

Where an incident involving a medicine has occurred, which falls within the remit of the Medicines Act and the Pharmacy Inspectorate of the DHSSPS, organisations should comply with regional reporting arrangements and co-operate with the investigation.

3.7 ENHANCED ASSESSMENT OF CLINICAL AND SOCIAL CARE PRACTICE

In countries that have promoted safety and quality in healthcare, there is a link between institutional assessment, reviews, accreditation and safety and quality initiatives; the assumption being that quality and safety, to some extent, can be assured by a review, inspection or an accreditation process. All of these processes take account of recognised standards of care.

This inspection, review or accreditation can take place at different levels, for example at:

- national level – through professional bodies and national accreditation schemes;

[20] http://www.dhsspsni.gov.uk/mou_investigating_patient_or_client_safety_incidents.pdf

- regional level – though statutory inspection procedures and clinical and social care governance reviews;
- local level – through commissioning arrangements with providers of care; and
- individual level – through the organisational assessment of individual performance.

The RQIA will be reviewing clinical and social care governance within the HPSS using the five themes contained within the Quality Standards, with particular emphasis on Safe and Effective Care. This approach will assist RQIA and the HPSS in the future development of methodologies and the refinement of self-assessment processes.

RQIA will report on the quality of care provided by the HPSS following its governance reviews. This developmental approach will promote quality improvement across organisations.

In addition to RQIA's inspection and review functions, it also has the power to investigate serious incidents at the request of the Minister, Department or the public. It will report to the Department on the quality of care within all HPSS services. As the work of RQIA progresses, it will provide a rich source of learning for the HPSS, the DHSSPS and the public.

At national level, the impact of major inquiries such as Shipman, Kerr/Haslam and Climbié, will continue to have a major impact on organisational and professional practice locally. In addition, reviews[21], such as those currently being undertaken by Sir Liam Donaldson and Mr Andrew Foster will impact on clinical and social care governance arrangements locally, including how an individual practitioner's fitness to practise is assessed.

A formal link with the National Clinical Assessment Service has already been established to provide advice, support and, where appropriate, full assessment for HPSS organisations, where a doctor's or dentist's performance is called into question. In addition, annual appraisal of individuals is now a reality for many HPSS staff. Where performance of an individual is considered to put patients or service users at risk, then the organisation must have processes in place to facilitate action and prevent harm.

[21] CMO Review of Medical Revalidation: A Call for Ideas, 3 March 2005 – www.dh.gov.uk; Review of Non-Medical Regulation – Call for Ideas, 29 June 2005, Mr Andrew Foster – www.dh.gov.uk

New disciplinary procedures for HPSS-employed doctors and dentists have been introduced to promote the early and active assessment and resolution of concerns regarding clinical practice. In addition, primary legislation is being drafted for the family practitioners services, to further extend the function of the Health Service Tribunal and the powers of HSS Boards where there is a concern about professional or personal conduct or practice.

A local response to Shipman Inquiry recommendations will be produced, to cover:

- Shipman 3 – Recommendations on new death certification pathways and investigation;
- Shipman 4 – Recommendations on enhanced monitoring and inspection of controlled drugs; and
- Shipman 5 – Recommendations on complaints, whistle-blowing, appraisal and professional performance.

3.8 DESIGNING AND IMPLEMENTING SOLUTIONS

The HPSS does not, as yet, have good mechanisms to facilitate the sharing of solutions on quality and safety problems. There is often excellent work in progress across the HPSS but no clear forum for sharing this work to others in similar situations. This may lead to duplication and wasted resources and the reoccurrence of adverse incidents. The measures identified in paragraph 3.4 will facilitate the cascade of effective solutions. So too will links with national bodies specifically involved with solutions development such as the NPSA, MHRA and the NHS Purchasing and Supply Agency.

Whilst reporting systems are a pivotal part of the identification of trends and themes requiring solutions, they are not the only source of information at local or national level. There is a need, therefore, to promote partnership working within the HPSS and at national level to share resources in solutions development. However, where a solution needs to be developed and implemented locally, it should be specifically commissioned by the DHSSPS with the scope of the project clearly defined and resourced.

To facilitate implementation, where appropriate, a solution should be designed in toolkit format in order to promote consistency of approach across the HPSS. As identified in the Safety Alert Broadcast System (SABS), there should be a feedback loop to confirm that implementation is completed. New arrangements for regional audit should be linked to the wider quality and safety

agenda and used to facilitate implementation of solutions, where appropriate.

The development of a Service Level Agreement with the NPSA opens up the possibility for the HPSS to be selected to pilot new approaches to the delivery of care/improvements in patient safety. This is particularly appropriate in areas where the HPSS has carried out innovative work e.g. Medicines Governance and in areas where the HPSS presents a unique challenge, for example, the large and complex area of social care. Participation in the development of innovative work will stimulate the further development of a safety culture across the HPSS and will engage both health and social care professionals.

Effective design of health and social care facilities remains an important aspect of quality of care. This is because effective design thinking can deliver products, services, processes and environments that are simple to understand, to use, comfortable and convenient, and consequently less likely to lead to accidental misuse, error and accidents. The report, *Design for Patient Safety* [22] identifies opportunities for improving patient and service user safety through the more effective use of design.

[22] Design for patient safety: A system-wide design-led approach to tackling patient safety in the NHS Department of Health and the Design Council. February 2004. Available at : http://www-edc.eng.cam.ac.uk/medical/reports.html

KEY POINTS

- An **informed** organisational culture, that builds on many data sources, is necessary to promote safety and quality. This culture requires endorsement and agreement by senior management in order to promote a **reporting** culture, and one, which is seen to be **just**, **flexible** and has the capacity to **learn** from errors.
- A systematic approach to raising awareness of risk of the factors that contribute to human and organisational failures is essential for staff, especially new recruits.
- Promoting timely open reporting is a major challenge for all HPSS organisations; the benefits of reporting should be highlighted to staff with clear feedback mechanisms identified.
- The first step to a comprehensive approach to safety, is obtaining and analysing **all** incident data. Clear policies and procedures for the reporting and investigation of serious incidents are the responsibility of senior management.
- The NPSA's National Reporting and Learning System will facilitate a cohesive approach to data collection in Northern Ireland and will facilitate benchmarking against other regions.
- Links to the NPSA, through its "Seven Steps" Programme together with use of tools and guidance will promote reporting and investigation of serious incidents in secondary and primary care, and build on existing work.
- Designing and sharing the solution, should draw on national and local work; where appropriate, local organisations should lead in the piloting of such solutions.
- Enhanced assessment of clinical and social care practice through HPSS Regulation and Quality Improvement Authority will promote learning.
- Where individual performance is called into question, the National Clinical Assessment Service will provide advice and support to organisations, and formal assessment of the individual, if required.

SECTION 4 – INVOLVING AND COMMUNICATING WITH THE PUBLIC

4.1 INTRODUCTION

There is now good evidence that trusting and respecting the patient/user at a number of levels (e.g. individual and community) in the health and social care system improves health and well-being significantly[23]. Patients, service users and the public have a major part to play in the prevention and detection of errors in health and social care.

4.2 PUBLIC INVOLVEMENT IN PROMOTING HEALTH, WELL-BEING AND SAFETY

People are ultimately responsible for their own health and well-being, and that of their dependants. However, it is acknowledged that health and well-being are influenced by many factors, such as poverty, crime, violence, education and unemployment. HPSS service provision plays but one part in the overall health of the population. The HPSS needs to work in partnership with other agencies, communities and the media to seek to influence and improve the health, social well-being and safety of the public and their staff. In this regard the media have an important public health and safety role in tandem with their duty to responsibly hold public bodies to account.

The Quality Standards for Health and Social Care set out the values and principles which all HPSS organisations and staff should adopt when engaging with the public and service users. These include the need to involve people in all stages of care and to provide timely and appropriate information to assist in decision-making.

Integration of service users, carers and local communities into all stages of planning, development, evaluation and review of health and social care services is an important part of continuous quality improvement and the open culture which should be promoted throughout the HPSS.

Through proactive involvement of the public in safety matters, it is hoped that:

[23] www.pickereurope.org

- risks will be identified;
- concerns and ideas for improvement will be shared; and
- solutions will be generated in partnership with service users and the public which will be more realistic and achievable.

4.3 PUBLIC EXPECTATION OF A QUALITY SERVICE

Understanding the expectations of the public, staff, media and an organisation can sometimes be difficult. But proactive involvement of the public and staff will lead to a mutual understanding of needs and drivers for change; for example, why certain HPSS services require development to ensure safe and effective care and others do not. In addition, it will promote an understanding of the complexity of factors which determine why health and social care services will never be error free, but minimisation of the risk of error is important for service improvement and health and social care outcomes. But when things go wrong, people have a right to feel let down by the Service, to make a complaint and to seek redress if harm has been caused. Some organisations and staff have a tendency to think of these actions in a negative light because of fear of litigation, adverse media coverage and potential for destruction of reputation and career pathway. Both service users and staff need open and fair processes to investigate and determine the cause of what went wrong. For this to happen means that there are special responsibilities placed on the media, the public, service users and staff. A system that does not support an open and fair process is to no-one's advantage in Northern Ireland, as it will not encourage open reporting, communication or learning.

4.4 CHANGING LOCAL COMPLAINTS PROCEDUES

The reporting and handling of complaints are also part of a learning culture. The public has a right to complain when concerned about their treatment or care. Complaints tend to be seen in a negative light, but nonetheless are a significant source of learning for individuals and organisations.

The Department is currently undertaking a review of the HPSS complaints procedures, with the aim of making complaints systems more effective for the public, staff and organisations. It is anticipated that a public consultation on the new procedures will commence in early 2006. This consultation will also incorporate some of the recommendations contained in the 5th Shipman Inquiry Report.

In reviewing the HPSS complaints procedures, the aim is to:

- make procedures easier to access;
- be fair to all parties;
- respond to complaints in a timely way;
- emphasise early resolution;
- ensure the process is aimed at satisfying the complainant's concerns; and
- promote learning across the HPSS.

4.5 A SYSTEM OF REDRESS

Errors will happen and although most do not lead to harm, some will. But what happens when things go wrong and a service user is harmed? Not all service users and carers are content with the current system and sometimes find it hard to engage with HPSS organisations to find out what happened to themselves or to their loved one.

Openness is fundamental to the partnership between the service user and those who provide care. In support of that openness, people should be given an explanation of what has happened, an apology, reassurance, remedial treatment and compensation, where appropriate. A unified approach to redress should be developed. Effective redress will be part of the regional and local goal to promote a timely response for the service user. It will also set "error" in the context of learning in order to promote quality improvements within the HPSS.

4.6 COMMUNICATING SERIOUS INCIDENTS

All organisations should have a clear policy on how to communicate a serious incident to individuals, families and carers, staff and to the media, where appropriate. This policy should comply with best practice relating to the confidentiality of information, human rights, and privacy for service users and staff. The six major parts of this policy should include:

- a unified approach to redress (as identified above) for the individual, their family and carers;
- support for service users and carers during the course of an investigation and/or further treatment;
- support for individuals within the organisation to cope with the physical and psychological impact of what has happened;
- a timely inter-organisational communication system;

- designated and trained key people within the organisation with responsibility for communication; and
- how and by whom the incident should be investigated.

KEY POINTS

- Individuals have responsibility for their own health, and that of their dependants.
- The HPSS, public and media need to work in partnership to promote public health and social well-being, and to enhance safety for service users and staff.
- Provision of information, in accessible format, to support decision-making in treatment and care, and to enhance safety, is essential for service users and carers.
- The public has a pivotal role in the prevention and detection of error.
- The public has a right to complain when concerned about their treatment or care. Complaints are a significant source of learning for HPSS organisations.
- The public and media have important responsibilities regarding the promotion of an open and fair culture, in order to prevent reoccurrence of incidents.
- Service users and staff need open and fair processes when a serious adverse incident is being investigated.
- Redress means having systems in place to offer an apology, reassurance, speedy remedial treatment, and compensation, if appropriate, when harm has been caused to an individual.
- All HPSS organisations should have an effective communication policy in place.

SECTION 5 – ACTION PLAN AND STEPS TOWARDS SUSTAINABLE IMPROVEMENT

5.1 INTRODUCTION

In this section, the action plan and steps underpinning sustainable improvement in the HPSS are brought together in five key themes:

- implementing evidence–based best practice and learning from adverse events;
- agreeing common systems for collection, analysis and management of adverse events;
- sharing the learning;
- building public confidence; and
- promoting education, training and support for health and social care staff.

The audience for this action plan is HPSS managers, staff, educationalists and practitioners, including those working within the family practitioner services. The plan also includes action which will be undertaken by the DHSSPS as part of its commitment to safe and effective care. Given the broad nature of the safety and quality agenda, the plan does not aim to be all-encompassing but rather to focus on high level actions which need to take place in order to prevent adverse outcomes, and to improve service user, carer and staff experiences. It is seen as complementary to the many other initiatives which are ongoing in the HPSS primary, secondary and community sectors to improve health and social care outcomes.

The vision for the future is a safer service, where there is a systematic and co-ordinated approach to safety and quality. This requires staff, organisations and the public to work in partnership to promote a culture of learning, which is open and fair to service users, carers and staff, and one which minimises errors.

The following action plan will be reviewed and updated in 2007 to take account of progress and local and national developments.

5.1.1 Implementing evidence based practice and learning from adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS	Links to the National Patient Safety Agency will be agreed and guidance issued to the HPSS	Access to training, tool and guidance for the HPSS and the Department	April 2006
DHSSPS	A phased implementation plan to support joining the National Reporting and Learning System (NRLS) will be put in place	Triangulation of data sources, benchmarking and cascade of learning	June 2006
DHSSPS	All HPSS organisations will be part of NRLS	Triangulation of data sources, benchmarking and cascade of learning	December 2007
DHSSPS	Guidance on the nature of links to NICE and local pathways will be cascaded to the HPSS	Promotion of evidence based best practice	February 2006
DHSSPS	Following links with NICE, specific guidance on the introduction of new interventional procedures into the HPSS will be produced	Safer introduction of new diagnostic equipment and treatments.	April 2006
DHSSPS, CREST	CREST together with the Department will agree and publish the process for development of its annual work programme	Better linkage of regional priorities and audit programmes	June 2006
DHSSPS, CREST, RMAG	The Review of Regional Audit Arrangements will be implemented. Regional audit programmes will be linked to the wider safety and quality agenda	Better linkage to regional priorities and audit programmes	April 2006 Ongoing
RQIA	Will commence evaluation of HPSS quality of care	Assessment quality of care	From April 2006 ongoing

5.1.2 Agreeing common systems for data collection, analysis and management of adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS, HPSS	All organisations will adopt the definition of an adverse incident as identified in Section 1	Standardisation of definition and local data collection in adverse incidents	March - 2006 ongoing
DHSSPS, HPSS	All organisations will recognise the need for an informed safety culture	Supports timely reporting and an open, fair, flexible and learning culture	March 2006
DHSSPS	Better linkage on quality and safety agenda within Departmental structures	Integration of quality and safety issues	April 2006
DHSSPS, HPSS	Safety and quality will be a standing agenda item at board meetings	Senior management commitment to quality and safety	February 2006 and ongoing
HPSS	Organisations will have incident reporting levels reviewed at least quarterly by senior management	Regular analysis of adverse incidents and near misses	March 2006 ongoing
HPSS	All organisations will have a designated lead to determine when a serious incident investigation should be instigated	Clarity and consistency in handing investigation of major incidents	April 2006
DHSSPS, HPSS	Algorithms on common and specific reporting systems will be designed and cascaded for use in HPSS	Avoidance of duplication and clarity of reporting arrangements	September 2006
DHSSPS	Develop and publish policy guidance to clarify the role and function of Interim Arrangements for the Reporting of Serious Adverse Incidents	Clarity for the HPSS and the Department in the Reporting of Serious Adverse Incidents	February 2006
DHSSPS	Review local Interim Arrangements for the Reporting of Serious Adverse Incidents, in light of links with the NPSA's Patient Safety Observatory	Clarification of purpose and avoidance of duplication	April 2007
DHSSPS, HPSS	Regional Reporting Systems Project for primary and secondary care will be completed, and linked to joining with NRLS	Standardisation of definitions, reporting forms and coding of incidents	April 2007

5.1.2 Agreeing common systems for data collection, analysis and management of adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS	A centralised database of clinical negligence claims will be developed	Enhanced data analysis and sharing the learning	December 2006
DHSSPS, in collaboration with PSNI, HSE, and Coroner's service	A Memorandum of Understanding will be published on the investigation of unexpected death or serious harm, which will complement existing procedures and processes for protection of children and vulnerable adults	Promoting communication and shared working between the public sector	March 2006
DHSSPS	Further guidance will be issued on how and when to investigate a serious adverse incident	Clarity and consistency in handling investigations	September 2006

5.1.3 Sharing the learning			
Responsibility	**Action**	**Purpose**	**Completion date**
HPSS, including FPS	Each organisation will have a policy on incident management which will be endorsed by senior management and will be regularly reviewed	Consistency of approach in incident management and learning throughout the organisation	March 2006
DHSSPS, HPSS including FPS	Each organisation will demonstrate a multidisciplinary team approach to reducing risk and improving reporting	Engagement with staff. Consistency of approach in incident management and learning throughout the organisation	April 2006
HPSS including FPS	Each organisation will have a feedback mechanism in place when an incident is reported by an individual or team	Facilitation of action, learning and service change	March 2006
DHSSPS, HPSS	Where a major incident has been identified locally, local solutions will be designed by convening a panel of experts and/or building into existing programmes e.g. CREST, NPSA	Facilitation of action, learning and service change	Ongoing
DHSSPS	An annual report on local serious adverse events will be issued to the HPSS	Sharing the learning and implementing change	March 2006 and Ongoing
RQIA	Following investigation of specific serious adverse incidents, RQIA will produce and cascade a report	Cascade of learning and prevention of reoccurrence of adverse incident	April 2006 and ongoing
DHSSPS, HPSS	A review of communication channels will be undertaken by the Department to include; - consideration of links with SABS, a gateway approach to provision of information, revision of departmental website “governance” pages and extranet access on the results of root cause analysis in the HPSS	Enhanced communication, timely distribution of urgent communications and sharing of learning	December 2006

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS, HPSS	Organisations will recognise that health and social care will never be error–free, but patients, clients, service users and carers have an important partnership role to play in identification and reduction of errors	Better information to service users and acknowledgement of their role as partners in care	February 2006 Ongoing
DHSSPS, HPSS	Organisations will have a policy on how to communicate a serious adverse incident to individuals/families/staff and the media	Better information and coordination of communication with stakeholders	April 2006
DHSSPS in collaboration with NISCC	A programme for roll-out of registration for the social care workforce will be agreed and commenced in April 2006	Enhanced regulation of the workforce	April 2006
DHSSPS	A public consultation will be undertaken on a new HPSS complaints system	Improved openness, transparency and learning	April 2006
DHSSPS, in collaboration with HPSS	Guidance on redress, where harm is caused to service users, will be developed and implemented in the HPSS	Supporting openness, an apology, an explanation, remedial treatment and compensation, where appropriate	December 2006
DHSSPS, in collaboration with HPSS	A composite set of safety/quality performance indicators will be developed encompassing clinical and non-clinical care, and social care	Enhanced accountability and performance management on safety and quality	July 2006
DHSSPS	New Primary Care legislation will be introduced to enhance the role and functions of the Health Service Tribunal and powers of the HSS Boards	Improved procedures for considering the conduct or performance of family practitioners	November 2006
DHSSPS, HPSS Boards and Trusts	A specific project will be convened to consider key elements to enhance safety and communication at the interface of primary and secondary care	Enhanced safety and quality of care at the interface of primary and secondary care	February 2007
DHSSPS, HPSS Boards, Primary care	Medicines Governance Team Programme will extend into primary care	Promotion of medicines risk management and improvement in quality of	January 2006 Ongoing

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
practitioners Medicines Governance Team		care	
DHSSPS	A Northern Ireland response to Shipman Inquiry Report Recommendations will be consulted upon and published	Improved professional practice and public protection	July 2006
DHSSPS	A review of existing appraisal systems (medical) will be undertaken	Improved professional practice and public protection	January 2006
DHSSPS	Following the outcome of Donaldson & Foster reviews on professional regulation, implementation of national recommendations will be implemented	Improved professional practice and public protection	Date to be determined
DHSSPS	The Department will publish guidance on Protecting Personal Information	Supports confidentiality and implementation of professional practice and legislation	January 2006
DHSSPS	Guidance on a new disciplinary framework for employed doctors and dentists will be published and implemented in the HPSS	Improved procedures for considering the conduct or performance of doctors/dentists in the HPSS	February 2006
CREST, DHSSPS, HPSS	All organisations will implement CREST guidance on Inter-hospital transfer of medical records	Reduction of risk to service user, when transferred in or between HPSS establishments	April 2006
HPSS	HPSS will complete implementation of the Hine Review on endoscope decontamination	Consistent approach to disinfection and decontamination of endoscopes	July 2006
DHSSPS, HPSS	A response to the O' Hara Inquiry Recommendations will be published and implemented	Safer care for sick children who require intravenous fluid	Date to be determined
DHSSPS, HPSS, in collaboration with Universities, CREST RMAG NIPEC,	The recommendations from the RQIA report on *Review of the lessons arising from the death of Mrs Janine Murtagh* will be implemented	Consistent and improved approach to consent, pre and post operative care, leadership and communication, and the implementation of policies and procedures	March 2007

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
NIMDTA			
DHSSPS	A Regional Procurement Strategy, incorporating safety, will be published for the HPSS	Safer health service procurement, design and practice	January 2006

5.1.5 Promoting education, training and support for all health and social care staff			
Responsibility	**Action**	**Outcome**	**Completion date**
HPSS	All HPSS organisations will include risk awareness within induction programmes to the organisation, and in specific areas of care	Awareness of risk and of organisational reporting policies and procedures	April 2006 Ongoing
DHSSPS, in collaboration with NIMDTA	A project will be convened to consider the generic contents of an induction programme for new doctors, building on recent learning from adverse events	Standardisation of induction, for new doctors	February 2006
DHSSPS, in collaboration with Universities, NIPEC, NICPPET, NIMDTA NISCC NPSA	Discussion will be held with key stakeholders to incorporate risk awareness, and adverse incident policies and procedures into basic training modules, including specific high risk areas such as medicines, medical devices and child protection issues	Promotion of safety and quality and cascade of learning	December 2006

5.2 CONCLUSION

Safety First: A Framework for Sustainable Improvement in the HPSS sets out a clear policy direction to improve quality of care. This policy and action plan is part of the modernisation and reform agenda and places safety and quality at the heart of good governance.

It recognises that major steps are needed to promote partnership working and enhance public confidence in the services provided. Support, training and education of staff are vital to its success.

The action plan will be reviewed in 2007 to assess progress on implementation. Quality and safety are part of good governance and will be reported on by the HPSS Regulation and Quality Improvement Authority. In addition, the action plan will form part of the ongoing accountability review processes for HPSS organisations, including primary care practitioners. A number of quality and safety performance indicators will be developed as part of implementation of the action plan.

GLOSSARY

ACCREDITATION

Formal recognition or approval of a service or training programme from a recognised authority e.g. a royal college.

ADVERSE EVENT OR INCIDENT

Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.

CARER

A carer is an individual who looks after someone who is unwell and/or who requires special assistance to manage their complex needs or situation.

CLINICAL AUDIT

A quality assessment and improvement mechanism in which healthcare professionals peer review their practice, compare it to best practice and introduce improvement in line with their findings.

Clinical and social care audit is interpreted as multi-disciplinary or multi-professional audit, involving a wide range of clinical and social care professions, with inputs from all its constituent groups working together or in single disciplines.

CLINICAL AND SOCIAL CARE GOVERNANCE

A framework through which local organisations are accountable for the quality of service they provide.

CLINICAL NEGLIGENCE

Failure to exercise a reasonable standard of care appropriate to the circumstances, resulting in unintended injury, loss or death to another party.

CULTURE

The general customs and beliefs, of a particular organisation at a particular time. ‘How we do things around here.’

HEINRICH RATIO

A proactive check on a systems “vital signs”- The Heinrich ratio of one major injury to twenty nine minor injuries to three hundred no-injury incidents.

HOMICIDE

An act of murder.

HOSPITAL AND SOCIAL CARE EPISODE STATISTICS

Statistics on hospital and social care episodes of care, e.g. admissions, outpatients appointments, domiciliary care hours provided.

INTELLIGENCE MECHANISMS

The mechanisms for the collection and co-ordination of data.

MEDICINES GOVERNANCE

A focus on risk management involving the prescription, supply, dispensing administration and disposal of medicines. It aims to improve patient & client care through a programme of continuous improvement in medicines management.

NEAR MISS

An unexpected or unintended incident that was prevented, resulting in no harm.

RISK REGISTER

A record of residual risk which details the source, nature, existing controls, assessment of the consequences and likelihood of occurrence, action necessary to manage risk, person responsible for implementing action and timetable for completion.

SERVICE LEVEL AGREEMENT

A service level agreement is a document, which defines the relationship between two parties: the provider and the recipient.

SERVICE USER

Anyone who uses, requests, applies for, or benefits from health and social care services. They may also be referred to as clients, patients or consumers.

ABBREVIATIONS AND ACRONYMS

CEMACH

Confidential Enquiry on Maternal and Child Health.

CISH

Confidential Inquiry into Suicides and Homicides by people with mental illness.

CREST

Clinical Resource Efficiency Support Team.

CSCG

Clinical and Social Care Governance.

DHSSPS

Department of Health, Social Services and Public Safety (Northern Ireland).

DIS

Directorate of Information Systems (DHSSPS).

FPS

Family Practitioner Services- e.g. general medical practitioners, community pharmacists, general dental practitioners, and optometrists.

GB

Great Britain.

GDC

General Dental Council.

GMC

General Medical Council.

HPSS

Health and Personal Social Services commissioning and providing treatment and care in hospitals, communities and through family practitioner services.

HRD

Human Resources Directorate (DHSSPS).

HSENI

Health and Safety Executive Northern Ireland.

IHI

Institute for Healthcare Improvement in the United States of America.

MHRA

Medicines and Healthcare products Regulatory Agency.

MRSA

Methicillin-Resistant Staphylococcus Aureus.

NCAS

National Clinical Assessment Service now part of NPSA but previously the autonomous NCAA (National Clinical Assessment Authority)

NCEPOD

National Confidential Enquiry into Patient Outcome and Death.

NHS

National Health Service.

NI

Northern Ireland.

NIAIC

Northern Ireland Adverse Incident Centre.

NICE

National Institute for health and Clinical Excellence.

NIMDTA

Northern Ireland Medical and Dental Training Agency.

NIPEC

Northern Ireland Practice and Education Council for Nursing and Midwifery.

NICPPET

Northern Ireland Council for Pharmaceutical Postgraduate Education and Training.

NISCC

Northern Ireland Social Care Council.

NPSA

National Patient Safety Agency.

NRLS

National Reporting and Learning System.

PCD

Primary Care Directorate (DHSSPS).

PPMD

Planning and Performance Management Directorate (DHSSPS).

RMAG

Regional Multi-professional Audit Group.

RQIA

Health and Personal Social Services Regulation and Quality Improvement Authority.

SABS

Safety Alert Broadcast System.

SAI

Serious Adverse Incidents.

SCD

Secondary Care Directorate (DHSSPS).

SCIE

Social Care Institute for Excellence.

APPENDIX A - TERMS OF REFERENCE AND MEMBERSHIP OF GROUPS

The terms of reference for this project are as follows:

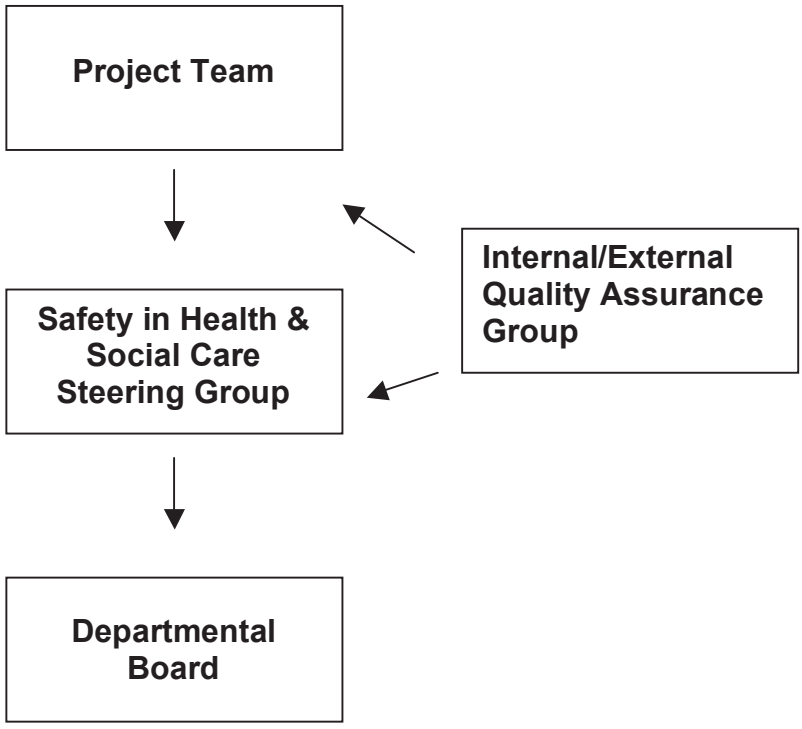
Service user and staff safety concerns everyone who uses or works in the HPSS. The safety policy framework will:

- identify the key components of a safety policy;
- consolidate good practice;
- promote and support an open and fair safety culture;
- link local objectives and priorities, with national developments;
- build capacity and capability at local level; and
- embed service user and staff safety in everyday practice, clinical and social care governance systems and health and social care environments.

The safety framework will be accompanied by an action plan, which will identify key tasks to be taken forward by the Department and the HPSS. This policy framework and action plan will be reviewed in early 2007.

Reporting arrangements

The Safety in Health and Social Care Steering Group will act as the steering group for this project. This Group will report to the Departmental Board by early September 2005.



Safety in Health and Social Care Steering Group

Chair: Dr Ian Carson – Deputy Chief Medical Officer, DHSSPS

Members: Mr Jonathan Bill, DHSSPS
Ms Tracey Boyce, RGH
Mr Brian Godfrey, DHSSPS
Dr Maura Briscoe, DHSSPS
Dr Glenda Mock, DHSSPS
Mr Don Hill, DHSSPS
Ms Irene Low, Ulster Community Hospitals Trust
Ms Nicola Kelly, Belfast City Hospital Trust
Ms Yvonne Kirkpatrick, Belfast City Hospital Trust
Mrs Nuala McArdle, DHSSPS
Dr Norman Morrow, DHSSPS
Mr Pat Newe, DHSSPS
Mrs Elizabeth Qua, DHSSPS
Mr Robert Sergeant, DHSSPS
Mrs Heather Shepherd, Regional Governance Adviser HPSS
Mrs Doreen Wilson, DHSSPS

The Project Team

The project team will comprise:

Mrs Heather Shepherd – Regional Governance Adviser, HPSS
Dr Maura Briscoe – Medical & Allied Group (lead), DHSSPS
Mr Jonathan Bill- Planning & Performance Management Directorate, DHSSPS
Ms Tracey Boyce – Medicines Governance Advisor, NI Medicine Governance Team, Royal Group Hospitals Trust
Mr Brian Godfrey – Health Estates Agency, DHSSPS
Mrs Liz Qua - Health Estates Agency, DHSSPS
Mr Pat Newe – Social Services Inspectorate, DHSSPS

Secretariat – Mr Jonathan Wright, Medical & Allied Group, DHSSPS

Quality Assurance Group

There will be a virtual QA Group comprising nominees from:

- Primary Care Directorate DHSSPS;
- Secondary Care Directorate DHSSPS;
- Community Care Directorate DHSSPS;
- Human Resources Directorate DHSSPS;
- Best Practice, Best Care Steering Group;
- Finance Management Directorate (Claims and Litigation) DHSSPS;
- Public Safety Unit DHSSPS;
- Planning and Performance Management Directorate DHSSPS;
- Professional Groups within the DHSSPS;
- Health and Personal Social Services Regulation and Quality Improvement Authority;
- Health Estates Agency DHSSPS;
- Northern Ireland Social Care Council;
- Mr Howard Arthur, CGST, Modernisation Agency
- HPSS Trusts & Boards; and
- HSS Councils.

APPENDIX B – EXAMPLES OF DATA SOURCES AND FINDINGS

Information Source	Examples of factors that will affect findings	Examples of findings
Incident reporting Systems	More likely to record near misses and errors which did not lead to harm. May be less likely to report known side effects and complications of treatment.	4.9 incidents reported for every 100 hospital admissions, and 1.2 incidents reported for every 100 bed days (England). 1.1 to 3.8 incidents for every 100 bed days (Regions, Pennsylvania, USA)[24]
Medical record review	The threshold that is used for including minor errors or deviations from standards of care. The threshold that is used for determining that harm to a patient was preventable.	Four to 17 adverse events in every 100 hospital admissions (studies in North America and Europe).
Routine data Collection	Recording of adverse events likely to be incomplete. Recording likely to improve with greater awareness of issues.	About two adverse events in every 100 hospital admissions in England[25]. 16 deaths from MRSA in every million men, and 8.5 deaths for every million women[26].
Surveys of patients and staff	Level of awareness of staff and patients. Patient's condition: for example, people with long-term conditions are more likely to be aware of errors than those receiving life-saving treatment.	35 in every 100 NHS staff reported seeing at least one error or near miss that could have harmed patients during the month before the survey[27]. 18 to 28 in every 100 patients with health problems from five countries believe a medical mistake or medication error affecting them had occurred in the two years before the survey[28].

Source:- *Building a memory: preventing harm, reducing risk and improving patient safety*. National Patient Safety Agency, July 2005.

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APPENDIX C

RAISING AWARENESS OF RISK, AS PART OF AN INDUCTION PROGRAMME FOR NEW RECRUITS, AND THE TRAINING OF IN-SERVICE STAFF

To improve patient and service user safety, the education and training of all HPSS staff must include risk awareness. Inclusion of "risk awareness" is an integral part of the risk management standard included in Controls Assurance Standards, the HPSS Quality Standards and the Care Standards.

Particular attention needs to be paid to the induction of temporary staff to ensure that key policies and procedures relevant to their level of competence are known prior to the commencement of practice.

Induction and in-service training programmes, should include:

- an overview on the organisation's safety culture, policies and procedures;
- basic awareness of the systems approach to patient and service user safety;
- awareness that health and social care is a high risk industry and the importance of being risk aware;
- awareness of their own personal responsibilities within their specific areas of work;
- the current incident statistics for health and social care within the organisation;
- examples of how things can go wrong;
- why incidents happen;
- how to report incidents;
- the importance of working within one's own ability; and,
- practical skills to practise safely.

APPENDIX D

How to Classify Adverse Incidents and Risk

Guidance for Senior Managers Responsible for Adverse Incidents Reporting and Management

Summary Version

The full version of this document will be subject to review and up-to-date versions will be available on the governance website.

http://www.dhsspsni.gov.uk/index/hss/governance.htm

Contents

1.0 Introduction

2.0 Stages of Adverse Incident Management

3.0 Flowchart One

1.0 Introduction

1.1 This is a shortened version of a document produced to assist Health and Personal Social Services organisations (HPSS) in developing or reviewing processes to assess incidents and their consequent risk implications. It has been written for senior managers responsible for reporting and overall management of adverse incidents and it is not intended as guidance for all staff. It does not provide detailed guidance for HPSS incident investigation, as this will be the subject of further work.

1.2 The following pages outline a tool to help managers classify incidents and risk, using the Australian / New Zealand Standard: Risk Management (AS/NZS 4360: 2004) and "Step 4 – Promote Reporting" from the National Patient Safety Agency (NPSA) publication "Seven Steps to Patient Safety" as primary sources.

1.3 The guidance should be used for all incidents not just those that involve patients / service users. This is in line with the current systems and processes that HPSS organisations use to manage incidents. The tool has been developed for use across the HPSS including the primary care sector and covers all incidents including clinical and social care incidents.

1.4 HPSS and primary care organisations should follow the principles of this guidance when developing, revising and implementing their own local policies and procedures. It is of key importance however that these principles are tailored to suit the objectives, nature and size of the particular organisation. The broad aim of this document is to facilitate better systems for sharing learning from adverse incidents across the HPSS and beyond. It provides a framework for appropriate and sufficient analysis of, and learning from events where there has been significant harm or potential harm to, and/or death of a patient, service user, staff member, visitor and/or significant damage to property or the environment.

1.5 One important principle is that all adverse incidents should be considered and recorded centrally within organisations so that any organisation-wide implications can be captured as early as possible. However, this must not negate the importance of local management responsibility for handling incidents in their area. All types of incidents should be included; for example; social care, clinical, health and safety, fire, infection control etc.

1.6 To help with capturing all incidents within similar processes an HPSS regional definition of an incident has been devised; an adverse incident within the HPSS context is therefore defined as;

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation"

1.7 Further associated work in this area will include a regional minimum dataset for recording incidents and a set of regional codes for the most prevalent types of incidents.

2.0 Stages of Adverse Incident Management (See Flowchart One)

Stage 1 – Incident occurs and is reported via the organisations' internal reporting mechanism to the organisations' central recording system. Incident details are communicated internally as necessary.

Stage 2 – Determine actual incident severity.

Stage 3 – Assess incident to determine immediate action required. Following initial assessment consider whether it is appropriate to report to external organisations (See flowchart for examples)

Stage 4 – Initiate incident investigation as appropriate. Consider whether it is appropriate to report to external organisations. (See examples of organisations requiring reports in Flowchart One)

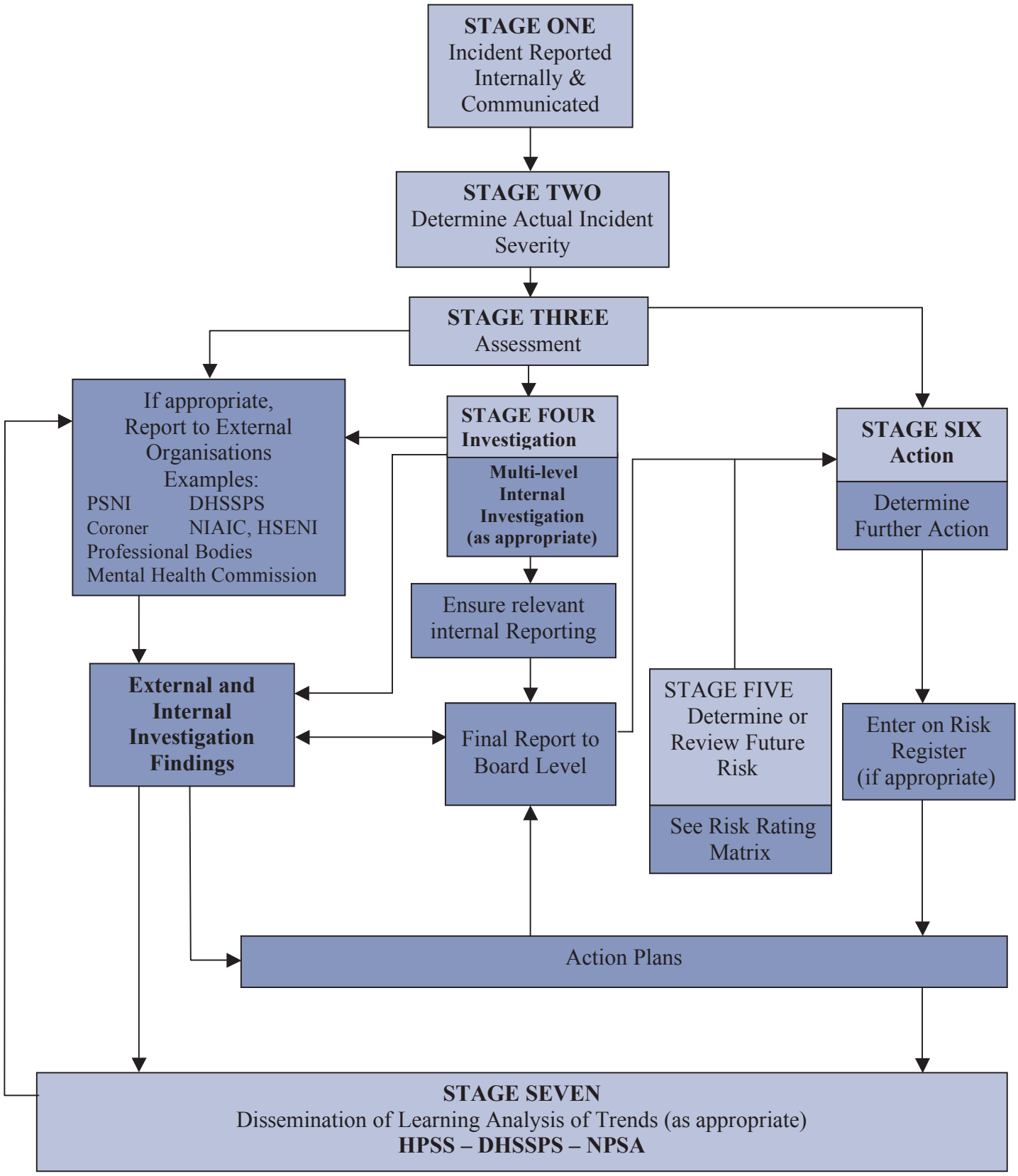
Stage 5 - This is a secondary classification mechanism for assessing ***potential future risks***. Use the following prompts:

(a) Think about the likely impact if the incident were to occur again without any intervening circumstances that made the incident less severe.
(b) Assess the likelihood of the incident occurring again.
(c) Use the Risk Rating Matrix (available in the full version of this document) to determine the risk severity.

Stage 6 – Use the Action Guidance to determine what further action should be taken. For example, consider whether this issue needs to be entered on the risk register.

Stage 7 – Determine any local and regional learning and communicate this within the organisation and with the appropriate regional / national bodies. Following the outcome and learning from investigations keep the future risk rating (Stage 5) under regular review.

STAGES OF ADVERSE INCIDENT MANAGEMENT FLOWCHART ONE



APPENDIX E

PROMOTING EQUALITY AND HUMAN RIGHTS

Section 75 of the Northern Ireland Act 1998 requires the Department, in carrying out its functions, powers and duties, to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

Members of the project team met to consider the equality and human rights implications of the safety framework and action plan. A screening exercise was undertaken, against four questions, which are identified below. The following text represents a summary of the discussion.

Is there any evidence of higher or lower participation or uptake by different groups?

The Group discussed the potential for greater integration of safety and quality policy development and action. It recognised that diminished standards on safety reflected a poor quality of treatment and care, for service users across the spectrum of care provided. Given the diverse nature of this framework, no one particular section 75 category would be disadvantaged. Indeed, the aim was to benefit all service users by promoting a safety culture, and a systematic approach to prevention, detection, reporting and management of adverse incidents. A part of this safety culture was the promotion of learning to prevent reoccurrence of incidents.

It was noted that whilst all people have the right to access HPSS services, greater use of these services are made by the very young, older people and those with complex needs and chronic conditions. The safety framework acknowledges the complexity of health and social care provision and environments. It advocates an open and fair culture which promotes involvement of all service users, particularly in relation to identification of risk and the part that service users, carers and the wider public have to play in the minimisation of that risk and in the development of solutions appropriate to their needs.

The safety framework links to the values and principles identified in the Quality Standards for the HPSS. These have been consulted upon;

these values include equality, diversity, choice, rights and respect for the individual.

Is there any evidence that different groups have different needs, experience, issues and priorities in relation to the particular policy?

No. It was considered that religion, political opinion, racial group, marital status, sexual orientation, gender or disability had no direct impact on this high level policy document or action plan. It was noted that there was a full section contained in the framework on involving and communicating with service users, carers and the public. This recognised that all people had a right to complain when concerned about their treatment or care, and that appropriate redress was an integral part of a quality system, when things go wrong. It was felt that the action plan was a relatively high level one which brought together many different strands of the quality and safety agenda. The action plan also attributed action to a number of organisations. In such circumstances, there would be a general need to consider equality and human rights implications when implementing specific actions.

Is there an opportunity to better promote equality of opportunity or good relations by altering policy or working with others in government or the community at large?

Equality of opportunity and good relations will be promoted through development of this policy. The policy and action plan recognise the need for:

- Enhanced promotion of health and safety for **all** service users, carers, staff, practitioners and visitors;
- Development of organisational communication policies and the training of staff to enhance engagement with service users and carers;
- Promotion of good relations through development and support of an informed safety culture;
- Increase in the reporting of adverse incidents and shared learning of experience;
- A more systematic approach to redress, when things go wrong;
- Enhanced communication across primary, secondary and community care, and with other agencies, for example, police, Health and Safety Executive and coroners;

- Increase in the availability of information and consultation on treatment and care with service users, carers and practitioners; and

- Enhanced education, training and development of staff.

How will this impact on complementary policy areas?

The safety framework and action plan complement other policy areas. It is part of the overall quality framework as set out in Best Practice Best Care (2001), which was subject to extensive consultation. Safety is an integral part of clinical and social care governance, care standards, controls assurance and quality standards. All of these developments are aimed at enhancing health and social care outcomes and the service user experience. The safety framework also supports other initiatives to promote continuous professional development, life-long learning and enhanced regulation of the workforce. The safety framework and action plan is underpinned by the Duty of Quality as outlined in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

Conclusion

The safety framework is a high level document, which aims to bring together different strands of the wider safety and quality agenda. It draws on existing policy developments and identifies, in a single plan, actions which need to take place within the next two years to enhance safety within health and social care services. The project team concluded there was no adverse impact on equality or human rights arising from the safety framework. It was also noted that equality and human rights implications would be considered as part of the development and implementation of specific actions associated with the framework.

APPENDIX F

REFERENCES, CIRCULARS AND GUIDANCE

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FROM THE ACTING CHIEF MEDICAL OFFICER
Dr Ian Carson

Department of
Health, Social Services and Public Safety
An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
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Fax: 028 9052 0574
Email: ian.carson@dhsspsni.gov.uk

Your Ref:
Our Ref: iwc
Date: 24 April 2006

TO:- Chief Executives of:
HSS Trusts and Boards
NI Blood Transfusion Service
Central Services Agency
NI Postgraduate Education Council
NI Social Care Council
NI Medical and Dental Training Agency
NI Guardian ad Litem Agency and
NI Medical Physics Agency

For onward transmission by the Chief Executive to relevant staff including:

Executive Leads Governance / Clinical and Social Care Governance
Executive Leads Adverse Incident Management Governance / Clinical and Social Care Governance/ Risk Managers
Medical Directors
Directors of Nursing
Directors of Social Services
Directors of Pharmaceutical Services
Directors of Public Health
Directors of Primary Care

Dear Colleague

GUIDANCE DOCUMENT – "HOW TO CLASSIFY INCIDENTS AND RISK"

Introduction

I attach a copy of "*How to Classify Incidents and Risk*" as guidance to assist HPSS organisations in developing or reviewing processes to assess adverse incidents and their risk implications. The purpose of the guidance is to act as a model that can be adapted for local use. The target audience for this document is senior managers and those involved in adverse incident management.

Background

This guidance is the product of a wider project that was convened in 2005, under the auspices of the Safety in Health and Social Care Steering Group, to enhance systems and processes in the HPSS to better manage adverse incidents and risk arrangements. It is designed to promote greater consistency of approach within the HPSS and to make it easier for the HPSS to share learning from adverse incidents. The project also fits into the wider context of *HPSS Controls Assurance Standards (*in particular, the criteria concerning adverse incident management), *The Quality*

Standards for Health and Social Care (specifically the theme of "Safe and Effective Care") and the recently issued *Safety First: A Framework for Sustainable Improvement in the HPSS.*

The project team, lead by the Regional Governance and Risk Management Adviser, consists of clinical and social care governance managers and risk managers from across the HPSS. The project work is quality assured by HPSS Clinical and Social Care Governance Executive Leads.

Action
Organisations will have already set up a centralised system for collating and analysing all adverse incidents. The attached document provides a steer for how these incidents are defined and how they should be analysed; however, each HPSS organisation will need to tailor this advice to best suit their own organisational needs and requirements.

It is recommended that the content and applicability of this document be discussed at senior management level within your organisation. It is not intended that this guidance be used without adaptation to the specific requirements of each organisation. For example; the flowchart contained within the guidance (Page 3) can be used to review existing procedures and can be altered to suit the many different situations that exist across the HPSS.

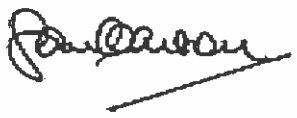
Future Pathway
This project has two further phases:-

- → Phase II will produce a Regional Minimum Dataset and will be completed within the next few months; and
- → Phase III will produce a set of regional codes for adverse incidents and will be completed in March 2007.

The above work is seen as complementary to any future link with the National Patient Safety Agency (NPSA).

I would like to take this opportunity to thank the project manager, Heather Shepherd, Regional Governance and Risk Management Adviser and her HPSS-wide project team for their effort in putting together this complex work.
The document will be kept under review with the most up-to-date version available from the departmental governance webpage on
http://www.dhsspsni.gov.uk/index/hss/governance.htm

Yours sincerely



DR IAN CARSON
Chair of the Safety in Health and Social Care Steering Group

This letter is available at www.dhsspsni.gov.uk and also on the DHSSPS Extranet which can be accessed directly at http://extranet.dhsspsni.gov.uk or by going through the HPSS Web at http://www.n-i.nhs.uk and clicking on DHSSPS.

How to Classify Adverse Incidents and Risk

Guidance for Senior Managers Responsible for Adverse Incident Reporting and Management

April 2006

This document will be subject to review and up-to-date versions will be available on the governance website.

http://www.dhsspsni.gov.uk/index/hss/governance.htm

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Introduction

1.1 This document has been produced to assist Health and Personal Social Services organisations (HPSS) in their clinical and social care governance arrangements. In particular to help develop or review processes to assess adverse incidents and their risk implications. It has been written for senior managers responsible for the reporting and overall management of adverse incidents and it is not intended as guidance for all staff. It does not provide detailed guidance for HPSS incident investigation, as this will be the subject of further work.

1.2 The following pages outline a tool to help managers classify incidents and risk, using the Australian / New Zealand Standard: Risk Management (AS/NZS 4360: 2004) and "Step 4 – Promote Reporting" from the National Patient Safety Agency (NPSA) publication "Seven Steps to Patient Safety" as primary sources.

1.3 The guidance should be used for all incidents not just those that involve patients / service users. This is in line with the systems and processes that HPSS organisations currently use to manage incidents. This document has been designed for use across the HPSS including the primary care sector and covers all incidents including clinical and social care incidents.

1.4 Organisations should follow the principles of this guidance when developing, revising and implementing their own local policies and procedures. It is of key importance however that these principles are tailored to suit the objectives, nature and size of the particular organisation. The aim of this document is to facilitate better systems for sharing learning from incidents across the HPSS and beyond. It provides a framework for appropriate and sufficient analysis of, and learning from incidents where there has been significant harm or potential harm to, and/or death of a patient, service user, staff member, visitor and/or significant damage to property or the environment.

1.5 One important principle is that all incidents should be considered and recorded centrally within organisations so that any organisation-wide implications can be captured as early as possible. However, this must not negate the importance of local management responsibility for handling incidents in their area. All types of incidents should be included: for example, social care, clinical, health and safety, fire, infection control etc.

1.6 To help with capturing all incidents within similar processes an HPSS regional definition of an incident has been devised; an adverse incident within the HPSS context is therefore defined as:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation."

1.7 Further associated work in this area will include the development of a regional minimum dataset for recording incidents and a set of regional codes for the most prevalent types of incidents.

2.0 Stages of Adverse Incident Management (To be read in conjunction with Flowchart One)

This section provides further guidance to support Flowchart One overleaf and gives further detail relating to each stage in the process.

Stage 1 – Incident occurs and is reported via the organisation's internal reporting mechanism to the organisation's central recording system. Incident details are also communicated internally as necessary.

Stage 2 – Determine actual incident severity (using Table 1 and Table 2). An incident will often have multiple aspects – considering all these aspects (see Table 2) decide the level of severity.

Stage 3 – Assess incident to determine immediate action required. Following this initial assessment consider whether it is appropriate to report to external organisations (See examples of organisations requiring reports in Flowchart One). If the severity of the incident means that action must precede investigation – go straight to Stage 6.

Stage 4 – Initiate incident investigation as appropriate. Following investigation re-consider in the light of further information whether it is appropriate to report to external organisations. (See sample list of organisations that may require reports in Flowchart One).

Stage 5 - This is a secondary classification mechanism for assessing ***potential future risks***. Use the following prompts:

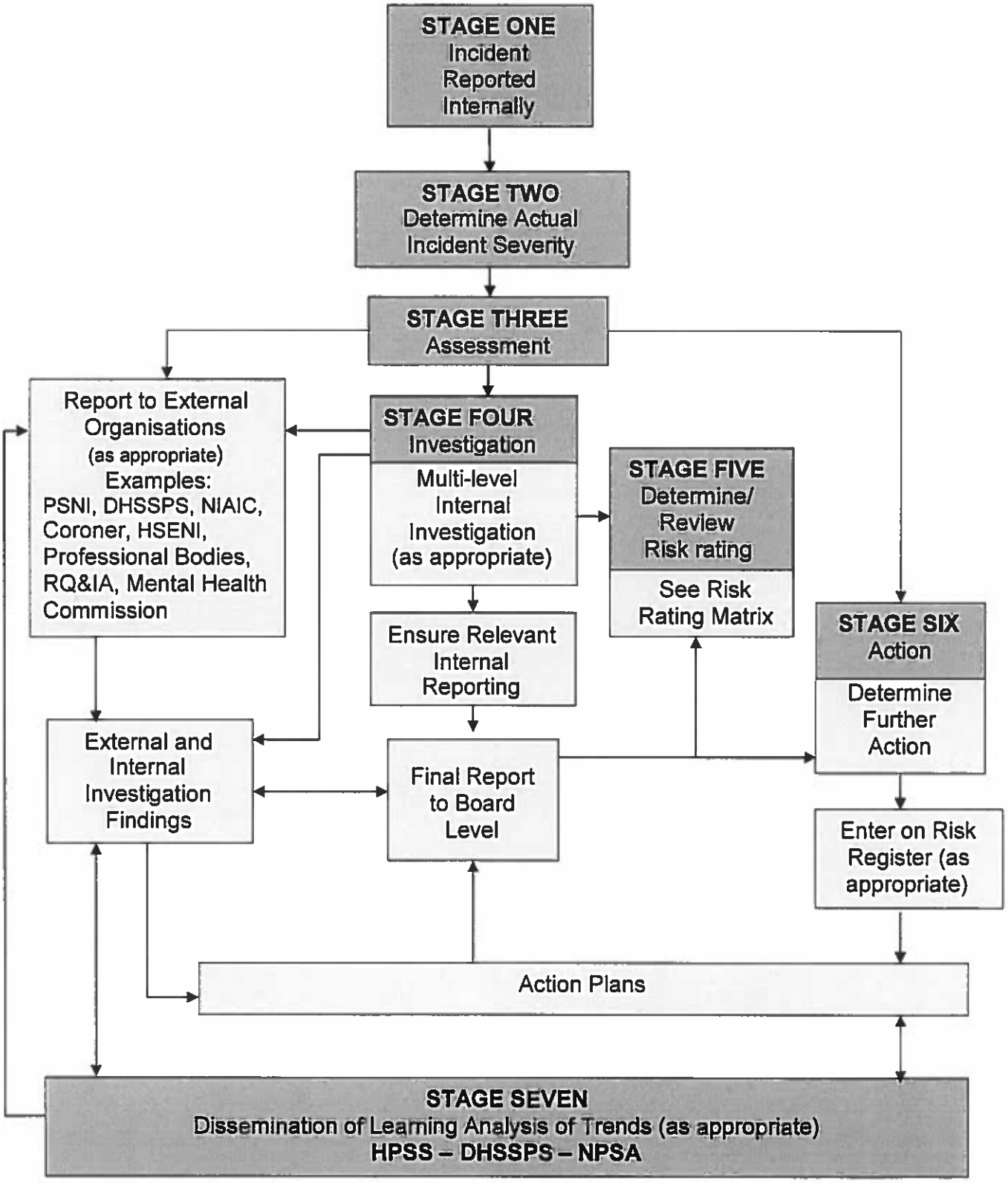
(a) Think about the likely impact if the incident were to occur again without any intervening circumstances that made the incident less severe. (Use the Impact Table – Table 2)
(b) Assess the likelihood of the incident occurring again.
(c) Use the Risk Rating Matrix (Page 6) to determine the overall risk rating.

Stage 6 – Use the Action Guidance (Table 3) to determine what further action should be taken. For example, consider whether this issue needs to be entered on the risk register and/or any organisation-wide action is required.

Stage 7 – Determine any learning from the adverse incident and communicate this within the organisation and with the appropriate regional / national bodies. Following the outcome and learning from investigations review the risk rating in Stage 5 and keep this under regular review.

STAGES OF ADVERSE INCIDENT MANAGEMENT FLOWCHART ONE

(please read in conjunction with commentary on Page 2)



3.0 Initial Grading of Incident Severity

The initial assessment of an incident should be performed quickly, even when all facts may not be available. There is always scope to re-grade as facts and issues emerge over time and following investigation. This guidance is primarily for internal reporting mechanisms but please note one particular external reporting route - Serious Adverse Incidents (most probably incidents from the Catastrophic and Major severity levels) should be reported to the DHSSPS (see Circular HSS (PPM) 02/06) - i.e. those incidents that meet the following criteria:

- Be serious enough to warrant regional action to improve safety or care;
- Be of public concern; or
- Require an independent review.

Table 1 - Actual Incident Severity (according to the facts available)

In determining the actual severity consider the outcome of the incident in terms of harm to people / resources / environment / reputation / quality.

Severity of incident	High Level Descriptors (see Impact Table 2 overleaf for a more detailed list)
Catastrophic	Incident with widespread implications to services
Major	Significant disruption to services
Moderate	Short term disruption to services
Minor	No interruption to services
Insignificant	No adverse outcome but risk potential evident

Impact Table 2 (based on facts available about the incident)

This table may also be used to assess the impact of risks in order to analyse future risks

	PEOPLE (Any person affected by an Incident: Staff, User, Visitor, Contractor)	**RESOURCES** (Premises, money, equipment, Business interruption, problems with service provision)	**ENVIRONMENT** (Air, Land, Water, Waste management)	**REPUTATION** (Adverse publicity, Complaints, Legal/Statutory Requirements, Litigation)	**QUALITY AND PROFESSIONAL STANDARDS** (including government priorities, targets and organisational objectives)
CATASTROPHIC	Incident that lead to one or more deaths	Severe organisation wide damage/ loss of services /unmet need	Toxic release affecting off-site with detrimental effect requiring outside assistance.	National adverse publicity. DHSSPS executive investigation following an incident or complaint. Criminal prosecution.	Gross failure to meet external standards, priorities
MAJOR	Permanent physical/emotional injuries/trauma/harm.	Major damage, loss of property / service /unmet need	Release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc)	Local adverse publicity. External investigation or Independent Review into an incident/complaint. Criminal prosecution /prohibition notice	Repeated failure to meet external standards.
MODERATE	Semi permanent physical/emotional injuries/trauma/harm (recovery expected within 1 year).	Moderate damage, loss of property / service /unmet need	On site release contained by organisation	Damage to public relations. Internal investigation (high level), into an incident/complaint. Civil action	Repeated failure to meet internal standards or follow protocols.
MINOR	Short-term injury/harm. Emotional distress. (Recovery expected within days /weeks.)	Minor damage, loss of property / service /Unmet need	On site release contained by organisation	Minimal risk to organisation. Local level internal investigation into an incident/complaint Legal challenge	Single failure to meet internal standards or follow protocol.
INSIGNIFICANT	No injury/harm or no intervention required / near miss	No damage or loss, no impact on service Insignificant unmet need	Nuisance release	Minimal risk to organisation, Informal complaint	Minor non compliance,

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RISK RATING MATRIX (adapted from AS/NZ 4360, 2004 MODEL)

LIKELIHOOD	CONSEQUENCE (Potential Impact)				
	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain (will undoubtedly recur, a persistent issue)					
Likely (will probably recur, not a persistent issue)					
Possible (may recur occasionally)					
Unlikely (do not expect it to happen again)					
Rare (can't believe it will ever happen again)					

Risk Rating

Low	Medium	High	Extreme

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Table 3 - Action Guidance

Risk Rating Level	Descriptors
Extreme	Identified risks which fall in the red area are deemed extreme risk to the organisation and must be reported to the appropriate Governance Group. These risks require immediate action to reduce the level of risk and the relevant Director / Officer will ensure they are forwarded to the Executive Management Board/Governance Committee. The appropriate Director / Officer will ensure the implementation of a time monitored action plan and provide regular reports to the Executive Management Board/Governance Committee.
High	Identified risks which fall in the orange area are deemed high risk to the organisation and require prompt action to reduce the risk to an acceptable level. These risks and agreed action plans should be considered by the local Governance Group. Risks that cannot be reduced locally should be forwarded for consideration by the Executive Management Board/Governance Committee.
Medium	Identified risks which fall in the yellow area are deemed medium risk to the organisation and require action to reduce risk to an acceptable level. Responsibility for taking action would normally remain at a local level within the appropriate Directorates/Programmes/Service Areas and monitored by the relevant Local Governance Group and entered on the Directorate Register.
Low	Identified risks which fall in the green area are deemed as acceptable risks and require no immediate action, but must be monitored regularly.

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Appendices

APPENDIX A - TERMS OF REFERENCE AND MEMBERSHIP OF GROUPS

This project aims to create a standard method of adverse incident reporting across the Health and Personal Social Services including Trusts, Boards and across the Primary Care sector. This will include creating HPSS agreed standard incident definitions, a minimum dataset and recommended reporting form and regional coding of incidents.

Project Reporting Arrangements

The Project Team

The project team is multi-disciplinary and drawn from across the HPSS. The project has been able to access HPSS best practice in adverse incident management.
A list of project team members is set out below:

Dr Kathryn Booth, Medical Adviser, EHSSB GP Unit / DHSSPS
Ms Tracey Boyce, HPSS Medicines Governance Project Manager, Royal Hospitals Trust
Mrs Therese Brown, Risk Management Director, Altnagelvin HSS Trust
Mrs Jacqui Burns, Risk Manager, NHSSB
Ms June Champion, Risk Manager, Royal Hospitals Trust
Dr Martina Hogan, Consultant Paediatrician, Craigavon Area Hospital Group Trust
Mrs Yvonne Kirkpatrick, Governance Manager, Belfast City Hospital Trust
Ms Irene Low, Risk Manager, Ulster Community and Hospitals Trust
Mr Alex Lynch, Governance Manager, Homefirst Community HSS Trust
Ms Marita Magennis, Social Services, Newry and Mourne HSS Trust
Mrs Mairead Mitchell, Assistant Director, Improvement and Governance, North and West Belfast Community Trust
Mr Brian Mullin, Acting APSW, Causeway HSS Trust
Ms Heather Shepherd, HPSS Regional Governance and RM Adviser
Mrs Roberta Wilson, Clinical and Social Care Governance Co-ordinator

Quality Assurance Group

Quality Assurance for the project was arranged via a virtual QA Group comprising governance leads from all HSS Trusts and HSS Boards.

APPENDIX B

REFERENCES, CIRCULARS AND GUIDANCE

The following is a list of useful documents providing further guidance in this area.

Being Open. Communicating patient safety incidents with patients and their carers. National patient safety Agency (2005) www.npsa.nhs.uk

Department of Health, Social Services and Public Safety Memorandum of Understanding

Department of Health, Social Services and Public Safety - Safety in Health and Social Care Project – Clinical and Social Care Governance - Deloitte, 31st March 2004

Circular HSS (PPM) 02/2006 – Reporting and Follow-Up on Serious Adverse Incidents within the HPSS
www.dhsspsni.gov.uk/hss/governance

Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 6/2002 – AS/NZS 4360:1999-Risk Management (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 6/2004 – Reporting and follow-up on serious adverse incidents: Interim Guidance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 8/2002 – Risk Management in the Health and Personal Social Services (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 8/2004 – Governance in the HPSS: Controls assurance standards – update http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 10/2002 – Governance in the HPSS: Clinical and Social Care Governance – Guidance on Implementation (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 13/2002 – Governance in the HPSS – Risk Management (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Creating the virtuous circle: patient safety, accountability and an open and fair culture, NHS Confederation 2003.

Doing Less Harm; Improving the Safety and Quality of Care Through Reporting, Analysing and Learning from adverse incidents, Department of Health and NPSA Draft August 2001.

Making it happen – A guide for risk managers on how to populate a risk register (CASU, Keele University) www.dhsspsni.gov.uk/hss/governance

National Patient Safety Agency. 2004 Seven Steps to Patient Safety www.npsa.nhs.uk/health/resources/7steps

NIAIC Safety Notice MDEA (NI) 2006/01 Reporting Adverse Incidents and Disseminating Medical Device/Equipment Alerts. Health Estates, Northern Ireland Adverse Incident Centre.
www.dhsspsni.gov.uk/index/hea/niaic

Patient Safety: Towards Sustainable Improvement, Fourth Report to Australian Health Ministers' Conference, Australian Council for Safety and Quality in Healthcare, July 2003

Shipman Inquiry Reports www.the-shipman-inquiry.org.uk/reports

The Bristol Royal Infirmary Inquiry
www.bristol-inquiry.org.uk/final_report/report/sec2chap21_3.htm

The Confidential Enquiry into Maternal and Child Health; the Confidential Enquiry into Patient Outcome and Death; and the Confidential Enquiry into Homicide and Suicide in Hospital www.national-confidential-inquiry.ac.uk/nci/index.cfm

Exhibit 39

Safety, Quality and Standards Directorate
Office of the Chief Medical Officer

Department of
Health, Social Services and Public Safety

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Chief Executives of Boards and Trusts for cascade to
- Governance/CSCG leads
- Risk managers

Mr David Sissling – Chief Ex. Designate, HSCA
Dr Anne-Marie Telford, Regional Director of Public Health & Care Standards Designate, HSCA
Medical Directors of HSC Trusts
Directors of Nursing -Boards and Trusts
Pharmacy Directors -Boards and Trusts
Directors of Public Health- HSS Boards
Directors of Primary Care -HSS Boards
Directors of Social Services -Boards and Trusts
Chair and Chief Executive RQIA (for cascade to independent hospitals, hospices, clinics and establishments)
Office of the Ombudsman
Chief Executive NISCC
Chief Executive NIPEC
Director, NI CSCG Support Team
Chief Executive, Mental Health Commission

Castle Buildings
Stormont Estate
Belfast
BT4 3SQ
Tel: 02890 520724
Fax: 02890 520725
Email:
Maura.briscoe@dhsspsni.gov.uk
Your Ref:
Our Ref: HSS(SQSD) 34/2007
Date: 12 September 2007

Dear Colleague

HSC REGIONAL TEMPLATE AND GUIDANCE FOR INCIDENT REVIEW REPORTS

This HSC Regional Template and Guidance for Incident Review Reports has been developed on behalf of the Department's Safety in Health and Social Care Steering Group. This work represents part of an on-going process to develop clarity and consistency when conducting reviews as outlined in *Safety First: A Framework for Sustainable Improvement in the HPSS* (March 2006).

This template and guidance notes should be used, in as far as possible, for the drafting of all HSC incident review reports whether internal or external to the organisation. However, it is not intended that the template be used without adaptation as it is recognised that certain incident review reports may require a greater level of

detail appropriate to the specialist nature of the incident. In such circumstances, the template may be tailored to suit the specific requirements of each HSC organisation.

The attached guidance makes reference to the importance of independence in investigations/ reviews particularly in relation to incidents involving suicide and of the need to have corporate systems in place to ensure learning and effective closure of the incident within a HSC organisation.

Further recommended reading is provided within the bibliography and in particular I would draw your attention to the principles outlined in the NPSA policy document *Being Open: Communicating Patient Safety Incidents with Patients and their Carers* http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy1_11.pdf and to the guidance contained in *A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises* *http://www.dhsspsni.gov.uk/microsoft_word_-_hss_sqsd_18-07_patient_service_review_guidelines_-_final_feb07.pdf*

The Department will evaluate the impact of this guidance over the coming year through the incident reports received via the SAI Review Group. It is hoped that the standardisation of Incident Review Reports will facilitate the future collation and dissemination of regional learning.

I would like to take this opportunity to thank Mrs Heather O'Neill, Regional Governance & Risk Management Advisor and her Project Team for their contribution.

Yours sincerely

Maura Briscoe

DR MAURA BRISCOE
Safety, Quality and Standards Directorate
Office of the Chief Medical Officer

cc: Departmental Board Members & Directors
Safety in Health & Social Care Group

MAHI - STM - 300 - 1102

Department of
Health, Social Services and Public Safety

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Health and Social Care Regional Template and Guidance for Incident Investigation/Review Reports

September 2007

Working for a Healthier People

Introduction

This work has been commissioned by the DHSSPS Safety in Health and Social Care Steering Group as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS*" (under 5.1.2 Agreeing Common systems for Data Collection, Analysis and Management of Adverse Events). The following work forms part of an on-going process to develop clarity and consistency in conducting investigations and reviews. This is an important aspect of the safety agenda.

This template and guidance notes should be used, in as far as possible, for drafting all HSC 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. It 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.

All investigations/reviews within the HSC should follow the principles contained within the National Patient Safety Agency (NPSA) Policy documents on "*Being Open – Communicating Patient Safety Incidents with Patients and their Carers*".
http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy1_11.pdf

It is also suggested that users of this template read the guidance document "*A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises*" – Regional Governance Network – February 2007.
http://www.dhsspsni.gov.uk/microsoft_word_-_hss__sqsd__18-07_patient_service_review_guidelines_-_final_feb07.pdf

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

The suggested template can be found in the following pages.

Template Title Page

Date of Incident/Event

Organisation's Unique Case Identifier (for tracking purposes)

Introduction

The introduction should outline the purpose of the report and include details of the commissioning Executive or Trust Committee.

Team Membership

List names and designation of the members of the Investigation team. Investigation teams 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. 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. There may be specific guidance for certain categories of adverse incidents, such as, the Mental Health Commission guidance
http://www.dhsspsni.gov.uk/mhc_guidance_on_monitoring_untoward_events.pdf

Terms of Reference of Investigation/Review Team

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

- To undertake an initial investigation/review of the incident
- To consider any other relevant factors raised by the incident
- To agree the remit of the investigation/review
- To review the outcome of the investigation/review, agreeing recommendations, actions and lessons learned.
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate

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

Summary of Incident/Case

Write a summary of the incident including consequences. The following can provide a useful focus but please note this section is not solely a chronology of events

- Brief factual description of the adverse incident
- People, equipment and circumstances involved
- Any intervention / immediate action taken to reduce consequences
- Chronology of events
- Relevant past history
- Outcome / consequences / action taken

This list is not exhaustive

Methodology for Investigation

This section should provide an outline of the methods used to gather information within the investigation process. The NPSA's "Seven Steps to Patient Safety" is a useful guide for deciding on methodology.

- Review of patient/ service user records (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
- Engagement with patients/service users / carers / family members
- Review of Trust and local departmental policies and procedures
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

Analysis

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 provided.

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
- 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 investigated and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful.
www.npsa.nhs.uk/health/resources/7steps

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

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 ongoing engagement / contact with family members or carers.

Involvement with Patients/Service Users/ Carers and Family Members

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

Recommendations

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

- Local recommendations
- Regional recommendations
- National recommendations

Learning

In this final section it is important that any learning is clearly identified. Reports should indicate to whom learning should be communicated and copied to the Committee with responsibility for governance.

Further Reading

A Protocol for the Investigation and Analysis of Clinical Incidents. Clinical Risk Unit, University College London and ALARM (September 1999).

A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises – Regional Governance Network – February 2007
http://www.dhsspsni.gov.uk/microsoft_word_-_hss__sqsd__18-07_patient_service_review_guidelines_-_final_feb07.pdf

Being Open. Communicating Patient Safety Incidents with Patients and their Carers. The National Patient Safety Agency, 2005.
http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy1_11.pdf

Circular HSS (PPM) 06/2004 -Reporting and Follow-up on Serious Adverse Incidents: Interim Guidance

Circular HSS (PPM) 05/2005 – Reporting of Serious Adverse Incidents

Circular HSS (PPM) 2/2006 – Reporting and Follow-up on Serious Adverse Incidents.

Circular HSS (MD) 12/2006 – Guidance Document – How to classify Incidents and Risk

SAI Reporting Template from 1st April 2007 (PDF 20 KB) - Reporting and Follow-up on Serious Adverse Incidents
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-circulars.htm

Confidentiality: Protecting and Providing Information. General Medical Council 2004

Decision making tool to reduce unnecessary suspensions and support a safety culture – The National Patient Safety Agency
www.npsa.NHS.uk/idt

Dineen, M 2002, Six Steps to Root Cause Analysis, *Consequence UK Ltd.* Oxford.

Doing Less Harm; Improving the Safety and Quality of Care through Reporting, Analysing and Learning from Adverse Incidents, Department of Health and The National Patient Safety Agency, 2001

Mental Health Commission for Northern Ireland: Monitoring of Untoward Events by the Mental Health Commission (Revised Guidance) S6/2006 April 2006.

Managing risk and minimising mistakes in services to children and families, (SCIE: Children and Families' Services Report 6) 2005, http://www.scie.org.uk/publications/children.asp

Memorandum of Understanding Investigating patient or client safety incidents (Unexpected death or serious untoward harm) DHSSPS, PSNI, Coroners Service and HSENI, February 2006

Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults DHSSPS & PSNI 2003

Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – NI September 2004

Root Cause Analysis: Simplified Tools and Techniques, Anderson B, Fagerhaug T Quality Press, Milwaukee, 2000.

Seven Steps to Patient Safety A guide for NHS staff SSG/2003/01 - The National Patient Safety Agency, April 2004 (including the RCA tool kit) www.npsa.nhs.uk/health/resources/7steps

Managing risk and minimising mistakes in services to children and families, (SCIE: Children and Families' Services Report 6) 2005, http://www.scie.org.uk/publications/children.asp

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From the Director Safety, Quality & Standards
Dr Jim Livingstone

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

Castle Buildings
Upper Newtownards Road
BELFAST
BT4 3SQ

Tel: 02890 522788
Fax: 02890 520725
Email: jim.livingstone@dhsspsni.gov.uk

Your Ref:
Our Ref:

Date: 19 September 2011

Chief Executive, HSC Board, for cascade to:
- Director of Nursing
- Director of Public Health
- Director of Pharmacy
- Director of Primary care
- Director of Social Care/Childcare
- Governance Managers

Chief Executive, PHA for cascade to:
- Director of Public Health
- Director of Nursing

Chief Executive, HSC Trusts, for cascade to:
- Medical Directors
- Nursing Directors
- Directors of Pharmacy
- Directors of Social Care/Childcare
- Directors of Mental Health
- Governance leads

Chief Executive, RQIA

SUPPORTING SAFER SERVICES 2011

The Department established a serious adverse incident (SAI) reporting system in July 2004, which provided an important source of learning for HSC organisations. This learning has been summarised in previous ***Supporting Safer Services*** reports issued in June 2006 and January 2008.

The final report in this series provides an overview of 1023 SAIs reported to the Department between April 2007 and April 2010, after which responsibility for management of SAIs transferred to the Health and Social Care Board/Public Health Agency.

The report does not deal with individual SAIs or the learning specific to individual cases. It is being made available to HSC organisations in the interests of promoting safety and learning and the concept of incident reporting as a tool to improve performance.

Key learning has been grouped into the following categories:

- Record Keeping and Documentation.
- Communication.
- Mental Health.
- Clinical Treatment and Care.
- Medicines Management.
- Children's Services.

The Department wishes to acknowledge the commitment, contribution and determination of staff across all parts of the HSC to driving forward the safety agenda for patients and clients.

“Quality 2020: a 10-Year Quality Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland” will shortly be launched to help ensure that we continue to make improvements in the safety, effectiveness and patient/client focus of services here. I look forward to working with you on this next step to support safer services.

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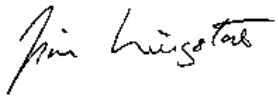
Yours sincerely



Dr J F Livingstone

Exhibit 41

MUCKAMORE ABBEY HOSPITAL – BHSCT MONTHLY UPDATE MEETING

KEY ACTION POINTS

10 APRIL 2019

DoH Attendees:
Jerome Dawson
Rodney Morton
Siobhan Rogan
Alison McCaffrey
Darren McCaw

BHSCT Attendees:
Marie Heaney

HSCB Attendees:
Valerie McConnell

Apologies:
Marie Roulston (HSCB)
Brenda Creaney (BHSCT)

Subject	Update	Person Responsible
Introduction	Jerome welcomed everyone to the first monthly update meeting of the group and commenced a round of introductions. Rodney introduced Siobhan Rogan, who has recently joined the Department and will be leading on the LD Nursing Review.	
RQIA Inspection – follow up/update/additional support requirements	Jerome advised that a further letter from the Department had been drafted following a meeting between Richard and the RQIA, but is still under consideration. Jerome also advised that a response to BHSCT would issue once the Department had responded to the RQIA. **AP1** Next MLA briefing due in May. It was noted that this may be affected by elections/purdah.	**J Dawson**
Governance Arrangements	To inform future advice to Richard on options for further scrutiny, it was agreed that earlier correspondence/commitments would be reviewed – in particular leadership and governance was highlighted as an	**J Dawson**

	outstanding issue during discussion. Jerome also indicated that he intended to discuss with PSNI. **AP2**	
Staffing Issues	Marie clarified recent Early Alert updates regarding further precautionary suspensions arising from CCTV viewing of Sixmile (one due to retire, others on sick leave bar one on mental health training who is now on enhanced supervision in Mater). She also advised that staffing remains a very difficult risk management task. Monthly written reports from BHSCT to continue. **AP3**	**M Heaney – to submit written report prior to monthly meetings**
PSNI Investigation	Marie advised that BHSCT is in the process of appointing a Project Manager to coordinate requests from PSNI relating to current and historical allegations, and continues to cooperate fully with the PSNI investigation.	
CCTV Viewing	Marie provided an update on CCTV viewing advising: • Less than 50% of the footage for Sixmile has currently been viewed; and • Contemporaneous viewing of footage continues each week.	
Disciplinary Processes (Trust and Professional Bodies)	Marie provided an update advising: • Material on all those on suspension have been referred to PSNI; • BHSCT keen to progress disciplinary processes for those who were bystanders, however PSNI consider them as potential witnesses and do not want BHSCT to progress until they complete their investigations; and • BHSCT are taking legal advice on potential options to proceed.	

Engagement with Families	Marie advised that: • BHSCT have appointed a Band 8A Trust liaison officer to support affected families who will work closely with the PSNI liaison officer. • A Carers consultant has also been appointed to work with all families (75 invited to recent meeting) to develop a new model of advocacy in Muckamore; • A Carers Oversight Committee, comprising 8 carers, was established 2 weeks ago and receive weekly governance reports; and • All affected families have been offered access to psychological/counselling support services. Alison referred to recent discussions with Counsel during which he emphasised the critical importance of support for/engagement with families and patients at this time, and going into the future. The role of PCC was discussed. BHSCT to follow up with PCC. **AP4** Valerie advised that the HSCB have a regional contract with the Law Centre (NI) and there was potential to make use of this as required. **AP5** Rodney referred to the Inquiry into Hyponatraemia Related Deaths (IHRD) advocacy workstream. Siobhan referred to recent research around the impact of trauma on LD population – seen as a major gap following Winterbourne. Valerie mentioned recent discussions with	**M Heaney** **V McConnell to circulate details** **HSCB to consider further**

	colleagues working on the Regional Trauma Network around this. This was considered important to reflect in the Muckamore Action Plan. **AP6**	
Meeting with Gavin Robinson – update and actions arising	Marie confirmed that a bespoke arrangement is to be put in place between the BHSCT families' liaison officer and Mr Brown. The Chair of the Trust would be writing to Mr Brown with details. BHSCT to share a copy of the letter to Mr Brown with the Department. **AP7** Any future FOI requests from Mr Brown are to be redirected to Marie to be picked up and actioned directly.	**M Heaney**
Action Plans	Valerie circulated a 'to do list' of issues relating to the current delayed discharge population, and indicated that a draft paper was currently with Marie Roulston for consideration. It was agreed that this should be forwarded to the Department, quickly, to inform advice to Richard. **AP8** The potential for additional capital funding in 2019/20 was raised, and whether this could be channelled to the voluntary sector.	**V McConnell**
Iveagh – follow up	Notes of meeting to discuss RQIA letter to be checked to ensure all relevant actions were captured, and updates to be provided to Department as soon as possible to inform response to RQIA. **AP9** Marie advised that the mindset that people automatically move from Iveagh to Muckamore once they turn 18 needs to be addressed.	**R Morton** **HSCB/BHSCT**
AOB	Valerie advised that, further to recent discussions with Trust ADs, she had advised them that there was no more time available for workshops on the LD acute care and treatment review and that this work needed to proceed in order to meet the timetable set for completion.	

	Jerome provided an update on recent meetings with Mrs Blake, and referred to the draft ToRs for SAI Level 3 investigation sent recently by Richard Dixon (Mrs Blake's advocate). Marie to consider the detail and respond to Rodney, copied to Jerome. **AP10**	**M Heaney**
Date of Next Meeting	The next meeting will take place on 8 May 2019 in Marie Heaney's office, BHSCT.	

MAHI - STM - 300 - 1118

MUCKAMORE ABBEY HOSPITAL – BHSCT MONTHLY UPDATE MEETING

TABLE OF ACTION POINTS

AP No.	Meeting Date	Action	Person Responsible	Comments
AP1	10/04/19	A response to issue to BHSCT once the Department had responded to the RQIA.	J Dawson	
AP2	10/04/19	Discussion with PSNI to help inform detail on future options for scrutiny.	J Dawson	
AP3	10/04/19	Monthly written reports from BHSCT to be received in advance of update meeting.	M Heaney	
AP4	10/04/19	BHSCT to engage with PCC re role of PCC.	M Heaney	
AP5	10/04/19	Detail of HSCB contract with Law Centre (NI) to be circulated.	V McConnell	**Complete.** Received 10/04/19
AP6	10/04/19	Consideration re detail on Regional Trauma Network to be reflected in Muckamore Action Plan.	HSCB	
AP7	10/04/19	BHSCT to share copy of letter to Mr Brown with the Department.	M Heaney	
AP8	10/04/19	Draft paper re delayed discharge 'to do list' to be shared with Department asap.	V McConnell	**Complete.** Received 10/04/19
AP9	10/04/19	Note of meeting to discuss RQIA letter to be checked for completeness and updates to be provided to the Department asap.	R Morton HSCB/BHSCT	
AP10	10/04/19	BHSCT to consider detail re SAI Level 3 investigation recently provided by PCC advocate and respond to the Department.	M Heaney	

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Reference: HSC (SQSD) 64/16

Date of Issue: 28 November 2016

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive PHA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

For Information:
Distribution as listed at the end of this Circular.

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

HSC (SQSD) 07/14: Proper use of the Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-14.pdf

Superseded documents: N/A

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue the guidance and Early Alert notification to advise staff of the procedures to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations 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.

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in 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.

Criteria for using the Early Alert System

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 event may attract media interest;*

5. *The Police Service of Northern Ireland (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 the 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.*

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

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.

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.

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@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: 028 9052 3775
qualityandsafety@health-ni.gov.uk

Yours sincerely

Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Dir of Performance Management & Service Improvement, HSCB
Dir of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts

Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Prof. Sam Porter, Head of Nursing & Midwifery, QUB
Prof. Pascal McKeown, Head of Medical School, QUB
Prof. Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Owen Barr, Head of School of Nursing, UU
Prof. Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

ANNEX A

☒ **Initial call made to** _____ **(DoH) on** _____ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from paragraph 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.***

……

……

……

……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: _____

Contact details:

Email address (work or home) ……

Mobile (work or home) …… Telephone (work or home) ……

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: …… Office: ……

Forwarded for consideration and appropriate action to: …… Date: ……

Detail of follow-up action (if applicable) ……

DoH CIRCULAR

CIRCULAR (OSS) 01 / 2022: LEGISLATIVE AND STRUCTURAL ARRANGEMENTS IN RESPECT OF THE AUTHORITY OF THE CHIEF SOCIAL WORK OFFICER, THE OFFICE OF SOCIAL SERVICES AND THE SOCIAL CARE AND CHILDREN'S DIRECTORATE OF THE STRATEGIC PLANNING AND PERFORMANCE GROUP IN THE DEPARTMENT OF HEALTH AND HEALTH AND SOCIAL CARE TRUSTS, IN THE DISCHARGE OF SOCIAL CARE AND CHILDREN'S FUNCTIONS (FORMERLY RELEVANT PERSONAL SOCIAL SERVICES FUNCTIONS);

SOCIAL CARE AND CHILDREN'S FUNCTIONS (STATUTORY FUNCTIONS)

1 INTRODUCTION

1.1 Social care services occupy a unique position in the Health and Social Care (HSC) system by virtue of the range of statutory powers and duties which direct and inform the provision of services in both Children's and Adult Programmes of Care.

1.2 'Relevant' statutory functions, include all functions under the Adoption (NI) Order 1987; the Disabled Persons (NI) Act 1989; the Children (Northern Ireland) Order 1995 (with the exception of the Children's Services Plan) and the Carers and Direct Payments Act (NI) 2002. Other relevant functions are specified under the Health and Personal Social Services (Northern Ireland) Order 1972; the Chronically Sick and Disabled Persons (NI) Act 1978 and the Mental Health (NI) Order 1986 and the Mental Capacity Act (NI) 2016 and Autism Act (Northern Ireland) 2011.

1.3 Relevant functions, described in the Health and Social Care Act (NI) 2022 as social care and children's functions, cover a range of duties, powers and responsibilities, including:

- matters which may impact upon an individual's rights;
- interventions which may impinge on personal liberty;
- the protection of children or adults from harm, or risk of harm, including risk of neglect, abuse or exploitation;
- the provision of vital social care services; and
- the exercise of regulatory functions.

These functions are exercised primarily by social workers[1] whose role is to improve and safeguard the social well-being of people in Northern Ireland on behalf of the State.

[1] Article 8, Health and Personal Social Services Act (Northern Ireland), 2001.

1.4 This circular sets out the legislative and structural arrangements for the discharge of relevant statutory functions by the HSC system from 1972 and up to the present day.

It also sets out the authority, legal relationship and framework of accountability between the Department of Health (DoH) and the Health and Social Care Trusts (HSCTs) in relation to the discharge of relevant functions.

1.5 This circular replaces Circular (OSS) 03 / 2015: (Statutory Functions). It should be read in conjunction with:-

- Circular (OSS) 02 / 2022: Social Care and Children's Functions (Statutory Functions): Management and Professional Oversight.

which sets out the roles and responsibilities of the Chief Social Work Officer, the Office of Social Services and the Social Care and Children's Directorate (SCCD) in the Strategic Planning and Performance Group in the Department of Health and HSCTs for the management and professional oversight of the discharge of relevant functions consistent with each organisation's respective roles and functions as set out in legislation.

2 LEGISLATIVE AND STRUCTURAL ARRANGEMENTS

2.1 The Department

2.1.1 The Department's powers derive from the Health and Personal Social Services (Northern Ireland) Order 1972[1] (the 1972 HPSS Order) and subsequent amending and additional legislation.

2.1.2 On 1 January 1974, the Ministry of Health and Social Services became known as the Department of Health and Social Services.

On 1 December 1999, the public safety functions of the Department of the Environment were transferred to the renamed Department of Health, Social Services and Public Safety (DHSSPS)[2].

The Department was subsequently renamed the Department of Health on 9 May 2016.

2.1.3 In 2002 the Northern Ireland Executive initiated the Review of Public Administration (RPA).
Subsequent reforms streamlined the HSC system and the Health and Social Care Reform Act 2009 (the Reform Act) resulted in the establishment of one

[1] S.I.1972/1265 (N.I.14)
[2] See S.R. 1999 No. 481 and I.1999/283 (N.I.1)

regional Health and Social Care Board (HSCB) and six HSCTs (five community HSCTs and the Northern Ireland Ambulance Service HSCT).
A Regional Agency for Public Health and Social Well-being was also established reflecting the focus on public health and wellbeing and an emphasis on prevention and support for vulnerable people to live independently in the community for as long as possible.

2.1.4 The Reform Act provided the legislative framework within which the then Health and Social Care (HSC) structures operated. It set out the high level functions of the various HSC bodies. It also provided the parameters within which each body was to operate, and described the necessary governance and accountability arrangements to support the effective delivery of HSC in Northern Ireland.

2.1.5 Section 2 of the Reform Act placed on the Department a general duty to promote an integrated system of:

i. health care designed to secure improvement:

- in the physical and mental health of people of Northern Ireland, and
- in the prevention, diagnosis and treatment of illness; and

ii. social care designed to secure improvement in the social well-being of people in Northern Ireland.

2.1.6 Further details on the roles and functions of HSC bodies and the systems that governed their relationships with each other and the Department were set out in the Framework Document[1] produced by the Department in 2011 to meet the statutory requirements placed on it by the Reform Act.

2.1.7 The Health and Social Care Act (NI) 2022 provides the legislative framework for the closure of the HSCB and the transfer of its functions to the HSCTs and DoH and sets out the roles and functions of the HSC bodies within the new system and their relationships with each other and the Department.

2.2 Health and Social Services Boards

2.2.1 On 1 September 1972, Health and Social Services Boards (HSSBs) were established under Article 16 of the 1972 HPSS Order. The Health and Personal Social Services (Establishment and Determination of Areas of Health and Social Services Boards) Order (Northern Ireland) 1972[2] determined the geographical area of each Board and specified its administrative Districts.

2.2.2 Article 17 of the 1972 HPSS Order specified the key functions of the Boards in respect of health and personal social services. These included, inter alia:

[1] http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf
[2] S.O. 1972 No. 217

- the exercise on behalf of the then Ministry of Health and Social Services, such functions (including functions imposed under an order of any court) with respect to the administration of such health and personal social services as the Ministry may direct; and

- the exercise on behalf of the then Ministry of Home Affairs such functions (including functions imposed under an order of any court) with respect to the administration of such personal social services under the Children and Young Persons Act (Northern Ireland) 1968 (the Children and Young Persons Act) and the Adoption Act (Northern Ireland) 1967 (the Adoption Act) as the Ministry may direct;

- in accordance with regulations and directions, Article 17 (2) of the 1972 HPSS Order also provided that where a function was conferred on a Board by any other legislation, that function shall be deemed to be a function which the Department had directed a Board to exercise on its behalf under Article 17 (1).

2.2.3 The Functions of Health and Social Services Boards (No.1) Direction (Northern Ireland) 1973 (The No. 1 Direction) specified the functions under the 1972 HPSS Order to be exercised by HSSBs on behalf of the then Ministry of Health and Social Services subject to the conditions contained in the Direction.

2.2.4 The Functions of Health and Social Services Boards (No. 2) Direction (Northern Ireland) 1973 (the No 2 Direction) specified functions of the then Ministry of Home Affairs under Articles 72 and 73 of the1972 HPSS Order relating to personal social services under the Children and Young Person's Act and the Adoption Act which were to be exercised by HSSBs on behalf of the Ministry of Home Affairs subject to the conditions contained in the Direction.

2.2.5 A number of functions under the Children and Young Person's Act, including those relating to training schools, attendance centres and remand homes were reserved to the Secretary of State in accordance with the provisions of the Northern Ireland (Modification of Enactments – No 1) Order 1973 (the 1973 Order) made under the Northern Ireland Constitution Act 1973. These remained the responsibility of the Northern Ireland Office.

2.2.6 Additional functions under the Children and Young Person's Act, including Fit Person's Orders, in so far as they related to the treatment of children and young persons found guilty of offences were also reserved in the 1973 Order to the Secretary of State. Operational difficulties that this presented to HSSBs were overcome by a subsequent agency arrangement made under section 11 of the Northern Ireland Constitution Act 1973, whereby the Department undertook these functions on behalf of the Secretary of State. The Functions of Health and Social Services Boards (No 1) Direction (Northern Ireland) 1974 provided for the local discharge of these functions by HSSBs.

2.2.7 By virtue of the Departments (Transfer of Functions) Order (Northern Ireland) 1973[1], all functions under the Adoption Act and all remaining functions under the Children and Young Persons Act transferred on 1 January 1974 to the Department from the Ministry of Home Affairs[2] subject to the provisions of the 1973 Order as referred to in paragraph 2.7. The No. 2 Direction (see paragraph 2.6) remained the applicable instrument of delegation for these functions.

2.2.8 Arrangements in respect of Youth Justice were subsequently included in the Criminal Justice (Children) (Northern Ireland) Order 1998[3] and all responsibilities for Youth Justice were transferred to the Department of Justice in The Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010[4].

2.2.9 With the introduction of the Adoption (Northern Ireland Order) 1987 (the Adoption Order) certain functions were conferred directly on HSSBs. Article 17 (1) of the 1972 HPSS Order was amended by that Order so that those functions under the Adoption Order are functions which the HSSB was required to exercise in accordance with regulations made by, and directions given by, the Department.

2.2.10 Prior to the commencement of the Children (Northern Ireland) Order 1995 (the Children Order) in November 1996, the Department amended the Exercise of Functions Regulations[5] to prescribe as relevant functions all functions under the Children Order.

The Department subsequently approved schemes to enable the Trusts to discharge specified relevant functions under the Children Order and the Adoption Order.

2.2.11 In 1998, the Department amended the Children Order to add to the duties of HSSBs in the Children (1995 Order) (Amendment) (Children's Services Planning) Order (Northern Ireland) 1998[6]. This required each HSSB to review the services provided in its area under Part IV of the Children Order and prepare and review plans in light of the review of services.

Since the 2009 reforms, this function is currently fulfilled on a regional basis by the Children and Young People's Strategic Partnership (CYPSP).

2.2.12 In 2003, functions previously carried out by HSSBs under Articles 80 – 87 and 96 – 103 of the Children Order, which deal with the registration and inspection of children's homes and under Article 176 of the Order (which provides for the inspection of schools accommodating children) transferred to the Regulation and Quality Improvement Authority following the introduction of the Health and

[1] SR & O 1973 No 504
[2] See S.I. 1973/2162 (C.64)
[3] See 1998 No. 1504 (N.I. 9)
[4] See S.I 2010/976
[5] SR 1996 No. 439
[6] SR 1998 No. 261

Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

2.2.13 Section 1 of the Health and Social Care (Reform) Act (NI) 2009 (the Reform Act) dissolved the four HSSBs and replaced them with a single Regional Health and Social Care Board.

Section 1 of the Health and Social Care Act 2022 dissolved the Regional Health and Social Care Board.

Schedule 1 of the Act outlined amendments providing for the transfer of the Regional Board's functions to Health and Social Care Trusts or to the Department of Health and the amendments consequential on the transfer of those functions.

Community Care Reforms

2.2.14 During the early 1990s, the changes introduced by the White Papers "Caring for People" and 'Working for Patients', (DoH, 1989) respectively set out proposals for improving community care services and health services in England and Wales. The equivalent Northern Ireland policy document, "People First" (DHSS,1990) introduced for the first time a division between the purchasing and provider roles within health and personal social services in Northern Ireland.

2.2.15 The role of HSSBs as coordinators, purchasers and quality controllers was strengthened relative to their primary role, at that time, as service providers. Management at local level was also strengthened through the appointment of Unit General Managers.
In the early 1990s this internal re-organisation changed the administrative structure from districts to General Units of Management, and reconfigured the geographical areas of the former administrative districts.

2.2.16 Under the People First policy reforms, HSSBs as commissioners and purchasers of services, were responsible for:

- assessing the health and social care needs of their resident population;
- strategic planning to meet need; and
- the development of purchasing plans.

2.2.17 People First required HSSBs to promote a mixed economy of care and a range of providers to maximise user choice and ensure the economic, effective and efficient delivery of services.

2.2.18 The Health and Personal Social Services (Northern Ireland) Order 1991 (the 1991 HPSS Order) gave effect to these changes and enabled health services

bodies to enter into arrangements (HSS contracts) for the provision of goods or services to or by them.

2.219 Section 24 of the Reform Act provided that the functions of the HSSBs relating to health improvement and health protection functions (as defined in section 13 of the Reform Act) were then exercisable by the Regional Agency for Public Health and Social Well-being (the Regional Agency) established by section 12 of the Reform Act.

The other functions of the HSSBs were then exercisable by HSCB.

The Health and Social Care Board

2.2.20 The Regional Health and Social Care Board was established in April 2009 under Section 7(1) of the Reform Act; it subsequently became known as the Health and Social Care Board (HSCB). It amalgamated and replaced the previous four area Health and Social Services Boards (HSSBs) that had been established under the Health and Personal Social Services (Northern Ireland) Order 1972. It had a range of functions that can be summarised under three broad headings:-

- **commissioning** the provision of health and social care and other related interventions, organised around a "commissioning cycle" 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 to ensure that it meets established quality standards, and evaluating the impact and feeding back into a new baseline position in terms of how needs have changed.

- **performance management and service improvement** – developing a culture of continuous improvement in the interests of patients, clients and carers by monitoring health and social care performance against relevant objectives, targets and standards; promptly and effectively addressing poor performance through appropriate interventions; service development; identifying and promulgating best practice; and, where necessary, the application of sanctions.

- **resource management** – ensuring the best possible use of the resources of the health and social care system, both in terms of quality, accessible services for users and value for money for the taxpayer.

2.2.21 The HSCB was accountable for its performance and for ensuring that appropriate assurance mechanisms were in place. This obligation rested with the HSCB's board of directors. It was the responsibility of the HSCB board to manage HSCTs' performance and to manage emerging issues in the first instance.

2.2.22 The HSCB was responsible for monitoring and reporting to the Department on the implementation of statutory functions it had delegated to HSCTs under Schemes

of Delegation (Schemes) as part of its performance and assurance responsibilities.

In line with the key principles underpinning the performance and assurance roles of all HSC bodies, the HSCB maintained a relationship with HSCTs based on openness and the sharing of information, adopting an informal, supportive approach to clarify and resolve issues as they arose, and thereby minimising the need for formal intervention.
Only unresolved performance issues of HSCTs were escalated to the Department for intervention.

Health and Social Services Trusts

2.4.1 Central to the community care reforms in England and Wales in the early 1990s was the concept that hospitals and community health providers were to be given the option to become self-governing Trusts.

2.4.2 As health and personal social services in Northern Ireland were integrated under the 1972 HPSS Order, account had to be taken of the HSSBs' responsibilities for the discharge of certain functions in relation to personal social services. Under the 1972 HPSS Order, these included services delivered under the Children and Young Person's Act and the Adoption Order.

2.4.3 Heath and Social Services Trusts (HSSTs) were established under Article 10 of the 1991 Health and Personal Social Services Order. The first of these were established in shadow form in 1993 as corporate bodies, managerially and administratively independent of HSSBs. Further primary legislation was required to enable HSSTs to discharge personal social services functions on behalf of their respective HSSBs.

2.4.4 HSSTs were statutorily independent organisations within the HSC system, responsible for the delivery of health and social care services in line with Ministerial priorities, standards and targets and as commissioned by the HSSBs and subsequently by HSCB.

2.4.5 The number of HSSTs was reduced from eighteen to six under the Review of Public Administration in 2007. Subsection 1(3) of the Reform Act makes provision to rename the HSSTs as Heath and Social Care Trusts (Trusts).

Health and Social Care Trusts

2.4.6 The six Trusts provide goods and services for the purposes of health and social care and, with the exception of the Ambulance Trust, were also responsible for exercising, on behalf of the HSCB, the statutory functions which were delegated to them by virtue of authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994 (the 1994 HPSS Order).

Each Trust also had a statutory obligation to put and keep in place arrangements for monitoring and improving the quality of health and social care which it provided to individuals and the environment in which it provides them.[1]

2.4.7 Section 21 of the Reform Act placed a specific duty on each Trust to exercise its functions with the aim of improving the health and social wellbeing of, and, reducing the health inequalities between, those for whom it provides, or may provide, health and social care.

2.4.8 Each HSCT was accountable for its performance and for ensuring that appropriate assurance mechanisms were in place. This obligation rested with the HSCT's board of directors. It was the responsibility of the HSCT board to manage local performance and to manage emerging issues in the first instance. HSCT boards remain responsible for performance management and assurance in respect of all of the HSCT's activities.

2.4.9 Prior to the Health and Social Care Act (NI) 2022, HSCTs were accountable to the HSCB for the availability, quality and efficiency of the services they provided against agreed resource allocations. They were also accountable to the Minister through the Department and the HSCB for performance against Ministerial targets including compliance with any statutory obligations.

2.4.10 The roles and responsibilities of HSCTs in respect of Delegated Statutory Functions (DSFs) were set out in the 1991 HPSS Order, the 1994 HPSS Order and the Reform Act.

They were further elaborated under formally agreed *Schemes for the Delegation of Statutory Functions* that were agreed between Trusts and HSCB and approved by DoH.

2.4.11 Under the Health and Social Care Act (NI) 2022 HSCTs became directly responsible in respect of their delivery of social care and children's functions to the Department.

2.4.12 To ensure legislative and service continuity in terms of HSCT responsibility for the exercise of relevant social care and children's functions, following the closure of the HSCB, the Act provides that the Department may by Order require HSCTs to exercise social care and children's functions. The means by which this is achieved is by way of amendment of the existing relevant Trust Establishment Orders.

2.4.13 These have been amended to revise the definition of social care and children's functions, and also, to update the functions of the Trusts and the DOH's power, by direction, to provide for specified functions to be undertaken by HSCTs on behalf of the Department. Thus ensuring that HSCTs retain the full range of duties, powers and responsibilities currently facilitated by the delegation of functions from

[1] Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003

the HSCB following its closure and thus safeguarding the continuation of current service delivery by HSCTs and maintaining their legal responsibility for same.

3 AUTHORITY AND LEGAL RELATIONSHIP BETWEEN THE SCCD WITHIN SPPG AND HSCTs IN RELATION TO THE DISCHARGE OF RELEVANT FUNCTIONS

3.1 Authority for the discharge of relevant functions

3.1.1 From 1972-1994, the HSSBs were the 'named authority' responsible for the delivery of relevant statutory functions. Following the establishment of HSS Trusts in 1991 and the introduction of the purchaser/provider split within the HSS system, HSSBs were enabled through the 1994 HPSS Order to delegate the discharge of statutory functions to HSS Trusts.

'Relevant' statutory functions were thereafter referred to as 'Delegated Statutory Functions'.

3.1.2 The 1994 HPSS Order provided for certain functions of HSSBs to be exercisable on their behalf by the HSSTs. These functions were prescribed for the purposes of the 1994 HPSS Order in The Health and Social Services Trusts (Exercise of Functions) Regulations (Northern Ireland) 1994 (The Exercise of Functions Regulations) and are known as "relevant functions." It includes functions under the Adoption Order and the Children and Young Person's Act. The Health and Social Services Trusts (Exercise of Functions) (Amendment) Regulations (Northern Ireland) 1996 amended of the Health and Social Services Trusts (Exercise of Functions) Regulations (Northern Ireland) 1994 to include all functions of the Children (Northern Ireland) Order 1995.

3.1.3 With the dissolution of the HSSBs and the establishment of the HSCB under the Health and Social Care (Reform) Act (NI) 2009 (the Reform Act), the responsibility for the delivery of the relevant statutory functions and oversight of same became the responsibility of the HSCB.

HSCTs also fulfil functions conferred upon them by the Carers and Direct Payments Act (Northern Ireland) 2002, the Children's Services Co-operation Act (Northern Ireland) 2015 and the Mental Capacity (Northern Ireland) Act 2016.

Section 21 of the Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015 has been amended to require the Department of Health to make arrangements to enable an "independent guardian" to be appointed to assist, represent and support a child to whom this section applies.

3.1.4 The Health and Social Care Act (NI) 2022 made HSCTs directly responsible to the Department in respect their performance of social care and children's functions.

3.2 **The legal relationship between the HSCB and HSCTs in relation to the discharge of relevant functions**

3.2.1 Under the 1994 HPSS Order, the HSCB could, by instrument in writing under seal ("an authorisation") provide for such relevant functions of the HSCB as are specified to be exercised by a HSCT on behalf of the HSCB.

Authorisations required the approval of the Department.

The 1994 HPSS Order required that each HSCT submit to the HSCB for approval a scheme for the exercise by the HSCT of specified relevant functions.

The HSCB was then obliged to submit the scheme for the approval of the Department.

3.2.3 Schemes, known as "Schemes for the Delegation of Statutory Functions" were developed by HSCTs in co-operation with the HSCB, which subsequently approved each scheme and submitted it to the Department for approval.

As part of the approval process, the Department's role was to ensure that proper provision has been made for the exercise of the relevant functions to be delegated to HSCTs and that the HSCB had appropriate arrangements in place to assure itself that HSCTs were exercising relevant functions effectively.

3.2.3 The HSCB could, with the approval of the Department, revoke an authorisation to a HSCT to exercise relevant functions, should circumstances have warranted such action.

3.2.4 The Health and Social Care Act (NI) 2022 dissolved the HSCB and responsibility for the discharge of the aforementioned relevant functions (described in the 2022 Act as ***"social care and children's functions"***) was placed directly onto HSCTs with a direct line of accountability to the Department.

3.3 **The DoH Strategic Planning and Performance Group (SPPG)**

3.3.1 The Health and Social Care Act (Northern Ireland) 2022 dissolved the HSCB and provides for the transfer of powers, duties and responsibilities including; commissioning, performance management and resource management held by the HSCB to the DoH.

Responsibility for the oversight and performance management of the Social Care and Children's Directorate of the Board, is now placed within the Department under the new Strategic Planning and Performance Group (SPPG).

The HSCB Social Care and Children's Directorate (SCCD) became a directorate within the Department's SPPG and continues to perform commissioning,

resource management, performance management and service and quality improvement functions.

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3.3.2 The Deputy Secretary of the DoH SPPG is responsible for the performance management of the SCCD and is accountable to the Department's Permanent Secretary, who in turn is responsible to the Minister, for the delivery of functions by the SCCD.

3.3.3 The Director of SCCD of the DOH SPPG is responsible for the professional oversight, governance, performance management and accountability, and strategic oversight of HSCTs in relation to the exercise of social care and children's functions. The Director of SCCD of the DOH SPPG is required to be a professionally qualified social worker registered with the Northern Ireland Social Care Council (NISCC).

3.3.4 Article 10A of the Health and Social Care Act (NI) 2022 provides for HSCTs becoming directly responsible for social care and children's functions directed to them under **Direction Delegations** by the Department.

Within DoH, SCCD of the SPPG is responsible for the oversight, governance, performance management and accountability in respect of how HSCTs perform social care and children's functions.

4 ACCOUNTABILITY

4.1 Legal accountability

4.1.1 In accordance with the common law principle of 'parens patriae', the State has the power to act as the public guardian for those who are incapacitated and/or unable to legally act on their own behalf, or for children whose parents are unable or unwilling to look after them.

4.1.2 Generally, the State exercises its powers to safeguard and promote the welfare of children or those who cannot care for themselves through statutory agencies, named as the responsible authorities in primary legislation. Legislation specifies, in broad terms, what the State considers is required to safeguard and promote the welfare of children or those who cannot care for themselves and provides the legal authority for responsible authorities to discharge statutory functions on behalf of the State. There are circumstances in which the State names the appropriate Government Department in legislation as the responsible authority. In these situations the Department is responsible in law for the exercise of the statutory functions unless it has delegated the functions to another statutory body.

4.1.3 Prior to the dissolution of the HSCB, in preceding primary legislation, where the HSCB was named as the responsible authority for the exercise of the functions, these functions were deemed to be a function which the Department had directed the HSCB to exercise under Article 17 (1) of the 1972 HPSS Order.

Where the HSCB delegated relevant functions to a Trust in accordance with the provisions of the 1994 HPSS Order, under Article 3(7) of that Order, the Trust:

> "…shall be liable in respect of any liabilities (including any liability in tort) in the exercise of these 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 HSS Trust in its own name".

4.1.4 The Children Order, Article 2(3), confirmed that "where a function was exercisable by a Health and Social Services Trust by virtue of an authorisation for the time being in operation under Article 3(1) of the Health and Personal Social Services (Northern Ireland) Order 1994, references to an authority were, to the extent that that function was exercisable by that Trust, references to that Trust".

HSCTs, therefore, were responsible in law for the discharge of all relevant functions delegated to them by the HSCB.

4.1.5 With the dissolution of the HSCB by the Health and Social Care Act (Northern Ireland) 2022, the responsibility for the exercise of functions is placed directly onto HSCTs with direct accountability to the Department.

The Department confers responsibility for the exercise of social care and children's functions on to a HSCT by a **Delegation Direction**.

HSCTs therefore are responsible in law for the discharge of all social care and children's functions they are required to exercise under the direction of the Department.

4.2 Accountability for Implementing the Schemes

4.2.1 Accountability is a key element in the discharge of statute. Prior to the dissolution of the HSCB, the Department, as the parent sponsor body of the HSCB and HSCTs, carried ultimate responsibility for the oversight of the performance of these organizations, including the implementation of the Schemes within a system of delegation.

4.2.2 Within the system of delegation, there was a requirement for an unbroken line of professional oversight from HSCTs to the HSCB and ultimately to the Department to ensure that the Schemes are implemented in accordance with the law and in full compliance with relevant professional standards

4.2.3 Following the dissolution of the HSCB, HSCTs became directly accountable to the Department for ensuring that the Schemes for the exercise of social care and children's functions are implemented in accordance with the law and to all relevant professional standards.

Arrangements for the professional oversight of the discharge of functions is set out in:-

- Circular (OSS) 01 / 2022: Legislative and Structural Arrangements in Respect of the Authority of the Department of Health, Chief Social Work Officer, the Office of Social Services and the Social Care And Children's Directorate of the Strategic Planning and Performance Group in the Department of Health and Health and Social Care Trusts, in the Discharge of Social Care and Children's Functions (Formerly Relevant Personal Social Services Functions); and

- Circular (OSS) 02 / 2022: Social Care and Children's Functions (Statutory Functions): Management and Professional Oversight

5 WORKING RELATIONSHIPS

5.1 Collaboration is a core principle in securing the social well-being of the people of Northern Ireland.

5.2 Previous to the migration of SCCD into the SPPG of the DOH, a number of agencies were required to assist the HSCB and HSCTs with the discharge of certain functions in respect of children, in so far as this is compatible with that body's own statutory or other duties and obligations and does not unduly prejudice the discharge of any of its functions (Article 46 of the Children Order) and in the investigation of matters under Article 66 of the Children Order, unless to do so would be unreasonable in all of the circumstances of the case.

5.3 The HSCB and HSCTs were among a number of named agencies under Article 1 (3) of the Safeguarding Board Act (Northern Ireland) 2011 that together constitute the Safeguarding Board for Northern Ireland (SBNI).

The Director of SCCD of the SPPG of the DOH (or his/her delegate) will now represent SPPG of the DOH on the SBNI.

Article 10 of the Safeguarding Board Act (Northern Ireland) 2011 places a duty to co-operate on SBNI member agencies in respect of functions relating to safeguarding or promoting the welfare of children insofar as this is compatible with each member organisation's statutory duties and obligations.

5.4 Although not enshrined in law, the principle of collaborative working applies equally to working with adults, in particular in respect of adult safeguarding which

will be most effective when it has the full support of partners across the statutory, voluntary, community, independent and faith sectors.

5.5 The HSCTs are required to give priority to developing and maintaining good working relationships with other relevant agencies in the discharge of functions of statute to secure improvement in the social well-being of the people in Northern Ireland.

5.6 The SCCD Directorate of the Department's SPPG will work directly with HSCTs to ensure the development and maintenance of the good working relationships continues to be a priority.

CIRCULAR (OSS) 02 / 2022:

SOCIAL CARE AND CHILDREN'S FUNCTIONS (STATUTORY FUNCTIONS): MANAGEMENT AND PROFESSIONAL OVERSIGHT

DEPARTMENT OF HEALTH (DOH) CIRCULAR

ROLES AND RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH, CHIEF SOCIAL WORK OFFICER AND OFFICE OF SOCIAL SERVICES; HOSPITAL AND COMMUNITY CARE DIRECTORATE IN THE STRATEGIC PLANNING AND PERFORMANCE GROUP, DEPARTMENT OF HEALTH AND THE HEALTH AND SOCIAL CARE TRUSTS (HSCTs), FOR THE MANAGEMENT AND PROFESSIONAL OVERSIGHT OF THE EXERCISE OF STATUTORY FUNCTIONS

1 INTRODUCTION

1.1 The Health and Social Care Act (NI) 2022 has dissolved the Health and Social Care Board (HSCB) and placed responsibility for the management and professional oversight of the exercise of children's and social care functions (statutory functions) directly with the Department.

1.2 Under the 1994 Health and Personal Social Services (Northern Ireland) Order 1994, provision was previously incorporated for the discharge of functions to be delegated to and exercised byHealth and Social Care Trusts (HSCTs) on behalf of the HSCB by way of an instrument in writing under seal ("an authorisation").

Authorisations required the approval of the Department of Health (DoH).

The 1994 HPSS Order required that each HSCT submit to the HSCB for approval a scheme for the exercise by the HSCT of specified relevant functions. The HSCB was then obliged to submit the scheme for the approval of the Department.

1.3 Schemes, known as "Schemes for the Delegation of Statutory Functions" were developed by HSCTs in co-operation with the HSCB, which subsequently approved each scheme and submitted it to the Department for approval.
As part of the approval process, the Department's role was to ensure that proper provision has been made for the exercise of the relevant functions to be delegated to HSCTs and that the HSCB had appropriate arrangements in place to assure themselves that HSCTs were exercising relevant functions effectively.

A review of the arrangement for the delegation of statutory functions undertaken in 2011/12 recommended that HSCB agree one single uniform

template Scheme with each of the five HSCTs to ensure that there was regional consistency in the Schemes approved.

1.4 The HSCB could, with the approval of the Department, revoke an authorisation to a HSCT to exercise relevant functions, should circumstances warrant such action.

1.5 The requirement for an unbroken line of assurance and professional oversight of the discharge of Delegated Statutory Functions (DSFs) from HSCTs to the HSCB and ultimately to the Department of Health (DoH) came into place in 1994 following concerns raised by the judiciary with the introduction of legislation[1] which enabled the delegation of relevant statutory functions from the legacy Health and Social Services Boards to HSCTs.

Arrangements for professional oversight were designed to ensure that DSFs were discharged in accordance with the law and to relevant professional standards within a system of delegation.

1.5 The Chief Social Work Officer (CSWO) in the Department, the previous Director of Social Care and Children's Directorate in the HSCB (the HSCB Director) and the Executive Director for Social Work (EDSW) in each of the HSCTs' were individually and collectively responsible for the effective operation of an unbroken line of professional oversight of DSFs Delegated Statutory Functions.

1.6 Professional oversight arrangements were an integral part of the overall system of checks and balances that held the HSCB and HSCTs' to account for their performance. Professional oversight involved:

- Approval of Schemes for the Delegation of Statutory Functions
- The appropriate discharge of functions of statute
- Performance management
- Strategic oversight
- Quality Assurance
- Continuous improvement
- Reporting

1.7 The Health and Social Act (NI) 2022 dissolved the HSCB.

To ensure the continued effective performance of functions of statute relevant to social care and children's functions the Social Care and Children's Directorate (SCCD) was included into the Department's Strategic Planning and Performance Group (SPPG).

[1] Health and Personal Social Services (Northern Ireland) Order, 1994

The Directorate has subsequently been renamed as the Hospital and Community Care Directorate (HCCD).

1.8 The Director of HCCD of the SPPG is responsible for the performance management of the HCCD and is accountable to the Deputy Secretary of the SPPG who in turn is responsible to the Department's Permanent Secretary, and on to the Minister.

The Director of HCCD of the SPPG will work works in partnership with the Department's Social Services Group (SSG) and the Office of Social Services (OSS) and will be is accountable to the Deputy Secretary regarding matters of professional advice, guidance and insights in relation to the provision of the full range of children's and social care functions and services to children and families.

1.9 The Health and Social Care Act (NI) 2022, revised the 1991 and 1994 Health and Personal Social Services (Northern Ireland) Orders.

Articles 3 and 4 of the Health and Personal Social Services (Northern Ireland) Order 1994, (which provided for relevant functions of the HSCB, as specified, to be exercisable on their behalf by HSCTs, with the approval of the Department, by instrument in writing signed under seal (an authorisation), and requiring HSCTs to submit a scheme for the exercise by HSCTs of functions on behalf of the HSCB, were removed.

The inclusion of Article 10A into the Health and Personal Social Services (Northern Ireland) Order 1991 defined "social care and children functions" that are directly exercisable by HSCTs under the provisions conferring them.

The addition of Article 10B to the Health and Personal Social Services (Northern Ireland) Order 1991 by the Health and Social Care (Northern Ireland) Act 2022 provided that the Department could direct, by way of a "delegation direction", that specified functions would be exercisable by HSCTs on behalf of the Department.

The addition of Article 6B (in Schedule 3 of the Health and Personal Social Services (Northern Ireland) Order 1994,) provided that the HSCTs must submit to the Department a scheme for the exercise of its social care and children's functions.

The requirement for approval by instrument in writing under seal (an authorisation) was removed.

2. PURPOSE OF THIS CIRCULAR

2.1. This circular outlines the roles and responsibilities of the Chief Social Work Officer (CSWO) and Director of the Office of Social Services (OSS) in the DoH SSPG , the Deputy Secretary of the Department of Health's (DoH) Strategic Planning and Performance Group (SPPG) the Director of Hospital and Community Care – HSC in the SPPG, , and the HSCT Executive Directors of Social Work (EDsSW) for the management and professional oversight of social care and children's functions exercised by HSCTs.,

2.2 This circular should be read in conjunction with Circular (OSS) 01 / 2022 which sets out the legislative and structural arrangements in respect of the authority of the Department and HSCTs in the exercise of statute related to social care and children's functions.

3. STATEMENT OF PRINCIPLES

3.1 Arrangements for the management of and professional oversight of social care and children's functions exercised by HSCTs should be based on a commitment to:

(i) co-operation in the interests of improving and safeguarding the social wellbeing of children, families and adults;

(ii) evidence-informed decision-making;

(iii) the provision of quality services and securing improved outcomes for service users;

(iv) regional consistency and fairness in availability, quality and effectiveness of services;

(v) continuous improvement based on learning from the professional oversight processes;

(vi) timely reporting, prompt responses and early resolution of issues;

(vii) efficiency, proportionality and effectiveness.

4. ACCOUNTABILITY

4.1 Accountability is a key element in the exercise of functions of statute.

The Department, as the parent sponsor body, carries ultimate responsibility for the performance of HSCTs, including the exercise of functionsconferred

directly upon HSCTs (so far as they are exercisable by HSCTs under the provisions conferring them).

This responsibility is not transferable to any other body.

4.2 The Director of the HCCD in the DoH is responsible for the professional oversight, governance, performance management and strategic oversight of HSCTs in relation to the exercise of social care and children's functions (statutory functions).

4.3 The CSWO/ Director of OSS, the Director of Hospital and Community Care – HSC and the EDSW of each HSCT are individually and collectively responsible for:

- providing management and professional leadership on all social work and social care matters, including the exercise of social care and children's functions within their respective organisations, and, where relevant, to other organisations;

- ensuring appropriate internal organisational, managerial and professional arrangements are in place for the management and professional oversight of social care and children's functions in line with the requirements set out in this and other relevant guidance;

- providing authoritative managerial and professional advice and analysis in respect of the exercise of social care and children's functions to their Accounting Officer and board of directors;

- maintaining open and constructive working relationships and sharing information with each other as appropriate; and

- adopting a collaborative and supportive approach to clarifying and resolving issues as they arise thereby minimizing the need for escalation and/or formal intervention.

4.4 The CSWO/Director of OSS, the Director of of Hospital and Community Care – HSC and EDsSW of HSCTs are required to be professionally qualified social workers in accordance with Article 8 (1) of the Health and Personal Social Services Act (Northern Ireland) 2001 (the 2001 Act) and registered with the Northern Ireland Social Care Council (NISCC).

They are responsible for ensuring the availability of high-quality professional advice within their respective organisations on the complex issues involved in the exercise of duties, powers and responsibilities particularly, but not

exclusively, with regard to protecting individuals from risk of harm of neglect, abuse or exploitation.

5. Social care and children's functions

5.1 Article 10A of the Health and Personal Social Services (Northern Ireland) Order 1991 defines "social care and children functions" that are directly exercisable by HSCTs under the provisions conferring them as:-

a) functions under sections 35 and 96 of the Children and Young Persons Act (Northern Ireland) 1968;

(b) functions under Articles 15, 36, 37, 38, 39, 99, 101 and 101A of, and Schedule 6 to, the Health and Personal Social Services (Northern Ireland) Order 1972;

(c) functions under sections 1(2), 2 and 12(1) of the Chronically Sick and Disabled Persons (Northern Ireland) Act 1978;

(d) functions under the Mental Health (Northern Ireland) Order 1986;

(e) functions under the Adoption (Northern Ireland) Order 1987;

(f) functions under sections 4 to 9 of the Disabled Persons (Northern Ireland) Act 1989;

(g) functions under the Children (Northern Ireland) Order 1995;

(h) the function of making or submitting pre-sentence reports within the meaning of Article 2(2) of the Criminal Justice (Northern Ireland) Order 1996 or Article 4(1) of the Criminal Justice (Northern Ireland) Order 2008;

(i) functions under the Carers and Direct Payments Act (Northern Ireland) 2002;

(j) functions under the Mental Capacity Act (Northern Ireland) 2016.

The Department may by regulations amend the list of social care and children functions.

6. Delegation Directions

6.1 The Health and Social Care Act (NI) 2022 empowers the Department of Health to make **Delegation Directions**[2] to HSCTs to enable future specified functions of the Department to be exercisable by a specified HSCT in relation to the operational area of that HSCT on behalf of the Department.

6.2 HSCTs will be required to submit a scheme confirming that they have proper provision in place for the effective exercise of these functions.

The HCCD will provide a template to the HSCTs to be used in submitting a Scheme to the Department.

6.3 The Director of Hospital and Community Care – HSC will consider the submitted schemes in consultation with OSS in the DoH.

The CSWO may approve a scheme recommended by the Director of Hospital and Community Care – HSC either without modifications or with such modifications as are agreed with the Director of Hospital and Community Care – HSC and the HSCT concerned.

6.4 The HCCD will agree with the HSCTs any necessary modifications or amendments and will then recommend the Schemes to the CSWO for approval and issue.

6.5 The HCCD are responsible for the design and issue to the HSCTs of a single regional performance management and reporting template in relation to the exercise of social care and children's functions.

7. The DoH's Responsibilities for Delegation Directions

7.1

7.2 The HCCD of the Department will inform the HSCTs of all relevant changes in legislation which require an amendment or update to the Schemes in a timely way.

XXXXX will issue a "delegation direction"to provide for the specified functions to be exercisable by the HSCT9s) within the operational area of the HSCT

[2] "Delegation direction" means a direction under paragraph 10B (1) of the Health and Personal Social Services (Northern Ireland) Order 1991

7.3 The Department may, by direction, provide for specified social care and children's functions to cease to be exercisable by a HSCT and to be exercised instead by; the Department, another HSCT by Delegation Direction, or by another specified person or body.[3]

7.4 The HCCD in the DoH will agree the HSCTs' internal monitoring arrangements, as well as direct the HSCTs regarding the information they must record in respect of the exercise of these functions, in what form it is to be recorded, at what intervals it should be provided and for how long it should be retained.

7.5 The HCCD should ensure that HSCT Schemes have been agreed and include any "delegation directions" issued by the HSCT Accounting Officer prior to submission to the Department for approval.

7.6 The HCCD is responsible for considering the submitted Schemes in collaboration with OSS and recommending approval and issue of the Scheme to the CSWO.

7.7 The HCCD, in consultation with OSS, are required to keep the Schemes and "delegation directions" issued under regular review to ensure their adequacy and fitness-for-purpose and should formally review Schemes along with HSCTs at a minimum of three yearly intervals

7.8 The HCCD is required to retain a copy of the approved Schemes of Directed Delegation.

8.0 Health and Social Care Trusts (HSCTs) Responsibilities

8.1 Under the provisions of paragraphs 6B and 6C of Schedule 3 of the Health and Personal Social Services (Northern Ireland) Order 1991, HSCTs have a responsibility to submit a Scheme for their arrangements for the exercise of social care and children's functions under a delegation direction from the Department.

The Department may approve a scheme submitted to it by an HSCT either without modifications or with such modifications as my be agreed with the HSCT.

8.2 HSCTs must complete the single regional performance management reporting template, as provided by the HCCD, at intervals prescribed by the

[3] HPSS (NI) Order 1991, Schedule 3, PART 3A DIRECTIONS THAT CERTAIN FUNCTIONS BE EXERCISED BY OTHERS 22A (1) as amended by the HSC (NI) Act 2022.

HCCD and retained as prescribed by the HCCD on the exercise of their social care and children's functions.

8.3 The HCCD will, with HSCTs at least every 3 years, keep their Schemes under review.

New, amended or updated Schemes require approval of the CSWO in the Department,

8.4 The Chief Accounting Officers of the HSCTs are required to agree their Schemes for the exercise of social care and children's functions and any "delegation directions" issued by the Department prior to submission to the HCCD in the Department.

8.5 HSCTs are required to retain a copy of the Scheme agreed and approved by the DoH.

8.6 HSCTs are required to record and report such information with respect to the exercise of its functions as the HCCD in the DoH may direct[4].

8.8 An HSCT must give effect to any scheme approved by the Department[5].

8.9 An HSCT must, if so requested by the HCCD in the Department, submit a new scheme to the DoH for approval[6]

7.10 HSCTS, as separate legal entities, are responsible in law for the discharge of social care and children functions and any future functions directed to them or delegated to them by the Department under a Delegation Direction.

7.11 HSCT EDSWs are responsible for ensuring approved Schemes for social care and children functions and any delegation directions are properly implemented and managed within all programmes of care. This includes ensuring:

- legal and professional responsibilities are assigned and necessary systems and procedures are in place;

- compliance with all statutory, regulatory or professional requirements;

- all staff responsible for the discharge of social care and children's functions have access to relevant training, professional support and supervision;

[4] Paragraph 6A of Schedule 3 of the Health and Personal Social Services (Northern Ireland) Order 1991
[5] Paragraph 6B (3) of Schedule 3 of the Health and Personal Social Services (Northern Ireland) Order 1991
[6] Paragraph 6B (4) of Schedule 3 of the Health and Personal Social Services (Northern Ireland) Order 1991

- the maintenance and operation of an efficient data collection system and provision of data and reports to HCCD in the Department as required;

- implementation of actions, including improvement plans agreed with the SCCD in the Department, to improve the safety, quality and effectiveness of services;

- the Accounting Officer, HSCT Board and the HCCD and OSS in the Department are informed, at agreed intervals, on the HSCT's performance in respect of social care and children's functions, including early notification of risks, resource pressures and legal challenges and proposed actions to address;

- timely action to address and/or prevent the escalation of any identified issues;

- the HCCD and, where appropriate, OSS are notified in a timely way of any relevant issues through established mechanisms[7] and proposed actions to address.

7.12 HSCT EDSWs will be supported in their responsibilities by a Social Care Governance Officer (HSCT Governance lead) who will report directly to the EDSW in relation to the HSCT's compliance with social care and children's functions and related governance issues.

7.13 The HSCT Governance lead will be supported by an identified social work lead in each programme of care who is responsible for reporting to and informing the HSCT Governance lead in relation to their respective area's compliance with social care and children's functions and related governance issues.

7.14 HSCT Governance leads and identified social work leads are required to be suitably qualified professional social workers in accordance with Article 8(1) of the Health and Personal Social Services Act (Northern Ireland) 2001 (the 2001 Act).

7.15 Responsibility for the performance of HSCTs in respect of the exercise of functions rests fully with the organisation's Chief Executive Officer (CEO) who acts as the organisation's Accounting Officer. The CEO is required to account for the HSCT's performance as part of the formal Assurance and Accountability processes between the Department and the HSCTs.

[7] Established mechanisms include the Early Alert, Serious Adverse Incident, Adverse Incident, Untoward Incident and Complaints reporting systems.

7.16 Professional oversight arrangements ensure the Accounting Officer and the board of directors of each HSCT receive authoritative professional advice and analysis regarding their organisation's exercise of functions.

This enables each Accounting Officer to account to the Department as appropriate. The Department's Accounting Officer is advised by the CSWO and the Deputy Secretary of the DOH SPPG on all relevant performance and professional matters, including the exercise of relevant functions of statute.

7.17 As such, arrangements for the professional oversight of functions exercisable by HSCTs as directed by the Department are an integral part of each HSCT's internal corporate governance and accountability arrangements and should not duplicate reporting processes in place for these purposes.

7.18 Due regard will be given by the Department and HSCTs as to the views of individuals and/or agencies in terms of the performance of the HSC system in improving and safeguarding the social wellbeing of people in Northern Ireland.

8.0 PERFORMANCE MANAGEMENT RE: Directed Social Care and Children's Functions Under Direction/Delegation Directions.

8.1 HSCTS are responsible for ensuring the approved Schemes for Delegation Directions are implemented by the HSCTs through agreed performance management and quality assurance mechanisms.

8.2 The Director of the HCCD is responsible for ensuring approved Schemes for Delegation Directions are properly implemented by the HSCTs to agreed standards. This includes:

- ensuring effective arrangements within the HCCD for monitoring and quality assurance of each HSCT's management and discharge of social care and children's functions in compliance with approved schemes and all statutory, regulatory and professional requirements;

- maintaining oversight of individual HSCT compliance with social care and children's functions through regular liaison with HSCTs and receipt and analysis of relevant information, data and reports;

- maintaining regional oversight of consistency of HSCTs' compliance with social care and children's functions and related governance issues and ensuring the best use of resources;

- taking prompt action to address and/or prevent escalation of any issues, including under performance or non-compliance;

- overseeing the implementation of HSCT improvement/action plans approved by the HCCD;

- advising the Deputy Secretary of the SSPG and the CSWO, at agreed intervals, on the HSCTs' performance in respect of social care and children's functions , including timely notification of risks, resource pressures and legal challenges and proposed actions to address;

- alerting the Deputy Secretary of the SSPG and and the CSWO in a timely way of any unresolved disputes, substantive issues or concerns regarding a HSCT's discharge of social care and children's functions and proposed actions to address.

8.3 The Director of HCCD will be supported by a Social Care Governance Officer. The Social Care Governance Officer will report directly to the Director of HCCD in relation to the HSCTs' compliance with social care and children's functions and related governance issues.

The Social Care Governance Officer will be supported by the professional social care commissioning leads for each programme of care in the HCCD of the SPPG and the HSCT Governance leads. The HSCT Governance leads will inform and/or report to the HCCD Governance lead on social care and children's functions and related governance issues to ensure a comprehensive overview of performance at programme of care level, individual HSCT level and regionally is available.

The Social Care Governance Officer and professional social care commissioning leads and HSCT Governance leads are required to be a suitably qualified professional social worker in accordance with Article 8(1) of the 2001 Act.

8.4 The Deputy Secretary of the DOH SPPG is ultimately responsible for ensuring approved schemes for Delegation Directions are implemented by the HSCTs through agreed performance management and quality assurance mechanisms.

9. STRATEGIC OVERSIGHT of Social Care and Children's Functions under Delegation Directions

9.1 OSS/the CSWO is responsible for maintaining a strategic professional oversight of the effectiveness of the HCCD arrangements for professional oversight of each HSCT's exercise of their social care and children's functions.

9.2 The Deputy Secretary of the SPPG and the CSWO are responsible for ensuring that each HSCT discharges their responsibilities as the named 'authority' for the discharge of relevant social care and children's functions in accordance with the law, approved Schemes for Delegation Directions and relevant policies, guidance, standards and directions. This includes:

- ensuring effective arrangements within the Department to maintain ongoing oversight of all relevant information including the receipt and analysis of data and reports in respect of social care and children's functions submitted by HSCTs;

- ongoing engagement with the HSCT EDSWs through established mechanisms and as and when required;

- providing authoritative professional advice and/or direction from OSS/CSWO/Deputy Secretaries, and Director of SCCD to the HSCTs to address identified issues of concern, non-compliance or under-performance;

- advising the Permanent Secretary and Departmental Board at agreed intervals on social care and children's functions, including timely notification of risks, resources pressures or legal challenges and proposed actions to address.

9.3 In the event of significant concerns arising from any HSCTs performance in relation to the discharge of social care and children's functions, the Department may use its powers under Articles 10B of the Health and Personal Social Services (Northern Ireland) Order 1991 to direct the HSCTs to take specific actions that the Department deems necessary to improve a HSCT's performance.

9.4 The CSWO will be supported in his/her responsibilities by the Deputy CSWO who will report directly to the CSWO on the HSCTs' discharge of social care and children's functions.

The CSWO will be supported by professional and policy officers with responsibility for professional and/or policy lead for children's and adult social care services.

The CSWO and professional officers are required to be suitably qualified social workers, registered with NISCC in accordance with Article 8(1) of the Health and Personal Social Services Act (Northern Ireland) 2001.

10. CONTINUOUS IMPROVEMENT Re: Directed Social Care and Children's Functions Under Directions/Delegation Directions

10.1 Arrangements for the professional oversight of social care and children's functions should support a systems-wide culture of learning and continuous improvement and contribute to HSCTs compliance with the statutory duty to monitor and improve the quality of services[8].

10.2 Continuous improvement will continue to be supported by:

- evidence-informed improvement initiatives;
- programmes of audit; and
- Identification and promulgation of good practice.

Evidence informed improvement initiatives

10.3 Proposals for improvement initiatives should be: designed and planned to improve outcomes for service users; informed by research, evidence and people's experiences of services; and measured for impact and outcomes.

Programmes of audit

10.4 Each HSCT is required to plan and undertake an annual programme of audit as part of the internal monitoring and quality assurance of the discharge of social care and children's functions. The learning and outcomes of audit activity will be used to inform improvements in each HSCT's arrangements for the discharge of social care and children's functions.

10.5 Each HSCT will report on its audit and improvement activity in its end year report to the HCCD.

10.6 The HSCTs will carry out and/or commission a programme of audit to be undertaken each year as part of its performance management and monitoring arrangements. The learning and outcomes of this audit activity will be used to inform improvements in individual HSCT and/or regional arrangements for social care and children's functions.

10.7 The HSCTs will report on its audit and improvement activity in its end of year overview report to the Department.

10.8 The Department ensures an internal audit of the HCCD's arrangements for the professional oversight of HSCTs' discharge of social care and children's functions is carried out at agreed intervals, but no longer than 5 yearly

[8] Article 34, HPSS Quality, Improvement and Regulation (Northern Ireland) Order, 2003

intervals. The learning and outcomes of this audit activity will inform improvements in the management and professional oversight arrangements.

10.9 It is imperative that the Department and HSC audit activity does not duplicate their efforts. The outcomes of other relevant audit activity should be used by the Department, and HSCTs as part of their compliance with the requirements of this Circular and Circular (OSS) 01 / 2022: Legislative and Structural Arrangements in Respect of the Authority of the Department of Health, Chief Social Work Officer, the Office of Social Services and the Social Care And Children's Directorate of the Strategic Planning and Performance Group in the Department of Health and Health and Social Care Trusts, in the Discharge of Social Care and Children's Functions (Formerly Relevant Personal Social Services Functions).

10.10 All audits of Directions and performance management in respect of social care and children's functions should be led by suitably qualified staff in accordance with Article 8 (1) of the Health and Personal Social Services Act (Northern Ireland) 2001 who have relevant experience and/or expertise in audit and/or social care governance.

11. REPORTING ARRANGEMENTS

In-year reporting

11.1 Effective performance management and professional oversight is a dynamic process and involves ongoing monitoring and reporting throughout each reporting year. This is done through established Departmental mechanisms.

11.2 Timely reporting in respect of the exercise of social care and children's functions is important and early reporting of emerging concerns or significant issues is crucial in order to facilitate appropriate decision making and, where necessary, timely responses.

11.3 Any substantive issues regarding the exercise of social care and children's functions should be reported promptly to the HCCD in the Department to facilitate timely action.

End year reporting

11.4 End year reports provide an opportunity for both the HSCTs and the Department to take stock of performance throughout the year and plan for the

future. End year reports should facilitate strategic decision making about actions required to further improve services and outcomes for service users.

11.5 Each HSCT is required to submit an annual end year report, approved by its Board, on how it has exercised its social care and children's functions to the HCCD no later than end of May each year.

11.6 The HSCT end year report should include an analysis of data and performance to assist the HSCT board and the Department in their respective governance, accountability and strategic planning roles to identify the HSCT's:

- compliance with the law and agreed standards and targets;
- performance gaps and/or areas of concerns, including non-compliance with social care and children's functions;
- effectiveness of HSCT's monitoring and reporting arrangements;
- outcomes of in-year audit and improvement activity;
- outcomes for service users;
- new or emerging trends or pressures.

11.7 The HCCD will produce an annual end year overview report to the Office of Social Services (OSS), approved by the Deputy Secretary of the DOH SPPG, by the end of June each year based on its analysis of HSCTs' end year reports and any other relevant data and information gathered as part of its professional oversight throughout the year.

11.8 The end year overview report should reflect both operational performance and strategic issues and assist the OSS, the CSWO and the Permanent Secretary in their governance, accountability and strategic planning roles including:

- overview and analysis of HSCTs' performance in respect of social care and children's functions , including good practice and performance gaps;
- level of compliance with the law, policy, procedures, guidance, professional standards and targets;
- outcomes of in-year audit and improvement activity;
- emerging pressures and/or concerns;
- regional comparison and trends.

11.9 The HCCD will agree an action/improvement plan with agreed timelines for implementation with each HSCT by end of June each year.

11.10 The HCCD will also submit within the same timeframe, either separately or as an integral part of its end year overview report: data on the configuration of the Social Work workforce in all Programmes of Care across HSCTs; an update on the qualification profile of the social work workforce in HSCTs including numbers of relevant qualifications achieved in-year against Departmental targets; the volume and range of learning and development activity including spend against Departmental commissioning priorities.

11.11 The CSWO will advise the Permanent Secretary and Departmental Board of the key findings of the approved end year overview report from the HCCD within 6 weeks of receipt and/or confirmation of approval.

11.12 Where a significant issue is identified in the process of compiling end year reports which has not been previously reported during the year, the OSS should be alerted immediately by the HCCD in advance of submission of the end year report.

12. Chief Social Work Officer – Role and Responsibilities

Introduction

12.1 Chief Professional Officers, including a CSWO, are employed by the Department at a senior level to provide the Minister, Permanent Secretary and Department board with authoritative professional advice and insights in respect of the provision of the full range of health and social care.

12.2 The CSWO is the lead professional officer for social work and social care in Northern Ireland and sets the strategic direction for relevant service areas. S/he provides strategic professional advice and expertise to policy colleagues, government Departments, HSC agencies and other organizations as required.

12.3 The CSWO has a wide range of professional responsibilities including responsibility for the professional oversight of the exercise of statutory functions within an integrated HSC system. This oversight is part of the overall system within the Department for monitoring the delivery of the Department's policies by HSCTs and holding them to account.

12.4 The CSWO is responsible for issuing and keeping under review all relevant Circulars, professional standards, guidance or directions in respect of arrangements for the exercise of social care and children's functions.

Accountability

12.5 The CSWO is directly accountable to the Permanent Secretary (PS) and to the Minister for the provision of authoritative professional advice and insights in respect of all social work and social care matters and for reporting on relevant social care and children's functions across a range of children's and adult services.

Professional Leadership

12.6 The CSWO is responsible for providing professional leadership for the social work and the social care workforces in Northern Ireland, including:

- Setting the strategic direction for social work and social care within an integrated HSC system;
- Promoting a strong voice for all adults, families, children and carers using social care services and for frontline workers delivering services in the development of policies, strategies and standards;
- Working collaboratively with others, including other Government Departments, the Executive Directors of Social Work (EDsSW) within the HSC system and other key stakeholders in the public, voluntary and private sectors to improve and safeguard the social wellbeing of people in Northern Ireland;
- Promoting and supporting evidence-informed approaches to decision making at practice, service and policy levels.
- Promoting and supporting a culture of innovation, continuous learning and improvement and implementation in social work and social care practice and service provision;
- Building and maintaining East/West, North/South and international professional relationships and networks to share best practice and learning;
- Communicating the positive contribution of social workers and social care workers in improving and safeguarding social wellbeing based on evidence and outcomes.

Professional Advice

12.7 The CSWO is responsible for providing authoritative professional advice and insights to the Minister of Health, and other Executive Ministers in respect of social work and social care matters including social care and children's functions, including:

- Providing authoritative professional advice and insights to the PS, senior policy colleagues, other Departments and their ALBs, the NI Assembly and its Committees, HSC agencies, community, voluntary and the independent sector, the Further and Higher Education Sector and the media.

- Working in collaboration with the Director of the DOH Strategic Planning and Performance Group, Hospital and Community Care Directorate and HSCT EDsSW with regard to seeking and giving professional advice on social work and social care matters including social care and children's functions.
- Ensuring appropriate professional advice in the development and implementation of policies, strategies and standards and in Departmental responses to Regulatory reports, Judicial Reviews, Tribunals, Inquiries and Assembly Questions.

Senior Professional Practice Lead

12.8 The CSWO is responsible for making authoritative and final decisions on complex/controversial professional practice matters, including intervention action through the HCCD, including;

- Providing professional advice on the most complex cases, where individual cases may be the subject of public and/or media interests and in which the Minister may be asked/be required to become personally engaged;
- Ensuring appropriate professional input for discharging Departmental responsibilities in respect of Intercountry Adoptions in accordance with the Adoption (NI Aspects) Bill 2002 and obligations under the Hague Conventions;
- Professional endorsement of HSCT applications for admission of under 13s to secure accommodation in line with Volume 4 of the Children (NI) Order 1995 Regulations and Guidance;
- Discharging the responsibility of the Department's Child Protection Officer;

Professional Governance

12.9 The CSWO is responsible for ensuring effective arrangements within the Department for the approval of schemes for the exercise of Directions/Delegation Directions and professional oversight of social care and children's functions , including fulfilment of Corporate Parent duties, within an integrated HSC system in line with this Circular and Circular (OSS) 02 / 2022: Social Care and Children's Functions (Statutory Functions): Management and Professional Oversight.

12.10 S/he is also responsible for:

- ensuring effective arrangements within the Department for professional advice and responses to professional issues raised by MLAs, members of the public or

through established reporting mechanisms[9] that relate to social care and children's functions;

- Contributing as a senior professional lead to the Department's formal assurance and accountability arrangements with HSCTs;
- Accounting directly to the Permanent Secretaries and the Departmental Board on the discharge of the Department's social care and children's functions;
- Promoting (alongside those responsible in the Department for advice on the commissioning system) a robust framework for commissioning and delivery in social care and children's services, including the continuing development of standards for social care and children's services;
- Escalating any issues of concern and/or risks, including issues regarding performance or resource or service pressures on social care provision, to the Permanent Secretary and relevant policy leads;
- Sponsorship of the Northern Ireland Social Care Council (NISCC), the Northern Ireland Guardian ad Litem Agency (NIGALA) and the Safeguarding Board for Northern Ireland (SBNI).

Professional Capacity and Capability

12.11 The CSWO is responsible for the promotion of professional standards, education, training and workforce regulation to ensure safe and effective practice and service provision, including social care and children's functions , and compliance with all relevant standards;

- Commissioning sufficient social work student places to ensure an adequate supply of qualified social workers to meet social care and children's service needs;
- Contributing to workforce planning to identify the numbers and skills requirements of social workers and social care workers in specific practice/service areas for the future linked to service need;
- Setting the strategic direction and annual commissioning priorities and targets for the education and training of social workers and social care workers;
- Promoting a robust infrastructure for the professional development, supervision and support of social workers and social care staff
- Working collaboratively within the HSC system to agree strategic priorities in respect of building the capacity and capability of the social work and social care workforces;
- ensuring that social workers and all relevant social care workers are registered with the NISCC, comply with their Codes of Practice and associated regulatory requirements and take appropriate action for non- compliance;
- make recommendations, as necessary, to the Department in relation to professional and disciplinary matters regarding social services issues;

[9] Established mechanisms include Early Alert, Serious Adverse Incident, Adverse Incident, Untoward Incident and Complaints reporting systems.

13.0 Deputy Chief Social Worker/Office of Social Services – Roles and Responsibilities

Introduction

13.1 The Office of Social Services (OSS) is a Professional Social Work Group[10] within the Department of Health led by the DCSWO.

Accountability

13.2 The DCWO reports directly to the CSWO/Deputy Secretary of the SSPG.
Role

13.3 The DCSWO and OSS support the professional social work role of the CSWO.

13.4 The DCSWO/OSS provides professional social work advice and expertise to the Minister, the DoH, other government departments, social care and criminal justice agencies, education, and the voluntary and community sector in the arena of social work and social care and children's functions.

13.5 The DCSWO/OSS works with others to ensure that social work and social care services are responsive to the needs of people living and working in Northern Ireland and are of the highest possible standard in keeping with the resources available.

The DCSWO/OSS is responsible for:

- promoting the quality of social work and social care services, improving their efficiency and effectiveness and ensuring the safety and well-being of service users and carers;

- providing professional advice and expertise to Ministers, government departments, agencies, statutory, voluntary, private and community

[10] In accordance with Article 8 (1), Health and Personal Social Services Act (Northern Ireland) 2001, anyone taking or using the title social worker, or any title or description implying same, is required to be a qualified social worker and registered on the Northern Ireland Social Care Council (NISCC) Social Work Register.

sector organisations, where appropriate, on the formulation of policy and procedures;

- the implementation and review of social care and children's services and related health policies, and the efficient and effective delivery of social work and social care services;

- developing and promoting policy on training, qualifications and staff development for the social services workforce and ensuring effective policy implementation;

- Leading on social work and social care workforce policy and strategy in conjunction with DoH Workforce Policy Unit;

- The development of social work and social care professional and quality standards;

- sponsoring and holding to account the Northern Ireland Social Care Council (NISCC), which is the regulator of the social care workforce and professional social work training in Northern Ireland;

- facilitating the conduct of business between DoH, commissioners and providers of social work and social care services and other agencies;

- Ensuring appropriate professional input for discharging Departmental responsibilities in respect of Intercountry Adoptions in accordance with the Adoption (NI Aspects) Bill 2002 and obligations under the Hague Conventions;

- Professional endorsement of HSCT applications for admission of under 13s to secure accommodation in line with Volume 4 of the Children's (NI) Order 1995 Regulations and Guidance.

14.0 Deputy Secretary of the DOH Strategic Planning and Performance Group Role and Responsibilities

Introduction

14.1 The Deputy Secretary of the DOH SPPG is responsible for the performance management of the HCCD within the SPPG.

14.2 The Deputy Secretary of the DoH SPPG sits as an executive member of the DoH Board.

Accountability

14.3 The Deputy Secretary of the SPPG is directly responsible to the Permanent Secretary of the DoH.

Role

14.4 S/he is required to work collaboratively with the CSWO who is responsible for providing professional leadership and strategic direction for social work and social care within an integrated HSC system.

14.5 The Deputy Secretary of the SPPG is also responsible for the performance management of the exercise of social care and children's functions by HSCTs and for providing strategic advice at board level on future developments and direction.

14.6 The CSWO and the Deputy Secretary of the SPPG Group are together responsible for ensuring coherent regional arrangements for the delivery of relevant services.

14.7 The Deputy Secretary of the SPPG is responsible for the oversight, performance management and direction of the HCCD in relation to Social Care and Children's Functions and reports on same to the Department's Permanent Secretary, who in turn reports to the Minister

14.8 The SPPG is also responsible for providing strategic oversight and ensuring that each HSCT discharges their responsibilities as the named 'authority' for the discharge of relevant social care and children's functions in accordance with the law, approved Schemes for Delegation Directions and relevant policies, guidance, standards and directions; and for providing strategic advice at board level on future developments and direction.

14.9 The SPPG, working collaboratively with OSS, is responsible for reviewing Schemes of Delegation Directions received from HSCTs; and ensuring approved Schemes are implemented by HSCTs through agreed performance management and quality assurance mechanisms.

14.10 The SPPG consider and make determinations on recommendations and advice from the Director of HCCD, after consultation with the CSWO, for the revocation of Delegation Directions to HSCTs and recommend and advise Permanent Secretary on same.

14.11 The SPPG consider notifications of risk, resource pressure and legal challenges and proposed actions to address; escalating to the Deputy Secretary/CSWO, Permanent Secretary and the Departmental Board as necessary.

14.12 The SPPG approve annual end year overview report received from HCCD for submission to OSS.

14.13 SPPG, provide the approved end year overview report and any proposed actions to OSS, who provide the CSWO with a professional overview of issues, who in turn, advises the Permanent Secretary and Departmental Board.

15.0 Director of the HCCD in the SPPG – Role and Responsibilities

Introduction

15.1 The Director of the Hospital and Community Care Directorate is responsible for the professional oversight, governance, performance management and accountability and strategic oversight of HSCTs in relation to the exercise of social care and children's functions.

15.2 The Director of the HCCD is, in accordance with Article 8 of the Health and Personal Social Services Act (Northern Ireland) 2001, required to be a social worker and a registrant with the Northern Ireland Social Care Council (NISCC). S/he works collaboratively with the CSWO/OSS and the Deputy Secretary of the SSPG who are responsible for providing strong professional leadership and strategic direction for social work and social care within an integrated HSC system.

15.3 The Director of the HCCD is also responsible for the review of the Schemes of Delegation Direction submitted by HSCTs, in collaboration with OSS, and recommending the approved schemes to the CSWO.

Accountability

15.4 The Director of the HCCD reports directly to the Deputy Secretary of the SPPG, in respect of compliance and performance management issues related to the delivery of social care and children's functions and, through CSWO, in respect of professional social work issues related to same.

Performance Management Accountability

15.5 The Director of HCCD is responsible for providing managerial accountability for the performance of the social work and the social care workforces in Northern Ireland, including:

- Contributing to the strategic direction for social work and social care within an integrated HSC system;
- Promoting a strong voice for all adults, families, children and carers using social work and social care services;

- Working collaboratively with the HSCTs' EDsSW and other professional leads, agencies and key stakeholders in the public, voluntary and private sectors to improve and safeguard the social wellbeing of people in Northern Ireland;
- Promoting and supporting evidence-informed approaches to decision making at practice, service and policy levels.
- Promoting and supporting a culture of innovation, continuous learning and improvement and implementation in social work and social care practice and service provision;
- Building and maintaining internal and cross-Departmental regional relationships and networks to share best practice and promote continuous learning;
- Communicating the positive contribution of social work and social care services to improving and the social wellbeing of adults, families, children and carers;
- Providing strong managerial leadership across different staff groups, professions and Government Departments to plan, commission, secure and sustain social care and children's social care services based on assessed need, including child and adult safeguarding and protection services, to improve and safeguard social wellbeing of people in Northern Ireland;
- Building and sustaining effective partnerships with and between all relevant bodies in the statutory, voluntary, community and private sectors, to improve the health and social wellbeing of adults, children and young people and their families.
- Working in collaboration with the CSWO/OSS, the Deputy Secretary of SSPG and HSCT EDsSW to support their professional advice on social work and social care matters and in relation to social care and children's functions.
- Providing senior managerial advice in the development and implementation of policies, strategies, standards and guidance and in Departmental responses to Regulatory reports, Judicial Reviews, Tribunals, Inquiries and Assembly Questions;
- Responsibility for ensuring that the HCCD:-

    - discharges its duties in relation to social care and children's functions and in respect of children's services planning as required by the Children (Northern Ireland) Order 1995 as amended by the Children (1995 Order) (Amendment) (Children Services Planning Order) (Northern Ireland) 1998;

    - fulfils its obligations as set out in departmental circulars and guidance;
    - provides authoritative managerial and oversight advice and guidance and recommendations to Departmental Board in relation to the numbers of

children in need[11] within the HSCT's area, the nature and extent of those needs and the services requires to meet those needs;

- contributes professional social work advice to the CSWO on guidance and recommendations to Departmental Board on the most complex cases, where individual cases may be the subject of public and/or media interests.

- Taking a lead managerial role for the development of HCCD's strategic and operational policies for meeting the social care needs of adults, children and young people, families and carers;
- Involving and listening to children, adults who use services , families and carers to ensure their views inform the HCCD's planning and commissioning of services for them;
- Ensuring compliance with professional and other quality standards through appropriately informed commissioning of social services at both regional and local levels and through audit and review of services;

Professional Governance

15.6 The Director of HCCD is responsible for establishing and operating an efficient system to ensure effective social care governance arrangements within the HCCD and overseeing social care governance arrangements within HCCD;

- Ensuring, in collaboration with the CSWO that there are effective arrangements within the HCCD for the managerial and professional oversight of the discharge of social care and children's functions, including fulfilment of Corporate Parent duties within an integrated HSC system in line with this circular and:-

  Circular (OSS) 01 / 2022: Legislative and Structural Arrangements in Respect of the Authority of the Department of Health, Chief Social Work Officer, the Office of Social Services and the Social Care And Children's Directorate of the Strategic Planning and Performance Group in the Department of Health and Health and Social Care Trusts, in the Discharge of Social Care and Children's Functions (Formerly Relevant Personal Social Services Functions

- assuring the HCCD is discharging relevant functions effectively and in accordance with statutory requirements, departmental circulars and guidance and, where appropriate, take remedial action;
- Managerial responsibility and accountability for the effectiveness, availability, quality and value for money for social care and children's services commissioned by, and delivered as directed by the HCCD;

[11] A definition of 'child in need' is provided in Article 17 of the Children (Northern Ireland) Order 1995

- Providing managerial leadership and ensuring regional consistency of high standards of social work and social care services provided to adults, families, children and carers by HSCTs;
- ensuring the appropriate collection, maintenance and analysis of data to monitor the discharge of social care and children's functions and sharing such information with the Department;
- ensuring that resources allocated to and by the HSCTs are efficiently and effectively used to ensure the safe and effective discharge of social care and children's functions;
- Providing feedback to HSCTs regarding their performance in respect of social care and children's functions and the agreement of action plans to address non-compliance and/or areas of concern, ensuring the resolution of any performance issues in respect of a HSCT's discharge of social care and children's functions;
- Oversight of the production of an Annual Action Plan for each HSCT identifying improvements required in relation to a HSCT's performance in respect of social care and children's functions and Corporate Parenting responsibilities, a prescribed timescale for actions required and arrangements for review and assurance that improvements have been achieved and maintained;
- Ensuring, in collaboration with CSWO and Deputy Secretary of SSPG and Deputy Secretary of SPPG, that the permanent Secretary and Departmental Board are appropriately briefed in relation to HSCTs' discharge of social care and children's functions, the Action Plans agreed with each HSCT in respect of social care and children's functions and Corporate Parenting responsibilities, and any instances of non-compliance
- the production and submission to the Department of an annual regional Overview Report in respect of the HSCTs' discharge of social care and children's functions, including the HCCD's critical analysis of the HSCTs' performance;
- escalating
    - issues that the HCCD has been unable to resolve with a HSCT
    - issues of concern and/or risks, including resource issues and/or service pressures in relation to social care and children's functions,

  to the CSWO, SSPG Deputy Secretary and SPPG Deputy Secretary and in turn to the Permanent Secretary and the Departmental Board as appropriate.

Capacity and Capability

15.7 The Director of HCCD is responsible for working, collaboratively within DoH and HSCTs, to ensure strategic priorities in respect of building the capacity and capability of the social work and social care workforces are met, including;

- Promoting and monitoring compliance with professional and regulatory standards/requirements for the workforce and commissioning relevant education and training to ensure safe and effective practice and service provision, including discharge of social care and children's functions ;
- Specifying, in agreement with the OSS and CSWO, through the commissioning process, the workforce skills and qualifications required for high quality, safe and effective service provision;
- Advising, in agreement with the OSS and CSWO the Permanent Secretary and Minister on staffing levels which are sufficient to ensure the safe discharge of

social care and children's functions and delivery of commissioned social work and social care services by HSCTs for which the HCCD is responsible;

- Promotion of professional standards, education, training and workforce regulation to ensure safe and effective practice and service provision, including the discharge of social care and children's functions , and compliance with all relevant standards;
- Contributing to workforce planning to identify the numbers and skills requirements of social workers and social care workers in specific practice/service areas for the future linked to service need;
- Ensuring that each HSCT has adequate numbers of professionally qualified social work staff and social care staff to ensure effective management and delivery of effective services to fulfil social care and children's functions;

    - Ensuring in agreement with the OSS and CSWO, that adequate, high quality education and training is provided for social work students and social workers and social care workers employed in HSCTs to ensure the safe and effective discharge of social care and children's functions;

    - Promoting a robust oversight infrastructure to ensure that all social workers receive professional supervision in compliance with professional standards and regional guidance and that social care workers receive appropriate and adequate training, supervision and support;

    - Ensuring that systems are in place to ensure that social workers and all relevant social care workers are registered with the NISCC, comply with their Codes of Practice and associated regulatory requirements and take appropriate action to remedy non-compliance.

16.0 HSCT Executive Director of Social Work (EDSW) – role and responsibilities

Introduction

16.1 The role of a HSCT EDSW is to provide strong professional leadership for social work and social care across the full range of social care services provided by or commissioned within his/her HSCT for children and adults in the statutory, voluntary and private sectors; and providing assurance that satisfactory arrangements are in place for the exercise of social care and children's functions by the HSCT.

This includes professional responsibility for ensuring the exercise of social care and children's functions in accordance with the law, the approved Scheme for the exercise of Delegation Directions to agreed professional

standards and for providing strategic advice at board level on future developments and direction.

The EDsSW have key responsibilities within the HSCT to provide professional advice and support to the CEO and HSCT Board to ensure that all legislative requirements and social care and children's functions are fulfilled in compliance with regulations, guidance and procedures and to a high quality standard, including high professional standards.

The EDSW is responsible for seeking assurances from any other Operational Directors who have responsibility and accountability for the relevant service area that all social care and children's functions are being fulfilled to the required standard.

HSCT EDSWs are prescribed members[12] on HSCT Boards and are required to participate in and share corporate responsibility for the work of the HSCT.

Accountability

The EDsSW are responsible for the managerial and professional oversight of the social care and children's functions exercised by the HSCTs as directed by the Department and are directly accountable to their HSCT's CEO who reports to the HSCT Board in relation to the HSCT's performance in respect of social care and children's functions.

EDsSW are directly accountable to the HSCT CEO and HSCT Board for the provision of authoritative professional advice and insights in respect of all social work and social care matters, social care and children's functions and for reporting on relevant statutory functions across a range of children's and adult services.

Role

A summary of the professional responsibilities of the EDsSW are provided below:

Professional Leadership

- Providing strong professional leadership for the social work and the social care workforces in the HSCT , ensuring high standards of social work and social care

[12] Section 4(1)(d) The Health and Social Services HSCTs (Membership and Procedure) Regulations (Northern Ireland) 1994

provision and full compliance with legislative, policy and procedural requirements and compliance with standards established by the Department;

- Providing professional advice and support to the CEO and HSCT Board to assist setting the strategic direction for social work and social care within the HSCT;
- Promoting a strong voice for all adults, families, children and carers who use or need social work and social care services;
- Supporting HSCT managers, frontline social workers and social care workers delivering social care and children's functions and services by the HSCT;
- Working collaboratively with other EDsSW, the Director of the DOH SPPG and the CSWO and Deputy Secretaries to deliver social care and children's functions and to improve and safeguard the social wellbeing of people in Northern Ireland;
- Working collaboratively within the HSC system and with other key stakeholders in the public, voluntary, community and private sectors to improve and safeguard the social wellbeing of people in Northern Ireland;
- Promoting and supporting evidence-informed approaches to decision making at managerial and operational practice levels.
- Promoting and supporting a culture of innovation, continuous learning and improvement and implementation in social work and social care practice and service provision;
- Communicating, at local and regional levels, the positive contribution of social workers and social care workers in improving and safeguarding social wellbeing based on evidence and outcomes.

Professional Advice

- Responsibility for giving advice and assistance to the HSCT in determining its policies and strategies for personal social services and for executing those policies and strategies to deliver social care and children's functions;
- Advising the HSCT on professional social services issues and ensure robust professional governance arrangements for the exercise of social care and children's functions within Children's and Adult Social Care Services;
- Giving advice and assistance to the HSCT Board and CEO in determining its policies and strategies for social care services and for executing those policies and strategies ;
- Advising and assisting the HSCT Board and CEO in determining its expenditure on personal social services and securing the resources required to deliver social care services, including exercise of social care and children's functions, and in tracking expenditure on service delivery;
- Providing authoritative professional advice and insights to the CEO and HSCT Board in respect of social work and social care matters and social care and children's functions;
- Proving authoritative professional advice and insights to other professional leads, partner and key stakeholder organisations, the independent sector and the media.
- Working in collaboration with the Director of the DOH SPPG and SSPG, Director of HCCD, other EDsSW and the CSWO and Deputy Secretaries with regard to

seeking and giving professional advice on social work and social care matters and social care and children's functions.

- Ensuring appropriate professional advice in the development and implementation of HSCTs policies, strategies and standards and in responses to Regulatory reports, Judicial Reviews, Tribunals, Inquiries and Assembly Questions.

Senior Professional Practice Lead

- Providing authoritative professional advice to the CEO and, when necessary, making authoritative and final decisions on complex/controversial professional social work and social care practice matters and social care and children's functions by the HSCT;
- Providing authoritative professional advice and, as necessary, making decisions/recommendations on the most complex social work and social care cases and social care and children's functions, where individual cases may be the subject of public and/or media interests;
- Encouraging the development and maintenance of relationships with the voluntary and private sectors to foster constructive and collaborative relationships.

Professional Governance

- Ensuring compliance with the general guidance issued by the Department of Health and within the terms of contracts with purchasers;

Ensuring effective arrangements within the HScTs for the professional oversight of the exercise of social care and children's functions, including fulfilment of Corporate Parent duties, within an integrated HSC system in line with this Circular and Circular (OSS) 01 / 2022: Legislative and Structural Arrangements in Respect of the Authority of the Department of Health, Chief Social Work Officer, the Office of Social Services and the Social Care And Children's Directorate of the Strategic Planning and Performance Group in the Department of Health and Health and Social Care Trusts, in the Discharge of Social Care and Children's Functions (Formerly Relevant Personal Social Services Functions

- Ensuring effective arrangements within the HSCT for professional advice and responses to social work and social care issues and social care and children's functions raised through established reporting mechanisms;
- Accounting directly to the HSCT's CEO and HSCT Board on the exercise of social care and children's functions and ensuring they are briefed about the HSCT's performance in respect of social care and children's functions and Corporate Parenting responsibilities and any instances of non-compliance

- Implementing any actions or directions agreed within the HSCT to address any issues of under-performance and/or non-compliance;
- Promoting a robust framework for commissioning and delivery in social care services, including the development of standards for social care services to deliver services.
- Escalating any issues of concern and/or risks, including issues regarding performance or resource or service pressures on social work/social care provision, to the HSCT's CEO and HSCT Board;
- Submitting to the Department for approval the Schemes for the exercise of social care and children's functions ;
- Ensuring that the HSCT's legal responsibilities in relation to social care and children's functions are assigned and the necessary systems and procedures developed within the context of the scheme devised by the HSCT and agreed by HCCD and the Department;
- Monitoring the operation of those systems and procedures and reporting to the HSCT Board;
- Ensuring that an appropriate system of professional audit exists for assessing and reviewing the quality of social work and social care practice and services and the delivery of social care and children's functions;
- Monitoring, evaluating and quality assuring the provision of social care services commissioned by the Regional Group and in particular the exercise of social care and children's functions through audit and review;
- Establishing appropriate monitoring arrangements to assure the HCCD and Department that the HSCT is exercising social care and children's functions effectively and in accordance with statutory requirements, departmental circulars and guidance and, where appropriate, taking immediate remedial action;
- Ensuring the appropriate collection, maintenance and analysis of data to monitor service provision, including the exercise of social care and children's functions, and sharing such information with the HCCD and Department;
- Establishing and operating an efficient system to ensure effective social care governance arrangements within the HSCT and to oversee social care and children's functions and the social care governance arrangements associated with them within the HSCT;
- Submitting an annual report, including a self-assessment and critical analysis of performance, to the HCCD, OSS and Department on the exercise of social care and children's functions;
- Escalating any issues of concern and/or risks, including resource issues and/or service pressures, to the HSCT Board and, where appropriate, to the HCCD and Department.

Professional Capacity and Capability

- Contributing to workforce planning within the HSCT to identify the numbers and skills requirements of social workers and social care

workers in specific practice/service areas for the future linked to service need;

- Advising the HSCT Board and CEO on staffing levels which are sufficient to ensure the safe exercise of social care and children's functions and social work and social care services for which the HSCT is responsible;
- Ensure all social work staff have a working knowledge of and comply with all relevant legislation, regulations, Departmental Circulars, policies, procedures, protocols and guidance in their practice, exercise of social care and children's functions and delivery of social care and children's social care services;
- Promoting high standards of professional practice by identifying training needs and ensuring social workers and social care staff receive appropriate learning, training and development opportunities and professional supervision to support effective practice and the safe exercise of social care and children's functions;
- Working collaboratively within the HSC system to agree strategic priorities in respect of building the capacity and capability of the social work and social care workforces;
- Ensuring that social workers and all relevant social care workers are registered with the NISCC, comply with their Codes of Practice and associated regulatory requirements and take appropriate action for non-compliance;
- Make recommendations, as necessary, to the HSCT in relation to professional and disciplinary matters affecting social services staff.

CIRCULAR (OSS) 03 / 2022: ROLE AND RESPONSIBILITIES OF THE DOH DEPUTY SECRETARY/CHIEF SOCIAL WORK OFFICER, DIRECTOR OF HOSPIAL AND COMMUNITY CARE DIRECTORATE -HSC , AND EXECUTIVE DIRECTORS OF HEALTH AND SOCIAL CARE TRUSTS FOR CHILDREN IN NEED[1], CHILDREN IN NEED OF PROTECTION[2] AND LOOKED AFTER CHILDREN[3].

1 PURPOSE OF THIS CIRCULAR

1.1 The purpose of this Circular is to ensure that:

- the DOH Deputy Secretary/Chief Social Work Officer (CSWO);
- the Director of the Hospital and Community Care Directorate – HSC (HCCD) within the DOH Strategic Planning and Performance Group (SPPG) (The Director of SCCD);
- the Executive Director of Social Work (EDSW) in each Health and Social Care Trust (HSCT); and
- the Board of Directors of each HSCT, **both executive and non-executive**

are aware of the responsibilities which they have under the Children (Northern Ireland) Order 1995 (The Children Order) towards all children in need, children in need of protection and, in particular, as "Corporate Parents" for 'Looked After' children and those young people in receipt of Leaving Care and Aftercare services.

1.2 The Director of HCCD and Directors within HSCTs have responsibility for the care and protection of all Children in Need (as defined by Article 17[4] and Article 17A[5] of the Children [Northern Ireland] Order 1995).

HSCT Directors have responsibility for all such children and young people within the area of their Trust, and must take reasonable steps to identify them and ensure services are provided to meet their needs.

1.3 The roles and responsibilities of the organisations to whom this circular applies are outlined in **Annex A**.

1.4 The legislative framework that governs the roles and responsibilities of the Director of HCCD and Directors of HSCTs for children in need, children in need of protection and 'Looked After' Children and associated services delivery arrangements are outlined in Circular (OSS) 01 / 2022 Social Care and Children's Functions (Statutory Functions).

[1] The definition of a Child in Need is included in Article 17 of the Children (Northern Ireland) Order 1995.
[2] A child/young person is 'in need of protection' if he/she has suffered or is likely to suffer 'significant harm' as defined by the Children (Northern Ireland) Order 1995.
[3] A child/young person is 'Looked After' by a Trust if he/she is subject of a legal order made in favour of that Trust or if he/she has been accommodated by the Trust for a period exceeding 24 hours
[4] https://www.legislation.gov.uk/nisi/1995/755/article/17
[5] https://www.legislation.gov.uk/nisi/1995/755/article/17A

1.5 This Circular **replaces** Circular (OSS) 01/2018 *Role and Responsibilities of Directors of Health and Social Care Board and Health and Social Care Trusts for Children in Need, Children in Need of Protection and Looked After Children*.

2. ROLE AND RESPONSIBILITIES OF ACCOUNTING OFFICERS

2.1 Chief Executive Officers of HSCTs act as the **Accounting Officer** for their organisations and are responsible for providing assurances that all social care and children's functions[6] are fulfilled in compliance with all statutory and procedural requirements and within a framework of quality service provision and continuous improvement.

2.2 The Department may by direction provide for specified functions of the Department to be exercisable, in relation to the operational area of a specified HSC Trust, by that HSCT on behalf of the Department.

The Department may also, by regulations, amend the list of social care and children functions set out in paragraphs 10A and 10B of the Health and Personal Social Services (Northern Ireland) Order 1991.

2.2 To fulfil their Accounting Officer functions, Chief Executive Officers must be assured that the Board of their organisation and their senior management staff can effectively satisfy them that their organisation is delivering its statutory responsibilities towards children in need, children in need of protection and Looked After children and young people in compliance with all legislative and procedural requirements and to a high quality standard.

2.3 As Accounting Officers, they also have responsibility to ensure high levels of social care governance and an obligation to demonstrate how the services are co-produced, reviewed and improved with service recipients' direct involvement.

3 ROLE AND RESPONSIBILITIES OF DIRECTORS OF HSCTs

3.1 Children require timely assistance and appropriate help when they are in need, in need of protection or looked after. The degree to which Directors exercise their responsibilities for children will shape not only the type and quality of services which children receive on a day-to-day basis but the longer term outcomes upon which the quality of their adult life will depend.

[6] Described in Article 10a , added to Health and Personal Social Services (Northern Ireland) Order 1991 pursuant to the enactment of the Health and Social Care Act 2022

3.2 On appointment, Directors of the Health and Social Care Trusts, whether in **an executive or non-executive capacity**, take on important responsibilities for the health and wellbeing of children in their area.

There are, in addition, particular responsibilities for children who are Looked After by a Trust.

Directors set the strategic direction of the HSCTs' services and determine HSCTs' policy and priorities within the overall objectives set by Government and the Department.

The Board of Directors is responsible for ensuring that their HSCT structures and organisational arrangements enable them to;

- fulfil their social care and children's functions and statutory duties effectively and efficiently, in compliance with all statutory, regulatory, policy and procedural requirements
- ensure services provided are of a high quality and a focus is maintained on continuous improvement in all aspects of service delivery ;
- contribute to service improvement, positive user experiences and improving outcomes;
- be transparent about responsibilities and accountabilities;
- support effective inter-agency and partnership working.

3.4 Effective multi-agency responses to children in need and their families should begin at an early stage to prevent deterioration in a child's/young person's circumstances, to safeguard and promote his/her welfare and secure improved outcomes for the child/young person.

3.5 **All HSCT Directors** should ensure that continuous improvement in quality of service provision remains a demonstrable activity in all aspects of service provision and the Trust's Annual Quality Improvement Report should inform the Board of the organisation in relation to the achievements made to improve the quality of services delivered.

3.6 Executive Directors of Social Work have a lead responsibility to provide a high quality of professional social work advice to ensure the Board of Directors can fulfil this function effectively and efficiently.

3.7 All Directors of the Board of a HSCT have responsibilities to ensure that this happens in a planned, strategic and coordinated way.

In order to do so, they must make sure they have up-to-date, relevant information on which to base their decisions. They need to know about the needs of children within their area and the services and resources available, and those required, meet the needs of these children.

3.8 Directors and the Boards of the HSCTs require robust and reliable information to plan effectively for children's services and ensure the needs of children within their areas are effectively and efficiently met.

Directors and HSCT Boards will require regular information in relation to:-

- the overall needs of children in their area and the likely demand for services;
- what methods have been used to assess children's needs in their area;
- what services are being provided and how much is being spent on them;
- what measures are being used to monitor whether needs have been met and to assess outcomes;
- how effective is the multi-agency system in the HSCT's area;
- how this information is used to inform the improvement of outcomes for children and young people in their area.

3.9 Under Article 6B of Schedule 3 of the Health and Social Care Act 2022, the HCCD of the SPPG of the Department of Health requires HSCTs to provide information in relation to their delivery of social care and children's functions.

3.10 This Circular reaffirms the responsibilities of HSC Trust Executive Directors as detailed in Correspondence (METL 2/94) from the Management Executive (Provider Development Directorate), Department of Health and Personal Social Services, Northern Ireland "HSS Trusts - Role of Executive Directors with Professional Qualifications

Acknowledging the variation in specific duties and responsibilities of individual executive Directors of a Trust, it clarified that the role of each professional director included;-

- Participating in and sharing the corporate responsibility for the work of the Trust;
- Fulfilling a functional role as a second line manager responsible directly to the chief executive of the Trust; and
- Providing professional leadership throughout the Trust.

3.11 The Annex to the letter (METL 2/94) provided detailed guidance on the professional role of the Executive Director of Social Work, including the specific role of providing the Trust with the necessary professional social work advice and expertise required to ensure the effective and efficient delivery of personal social services and the satisfactory discharge of the statutory functions delegated to the Trust.

4. THE CORPORATE PARENT[4]

4.1 The HSCTs have a legal and ethical duty to provide children who are Looked After with the kind of support that any good parents would give to their children. In this context the Board of Directors of the Trust act as the **"Corporate Parent"**[7] for all children and young people who are Looked After by the Trust and are corporately responsible for all aspects of those children's and young people's well-being.

4.2 Children who are Looked After are vulnerable and one of the best safeguards against abuse or harm to these children is a high standard of management and practice in planning, monitoring and resourcing a range of social services for children and their families.

4.3 As well as ensuring that children are kept safe and well in the present, high standards of service and professional practice, managerial and corporate oversight will give children who are Looked After enhanced life chances so that when they cease to be Looked After they have much better prospects and ultimately a more settled adult life.

7
See section 2.3 of A LIFE DESERVED: A STRATEGY ON 'CARING' FOR CHILDREN & YOUNG PEOPLE IN NORTHERN IRELAND
https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-lac-strategy.pdf

Annex A

ORGANISATIONAL ROLES AND RESPONSIBILITIES

THE ROLE OF THE DEPARTMENT OF HEALTH (THE DEPARTMENT)

The Department has responsibilities in relation to children in need and their families. These include:-

- the establishment and review of the legislative and policy context for the planning and delivery of health and social care services for children and their families;
- providing regulations, guidance and standards for services to help ensure the quality and effectiveness of social care services provision; and
- discharging, monitoring and accountability functions through collation and analysis of regional information and bilateral meetings with HSCTs on their discharge of their social care and children's functions (the statutory responsibilities that have been delegated to them for children in need and their families).

The Department has provided Regulations and Guidance to accompany the Children (Northern Ireland) Order 1995 (the Children Order) and has provided and contributed to further procedures, guidance and standards to assist HSCTs deliver their social care and children's functions and the statutory functions contained in the Children Order and related legislation and Regulations.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the 2003 Order)[8] also places a statutory duty of quality upon health and social care organizations and requires the Department to develop standards against which the quality of services can be measured.

The Department provides oversight of HSCTs' social care and children's functions and, through established reporting arrangements and assurance and accountability processes, monitors the effectiveness and efficiency of service provision to meet the needs of children and families.

[8] http://www.legislation.gov.uk/nisi/2003/431/contents

OFFICE OF SOCIAL SERVICES

A Professional Social Work Group is located within the Office of Social Services (OSS) in the Department of Health. OSS provides professional social work advice and expertise to the Minister, the Deputy Secretary/Chief Social Work Officer the Department of Health, other government departments and social care and criminal justice agencies in the arena of social work and social care and children's function OSS works with others to ensure that social work and social care services are responsive to the needs of people living and working in Northern Ireland and are of the highest possible standard in keeping with the resources available

OSS is responsible for:

- promoting the quality of social work and social care services, improving their efficiency and effectiveness and ensuring the safety and well-being of service users and carers;
- providing professional advice and expertise to Ministers, government departments, agencies, statutory, voluntary, private and community sector organisations, where appropriate, on the formulation of policy and operational procedures;
- the review of social care and children's functions, services and related health policies, and the efficient and effective delivery of social work and social care and children's services;
- developing and promoting policy on training, qualifications and staff development for the social services workforce and ensuring effective policy implementation;
- sponsoring and holding to account the Northern Ireland Social Care Council (NISCC), which is the regulator of the social care workforce and professional social work training in Northern Ireland;
- facilitating the conduct of business between DoH, commissioners and providers of social work and social care services and other agencies;
- Leading on social work and social care workforce policy and strategy in conjunction with DoH Workforce Policy Unit;
- The development of social work and social care professional and quality standards.

- Professional endorsement of HSCT applications for admission of under 13s to secure accommodation in line with Volume 4 of the Children (NI) Order 1995 Regulations and Guidance.

- Ensuring appropriate professional input for discharging Departmental responsibilities in respect of Intercountry Adoptions in accordance with the Adoption (NI Aspects) Bill 2002 and obligations under the Hague Conventions;

THE HOSPITAL AND COMMUNITY CARE DIRECTORATE - HSC

Following the closure of the Health and Social Care Board (HSCB), the HSCB Social Care and Children's Directorate (SCCD) 'migrated' into the Department of Health within the Strategic Planning and Performance Group (SPPG).

The SCCD was subsequently reconfigured into the Hospital and Community Care Directorate (HCCD) reports directly to the Grade 3 Deputy Secretary of the Department of Health SPPG in respect of compliance and performance management issues related to social care and children's functions and, through OSS, to the Chief Social Work Officer in respect of professional social work issues related to social care and children's functions.

The Director of SPPG and the Chief Social Work Officer both report to the Department's Permanent Secretary in relation to their respective responsibilities for social care and children's functions.

The HCCD is responsible for professional oversight, governance, performance management and accountability as well as strategic oversight of HSCTs in relation to the exercise of social care and children's functions (statutory functions).

The HCCD of the Departmental SPPG plays a key role in the approval process in relation to the approval of Schemes. The Department (HCCD) will issue an instruction (delegation direction), signed by the Deputy Secretary / Chief Social Work Officer, for specified functions of the Department to be exercisable by the HSCTs and requesting the HSCTs to submit a Scheme on an approved template to assure the Department that proper provisions are in place for the effective exercise of the said functions.

The HCCD are responsible for the design and issue of a single regional performance management and reporting template in relation to the exercise of social care and children's functions.

HEALTH AND SOCIAL CARE TRUSTS (HSCTs)

The Health and Social Care Act 2022 amended previous legislation and provided the legislative basis for the exercise of statutory functions by HSCTs by the addition of Article 10 A and 10 B to Health and Personal Social Services (Northern Ireland) Order 1991.

The arrangements for the exercise of statutory functions related to social care and children's are specified in Departmental Circular (OSS) 01 / 2022: Social Care and Children's Functions (Statutory Functions) and Circular (OSS) 02 / 2022: Social Care and Children's Functions (Statutory Functions): Management and Professional Oversight

The HSCTs' Executive Director of Social Work (and the Department's Director of Hospital and Community Care Directorate) are the officers with prescribed responsibility for organisational oversight of the discharge of social care and children's functions (Statutory Functions) and their roles and responsibilities in relation to management and reporting arrangements are clearly outlined in:-

Circular (OSS) 01 / 2022: Legislative and Structural Arrangements in Respect of the Authority of the Department of Health, Chief Social Work Officer, the Office of Social Services and the Hospital and Community Care Directorate of the Strategic Planning and Performance Group in the Department of Health and Health and Social Care Trusts, in the Discharge of Social Care and Children's Functions (Formerly Relevant Personal Social Services Functions); and

Circular (OSS) 02 / 2022: Social Care and Children's Functions (Statutory Functions): Management and Professional Oversight.

However, as a Board of Directors, all Directors of HSCTs - executive and non-executive - have a duty to ensure that the management and other arrangements in place within HSCTs are appropriate to the delivery of high quality and well managed services for children and that all social care and children's functions (statutory functions) are effectively and efficiently delivered.

CHILDREN'S AND YOUNG PEOPLE'S STRATEGIC PARTNERSHIP

The Children & Young People Strategic Partnership (CYPSP) previously led by HSCB is led by HCCD. It is a multiagency strategic partnership consisting of the leadership of all key agencies across statutory, voluntary and community sectors who have responsibility for improving outcomes for all children and young people in Northern Ireland.

CYPSP develops and reviews the Children's Services Plan which HCCD is required to deliver in compliance with the Children (1995 Order) (Amendment) (Children's Services Planning) Order (Northern Ireland) 1998.[10]

REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

The Regulation And Quality Improvement Authority (RQIA)[9] was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the 2003 Order) and is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvement in the quality of those services.

[9] https://www.legislation.gov.uk/nisi/2003/431/article/40

KH15 / KH15b: ADMISSIONS UNDER MENTAL HEALTH (NI) ORDER 1986: LEGAL STATUS

Please return this form to: HIB.Returns@health-ni.gov.uk

Trust:		**Quarter End:**	
Hospital:		**Hospital Code:**	
Contact Name:		**Telephone No:**	

1) *More detailed instructions on completion of this return can be found on the Guidance tab.*

2) *If you have any queries regarding completion of this form, please contact Hospital Information Branch:*
Telephone No: 028 905 22521 / 028 905 23877
Email: HIB.Returns@health-ni.gov.uk

Comments:

I certify that these data are correct

Name:		**Date:**	
Position Held:			

KH15

PART A: Compulsory Admissions During the Quarter by Article and Category of Patient

Detained under Mental Health (NI) Order 1986	Compulsory Admissions During the Quarter									
	Mental Illness		Learning Disability		Severe Learning Disability		Severe Mental Impairment		Other	
Article:	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
4										
12										
13										
42										
43										
44/47										
44										
44(4)										
45										
52										
53/55										
53										
54/55										
54										
129										
130										
Other Articles										

MAHI - STM - 300 - 1184

Previous (6th sch)										
Other Acts										
Total	0	0	0	0	0	0	0	0	0	0

KH15b

PART B: Compulsory Admissions During the Quarter by Age Group and Gender

Age Group	Compulsory Admissions During the Quarter					
	Mental Illness (all)		Learning Disability (all)		Other	
	Male	Female	Male	Female	Male	Female
Under 16						
16 - 17						
18 - 44						
45 - 64						
65 - 74						
75+						
Total	0	0	0	0	0	0

Validation checks

No. of mental Illness/severe mental impairment male patients should match in KH15 and KH15b	**TRUE**
No. of mental Illness/severe mental impairment female patients should match in KH15 and KH15b	**TRUE**
No. of learning disability/severe learning disability male patients should match in KH15 and KH15b	**TRUE**
No. of learning disability/severe learning disability female patients should match in KH15 and KH15b	**TRUE**
No. of other male patients should match in KH15 and KH15b	**TRUE**
No. of other female patients should match in KH15 and KH15b	**TRUE**
Total in KH15 and KH15b should match	**TRUE**

KH15 / KH15b: ADMISSIONS UNDER MENTAL HEALTH (NI) ORDER 1986: LEGAL STAT

INTRODUCTION

1.This return relates to all patients admitted during the course of the previous quarter who were de whether or not they have been discharged subsequently. Voluntary patients should not be included made by all hospitals with a Directly Managed Unit or HSC Trust.

INFORMATION REQUIRED

2. For each patient, information is required on the following data items:

a. legislation under which the patient is detained;
b. mental category of the patient;
c. sex of the patient; and
d. age group of the patient (KH15b)

MENTAL CATEGORY

3. Mental category combines the diagnosis and legal status of a patient. It is appropriate for patient consultant in a psychiatric specialty, who have been formally detained or have been in hospital for a

4. The mental category classification is as follows:

a. mental illness;
b. learning disability;
c. severe learning disability;
d. severe mental impairment; or
e. other.

5. A patient should only be classified as 'other' if the mental category has not been specified by the be submitted to the Department.

6. A patient should be included under only one mental category. Where a patient has been assigned mental illness takes precedence over the others. Thus:

a. Mental illness should be recorded for a patient assigned:

i. mental illness and learning disability;
ii. mental illness and severe learning disability;
iii. mental illness and severe mental impairment.

b. Severe learning disability should be recorded for a patient assigned:

iv. severe learning disability and learning disability.

c. Severe mental impairment should be recorded for a patient assigned:

v. severe mental impairment and learning disability.
vi. severe mental impairment and severe learning disability.

LEGAL STATUS UNDER WHICH DETAINED

7. Each patient, whether in hospital or not, may have a legal status. This indicates that either the pa
detained under an appropriate order, or they are a long stay psychiatric patient. The legal status of
informal or detained. A psychiatric patient who is not formally detained and is not a long-stay patie
does not have a legal status. This table lists those articles of legislation under which a patient may b

A. MENTAL HEALTH (NI) ORDER 1986

Articles

4 - Admission for assessment
12 - Detained for treatment
13 - Renewal of detention
42 - Remand to hospital for report on metnal condition
43 - Remand to hospital for treatment
44/47 A44 (excluding A44(4)) with A47 restrictions - Court order for hospital admission/ guardiansh
restricted
44 - Court order for hospital admission/ guardianship
44(4) - Court order for hospital admission/ guardianship without conviction
45 - Interim hospital order
52 - Detained in hospital during HM pleasure
53/55 A53 with A55 restrictions - Removal to hospital of sentenced prisoner with discharge restrict
53 A53 without A55 restrictions - Removal to hospital of sentenced prisoner
54/55 A54 with A55 restrictions - Removal to hospital of other prisoner with discharge restricted
54 A54 without A55 restrictions - Removal to hospital of other prisoner
129 - Admission due to neglect/ ill treatment/ inability to care for self
130 - Found in public place and in need of care/ control
other Articles

B. PREVIOUS LEGISLATION -SIXTH SCHEDULE

This relates only to patients who prior to the implementation of the Mental Health (NI) Order 1986,
the Sixth Schedule of that Order.

C. OTHER ACTS

Any other relevant acts apart from those listed at A and B above.

AGE GROUP

8. Age should refer to the patients' age group at the time of their compulsory admission.
Mental Illness (all) includes Mental Illness and Severe Mental Impairment
Learning Disability (all) includes Learning Disabiltiy and Severe Learning Disability

ΓUS

etained at admission
d. The return should be

ts under the care of a
a year or more.

time the return has to

d to more than one,

ıtient has been formally
a patient can be
nt as described above
ɔe detained.

ıip with discharge

:ed

, were detained under

KH16: CHANGES IN LEGAL STATUS OF PATIENTS

Please return this form to: HIB.Returns@health-ni.gov.uk

Trust:		**Quarter End:**	
Hospital:		**Hospital Code:**	
Contact Name:		**Telephone No:**	

1) *More detailed instructions on completion of this return can be found on the Guid*

2) *If you have any queries regarding completion of this form, please contact Hospit*
Information Branch:
Telephone No: 028 905 22521 / 028 905 23877
Email: HIB.Returns@health-ni.gov.uk

Comments:

I certify that these data are correct

Name:		**Date:**	
Position Held:			

Number of changes made under Mental Health (NI) Order 1986, during quarter

MAHI - STM - 300 - 1190

LEGAL STATUS: Before Change ↓ / After Change →	Voluntary	Article: 4	12	13	7(2)	7(3)	44/47
Voluntary							
Article: 4							
12							
13							
7(2)							
7(3)							
42							
43							
44/47							
44							
45							
52							
53/55							
53							
54/55							
54							
129							
130							
Other Articles							
Previous (6th sch)							
Other Acts							
Total	0	0	0	0	0	0	0

MAHI - STM - 300 - 1191

ance tab.

al

KH16

		Other Acts
44	53	
0	0	0

KH16: CHANGES IN LEGAL STATUS OF PATIENTS

INTRODUCTION

1. This return relates to all changes in legal status of patients in the hospital which occurred during quarter. Voluntary patients are included in this return. All appropriate hospitals within a Directly M Unit or HSC Trust should make the return.

DETAILS OF THE RELEVANT LEGISLATION

2. The relevant legal status categories are itemised on the return and listed below. It should be not a change from voluntary to detained or vice versa is also a change in legal status.

3. The shaded boxes in the return are locked to prevent unintentional data entry into these boxes a do not represent a change in legal status.

4. Sometimes a patient is admitted with the intention that he/she will be formally detained, howev time of admission the necessary paperwork is not complete. In such cases administrative delays of hours should be ignored ie the patient should be recorded as formally detained on admission.

Legal Status
Voluntary
Art 4 - Admission for assessment
Art 12 - Detained for treatment
Art 13 - Renewal of detention
Art 7(2) - Application for assessment of patient already in hospital
Art 7(3) - Application for assessment of patient already in hospital being treated for mental disorde
Art 42 - Remand to hospital for report on mental condition
Art 43 - Remand to hospital for treatment
Art 44/ 47 - Court order for hospital admission/ guardianship with discharge restricted
Art 44 - Court order for hospital admission/ guardianship
Art 45 - Interim hospital order
Art 52 - Detained in hospital during HM pleasure
Art 53/ 55 - Removal to hospital of sentenced prisoner with discharge restricted
Art 53 - Removal to hospital of sentenced prisoner
Art 54/ 55 - Removal to hospital of other prisoner with discharge restricted
Art 54 - Removal to hospital of other prisoner
Art 129 - Admission due to neglect/ ill treatment/ inability to care for self
Art 130 - Found in public place and in need of care/ control
Other Articles
Previous legislation
Other Acts

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up to 24

r

MAHI - STM - 300 - 1196

KH17: ELECTRO-CONVULSIVE THERAPY: TREATMENTS ADMINSTERE

Please return this form to: HIB.Returns@health-ni.gov.uk

Trust: **Quarter End:**

Hospital: **Hospital Code:**

Contact Name: **Telephone No:**

1) *More detailed instructions on completion of this return can be found on the Gu tab.*

2) *If you have any queries regarding completion of this form, please contact Hosp Information Branch:*
Telephone No: 028 905 22521 / 028 905 23877
Email: HIB.Returns@health-ni.gov.uk

Comments:

I certify that these data are correct

Name: **Date:**

Position Held:

Type of Patient	Number of Patients who received ECT	Number of ECT tre administere
Ordinary Admissions		

MAHI - STM - 300 - 1197

Other Patients		
Total	0	0

MAHI - STM - 300 - 1198

ED

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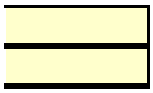
pital

KH17

atments
ed

MAHI - STM - 300 - 1199



KH17: ELECTRO-CONVULSIVE THERAPY: TREATMENTS ADMINISTERED

INTRODUCTION

1. This return records the number of patients receiving ECT treatment and the total number of indi
treatments administered in each hospital within a Directly Managed Unit or HSC Trust.

2. This return should include all patients who received ECT in the quarter, regardless of whether th
received ECT previously in the quarter or in previous quarters of the same financial year. The "num
who received ECT" column should count all patients who have received ECT treatment in the perio
new patients, i.e. the "patients" figure cannot be zero if the treatments figure is not zero.

3. Data should be collected on all patients using Health and Social Care facilities and services includ
patients.

4. The patient type should be recorded as ordinary admission or other patient for each administrat
regardless of its location.

PATIENT TYPE

5. Ordinary admissions comprise:

a. all patients using a hospital bed not admitted electively;

b. patients admitted electively with the expectation that they will remain in hospital at least one ni
those admitted with this intention who leave hospital for any reason without staying overnight;

c. patients admitted electively with the intention of not staying overnight but who do not return ho

d. patients on home leave.

6. Other patients are those not counted as ordinary admissions and include:-

a. other type of hospital admission, such as day case admission;
b. out-patient attenders;
c. day care attenders.

These patients do not stay in hospital for the night either before or after the administration of ECT.

ividual ECT

at patient
ıber of patients
d and not just

ding private

:ion of ECT,

ight including

ome as scheduled;

.

MAHI - STM - 300 - 1202

Annual Mental Illness/Learning Disability Census (MILD)

Part 1: Mental Illness

Name of Hospital[1]: Provider Trust:

Contact Name: Telephone Number:

Source:

NOTES:

1. More detailed instructions on completion of this return can be found on the Guidance tab.

2. If you have any queries regarding completion of this form, please contact Hospital Information Bra
Tel: 028 9052 3309 or email: HIB.Returns@health-ni.gov.uk

3. Please return to: HIB.Returns@health-ni.gov.uk

Table 1: Mental Health Inpatients Resident at 17 February 2024 (including patients on Hom

For the purposes of this survey, home leave includes all inpatients who were not actually resident in t
(e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Length of Stay	Age in Years						
	0-15	16-18	19-24	25-34	35-44	45-54	55-64
0-6 months							
>6-12 months							
>1-2 years							
>2-3 years							
>3-5 years							
>5-10 years							
>10-20 years							
>20-30 years							
>30 years							
TOTAL							

Please provide the total number of mental health inpatients on home leave (included in the table abc

nch:

ıe Leave) [4]

the hospital on the survey date

		TOTAL
65-74	75+	

ove)[7]:

MAHI - STM - 300 - 1204

Annual Mental Illness/Learning Disability Census (MILD)

Part 1: Mental Illness

Name of Hospital[1]: | Provider Trust:

Contact Name: | Telephone Number:

Source:

NOTES:

1. More detailed instructions on completion of this return can be found on the Guidance tab.

2. If you have any queries regarding completion of this form, please contact Hospital Information Bra
Tel: 028 9052 3309 or email: HIB.Returns@health-ni.gov.uk

3. Please return to: HIB.Returns@health-ni.gov.uk

Table 1: Mental Health Inpatients Resident at 17 February 2024 (including patients on Hom

For the purposes of this survey, home leave includes all inpatients who were not actually resident in t
(e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Length of Stay	Age in Years						
	0-15	16-18	19-24	25-34	35-44	45-54	55-64
0-6 months							
>6-12 months							
>1-2 years							
>2-3 years							
>3-5 years							
>5-10 years							
>10-20 years							
>20-30 years							
>30 years							
TOTAL							

Please provide the total number of mental health inpatients on home leave (included in the table abc

nch:

ıe Leave) [4]

the hospital on the survey date

		TOTAL
65-74	75+	

ove)[7]:

MAHI - STM - 300 - 1206

Annual Mental Illness/Learning Disability Census (MILD)

Part 1: Mental Illness

Name of Hospital[1]: | Provider Trust:

Contact Name: | Telephone Number:

Source:

NOTES:

1. More detailed instructions on completion of this return can be found on the Guidance tab.

2. If you have any queries regarding completion of this form, please contact Hospital Information Bra
Tel: 028 9052 3309 or email: HIB.Returns@health-ni.gov.uk

3. Please return to: HIB.Returns@health-ni.gov.uk

Table 1: Mental Health Inpatients Resident at 17 February 2024 (including patients on Hom

For the purposes of this survey, home leave includes all inpatients who were not actually resident in t
(e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Length of Stay	Age in Years						
	0-15	16-18	19-24	25-34	35-44	45-54	55-64
0-6 months							
>6-12 months							
>1-2 years							
>2-3 years							
>3-5 years							
>5-10 years							
>10-20 years							
>20-30 years							
>30 years							
TOTAL							

Please provide the total number of mental health inpatients on home leave (included in the table abc

nch:

ıe Leave) [4]

the hospital on the survey date

		TOTAL
65-74	75+	

ove)[7]:

MAHI - STM - 300 - 1208

Annual Mental Illness/Learning Disability Census (MILD)

Part 2: Learning Disability

Name of Hospital[1]: Provider Trust:

Contact Name: Telephone Number:

Source:

NOTES:

1. More detailed instructions on completion of this return can be found on the Guidance tab.

2. If you have any queries regarding completion of this form, please contact Hospital Information Branch:
Tel: 028 9052 3309 or email: HIB.Returns@health-ni.gov.uk

3. Please return to: HIB.Returns@health-ni.gov.uk

Table 2: Learning Disability Inpatients Resident at 17 February 2024 (including patients on Home Le

For the purposes of this survey, home leave includes all inpatients who were not actually resident in the hospi
(e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Length of Stay	Age in Years							
	0-15	16-18	19-24	25-34	35-44	45-54	55-64	65-74
0-6 months								
>6-12 months								
>1-2 years								
>2-3 years								
>3-5 years								
>5-10 years								
>10-20 years								
>20-30 years								
>30 years								
TOTAL								

Please provide the total number of learning disabled inpatients on home leave (included in the table above)[11]

eave)9

ital on the survey date

	TOTAL
75+	

:

MAHI - STM - 300 - 1210

Annual Mental Illness/Learning Disability Census (MILD)

Part 2: Learning Disability

Name of Hospital[1]: Provider Trust:

Contact Name: Telephone Number:

Source:

NOTES:

1. More detailed instructions on completion of this return can be found on the Guidance tab.

2. If you have any queries regarding completion of this form, please contact Hospital Information Branch:
Tel: 028 9052 3309 or email: HIB.Returns@health-ni.gov.uk

3. Please return to: HIB.Returns@health-ni.gov.uk

Table 2: Learning Disability Inpatients Resident at 17 February 2024 (including patients on Home Le

For the purposes of this survey, home leave includes all inpatients who were not actually resident in the hospi
(e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Length of Stay	Age in Years							
	0-15	16-18	19-24	25-34	35-44	45-54	55-64	65-74
0-6 months								
>6-12 months								
>1-2 years								
>2-3 years								
>3-5 years								
>5-10 years								
>10-20 years								
>20-30 years								
>30 years								
TOTAL								

Please provide the total number of learning disabled inpatients on home leave (included in the table above)[11]

eave)9

ital on the survey date

	TOTAL
75+	

:

Annual Mental Illness/Learning Disability Census (MILD)

Part 3: MILD by Bed Type

Table 3: Patients in RESIDENCE by Type of Care Bed (Mental Health Hospitals)[12]

Hospital	Acute	Psychiatric Intensive Care Unit	FMI	Psych of Old Age	Continuing Care
HSC Trust Total					

Table 4: Patients on HOME LEAVE by Type of Care Bed (Mental Health Hospitals)[13]

Hospital	Acute	Psychiatric Intensive Care Unit	FMI	Psych of Old Age	Continuing Care
HSC Trust Total					

Table 5: Total COMPLEMENT of Beds by Type of Bed (Mental Health Hospitals)[14]

Hospital	Acute	Psychiatric Intensive Care Unit	FMI	Psych of Old Age	Continuing Care
HSC Trust Total					

Table 6: Patients in RESIDENCE by Type of Care Bed (Learning Disability Hospitals)[15]

Hospital	Acute	Assessment & Treatment	Psychiatric Intensive Care Unit	Longstay/PTL Resettlement	Resettlement / Rehabilitation
HSC Trust Total					

Table 7: Patients on HOME LEAVE by Type of Care Bed (Learning Disability Hospitals)[16]

Hospital	Acute	Assessment & Treatment	Psychiatric Intensive Care Unit	Longstay/PTL Resettlement	Resettlement / Rehabilitation
HSC Trust Total					

Table 8: TOTAL Complement of Beds by Type of Bed (Learning Disability Hospitals)[17]

Hospital	Acute	Assessment & Treatment	Psychiatric Intensive Care Unit	Longstay/PTL Resettlement	Resettlement / Rehabilitation
HSC Trust Total					

MAHI - STM - 300 - 1214

Addictions	Dementia	Brain Injury	Regional Secure Unit	Forensic	Long-stay	Other

Addictions	Dementia	Brain Injury	Regional Secure Unit	Forensic	Long-stay	Other

Addictions	Dementia	Brain Injury	Regional Secure Unit	Forensic	Long-stay	Other

Children's	RESPITE	Continuing Care Mental Illness	Forensic	Other	Total

MAHI - STM - 300 - 1215

Children's	RESPITE	Continuing Care Mental Illness	Forensic	Other	Total

Children's	RESPITE	Continuing Care Mental Illness	Forensic	Other	Total

MAHI - STM - 300 - 1216

Total

Total

Total

MAHI - STM - 300 - 1217

MENTAL ILLNESS/LEARNING DISABILITY CENSUS - GUIDANCE

NOTES

1 The Census is carried out annually and is a count of all mental illness and learning disability patients resident in the hospital or on home leave at the time of the Census. Information is collected separately for each hospital on the basis of age and length of stay. Please complete a separate sheet for each hospital.

2 This Census is carried out to fulfil the requirements of Section 10 of the Disabled Persons (NI) Act, 1989.

3 The Census is a snapshot of the resident population as at 17 February in the appropriate year. For the first two years of the Census (1991 and 1992), the snapshot date was 17 December.

Please duplicate the spreadsheets at Part 1 and Part 2 for the number of units/hospitals being reported on. Complete a separate sheet for each unit/hospital. Three sheets, ready for your data, have already been provided for Part 1 Mental Health and two sheets for Part 2 Learning Disability.

Part 1 Mental Illness inpatients resident at 17 February (including patients on home leave)

4 Table 1 records the number of mental illness inpatients resident (including those on home leave) at 17 February for each hospital by age and by length of stay.

5 Mental illness inpatients (**including those on home leave**) should be recorded in the following age groups:

0-15 years
16-18 years
19-24 years
25-34 years
35-44 years
45-54 years
55-64 years
65-74 years
75+
Total

6 They should also be cross-tabulated against length of stay as the other variable, with the following groups:

0-6 months
>6-12 months
>1-2 years
>2-3 years
>3-5 years
>5-10 years
>10-20 years
>20-30 years
>30 years
Total

7 Enter the total number of inpatients on home leave which are included in Table 1. For the purposes of this survey, home leave includes all inpatients who were not actually resident in the hospital on the survey date (e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Part 2 Learning Disability inpatients resident at 17 February (including patients on home leave)

8 Table 2 records the number of learning disability inpatients resident (including those on home leave) at 17 February in each hospital by age and by length of stay.

9 Learning disability inpatients (**including those on home leave**) should be recorded in the following age groups:

0-15 years
16-18 years
19-24 years
25-34 years
35-44 years
45-54 years
55-64 years
65-74 years
75+
Total

10 They should also be cross-tabulated against length of stay as the other variable, with the following groups:

0-6 months
>6-12 months
>1-2 years
>2-3 years
>3-5 years
>5-10 years
>10-20 years
>20-30 years
>30 years
Total

11 Enter the total number of inpatients on home leave which are included in Table 2. For the purposes of this survey, home leave includes all inpatients who were not actually resident in the hospital on the survey date (e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Part 3 MILD by Bed Type at 17 February (patients in residence and on home leave)

12 Table 3 This is the number of mental health inpatients resident (**not** on home leave) at 17 February in each hospital by type of bed.

13 Table 4 This is the number of mental health inpatients on home leave at 17 February in each hospital by type of bed occupied prior to home leave.

14 Table 5 This is the complement of beds in each hospital by type of bed. It is the number of beds available and not the number of beds occupied.

MAHI - STM - 300 - 1218

15 Table 6 This is the number of learning disability inpatients resident (**not** on home leave) at 17 February in each hospital by type of bed.

16 Table 7 This is the number of learning disability inpatients on home leave at 17 February in each hospital by type of bed occupied prior to home leave.

17 Table 8 This is the complement of beds in each hospital by type of bed. It is the number of beds available and not the number of beds occupied.

MAHI - STM - 300 - 1219

SUMMARY OF AVAILABLE and OCCUPIED BED DAYS and DISCHAR KH03A
and DEATHS and DAY CASES

Provider Name: Quarter Ending:

Hospital name: Hospital Code

Contact Name: Telephone No:

1 More detailed instructions on completion of this return can be found in Guid Korner Hospital Services: Central Requirements

2 If you have any queries regarding completion of this form, please contact Ho
Telephone 028 90 522521/028 90 522575
Fax: 028 90 523288
E-mail: HIB.Returns@dhsspsni.gov.uk

3 Please retı HIB.Returns@dhsspsni.gov.uk

Provider comment:
(please include details of official changes in bed complement and/or any reason for cha

I certify that these data are correct

Signed: Date

Name (PRINT): Tel No:

MAHI - STM - 300 - 1220

Position Held:

For HIB use only

Return received date:

POC 1: Acute Services

Main specialty functic	Code	Available b	Occupied bed days in wards open overnight
General Surgery	100		
Urology	101		
Trauma & Orthopaed	110		
ENT	120		
Ophthalmology	130		
Oral Surgery	140		
Restorative Dentistry	141		
Paediatric Dentistry	142		
Orthodontics	143		
Neurosurgery	150		
Plastic Surgery	160		
Cardiac Surgery	170		
Paediatric Surgery	171		
Thoracic Surgery	172		
Accident & Emergenc	180		
Anaesthetics	190		
Pain Management	191		
General Medicine	300		
Gastroenterology	301		
Endocrinology	302		
Haematology (clinical	303		
Clinical Physiology	304		
Clinical Pharmacology	305		
Audiological Medicine	310		
Clinical Genetics	311		
Cl. Cytogenetics & Mc	312		
Clinical Immunology &	313		
Rehabilitation	314		
Palliative Medicine	315		
Cardiology	320		
Dermatology	330		
Thoracic Medicine	340		
Infectious Diseases	350		
Genito-Urinary Medic	360		
Nephrology	361		

Medical Oncology	370
Nuclear Medicine	371
Neurology	400
Clinical Neuro-Physiol	401
Rheumatology	410
Paediatrics	420
Paediatric Neurology	421
Dental Medicine Spec	450
Medical Ophthalmolc	460
Obs & Gyn (Gynaecol	502
General Practice (Nor	620
Clinical Oncology	800
Radiology	810
General Pathology	820
Blood Transfusion	821
Chemical Pathology	822
Haematology	823
Histopathology	824
Immunopathology	830
Medical Microbiology	831
Neuropathology	832
Community Medicine	900
Occupational Medicir	901
Joint Consultant	990

POC 2: Maternity and Child Health

Main specialty functic	Code	Available b	Occupied b	Discharges	Day Cases
Obs & Gyn (Obstetrics	501				
Well Babies (Obstetri	540				
Well Babies (Paediatr	550				
General Practice (Mat	610				

POC 4: Elderly Care

Main specialty functic	Code	Available b	Occupied b	Discharges	Day Cases
Geriatric Medicine	430				
Old Age Psychiatry	715				

POC 5: Mental Health

Main specialty functic	Code	Available b	Occupied b	Discharges	Day Cases
Mental Illness	710				
Child & Adolescent Ps	711				
Forensic Psychiatry	712				
Psychotherapy	713				

POC 6: Learning Disability

Main specialty functic	Code	Available b	Occupied b	Discharges	Day Cases
Mental Handicap	700				

Total				
	4	4	4	4

* Note: do not include beds occupied by healthy persons

spital Information Branch:

Exhibit 49

The Regulation and Quality Improvement Authority

Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland

Overview Report

February 2013

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health Social Services and Public Safety and are available on the RQIA website at www.rqia.org.uk.

Membership of the Review Team

Theresa Nixon	Director of Mental Health and Learning Disability and Social Work
Patrick Convery	Head of Mental Health and Learning Disability
Margaret Cullen	Mental Health Officer/ Inspector
Rosaline Kelly	Mental Health Officer/ Inspector
Carolyn Maxwell	Mental Health Officer/ Inspector
Janet McCusker	Mental Health Officer/ Inspector
Audrey Murphy	Mental Health Officer/ Inspector
Patricia Corrigan	Project Administrator

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Executive Summary

The Regulation and Quality Improvement Authority (RQIA) believes the right to be protected from abuse or harm is a fundamental principle underpinning the safeguarding of children and vulnerable adults. Individuals who are vulnerable because they lack capacity rely on others to keep them safe from abuse or potentially abusive situations. Those who abuse that trust are liable to prosecution under the criminal law.

RQIA is one of four organisations which collaborate to ensure that alleged and suspected cases of abuse of vulnerable adults are fully investigated and that measures are in place to offer appropriate protection. RQIA also works closely with other agencies to ensure appropriate measures are in place to protect children from abuse.

In April 2011 the Department for Health, Social Services and Public Safety (DHSSPS) commissioned RQIA to carry out a review of the effectiveness of safeguarding arrangements within mental health and learning disability (MHLD) hospitals across the five health and social care (HSC) trusts in Northern Ireland.

RQIA's Mental Health and Learning Disability Team incorporated the theme of safeguarding into a planned programme of inspections for 2011-2012. This report summarises the findings from 33 inspections carried out between December 2011 and July 2012. It contains 26 recommendations to ensure the continued safeguarding and protection of children and vulnerable adults.

Inspectors found that all trusts had policies and procedures in place to keep people safe from the risk of harm and abuse. Trusts had established safeguarding partnerships to promote the awareness of safeguarding. Much effort has been made to ensure staff were appropriately trained.

Responsibility for safeguarding adults was vested in the Northern Ireland Adult Safeguarding Partnership (NIASP). At the time of the review, the Regional Child Protection Committee (RCPC) had responsibility for safeguarding and promoting the welfare of children. The new independent Safeguarding Board for Northern Ireland (SBNI) has now been established to include the duties of the former RCPC. These arrangements had not been fully reflected within the trust's safeguarding policies and procedures. Further work is required to ensure this occurs in a timely way.

Although there was evidence that safeguarding was being promoted, a common theme across all trusts was that there were instances where procedures were not always being appropriately and consistently applied.

To ensure that patients' rights are fully protected, there are areas that require improvement by trusts. These include: variation in thresholds for referring safeguarding concerns; the inappropriate use of restraint by untrained staff; and the lack of application of the correct procedures to protect patients' money and possessions.

Trusts need to continue their efforts to ensure staff are made aware of the indicators of abuse, and monitor closely the evidence of the effectiveness of the implementation of safeguarding policies, procedures and practices.

Inspectors noted the efforts made by all trusts to increase advocacy services for patients, but this was variable in some places. Discrepancies were noted in record keeping and many records were not appropriately signed. Assessments were not always updated and the types of interventions made were not appropriately recorded.

Recommendations for improvement are made within this report. These have been raised with the DHSSPS, HSC Board and with the trusts, through the inspection process.

In order that children and vulnerable adults are protected and kept safe from harm, the focus on safeguarding needs to continue to be a priority for all HSC organisations.

The findings of all adult mental health and learning disability inspections are reported on the RQIA website. The MHLD team also continues to follow up progress in respect of the implementation of the recommendations contained in the individual inspection reports.

Section 1 – Introduction

1.1 Context for the Review

In April 2011 DHSSPS commissioned RQIA to carry out a review of safeguarding in mental health and learning disability hospitals. The purpose of the review was to consider and report on the effectiveness of the safeguarding arrangements in place within the MHLD hospitals across the five HSC trusts in Northern Ireland.

This review focused primarily on the arrangements in place to prevent abuse and assist staff to protect patients and themselves. The inspectors also examined a number of aspects of patient care and the findings are detailed in the individual inspection reports.

Safeguarding is a generic term which is used to describe the multidisciplinary measures put in place to minimise and manage risks to children and vulnerable adults. The safeguarding of children and vulnerable adults is a shared responsibility. Safeguarding arrangements require to be effective across a number of dimensions including awareness, prevention, identification and response.

To further develop the existing standards and guidance for safeguarding children and vulnerable adults, in 2009, DHSSPS introduced the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults.

For the purpose of this report, the term safeguarding refers to the HSC organisations' responsibilities to protect people whose circumstances make them particularly vulnerable to abuse. For adults, the definition of vulnerability is defined as:

> "a person aged 18 years or over who is, or may be, in need of community care services, or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation."[1]

It is accepted that a person's need to be safe from harm is determined, not only by their individual circumstances, but also by the care setting they are in. Abuse may be committed as the result of negligence, ignorance or deliberate intent and targeting of vulnerable people, either in a single act or on a continuing basis.

At the time of the review, the definitions of abuse for both children and vulnerable adults were determined from available guidance. For adults, the

[1] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance. (September 2006)

Safeguarding Vulnerable Adults Guidance (September 2006) defined abuse as:

> "The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship."[2]

For children, Co-operating to Safeguard Children (DHSSPS, 2003) document defined abuse as:

> "Child abuse occurs when a child is neglected, harmed or not provided with proper care. Children may be abused in many settings, in a family, in an institutional or community setting, by those known to them, or more rarely, by a stranger. There are different types of abuse and a child may suffer more than one of them."[3]

For the purposes of the inspections, forms of abuse were categorised as:

- physical abuse (including inappropriate restraint or use of medication)
- emotional abuse
- sexual abuse
- psychological abuse
- financial or material abuse
- neglect and acts of omission
- institutional abuse
- discriminatory abuse

In meeting the objectives of the term of reference, the review focused on:

- policies and procedures associated with safeguarding
- management, supervision and training of staff
- arrangements for the recruitment of staff
- awareness and response to safeguarding concerns
- identification and prevention of abuse
- concerns and complaints from patients and relatives
- records management arrangements

[2] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance. (September 2006)
[3] Co-operating to Safeguard Children (DHSSPS, 2003)

Inspectors examined the safeguarding arrangements in place across the MHLD hospital wards in all five HSC trusts, including:

- children's learning disability wards
- children's and adolescent mental health wards
- acute learning disability wards
- acute mental health wards
- brain injuries units
- continuing care learning disability wards
- continuing care and rehabilitation units
- dementia wards and
- psychiatric intensive care units

Relevant legislation, policies, procedures, guidance and best practice documents were considered by the inspectors in their assessment of the effectiveness of each trusts' safeguarding arrangements.

Services or facilities excluded from this review included: those attended by children and vulnerable adults that are not either mental health or learning disability facilities; any MHLD services provided by private, independent and voluntary agencies; and the agencies and establishments (see Appendix 1) currently regulated by RQIA.

This report summarises the findings from these inspections and makes the recommendations necessary to ensure the continued safeguarding and protection of vulnerable adults and children.

1.2 Review Methodology

Seventy-two MHLD wards fell within the scope of this review. It was necessary to adopt a suitable methodology that would maximise the ability to validate the quality of safeguarding arrangements across the trusts. The review team agreed that validation of the safeguarding arrangements would be undertaken through a programme of announced inspections, carried out by RQIA's MHLD team. The rationale for this approach was to maximise the number of facilities inspected and make best use of the time available for discussions with management, staff and patients.

The Review Process:

1. Prior to the inspections 113 patient experience interviews were undertaken by RQIA from July to September 2011. Patients' views were used to inform the assessment of the effectiveness of the safeguarding arrangements in place.

2. Prior to inspection each ward completed a self-assessment questionnaire, detailing its safeguarding arrangements. Each HSC trust was also asked to complete a questionnaire regarding its corporate responsibility in all areas of safeguarding.

3. In view of the timescale for reporting, it was not possible to inspect all 72 MHLD wards. A proportionate risk-based approach was adopted to determine the wards to be inspected. Wards considered to have a higher risk rating, based on certain criteria, were selected over those wards that had a lower risk rating. RQIA's MHLD team analysed the available information on each ward and used the following risk based criteria to select the wards to be inspected:

   - intelligence and recommendations made from previous inspections
   - information gathered from patient experience reviews
   - information received from complaints and serious adverse incidents
   - the analysis of self-assessment questionnaires returned by the trusts
   - type of ward or service provided

   From this analysis, 33 wards (four children's and 29 adult wards) were rated as high priority and selected for inclusion in the inspection programme (see Appendix 2). RQIA agreed with DHSSPS that this sample would provide an overview of the quality of safeguarding and safety arrangements across the five trust areas. While every effort was made to select wards in each trust based on the type of care provided, on occasion the need to inspect wards identified with a higher risk rating took precedence.

4. Each inspection examined aspects of safeguarding arrangements. Evidence to support the findings was drawn from:

    - meetings held with patients, staff and other professionals
    - an examination of patient case files, complaints and serious adverse incidents
    - an analysis of the findings from recent RQIA inspections and reviews.

5. In line with the methodology, two stages of reporting of the findings were agreed:

    - individual inspection reports would be produced for each ward and presented to the trusts in line with the normal inspection process.
    - a single overview report containing a summary of the regional findings would be produced for the DHSSPS.

Section 2 – Findings from the Review

2.1 Background to the Findings

The findings of this review are presented under the following themes:

- governance arrangements both in the trust and in specific hospital wards
- the level of awareness of safeguarding arrangements and issues
- the ability of trust staff to recognise signs of abuse
- the mechanisms in place to prevent people experiencing abuse in the first place
- the procedures in place for staff to act appropriately if made aware of allegations or cases of abuse

In measuring effectiveness, it was important to recognise the broader context of practice and the internal and external challenges that impact on performance. It was not appropriate to judge safeguarding arrangements using a single effectiveness measure, as there are many components that need to be considered. Rather, different evidence was used to inform the development of indicators that could be used to assess the effectiveness of safeguarding arrangements.

Inspectors considered these would offer an appropriate basis for determining whether the safeguarding arrangements were sufficient to enable staff to effectively promote the welfare of children and vulnerable adults.

During the course of the inspections of the wards, issues were identified such as: a lack of consultation regarding human rights; environmental issues; and other areas not directly associated with safeguarding. Any issues identified during the inspection were brought to the immediate attention of relevant trust personnel for action, or raised under RQIA's escalation policy and procedure. The required action was detailed in the relevant quality improvement plan, for response by the trust.

The only provision for dedicated MHLD children's wards were in the Belfast Health and Social Care Trust (Belfast Trust) and the Western Health and Social Care Trust (Western Trust). The policy within the Western Trust was to minimise the admission of young people under 18 and to strive for a hospital at home model[4]. Although there were no children admitted to Crannog ward (Western Trust) at the time of the inspection, the ward still fell within the scope of the review and was inspected.

Although there were four dedicated MHLD children's wards, inspectors identified the continued admission of young people under 18 to adult wards in all trusts.

[4] This enables specialist supports to be provided in the community as an alternative to hospital admission.

2.2 Governance Arrangements in Respect of Safeguarding

A successful safeguarding agenda requires the support of a wide network of agencies, organisations and communities of interest from across the statutory, voluntary, community, private and faith sectors.

Unlike child protection, prior to 2010 the coordination of arrangements for the safeguarding of vulnerable adults was limited. However, the recent work undertaken by DHSSPS and the Department of Justice (DoJ), formerly the Northern Ireland Office, led to the establishment of safeguarding partnerships and to the development of working groups to standardise regional policies and procedures.

Adult Safeguarding Partnerships

While HSC organisations were able to clearly demonstrate their structures, governance and working arrangements, inspectors considered that safeguarding arrangements were in the early stages of development, as many policies and procedures were not updated. At the time of the review, the adult safeguarding partnerships had been in place for approximately 18 months. Inspectors considered that the publication of new regional adult safeguarding policy and procedures, completion of further safeguarding training for all staff, and the compilation of information on safeguarding are key factors requiring progression, to bring these partnerships to a more established stage of development.

Overall regional responsibility for adult safeguarding rests with the Northern Ireland Adult Safeguarding Partnership (NIASP), chaired by the HSC Board. The NIASP includes representatives from the statutory, voluntary, community and faith sectors. It has responsibility for the strategic direction and development of adult safeguarding throughout health and social care.

Within each trust area, a Local Adult Safeguarding Partnership (LASP) has been established, with responsibility for implementing the NIASP's guidance and operational policies and procedures at local level. Each LASP is chaired by an assistant director from the trust and includes representation from the trust and statutory, voluntary, community and faith sectors. The chairs of the LASPs are integral members of the NIASP, which provides direct links for communication and reporting between the partnership groups.

Inspectors considered there is an effective infrastructure in each trust to support the operation of partnership groups. This includes sub-groups of NIASP, which lead in the areas of: policies and procedures; performance management and information; training; and communication and service user experience. During the review, some representatives of the partnerships suggested that the effectiveness of the sub-groups could be further improved by restructuring into trust led sub-groups, with a regional focus to improve practice.

Communication and reporting arrangements between the LASPs and NIASP were considered to be effective. LASPs regularly report on standards and outcomes such as training, trends, serious incidents related to adult safeguarding and vulnerable adult reviews. This information is used in the compilation of NIASP progress reports and a delegated statutory functions report is delivered annually by each trust to the HSC Board.

The only vacancy reported in the LASP, was one position within the Northern Health and Social Care Trust's (Northern Trust). This was in the process of being filled and was not adversely impacting on the activities of the group. Good attendance at NIASP and LASP meetings was reported, but attendance had fallen in both, particularly at the sub-group level.

Child Safeguarding Partnerships

Well established child protection arrangements have been in place in HSC organisations for many years, in response to the events surrounding child abuse and historical child abuse inquiries. These focused more on child protection, than on wider aspects of safeguarding. However, this focus will change with the introduction of new child safeguarding legislation by DHSSPS and the establishment of new safeguarding structures. These new structures include a regional independent Safeguarding Board for Northern Ireland (SBNI) and five safeguarding panels located within each trust geographical area. These will mirror existing child protection arrangements, but with increased independence and direct accountability to the Minister for Health, Social Services and Public Safety.

As child protection partnerships have been in place for many years, HSC organisations were able to demonstrate evidence of appropriate structures, governance and joint working arrangements. At the time of the review, the Regional Child Protection Committee (RCPC) held overall responsibility for child safeguarding partnerships, which was chaired by the HSC Board. The RCPC is made up of representatives from the statutory, voluntary and community sectors and has responsibility for the strategic direction and development of child protection throughout Northern Ireland.

Considerable progress has been made in establishing new child safeguarding arrangements. During the transition period, the chair of the SBNI sat on the RCPC partnership, and the RCPC continued responsibility for child protection on an interim basis. During the review, it was established that the delay in transition of responsibility was impacting on the development of some aspects of child safeguarding arrangement, in particular, the development of up-to-date policies and procedures.

Within each trust area, a child protection panel (CPP) was established, with responsibility for implementing RCPC guidance and operational policies and procedures at local level. Each CPP was chaired by a trust assistant director and included representatives from the trust and the statutory, voluntary and community sectors. The chairs of the CPPs are also integral members of the

RCPC, which provides direct links for communication and reporting between the partnership groups.

Inspectors considered that there was an effective infrastructure to support the operation of the partnership groups. Established RCPC sub-groups had taken a lead in the areas of: policies and procedures; case management reviews; education, training and audit; and communication and media management.

Communication and reporting arrangements between the CPPs and the RCPC are considered to be effective as there is a set of requirements for regular reporting and direct links for communication. CPPs regularly reported on standards and outcomes, which included statistical reporting, training, serious incidents related to child safeguarding and case management reviews. This information is used to compile RCPC quarterly reports and each trust's delegated statutory functions report to the HSC Board.

No vacancies were reported on the RCPC or CPPs, and attendance at their meetings was generally good. Inspectors noted that the position of the designated paediatrician for child protection within the HSC Board was vacant; however, another paediatrician was currently fulfilling the responsibilities of the post.

Policies, Procedures and Protocols

While partnership groups were able to demonstrate a strategic plan for adult safeguarding, inspectors were concerned about the lack of an up-to-date regional policy and procedures for safeguarding vulnerable adults. Some trusts had developed their own policy and procedures in accordance with the DHSSPS regional guidance - Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance (2006) and the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009). Others had embraced the best practice elements from Safeguarding Vulnerable Adults - A Shared Responsibility: Standards and Guidance for Good Practice in Safeguarding Vulnerable Adults (Volunteer Now, 2010). However, the most used guidance by most MHLD hospital settings was the 2006 document Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance[5]. Inspectors considered the 2006 document to be out-dated as it does not reflect current best practice for safeguarding vulnerable adults.

A NIASP sub-group has developed new draft operational policy and procedures for regional adoption, which are currently under review. However, given the direct relationship between these procedures and the development of an Adult Safeguarding Policy Framework being undertaken between DHSSPS and DoJ, the policy and procedures will not be released in advance of the Adult Safeguarding Policy Framework being published. Inspectors considered that until this is published, NIASP will be unable to fully deliver an

[5] Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance (2006)

effective safeguarding plan in the absence of up-to-date policies and procedures.

While children's partnership groups were able to demonstrate a strategic plan for child protection based on regional policy and procedures, few trusts had taken steps to further develop trust specific child safeguarding policy and procedures. With the transfer of responsibility to SBNI, both the regional policy and procedures and trust specific child safeguarding policies and procedures will need to be updated accordingly.

Patient Experiences

An area that was not fully evident in the reporting process was that of the lack of reporting of adult patient experience. The inspectors considered that work on patient experience with adults, undertaken within the trusts, should be reported on and the information used to inform the commissioning of services by the HSC Board. NIASP has already been tasked with establishing arrangements for user engagement.

While work on patient experience of children has been initiated, it was not evident in the reporting process. The RCPC had already identified this gap and was planning to incorporate this in its work in the period before transfer to the SBNI. The communication between the SBNI and children and young people had already been established as a key priority of the new SBNI.

Inspectors considered that the newly established partnerships within children and vulnerable adult services provide effective arrangements in terms of leadership, governance, infrastructure, communication and reporting. This constitutes a sound foundation for safeguarding in Northern Ireland. The findings from inspections also indicated a number of on-going challenges, including the need for more direct patient experience and feedback; the release of revised regional policy and procedures; and the further development of the new safeguarding structures.

Recommendations

1. The DHSSPS should prioritise the publication of the Adult Safeguarding Policy Framework to facilitate the release of the new Adult Safeguarding Policy and Procedures.

2. Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports to the HSC Board.

2.3 Awareness of Safeguarding Practice

The abuse of children or vulnerable adults can occur when a person is neglected, harmed or not provided with proper care. Raising awareness of abuse is one of the building blocks of effective safeguarding and not only enables staff within services to recognise and prevent it, but assists those at risk to recognise it and to seek help in protecting themselves.

For systems to be fully effective, all safeguarding arrangements must be promoted and not limited to the awareness of abuse. Staff must be familiar with the safeguarding structures within their organisation; understand their role and the roles of others; be aware of the policies and procedures; and know what action to take in relation to safeguarding issues. Similarly, patients and relatives should be made aware of the procedures and support arrangements associated with safeguarding.

Responsibility for safeguarding children and vulnerable adults is not specific to MHLD staff and applies equally across all services provided by the trusts. Information obtained during this review and also from the previous RQIA review of the Joint Protocol[6], demonstrated that trusts had clear lines of management accountability and corporate responsibility in relation to safeguarding children and vulnerable adults.

Whilst structures associated with the safeguarding of children and vulnerable adults are in place, they differ from trust to trust. Each trust has representation at board and director level; designated officers[7] and investigating officers[8] for vulnerable adults; and designated paediatricians and named nurses for child protection. The effectiveness of the structures was confirmed by evidence of clear channels of accountability and communication. All trusts were able to demonstrate how they reported information from service level to trust board, and externally to the HSC Board. This included general information, performance returns, case management, risk management, governance oversight arrangements and information on the discharge of statutory functions.

On adult wards, inspectors considered that staff awareness of the designated officer role was not fully understood. However, in speaking with staff during inspections it was clear to inspectors that awareness of the role still not fully developed, as a limited number of staff were unsure of, or unable to identify the designated officer. Of the staff who replied to the questionnaires, approximately 15% claimed to be unable to identify their designated officer. A

[6] RQIA Review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults

[7] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance, defines the Designated Officer as: The person within the Trust deemed to be responsible for the decision to proceed under the Adult Protection Procedures and for coordinating any subsequent investigation which takes place.

[8] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance, defines the Investigating Officer as: The experienced and suitably qualified professional appointed by the Designated Officer to carry out an investigation of the alleged abuse as agreed at the Strategy Discussion.

similar view was expressed by visiting professionals, such as consultant psychiatrists, social workers and therapists. Staff perceptions of their roles in relation to safeguarding vulnerable adults varied and was clearly linked to awareness and understanding received through training. Staff who had received training considered that it was mostly effective in terms of raising awareness of their roles in safeguarding vulnerable adults.

Each trust was developing the role of the designated officer and also the role of the investigating officer within MHLD services, either in individual wards or in covering a hospital site. Inspectors considered this development to be beneficial in terms of improved communication, reporting and providing advice on adult safeguarding issues. The Northern Trust had the lowest number of designated officers, compared to other trusts. Its approach is to establish the number of designated officers proportionate to the level of safeguarding activity. The trust confirmed that the number of designated officers would increase if the level of safeguarding activity increased.

In relation to child safeguarding, the roles of designated paediatricians and named nurses were clear in all trusts and staff awareness was also very good.

All wards were noted to be proactive in promoting the awareness of child and adult safeguarding and had information regarding safeguarding displayed appropriately on notice boards. Posters and information leaflets were displayed at the entrance to wards to alert relatives and visitors. Policy and procedures and other information was available for staff in ward offices.

Training in Safeguarding Children and Vulnerable Adults

Awareness of adult safeguarding and knowing what to do in a safeguarding situation can be improved through experience. If staff are to be equipped to deal effectively with an adult safeguarding situation, they must be appropriately trained. Approximately 66% of staff across the trusts were trained in safeguarding vulnerable adults. At the time of the review, only 16 wards were found to have had all staff trained in safeguarding vulnerable adults, although training schedules were noted to be in place for those who had not been trained.

On children's wards, child protection training was considered to be an integral element in maintaining appropriate child safeguarding arrangements. However, inspectors identified 16 staff working on the wards that had not received child protection training or training in Understanding the Needs of Children in Northern Ireland (UNOCINI)[9]. Inspectors expressed concern about this and recommended that all staff working on children's wards are appropriately trained in child protection

[9] UNOCINI Guidance - Understanding the Needs of Children in Northern Ireland (Revised 2011)

Knowledge and Awareness of Policy and Procedures

Effective adult safeguarding is unsustainable without appropriate guidance or policy and procedures. Arrangements for ward staff to access adult safeguarding guidance, policy and procedures were in place, with information being maintained and accessible either in hard copy or electronically via the trust's intranet. Inspectors identified that supporting procedures, such as the joint protocols[10] for investigations for both children and vulnerable adults and procedures for reporting and responding to allegations made against staff were absent from 15 wards across the Belfast (six wards), Western (five wards) and South Eastern Health and Social Care Trusts (South Eastern Trust) (four wards).

Staff awareness of each trust's policy and procedures for safeguarding vulnerable adults is an indicator of how alert an organisation is to the possibility of abuse occurring. During inspections, inspectors encountered a small number of staff in a few wards who claimed not to be aware of these policies and procedures. Even though it had been previously identified that not all staff across the trusts had completed safeguarding vulnerable adults training, inspectors considered that this was unlikely to be the primary contributing factor for the lack of awareness.

While trusts are taking positive steps in this area, inspectors considered that current regional guidance for adult safeguarding is not fully effective. Inspectors considered that the guidance was not up-to-date and did not reflect current best practice for safeguarding vulnerable adults. NIASP is in the process of developing a new operational policy and procedure. However, the delay in release of the revised guidance is having an impact on the ability of trusts to fully progress the adult safeguarding agenda at a local and regional level.

Guidance, policy and procedures for safeguarding children, the ACPC Regional Policy and Procedures (2005), were well established within all trusts and staff within children's wards were aware of them. Inspectors also observed appropriate policies and procedures specific to looked after children on the children's wards. The arrangements for staff on children's wards to access each trust's guidance, policy and procedures were considered to be effective, with information both available and accessible either in hard copy or electronically via trusts' intranets.

It was identified that supporting documentation on three of the four children's wards was outdated. Although these wards were aware of this, it was highlighted they had refrained from instigating any changes to documentation until the completion of the transfer of responsibilities and updated regional policies and procedures were available.

[10] The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults and the Protocol for Joint Investigation by Social Workers and Police Officers, of Alleged and Suspected Cases of Child Abuse.

Policies and procedures to support adult safeguarding and child protection, such as policies for management of violence and aggression, restrictive practices and the use of restraint and physical interventions were in place across all trusts. The majority of staff across all trusts demonstrated an awareness of the supporting policies and procedures and how and where to access them, if required. However, on a small number of wards some of these policies were not up-to-date.

Effective awareness of safeguarding should not be limited to trust staff, but should include both patients and relatives. While wards were actively promoting safeguarding and raising the awareness through posters and information leaflets, many patients and relatives had little understanding or awareness of their respective trusts' safeguarding arrangements. On average, 42% of patients and 43% of relatives who responded during the review, claimed to be unaware that the ward had a safeguarding vulnerable adults policy. Inspectors considered patients and relatives should have been made aware of trust procedures in order to be able to reflect any safeguarding concerns.

Recommendations

3. Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.

4. Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).

5. Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards and ensure that this information is readily accessible to staff, patients, relatives and visitors.

2.4 Identification of Safeguarding Concerns

Determining whether abuse has occurred or not, can be a difficult task. To help to ensure effective safeguarding arrangements are in place, staff must be suitably skilled and competent in identifying signs of abuse and managing potential risks to vulnerable adults or children.

At the time of the review, inspectors were advised that about one third of staff had not received updated training in safeguarding vulnerable adults. While almost all staff were able to demonstrate good working knowledge and understanding of adult safeguarding and the types of abuse, a small number of staff were less able to demonstrate the same levels of knowledge or understanding. This was evidenced across all trusts during the inspection of wards.

The lack of ability to identify safeguarding issues was an area of particular concern to inspectors. Inspectors identified that on ten of the wards inspected, instances where safeguarding cases were not being classified by staff as a safeguarding concern. This meant that appropriate follow up and prevention mechanisms were not initiated. Such cases included patient on patient assaults or unexplained bruising. Lack of consideration of these incidents as possible abuse, was associated with what staff determined to be the threshold at which an incident should be designated as a safeguarding issue. In cases where a staff member is faced with doubt about a threshold decision, the appropriate course of action should be a referral to the designated officer for advice, but on occasions this did not occur. Nine wards received a recommendation in relation to the identification of threshold levels.

A lack of training was cited by some to be a contributing factor, however, not the only factor. Inspectors also found that a limited number of staff were unable to provide assurances that they fully understood safeguarding procedures and requirements, while others stated they did not feel confident in dealing with safeguarding issues, even after receiving training.

In light of this, inspectors considered that some aspects of safeguarding vulnerable adults training were not effective in providing staff with the understanding and confidence necessary to discharge their roles. A similar view was shared by a ward manager in one trust, who stated that clarification on the content of adult safeguarding training was required. Inspectors considered that the understanding of staff of the threshold level for reporting issues requires to be reviewed by NIASP.

Risk Assessment and Management

Identifying potential risks and putting measures in place to deal with them are crucial in the prevention of abuse. All trusts have systems in place to identify and manage risks to patients, which included the use of the DHSSPS 2010 guidance on Promoting Quality Care (PQC).

Patient files were reviewed in all trusts and it was noted that risk assessments and care plans were completed for all patients. There was also clear evidence of these documents being reviewed and discussed at multidisciplinary team meetings, with many instances of the patients being involved. Information provided by relatives indicated that some considered they were not being informed or kept up-to-date with what was happening on the ward. Although this was not the case in all wards, many relatives expressed dissatisfaction with the feedback they had received from staff.

While patients in all trusts had received a risk assessment following admission to the ward, inspectors identified that the comprehensiveness of the documentation varied considerably between trusts. Concerns included:

- risks had been identified and recorded, but sometimes subsequent management plans had not been recorded in the notes, or notes were not correctly updated
- records were not updated to reflect patients' changing circumstances
- occurrences of risks that were considered to be serious had not been reviewed in detail
- some risks were not being recorded within the risk assessment
- patient assaults on staff were not reported as a risk

Staff indicated that assaults from patients formed part of the job; however, inspectors considered this may also be an indicator of potential risk to others and should be reported. A strategy should also be put in place to review, manage and minimise the risk.

Although each trust was able to demonstrate they had risk management systems in place, inspectors considered that staff on at least eight wards were not adhering or fully using the policy and procedures. A risk management plan is considered to be a live document and should be regularly updated to reflect any changes in patients' assessed needs and risks. Inspectors concluded that while the initial stages of the risk management process were being adhered to in all trusts, follow-up actions to update these documents were not always occurring. In the absence of updated and accurate patient documentation, arrangements to safeguard patients could be compromised.

All staff reported being aware of the risk assessment procedure. However, of the 345 staff across all trusts who replied to the questionnaires, approximately 61% advised of receiving training in how to carry out a patient risk assessment. While it is possible that not all staff would be required to carry out a patient risk assessment, inspectors considered this training would enhance their skills in the identification of risks.

Key indicators used in identifying child or adult safeguarding issues include accidents, incidents and near misses, where recurrences can highlight potential risks. It is important therefore, that trusts have in place procedures for reporting and recording accidents, incidents and near misses. Lessons can be learned from the analysis of these events which should be

disseminated to staff and used to inform changes in practice, policy and procedures.

Serious Adverse Incidents and Complaints

All trusts had policies and procedures in place for recording and reporting accidents and incidents, supported by accident and incident log books on the wards. Staff demonstrated high levels of awareness of the accident and incident reporting process.

Each trust had its own individual reporting process and demonstrated how accidents and incidents were regularly reported and discussed at respective governance meetings. Mechanisms to bring risks and concerns to the attention of the trust board/ senior management were also in place. Evidence of the analysis and learning being fed back to the wards was presented, and staff also confirmed that learning was discussed at staff meetings.

Inspectors identified effective accident and incident reporting processes in place across all trusts to complement their safeguarding arrangements. However, the effectiveness of these processes was, on occasions, comprised by the lack of application of the procedures by some staff on at least seven wards. In particular, the previously identified problem associated with the threshold level for reporting an incident of abuse resulted in cases not being entered into the safeguarding process. These cases were not being investigated and learning from them could not be identified and shared appropriately with staff.

Other indicators applied to the identification of safeguarding issues include the concerns and complaints received from patients, relatives and staff. Information of this nature can highlight issues or cases of abuse never previously identified or reported. When patients, relatives or staff have a concern or complaint they should have access to the organisation’s complaints procedure.

The arrangements for complaints were well established in all trusts, with policy and procedures in place in all wards, supported by robust recording and reporting mechanisms. All staff demonstrated a high awareness of the complaints procedures. However, just under 50% of staff who responded to the questionnaire indicated that they had received complaints training. The high levels of awareness in this area were attributed to staff experience of managing complaints over the years.

Inspectors considered that effective arrangements were in place for the handling of complaints in order to provide patients, relatives or staff the opportunity to have their issues addressed. However, awareness and access to the process needs to be addressed. It was identified on the majority of wards visited, that information regarding the complaints policy was displayed and was available either on a poster, in leaflets or both. Information regarding complaints was also included in the information packs provided for patients and relatives on admission. Even though this information was readily

available, patients and relatives still reported having low awareness. Of the wards inspected, 17 received a recommendation in relation to promoting the complaints procedure with patients and relatives. Of the remaining 16 wards, only a small number demonstrated evidence of being proactive in the promotion of the complaints procedure. Inspectors were unable to determine a reason for low levels of awareness of the complaints procedure among patients and relatives and considered this as an area the trusts should investigate further.

The awareness of whistleblowing and cases arising from it are becoming more prevalent and offers a further opportunity for the identification of safeguarding issues. All trusts have a whistleblowing policy which was observed on all wards visited and all staff indicated a high awareness of the policy. While inspectors considered that effective arrangements are in place in relation to whistleblowing, they considered that trusts needed to update their whistleblowing policies to indicate that RQIA is a designated body under the provision of the Public Disclosure (Northern Ireland) Order[11] which staff can contact if they are concerned about abuse.

Recommendations

6. Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.

7. Trusts should undertake an audit of practice to determine if all staff are robustly adhering to safeguarding policies and procedures.

8. Trusts should ensure that comprehensive investigations and risk assessments are carried out as required by relevant staff.

9. Trusts should ensure that risk assessment training is provided for all staff.

10. Trusts should ensure that all staff receive training in relation to the complaints policy and procedure.

11. Trusts should ensure that the complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.

[11] The Public Interest Disclosure (Northern Ireland) Order 1998

2.5 Safeguarding Practice in Preventing Abuse

It is often difficult to prove that an abusive event has occurred and equally difficult to demonstrate that an abusive event has been prevented. Identifying what constitutes a successful preventative intervention is difficult to determine. It is for this reason that appropriate safeguarding prevention arrangements need to be in place. The prevention of abuse is preferable to supporting children or vulnerable adults after an abusive event has taken place.

Prevention is most likely to be effective where proper arrangements are in place such as: legislation and regulation; policies and procedures; training; awareness raising; information, advice and advocacy; interagency collaboration; and promoting the involvement of patients and relatives. However, the success of these arrangements will be determined by how well staff operate and adhere to them.

Appropriate recruitment and selection procedures are required to minimise the opportunity for unsuitable people to work with children or vulnerable adults. All trusts confirmed they had arrangements in place for vetting applicants, including carrying out pre-employment checks, requesting evidence of qualifications and registration with professional bodies, the provision of written references, and Access NI checks. Inspectors found these arrangements to be evident as protective measures in preventing unsuitable applicants from being employed by the trusts.

Good organisational practice requires a thorough induction process. In all trusts, new staff were required to undertake both a corporate induction and a local ward induction. Three trusts advised that the induction process included information on the trust's safeguarding arrangements. However, in the South Eastern and the Northern Trusts inspectors noted that safeguarding was not included in the corporate induction process. Inspectors considered this should be addressed, and safeguarding included as an integral part of all trusts' induction programmes.

Ward inductions tended to include reference to safeguarding arrangements. Evidence of the use of an induction checklist was observed on the wards. The only notable exception was in one ward in each of the Belfast and Western Trusts, where adult safeguarding was not observed to be part of the induction process. From observation of induction processes on other wards, inspectors considered the arrangements to be effective, as they provided an appropriate introduction to safeguarding for all new staff.

Good management of staff will ensure that everyone on the wards is clear about their roles and responsibilities in relation to safeguarding. Alongside the daily management responsibilities, supervision and appraisal should be available to assure the trusts that staff are carrying out their work to the required standard. Supervision is also essential to ensure that staff feel supported.

All trusts were noted to have policies and procedures in place for supervision and appraisal, although it was only in approximately half of wards visited that both processes occurred on a regular basis in line with the trusts' policies and procedures. Feedback from staff in these wards confirmed that regular supervision is offered and staff stated they felt supported by the ward manager. However, in 17 wards it was observed that no regular supervision was offered, or no supervision was taking place.

Appraisals had taken place in the majority of wards, with the exception of five wards in the Western Trust, where the absence of appraisals had been confirmed by staff. The Western Trust advised that in one instance this was due to no permanent ward manager being in place.

Inspectors considered there were effective arrangements in place to facilitate appropriate supervision and appraisal; however, these were not being applied consistently in 17 of the wards inspected. Inspectors also considered that by not adhering to supervision and appraisal procedures there is a risk that safeguarding arrangements may be compromised by the failure to identify potential safeguarding issues and staff training needs.

For those staff receiving supervision and appraisal, the tools used to identify training needs included personal development plans and the Knowledge and Skills Framework. While most staff members were satisfied that their training needs were being met, there were a couple of instances where staff indicated this was not the case, with a few staff stating they had found it difficult to access appropriate training or be released to attend training.

Safeguarding practices were assessed in several areas on the wards to determine what arrangements were in place and whether staff were adhering to best practice guidance, policies and procedures. The areas covered included aspects of care considered under the following headings:

- the practice of seclusion and restraint
- protecting patients' money and possessions
- visitation of children to the wards
- admission of young people under 18 years of age to adult wards
- management of records and record keeping

These areas must be properly managed and controlled to prevent potential abuse occurring.

The Practice of Seclusion and Restraint

Inspectors examined the circumstances in which patients may be subject of seclusion and/or restraint, and the practice of close observation of both adult and children on wards. All trusts had policies and procedures for the management of interventions. Nine wards received a recommendation in relation to updating their policy on restraint, while on one ward within the South Eastern Trust, no policy on restraint was available.

Staff demonstrated good awareness of the need for documentation associated with close observation and restraint. Staff on two wards seemed less aware of the need to monitor seclusion and a recommendation was stated. The Southern and Northern Trusts advised of using seclusion as an intervention on a limited number of wards. Of the staff who responded in the questionnaire, approximately 49% advised of being trained in seclusion; however, this may be a consequence of seclusion no longer being practiced within three of the five trusts.

The numbers of staff trained in close observation and restraint was high, but not all staff had completed this training. Of the staff who responded, approximately 67% advised of being trained in close observation and 85% advised of being trained in restraint. To prevent unintentional abuse to patients, and to ensure staff are protected from inadvertently causing harm to a patient, inspectors considered that further training in this area is required.

The appropriate management of challenging behaviour could reduce the need for further interventions and limit the number of potential safeguarding cases. In the Western Trust it was noted that the use of de-escalation techniques had resulted in a reduction in the number of incidents of physical aggression. From the information provided by the five trusts, not all staff were trained in this area. The majority of staff were trained in de-escalation techniques and the management of challenging behaviour, the exception being the South Eastern Trust which reported having less than 50% of staff trained.

Throughout the trusts, it was observed that the application of policies and procedures for seclusion, restraint and close observation varied between wards. It was noted that the use of such interventions was only employed after discussion and agreement during multidisciplinary team meetings or after a risk assessment had been completed. A review of a number of patient records confirmed this to be the case and inspectors noted that staff were following the recommendations contained within patients' care plans. While there were areas of good practice, there were cases where the interventions had not been recorded or updated in patients' notes in eight wards and recommendations was stated. A concern was raised on five wards in relation to a small number of staff who were not adequately trained in applying behaviour intervention techniques on patients and a recommendation was stated. Since not all staff were fully adhering to the procedures and others were not fully trained, inspectors considered the arrangements for managing interventions could not be deemed to be fully effective.

Protection of Patients' Money and Property

While children and vulnerable adults are in hospital, protection arrangements should be in place to safeguard their property and possessions. It was recognised that this was a difficult area to administer and manage, a view reiterated by staff across all trusts.

Where children and vulnerable adults are incapable of managing their affairs, suitable arrangements must be in place to protect them from financial abuse.

Each trust has arrangements in place which govern the management of patients' money, which include policies and procedures and mechanisms for receipt and storage of patients' property, including personal finance. The majority of staff in all trusts were familiar with the arrangements for handling patients' money. Staff expressed concern that the processes were applied on a trust wide basis and were not specific to MHLD wards, and suggested that further clarification was necessary.

Each trust had its own policy and procedure to govern patients' property. Patients were actively discouraged from bringing valuable items onto the wards. This was considered a sensible approach; safeguarding patients' property effectively requires trusts to redirect staff resources away from patient care.

When patients deposit money, it is recorded in an inventory book and deposited in the ward safe, a locked cabinet or lodged in the trust's cash office. Each ward had arrangements to allow patients access to their money. Even though patients and relatives did not raise concerns about the arrangements in relation to patients' money, inspectors identified issues in relation to how patients' money was managed. Records of expenditure were not always maintained. In particular, inspectors identified that on some wards, patient finances were used to purchase furnishings for the ward, such as curtains and bed linen. Trusts advised that such items could not be given to the patients upon discharge. This matter was raised with the trusts following the inspections.

In the management of patients' property, wards provided guidance and information to patients and relatives upon admission, used an inventory book to record patients' property brought onto the ward and provided patients with locked storage facilities. Relatives were also requested to label patient's property and clothing. Even with these arrangements in place, staff found this a difficult area to manage and patients regularly advised of items going missing. A contributing factor to this issue was that clothing and personal possessions were brought to and from the wards by relatives, which were not recorded in the inventory books. In these circumstances, staff had no way of maintaining an accurate inventory of patients' possessions. Inspectors considered that trusts had put basic arrangements in place to safeguard patients' property but considered that unless patients and relatives fully adhered to the arrangements, it was difficult to see how the wards could be expected to achieve effective oversight of this area.

Although there were policies and procedures in place, as well as mechanisms to record the receipt of patients' money, inspectors considered the current arrangements were not sufficiently robust to provide effective safeguarding of patients finances. This matter is being closely monitored by RQIA. Inspectors also considered that guidelines on the use of patients' money needs to be further developed and communicated to all relevant staff.

Visits of Children to the Wards

Children visiting parents and relatives is central to maintaining normal family relationships. However, the best interests of the child must be paramount and taken into account when considering a visit. All trusts have incorporated this into their safeguarding prevention arrangements and it has been outlined in policies and procedures for children visiting MHLD wards. This was not fully reflected in the practice observed on some wards.

While many staff on adult wards demonstrated awareness of the procedures associated with child protection, there were instances where the procedures were not available on the ward and staff did not know what the arrangements were. There was a perception from some staff that they did not require extensive knowledge of child protection, as they worked in predominantly adult services. Inspectors considered that these staff had failed to understand the importance of child protection issues of children visiting adult wards.

The number of staff on adult wards trained in child protection varied considerably across trusts, with an overall average of only 50% recorded as having received child protection training.

Information provided in relation to children visiting adult wards included posters, leaflets and a patient information booklet. This information was only observed on some wards throughout the trusts. In the Southern Trust it was observed that risk assessments were carried out prior to the child visiting, to allow for suitable monitoring arrangements to be put in place. In the Northern Trust, there was a protocol that stipulated that all child visits were to be pre-arranged with the ward manager. However, staff advised that this was difficult to manage as relatives did not adhere to this protocol and often arrived at the ward unannounced.

The physical arrangements in place on the wards to facilitate a child visiting varied considerably. While many wards had separate rooms to accommodate such a visit, many had no visiting area and some visits took place in the manager's office or the patient's bedroom.

Inspectors considered that the arrangements for children visiting adult wards are only partially effective, due to the lack child protection training, staff understanding of the procedures and the lack of suitable visiting arrangements on the wards.

Admission of Young People Under 18 to Adult Wards

In accordance with best practice, all children and adolescents should be accommodated within age appropriate services, rather than admitted onto adult wards. During the period from November 2010 to November 2011, a total of 71 admissions of young people under 18 to adult wards were reported by the five trusts.

All trusts had policies and procedures in place for the admission of young people under 18 to adult wards and staff demonstrated high levels of awareness in relation to this. Evidence was observed of wards adhering to the relevant guidance from DHSSPS and of the arrangements put in place by the trusts for such occurrences. These included: one-to-one nursing care; admission to single bedded rooms; and close observation. Admission of young people under 18 to adult wards is categorised as a serious adverse incident and requires notification to external organisations. Evidence of notification of these incidents to RQIA was presented to inspectors.

Inspectors were concerned about the level of adequate child protection training in respect of arrangements for the admission of young people under 18 to adult wards. Of the wards which admitted young people under 18, only one ward in the Western Trust was recorded as having all staff trained in child protection. The lack of staff with appropriate child protection training in the other wards was considered a potential risk to the safeguarding of children admitted to these wards. Inspectors recommended that immediate action is required in relation to child protection training.

Management of Records and Record Keeping

As well as a requirement to implement best practice, the mechanisms that support robust safeguarding prevention arrangements, such as good records management, contribute in their own right to better safeguarding arrangements. Accurate recording of clinical outcomes, interventions, training and supervision help to ensure appropriate information is available for the purposes of patient care and also assists managers to identify gaps in staff capability that might impact on patient care.

Records management policies and procedures have been established in all trusts and schedules for auditing of records were identified by each trust. Staff demonstrated a high awareness of the procedures. However, information provided by staff indicated that on average, only 41% of staff had received records management training. In the majority of patient records reviewed, the notes reflected good record keeping, but there were some instances where information had not been recorded in line with trust procedures or best practice. In particular, discrepancies included: notes that had not been signed; risk assessments not being updated or completed; and interventions not having been recorded.

Records management procedures were also applicable to recording information about training, supervision and appraisal. Recording in this area was generally acceptable, with up-to-date information being maintained about staff training and the dates for supervision and appraisal. However, the review of records highlighted some gaps in mandatory training, out-of-date training and also that supervision and appraisal were not taking place. With such information readily available, the inspectors raised concerns in respect of the lack of application of training, supervision and appraisal.

While inspectors determined there were effective arrangements in place to facilitate best practice in records management, this area was only considered to be partially effective as there were too many instances where the procedures were not being followed.

Recommendations

12. Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.

13. Trusts should ensure that all staff receive regular supervision and appraisal.

14. Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to all staff on the wards.

15. Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.

16. Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.

17. Trusts should ensure that only staff who are appropriately trained should employ restrictive intervention techniques.

18. Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.

19. Trusts should ensure that all staff have received the appropriate level of training in child protection.

20. Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.

21. Trusts should ensure that all staff receive training in records management.

22. Trusts should ensure that all staff adhere to the records management policy and procedures.

2.6 Response to Safeguarding Concerns

Even when organisations have arrangements in place to safeguard people from abuse, there can still be instances where abuse occurs. In such cases, it is the safeguarding response employed by the organisation that will determine whether appropriate action and support has been provided to individuals who may have been abused.

The response arrangements do not operate in isolation, or only when abuse occurs. These are intertwined throughout the policies, procedures and training, which are the mechanisms that enable staff to know how to respond following an incident of alleged abuse. The effectiveness of many aspects in these areas have been discussed throughout the report.

This section focuses on the arrangements for communication and the involvement of and support available for patients.

For people who experience abuse, the need to involve and work with other organisations is key in protecting them from further abuse. Promoting the welfare of patients is a joint responsibility that should be shared by a range of organisations. Engagement with other organisations was observed to be working well in all trusts. In particular, representatives from external organisations were represented on the RCPC, CPPs, NIASP and LASPs and were involved in serious case reviews. This was similar to the findings obtained during RQIA's Review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (February 2012). Inspectors considered that the arrangements in place for liaison with other organisations were effective due to the multiagency approach, established lines of communication and regular meetings.

Each ward advised of promoting and communicating an ethos of inclusion and transparency to patients and relatives. While the majority of wards displayed a philosophy or mission statement either on the ward or in their information booklets, there were still a small number of wards where such information was not evident. It is therefore important to communicate a commitment to the principles of openness and transparency to patients, relatives, advocates and staff. Of the 33 wards inspected, 26 received a recommendation in relation to information provided to patients and relatives.

Although there was good communication throughout each trust, and externally to other organisations, inspectors identified that communication with patients and relatives was not always of an appropriate standard. Communication and involvement were also areas highlighted by both patients and relatives. While many felt they had received adequate communication, others were concerned about the lack of information regarding their relative’s care and about incidents that happened on the ward. Across all trusts, patients' notes identified that many relatives were being informed about incidents, but other patients' notes and reports from relatives identified this practice was not happening routinely on all wards.

The inclusion of patients and relatives was often referenced in patients' notes; however, there were cases in each trust where they were not represented during discussions about care practices. Recommendations for involving patients and relatives were applied to 15 wards. The instances of weekly meetings with patients and relatives were limited to a few wards in each trust.

In terms of openness and transparency, a concern raised by many relatives was their access to the wards to see where their relatives were staying. All visits were facilitated in side rooms or outside the ward, with the exception of only a limited number of wards, where relatives were permitted access to the ward. While this practice was to facilitate ward routine and reduce disruption, relatives viewed it as a lack of transparency. In some cases the ward manager facilitated relatives access to the ward, but this was limited. RQIA believes that an appropriate balance needs to be struck between assuring relatives of the comfort of the ward, including sleeping arrangements, without comprising the privacy and dignity of the patients.

Patients' access to information held about them was considered an area that was not well promoted in most trusts and was further reflected in the comments from patients and relatives. While the trusts advised of having policies and procedures in place, it was determined these were simply freedom of information procedures. The South Eastern Trust had additional information about accessing personal information made available to patients on the wards. Inspectors considered the current arrangements were only fulfilling the minimum requirements in respect of access to information and considered that trusts should be more proactive in informing patients of their rights.

Where patients, relatives or their advocates have concerns or complaints about any aspect of treatment or care, they should have access to the trust's complaints procedure. Although there was evidence of relatives being encouraged to make a complaint in some patients' records, patients and relatives claimed not to be aware of the complaints procedures. From the patients and relatives who replied during the review, approximately 53% advised of being aware of their respective trusts' complaints policy. In 15 wards throughout the trusts, there was no evidence of informing or promoting the procedures to patients or relatives.

While the trusts strived to have a culture of openness and transparency in safeguarding practice, this was not evident on all wards. Inspectors considered the arrangements to promote inclusion were not sufficiently effective, as 15 wards received a recommendation in relation to involving patients and relatives. Although many mechanisms were in place to facilitate best practice, they were not being fully applied.

Advocacy services can make a significant contribution to the prevention of abuse, by enabling patients to become more aware of their rights and facilitating them to express their concerns. The availability of advocacy services varied considerably across trusts and between wards. Most wards

were promoting advocacy services to patients and relatives, through leaflets and posters. In a few wards, where advocacy services were available, the ward was not seen to be promoting this service to patients or relatives. To improve the advocacy arrangements for patients, 16 wards received a recommendation in this area.

Advocates spoken to during the review confirmed the benefits of promoting the services and reported an increase in the number of consultations. While many patients had access to advocacy services there were still a number of patients who were unable to avail of this service. The most proactive wards had patient advocates attending on a regular basis.

Inspectors considered the trusts were making good progress in providing advocacy services, but this should be available to patients in all wards.

Recommendations

23. Trusts should ensure that a culture of inclusion of patients and relatives and transparency in communication across all wards.

24. Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.

25. Trusts should ensure that patients and relatives are fully communicated with in relation to their care, and about incidents and accidents on the wards.

26. Trusts should ensure that patients and relatives on all wards have access to advocacy services.

Section 3 - Conclusion and Recommendations

3.1 Conclusion

This report presents an overview of the safeguarding arrangements in place to protect children and vulnerable adults in mental health and learning disability hospitals across Northern Ireland. The recommendations apply to all trusts even though some may already be compliant. All five trusts have made good progress in establishing effective safeguarding arrangements for both children and vulnerable adults, although inspectors found that the levels of progress varied both across trusts and between wards.

Wards, where a designated officer or safeguarding lead was based or spent a considerable amount of time, demonstrated higher levels of safeguarding awareness, more up-to-date training, and the application of policies and procedures was more evident. The role of the designated officer is invaluable in establishing and delivering more effective safeguarding arrangements. Local and regional groups were established to facilitate multiagency working and clear communication protocols were in place for staff to report any concerns about the safeguarding of vulnerable people. Through these groups, trusts are able to share information, and to work on regional initiatives to drive further improvements in safeguarding practice.

The overall governance arrangements in place to support effective safeguarding were considered to be robust, with clear management and accountability structures evident in both children and adult wards.

Generally, the trusts have successfully determined the main priorities for safeguarding and maintained a focus on meeting these. However, the areas requiring progression were the development of the new adult safeguarding policy framework and the transfer of responsibilities for children to the new SBNI. Once in place a clearer focus can be brought to further improvements in safeguarding practices.

Most staff were able to demonstrate a basic awareness of safeguarding issues, of policies and procedures and of the required reporting arrangements. Improvement is required to ensure that all staff are trained appropriately in vulnerable adults and child protection procedures; that all relevant policies and procedures are updated and implemented; and that staff are proactive in the promotion of safeguarding processes to patients and relatives.

Inspectors found that different thresholds and mechanisms are being employed by trusts to identify potential safeguarding issues, such as patient risk assessments, reporting accidents and incidents and in the promotion of training in the complaints procedures. Although procedures are in place to support best practice, their effectiveness is being hindered by the lack of implementation by some staff. Although complaints policies and procedures are in place, 53% patients and relatives indicated through the questionnaires

that they were not familiar with or aware of them. The complaints process needs to be promoted further with patients and relatives.

The reporting and analysis of accidents and incidents is being carried out, but inspectors noted that many incidents had not been considered as a safeguarding concern and subsequently were not appropriately reported. There was evidence of risk management of patients and of risks being discussed at multidisciplinary meetings; however, there were instances where further follow-up was required. Further training is required to drive improvement in this area.

All trusts had effective arrangements in place to prevent unsuitable people working with children or vulnerable adults. Policies and procedures for supervision and appraisal were noted to be in place in all trusts. Many staff reported they were supported by management, but there were still cases where both regular supervision and appraisal were only being carried out in half of the wards visited.

All trusts had policies and procedures in place to prevent abuse. In some instances trusts' arrangements for managing patients' money and property were not wholly effective in providing adequate protection of patient money and belongings.

Although there was evidence of policy and procedures in relation to deprivation of liberty, a number of concerns were evident. Inspectors found that physical restraint was being applied by a small number of staff who were not appropriately trained. Nine wards received recommendations on updating their policy on the use of restraint.

Procedures were in place for children to visit adult wards. However, inspectors considered that the current arrangements on each ward should be reviewed to ensure that child protection procedures are being consistently followed. Further staff training in child protection in both staff in adult and children's wards is required, and this was recognised by the trusts.

The arrangements for responding to safeguarding issues varied across trusts. While arrangements for working with other organisations were in place, the internal arrangements and communication with relatives requires improvement in relation to the types and levels of information provided to them. Both patients and relatives should be consulted and involved more in decisions about safeguarding and patient care.

Advocacy services were available to most patients and relatives; however, inspectors noted many wards did not actively promote the services to patients or relatives. 16 wards required recommendations in this regard.

RQIA wishes to thank the management and staff from the Health and Social Care Board, the health and social care trusts, and all the patients and relatives who agreed to be interviewed for their cooperation and contribution to this review.

3.2 Summary of Recommendations

1. The DHSSPS should prioritise the publication of the Adult Safeguarding Policy Framework to facilitate the release of the new Adult Safeguarding Policy and Procedures.

2. Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports.

3. Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.

4. Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).

5. Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards and ensure that this information is readily accessible to staff, patients, relatives and visitors.

6. Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.

7. Trusts should undertake a review to determine if all staff robustly adhere to safeguarding policies and procedures.

8. Trusts should ensure that comprehensive investigations and risk assessments are carried out when required by relevant staff.

9. Trusts should ensure that risk assessment training is provided for all staff.

10. Trusts should ensure that all staff receive training in relation to the complaints policy and procedure.

11. Trusts should ensure that the complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.

12. Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.

13. Trusts should ensure that all staff receive regular supervision and appraisal.

14. Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to all staff on the wards.

15. Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.

16. Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.

17. Trusts should ensure that only staff who are appropriately trained should employ intervention techniques.

18. Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.

19. Trusts should ensure that all staff have received the appropriate level of training in child protection.

20. Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.

21. Trusts should ensure that all staff receive training in records management.

22. Trusts should ensure that all staff adhere to the records management policy and procedures.

23. Trusts should ensure that a culture of inclusion of patients and relatives and transparency in communication across all wards.

24. Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.

25. Trusts should ensure that patients and relatives are fully communicated with, in relation to their care and incidents and accidents on the wards.

26. Trusts should ensure that patients and relatives on all wards have access to advocacy services.

Glossary of Terms

Belfast Health and Social Care Trust (Belfast Trust)

Child Protection Panel (CPP)

Department of Health, Social Services and Public Safety (DHSSPS)

Department of Justice (DoJ),

Health and Social Care (HSC)

Local Adult Safeguarding Partnership (LASP)

Mental Health and Learning Disability (MHLD)

Northern Ireland Adult Safeguarding Partnership (NIASP)

Northern Health and Social Care Trust's (Northern Trust)

Promoting Quality Care (PQC)

Regional Child Protection Committee (RCPC)

Regulation and Quality Improvement Authority (RQIA)

Safeguarding Board for Northern Ireland (SBNI)

South Eastern Health and Social Care Trust (South Eastern Trust)

Southern Health and Social Care Trust (Southern Trust)

Understanding the Needs of Children in Northern Ireland (UNOCINI)

Western Health and Social Care Trust (Western Trust)

APPENDIX 1 - Types of Agencies and Establishments Regulated by RQIA

- Adult Placement Agencies
- Children's Homes
- Day Care Settings
- Domiciliary Care Agencies
- Nursing Homes
- Residential Care Homes
- Residential Family Centres

APPENDIX 2 - List of Wards Inspected

Trust	Hospital	Ward
Belfast Trust	Mater Hospital	Ward L
	Foster Green Hospital	Beechcroft Adolescent Unit
	Foster Green Hospital	Beechcroft Children's Unit
	Muckamore Abbey Hospital	Iveagh Centre
	Muckamore Abbey Hospital	Greenan
	Muckamore Abbey Hospital	Cranfield ICU
	Muckamore Abbey Hospital	Moylena
	Muckamore Abbey Hospital	Finglass
	Knockbracken Healthcare Park	Avoca
	Knockbracken Healthcare Park	Valencia
Northern Trust	Causeway Hospital	Ross Thompson Unit
	Holywell Hospital	Inver 3
	Holywell Hospital	Carrick 4
	Holywell Hospital	Tardree 1
	Holywell Hospital	Inver 4
	Holywell Hospital	Lissan 1
South Eastern Trust	Lagan Valley Hospital	Ward 12
	Downe Hospital	Downe Acute
	Downshire Hospital	Ward 28
	Downshire Hospital	Ward 29
	Downe Hospital	Downe Dementia Ward
	Lagan Valley Hospital	Ward 11
Southern Trust	Longstone Hospital	Sperrin
	Longstone Hospital	Donard
	Longstone Hospital	Cherry Villa
	Longstone Hospital	Mourne
	St. Lukes Hospital	Gillis Memory Centre
Western Trust	Lakeview Hospital	Brooke Lodge
	Lakeview Hospital	Crannog
	Tyrone and Fermanagh Hospital	Ash
	Lakeview Hospital	Strule
	Waterside Hospital	Wards 1 and 3

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel: (028) 9051 7500
Fax: (028) 9051 7501
Email: info@rqia.org.uk
Web: www.rqia.org.uk

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Exhibit 50

The Regulation and Quality Improvement Authority

A Baseline Assessment and Review of Community Services for Adults with a Learning Disability

August 2013

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reports are submitted to the Minister for Health, Social Services and Public Safety and are available on the RQIA website at www.rqia.org.uk.

RQIA would sincerely thank everyone for their openness, honesty and their willingness to engage with us. We will continue our engagement during the second phase of this review, which is scheduled to commence in 2014/15.

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Executive Summary

RQIA, as part of the three year review programme, planned an initial baseline review of the composition and function of community learning disability teams. The review looked at the services provided across the five health and social care (HSC) trusts in Northern Ireland, both for adults with a learning disability and children with a disability.

This report sets out the position in relation to community services for adults with a learning disability. A separate report is available in relation to children with a disability.

In Northern Ireland there are approximately 26,500[1] people with a learning disability of whom about half are aged between 0-19 years[2]. People with a learning disability should be able to access a person centred, seamless community service, in the right place, at the right time and informed by the views of service users and carers.

The review team met with trust staff from community based teams, the Health and Social Care Board (HSC Board), the Department of Health, Social Services and Public Safety (DHSSPS), other voluntary and charitable bodies involved in providing services, and with a number of service users and their families.

The review team noted that trusts have reduced the need for hospital based care by progressing the resettlement of patients into more personalised services in the community. The slow rate of progress with resettlement into the community has been influenced by inadequate funding and competition with other programmes for access to additional investment in community care.

It was difficult to obtain clear and accurate financial data from trusts, in relation to expenditure on adult services, as staff often work across community teams working with both adults with a learning disability and children's disability services. In 2010-11 the five HSC trusts spent over £30million on the provision of both these services.

The review team commented on the variation in team structures across each trust and how individual professionals are deployed within teams. Several professionals continue to provide lifespan cradle to grave services to this specific client group, contrary to the national driver for a more integrated pattern of service delivery across primary care especially. The overall model of community services for adults was delivered mostly by teams of social workers and specialist community learning disability nurses, assisted by allied health professionals and clinical psychology staff.

[1] NB: Equal lives applied an incident rate of 1.5% to the overall population which includes a substantial number of children who may not seek HSC services, although they may seek services from education.
[2] Delivering the Bamford Vision, June 2009. DHSSPS. Actual figure, not published figure, from 2009, confirmed by DHSSPS on 29-07-2013

Four trusts had developed specialised services for managing challenging behaviour, and three had developed specialist teams to work with offenders, referred by the courts. There was limited evidence of a tiered model of intervention being delivered due, in large measure, to the blurring and duplication of roles and responsibilities of those employed in community services. The review team found that all of the trusts had relied on informal networking rather than using clear clinical pathways and well developed interfaces between services. There was evidence of the development and use of key performance indicators and outcome measures. These were developed mostly by smaller specialist teams, led either by clinical psychologists or speech and language therapists, to help assess the clinical effectiveness of their services.

Psychiatrists worked mostly in the learning disability hospitals. The review team found little evidence of psychiatrists working as full members of community based teams in any of the five trusts. The role of the consultant psychiatrist is largely restricted to a clinical role, rather than providing clinical leadership in developing or influencing assessment and treatment strategies in the community.

The review team found there was widespread exclusion of people with a learning disability from mental health services and services for older people. An almost total exclusion of people with a learning disability from newly established autism services within trusts was noted.

The review team found evidence of good practice in relation to the development of information packs by speech and language therapy staff, referred to as communication passports in the Belfast and South Eastern trusts. These contain important information about the person, such as their health and social care difficulties, likes and dislikes, and any medication they may be taking. They also assist hospital staff to provide better care for the person. Health facilitators were also appointed to organise health promotion screenings by GP practices.

There was evidence of some sharing of good practice between trusts in relation to supported housing options for people with a learning disability. The review team considered that it would be helpful if trusts could share learning from evaluations of new models of service provision in the community, of which there are a growing number of examples in Northern Ireland, as well as nationally.

The review team believes that the HSC Board should use this report to facilitate a better understanding of the needs of adults with learning disabilities and their families. They should ensure that the most suitable and equitable range of service provision is in place to meet current and future needs. There was limited evidence of the use of caseload weighting or benchmarking across the community teams. However, the Southern Trust has a new initiative in the early stages of development. All of the teams visited reported high levels of bureaucracy and crisis management.

The adult learning disability teams did not have clear measures in place to gauge the effectiveness of interventions with service users and carers, or consistent and tangible ways of obtaining service user or carer feedback. The review team noted a reliance on the recording of interventions, with less focus on outcomes for users and family carers. There was evidence of user engagement emerging across the five trusts. Some carers raised concerns about a lack of clear information about services and frustration caused by delays in accessing some services for example day care opportunities and respite care.

A reliance on inpatient care in specialist hospitals was evident, along with the lack of effective community based alternatives, such as extended hours of service, or home treatment services. This has resulted in consequential delays in the discharge of some patients.

The change in responsibility to the local commissioning groups (LCGs) provides an opportunity for focussing on prevention and ensuring safe and sustainable services, which respond effectively to population need. Moreover the new Learning Disability Service Framework[3], launched September 2012, (DHSSPS) builds on the work undertaken by the Bamford Review[4]. It sets out guidance on the core standards applicable to all trusts. Some critical decisions are required by the HSC Board in terms of when and how these standards can be fully implemented.

The future commissioning of services needs to be undertaken within a framework of formal evidence based practice guidance about the standards and outcomes, as set out in the DHSSPS Service Framework for Learning Disability. This development would help provide a context for rebalancing the existing workforce, as well as identifying priorities for investment.

All trusts continue to report unmet needs; for respite services; dementia services; home treatment; crisis response teams and advocacy services; as set out in the HSC Commissioning Framework. This report should be used by the HSC Board to inform future commissioning of services. At the time of the review, plans were only at an early stage in relation to the targeting of investment in additional community based services. The provision of funding by 2015 to meet hospital resettlement targets and the aging profile of family carers needs to continue to be prioritised by the HSC Board.

It is critical that the HSC Board ensures that information is gathered consistently about the clinical and social needs of adults with a learning disability. The HSC Board should also complete a profile of each trust, regarding the effectiveness and efficiency of service delivery which should include a review of staff roles and team working. The level of investment in workforce skills and management of clinical networks should be reviewed by HSC Board in order to ensure a more equitable service is delivered by community staff.

[3] Learning Disability Service Framework, September 2012. Belfast, DHSSPS.
[4] The Bamford Review of Mental Health and Learning Disability, 2007

The review team found it difficult to obtain a clear vision from trust staff about the best configuration of teams and structures to meet identified and future needs. Many of the challenges set out in this report are as a result of long-established cultures and practices. Each trust will require to develop effective partnerships coupled with determined leadership before sustainable transformation can emerge.

The review team acknowledge that a considerable number of changes and improvement may have occurred since April 2011.

1.0 Introduction

1.1 Background to the Review

The formal definition of people with a learning disability, Equal Lives (DHSSPS, 2005) is as follows:

"Learning disability includes the presence of a significantly reduced ability to understand new or complex information or to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning) which started before adulthood with a lasting effect on development."[5]

As a consequence, the individual is likely to experience difficulty in understanding new or complex information or learning new skills. The individual may also have difficulties with social and/or communication skills, with carrying out activities of daily living independently, and may have associated physical and sensory disabilities.

In Northern Ireland around 26,500 people have a learning disability, of whom about half are aged between 0 – 19 years[6] The Equal Lives report described the prevalence of learning disability in Northern Ireland as "difficult to secure" and asserted that the often quoted figure of around two per cent of the population is likely to reflect overall prevalence rather than service need. Less than four per cent of people with a learning disability are in hospitals, the majority live with family carers (66 per cent) and another 30 per cent in community-based accommodation (McConkey et al., 2003).[7]

People with learning disabilities are more likely to experience admission to acute hospitals than the general population. This is due to higher rates of, and vulnerability to, specific health conditions, increasing longevity, with the inevitable diseases of old age, for example dementia. It has also been projected that the number of people with a learning disability will increase by one per cent each year over the next 15 years, and that the number of children and older adults with complex physical health needs will both be large areas of growth (DHSSPS 2005)[5]. This is due to increasing life expectancy, advances in medical care, more mothers giving birth later, and increased survival rates of "at risk" infants due to improved healthcare.

Societal attitudes to learning disability have changed significantly in recent years. It is widely recognised that people with a learning disability have the right to live independently within the community, with meaningful choices in respect of their housing, care and support needs.

A stated objective of the Equal Lives report is to "secure improvements in the mental and physical health of people with a learning disability through developing access to high quality health services, that are as locally based as

[5] Equal Lives DHSSPS, 2005.
[6] Bamford Action Plan, DHSSPS, 2009
[7] McConkey et al 2003. Equality and Inequalities in Health and Social Care in Northern Ireland (DHSSPS 2004).

possible and responsive to the particular needs of people with a learning disability". This objective is underpinned by 14 recommendations for service improvements. Furthermore, specific legislation, including the Human Rights Act (1998)[8] and the Disability Discrimination Act (1995)[9] have highlighted the legal requirement to ensure equality, dignity and autonomy is afforded to service users. These statutes require that reasonable adjustments are made to ensure that services do not unlawfully discriminate against people with learning disabilities, and include the provision of accessible information.

Access to primary and secondary healthcare services for people with learning disabilities has been reflected in a number of reports and inquiries. National Patient Safety Agency (NPSA) (2004)[10] report, "Understanding the Patient Safety Issues for people with learning disabilities" highlighted that care of people with a learning disability in general hospitals was a major safety concern.

Within Northern Ireland a number of research projects such as Promoting Access[11] and Patient People[12], together with research specifically into access to accident and emergency services[13], have also identified major challenges in accessing general healthcare for people with learning disabilities.

The DHSSPS response to 'Delivering the Bamford Vision' (2008)[14] stated, "the Northern Ireland Executive accepts the thrust of the recommendations", and set out proposals to take the recommendations forward over the next 10 to 15 years. This envisages a model of community based care in which no one remains in hospital unnecessarily and people with a learning disability enjoy the maximum quality of life possible, consistent with their needs.

There have been a number of drivers for the modernisation, reform and restructuring of traditional models of community learning disability services. A traditional model of service provision consists of generic social service departments undertaking specialist functions with a range of services provided by social workers, nurses, psychologists and speech and language therapists.

Transforming Your Care (TYC) 2011[15] sets out a summary of key proposals, including a commitment to closing long stay institutions. TYC states that "By 2015, anyone with a learning disability is promptly and suitably treated in the community and no one remains unnecessarily in hospital."

[8] Human Rights Act, 1998
[9] Disability Discrimination Act, 1995
[10] The National Patient Safety Agency (NPSA), 2004
[11] Barr, O. (2004) Promoting Access: The experience of children and adults with learning disabilities and their families/carers who had contact with acute general hospitals in the WHSSB Area and the views of the nurses in these hospitals. A reported prepared for the WHSSB.
[12] Southern Health and Social Care Council (2008) Patient People: Experiences of adults with a learning disability as hospital in-patients in Craigavon Area Hospital and Daisy Hill Hospital. SHSCC, Lurgan.
[13] Sowney, M., Barr, O. (2007) The challenges for nurses within the accident and emergency care service communicating with and gaining valid consent from adults with intellectual disabilities. Journal of Clinical Nursing. 16 (9): 1678-1686
[14] Delivering the Bamford Vision DHSSPS, 2008.
[15] Transforming Your Care (A Review of Health and Social Care in Northern Ireland) DHSSPS, 2011.

This report presents a baseline assessment of the role and composition of community learning disability teams and teams for adults with a learning disability across the five trusts. It highlights the baseline level of investment in these services as at 1 April 2011. The review also provides information about access to and provision of learning disability services across community teams for adults with a learning disability and children with a disability (as at 1 April 2011). A separate report is available in respect of children with a disability. The adult report indicates the types of transitional arrangements in place for moving between adult services, the type of engagement and communication with service users and the information database systems in use. The report also provides information on unmet need for community services for adults with a learning disability.

1.2 Terms of Reference

The terms of reference for this review were agreed as follows. The review would be undertaken in two stages.

Phase 1 - (2011-12) a baseline assessment of teams for adults with a learning disability and children with a disability and service provision as at 1 April 2011.

Phase 2 - (2014-15) an assessment of the quality and effectiveness of trusts' Learning Disability Services for adults, against the DHSSPS's Learning Disability Service Framework.

The review excluded services that are currently regulated by RQIA, as outlined in the list below:

- Adult Placement Agencies
- Day Care Settings
- Domiciliary Care Agencies
- Supported Living Services
- Independent Hospitals
- Nursing Agencies
- Nursing Homes
- Residential Care Homes
- Independent Clinics

1.3 Membership of The Review Team

Ashok Roy	-	Consultant Psychiatrist, Coventry and Warwickshire Partnership Trust
Theresa Nixon	-	Director of Mental Health, Learning Disability and Social Work, RQIA
Patrick Convery	-	Head of Mental Health and Learning Disability, RQIA
Audrey Murphy	-	Inspector, Learning Disability, RQIA
Jill Munce	-	Complaints Manager, RQIA
David Philpot	-	Project Manager, RQIA
Janine Campbell	-	Project Administrator, RQIA
Professor Roy McConkey	-	Advisor to the Project Organisational Team

1.4 Methodology

All five HSC trusts were asked to complete a self-assessment questionnaire to provide information on the:

- role and compositon of learning disability community services for adults
- profile of staff and the level of investment in the community teams
- provision of learning disability services, across community teams for adults with a learning disability (as at 1 April 2011)
- information database systems
- carers' assessment and direct payments
- engagement and communication with service users
- transitional arrangements between children and adult learning disability services
- information on unmet need for community services for adults with a learning disability.

For each trust, RQIA met with a team providing front line services. A second team was asked to evidence models of current good practice.

Validation visits were made to each of the five trusts. Meetings were held with members for staff who provided adult learning disability services, and presentations were made by the teams (chosen either by their specialty or locality).

The review team also met with representatives of the HSC Board with lead responsibility of learning disability services, and with the DHSSPS.

Meetings were held by the review team with service users and their families before, during and after the visits to trusts to obtain their views about service provision.

2.0 Role and Composition of Community Learning Disability Teams and Profile of Investment in Staff across the Five Trusts

The Equal Lives report[16] (DHSSPS, 2005) of the Bamford Review observed: "The concept of a Community Learning Disability Team has been a feature of learning disability services in the UK since the 1970s. Traditional models of service delivery have consisted of generic social services departments undertaking specialist functions and providing a range of health and social services.

The form and function of these teams varies widely and there has been very little research undertaken into the effectiveness of the various models, despite the fact that they are an expensive component of health and social services provision"

Since the previous DHSSPS review of learning disability services[17] in 1995, community services for those with a learning disability have evolved in response to changes in policy, legislation and identified needs.

The HSC Board, in its Commissioning Plan 2011-12[18], set out an expectation that community learning disability teams will provide community based assessment and treatment services, comprising of psychiatry, learning disability nursing, allied health professionals (AHP) and social work inputs. The HSC Board Commissioning Plan also sets out targets with regard to the resettlement of patients currently in long-stay hospital placements.

The aims and scope of community learning disability services are as follows:

- to support individuals with a learning disability
- to support the carers of individuals with a learning disability
- to support staff and other carers involved in the lives of individuals with a learning disability
- to provide information and support to the wider community, including primary care professionals

As part of the RQIA review, health and social care trusts were asked to describe their current community teams, outlining their core functions, the type of services provided, and management/leadership arrangements. Table A2 in Appendix 2 provides a summary of the responses received. A number of different structures exist for adult learning disability teams, with evidence of collaborative working.

The review team noted that the structure of community teams providing services to people with a learning disability is changing across Northern Ireland. These changes have occurred in the context of the Review of Public

[16] Equal Lives, DHSSPS, 2005
[17] Review of Policy for people with a Learning Disability in Northern Ireland. Belfast: DHSS, 1995
[18] HSC Board Public Health Agency Commissioning Plan 2011-12. November 2011

Administration (RPA), resulting in mergers of trusts and reorganisation of service provision.

All trusts, at the time of the review, had maintained the teams which existed within the former legacy trusts, consisting mostly of social workers and learning disability nurses, with occupational therapists included as part of the teams in the Belfast, Northern and Southern trusts.

Four trusts had created challenging behaviour teams and three - the Belfast, Southern and Northern trusts, provided a specialist forensic team who work with people with a learning disability referred by the court.

The review team found that community learning disability services for adults fulfil a number of functions in relation to facilitating access to a range of services, from primary care through to the provision of highly specialised care. Service users should be able to step up or step down the care pathway according to their changing needs and in response to treatment. A stepped care model would normally consist of 1 to 4 tiers. Tier 1 services would provide the least intervention, tiers 2 and 3 providing more specialist community assessments and interventions, and tier 4 providing inpatient assessment and treatment services.

The review team noted various initiatives had taken place to develop a stepped care model of provision. However, this type of service model was not always clearly understood by staff. Transforming Your Care (DHSSPS, 2011) makes a number of recommendations in relation to the quality and accessibility of services for individuals with a learning disability in the community and states “tangible services on the ground are the touchstone by which those using the service judge its success”[19]. During the review a number of families described community services as fragmented. Some families reported having inputs from a variety of team members but did not always understand the role, task and function of the different team members.

The review team considered that trusts have a considerable way to go to ensure that the service improvements required under Transforming Your Care are fully achieved.

2.1 Profile of Investment in Staff Teams for Adults with a Learning Disability

Information was requested on the numbers of staff in post at 1 April 2011 for each grade within the various disciplines; along with the total gross salary costs (inclusive of employer’s costs) (see Table 1).

[19] Transforming Your Care (A Review of Health and Social Care in Northern Ireland) DHSSPS, 2011.

Table 1: The Total Amount of Funding across Staff Disciplines in 2010-2011 in Community Teams for Adults with a Learning Disability across the Five HSC Trusts

Discipline	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	Northern Ireland Total
Social workers and care management[1]	£1,288,000	£1,320,268	£893,600	£1,115,000	£728,000	£5,344,868
Community LD Nursing and Health Facilitators	£290,000	£722,292	£413,000	£650,000	£426,000	£2,501,292
Occupational Therapy	£118,000	£323,500	£83,000	£355,000	£52,000	£931,500
Speech and Language Therapy	£180,000	£252,000	£251,000	£216,000	£83,000	£982,000
Physiotherapy	£121,000	£245,000	£49,000	£183,000	£79,708	£677,708
Clinical Psychology	£115,000	£215,800	£234,000[4]	£141,789[4]	£70,500[4]	£824,352
Challenging Behaviour Services	£342,000	£391,889	£129,000[4]	£177,117[4]	£133,500[4]	£1,232,545
Psychiatry	£139,000	Not supplied	(£158,000)[3]	£106,785[4]	£218,000	£499,380[5]
Other specialist services[2]	£250,227	£99,000	-	£174,920	-	£524,147
Community support workers	£128,000	Included in Social Work	-	£293,899	-	£421,899
Management and Administration	£254,487	£133,477	£118,297	£144,084	£189,554	£839,899
Total reported by trust	**£3,225,714**	**£3,703,226**	**£2,170,987**	**£3,557,594**	**£1,980,262**	**£14,637,693**

A blank cell indicates that the trust made no report but it does not necessarily mean that no service of that type is provided. (Details of whole time equivalent (WTE) staffing is contained in Appendix 1 of this report)

[1] Social work costs includes team leaders and care management. Some trusts reported separately on these categories of staff.
[2] Certain trusts had developed other specialist services such as forensic psychology and for mental health and learning disability.
[3] The South Eastern Trust provided this as an estimate although the budget is with the Belfast Trust through Muckamore Abbey Hospital. (This arrangement also applies to the Northern Trust although no estimate of costs was provided). This amount is not included in the trust's total costs.
[4] For the South Eastern Trust and the Western Trust these costs have been apportioned 50/50 with Children's services and in the Southern Trust the apportionment is 75% adult: 25% children. However, the monies may sit within one budget within the trust.
[5] These costs would rise to £821,725 if the estimate cost for South Eastern Trust is included in the total and a pro rata amount of the average costs across four trusts in added in for the Northern Trust.

Figure 1: The Percentage Total Spend on Professionals Providing Community Services for Adults with a Learning Disability across the Five HSC Trusts

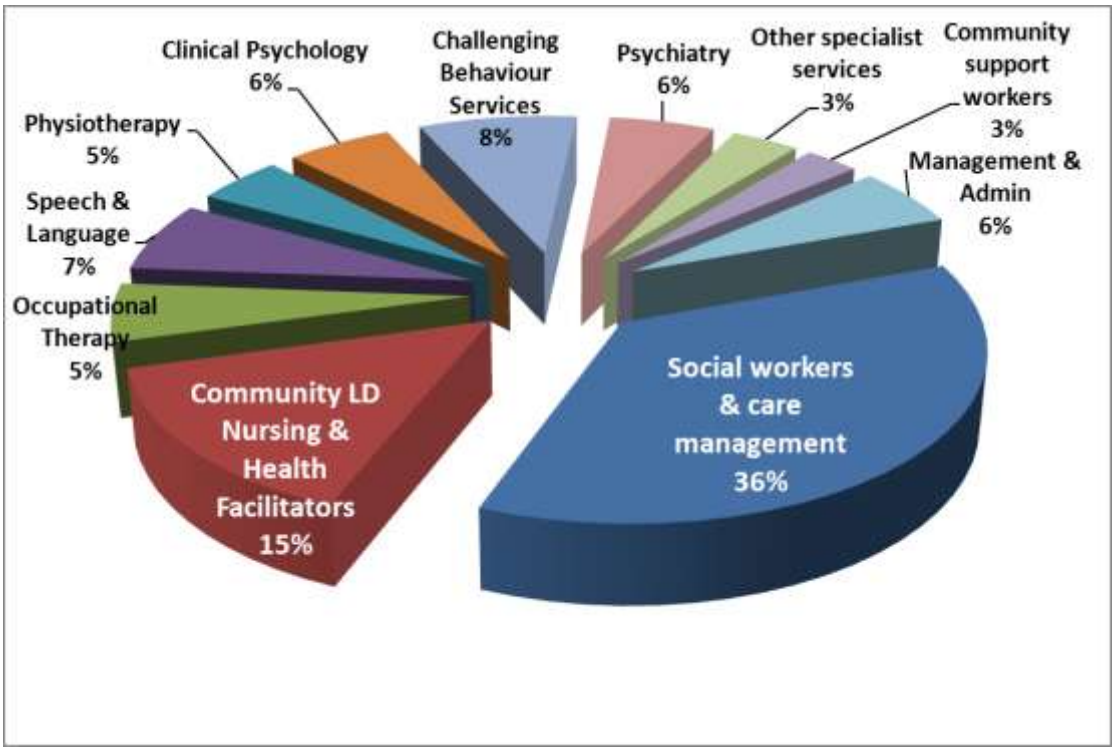

Figure 1 illustrates the percentage of total spend by discipline for Northern Ireland as a whole. (NB the costs for psychiatry have been calculated on a pro rata basis across the five trusts). This indicates that social workers accounted for over one third of the spend, followed by community learning disability nursing at 14 per cent. The three allied health professional therapists along with clinical psychology and challenging behaviour services, account for a further 33 per cent, with four per cent is spent on other specialist services and community support workers. The psychiatry costs, at three per cent, may be an underestimate of the amount expended in direct community services, as a component may be included within specialist hospital costings. Likewise, the management costs (at six per cent) are related to the direct management and administration costs of community services and do not include other support service such as human resources and finance.

2.2 Comparisons across the Trusts

Spending on services for adults with a learning disability across the five HSC trusts was calculated as an amount per adult (aged 20 to 64 years inclusive) within the overall trust population (see Appendix 2 Table A3). The adult populations are the actual numbers from census data and are not weighted populations based on deprivation indices. These calculations are based on 2010 mid-year estimates.

Table A3 in Appendix 2 illustrates the variation in terms of gross expenditure by disciplines within trusts. The total per capita spend on adult learning disability services is highest in the Southern and Belfast Trusts and lowest in the South Eastern Trust.

The review team made the following observations from the analysis of this data:

- The Belfast Trust spends proportionately more on social workers and care managers per head of population, whereas the Southern Trust concentrated its investment more heavily in community nursing staff with a learning disability specialism or community learning disability nurses.
- All of the trusts spend more on social work and nursing staff than all the other disciplines combined.
- The South Eastern Trust had a higher spend on speech and language therapy services per head of adult population than other trusts, nearly three times more per capita than the Western Trust, which had the least expenditure on speech and language therapy services to support adults with communication needs.
- Trust expenditure on occupational therapy funding was variable, with the Western Trust at less than half of the Belfast Trust and less than a fifth of that spent by the Southern Trust.
- The Belfast and Northern trusts spend significantly more on challenging behaviour services, with the South Eastern Trust spending least on this service, although this is compensated by a higher spend on clinical psychology which is highest in the South Eastern Trust and lowest in the Western and Northern trusts.

These calculations can be further refined by considering the distribution of adults with a learning disability reported by the trusts to be in receipt of services from community teams in 2010-11. This is given in Table 2 along with the percentage of the overall adult population (aged 20 to 64 years inclusive). The table also gives the total per capita spend for each person with a learning disability reported by the trust to have received services.

Table2: The Number of Adults in Receipt of Services from Community Learning Disability Teams in 2010-11 and the Total per Capita Spend per Person.

	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	Northern Ireland Total
Number of adult persons with a learning disability	1609	1989	1551	1660	1156[1]	7965
Adult population of trust	198,119	268,698	203,794	210,587	176,799	1,057,997
Number of persons with LD per 1,000	8.12	7.4	7.61	7.88	6.54	7.53
Total spend on LD	£3,225,714	£3,703,226	£2,170,897	£3,557,594	£1,980,262	£14,637,693
Per capita spend for persons with LD	£2,004	£1,862	£1,400	£2,143	£1,713	£1,838

[1] An additional 104 cases were known to the trust but were unallocated. If included in the total this would bring the rate per 1,000 to 7.13.

Table 2 denotes the range and variation between trusts in terms of the expenditure per capita for each person with a learning disability. The Belfast Trust provides a service to the highest number of individuals per capita; 25 per cent more than the Western Trust with the lowest ratio of 6.54 persons. It is unlikely the differential is explained by a higher prevalence of learning disability in the population of the Belfast Trust. This is more likely due to variations in the criteria used by trusts in assessing a person as having a learning disability and in the availability of access to these services, especially as the Western Trust reported knowing of around 1,700 adults with a learning disability in their area.

Moreover, there is marked variation in the average spend per person with learning disability across the five trusts, with over a 50 per cent difference between the South Eastern Trust (with the lowest spend) and the Southern Trust (the highest spend).

2.3 Structure of Community Learning Disability Teams - Adults: Model of Service Delivery and Outcome Measures

Each trust was asked for a range of information in relation to:

- the profile of its adult learning disability service
- referral criteria
- information database systems in place, and how they evaluated effectiveness
- information about carers' assessments and direct payments
- engagement with service users
- information on models of good practice
- unmet need
- specific challenges facing the services.

The review team noted that the existing community support teams for adults with a learning disability deliver a traditional model of service provision. Adults with a learning disability receive services provided by community nurses and social workers for learning disability, combined with services from allied health professionals and psychologists. The review team found no evidence of a tiered model of service provision similar to CAMHS, offering services such as crisis response or home treatment teams. Services were, in the main, delivered on a weekday basis.

2.3.1 Belfast Health and Social Care Trust

The Belfast Trust has four community learning disability teams (in North, South, East and West Belfast), which offer assessment and intervention to people with a learning disability and advice and support to their carers. The teams have a key responsibility in coordinating care planning and they sign-post people to appropriate services. In addition, the trust has a forensic service to support community teams to work effectively with people with offending behaviours and a specialist behaviour support service (PROMOTE) for people with learning disabilities and diagnosed mental health needs.

The review team met with the West and South Belfast community learning disability teams. Both teams comprised of social workers, community learning disability nurses and an assistant care manager. There were no occupational therapy and physiotherapy team members present; they are not part of the core team but are attached to the teams and located with them. The teams reported individual caseloads of 48 - 50 service users, and an increase in referrals was noted.

Referrals by Source and Access Criteria

Referrals to adult services may be made from schools, children's services, and from primary care services. Referral criteria are set by the trust's learning disability psychology services. All new referrals are assessed against eligibility criteria. Once deemed eligible for services, all referrals are allocated to a community team member for an initial assessment, which involves

service users and carers as appropriate. Multidisciplinary inputs are sought, as noted in the care plan. Caseloads were reported to range from 30 to 70 service users but there was no reported caseload weighting system and few case closures, reflecting a long term commitment of service provision for families. Adults requiring palliative care receive this in accordance with the trust's end of life care strategy. A learning disability carer representative was on the trust's palliative care steering group.

The trust has arrangements for responding to out-of-hours contacts, including a case alert system.

The teams reported good links with the trust's forensic services. There were less well developed links with mental health services; in particular, mental health crisis response services do not become involved with individuals with a learning disability. The review team noted that there was no clear plan to develop a stepped care model of intervention, with no crisis response provision available to individuals living in the community. People with a learning disability are largely excluded from mental health services for adults.

Psychiatry input is provided by three psychiatrists across three localities, covering children and adult services (combined total of 0.9 whole time equivalent). Concerns were raised by the trust staff in relation to the resettlement of patients without the transfer of funding for a community psychiatric service from Muckamore Abbey Hospital.

Staff reported a need for more forensic psychology and forensic psychiatry services for dealing with patients with offending histories.

Information Database Systems

The trust described a range of electronic systems for recording service user information. A range of disciplines were reported to have access to these systems. The trust reported limitations in relation to SOSCARE[20]. The PARIS[21] information database was reported to provide trust staff with current information quickly and accurately, and to promote better information flows between disciplines.

Evaluation of Service Effectiveness

The trust stated that service evaluation is undertaken on a case by case basis, and through the process of supervision and audit.

Carers' Assessment and Direct Payments

The trust reported that 297 carers had been advised of their right to a carer's assessment and that carers are routinely advised of this right at the point of

[20] SOSCARE: Social Services Client Information System
[21] PARIS: Patient Record Information System in the Belfast Trust

referral, at first assessment and reassessment points. The trust reported that this is monitored through staff supervision and audits of files.

The trust reported that 243 carers had requested an assessment of their carer's needs over the preceding 12 month period and that 265 people with a learning disability over 18 years received an assessment of their needs during this period. The trust reported that 102 carers received an assessment and a care package in respect of their identified needs.

There were only 71 adults with a learning disability receiving direct payments at the time of the review. This figure is low in relation to the adult learning disability population of the trust (four per cent of adults with a learning disability known to the trust).

Engagement with Service Users

The trust reported that service users' views are captured using different methods, including invitations to carers to attend senior trust management meetings on occasions. Workshops are organised by the trust for service users and carers, carer support groups are in place and, service users are involved in drawing up their care plans. Efforts are being made to provide information in a user friendly accessible format.

The trust reported that accessible documentation is being developed by behaviour support services and speech and language therapy teams. Community teams have developed information packs in relation to a wide range of services and the trust has engaged with a TILII (Telling it Like it is) group in the design of a 'Lost for Words' service for individuals with communication needs.

Model of Good Practice

An area of good practice in the South Eastern and the Belfast trusts was the development of information packs by speech and language therapy staff referred to as communication passports. These passports provide essential information for community care staff, secondary healthcare staff and acute hospital services. These were reported by service users and carers to have been beneficial.

The review team met with the trust's specialist PROMOTE team which was described as the only team of its kind in Northern Ireland. This team was established in 2005, led by a clinical psychologist to provide services for persons with a diagnosis of learning disability and mental health. There are inputs from speech and language therapy, psychiatry and therapeutic input from a social worker. The team's rationale is to address the prevalent mental health needs in the learning disability population. The PROMOTE team was described as part of a stepped care model (tier 3) and works alongside services for challenging behaviour and forensic services.

The review team was advised of the links between the community teams and the specialist PROMOTE team. Prior to the development of the PROMOTE team, it was reported that service users would receive mental health input from community learning disability team members who were skilled in this area.

The community teams act as the first point of contact and referrals are screened at weekly referral meetings. At the time of the review the PROMOTE service was in receipt of two new referrals per week and there were 80 - 100 service users known to the team.

The review team was advised of links between mainstream mental health services, the PROMOTE team, and of links with dementia services. It was acknowledged by PROMOTE team members that the trust's operational policies do not facilitate integration across mental health and learning disability services.

The PROMOTE team reported measuring effectiveness against an adult wellbeing scale, where service users are asked to identify objectives for improvement in their wellbeing goals. However, the review team noted there was no quality of life or engagement outcome measures developed within the service.

The review team considered that the PROMOTE team provided helpful training programmes to independent and residential sector staff and noted that the team often have to provide outreach services to individuals placed outside trust boundaries.

The link between tier 3 and tier 4 services was discussed. The PROMOTE team reported their role in the prevention of unnecessary hospital admissions. The service is operational during office hours. However there were no arrangements in place for out-of-hours support. Team members attend monthly resettlement meetings with hospital staff to review admissions, the times patients are admitted and any service failures.

The review team considered that further clarity is required in the provision of tier 3 and tier 4 services.

It was difficult to establish evidence of the psychiatrists acting as full members of the community teams, apart from their clinical role. The review team expected that consultant psychiatrists would be providing clinical leadership in developing and influencing a tiered model of service delivery, but found they were operating more at a day to day operational level with patients in hospital or in the community.

There was a lack of clarity about the vision for the infrastructure required for resettlement of people in the community by 2015, or of the specialist seven day week services that are required. There was also little evidence of outcome measurements being used to assess clinical effectiveness, of the

efficiency of teams, or services, with the exception of the PROMOTE behaviour support services.

Challenges Facing the Service

The requirements to respond to the growing numbers of service users known to teams, and maintaining the constant level of staffing presents a challenge to the trust, as does the increase in safeguarding vulnerable adult referrals. Other challenges noted by the trust were the timely availability and funding of community based packages of care, accommodation for young people with complex needs, and the planning for the resettlement of hospital patients to the community.

2.3.2 Northern Health and Social Care Trust

The Northern Trust had the highest population of adults with a learning disability (1,989) at the time of this review. Spend per person with a learning disability was just above the Northern Ireland average. The Northern Trust had the least expenditure on administration and management; less than half of the expenditure in this area, compared to the Belfast and Western trusts.

The review team met with the Magherafelt Locality Team which comprised social work, nursing, occupational therapist, forensic practitioner, clinical psychology, behaviour planner and a safeguarding officer. The trust reported that the community learning disability teams for adults were in transition. At the time of the review the traditional locality model of service delivery, consisting of generic social services departments undertaking specialist functions, was under review.

The adult learning disability community services are provided by three integrated specialist multidisciplinary teams which currently compromise social work, occupational therapy and nursing. Those teams have close links with other specialist professional teams, including psychiatry, psychology, speech and language therapy and physiotherapy. Older service users with a learning disability do not transfer to older persons services. However there are some informal arrangements in place in each locality to work with colleagues in the older persons' programme of care, where the person is assessed as requiring domiciliary care or other specialist resources. On a regional basis there is a drive to encourage this development by the HSC Board. There was no evidence of opportunities for knowledge/skills transfer between mental health and learning disability staff to enable them to deliver services in an integrated manner.

The review team met with a large community team, which comprised nurses, social workers, psychology, speech and language and an occupational therapist. Investment in community nursing was below average, but there was a significantly higher expenditure noted on clinical psychology services.

The community forensic mental health and learning disability multidisciplinary team supports the transition of adults with a learning disability from secure service provision to the community accommodation. In addition, an adult autism spectrum disorder (ASD) link service has been provided for older adolescents and adults with a diagnosis of ASD.

Referrals by Source and Access Criteria

The trust reported the main sources of referrals as coming from schools, primary care services, psychiatrists as well as self-referrals. All new referrals are allocated to a social worker who will arrange assessments and care planning, as required.

Information Database Systems

Northern Trust makes use of a range of electronic systems to record client information. These include SOSCARE, LCID[22] and a number of standalone, unidisciplinary systems. The trust acknowledged limitations with regard to SOSCARE, particularly in relation to the sharing of information across disciplines and recording of specific conditions. LCID was reported to be used by nursing and speech and language therapists.

Evaluation of Service Effectiveness

The Northern Trust reported positively on face-to-face contact with service users. Services are evaluated by seeking views from service users, and from complaints highlighted at its Governance Audit and Effectiveness Committee. Other methods of monitoring effectiveness include performance management, audits, supervision, and monitoring of waiting lists. There was no evidence of the trust having developed key performance indicators (KPIs) to measure effectiveness.

Carers' Assessment and Direct Payments

The Northern Trust advised that all carers of adults with a learning disability have been advised of their right to a carers' assessment. The trust reported the use of Northern Ireland Single Assessment Tool (NISAT) and social work assessment documentation to record needs.

In adult services, outcomes are monitored during professional supervision sessions. Information about carers' assessments are collated across the trust on a quarterly basis and in the annual discharge of statutory functions report for the HSC Board.

The trust reported that 73 carers' assessments were requested during the 12 month period prior to the review (April 2010 - March 2011). Fifty carers' assessments were undertaken during this period.

The trust reported that 55 service users were in receipt of direct payments, (three per cent of those adults with a learning disability known to the trust). On 9 January 2012, the trusts reported that due to the Girvan judgement[23] about gaps in direct payments, there had been no new direct payments made to service users who lack capacity. The trust retains a waiting list of those assessed who require direct payments.

Engagement with Service Users

The Northern Trust outlined the practice of involving service users in the assessment process and in care planning. The trust had engaged

[22] LCID; Local Community Information Development Database
[23] Gap in care payments legislation. http://www.courtsni.gov.uk. 7 March 2011

independent advocacy services, in particular for individuals being resettled from long stay hospitals.

The trust reported having little written information available to service users to outline the role specifically of community learning disability teams. The trust has however developed a range of products which include CDs and leaflets to provide information on complaints/comments, direct payments and day opportunities. There are also leaflets about supported living, adult placement and respite care. Information on the trust website and a range of referral forms provide contact details for specialist services. Some disciplines have been involved in educating acute service providers on the needs of individuals with a learning disability, e.g. accident and emergency staff. The trust acknowledged that this is an area requiring further improvement.

Model of Good Practice

The Adult Challenging Behaviour Service (ACBS) is managed and clinically led by a consultant clinical psychologist. This team offers behaviour intervention, advice, consultation and training for staff in the management of challenging behaviour.

Challenges Facing the Service

Challenges include the need to demonstrate efficiency savings, demographic changes in relation to prevalence of learning disability and other conditions, including dementia, service users living longer and individuals with complex needs. Ageing carers; meeting resettlement targets; higher expectations from service users and carers in relation to day service provision was also a significant challenge. The Home Treatment and Crisis Response Team available to those in mainstream mental health services, 24 hours per day, is not available to adults with a learning disability. Access to an intervention diversion bed in a community facility would assist in the prevention of hospital admissions for adults with learning disabilities. This service was available previously and has since been withdrawn.

2.3.3 South Eastern Health and Social Care Trust

The South Eastern Health and Social Care Trust had recorded a population of 1,551 adults with a learning disability receiving services at the time of the review.

There are three adult teams for learning disability which cover the Down, Lisburn and North Down/Ards area. Each multidisciplinary team provides an assessment, care planning and support service. A behaviour support service provides assessments, intervention and support to people with challenging behaviour, both adults and children. The review team met a large community learning disability team based at Thompson House, Lisburn. The team includes a team leader, social workers, assistant care manager and community learning disability nurses. The resettlement manager, lead clinical speech and language therapist, and epilepsy nurse specialist are trust wide posts. There is a health facilitator whose role focuses on the development of General Practitioner led services for persons with a learning disability. The team reported not having access to appropriately trained sensory integration staff. The health promotion message is reinforced by an enhanced service with GPs; Healthwise scheme; links with councils in relation to keep fit; aerobics; 'Health for Life' programme and a 'Cook It' programme. The learning disability service has a health development forum and there are audits of health development activity and training of staff. Partnership arrangements are in place with the Family Planning Association in relation to sexual health.

The trust is involved in a community integration project which aims to support 30 patients who will be resettled from long stay hospitals. The team reported good links with community groups and the development of health passports to facilitate better access to mainstream services. The team is co-located with the trust's behaviour support team which is helpful for staff communication.

Palliative care arrangements offered to people with a learning disability are similar to those provided to the general population and consist of GP, district nursing and AHP input. Additional support is available from community learning disability nursing and psychology services, as required.

Referrals by Source and Access Criteria

Referral sources are mainly from children's services and from other trust professionals. The speech and language therapy team and other allied health professionals may receive referrals from families and other services. Criteria used for access to services include use of ICD-10[24] and DSM IV[25] Referrals are allocated by locality, following case load weighting. An out-of-hours arrangement is available through Emergency Duty Team (EDT), which provides the services of an approved social worker (ASW), as required.

[24] ICD-10 10th revision of the International Statistical Classification of Diseases
[25] DSM IV Diagnostic and Statistical Manual of Mental Disorders 4th ed.

The review team also met the trust's behaviour support service which covers the whole catchment area. The team is nurse led and delivers services alongside psychology, with input from consultant psychiatry as required. Most referrals come from social workers as well as schools. Eligibility criteria for the service include aspects of Emerson's definition of challenging behaviour: "culturally abnormal behaviour(s) of such intensity, frequency or duration, that the physical safety of the person or others is placed in serious jeopardy, or behavior which is likely to seriously limit or deny access to the use of community facilities".[26]

While team members do not take on key worker responsibilities they reported undertaking a key worker role. It was reported that most contacts with the service were short term. The team reported having an educational role within day and respite services, and a role within resettlement planning in the hospital setting. Outcome measures were described by the team in the context of the reduction in frequency, duration and intensity of challenging behaviours.

The behaviour support service is operational during office hours. While a pilot has been undertaken to extend these hours, there were no plans to fully implement this arrangement. The trust indicated that the future configuration of the service will involve significant change to meet complex needs. The trust reported that a senior manager has been appointed to take forward the development of a complex needs service. Part of this work will be to develop opportunities for delivery of new community support services. Staff referenced a high number of people with autism on caseloads.

The review team considered that, in general, community staff are continuing to provide a traditional model of service delivery. Service users with a learning disability are currently unable to access mainstream mental health or services for older people. The review team would encourage the trust to move towards a care pathway model of intervention involving the development of step up / step down services. A resettlement post has been funded to provide the team with the opportunity to engage with hospital services to profile service user needs, inform service planning, and enable a person centred approach to resettlement from long stay hospitals to the community. This helps to improve user's experiences by shaping the care pathway. This in turn informs service development.

There were no waiting lists for services at the time of the review.

Information Database Systems

The South Eastern Trust reported the use of a number of electronic systems to record client information. These included SOSCARE, LCID, Trojan[27] and Microsoft Office programmes. A range of professionals and administrative staff are involved in the use of these systems. The trust outlined a number of

[26] Emerson, E. (1995) Challenging Behaviour. Analysis and Intervention in People with Learning Difficulties. Cambridge.
[27] An electronic systems to record client information

advantages and disadvantages associated with each system and made suggestions for improvements, including adding new fields to SOSCARE to capture more information. The trust reported a lack of uniformity across systems since legacy trusts merged in 2007. The review team considered that all trusts need to be able to link with each other. Further training is required for relevant staff using the systems.

Evaluation of Service Effectiveness

Outcomes are evaluated through service user engagement groups– e.g. Telling It Like It Is (TILII) group, service users' reviews, team action plans, team meetings; supervision; service level agreements; audit activity; and a reduction in recorded incidents and complaints.

The trust agreed that further work is required to develop effective outcome measures with service users.

Carers' Assessment and Direct Payments

The trust did not specify the breakdown between children and adult services.

In the period prior to the review, (April 2010 to 31 March 2011) the trust identified that 117 carers' assessments were offered and 75 completed. The trust reported that 206 carers have received services or a care package in respect of their assessed needs.

The trust reported that staff routinely advise carers of their right to a carer's assessment. This is monitored through supervision of staff. Respite care services are not allocated without a carer's assessment being completed.

The trust reported that 55 adults were in receipt of direct payments during the reporting period (9 January 2012) (four per cent of those with a learning disability known to the trust). The uptake of direct payments is still low for adults with a learning disability.

Effectiveness of direct payment is evaluated through supervision, complaints and adverse incident reviews, the use of the trust risk register, feedback from service users and carers, and staff, and through the audit of individualised management plans. The team reported using feedback from service users as an indicator of carer satisfaction. The trust has a range of formal measures for evaluating outcomes, including service level agreement contract reviews, which are convened quarterly. The trust completes a balanced scorecard, reports monthly on vulnerable adult activity, carers' assessments and direct payments.

Engagement with Service Users

Information available to adults with a learning disability and their carer's disability is limited. Front line staff at the point of assessment provide information. The trust reported on the development of service leaflets and advised that information is available on the trust's website, on direct

payments, complaints, compliments and comments. The trust reported positively on close links with a carers' forum in the Lisburn area and of the skills of learning disability team members in communicating with service users. The trust also reported on the development of software packages to promote the provision of information and service plans for service users. The trust has implemented essential lifestyle planning principles in the preparation of person centred plans with service users, who are encouraged to sign their plan and are provided with a copy.

The trust outlined a number of methods for consulting and involving service users in the design of community services. Examples included a peer advocacy and training group Telling It Like It Is (TILII), a carers' forum, individual advocacy service (Bryson House), person centred reviews and service user forums.

The trust reported holding a number of public meetings in relation to the modernisation of adult disability services and a number of meetings with carers to discuss future planned changes in service delivery.

Models of Best Practice

A number of steering groups with representatives, including adults with learning disability, were referenced, and an example of the reconfiguration of a day care service was cited as an example of innovation. The trust has also engaged with University of Ulster at Jordanstown and service users to promote the Bamford principles in their design of supported living services.

Challenges Facing the Service

The South Eastern Trust reported that funding challenges are impacting on the effectiveness of the delivery of adult services for respite care. There is a lack of specialist accommodation for individuals with complex needs, including forensic needs. Other challenges included the cost of transport, staffing resources within facilities and inequalities of access to day services.

The learning disability community teams continue to face problems in accessing mainstream services, particularly mental health services for adults with a learning disability and difficulties in developing partnership working between adult learning disability services and other mental health services, for example older people.

The trust reported a lack of community infrastructure to address the range of needs of individuals with learning disability, including meeting the forensic needs of people who have committed offences. The management of challenging behaviour and complex health needs, without step up / step down beds to avert inappropriate hospital admissions and facilitate earlier hospital discharges presents a challenge. Other challenges include demographics, ageing service users and carers, increased activity in adult safeguarding, variation in quality of trust commissioned services, with limited availability of specialist services outside of the trust.

2.3.4 Southern Health and Social Care Trust

The Southern Trust has the second highest number of adults with a learning disability (1,660) and has the highest expenditure on community learning disability services for adults in Northern Ireland.

The Southern Trust reported having three learning disability teams for adults that cover the areas of Newry and Mourne, Armagh and Dungannon and Craigavon/Banbridge. There is also a specialist service which offers a range of tertiary and support services.

The review team met members of the trust's specialist autism team. The trust reported having links and informal service level agreements with the South Eastern Education and Library Board. The trust operate in accordance with Regional Autism Spectrum Disorder Network and stated they measure effectiveness by consultation with carers and service users, and by monitoring readmission rates to hospital.

The review team met with one of the trust's community teams for adults with a learning disability (Newry and Mourne). The team consists of a team leader, social workers, nursing and care management staff, based within one office. Team members reported that sharing a base helps to enhance collaborative working and communication. Team members' caseloads were estimated to be in the region of 55 for social workers and 100 for care managers. The team was described as an 'integrated team' with easy access to allied health professionals. The team refers individuals to the behaviour support team and psychology services, as necessary, and can access inpatient services through consultation with psychiatry. The team reported involvement in discharge planning from hospital and attendance at ward based meetings.

The trust reported that service users have a designated key worker and there is a single point of entry into the service, and all newly referred individuals have a comprehensive assessment. Care plans and individual cases are reviewed on an annual basis. Community learning disability services are not provided out-of-hours.

The trust reported 10 – 15 adults with a learning disability who are parents of children under the age of 16. The trust indicated that joint working between adult and children's services is undertaken where there are recognised child support/safeguarding needs.

Health promotion is undertaken by two health facilitators who work alongside general practitioners. A health screening tool is drawn up for each service user, with an annual review of health needs undertaken. Other agencies involved in health promotion include community access officers who promote projects such as the Healthy Minds programme and have funding applications prepared for the PHA Investing for Health programme. Fit Futures[28] and FIT

[28] Fit Futures, Investing for Health DHSSPS, 2006

4 U[29] programmes have also been undertaken. The trust has developed guidelines for staff working in the area of sexual health with individuals with learning disability, however acknowledged that there are no formal procedures for this.

Palliative care is provided by multidisciplinary team members and links are made with Macmillan nursing and other palliative support services available in the community.

Referrals by Source and Access Criteria

Referrals are received mainly from children's disability teams, GPs, other disciplines or from carers. The trust's operational policy sets out referral criteria to include age (over 18), and the individual must be resident within the trust area to meet the criteria for a specialised service.

Referrals are allocated at referral meetings by the team leader. Out-of-hours arrangements are in place for social work services and on-call psychiatry, as required.

Information Database Systems

The Southern Trust outlined a range of information systems which are used to record client information and information about services received. These included SOSCARE and COMCARE. These were reported to be used by a range of professional and administrative staff. A number of disadvantages have been identified by the trust, which included complexities in the use of systems and the inability of systems to share client assessments and treatment plans.

Evaluation of Service Effectiveness

Outcomes are evaluated through service user engagement groups.
There was no evidence of the community teams having developed key performance indicators (KPIs) to measure the effectiveness of interventions.

Carers' Assessments and Direct Payments

The trust reported that all carers of children and adults with a learning disability are offered a carers' assessment in accordance with trust policy. The trust team managers regularly monitor assessment offered and report monthly to the HSC Board on the uptake of assessments.

The trust stated that carers do not usually request assessments of their needs but that 235 were offered during the April 2010 – March 2011 period. During this period, 126 new assessments were completed and 115 new or increased care packages were provided. The trust did not break down how many of

[29] Fit 4 U Project is funded by the Public Health Agency and led by the Southern Health and Social Care Trust

these were undertaken in respect of carers of children or adults with a learning disability.

The trust reported that 115 adults with a learning disability were in receipt of a direct payment (as of 9 January 2012) (seven per cent of those known to the trust). The uptake of direct payments is low for adults with a learning disability.

Engagement with Service Users

The Southern Trust stated that information leaflets and operational protocols are available to service users and carers on request. The leaflets outline the role of community learning disability teams/services in providing information to adults with a learning disability.

The trust reported using a number of methods for consulting and involving service users in the design and delivery of services, including carer's involvement in planning meetings, workshops and a carers' consultation group and autism forum. The trust also reported having a day opportunities and community access service user group.

Service users are encouraged to sign their person centred plans, but do not receive a copy of the plan, although they were reported as being available on request.

Other methods of consulting and involving service users include the use of an independent advocate, user forum, as well as the assessment, care planning and review processes.

The trust has produced an information pack for young people who are in transition from children's to adult services. This outlines the role and range of services available. Information is also available to service users in relation to regulated services and behaviour support services.

Model of Good Practice

The Southern Trust reported that behavioural services and specialist forensic practitioners were involved in risk assessment and management of a sex offender programme. The team is also involved in providing awareness-raising sessions, undertaken with carers, service users and the independent sector.

Challenges Facing the Service

The Southern Trust reported a need to make continued efforts to develop supported living and more suitable respite arrangements. An outreach team or crisis response team in the community would assist in preventing hospital admissions.

2.3.5 Western Health and Social Care Trust

The Western Trust has the smallest number of adults with a learning disability (1,156) and its spend per capita for adults with a learning disability receiving services from community teams is below the Northern Ireland average. The review team was advised that the prevalence of learning disability in Fermanagh is the highest of any county in the UK. The trust reported significant levels of deprivation recorded in Londonderry and Strabane. The trust also reported historical difficulties in recruiting learning disability community nursing and psychology staff.

The trust has two community learning disability teams. The teams described their role in the context of assessing needs and planning for service users to access day services and respite care. The trust reported challenges regarding the disaggregation of expenditure in children's disability and adult's learning disability services.

The review team met with the northern sector community learning disability team. The team comprised a team leader (nursing), social work, speech and language therapy and psychology staff. Input from psychology spans both children and adults with a learning disability in both hospital and community settings.

Speech and language therapy input was reported to be trust wide, with two therapists providing a service limited to eating and drinking assessments (dysphagia). At the time of the review there was no specific service to meet communication needs of people with a learning disability. Adults with palliative needs would have their needs met within the regional generic standard on palliative care. There was no evidence of inclusion of people with learning disability from mental health and other services. Learning disability team members acknowledged that a number of areas could be further developed. These included a single point of access, to speech and language therapy working with individuals with communication issues.

Referrals by Source and Access Criteria

Referral sources are mainly from children's disability services, primary care (GPs), social services, paediatric services and families. The adult programme reported the development of referral criteria likely to include diagnosis of learning disability through psychiatric and clinical psychology, following assessment. The service user is only referred to the team when agreement on the diagnosis of learning disability is confirmed. Referrals are allocated by the team leader to a key worker or care manager, on the basis of information provided in the referral and in terms of caseload capacity of staff. Individual caseloads are in the region of 35 to 40 cases.

The review team met with the trust's behaviour support team which was comprised of four behaviour therapists. Team members have a background in social work, nursing and applied behaviour analysis. The vision of the team

is to maintain service users in their own home and provide services to support patients discharged from hospital.

Children and other adult behaviour support services are provided by this team who work in parallel with community teams. At the time of the review, the behaviour support services were managed by a children's services manager. Team members reported that the behaviour support team is trying to move to the development of a tiered model of intervention and a more specialist team structure for adult services.

Information Database Systems

The Western Trust referred to a number of electronic systems used to record information including: SOSCARE, ePEX, and Understanding the Needs of Children in Northern Ireland (UNOCINI). The trust highlighted the limitations of SOSCARE and the plans to move to the ePEX information system for all disciplines across adult services.

Evaluation of Service Effectiveness

Team effectiveness is evaluated through monitoring, direct observations, and baseline and post intervention models.

The review team considered that there was over reliance on informal networking rather than the use of clear clinical pathways between services. There was little evidence provided relating to social or outcome measures of clinical effectiveness of teams or services. Further work is required to ensure adherence to pathway intervention following assessments of clinical needs of the population, in order to demonstrate improvement.

Carers' Assessment and Direct Payments

The Western Trust reported that all carers are advised of their right to a carers' assessment and that this is monitored through team leaders. There were 29 carer's assessments for carers of an adult with a learning disability having been offered during the 12 months prior to the review period (1 April 2010 to 31 March 2011), and 19 assessments were undertaken. The trust did not collate information in respect of services or care packages provided following the assessment of carers' needs at the time of review.

The trust reported that 61 adults with a learning disability were in receipt of direct payments (January 2012) (five per cent of those known to the trust). This figure remains low for adults with a learning disability.

Engagement with Service Users

The trust did not highlight any specific written information available to service users and their carers in relation to the role of community learning disability services / teams for adults with a learning disability. Individual service leaflets were reported to be available in respect of behaviour support services, speech

and language therapist, carers' assessments, direct payments, and financial assessments. The trust also referenced its website as an information source.

The trust referred to an established carers' network in the northern sector and of engagement with carers in relation to new service developments. The trust reported its intention to establish a similar network in the southern sector. The trust is developing a statement of purpose defining the role and function of the community team. This will be used to inform carers and service users of the services the team offer. The trust did not indicate a timescale for the completion of this work.

The trust reported that some staff within adult services have received training in person centred planning and that all service users are encouraged to sign their person centred plan and to retain a copy of the plan.

The trust acknowledged the need to review the guidance in relation to social and personal development for adults with a learning disability. A trust health improvement department is reported to be developing a sexual health workshop for staff working in learning disability services; at the time of reporting, sex education was being provided on a case-by-case basis.

Model of Good Practice

The trust is currently implementing a direct enhanced facilitation service in partnership with primary care, to ensure adults with a learning disability have ease of access to health promotion strategies.

Challenges Facing the Service

Challenges reported include complex needs, ageing population with no graduation to older person's services, increasing administrative requirements with reduced clerical input, and insufficient safeguarding designated officer capacity within the programme. The trust also reported not having a dedicated forensic service for adults with a learning disability referred by the courts and the challenge this presents to the community teams.

3.0 Management of Transitions and Interface Between Services

The review team focused attention on each trust's transition arrangements, to ensure that adults with a learning disability receive appropriate assessment and support throughout their lives. The review team used the standard set out in the DHSSPS Service Framework for Mental Health and Wellbeing[30] to assess the effectiveness of the trusts' transition arrangements.

The framework states that persons with learning disabilities experience four times the incidence of mental health disorders, compared to their non-disabled peers, and yet have limited access to generic mental health services. The framework sets out the need for individualised care plans and care pathways for individuals with a learning disability and mental health needs, and a coordinated approach to service provision. For an example of the components of a pathway of care see Appendix 4.

Standard 56 of the framework states: "A learning disabled person with mental health needs should have access to appropriate mental health support for their needs."

Trusts were also asked for information about any formal and informal arrangements in place to meet the transition needs of people with a learning disability and of any joint working arrangements across other disciplines for people with a learning disability.

Transitions to adult services for young people with a learning disability, were cited by trusts as a continuing concern both for young people and carers. The review team was told of significant difficulties on transition from school and from child to adult health and social care. Trusts reported that there are no statutory obligations to support young people with learning disabilities on transition into further education and from further education into employment. There are variations across Northern Ireland in terms of supported employment opportunities and available work placements. Furthermore, part time working can impact on entitlement to social security benefits. Young people with learning disabilities and their families do not always receive appropriate information about support available to young people on leaving school.

Parents of adults who have attended further education courses expressed concerns about the lack of support for the young adult settling into further education, and a lack of genuine options and subsequent opportunities for progression once a training course comes to an end.

[30] Standard 56 of Service Framework for Mental Health and Wellbeing. DHSSPS, October 2011

Belfast Health and Social Care Trust

The Belfast Trust had no formal arrangements for adults with a learning disability to access older persons' services, in terms of any planned transition. Staff reported having occasional joint working arrangements, which were agreed across services but only on a case by case basis for individuals with a learning disability who also have mental health needs.

The trust highlighted having links with dementia care services, palliative care, sensory support services, mental health services, employment services and with services in the private and voluntary sectors, including leisure services and further education. The trust had developed links across a range of acute healthcare providers and other specialisms including epilepsy, diabetes, and, ear nose and throat services. The trust has a health facilitation nurse who is involved in promoting direct enhanced services by GP practices, including accessing health checks and screening.

The trust's PROMOTE Service has developed protocols for securing access to services relating to self-harm, psychosexual or eating disorder.

Access to the Muckamore Abbey hospital for assessment or treatment is determined by the multidisciplinary team in accordance with the Mental Health (Northern Ireland) Order 1986, regardless of diagnosis. The trust reported that community staff remain in contact with all individuals in the inpatient setting throughout their admission and are involved in any discharge planning arrangements.

Northern Health and Social Care Trust

The Northern Trust has agreed arrangements for referring adults (with a learning disability) to a learning disability hospital for assessment or treatment. They are supported by learning disability community staff throughout their admission and discharge phase. Individuals who remain in hospital after one month are assessed for discharge from the adult challenging behaviour service. Long stay patients are considered for a preliminary behaviour assessment prior to their discharge. The trust reported that these arrangements work well. However, consideration by the trust is being given to a dedicated link worker to formalise transitions arrangements between hospital and community. The trust has not developed a step down arrangement to improve the individual's transition from hospital to the community and the review team considered this should be a priority in the future.

The trust reported that older persons with a learning disability do not transfer to older persons' services. Informal arrangements exist for joint working across localities and across teams in dementia care, palliative care, sensory support, mental health, employment and leisure services. However, people with a learning disability do not access mainstream mental health services.

The trust reported positively on the appointment of three health facilitators who liaise directly with GPs within their locality areas, and play an active role in health promotion and education.

South Eastern Health and Social Care Trust

The South Eastern Trust reported no formal joint working across mental health and learning disability services for adults. Adults with a learning disability do not transfer to older persons' services. Joint working arrangements have been developed within palliative care, sensory support services and employment and leisure services, through service level agreements.

The trust reported that the majority of GP practices have signed up to a direct enhanced service providing health screening for adults with a learning disability. A health facilitator has been organising health promotion and early intervention services. The trust identified a number of areas requiring improvement in relation to health care education for carers and staff, and raising awareness of mental health issues.

The trust has arrangements for accessing learning disability hospital services for adults, achieved through planned admissions with the consultant psychiatrists in Muckamore Abbey Hospital. The community based key worker maintains contact with the patient during admission and contributes to the discharge planning arrangements. The trust made a number of suggestions for improving transitional arrangements between hospital and community. These include improved information sharing and adequate notice given to community staff in relation to the discharge of hospital patients.

Southern Health and Social Care Trust

The Southern Trust reported that health facilitators have formal working relationships with GPs. However, joint working arrangements in respect of mental health, palliative care, sensory support, or dementia services were not well developed. Access for adults to the inpatient assessment and treatment unit is made through the GP and in conjunction with the consultant psychiatrist. There are arrangements in place, including post-admission and pre-discharge meetings, for community teams involved in the admission of an individual to the specialist unit.

Joint working arrangements have been established with a number of private and voluntary services. A link service exists between the community teams and leisure, further education and employment services.

Western Health and Social Care Trust

In the Western Trust some informal joint working arrangements are in place across services and providers. These included dementia, sensory support and palliative care services, and are negotiated by teams on a case by case basis. However, individuals with a learning disability do not routinely have

their mental health needs assessed or met by frontline mental health staff. The trust advised that adults with a learning disability do not transfer to older persons' services.

The trust has arrangements for admissions for adults with a learning disability to the specialist learning disability hospital at Lakeview, Gransha, (Londonderry). Community learning disability teams remain in contact with patients and plan for their discharge.

The trust has highlighted the need for more adults with a learning disability to be able to access mainstream specialist learning disability services.

4.0 Unmet Need

Each trust was asked to describe unmet need or identified gaps in community learning disability service provision for adults with a learning disability. There is no working definition of unmet need. The term unmet need relates to the possibility that persons may, for whatever reason, fail to be provided with a service, or timely provision of a service.

The review team noted that the endeavour to provide a definition of unmet need has been ongoing since 2007 and has been subject to a previous recommendation by the DHSSPS report Standards for Adult Social Care Support Services (2008)[31] This states: "Information collected by HSC Commissioners and trusts to identify and monitor unmet need is informed by collating information from individual assessments, care plans and reviews".

Unmet need is defined and recorded by trusts in terms of the numbers of people awaiting services, rather than reflecting the complexity of identified needs. The review team found that the arrangements for recording and reporting unmet need are inconsistent. Information on unmet need in trusts is currently collected manually from various sources and locations. Trusts provided comments on difficulties in trying to address unmet need and the impact of this on service users and their carers.

Belfast Health and Social Care Trust

The Belfast Trust identified unmet need for adults with a learning disability in respite care, domiciliary care, social and leisure provision, and community treatment and support services. This is compounded by the lack of specialist expertise in provider organisations.

The trust reported that shortages in community staff are adversely impacting on its ability to improve the transition arrangements between community and hospital services. This has resulted in unnecessary and avoidable hospital admissions due to the lack of wraparound services, access to early intervention and intensively staffed accommodation to support individuals with complex needs.

The trust did not provide a detailed account of how it responds to unmet needs but stated that care plans are reviewed when needs increase or change.

The trust reported that unmet need can lead to carers' stress, and deterioration in wellbeing or the breakdown of care arrangements for the person with a learning disability. The trust reports these gaps on a monthly basis and submits an annual return on the discharge of statutory functions report to the HSC Board.

[31] Standards for Adult Social Care Support Services, 2008

Work has commenced in the development of community services infrastructure. A critical review is being undertaken of home treatment options, particularly the trust's tier 3 services, including a behaviour support team. The trust reported the need to further develop these services and to focus on patterns of admission to hospital. The trust's PROMOTE service has established links with mental health services. However, the trust reported that there are no specific out-of-hours arrangements to support individuals with a learning disability in the community. The trust also indicated the need to undertake a review of the volume and quality of the advocacy services they commission from external agencies.

Northern Health and Social Care Trust

In the Northern Trust unmet need is reported and recorded monthly and highlighted to senior management. Waiting lists are also monitored and the trust's risk register is used to document any key concerns about the overall trends and lack of capacity to meet need where risks are identified.

Attempts to address unmet need were described by the trust in the context of resource constraints, staff sickness and vacancies. Unmet need was reported to impact on carers in terms of a breakdown of caring arrangements resulting in users requiring emergency placements; delaying the discharge of patients from hospital; and responding to higher level of behavioural difficulties, without a sufficient level of specialist staffing to meet assessed need.

The trust highlighted the resettlement needs of 42 adults with a learning disability in Muckamore Abbey Hospital and the development of supported living and adult placement services as a key priority. This is required in addition to the provision of step up/step down services, to prevent admissions to hospital. Funding for advocacy services also remain a priority.

The trust reported an identified gap in gaining access to mainstream mental health services for adults with a learning disability, in particular to the Home Treatment and Crisis Response Team, to reduce unnecessary hospital admissions. The trust reported having insufficient respite services, day services, dementia services and shortfalls in availability of specialist dental services.

South Eastern Health and Social Care Trust

In the South Eastern Trust unmet need is recorded within service user needs assessments and reviews. Monthly performance reports are provided to senior trust staff. Unmet needs are also recorded within the trust's annual statutory functions report to the HSC Board.

The trust reported the need to develop a step up/step down model of care provision supported by a seven day week crisis response team which delivers a service out-of-hours. The trust reported concerns about the lack of expertise by some independent care providers in appropriately managing people with challenging behaviours. This had led to more admissions to

hospitals whenever community care arrangements could not be sustained. Trusts reported insufficient funding for advocacy services as an unmet need.

The trust also reported a need to develop services for individuals with complex needs and for people with a learning disability referred by the courts with a history of offending. Service users' and carers' expectations of services has increased, corresponding with an increased demand for services from the trust. This has resulted in the limited resources being used to avert a crisis. The consequence of this is that less time is available to work with, for example, older carers to help them plan for a different form of service provision for their son/daughter in a community setting.

Southern Health and Social Care Trust

In the Southern Trust unmet need is captured on risk registers which are reviewed by management. The trust reported that unmet needs are discussed regularly at a senior level and with the HSC Board.

The trust highlighted the resettlement needs of a number of long- stay patients in Longstone Hospital, Armagh as a priority for investment. It also highlighted the need to further develop a range of community learning disability respite care and accommodation services, including a rapid response support service to assist individuals living in the community. The trust believes that early intervention and enhanced behaviour support staff would help reduce the need for hospital admissions and services for people referred by the courts with a history of offences. Additional funding for advocacy services is also required by the trusts.

The impact of unmet need was reported by the trust to cause stress to carers, impact on the mental health of service users, and can result in emergency admissions to hospital.

Western Health and Social Care Trust

In the Western Trust unmet needs and gaps in service provision include: forensic services for people with learning disability referred to the courts for offending behaviour, insufficient community team staff resources, limited access to psychology services and limited availability of challenging behaviour services (this is shared between children and adults services). A gap also exists in specialist accommodation required by individuals with challenging behaviours. The trust considered that admissions to hospital could be reduced by enhancing the capacity of the independent sector in responding to challenging behaviours, particularly at weekends.

The trust also identified problems experienced by individuals in making the transition from children to adult services. Some of these service users have presented with neurodevelopmental disorders, including autistic spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD).

The trust records unmet need quarterly and reviews waiting lists of unmet needs through the annual discharge of statutory functions report to the HSC Board. The trust also referred to working closely with the regional lead on adult learning disability services within HSC Board, in relation to improving transitions for older persons with a learning disability.

Service pressures are reported to the HSC Board, and discussed at the DHSSPS the Bamford Monitoring Group, and the local commissioning group. Unmet needs is recorded in the trust's risk register.

The trust identified a number of priority areas for investment, including the development of community infrastructure to reduce the number of hospital admissions, and advocacy services. The trust is involved in a Regional Community Integration Project and reported only small numbers of individuals from their trusts who need to be resettled from long stay hospitals.

The trust reported on the impact of unmet needs on carers' ability to cope, often resulting in a breakdown of care arrangements. This pressure also can lead to ill health in carers and a need for the trusts to invest in higher cost care packages to support people with a learning disability in the community.

5.0 Conclusion on Adult Teams and Services for People with a Learning Disability

The findings of this baseline review demonstrate that a high proportion of the investment in adult learning disability teams and services is committed to a traditional model of service provision. Community learning disability teams comprise of a range of services provided by social workers, nurses, psychologists undertaking specialist functions and speech and language therapists. The review team found there were no common managerial structures across the trusts for the delivery of adult learning disability services in the community.

The current model of delivery of services by community learning disability teams is configured along the lines of the former legacy trust structures. Many of the services currently provided in institutional settings could be provided in the community or in people's homes, making them more accessible. Services should be planned on the basis of the personalised needs of people with a learning disability. The delay in changing to a new model of service delivery has been constrained by inadequate bridging finance to support new developments in the community. The percentage of funding allocated to other programmes, hospital care, mental health services restricting access to adults with a learning disability, has also been a factor in moving to a new model of service delivery.

The findings of the review team indicate that the provision of various specialist therapeutic services for people with a learning disability is variable across the five trusts. At best this represents less than 25 per cent of the total expenditure on community services for adults with a learning disability. There is a need for trusts to consider how home treatment and crisis response teams could be developed to operate on a seven day week basis. If trusts continue to deliver services as they currently do, they risk failing to adequately meet the needs of adults with a learning disability. Whilst the review noted examples of innovative practice, there is a need for more joint planning and sharing of models of effective practice across trusts.

Consideration should be given to trusts to expand the hours of operation in the community, with the goal of establishing an extended hours service for families, or residential facilities in the community with the capacity to provide outreach support. Where a seven day per week service is not required, based on evidence of assessed need, the development of alternative early prevention and intervention models of care should be delivered by integrated health and social care partnerships.

A more robust review of the multiagency and integrated nature of team working is required by the HSC Board, in terms of assessing the effectiveness of the current method of service delivery. This should include some measurement of qualitative outcomes. This is essential so that trusts can manage the demands facing their services, as the population ages and more people require to be looked after in community settings. Further discussion is

required by the HSC Board regarding the future model of service provision, to ensure it is efficient, patient centred and provides high quality, evidence based outcomes for service users. The challenge for trusts is how best to utilise their existing resources while gathering evidence to support further transformation and extension of their service provision.

The review team found from discussions with the trust staff a reliance on informal networking by teams, without any use of clear clinical pathways and interfaces between services. Trusts are at an early stage in terms of achieving the Bamford vision of true partnership working with adult mental health services and those for older people. No trust demonstrated an attempt to consider the potential for a knowledge/skills transfer between mental health and learning disability staff, to deliver services in an integrated way. Given that trusts are integrated in terms of the provision of health and social care, more could be done to develop a skill mix, between professions in the combined directorates of mental health and learning disability. This would assist in the sharing of learning and encourage equality of access to mainstream services.

The review team noted that trusts are working to develop user friendly information for service users and their carers. Service users and carers stated that public communication could be improved. A number of families interviewed by the review team stated there was a lack of clear accessible information about services in their locality on trust websites. More innovative methods of communicating with service users and carers are required to ensure adults with a learning disability are involved in the planning and reviewing of services.

The progression of carers' assessments is critical to ensuring early support is available to meet carers' physical and emotional needs. A small number of people with a learning disability and their carers have taken up direct payments. Service users and carers indicated they need more clarity about this type of option, although the lack of financial resources from the trusts may also have been a factor in promoting this choice for carers. Further promotion of direct payments is required by trusts.

Carers reported that a range of respite and short breaks are available across the trusts. However these can be based in respite units which can reduce the flexibility of the service offered. Many parents and carers expressed frustration at the delay in the implementation of the Bamford proposals and waiting lists for particular services. Access to more a flexible model of service provision in the community is required.

It is crucial that further efforts are made to promote independence and personalisation; a more person centred service. The proposals set out in Transforming Your Care should aim to deliver tangible changes for adults with a learning disability and their families. At present, the provision of advocacy services is limited and further work and investment is needed to promote both peer and independent advocacy for adults with a learning disability. This is critical in supporting individuals to make informed decisions and in promoting

rights. The review team commends the partnership that trusts have developed with the community and voluntary sector in developing new service models. The continued involvement of this sector needs to be promoted in providing a varied range of additional support services. The target to end the long term hospital residency of people with a learning disability by 2015 means that early planning is required to develop the range of personalised housing and care supports to enable people to live independently in the community.

The review team considers there is still a need for consistent outcomes in terms of access to other mainstream health care services. Disability awareness training for clinical staff in the community is needed so that they can deal confidently and appropriately with adults with learning disability.

Exclusion of people with a learning disability from mental health services for adults/older people and from the newly established autism services was particularly evident.

The recent release of the Learning Disability Service Framework, DHSSPS September 2012, aims to promote and secure better integration of service delivery along the care pathway from prevention, diagnosis, treatment and rehabilitation to end of life care. Further work is required to ensure people with a learning disability can access the full range of health promotion initiatives available to the general population. Widening access to screening programmes and public health interventions will continue to require an increased focus by the LCGs. The review team considers that the planned integrated care partnerships should ensure that clinicians are facilitated to respond appropriately to the needs of people with a learning disability.

The Bamford Review of Learning Disability set out to reform and modernise the law, policy and provision affecting people with a learning disability in Northern Ireland. The proposed Mental Capacity (Health, Welfare and Finance) Bill also proposes changes in respect of the presumption of capacity and will create additional demands on trusts. Training will be required to support trusts in effectively delivering the requirements of the new legislation.

A review is required of current data systems and technology to ensure relevant information is available to professional staff about client assessment and treatment plans. The proposals set out in Transforming Your Care should aim to deliver tangible changes for adults with a learning disability and their families.

This report highlights the requirement to develop and improve community services to ensure they meet the needs of individuals in long stay hospitals, and address the current unmet needs that within community provision. This will require a determined programme of service change and reconfiguration to meet present and future health and social care needs of this population.

The increased level of care delivered in a community setting will need to be closely aligned with demand; with outcomes evaluated for effectiveness.

Trusts should formulate development plans for community learning disability services in the period 2013-2015 in full consultation with service users and carers. This is the most promising way to ensure that investment is used in the most effective way to produce the best possible patient and client outcomes.

6.0 Recommendations for Trusts – Adult Learning Disability Services

There are a number of areas for service improvement that trusts need to consider. This will require significant leadership in the planning, implementation and transformation of service provision.

Model of Community Service Provision

All trusts should review their current model of service provision to ensure that it actively promotes the prevention, inclusion and integration of people with a learning disability, in line with the principles set out in Equal Lives, particularly in the areas of housing, leisure, training, further education and employment opportunities.

Learning Disability services should be reviewed alongside mainstream mental health services, so that the skill and expertise from both services can be utilised in order to respond to individual need.

Review of Composition of Adult Learning Disability Teams

Each team should have clear statements of purpose, which determine the membership, from a range of disciplines such as community psychiatry; learning disability nursing; social work; allied health professionals; psychology; behaviour support; specialist epilepsy nurses and practitioners with forensic knowledge and experience.

Possible Approaches to the Development of Service Provision

A number of approaches could be considered by trusts in relation to the development of a tiered model of service provision. Suggestions are outlined in Appendix 3 for consideration by the trusts.

Developing a Personalised Pathway of Care for Learning Disability

Trusts should provide an individualised pathway of care, consisting of a coordinated assessment of need, agreement of expected outcomes, provision of care and treatment. This should be followed by a joint review of achieved outcomes along with the people receiving services, and their carers. See suggestions in Appendix 4.

Assessment of Clinical and Social Care Needs

To meet a variety of individualised needs consistently, effectively, safely and in partnership, commissioners need to:

- understand the needs of the population
- plan intervention and treatment based on assessed need
- ensure/develop corresponding skills in providers

- use person centred, outcome focussed treatment plans
- provide incentives to timely achievement of agreed outcomes
- develop a range of personalised pathways of care, the core components of which are shown on Figure 3.

Trusts should gather information about the clinical and social care needs of the populations they serve, in order to service development. Community learning disability teams have a key role to play in gathering and collating this information. This is a requirement under the Learning Disability Service Framework.[32]

Delivery of an Extended Hours Service

Trusts should review access to services and ensure that effective arrangements are in place for the provision of community learning disability teams for adults with a learning disability which can provide services outside 9am to 5pm, Monday to Friday, in community settings.

Trusts should ensure that family carers receive access to appropriate of support services. This should be based on assessed need, including domiciliary care on an extended hours basis, host family schemes with trained and approved carers, social and recreational activities provided by volunteer and paid staff, and short breaks and respite services.

Development of Interfaces between Services

Trusts should agree criteria to ensure effective interfaces from children to adult services and to other services, for example, to mental health services and older people services, to achieve a seamless transition to appropriate assessment and support.

Development of a Clinical Quality Dashboard

Trusts should agree a clinical quality dashboard (an information tool) to provide clinicians with relevant and timely information to inform daily decisions to improve the quality and measurement of effectiveness of health related patient care.

Use of Best Practice Evidence and Guidelines

All care should be delivered on the basis of standard evidence, good practice guidelines and in response to identified clinical need.

Health Related Outcome Measures

All adults should receive an annual physical and mental health check from their GP practice and arrangements should be in place to enable people with

[32] Learning Disability Service Framework, September 2012. Belfast, DHSSPS

a learning disability to access secondary care services in line with the GAIN Guidance[33].

Examples of related outcome measures for people with a learning disability that could be agreed during assessment are shown below

- reduction in level of health supports required
- improvement in functioning of persons with a learning disability so as they can live in the least restrictive environment
- shortest length of time taken to return to optimum functioning by moving through a personalised pathway of care and treatment
- reduction in levels of harmful effects of treatment e.g. medication, carer distress etc.
- maintenance of improved level of functioning
- long term impact of residual behaviours and on-going treatment.

Compliance with Standard 56 –Service Framework for Mental Health and Wellbeing[34]

Trusts should ensure that people with a learning disability, and particularly older people, have access to appropriate mental health support for their needs, in line with Standard 56, of the Service Framework for Mental Health and Wellbeing.

Provision of Specialist Care and Support Services in the Community

Trusts should liaise with housing providers to ensure effective arrangements to provide living accommodation in the community for people who currently residing in learning disability hospitals. Trusts should develop a range of partnerships to ensure that personalised supported living options are available. This is in line with the recommendations from the Bamford Review.

Development of Partnership Arrangements

Trusts in partnership with other statutory and voluntary agencies, should ensure that services are in place for people living in community settings, for example, access to day support services. Other services include further education, vocational training, supported employment and a range of day support services for people with more complex needs.

Managing Transitions

Trusts should ensure that effective arrangements are in place for adults transferring from hospitals to the community and to older people's services.

[33] Guidelines on Caring for People with a Learning Disability in General Hospital Settings. GAIN, DHSSPS. 2010.
[34] Service Framework for Mental Health and Wellbeing. DHSSPS, October 2011

Communication with Service Users using Accessible Formats

Staff should communicate directly with the patient with a learning disability, at all times, using accessible formats.

Advocacy

Trusts should ensure that people with a learning disability have appropriate access to independent advocates as a method of promoting a person centred approach to care and treatment, and particularly in facilitating and supporting service users in using personalised budgets. Where individuals do not wish to take financial control, they should have access to advocates to act on their behalf.

Listening to Carers

All care should be provided in a manner consistent with the Standards for Improving the Patient and Client Experience, Ensuring the Provision of Respectful and Dignified Care (DHSSPS 2008)[35]. Trusts should ensure that they listen to the family/carer, recognising their knowledge of the individual with a learning disability. This contribution should be acknowledged, valued, listened to and acted upon.

Review of Needs of Older Parents

Trusts should ensure that older carers' needs for respite assessed regularly and met, to support them in their caring role.

Direct Payments

Trusts should provide clearer information to service users, carers and families about direct payments, to ensure consistency in terms of equity, access and ease of use.

Increased Staff Training and Awareness

Trusts should ensure that staff receive training that increases their awareness of learning disability. Issues such as human rights, discrimination and the importance of good communication, attitudes and values should be included. In line with best practice, awareness training on learning disability issues should include people with learning disabilities and their family/carer, as experts through experience.

Transferability of Skills between Mental Health and Learning Disability Teams

Trusts should consider the potential for a knowledge/skills transfer between staff working in adult learning disability services and other mental health

[35] Standards for Improving the Patient & Client Experience, November 2008, Belfast, DHSSPS.

services for adults and older people, to deliver support services in an integrated way.

Information Database Systems

Trusts should review the suitability of their information database systems to ensure they are capable of informing the assessment of clinical and social care needs and the appropriate commissioning of services.

Use of Service Frameworks as a Tool for Improvement

Trusts should ensure that the learning disability service framework and agreed performance indicators are developed, as well as feedback from users and carers is used to inform a system of continuous improvement.

7.0 Recommendations for HSC Board - Adult Learning Disability Services

Review of Expenditure in Community Learning Disability Services

The HSC Board should ensure that the data in relation to expenditure on community learning disability teams is examined in terms of equity of investment in community staffing across the Board area. This should be compared with the guidelines that different professions have produced per 100,000 of the population.

Review of Effectiveness of Community Learning Disability Teams

The HSC Board should review the current membership of community learning disability teams to ensure they include psychiatry and experienced forensic practitioners.

Review of Availability of Specialist Support Services

In view of the low numbers of behaviour therapists, specialist support workers and psychiatric sessions available in the community, the Board should review the concept and effectiveness of specialist support services, their membership, functions, working protocols and the availability of services on an extended hours basis.

Development and Agreement of Performance Indicators

The HSC Board should inform the trusts of their requirements with respect to reporting on agreed performance indicators using the Learning Disability Service Framework and the arrangements the HSC Board has in place for auditing the adherence to these standards, set out in this framework.

Development of a Skilled Work Force

Commissioning of learning disability services should be needs led so that planned interventions are evidenced based and lead to the development of a skilled workforce in all tiers of the service delivery in the community.

Review of Additional Expenditure Required in Community Learning Disability Services

The HSC Board should plan to rebalance the community based investment in psychiatry, psychology and therapy services, as a consequence of hospital resettlement, by March 2015. New service provision should include appropriate step up/step down services and robust assessment and treatment services in the community.

Local Commissioning Groups (LCGs)

All LCGs should review the capacity of existing resources to deal with the needs of people with a learning disability, children with a disability and aging carers and develop support options in partnership with local housing, further education and leisure providers.

Evaluation of Outcomes

All services commissioned by the HSC Board should focus on outcomes and these should be monitored to ensure they are reducing health and social inequalities. The HSC Board should measure the quality of services from the perspective of the individual and their family carer, clinical effectiveness, outcomes and safety.

Training

The planned integrated care partnerships in consultation with the HSC Board, should ensure that clinicians receive appropriate training to assist them in communicating and responding appropriately to the needs of people with a learning disability.

List of Abbreviations

ADHD	Attention deficit-hyperactivity disorder
AHP	Allied health professions
ASD	Autism spectrum disorder
Assertive outreach	Term used for intervention that targets people with a learning disability with a mental health condition but have not been engaged with mental health services
Belfast Trust	Belfast Health and Social Care Trust
CAMHS	Child and adolescent mental health service
CFMHS	Community forensic mental health services
CMHT	Community mental health team
COMCARE	A community care client management system
CRIS	Clinical research information systems
CRHTT	Crisis response home treatment team
DHSSPS	Department of Health, Social Services and Public Safety
DPs	Direct payments involves the provision of funding directly to patients and clients who then directly purchase the services they feel best meet their needs.
DOLS	Deprivation of liberty safeguards
DSM IV	Diagnostic and Statistical Manual of Mental Disorders fourth edition
ePEX	Electronic information database
GP	General practitioner
ICD-10	Tenth revision of the International Statistical Classification of Diseases
LCID	Local Community Information Development
MDT	Multidisciplinary team
MH & LD	Mental health and learning disability
NISAT	Northern Ireland Single Assessment Tool
Northern Trust	Northern Health and Social Care Trust
OT	Occupational therapist
PARIS	Patient Record Information System
RCPsych	The Royal College of Psychiatrists
PROMOTE	The team that provides behaviour support services for persons with diagnosis of learning disability and mental health
RQIA	Regulation and Quality Improvement Authority
RPA	Review of Public Administration
SLT	Speech and language therapy
SOSCARE	Social Services Client Administration and Retrieval Environment
South Eastern Trust	South Eastern Health and Social Care Trust
Southern Trust	Southern Health and Social Care Trust
TROJAN	Electronic systems to record client information
UNOCINI	Understanding the Needs of Children in Northern Ireland
WHSCT	Western Health and Social Care Trust

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United Nations. Convention on the Rights of Persons with Disabilities. Ratified by UK 2009.

Appendix 1: Table A1: The Number of Whole Time Equivalent Staff Within the Major Disciplines in Community Services for Children with a Disability and Adult Persons with a Learning Disability Across the Five HSC Trusts.

Discipline	Service	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	Total
Social workers and care management	Child		21.6	22.3	29.84	18.6	**>92.34**
	Adult	26.19	34.15	21.09	25.64	16.5	**123.57**
Community Learning Disability Nursing and Health Facilitators	Child			6.0		4.0	**10.0**
	Adult	9.0	17.2	10.1	14.85	11.0	**62.15**
Occupational Therapy*	Child	16.31	4.0	5.1	12.5	10.77	**48.68**
	Adult	3.5	6.5	2.0	8.66	1.0	**21.66**
Speech and Language Therapy*	Child	20.36	20.5	7.37	33.09	17.7	**99.02**
	Adult	3.34	7.3	5.81	4.0	3.0	**23.45**
Physiotherapy*	Child	23.75	13.97	3.7	14.58	9.58	**65.58**
	Adult	5.5	7.63	1.16	4.0	0.0	**18.29**
Clinical Psychology (NB Working across child and adult services)	Child						**0.0**
	Adult	2.1	4.0	11.3	7.5	5	**29.9**
Challenging Behaviour Services (NB In some trusts, these personnel work across child and adult services)	Child		5.4			5	**10.4**
	Adult	5.8	10.9	6.16		2.6	**25.46**
Psychiatry (Sessional time only reported for children)	Child						**0**
	Adult	2			2.8	2.0	**6.8**

*Trusts may have included all therapy staff involved with children and not just those with a disability
(Note: A total in excess of 637 whole time equivalent (WTE) staff are currently employed in these services).
>The true figure is larger than 92.34, as the value for Children was not given.

Appendix 2: Table A2: The Teams Providing a Service to Adults with a Learning Disability, as Reported by Each Trust

Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust
Community Learning Disability Teams - North	Multi-disciplinary Team (Social Work; Occupational Therapy; Community Nursing for Learning Disability) – Mid-Antrim	Down sector multi-disciplinary team	Newry & Mourne Community team	Community Learning Disability Team - Northern Sector (1 team leader; 6 social workers; 6 community nursing staff)
Community Learning Disability Teams - South	Multi-disciplinary Team for Adults with Learning Disability - Loughside	North Down & Ards sector multi-disciplinary team	Armagh & Dungannon Community team	Community Learning Disability Team - Southern Sector (1 team leader; 9 social workers; 3 community nursing staff)
Community Learning Disability Teams - East	Multi-disciplinary Team for Adults with Learning Disability - Causeway	Lisburn sector multi-disciplinary team	Craigavon & Banbridge Community team	
Community Learning Disability Teams - West				
Behaviour Support Service	Adult Challenging Behaviour Service (ACBS)	Behaviour Support team (across three sectors)	Behaviour Support	*Behaviour Support managed by Childrens Service (see page 34)*
Forensic Service	Community Forensic Mental Health & Learning		Forensic service	

	Disability Multidisciplinary Team.			
PROMOTE (service for people with LD and mental health needs)				
Complex Health Service				
	Adult ASD Link Service			
	Speech & Language Therapy			
	Physiotherapy			
			Epilepsy service	
			Community access	

Appendix 2: Table A3: The Amount of Expenditure per Head of Adult Population Spent by the Five HSC Trusts in 2010-2011 in Community Disability Services for Adults with a Learning Disability

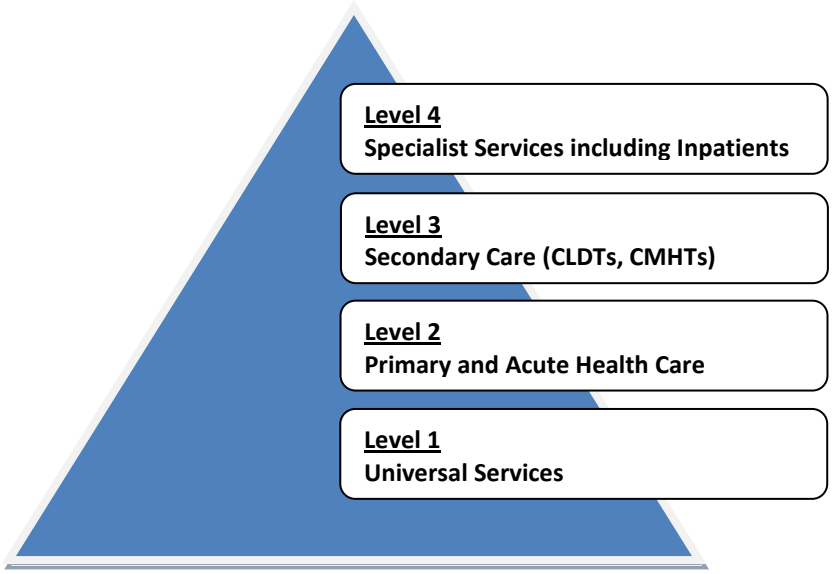
Discipline	Belfast Trust N=198,119	Northern Trust N=268,698	South Eastern Trust N=203,794	Southern Trust N=210,587	Western Trust N=176,799
Social workers & care management	£6.50	£4.91	£4.38	£5.29	£4.12
Community LD Nursing & Health Facilitators	£1.46	£2.69	£2.03	£3.08	£2.41
Occupational Therapy	£0.60	£1.20	£0.41	£1.69	£0.29
Speech & Language	£0.91	£0.94	£1.23	£1.02	£0.47
Physiotherapy	£0.61	£0.91	£0.24	£0.86	£0.45
Clinical Psychology	£0.58	£0.80	£1.15[1]	£0.67[2]	£0.40[2]
Challenging Behaviour Services	£1.73	£1.45	£0.63[1]	£0.84[2]	£0.76[2]
Psychiatry	£0.70	Not supplied	(£0.78)[3]	£0.51[2]	£1.23
Other specialist services[2]	£1.26	£0.37	-	£0.83	-
Community support workers	£0.64	-	-	£1.40	-
Management & Admin	£1.28	£0.50	£0.58	£0.68	£1.07
Total reported by trust	**£16.28**	**£13.78**	**£10.65**	**£16.89**	**£11.20**

1 These costs have been apportioned 50/50 with Children's services although the monies may sit within one budget within the trust.
2 These costs are apportioned 75 per cent adult: 25 per cent children services.
3 The South Eastern Trust provided this as an estimate although the budget is with the Belfast Trust through Muckamore Abbey Hospital. (This also applies to the Northern Trust). This amount is not included in the trust's total costs but if it were the costs would rise to £9.79 per head of adult population.

Appendix 3: Key Service Components in a Tiered Model of Service Provision

The whole population is eligible to receive universal services. A proportion will need additional secondary services and a minority will require the full a range of specialist services.

Figure 2 – Proposed Tiered Model for Service Provision to meet the needs for people with learning disabilities



Level 1 - Universal Services

These services are primarily focussed on improving the health of the whole population of people with learning disabilities. Good access to housing, leisure, education and employment are known to have a positive impact on mental health. Other priorities include neonatal screening, early detection and treatment for conditions such as congenital hypothyroidism and phenylyketonuria.

Level 2 - Primary and Acute Health Care

Trusts should ensure that people with learning disabilities have good access to mainstream health services. In primary care, this means regular health checks, advice and support on lifestyle factors such as diet, exercise, alcohol consumption and sexual health. Other services include health facilitation to improve access to primary care and health liaison to improve access to acute hospital based care. Training and support for carers should be made available.

Level 3 - Secondary Care by Community Learning Disability Teams / Community Mental Health Teams

Community and mental health learning disability teams need to provide assessment, treatment and some on-going support for people with moderate degree of mental health need (significant anxiety and depression, psychotic disorders, and cognitive impairment). These teams need to have expertise in

dealing with behaviour problems associated with these conditions with the whole range of learning disability and coexisting autism and ADHD. Improving Access to Psychological Therapies (IAPT) services is within this level.

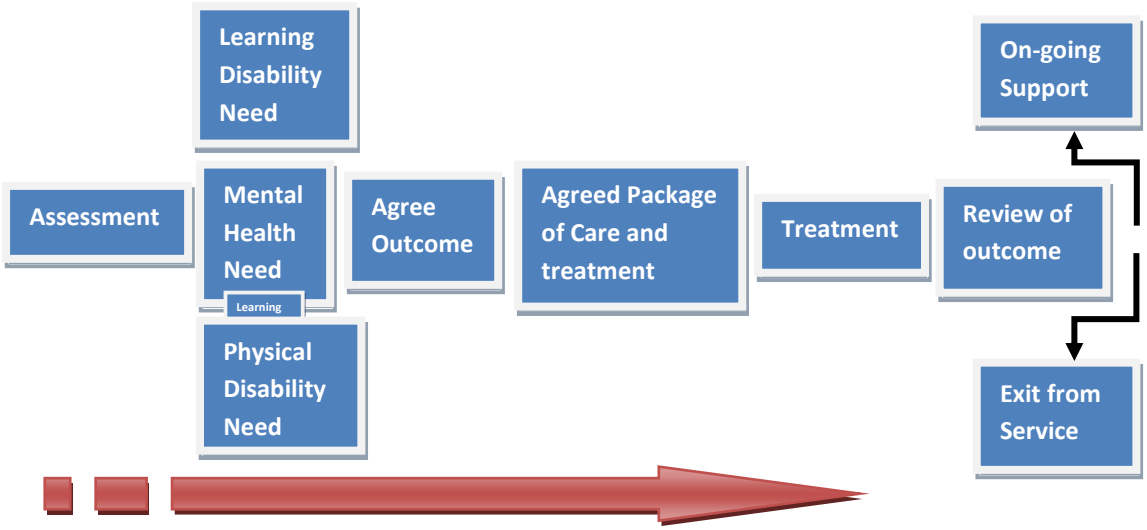
Level 4 - Specialist Services including Inpatients

These services need to have expertise in dealing with people who are a severe risk to themselves and others, often with chronic severe treatment resistant mental illness, behaviour problems and offending behaviour. Services at this level include community based assessment and treatment using a combination of crisis and home treatment teams, behaviour support services, forensic teams and experts in autism, ADHD, eating disorders, dementia and epilepsy. Inpatient services may also be required where 24 hour assessment and treatment would enable a safe return to well-resourced community based packages of care. The appropriate role for psychiatric hospital services for people with learning disabilities lies in short-term, highly focused assessment and treatment of mental illness. This implies a small service offering very specifically, closely defined, time-limited services.

The relationship between these key components of the service are represented in Figure 2.

Appendix 4: Components of Pathway of Care

Figure 3 – Components of Pathway of Care



Such a model of service provision relies on an integrated approach between learning disability and other services. There should be a single point of entry after which the assessment of need commences. This would clarify the range of skills best able to meet assessed need and achieve better outcomes. The agreed care package is provided by professionals with the appropriate skills to support the individual to achieve agreed outcomes effectively and safely, regardless of which service or agency they work for. In some instances the skills may be available wholly in the mental health service or in the learning disability service. In other cases there may be a need to share skills and work jointly across services. When care and treatment is provided by a team, a named person must coordinate the delivery of treatment. This process requires a defined leadership role with responsibility for making and communicating decisions to the team.

This would clarify the range of skills best able to meet the assessed need and achieve mutually agreed outcomes. The agreed care package is provided by professionals with the appropriate skills needed to support the individual to achieve agreed outcomes effectively and safely regardless of which service or agency they work for. In some instances the skills may be available wholly in the mental health service or in the learning disability service. In other cases there would be a need to share skills and work jointly across services. In complex care when several individuals provide care and treatment an agreed individual must coordinate the delivery of treatment.

People with learning disabilities must be able to access other specialist services, such as eating disorder, substance misuse, personality disorder services as well as early intervention, crisis and home treatment, and assertive outreach.

Planning ahead is crucial. Advocacy services should be available, and individuals should have proper person-centred plans for the services they need now and in the coming years. Planning ahead also implies building in some capacity in the system to cope with demand as it emerges, rather than waiting until crises occur. The relationships between these key components of the service are represented in Figure 2.

MAHI - STM - 300 - 1330

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel: (028) 9051 7500
Fax: (028) 9051 7501
Email: info@rqia.org.uk
Web: www.rqia.org.uk

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Exhibit 51

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

Mental Health and Learning Disability Directorate Annual Report

1 April 2013 to 31 March 2014

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

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This document sets out an overview of the activity of the Mental Health and Learning Disability (MHLD) Directorate from 1 April 2013 to 31 March 2014. It outlines the role of the Directorate and provides a summary of the outcomes from our monitoring of services delivered by the five HSC trusts.

During the 2013/14 year, the MHLD Directorate inspected 75 Mental Health and Learning Disability wards in Northern Ireland. This represents an increase of 63% in inspection activity from the 2012/13 year. Some of the additional inspections were undertaken due to complaints, whistleblowing and our need to review the management of patient's finance and belongings. We found that a number of safeguards were not in place in the management of patients' finances. A series of roadshows were undertaken, in June 2013, by the MHLD inspectors, across every trust to share the learning and the improvements required.

We have continued to highlight concerns about the safety and quality of service provision in the two children's specialist treatment units. The findings from recent inspections in the latter part of the year have demonstrated improvements in this area. Further progress is required to ensure young people have access to the right service, at the right time, in the right place. Eighteen young people under 18 were admitted to adult wards, which is unacceptably high. In one case a child was detained on an adult ward for 14 months. However the duration of time overall spent by children on adult wards has reduced. RQIA continues to maintain a close focus on the reasons for such admissions and reviews the patient pathway in each case.

Example of good practice and the main areas identified for improvement following inspections are detailed within this report. The number of wards for long stay patients continues to fall. It is expected that by 2015 all long stay patients will be relocated to suitable community care settings. RQIA has found that some patients are staying in hospital longer than necessary because of the lack of community care placements.

Inspections were carried out of all ECT suites, not accredited by the Electroconvulsive Therapy Accreditation Service (ECTAS). Questionnaires continue to be distributed to patients most of whom commented very positively about their experience of ECT.

RQIA revised their policy and procedures for the Appointment of Part II/ Part IV Medical Practitioners who are now appointed by an RQIA independent Appointment Panel.

We continue to monitor people subject to Guardianship Orders. Our figures are similar to last year (56), with variations noted in applications from trusts, with the Northern Health and Social Care Trust continuing to have the highest number of applications.

The MHLD Team monitored 6286 prescribed forms in 2013/14 of which 112 contained an error. Our inspectors meet with detained patients and provide feedback to ward staff about any issues raised either positively and negatively. RQIA has recently recruited lay assessors who will accompany inspectors when visiting wards and interviewing service users about their experience. We continue to strive to ensure that dignity, respect and compassion are the primary focus of all those involved in the care of people affected by mental health assessment.

One of our roles is to review treatment plans of patients who are detained for over three months. An audit was also undertaken of 132 treatment plans in 2013/14. This indicated that little improvement was made from our audit findings in 2012/13 as 80 treatment plans failed to meet the required standards.

Inspectors monitor all Serious Adverse Incidents received by the Team and made inquiry where it appeared that there may have been any ill treatment or deficiency in care or treatment. The MHLD Team are currently in discussion with the HSC Board and DHSSPS about a proposed new methodology for reviewing SAIs which will enable us to comment more critically on the implementation of the Mental Health and Learning Disability Frameworks.

An audit was undertaken by our Sessional Consultant Psychologist of 40 files to review access to psychological therapies for patients who subsequently completed suicide. The findings of the audit were disseminated at a workshop of Part II/Part IV Medical Practitioners, on 6 December 2013, and shared also with the Public Health Agency and Health and Social Care Board. The lessons learned are important to improve services and help staff recognise where risks exist. Concerns have been raised by RQIA with the HSC Board in regards to the under reporting of some SAIs, the delay in completing investigation reports and the lack of involvement of some families in the review process.

RQIA continues to seek the views of a wide range of stakeholders and are committed to putting people at the heart of what we do and reflect the things that matter most to patients and the public.

Our inspectors worked closely with patients in Muckamore Abbey Hospital (TiLii Group), following their request to have easy read version of our inspection findings. We have agreed that all MHLD inspection reports will be produced in easy read formats from April 2014.

Theresa Nixon
Director of Mental Health, Learning Disability and Social Work

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland.

The responsibilities of the Mental Health and Learning Disability Directorate within RQIA are defined under the Mental Health (Northern Ireland) Order 1986, as amended by the Health and Social Care Reform (Northern Ireland Act 2009).

These are:

- preventing ill treatment, remedying any deficiency in care or treatment
- terminating improper detention in a hospital or guardianship by monitoring the appropriateness of all applications forms received from HSC Trusts
- preventing or redressing loss or damage to a patient's property.

RQIA's designation as a National Preventative Mechanism (NPM)

RQIA is designated as a National Preventive Mechanism (NPM) by the United Kingdom Government under the, Optional Protocol to the Convention against Torture or other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The role of the NPM bodies is to:

- regularly examine the treatment of people deprived of their liberty with a view to strengthening their protection, prevent torture and other forms of Ill treatment
- make recommendations to the relevant authority with the aim of improving the treatment and conditions of detainees
- submit proposals and observations on existing or draft legislation

The MHLD Team has inspected a range of services including mental health hospitals and prisons under its responsibilities as a designated NPM.
A three year work plan has been agreed by all NPM members to take forward areas of joint work in 2014-2017.

RQIA will report on their progress in taking forward various aspects of this work plan in 2014 / 2015.

The Role of the Mental Health and Learning Disability Directorate

The Mental Health and Learning Disability Directorate undertake a programme of inspections and reviews annually. We had a footfall in every mental health / learning disability ward in the 2013/2014 year. The programme of inspections included inspections of wards where Electroconvulsive therapy was offered as well as additional inspections of patients' finance and property.

The inspections were both unannounced and announced and focused on the human rights theme and standards of protection. Six letters of escalation were sent to Trusts as RQIA had concerns about the safety or quality of care provided.

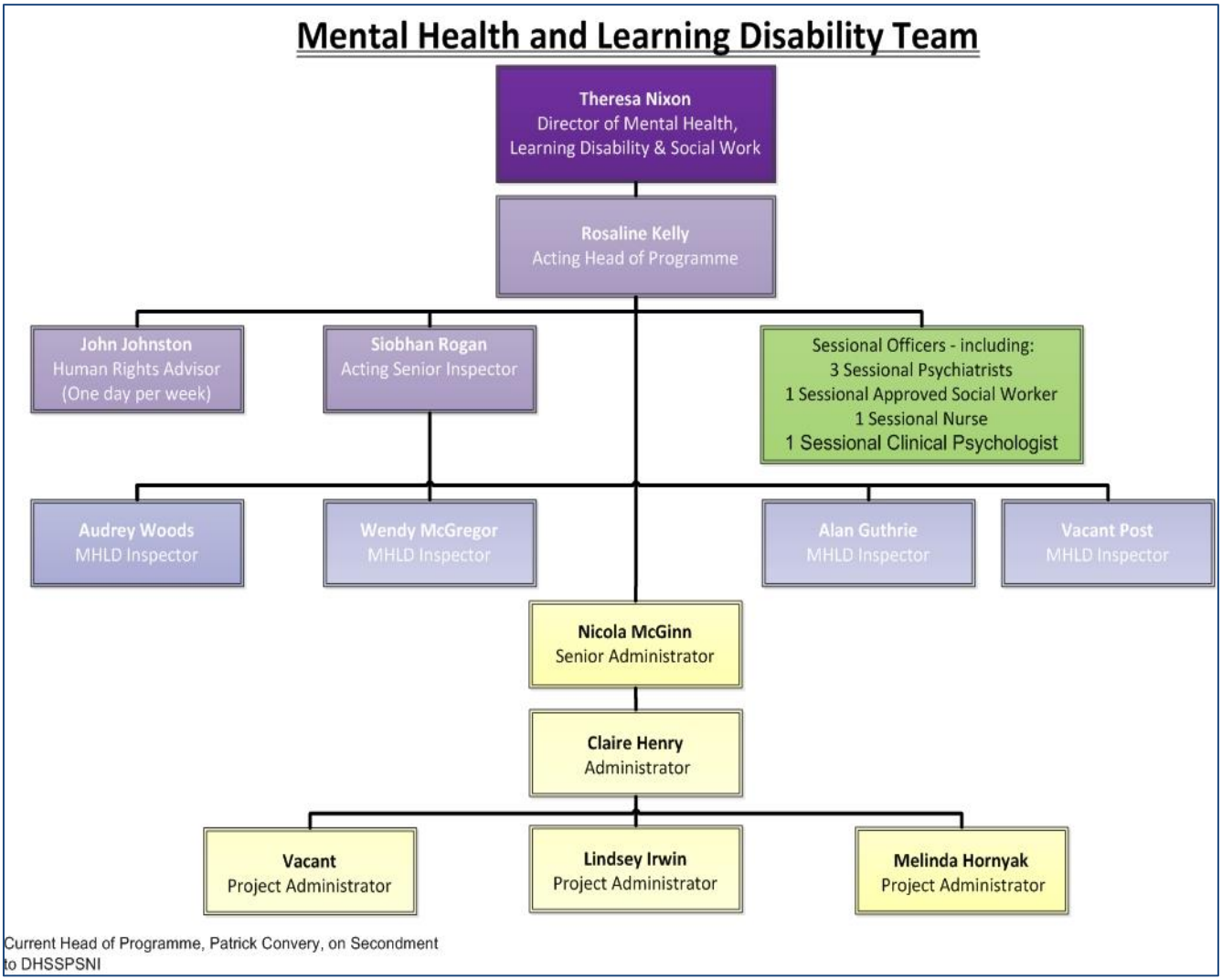
We speak directly to patients and ask them about their experiences. Their views inform the focus of our wider programme of announced and unannounced inspections. We identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest.

Our inspections are carried out by a team of inspectors, who have relevant experience and knowledge; our reports are available on the RQIA website at www.rqia.org.uk.

Structure of the MHLD Directorate

The MHLD Directorate is supported by 19 staff across a range of professions as set out in the organisational structure below.

Diagram 1: Mental Health and Learning Disability Team



A Human Rights Approach

Diagram 2: A Human Rights Approach

The MHLD Directorate underpins their inspection and review activities with a human rights approach to help safeguard the rights of service users. A suite of indicators and expectation indicators was developed to assess the safety and quality of care provided by trusts. This helped RQIA to assess whether care is designed and delivered in a way that reflects basic rights such as dignity, choice, privacy and respect, while reflecting an individual's needs and choices.

Our human rights advisor provided a training programme involving inspection staff from all Directorates in RQIA in 2013. A workshop was held for all providers of MHLD services, on 31 March 2013, to share the 2013/14 expectation statements using the human rights inspection theme of autonomy in 2014/15.

A meeting was held in London on 12 November 2013 involving RQIA, Health Inspectorate Wales, Mental Welfare Commission in Scotland and Care Quality Commission (CQC) and other bodies to review how inspectorate bodies underpin human rights in their inspection process. RQIA outlined their approach to human rights which led to RQIA hosting a further human rights workshop at the NPM five year anniversary conference, in Bristol, 8 April 2014. The event brought together all NPM members and international human

rights bodies to take stock of the NPM work to date and to look ahead to the future.

RQIA was also instrumental in providing information on defacto detentions. De Facto Detentions are where individuals who are not formally detained by law are deprived of their liberty in practice. With this come significant risks for individuals who do not enjoy a proper process for the review of their detention. The NPM identified a concern that those inspecting the conditions in which detention takes place may miss individuals who are de facto detained. Furthermore, general acceptance by professionals, carers and the public that such de facto detention is acceptable for some individuals because they cannot exercise choice may further jeopardise their human rights.

The findings on defacto detention were presented to the NPM meeting in October 2013 for discussion and agreement about further actions. The broad categories of recommendations made either in discussion or formal reports were about:

- Considering seeking proper legal authorisation.
- Assessing /reassessing capacity of service user.
- Considering changing/ reducing level of restriction.
- Ensuring staff have proper training.
- Developing clear policy and ensure service users know their rights.

More recent joint work has also involved NPM members in reviewing how regulators make recommendations and follow up on them most effectively. A further NPM report will be produced later this year.

Northern Ireland has higher mental health needs than other parts of the United Kingdom[1]. Based on the Northern Ireland Health and Social Wellbeing Survey (2001), 24% of women and 17% of men in Northern Ireland have a mental health problem – over 20% higher than the rates in England or Scotland.

Factors contributing to these rates include persistent levels of deprivation in some communities in Northern Ireland and the legacy of Northern Ireland's troubled history. For example, a recent study of the families of victims of Bloody Sunday found persistent effects of these traumatic events on the individuals concerned, with evidence of psychological distress still being found more than 30 years after the event.[2]

The incidence of suicide in Northern Ireland has been a particular concern in recent years. When a suicide takes place, the effects are devastating for relatives, friends and health care staff involved.

In 2011, there were 289 suicides in Northern Ireland, of these suicides 216 were among men and 73 among women.

The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The Bamford Review, which completed its work in 2007, has set the agenda for the transformation of these services.

[1] DHSSPS (2004) The Review of Mental Health and Learning Disability (Northern Ireland). A Strategic Framework for Adult Mental Health Services. Consultation Report.

[2] McGuigan, K., & Shevlin, M. (2010). Longitudinal changes in posttraumatic stress in relation to political violence (Bloody Sunday). Traumatology, 16, 1–6

Providing the Right Care in the Right Place at the Right Time

The model of mental health care has evolved which promotes greater care at home and in the community rather than in hospital. A stepped care approach has been adopted, providing a graduated range of care to meet the patient's needs:

Figure 1: Stepped Care Model

Step 1	Recognition, Assessment and Support
Step 2	Treatment for Mild Disorders
Step 3	Treatment for Moderate Disorders
Step 4	Treatment for Severe / Complex Disorders

Each of the HSC trusts has developed Crisis Response and Home Treatment teams that provide services for acutely ill people at home and in the community rather than in psychiatric hospitals. The role, number and location of psychiatric inpatient units are also changing as trusts are developing streamlined pathways for urgent mental health care.

These services have evolved differently in each area in terms of how people in crisis contact services, how they are triaged (by phone or in person at a hospital or other facility) and how they are treated in emergency departments. There is a need to ensure that there is a consistent outcome for those who use the service. Additional home treatment services still require to be developed for particular client groups including children and young people, people with a learning disability and older people.

Promoting Independence and Personalisation of Care

At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives. Meeting the goals of Transforming Your Care and ending institutional care by 2015 can only be achieved if there is a pathway to recovery for people with the most severe and complex illness, for example, people with schizophrenia and bi-polar disorder. Tangible services on the ground are the touchstone by which those using the service judge its success.

Institutional Care

There were 75 long stay mental health in-patients and 23 long stay learning disability in-patients who required to be resettled into the community by 31 March 2014. In both cases the target was achieved.

The RQIA review of Learning Disability Services in 2012/13 indicated that there is a continuing need to enhance the community infrastructure through investment in services to reduce unnecessary hospital admissions and promote timely discharges from learning disability hospitals.

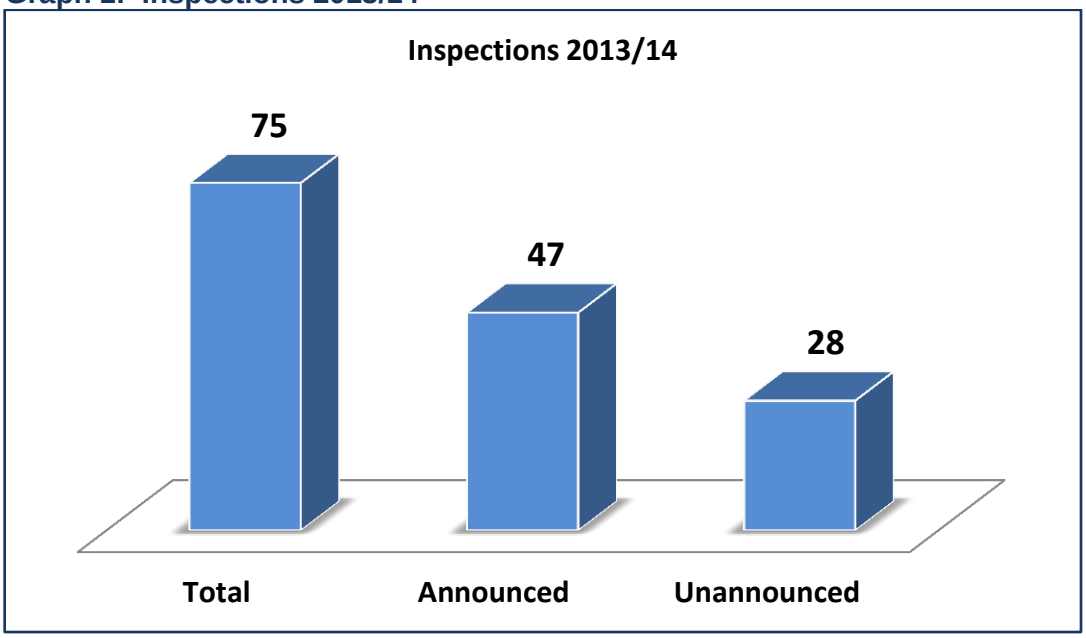
All services are subject to a process of ongoing risk assessment and review based on inspection findings and intelligence gained from SAI reports, complaints and whistleblowing to ensure our inspection programme is appropriately focused and proportionate. Our inspections focus on the safety, quality and effectiveness of service delivery to service users, as well as internal management and governance arrangements. Inspections are conducted by a range of qualified and experienced staff including nursing, social work, medical, psychology, occupational therapy and speech and language therapy staff as required.

Inspection Theme of Protection 2013/2014

The human rights theme of protection was selected for inspection in 2013/2014. Ten expectation statements were used by the Inspectors to review the safety and quality of care afforded to patients.

During the 2013/2014 year we undertook 75 inspections.

Graph 1: Inspections 2013/14



This represents an increase of inspection activity of 63% of inspections compared to the 2012/2013 year.

Of the 75 inspections 47 were announced and 28 were unannounced. Appendix 3 details the number of inspections by wards and type.

Assessment of Compliance

RQIA has adopted a five point scale for assessment of compliance as follows:

Table 1: Assessment of Compliance Levels

Table 1: Assessment of Compliance Levels		
Compliance Statement	**Definition**	**Resulting Action in Inspection Report**
Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.
Substantially compliant	Arrangements for compliance were demonstrated during the inspection; However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation or in some circumstances a requirement, being made within the inspection report.
Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report.
Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
Unlikely to become compliant	Compliance is unlikely to ever be achieved.	A reason must be clearly stated in the assessment contained within the inspection report.
Not applicable	Compliance is not applicable to this service setting.	A reason must be clearly stated in the assessment contained within the inspection report.

Table 2: Compliance Levels with Expectation Statements 2013/2014										
	Mental Health Statement									
Compliance Level	1	2	3	4	5	6	7	8	9	10
Not Compliant	5	2	9	5	1	10	3	1	1	0
Moving Towards Compliance	14	6	8	11	7	9	2	2	9	1
Substantially Compliant	13	15	16	14	10	14	8	13	17	10
Compliant	8	17	7	10	22	6	27	24	13	29

More than half of the wards inspected were fully compliant with five of the statements. The highest levels of non-compliance were with statements three, - awareness and application of safeguarding procedures and six - procedures in place for the effective management, support, supervision and training of staff.

Other aspects of concern were the limited use of evidence based practice, particularly within the areas of dementia, learning disability and mental health care. High levels of seclusion and reactive strategies were noted. A number of recommendations were also made in relation to poor record keeping and recording by staff.

Areas of good practice were noted in terms of the provision of GP and Primary health care services, in Shannon Clinic, to replicate those available in Primary health care services across Northern Ireland.

The increasing use of systemic therapies and the introduction of bio-psychosocial models of care delivery, particularly in children's treatment services were also commended by the inspectors.
The findings from the 2013/2014 of safeguarding indicated an improvement in standards across a range of services that were re-inspected.

Case Study 1: Service Improvement Though Inspection - Restrictive Practices

Inspectors have found many examples throughout the year whereby patients were subjected to practices of a restrictive nature that were excessive, not based on assessed need, and in some cases unnecessary.

One such example involved a patient who was subjected to restrictive interventions that impacted upon the patient's human rights. Records reviewed during inspection demonstrating that in a 52 hour period, the patient was restrained in a chair with use of a lap strap for a total of 42 hours; restrained in bed with the use of bedrails for 7 hours; and released from restraint for three single hours only in that 52 hour time period. This was despite records indicating that the patient was settled and/or sleeping during the time period concerned.

Inspectors found that this situation occurred as staff had not adhered to the agreed interventions in the risk management plan and care plan. Although the care plan included signatures to confirm a monthly review, there was no evidence that the actual use of restraint as the least restrictive measure available to keep the patient safe had been reviewed at weekly multidisciplinary team (MDT) meetings. Whilst it is acknowledged that the patient may have been agitated for extended periods of time, there was no evidence of the use of a stepped approach to minimise the need for the use of mechanical restraint, review of the appropriateness of use of mechanical restraint, or agreement for a maximum time limit for use of mechanical restraint. Additionally, due to the absence of psychological clinical specialities in the MDT and subsequent lack of psychotherapeutic inputs, there was lack of evidence to support the use of these interventions as the least restrictive, and the most effective evidenced based treatment option.

This practice was highlighted to senior trust representatives. During a follow up unannounced inspection, the inspector found that, whilst the patient continued to be cared for in this setting, they no longer required restrictive interventions. In addition, the inspector noted that the Trust had taken steps to ensure that all patients who were subject to restrictive interventions have the restrictive practice reviewed at least twice per day by staff on the ward and on a weekly basis by the multidisciplinary team.

This change in practice came about in direct response to recommendations made following an inspection of the facility.

Case Study 2: Service Improvement Though Inspection - Access to Person Centred Care and Treatment Appropriate to Assessed Need

During an inspection on a ward, inspectors noted that patients were presenting with needs that were not being appropriately assessed or addressed by the multidisciplinary team (MDT). Core care plans were being utilised and as a result patients were not in receipt of care that was individualised or person centred. Some patients on the ward were presenting with behaviours that others found challenging. These behaviours were not being addressed using evidence based interventions and the patient's behavioural presentations were having a detrimental impact on the patients' future independence and life choices.

RQIA highlighted this situation to senior trust representatives and made a number of recommendations to promote improvement in the safety and quality of care.

During a follow up inspection the inspector found that patients on the ward now have access to appropriately trained professionals who are using evidence based interventions. In addition, core care plans are no longer in use so that all care interventions are developed in response to individual assessed needs ensuring person centred care delivery.

This improvement in service delivery came about as a result of recommendations made by RQIA following inspection.

Inspection of Children's Specialist Treatment Services

There are two specialist assessment and treatment units in Northern Ireland for children under 18. The Iveagh Centre caters for young people with specialist learning disability needs and Beechcroft, for young people who require Child and Adolescent Mental Health Services. Both services run by the Belfast Health and Social Care Trust.

The MHLD Team noted an increase in the spring of 2014 of admissions for assessment of young people under 18. This matter is being followed up with the HSC Board and Trusts in order to understand the increase for such admissions. The MHLD Directorate consulted children and young people involving Voice of Young People in Care (VOYPC) advocates to elicit the young person's view about their experience. Both services required letters of escalation due to the concerns about both quality and safety of care in 2013/14.

During our inspection of The Iveagh Centre, we found that a number of areas requiring to be addressed in relation to child protection and safeguarding, including training for staff. A review of risk assessments and corresponding support plans for young people who exhibit challenging behaviour were recommended. Concerns were raised about recording and record keeping in terms of professional accountability.

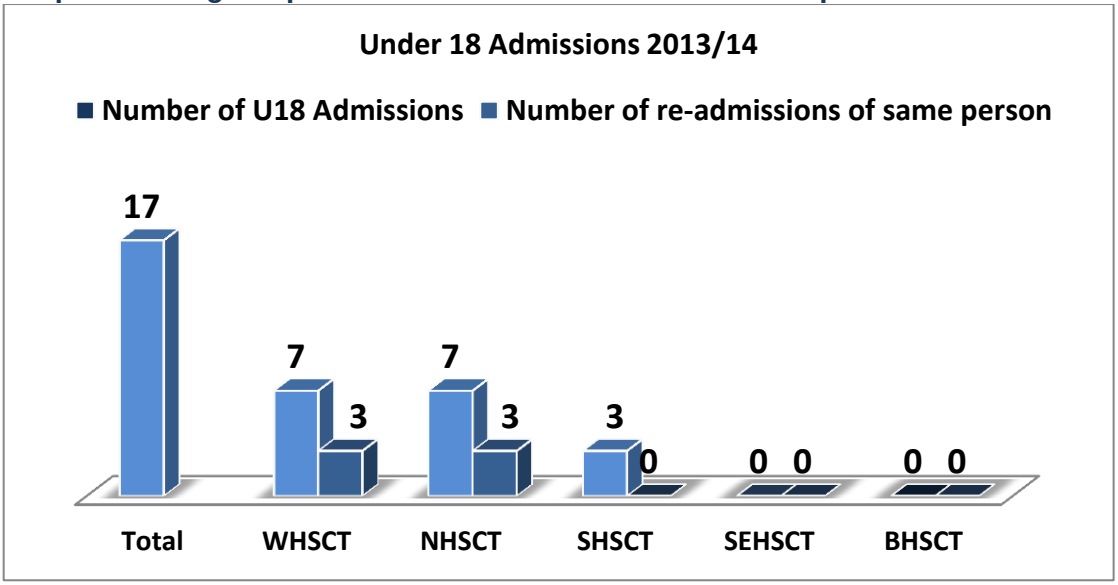
Young People Placed in Adult Wards

Inspectors were concerned to note the number of children receiving treatment in Adult psychiatric Wards.

All trusts need to continue to review their arrangements for child protection when a child is admitted to an adult ward. The inspectors review the appropriateness of arrangements made to meet the educational and recreational needs of young people admitted to adult wards.

RQIA will continue to review if children are safeguarded, in accordance with DHSSPS guidance and enquire if they have a patient advocate.

Graph 2: Young People under 18 Admitted to Adult Wards per Trust



There were no reports of young people admissions to adult wards in either the Belfast or South Eastern Heath and Social Care Trust areas. This may be attributed to the geographical location of the regional admission wards both located in the Belfast Trust area.

RQIA will continue to monitor access to the regional units by young people from the other Trust areas, to ensure equality in access to specialist services.

Letters of Escalation issued to Trusts

RQIA has a policy relating to the reporting and escalation by RQIA of concerns, direct allegations and/or disclosures, which have resulted, or are likely to result, in risk to patient safety and/or risk of service failure. These may arise during inspections and / or reviews carried out by RQIA. It applies to both the statutory and independent sectors.

Table 3: Letters of Escalation issued to Trusts in 2013/ 2014

Trust	Letters of Escalation
Belfast	0
Northern	1
South Eastern	1
Southern	1
Western	3

In addition, following inspections, a number of serious concerns were raised and followed up by the MHLD Team with the Trusts.

Table 4: Letters of Serious Concern issued to Trusts in 2013/2014

Trust	Letters of serious concern
Belfast	3
Northern	1
South Eastern	3
Southern	2
Western	4

The serious concerns were mostly issues regarding dignity and privacy of patients, quality of vulnerable adults' investigations, poor governance, lack of supervision, guidance and training of staff particularly in the management of challenging behaviour and risk management.

Whistleblowing and Complaints

Complaints and whistleblowing by members of staff and the public resulted in a number of unannounced inspections being undertaken. Action plans have been put in place to follow up the recommendations for improvement which have been shared with the HSC Board and DHSSPS. Whistleblowing concerns related mainly to the lack of an adequacy of staffing, care planning, consultation with relatives and carers, advocacy, discharge planning and the safeguarding of vulnerable adults.

Easy Read Version of Inspection Reports

Following joint work with patients from the TiLii group the MHLD Team listened to their views and developed an easy read version of our inspection reports

A sample of patients' views is included below:

- I enjoyed the report at least we have an Authority that monitors the patient experience'
- 'It was great involving the patients in inspection and improvement'
- 'It's service user friendly'
- 'I thought the pictures where big and brightful'
- 'I feel the symbols help a lot. I can't read although when staff read it to me I understood as it was easily worded'
- 'the symbols are my favourite'
- 'It is helpful'
- 'I think service users with a learning disability will be able to read the report'
- 'the easy read report was a great idea and very beneficial for the patients'
- 'It gives you some insight on what can be said about a place'
- 'It's good to see reports'
- 'use it because the content seems to be an honest one'

As of 1April 2014 all MHLD inspection reports will be made available in easy read format.

Involvement of Users by Experience in Inspection Programme for 2013/14

A pilot was undertaken involving three care experienced people with a learning disability in the inspection programme which concluded in June 2013. This was evaluated and it was agreed that it was more helpful to involve lay assessors in interviewing patients than the whole inspection programme. Three people with a learning disability have been recruited as lay assessors to interview patients. These lay assessors will be inducted, trained, supervised and supported by the MHLD Directorate.

Patient Experience Interviews 2013/14

During Patient Experience Interviews, the inspector interviews patients about their experience of being in receipt of care and treatment in an inpatient setting.

Aims

- To obtain the views of service users and their representatives on the inspection process and inspection themes.
- To establish a rapport with service users advocacy groups.
- To monitor the experiences of patients in Mental Health and Learning Disability wards.

Objectives

- Ensure patients are afforded due respect for individual human rights.
- Monitor the context and environment within which care is provided.
- Monitor quality and availability of care.
- Make appropriate recommendations.

During 2013/14 142 patient experience interviews were undertaken in a range of mental health and learning disability facilities across Northern Ireland. The aim was to fulfil RQIA's responsibilities under Article 82 (2) of the Mental Health Order regarding the monitoring of care provided to detained patients. A continuing programme of patient experience reviews is planned from April 2014.

In general most people were satisfied with the information given in relation to their rights and their right of referral to the Mental Health Review Tribunal. RQIA found that information relating to independent advocacy services was not always available on some wards or patients were not informed of the role and function of independent advocates. Whilst most patients said they felt safe on the ward, a number of patients said they were "Frightened when other patients were aggressive and shout".

Blanket restrictions were evident on some wards in each Trust. Some patients complained that "If there is not enough staff on duty I don't get out for a walk".

A number of patients complained that they did not get to attend their multi-disciplinary team meeting and one young person indicated that they had not seen their consultant in the previous three month period. Positive comments

also received “Staff have been very honest with me even when giving me difficult news” and “Staff on the ward know what I like to do and give me time to do it”.

A number of other issues raised concerned discharge arrangements. Some patients expressed frustration that they had to stay in hospital longer than necessary due to the lack of appropriate service provision in the community. One patient commented that they had limited space to meet with family or visitors and could not make a telephone call in private.

A number of patients commented about the lack of occupational therapy, psychology services and therapeutic activities.

“I become more anxious when I’m bored and this does not help me in my recovery”.

Following patient interviews a quality improvement plan is forwarded to each trust. This is followed up by RQIA in relation to improvements made at the next inspection visit. MHLD inspectors have also developed a direct observation tool for use on wards for patients who have no capacity to answer or understand a structured questionnaire.

Meeting with Independent Advocacy Groups

The MHLD inspector met with four independent advocacy groups in February 2014. These included;

- TILLI (individuals with a learning disability)
- Alzheimer’s society (individuals with dementia)
- NIAMH (individuals with mental health problems)
- VOYPIC (young people with mental health problems)

The following matters were discussed;

- The theme for RQIA inspection year 2014 / 2015
- Inspection and PEI processes
- Inspector’s conduct / behaviour / dress on inspection i.e. what would assist the patients to be more relaxed when being interviewed by RQIA.

The Theme for RQIA Inspection Year 2014 / 2015

All four groups agreed that the theme of autonomy was an appropriate theme. The theme of autonomy was broken into six statements; these were discussed with the service user groups, who indicated which they felt was most important to their group.

Future Plans

All groups agreed to meeting with the RQIA inspector twice yearly.
The PEI poster for the ward has been amended to reflect that patient interviews are offered by RQIA to all patients, not just patients subject to detention.
RQIA will also continue to meet the Bamford Monitoring Group as requested.

Monitoring of Compliance with Article 116 of the Mental Health (Northern Ireland) Order 1986 in Respect of Patient Finances / Belongings

The MHO defines a role for RQIA in Article 86 (2) (c) (iv) in "preventing or redressing loss or damage to [patients] property". RQIA monitors the arrangements put in place by trusts to safeguard patients' monies.

Assurances were requested from Trusts concerning records and procedures for monitoring patients' and residents' monies through reviewing:

- Compliance with DHSSPS Circular 57/2009 - Misappropriation of Residents' Monies – Implementation and Assurance of Controls in Statutory and Independent Homes. This applies to all Health & Social Care (HSC) facilities including hospitals.
- Application of accounting policies as detailed in their Standing Financial Instructions (SFIs).
- Implementation of comprehensive local procedures; and
- Application of Standard 15 of the DHSSPS Nursing Homes Minimum Standards, 2005 (in so far as this can be applied to hospital patients).

A sample of patient records were selected across all wards visited to review the following:

- cash and valuables were held securely
- appropriate and complete income and expenditure records were maintained
- all transactions in the audit period were appropriately recorded and supported by a receipt where necessary
- amounts received from finance departments were recorded and received intact and in full at the of the relevant wards
- expenditure recorded appeared to be reasonable
- Regular checks had been undertaken by ward managers on patients' income and expenditure records to confirm that entries were dual signed and expenditure was supported by receipts, where necessary, and that patients' balance reports were received on a monthly basis from the finance department and reviewed by ward managers.

Findings

The following findings were noted:

- Permission is not sought from RQIA requesting consent for trusts to hold balances of more than £20,000 for any single Mental Health and Learning Disability (MHLD) patient by any of the five Health and Social Care Trusts. This is required at Article 116(4) of the Mental Health Order
- Monies withdrawn from patients' accounts at the cash office by nursing staff for patients' use were not always recorded in cash record books at the wards and there was no evidence of receipt of these monies by patients in some cases. It was therefore difficult to confirm that these monies were used appropriately.
- Records of monies spent were not maintained and cash held by staff for group spend purposes was not stored securely.
- Access to keys of storage units where patients' monies / valuables were held was not strictly controlled.
- Patients' Property admission books had not been completed.
- Transactions in patients' cash record books (mainly withdrawals) were not signed by the patient and one staff member or by two staff members as per relevant procedures
- Receipts had not been issued to patients' relatives where monies had been handed in for patients' use or where relatives had received patient's property.

Quality improvement plans were issued to trusts with specific recommendations to address these areas. The MHLD team has drawn up a matrix to risk assess wards that will require financial inspections in 2014/15.

The MHLD team will also draw-up some guidance for the sector in terms of best practice in the management of patients' finances.

Working with Service Providers

The MHLD team held a roadshow on 31 March 2014 for all registered providers and managers in Antrim Civic Forum. The event was attended by 69 participants

.

The Roadshow focused on:

- The role of RQIA and the work of the Mental Health and Learning Disability Directorate.

- An outline of the main inspection findings 2013-14

- A list of the key themes and standards under the human rights focus of autonomy in 2014/2015, these include:
    - capacity and consent
    - individualised assessment and management of need and risk
    - therapeutic and recreational activity
    - information provided to patients about their rights
    - restriction and Deprivation of Liberty
    - discharge planning

- Human rights and how specific articles link with the inspection theme
- The letters of serious concerns and escalation and reasons for these in 2013/14 were shared for learning
- The outcomes of Patient Experience Interviews undertaken in 2013/14 and the plan for 2014-15
- The overview of the content of the new draft Mental Health Capacity Legislation was provided by the DHSSPS and;
- Best practice examples from inspections

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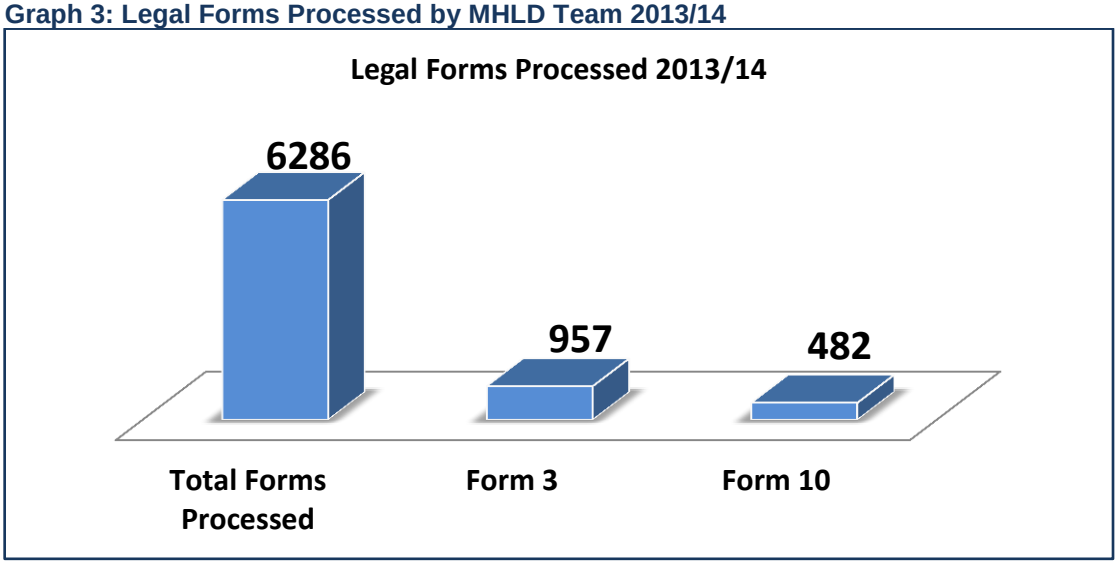
Monitoring of Detention and other Prescribed Forms by the MHLD Directorate

Detention is defined as the deprivation of liberty or imprisonment or the placement of a person who is detained under legislation in a public or private institutional setting, which they are not permitted to leave at will.
The number of people detained under the Mental Health (Northern Ireland) Order 1986 is showing a decrease since 2013/ 2014. This reduction may be due to the centralisation of services and the increasing development of crisis response/ home treatment teams in each HSC Trust, combined with managing patients in a voluntary capacity instead of the more restrictive use of the Mental Health (Northern Ireland (1986)) Order.

Graph 3: Legal Forms Processed by MHLD Team 2013/14

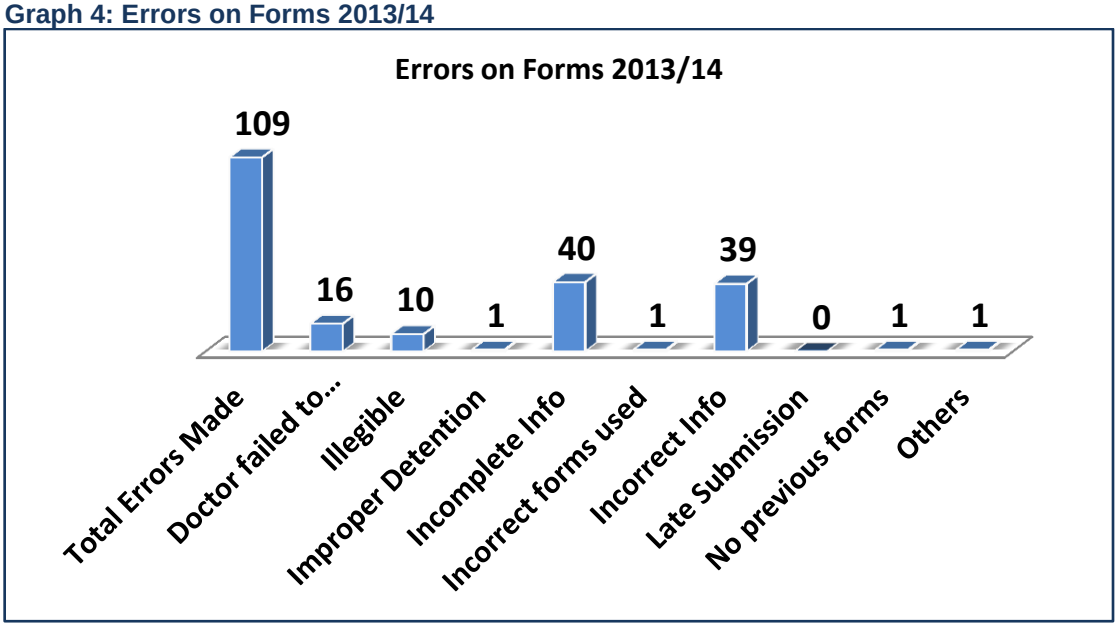


Form 3 is the form required to detain a patient for assessment and form 10 for detention for treatment. The purpose of the assessment period is to ensure that the patients' mental health condition is thoroughly investigated and the need for compulsory care or treatment fully established before they can be detained on a long term basis

Common errors on forms include the following:

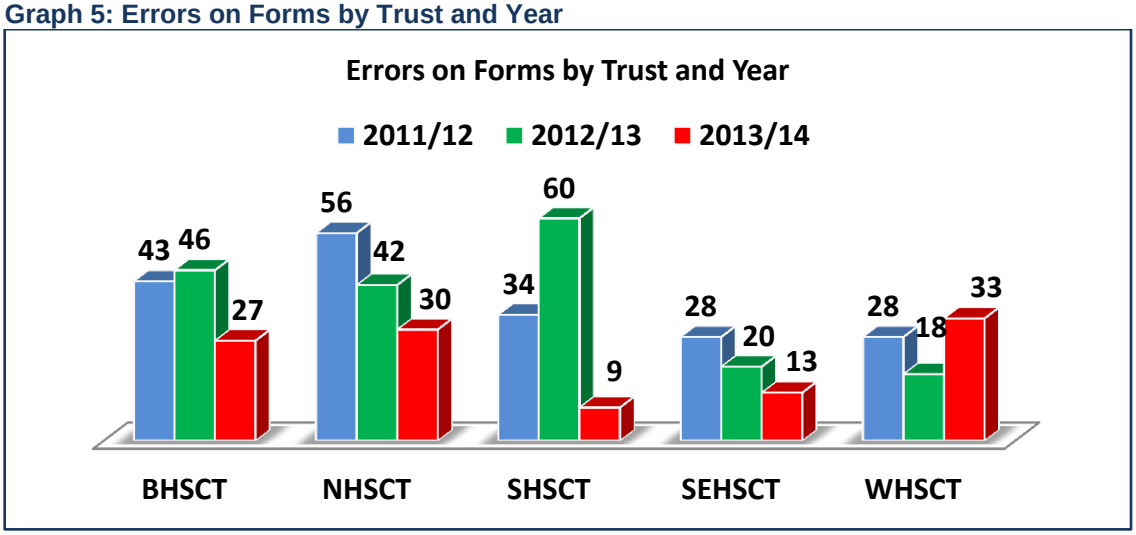
- Date had been entered incorrectly
- Full name of the patient spelled incorrectly
- Wrong name of patient entered
- Doctor failed to indicate reason for detention
- Writing illegible
- Full name for next of kin not completed
- Doctors status not indicated

Graph 4: Errors on Forms 2013/14



Errors in detention forms have continued to decrease since the transfer of functions in April 2009. The current rate of errors stands at 1.8%.

Graph 5: Errors on Forms by Trust and Year



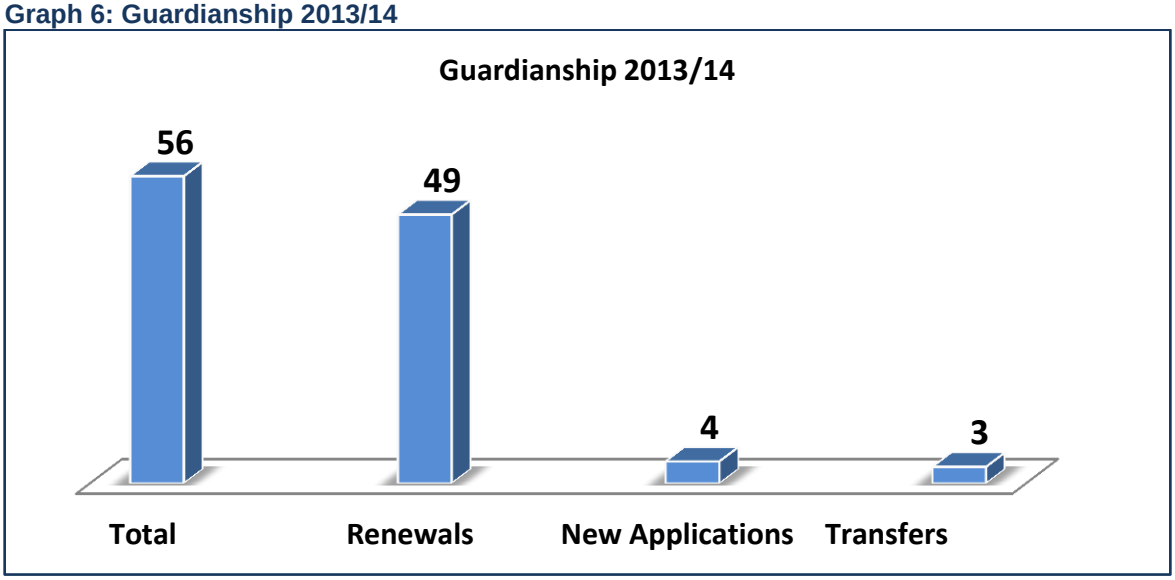
With the exception of the Western Trust there is a notable reduction in errors. This error rate may be caused by changes in personnel over the last year.

Guardianship

The MHLD Team quality assures all guardianship forms to ensure that the process is legal and measures compliance with Articles 22, 23, 24 and 86 of the Mental Health (Northern Ireland) Order 1986.

The purpose of guardianship is to ensure the welfare grounds (rather than medical treatment) of a patient in a community setting. This can be achieved with the use of some or all of the powers vested by guardianship. It provides a less restrictive means of offering assistance and an authoritative framework for working with a people with a minimum of constraint to help them to achieve as independent a life as possible in the community.

Graph 6: Guardianship 2013/14



Graph 5 indicates that there were 56 applications received by MHLD Team, 49 of which were renewals of guardianship orders, 4 new applications and three inpatients who were transferred from detention to guardianship.

RQIA noted that:

- different practices continue to exist within trusts and across programmes of care, in adopting a rights based approach to the assessment for guardianship
- variations in use of guardianship across trusts
- there was lack of access of advocacy services in some trusts and variances in information provided and in decision making/ care planning
- variances were noted also in the range of activities provided to individuals subject to guardianship, in relation to the management of services user's finances and in the training needs of guardians

- a lack of attention was noted in relation to health promotion and awareness programmes in relation to risk factors, including diet, exercise and smoking

RQIA published an article on the overview by RQIA of guardianship in the Professional Social Work Journal in November 2013.

RQIA is currently involved in a review of the service provision available to enhance the physical health needs of mental health and learning disability patients as there is a need to address the existing health inequalities experienced by people with a mental health condition or learning disability, to further improve lifespan and their physical health. A copy of this review report will be published in September 2014 by Dr Oscar Daly.

Audit of Treatment Plans 2013/14

Treatment Plans are referred to in the Mental Health (Northern Ireland) Order 1986 Code of Practice as essential in order to ensure that the different elements of patient care are coordinated, as part of an effective treatment programme for each patient.

Treatment Plans are required to be documented in each patient's clinical notes and must incorporate details of the patient's care, supervision and all forms of therapy received by the patient. The medicines for both physical and psychiatric conditions prescribed for the patient are written on their medicine Kardex.

Treatment Plans are recorded on Forms 22 and 23 and require a Part II Medical Practitioner to document the psychotropic medicines that the patient is receiving at that particular time.

Standards used by RQIA to Audit Treatment Plans

1) Legibility
2) Patient name (and DOB if under 18)
3) Hospital name
4) Consultants name
5) Medications
    a) Acceptable medication
    b) Dosage within BNF Guidelines
    c) Polypharmacy – indications e.g. changeover, treatment resistance etc.
    d) Pro re nata medication:
        1. Indications
        2. Minimum interval between dosages
        3. Maximum dosage in 24 hours
6) Signed and dated (within timescale)

Summary of Audit Findings on Standard of Treatment Plans

An audit was undertaken of 132 treatment plans in 2013 / 2014. This indicated that little improvement had been made from the audit undertaken of 40 treatment plans in 2012/2013 year.

Number of treatment plans received (Forms 22 and 23)	132
Not approved	36 = 27%
Failure to meet standards	80

Other Issues identified as a Result of the Audit

a) Capacity to give Valid Consent.

It is essential for Part II Medical Practitioners completing Form 22s to:

- Ensure that the patient can give their valid consent (i.e. that they are capable of understanding the nature, purpose and likely effects of the prescribed medicines) and to
- Make a clinical record in the patient's notes of the process of obtaining consent.

The Medical Panel members were unable to judge from the information contained on the Form 22 and Form 10 whether or not the patient had capacity to consent. This should be commented on by a psychiatrist in their completion of the treatment plan.

It was noted in a small number of cases of patients with learning disability that the accompanying Form 10 stated that the patient had severe impairment of intelligence. In these cases the Medical Panel considers it good practice that the Part II Medical Practitioner comments on this apparent anomaly.

b) Increase in Errors Noted where Treatment Plan is not written by Consultant.

Although not one of the standards, it was clear from an examination of the writing on some of the treatment plans that the actual psychotropic medicines may have been written by someone other than the Consultant in a significant number of cases.

The MHLD Team has recommended that this matter is reviewed by the Clinical Directors of each Trust.

c) Legibility and Clarity of Handwritten Forms

Although the legibility of the list of medicines on the Forms scored 96%, the Medical Panel had difficulty deciphering a significant number of the forms. The handwriting required close scrutiny and some of the forms were untidy with names or words frequently crossed out and re-written above or in the margin.

As treatment plans are legal documents, the Medical Panel recommended that these should be written clearly in capital letters and preferably completed by the Consultant.

Actions taken by the MHLD Team

1. The findings of this audit was shared with the Medical Directors and Clinical Directors in each Trust, with a request that the issue of errors, legibility, obtaining consent, PRN prescribing, BNF dosage and indicators for polypharmacy are reviewed by their psychiatric staff.

2. Clinical Directors were asked to review the process of completing Treatment Plans to ensure that Treatment Plans are completed solely by the Consultant.

3. RQIA shared the findings with the HSC Board/ PHA so that areas requiring improvement were reinforced with the five trusts.

4. RQIA will undertake a further audit of treatment plans in 2014-15 against the standards used in the 2013-14 audit. A report on the findings will be produced in November 2014 and shared at a workshop for Part II and Part IV Medical Practitioners.

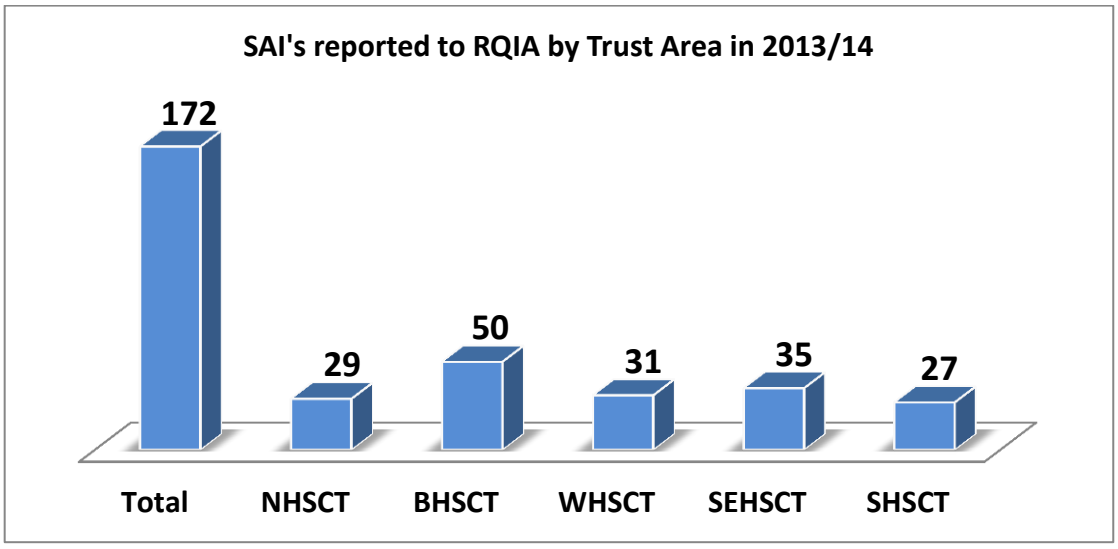
A function of the MHLD Team is to monitor Serious Adverse Incidents (SAIs), affecting users of MHLD health and social care services in Northern Ireland.

The duty is supported by the Mental Health (NI) Order 1986 Article 86 (2) (a) which requires RQIA to "make enquiry where it appears that there may be ill-treatment, deficiency in care and treatment".

Article 26 (2) (c) to "secure the welfare of any patient by (ii) remedying any deficiency in care and treatment.

With effect from 1 May 2010 Serious Adverse Incidents (SAIs) are no longer reported to DHSSPS. The responsibility for managing SAI reporting transferred to the HSC Board, working in partnership with the Public Health Agency (PHA) and RQIA. The DHSSPS has proposed that these interim arrangements will remain in place until a new Regional Adverse Incidents and Learning (RAIL) system is established.

Graph 7: SAI's reported to RQIA by Trust Area in 2013/14



RQIA Overview of SAI Investigations undertaken by Trusts

In the audit of access to psychological therapies it was indicated that the majority of the trust review teams were reported as multidisciplinary, with 16 (40%) deemed to have an independent chair. However, there was variation across trusts with regard to the make-up of review teams and a lack of clarity about what constitutes independence. It was unclear whether there was a range of clinical knowledge and skills within the review teams as the designation of team members often referred to management roles rather than clinical background.

Few review reports demonstrated how they followed a true root cause analysis format. A significant number of reports included family members and the treating doctors/therapists as members of the reviewing team.

A common conclusion from the review of suicide is the claim that the deaths were unexpected and could not have been predicted by staff.

Of the forty cases audited, 16 (40%) identified opportunities for learning, although these were very rarely related to clinical care and treatment.

RQIA has also highlighted the inadequate suicide prevention interventions for persons suffering from a dual diagnosis i.e. a mental illness and substance abuse problem, and particularly the need to review those who do not engage with services. The levels of staff support and debriefing following the reporting and investigation of SAIs was found to be variable across trusts.

RQIA has recommended that the provision of psychological therapies should be a core component of all mental health and learning disability services in the future.

Following the review of a number of Serious Adverse Incidents (SAIs) concerns were raised by MHLD staff about the number of cases where there appeared to be no access to psychological therapies.

The MHLD Sessional Psychologist agreed to undertake a random sample of 40 SAI reports from a list of list review reports, sent to RQIA. The findings and implications for future management were highlighted in the audit report which was shared with trusts at a workshop on 6 December 2013 with the Public Health Agency/ HSC Board in order to encourage improvement in this service.

Evidence of Good Practice

There were very many examples of efforts to engage service users who had difficulty connecting with services. It was clear that in a number of cases every attempt was made to follow-up patients where staff was concerned for their safety and health. There were clear instances of sharing of information and good engagement with GP's. A number of reviews included areas of good practice noted during the investigation.

Areas of Concern Noted by MHLD Inspector

1) Managing Co-Morbid Presentations

One area of particular concern is the passing of patients across teams where there is co-morbid (joint) alcohol and drug misuse (55% of the sample). We found that a number of individuals presenting with self-harm and suicide attempts were referred from Community Mental Health Team (CMHT) to Community Addiction Services (CAT) with no follow-up from mental health services. A significant proportion did not engage with CAT and were often discharged without being seen. There appeared to be little evidence of outreach working or co-working across teams which may have promoted better patient engagement and risk management.

There also appeared, from investigation reports, to be a lack of co-ordination across physical health and mental health services where the individual had co-morbid chronic physical illness and may have been attending health psychology, older people's services or community brain injury teams. Such services are often located within different directorates and information sharing can be difficult. RQIA recommend there should be opportunities for other teams to be involved in case discussion and care plans.

2) Co-Ordination of Input Across Teams and Services

Many patients experienced being passed between Home Treatment Teams (HTT) and CMHTs on a number of occasions. In addition, they were frequently seen by different psychiatrists, for example, in one case a person was referred to six different teams in the course of 7 months.
Given that research demonstrates the importance of the therapeutic relationship in achieving good mental health outcomes, without the opportunity to engage with key workers it is perhaps unsurprising that many service-users disengage from services.

A number of trust SAI report review recommendations also evidenced poor co-ordination and sharing of information across services and teams. We suggested that an opportunity for therapists to attend case discussions should be encouraged, particularly where there is involvement of community and voluntary services, or private therapy services. Without this there is no way of ensuring a co-ordinated care plan which includes the delivery of evidence-based interventions.

3) Limited Risk Assessment

The role of risk assessment in preventing suicide will always be a point of debate. Reviewing risk assessments in hindsight, does not have the benefit of the clinical presentation at the time. Nevertheless, while the reviews indicated evidence of completed risk assessments, the patient is reporting a lack of suicide plan seemed to over-rule other well established clinical risk factors.

> A case example of this involved Patient A, a 56 year old man presenting with low mood, reported feelings of life not worth living, a previous suicide attempt, suicidal ideation, poor appetite and sleep, following his wife's death. The notes record that he "denied having a plan and stated his children as protective factors". He was judged to be of low risk and given the telephone number of Lifeline. He subsequently completed suicide by hanging. The findings of the review stated that Patient A's death "could not have been foreseen".

Obviously, each individual case is different and must be assessed in context. Nevertheless, it is suggested that had Patient A's presentation and history been considered in terms of psychological formulation, given his gender, age, history of loss, low mood and previous suicide attempt, he would have been judged to have a number of significant risk factors, which could then be weighed against his denial of an active plan.

4) Poor Access to Psychological Therapies

Despite the growing evidence base, professional guidelines, local and national strategy, together with service-user preference for psychological interventions, there is very little evidence of improved access to psychological therapies. Medication appears to be the intervention of choice for all presentations, even when managing self-harm despite NICE guidance (CG133) stating "Do not offer drug treatment as a specific intervention to reduce self-harm."

This is not to say that those psychiatrists and mental health staff trained in evidence based therapies and interventions were not utilising them appropriately, but rather points to the lack of inclusion of such information within the investigation reports. However, it may well also relate to the fact that many mental health professionals express frustration over the lack of time and supervision available to implement therapies in which they have been trained.[3]

Furthermore, in relation to NICE guidelines for moderate to severe depression, there was little evidence that the full range of high-intensity psychological interventions should normally be offered in inpatient settings. (CG90). It was often unclear about the nature of intervention and support being provided by community nursing services, other than the monitoring of mental state and adherence to medical regimen.

Where the cases reviewed had a history of relapse, there was no evidence, as per NICE guidelines, that „People with depression who are considered to be at significant risk of relapse (including those who have relapsed despite antidepressant treatment or who are unable or choose not to continue antidepressant treatment) or who have residual symptoms, should be offered one of the following psychological interventions:

- Individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment

- Mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression.[4]

[3] QUB QPsyC report into Psychological Therapies Training 2013 (commissioned by HSCB Psychological Therapies Implementation Group)

5) Involvement of Families

Approximately 1/3 of families expressed dissatisfaction at their lack of involvement in their relative's care. There was a clear difference of approach when looking at statutory mental health services who report confidentiality issues as restrictive issues and in e.g. Lifeline, who regularly engage a contact person when working with individuals.

A number of reviews had clearly not engaged family members in the review process, whilst others appeared to include relatives as part of the review team.

Summary of Audit Findings

This audit represented an opportunity to consider suicide reviews in a group context, with particular attention to quality of treatment and care provided and focusing on access to psychological therapies. The main methodological drawback is that the audit only accessed trust review reports, as opposed to the patient clinical files, and was therefore reliant on the reports accurately recording clinical care decisions and the treatment provided.

Nevertheless, the study has used epidemiological data and trust investigations to identify recurring themes and potential learning opportunities.

Key Issues Identified

The care and treatment issues identified largely reflected those articulated by RQIA inspectors following their review of SAI reports, these included:

- The management of co-morbid presentations and dual diagnoses, particularly where this involves working and communicating across teams.
- The practice of transferring individuals across a number of teams, which affords little consistency in therapeutic relationships and presents as service-centred, as opposed to patient- centred, care.
- The nature and role of risk assessments and the need to be aware of the contribution of well recognised risk factors.
- The need to ensure an integrated and shared care plan which should include the interventions provided by external bodies.
- The apparent lack of awareness of/access to evidenced-based psychological therapies and interventions.
- The importance of considering each service user systemically, including appropriate family involvement and awareness of risk factors where children are involved.

In conclusion, as suicide rates in Northern Ireland continue to rise and constricting mental health services continue to manage increasing numbers of referrals, it is important to consider how best to review the treatment and care provided to our service users and their families. The methodology used in this audit provided a supplement to the SAI review process, whereby the identification of recurring themes of good practice and gaps in service provision provided an opportunity for increased learning and service improvement.

The findings of this report have important implications for the role of the RQIA in monitoring SAIs, who are identifying recurring themes and deficiencies in care and treatment
The MHLD team are currently auditing 100 patient pathways of people who have been known to addiction services as addiction to drugs and alcohol feature largely in serious adverse incident reports and will publish our findings by September 2014.

Electroconvulsive Therapy (ECT) is considered an important and necessary form of treatment for some of the most severe psychiatric conditions and is, in many instances, a life-saving treatment, particularly for patients with severe depression.

Treatment with ECT requires valid consent from the patient, where possible. The percentage of patients receiving ECT on a voluntary basis and capable of giving valid consent, was 70%. Some patients commenced their course of ECT on a detained basis and completed it as a voluntary patient. The number of patients receiving ECT on an outpatient basis varied between trusts, and some patients who commenced ECT as an inpatient completed their course as an outpatient.

Requests for Part IV Medical Practitioner's Opinions for ECT (1 April 2010 to 31 March 2013)

Forty five requests for Part IV Medical Practitioners' opinions were sought in relation to the administration of ECT from 1 April 2010 to 31 March 2013.

Table 5: Number of requests to RQIA for Part IV Medical Practitioners' opinions from 1 April 2010 – 31 March 2013

Trust	1 April 2010 / 31 March 2011	1 April 2011 / 31 March 2012	1 April 2012/ 31 March 2013
BHSCT	8	5	12
NHSCT	13	9	11
SHSCT	4	6	5
SEHSCT	11	8	10
WHSCT	8	8	7
Total	**44**	**36**	**45**

This demonstrates an increase of 9 second opinions in the 1April 2012 to 31 March 2013 period.

Table 6: Summary of rate of ECT per 100,000 of catchment population by Trust from 1 April 2012 to 31 March 2013

Table 6: Summary of rate of ECT per 100,000 of catchment population by Trust from 1April 2012 – 31 March 2013			
Trust	**Population**	**Number of Patients receiving ECT 2012/13**	**Rate per 100,000 population 2012/13**
BHSCT	335,774	30	9
NHSCT	458,746	37	8
SHSCT	358,647	15	4
SEHSCT	346,794	13	4
WHSCT	299,431	18	6
Total	**1,799,392**	**113**	**6**

Table 5 demonstrates a variation in the rate of the administration of ECT across the five trusts. A number of reasons may account for this variation. It should also be borne in mind when considering the disparity in these rates of administration of ECT that under-use of ECT is as undesirable as over-use. In respect of some patients with severe depression, treatment with ECT can bring about improvement in their mental state within a month of starting their course of ECT whereas drug therapy may require a high dosage or a combination of drugs given over several months to effect improvement. These factors may be extremely important in the management of an individual patient's illness when weighing up the risks and benefits of different treatments.

A survey of ECT administration in England carried out from January to March 2002 gives a figure of 4.6 people per 100,000 of the population. The most recent rate for England and Wales is approximately 0.4 patients per 100,000 population over 18 years of age (Personal Communication).

In Scotland, approximately 7.8 people per 100,000 of the population in 2009/2010 were treated with ECT[4]. The figure was 6.9 people per 100,000 of the population in 2012. (Personal Communication).

RQIA found it difficult to find accurate comparisons across the jurisdictions as the rates of ECT administration are not published on an annual basis.

Two Serious Adverse Incidents (SAIs) in relation to the administration of ECT were reported to RQIA during the period of this review. The Trust acted appropriately on the recommendations made for improvement.

[4] Scottish ECT Accreditation Network Annual Report 2011

Action taken in 2013/ 14

RQIA developed a template for the return of figures on the administration of ECT across Northern Ireland quarterly to enable MHLD Team to monitor trend data and any emerging themes.

RQIA updated the list of those Part IV Medical Practitioners available to deliver second opinions in relation to ECT and in addition revised their policy and procedures for the appointment of Part IV Medical Practitioners.

The Director of Mental Health and Learning Disability obtained permission from ECTAS in 2013 to use an adapted version of their Patient Experience Questionnaire to obtain the views of patients about their experience of ECT. It was agreed with trusts that patients, on completion of their treatment with ECT, would be asked to complete the patient questionnaire. At the time of the publication of this report, the majority of patients who returned their questionnaire commented very positively on the quality of care that they received when undergoing electroconvulsive therapy. This included the process of giving consent and the way in which they were given information about the treatment.

Sample of Comments from Patients

“ECT gave me my life back again…I thank god every day for ECT and getting my life back again…don’t know what would have happened if I hadn't received it”.

“I was in a very bad place for 9 months and I am almost back to my old self.”

“I felt ECT was very important and I saw a dramatic change in my mental health. I would have no issues to having this treatment again or recommending to others. I felt the staff provided excellent support, care and reassurance”.

A journal article will be published by Dr Sara Maguire / Dr Shelagh - Mary Rea in June 2014 about the views of patients about their experience.

Inspections of ECT Suites not Accredited by ECTAS 2013/14

Visits were undertaken to all ECT suites not accredited by ECTAS (Electroconvulsive Therapy Treatment Accreditation Service) across Northern Ireland to review the quality and safety of the administration of ECT in 2013/14.

RQIA found that the service was delivered effectively across Northern Ireland with some minor improvements required apart from the Tyrone County Hospital. The Western Trust temporarily had to cease operating the service until the required improvements were made in February 2014.
RQIA checked every Form 23 containing details of the treatment plan to administer ECT. All of the Form 23s completed by Part IV Medical Practitioners between 1 April 2010 and 31 March 2013 were checked and found to be correctly completed, in line with the legislative requirements.

MAHI - STM - 300 - 1376

Leadership Development Programme

A number of conferences were attended and presentations were delivered by MHLD staff from April 2013, these are outlined in Appendix 1.

Workshops for Part II / Part IV Medical Practitioners

A workshop was held on 6 December 2013 involving 80 consultant psychiatrists supported by the Royal College of Psychiatrists. Topics included:

- Audit of Treatment Plans
- Draft Mental Capacity (Health Welfare and Finance) Bill
- Access to Psychological Therapies / Review of SAI Report
- Key findings from Inspections of Safeguarding 2012 /13
- Inspection Standards 2013/14
- Co-morbid Physical Illness
- Overview of Implementation of ECT Recommendations

The Scottish and Republic of Ireland Mental Health Commissions were represented at the workshop.

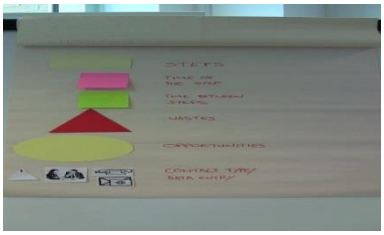
Response to Consultation Documents

Since April 2013 – March 2014 the MHLD Team has responded to 3 consultation documents;

- The RQIA Review of Fostering Services (December 2013).
- The Department of Justice Consultation on Custodial Arrangements for Children in Northern Ireland (January 2014).
- The DHSSPS Consultation on Foster Placement and Fostering Agencies Regulations (Northern Ireland) 2014 (January 2014).

Review of Internal MHLD Administration Systems

Work was undertaken to update all MHLD administrative systems and processes within the current programme following the Lean methodology process. This resulted in changes to the Inspection, SAI, Forms and PEIs policies and procedures, which are now clearer and more efficient in terms of staff time and resources.



Mental Capacity (Health Welfare and Finance) Bill

The Mental Health and Learning Disability Team requested that the DHSSPS in December 2013 outline the proposals of the Mental Capacity Bill at a workshop for all Part II / Part IV Medical Practitioners on 6 December 2013 and again at a roadshow for all providers on 31 March 2013 in Antrim. The new legislation will focus on the capacity of the individual to make decisions, and the issues requiring consideration where a person lacks capacity to make decisions. The Bill will allow for interventions to be made in a person's life but protection of the interests of the individual will require to be put in place. Feedback has been given by the MHLD team from a range of scenarios reflecting current practice issues and future challenges. It is anticipated that the new legislation will be released for consultation in May 2014.

RQIA will contribute to the DHSSPS working group to develop the guide and new code of practice. Further discussions will be required with the DHSSPS in relation to the transmission of new forms electronically under the proposed new Mental Capacity (Health, Welfare and Finance) Bill in 2016.

During the 2014/2015 year the MHLD plan to make further developments in terms of how we:-

- Monitor SAI reports using service frameworks as a benchmark of practice.
- Train and support peer reviewers and lay assessors to ensure their continued involvement in the inspection process
- Provide information at the end of March 2015 for providers about the 2015/2016 inspection focus.
- Produce all inspection reports in easy read versions from 1 April 2014
- Report on people admitted to places of safety under Article 29/30 of the Mental Health (Northern Ireland) Order 1986
- Interview people subject to guardianship in residential or other settings
- Review the Physical Health needs of people within Mental Health / Learning Disability in hospital wards.
- Present of our findings from the inspections of Tier 4 Addiction Services and the review of 100 patient pathways in addiction services
- Collaborate with other NPM colleagues and EPSO regulators, in reviewing best practice and disseminating any learning for improvement.

The MHLD Team will also undertake a review of access to services for people who have Eating Disorders and other actions as outlined in our business plan for 2014/15.

Theresa Nixon
Director of Mental Health, Learning Disability and Social Work

17 April 2014

Appendix 1 – Presentations made by MHLD Team since April 2013

- Director of MHLD presented a paper at the Equality and Human Rights Translating Equality and Human Rights into Care and Service Delivery Conference on 6 September 2013.
- Director of MHLD gave a presentation at the Four Jurisdictions Legal Conference on Capacity Issues for Individuals in Supported on 25 October 2013, London.
- Director of MHLD gave a presentation on Underpinning Human Rights in the Inspection Process at the Four Nations Regulators' Summit on Human Rights on 12 November 2013
- Director of MHLD gave a presentation at the BPS Division of Clinical Psychology 2013 Annual Conference at Riddel Hall, QUB, Belfast on 2 December 2013 (Good People Do Bad Things).
- Presentations were made by RQIA sessional staff Conference in Riddel Hall, QUB, Belfast on 6 December 2013
- Director of MHLD gave a presentation at the conference on Working Towards Improvement : Learning Disability Health Care & Improvement “Health for All – Everyone’s Business” at Mossley Mill, Newtownabbey on 7 March 2014
- MHLD Team presentations at provider roadshow, 31 March 2014.

Appendix 2: Financial Inspections undertaken under Article 116 of Mental Health (Northern Ireland) Order 1986

Appendix 2 : Financial Inspections undertaken under Article 116 of Mental Health (Northern Ireland) Order 1986			
No	**Trust**	**Site**	**Number of Patients Sampled**
1	WHSCT	Cedar Ward, Gransha Hospital	3
2	WHSCT	Carrick Ward, Grangewood, Gransha	3
3	WHSCT	Evish Ward, Grangewood, Gransha	1
4	WHSCT	Strule Lodge, Lakeview Hospital, Gransha	5
5	WHSCT	Beech Villa, Tyrone & Fermanagh Hospital	7
6	NHSCT	Holywell Hospital – Carrick 1	2
7	NHSCT	Holywell Hospital - Carrick 3	3
8	NHSCT	Holywell Hospital - Carrick four	8
9	NHSCT	Holywell Hospital - Inver 1	3
10	NHSCT	Holywell Hospital - Inver four	2
11	NHSCT	Holywell Hospital – Lissan 1	3
12	NHSCT	Holywell Hospital – Tardree	4
13	SEHSCT	Downshire - Kilclief (Ward 27)	5
14	SEHSCT	Downshire - Wards 28 /29 combined	7
15	BHSCT	Knockbracken Hospital – Avoca	5
16	BHSCT	Knockbracken Hospital – Clare	4
17	BHSCT	Knockbracken Hospital - Continuing Rehabilitation Unit	7
18	BHSCT	Knockbracken Hospital - Dorothy Gardiner Unit	4
19	BHSCT	Knockbracken Hospital – Inishfree	3
20	BHSCT	Knockbracken Hospital – Rathlin	1
21	BHSCT	Knockbracken Hospital – Valencia	1

Appendix 3: Announced and Unannounced wards inspections in 2013/14

Appendix 3: Announced and Unannounced wards inspections in 2013/14			
Wards Inspected	**Announced**	**Unannounced**	**Total**
Ward 6 (Addictions) St Luke's	1	0	1
Addiction & Treatment Unit, Omagh	1	0	1
Ash	1	0	1
Beech	1	0	1
Beechcroft Ward 1	1	2	3
Beechcroft Ward 2	1	1	2
Bronte	1	0	1
Brooke Lodge	0	1	1
Carrick - Male	1	1	2
Carrick 1	1	0	1
Cedar Ward	1	0	1
Clare Ward	1	0	1
Cranfield Female	1	0	1
Cranfield ICU	0	2	2
Cranfield Male	1	0	1
Donegore	1	0	1
Dorothy Gardiner Unit Bush Rehab	1	0	1
Downe Dementia Ward	0	1	1
ECT Suite - Altnagelvin	1	0	1
ECT Suite - Causeway	1	0	1
ECT Suite - Craigavon	1	0	1
ECT Suite - Mater	1	0	1
ECT Suite - Tyrone County	1	0	1
Elm	1	1	2
Erne	0	1	1
Evish – Grangewood	1	0	1
Gillis Memory Centre	0	3	3
Innisfree/Brain Injury	1	0	1
Inver 1	1	0	1
Inver 4	0	1	1

Iveagh Centre	1	3	4
Lime	1	0	1
Longstone Assessment and Treatment Unit	1	0	1
Oak A	1	0	1
Oak B	1	0	1
Oldstone	1	0	1
Rathlin	1	0	1
Ross Thomson Unit	0	1	1
Shannon Clinic Ward 1	1	0	1
Shannon Clinic Ward 2	1	0	1
Shannon Clinic Ward 3	1	0	1
Silverwood/Bluestone	1	0	1
Six Mile Ward	1	0	1
Slievemore - Waterside	0	1	1
Spruce/ICU	1	0	1
Strule Lodge	0	1	1
Tardree 1	0	1	1
Tobernaveen Centre	1	0	1
Tobernaveen Lower	1	0	1
Tobernaveen Upper	1	1	2
Ward 1 - Waterside	0	1	1
Ward 12 - Lagan Valley	0	1	1
Ward 15 - Downshire	1	0	1
Ward 27 - Downshire	1	0	1
Ward 27 - Ulster	0	1	1
Ward 28 - Downshire	1	0	1
Ward 3 - St. Luke's	1	0	1
Ward 3 - Waterside	0	1	1
Ward J - Mater	1	1	2
Ward K - Mater	1	0	1
Ward L - Mater	0	1	1
Grand Total:	**47**	**28**	**75**

Appendix 4 – Sample of Easy Read Report

The Regulation and Quality Improvement Authority

What we found when we visited **Cranfield Women's Ward**

Easy to read report.

	Cranfield Women's Ward Muckamore Abbey Hospital 1 Abbey Road Antrim Co. Antrim BT41 4SH
HSC Belfast Health and Social Care Trust	Trust: Belfast Health and Social Care Trust
July 2013 Sunday Monday Tuesday Wednesday Thursday Friday Saturday 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Date of RQIA inspection: 9 July 2013

Type of Ward:

Female admission

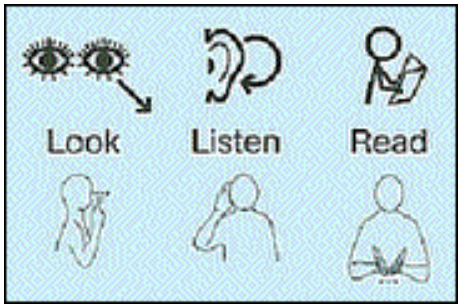
The Regulation and Quality Improvement Authority

Who is RQIA?

RQIA is the group of people in Northern Ireland that visit wards in hospitals, homes and other services to check that they are good and make sure that they are safe for everyone. RQIA call these visits inspections. The people from RQIA that visit the ward are called inspectors.

The inspectors that visited Cranfield Women's ward were called Siobhan and Gerry.

What did Siobhan and Gerry do?



What did Siobhan and Gerry do?

Siobhan and Gerry
- looked around the ward
- talked with patients on the ward
- talked to patients' families and carers
- talked to the staff working on the ward
- talked to the people that are in charge of Cranfield Women's ward

Siobhan and Gerry also
- read some of the notes that the staff write
- looked at some of the forms that the staff fill out

After Siobhan and Gerry visited the ward they wrote a report of what they found and sent it to the ward. RQIA asked the staff that work on the ward and the people that are in charge of the ward to make some changes. These will make the ward better place to be.

Siobhan and Gerry found it was good that	
	all of the staff working in Cranfield Women's went to special training to help keep patients on the ward safe
	there was a poster up on the wall to remind staff of what to do if they are worried about a patient's safety
	if staff were concerned about patient's they contacted people to help decide how best to keep the patient safe. This is called a vulnerable adults referral.
	all of the patients notes that Siobhan and Gerry looked at had a risk assessment and a care plan
	patients all had their own room with a shower and a toilet. Patients could have a key to their room and lock the door to their room.
	patients could leave their money and valuables in a safe place in the office. Two members of staff checked patients' money and valuables each morning and night.
	there was a cordless phone for patients to use so that they could make telephone calls in private
	there were activities on the ward for patients to take part in each day
	there was an information booklet about the ward for patients to keep. This booklet had lots of useful information for patients on - different types of staff that work on the ward and what they do - how to complain - patient rights

Siobhan and Gerry were concerned that	
	the patient's in Cranfield Women's ward had not signed their care plan
	the doors on the ward were locked but this was not in the patient's care plan
	there were things on the ward that patients were not allowed but this was not written down in the care plan
	the care plans were not always about the individual person
	some of the patient's on the ward said it was very noisy and they did not always feel safe
	some of the patients were ready to leave the hospital but there was nowhere for them to live in the community

What next?	What next?
	After the inspection Siobhan and Gerry met with the managers from Cranfield Women's ward. They are going to write back to Siobhan and tell her how they are going to fix the problems on the ward and make it a better place for patients. One of the inspectors will visit the ward again to see if the ward has improved.

Exhibit 52

The Regulation and Quality Improvement Authority

Review of Adult Learning Disability Community Services Phase II

October 2016

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

Membership of the Review Team

Roy McConkey	Independent Reviewer
Theresa Nixon	RQIA Director
Hall Graham	RQIA Head of Reviews
Dean McAllister	RQIA Project Administrator
David Philpot	RQIA Project Manager

RQIA thanks all those who provided data, responded to questions in an open and helpful manner, and assisted in the organisation of the fieldwork.

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Executive Summary

The purpose of this report is to highlight the progress made by the five Health and Social Care (HSC) trusts, in the implementation of 34 standards, relating to Adults with a Learning Disability in the Department of Health (DoH) Service Framework.

This framework was launched by the Department of Health, Social Services and Public Safety (DHSSPS) now Department of Health (DoH) in 2013.

The responsibility for monitoring the implementation of these standards rests with the Health and Social Care Board (HSC Board) in Northern Ireland.

RQIA completed a baseline review of each trusts' initial benchmarking of the standards in 2013.

The review team is satisfied that significant improvements have been made since 2013 in:

- safeguarding of vulnerable adults regionally
- providing access to a much wider range and choice of day activities for adults with a learning disability
- conduct of assessments by General Practitioners (GP) of the health needs of adults with a learning disability, with a much higher uptake of screening noted in four trusts (A lower uptake was noted in the Belfast Health and Social Care Trust (Belfast Trust).)
- establishment of specialist teams, to help carers to manage challenging behaviours improved in every trust
- communication with each trust having developed a range of stakeholder reference groups

More meaningful improvement however is required in the following areas:

- provision of an easy to read page on trusts' websites for adults with a learning disability
- the development of a single unified community based regional information system, as access to clear, reliable information continues to be problematic (This makes it difficult for the commissioner to monitor and measure outcomes across trusts. The review recommends that this matter should be reviewed by the HSC Board as a priority.)
- the use of family support services and in the numbers of direct payments made across the trusts (The uptake of direct payments also continues to lag behind the rest of the United Kingdom. The review team was concerned that the South Eastern Health and Social Care Trust (South Eastern Trust) and the Western Health and Social Care Trust (Western Trust) are only paying the minimum payment rate of £10 per hour, suggested by the HSC Board in November 2015. This matter should be monitored by the commissioner for improvement.)

Progress regarding the implementation of individual Health Action Plans has been slow, despite this being a target for achievement for trusts since March 2015. No regional agreement has been made as to the form these should take. The review recommends that this work is completed by the Public Health Agency (PHA). The trusts should also put in place a plan to measure and report on the health improvements annually to the PHA.

The evidence of admission of people with a mild learning disability to mainstream mental health services remains very low. Given the variation noted in practice regionally, trusts should be held to account by the HSC Board/PHA for the delay in the implementation of this standard.

The composition of learning disability community teams continues to show disparity with a multiplicity of job descriptions for team members evident across the five trusts. There was evidence in four trusts of consultant psychiatrists working in a more integrated way as part of the community teams.

None of the five community teams, however, demonstrated an evidence base for the model of service configuration they have put in place. The community teams have developed more as a result of historic custom and practice in each trust area, with little sharing of practice noted regionally regarding models of care used by each team. It was difficult for the review team, therefore, to effectively compare and contrast the models of service provision across Northern Ireland. The review found that there is no agreed uniform model for behavioural support services across the five trusts.

The Northern Health and Social Care Trust (Northern Trust) was the only trust, able to report having a comprehensive database of outcomes in their positive behaviour psychology support service over the past 11 years.

The review team recommends that the commissioner should consider if the model used by the Northern Trust could be used as a model for other trusts to follow, to determine the effectiveness and outcomes of their challenging behaviour support services.

The review team recommends that a formal evaluation should be undertaken, of the effectiveness of these specialist teams, and this should be commissioned by the HSC Board, involving professional organisations such as the Royal College of Psychiatrists (RCP) and the British Psychological Society (BPS).

The proportion of people with a learning disability in employment continues to be very low. Use of unpaid work experience placements still dominates, which runs the risk of trainee exploitation.

Trusts, as large employers, should consider, as part of their organisational development plans, a model of positive discrimination that seeks to provide employment opportunities for adults with a learning disability.

Young people with a learning disability making the transition to adult services continue to present challenges for carers as arrangements are handled differently across the five trusts.

Earlier planning from the age of 14 years is required in line with best practice guidance. Given the known complex physical and behavioural needs of a growing cohort of young people, clearer financial projections need to be made over the next five years to identify the increased resources required to meet their needs.

The review team found that despite funding being made available by the HSC Board to trusts, it is unlikely that the target of all long stay patients being resettled in the community will be achieved by June 2017. This delay is causing frustration for a number of people in hospital who wish to be resettled to a new home in the community. Sometimes when placements break down, an admission to a learning disability hospital has been used. Trusts should review best practice from other areas in preventing such hospital admissions and involve independent sector colleagues in service developments to help avoid the emerging development of new long stay patients.

A low uptake of carers' assessments was evident across Northern Ireland, but trusts were unclear why this might be the case. The review team recommends that the carers coordinator in each trust should meet with the HSC Board to review this matter and any action required to help avoid crisis intervention planning in the future.

Whilst the review team found staff were mostly familiar with the content of the service framework, the approach used by trusts in applying the standards varied across trusts. Trusts have also not all interpreted key performance indicators consistently. No evidence of comparative benchmarking was evident across trusts regarding the models of delivery of care, or with other models of service provision in the United Kingdom.

The report makes 25 recommendations to support the continual improvement of standards for adults with a learning disability in Northern Ireland.

In view of the closure announcement of the HSC Board, the DoH needs to now agree a future process for monitoring the implementation of the standards contained in the service framework for adults with a learning disability.

Section 1: Introduction

1.1 Introduction and Background

Learning disability includes the presence of a significantly reduced ability to understand new or complex information, or to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood, with a lasting effect on development. People with a learning disability may also have difficulties with social and/or communication skills and with carrying out activities of daily living independently. They may also have associated physical and sensory disabilities.

It is estimated that there is a population of 26,500 people in Northern Ireland with a learning disability of whom half are aged between zero to19 years[1]. It is projected that the number of people with a learning disability will increase by one percent each year over the next 15 years and that adults with complex needs will be a particularly large growth area.

Societal attitudes to learning disability have changed significantly in recent years. It is now widely recognised that people with a learning disability have the right to live independently within the community and to be provided with the opportunity to make meaningful choices in respect of housing, care and support needs.

In 2007, a United Kingdom Government commissioned inquiry chaired by Sir Jonathan Michael – Healthcare For All[2] - found that

- People with learning disabilities find it much harder than other people to access assessment and treatment for general health problems that have nothing directly to do with their disability.
- There is insufficient attention given to making reasonable adjustments to support the delivery of equal treatment, as required by the Disability Discrimination Act 1995[3].
- Parents and carers of adults and children with a learning disability often find their opinions and assessments ignored by healthcare professionals, even though they have the best information about and understanding of, the people they support.
- The health needs, communication problems and cognitive impairment characteristics of learning disability in particular are poorly understood by healthcare staff.

The Confidential Inquiry into the Premature Deaths of People with Learning Disabilities[4] (CIPOLD) in 2013 reviewed the death of 247 people with learning disabilities over the period 2010-2012.

[1] Bamford Action Plan, DHSSPS, 2009.
[2] Healthcare For All, Sir Jonathan Michael, 2007.
[3] Disability Discrimination Act 1995.
[4] Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD) 2013.

The findings demonstrated that people with a learning disability were a very vulnerable group in the context of health needs:

- 17 per cent were underweight compared to two per cent the general population
- 66 per cent lacked independent mobility
- 50 per cent had problems with vision
- 25 per cent had hearing problems
- 97 per cent had one or more long term or treatable health conditions

People with learning disabilities should also be supported to live independently in the community wherever possible. Delivery of the changes necessary to improve services requires effective partnership working with a variety of agencies, to design and provide a range of options to meet assessed needs, such as employment opportunities, day centres, day opportunities and accommodation. People with a learning disability should also be provided with clear information about self-directed support in order to give them control and choice over the type of care and support they receive.

1.2 Context for the Review

A key priority for health and social care services and also for the wider community is to tackle discrimination and inequality and to empower and support people with a learning disability and their families to be actively engaged in their care.

The onus on public authorities to promote equality of opportunity is enshrined in the Northern Ireland Act[5] which states that "a public authority shall, in carrying out its functions in Northern Ireland, have due regard to promote equality of opportunity between people with a disability and those without."

Other pieces of relevant legislation include:

- the Human Rights Act[6]
- the United Nations(UN) Convention on the Rights of Persons with Disabilities[7]

In October 2002, following similar exercises in Scotland and England, DHSSPS[8] initiated a major, wide-ranging and independent review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The review was overseen by a steering committee comprising representatives from professional and other interested groups in the mental health and learning disability fields, under the chairmanship of Professor David Bamford of the University of Ulster.

[5] Northern Ireland Act 1998
[6] The Human Rights Act 1998
[7] Convention on the Rights of Persons with a Disability 2006
[8] The Department of Health (DoH) encompasses the functions of the former Department of Health, Social Services and Public Safety (DHSSPS) as of 9th May 2016.

The Equal Lives[9] report made a number of recommendations, designed to secure improvements in the mental and physical health of people with a learning disability. The aim was to achieve this through developing access to high quality health services that are locally based and responsive to their particular needs.

Broadly the review called for:

- continued emphasis on promotion of positive mental health
- reform of mental health legislation
- a continued shift from hospital to community based services
- development of a number of specialist services, to include children and young people, older people, those with addiction problems and those in the criminal justice system
- an adequately trained workforce to deliver these services

The review also promoted involvement of service users to enable them to access mainstream services and be fully included in the life of the community.

The review envisaged a 10-15 year timescale for full implementation of its recommendations.

The Northern Ireland Executive accepted the broad thrust of the review's recommendations. The Executive's response to the findings of the Bamford Review, Delivering the Bamford Vision, led to the publication, in October 2009 of the Bamford Action Plan 2009-2011. The 2009-2011 plan set out the Executive's commitment across Departments to improving the mental health and wellbeing of the population of Northern Ireland and to improving services for those with a mental health need or a learning disability.

A follow on action plan was developed for 2012-2015 based on the lessons learned from the 2009-2011 evaluation, consultative workshops, new research and evidence based practice and the views of service users and their carers

A further report in December 2011, Transforming Your Care[10] (TYC), set out a review of health and social care in Northern Ireland and provided the blueprint for future health service provision in Northern Ireland. This has many parallels with the Bamford Vision in respect of mental health and learning disability service provision and enhancement including:

- early intervention and health promotion
- a focus shift to community care
- promotion of recovery practices
- personalisation of care
- resettlement
- service user and carer involvement
- advocacy
- provision of clearer information
- access to respite provision

[9] Equal Lives DHSSPS, 2005.
[10] Transforming Your Care 2011

In March 2016, the Minister for Health announced his intention to establish a commission[11] to reform adult care and support. This new three-person commission will be tasked with assessing the many challenges facing the care and support system and producing a set of recommendations to reform the funding structures, in order to ensure its future sustainability.

Service Frameworks

The DHSSPS Service Framework aims to set out clear standards of health and social care that service users and their carers can expect.

They are evidence based, measurable and are to be used by health and social care organisations to drive performance improvement, through the commissioning process.

The Service Framework for Learning Disability[12] was initially launched in 2013 and revised in January 2015. It sets out 34 standards in relation to the following key thematic areas:

- safeguarding and communication and involvement in the planning and delivery of services
- children and young people
- entering adulthood
- inclusion in community life
- meeting general physical and mental health needs
- meeting complex physical and mental health needs
- at home in the community
- ageing well
- palliative and end of life care

The standards provide guidance to the sector on how to:

- improve the health and wellbeing of people with a learning disability, their carers and families
- promote social inclusion
- reduce inequalities in health and social wellbeing and improve the quality of health and social care services, by supporting those most vulnerable in our society

Baseline Assessment and Review of Community Services for Adults with a Learning Disability 2013

In August 2013, RQIA published a report of a Baseline Assessment and Review of Community Services for Adults with a Learning Disability. This highlighted the role and composition of community learning disability teams and the level of investment in services for adults with a learning disability. The report set out recommendations for trusts and for commissioners in relation to the provision of learning disability services for adults.

[11] Health Minister to Establish Commission to Reform Adult Care and Support, DHSSPS 9 March 2016
[12] Service Framework for Learning Disability DHSSPS 2015

In November 2015, the Patient and Client Council (PCC) published its report on the findings from their engagement with 11 focus groups across Northern Ireland in relation to learning disability.

The PCC met with 48 service users and 24 carers who highlighted concerns about the following issues:

Service users	Carers
Day opportunities	Respite (short break) services
Supported housing	Transition from child to adult services
Respite (short break) services	HSC staff
Further education	Joined up working
Training and work	Information
HSC staff in learning disability support services	

The findings of this report have been considered by RQIA as part of this review.

The review also noted that the Northern Ireland Assembly Committee for Employment and Learning published in 2016 a report on day services that made 44 strategic recommendations.[13]

Focus of this Review

This review assesses the quality of learning disability services against 30 of the adult standards contained in the Learning Disability Service Framework. It also reports on the progress made by the trusts and the HSC Board in the implementation of the recommendations contained in the 2013 RQIA review report.

The report is structured to reflect the four RQIA domains of:

- safe care
- effective care
- compassionate care
- well led services

1.3 Terms of Reference

The terms of reference for this review are:

1. review the progress made against Phase 1 of RQIA's 2013 report, 'A Baseline Assessment and Review of Community Services for Adults with a Learning Disability'

[13] Report of the Inquiry into post Special Educational Need (SEN) Provision in education, employment and training for those with Learning Disabilities in Northern Ireland

2. review the quality and effectiveness of services for adults with a learning disability against the DHSSPS Service Framework for Learning Disability

3. gather the views of service users and carers

4. report on findings and make recommendations in a single report for publication

Exclusions

This review excludes services for children, and services provided for adults with learning disabilities that are currently regulated by RQIA, as set out below:

Adult placement agencies	Day care settings	Domiciliary care agencies
Independent clinics	Independent hospitals	Nursing agencies
Nursing homes	Residential care homes	Residential family centres

Autism services are not included in this particular review as RQIA is undertaking a specific review of autism in the future. However adults with a learning disability whose service provision is provided by adult community learning disability services were included in this review.

1.4 Outline Methodology

1. A review was undertaken of trusts' action plans and progress in relation to Phase 1 of the RQIA review.

2. A questionnaire was sent to all trusts asking them to provide information on progress against standards applicable to adults as set out in the service framework for learning disability.

3. Validation meetings were held with staff responsible for providing and managing learning disability services

4. Stakeholder engagement was held with adults with a learning disability and with carer groups, from all five trusts.

5. The review met with a range of voluntary organisations involved in providing adult learning disability services.

Section 2: Findings from the Review

2.1 Introduction to the Findings

In its 2013 report, RQIA made a number of recommendations for improvement. One of these recommendations was that trusts should provide better information regarding the number of people with a learning disability receiving care and their investment in the learning disability programme of care. This includes community service costs, community teams, day services, family support services, day centres and people in receipt of domiciliary care services. This review received updated information from the HSC Board and trusts regarding this area.

Total Number of People with a Learning Disability

The trusts remain unable to provide the HSC Board and the review team with an accurate figure of the total number of people with a learning disability in their area. This information is not collected in a single regional common information system with agreed data sets. All trusts have different systems to record information about people who have been identified with a learning disability. However the population of people with a learning disability is known to be larger than these figures. In addition to those people receiving social care, there are people in hospitals, people receiving only health services, people known to the trust who are no longer receiving any service (so-called dormant cases), and possibly people who would qualify for learning disability services but have never requested them. A figure of 8,326 was provided but it is likely to be much lower than the true prevalence of learning disability in the adult population in Northern Ireland. In the Phase 1 review RQIA reported that in 2010-2011 the number of adults in receipt of services from community learning disability teams was 7965. There has been an increase of 361 since the last RQIA review.

Number of People with Learning Disability in receipt of Health and Social Services in each HSC trust in 2014-2015

The number of people with learning disability in receipt of social care services in each trust in 2014-2015 is shown in Table 1 (note: social care includes social work, nursing homes residential homes, supported and other accommodation, day care facilities, domiciliary care grants, goods and services, meals delivered to clients' homes). In order to facilitate comparisons across trusts, the number of adults with learning disability is expressed as a proportion of the adult population in each trust area. Variation is evident across the trusts with proportionately more people with a learning disability receiving social care in the Southern Health and Social Care Trust (Southern Trust) and fewer in the Western Trust.

Table 1: The number of adults with learning disability receiving social care services 2014-2015

	Belfast	Northern	South Eastern	Southern	Western	Total
Number of adults with a learning disability receiving social care 2014-2015*	1816	1926	1516	1981	1087	8326
Adult population of trust (NISRA mid-year estimates)	265,372	348,254	263,059	265,794	216,431	1,358,910
2014 rate per 1,000 adult population	**6.84**	**5.53**	**5.76**	**7.45**	**5.02**	**6.13**

*Data provided by HSC trusts to HSC Board as of 31 March 2015

HSC Investment in Learning Disability Programme of Care 2015-2016

In 2015-2016, the HSC Board investment in the learning disability programme of care was £265.2 million, which was 7.79 per cent of the total investment in health and social care in that year (£3.406 million). This proportion has remained around this level since 2005-2006 (range 7.21per cent to 7.79 per cent). This investment covers services to children as well as adults. A breakdown of the apportionment is not available.

The amount invested by each Local Commissioning Group (LCG) in the learning disability programme of care is shown in Table 2. This includes specialist hospital costs as well as community service costs. Please note the following cautions regarding the tables.

Cautions

As all trusts do not keep a single common information system of people with learning disabilities, it is difficult to accurately calculate the number of people who receive services in any one year.

Variations in record keeping across trusts may also account for some of the differences noted above, which results from the lack of a common information system for community services.

Some of the information presented to the review was for 2013-2014 and may in some instances not reflect recent changes. However there are unlikely to be substantial variations from the patterns reported here.

Table 2: Investment by the HSC Board in the Learning Disability Programme of Care (PoC) compared to other non-acute programmes of care (based on Strategic Resource Framework Investment 2015-2016)

	Local Commissioning Groups (LCG)					
	Belfast	**Northern**	**South Eastern**	**Southern**	**Western**	**Grand Total**
Learning Disability PoC £k	£57,106	£60,708	£53,615	£55,418	£38,357	**£265,204**
All non-acute programmes of care £k (excluding regional investment)	£415,074	£448,916	£342,503	£358,371	£322,455	**£1,887,318**
Percentage invested on Learning Disability PoC	13.76%	13.52%	15.65%	15.46%	11.90%	**14.05%**
Population of Trust - Weighted for Learning Disability need	383,107	430,093	285,799	384,594	345,543	**1,829,136**
Average cost per capita of LCG	£149	£141	£188	£144	£111	**£145**

Table 2 shows the 2015-16 SRF investment split by Local Commissioning Group areas (LCGs). The learning disability PoC figures cover all people with a learning disability including children, adolescents and adults. The HSC Board uses a capitation formula to help inform the allocation of new funds across localities. Trusts may provide services to residents across a number of localities and residents from localities may access their local trust or another trust depending on the services used.

It should be noted that caution should be exercised when comparing investments at programmes of care level and between individual LCGs. For example, it is recognised that capitation formulae are less robust at smaller population levels and at individual programme of care levels and therefore variations between individual Programmes of Care at LCG level would not be unexpected. Within programmes of care, services may also be delivered differently across localities. The capitation formula for the learning disability programme of care is being reviewed.

Variation across trusts in the total investment in non-acute programmes of care is evident. The South Eastern LCG has a higher proportion of this investment, 15.65 per cent, allocated to the learning disability programme of care with the Western LCG having the lowest percentage at 11.90 per cent. When the differing size of the population in the trusts is taken into account and weighted for learning disability need, the South Eastern LCG has the highest per capita investment with the Western LCG having the lowest. These figures are however skewed by specialist hospital costs as outlined further in Table 3 which demonstrates that a differential continues to exist across trusts.

Investment in learning disability services is further subdivided into monies invested in specialist hospitals and in extra contractual referrals (generally used for person(s) with complex needs to be treated outside of Northern Ireland) and in community services. In 2015-2016 the planned investment in extra contractual referrals amounted to £1.110 million.

Table 3: The investment (£k) by HSC Board in Learning Disability Programme of Care in community and hospital services (Based on SRF Investment 2015-2016)

	Belfast	Northern	South Eastern	Southern	Western	Grand Total
Community/ Personal Social Services £k	£49,875	£52,665	£46,522	£50,676	£34,441	£234,180
Hospital £k	£7,231	£8,042	£7,093	£4,742	£3,916	£31,024
Total £k	**£57,106**	**£60,708**	**£53,615**	**£55,418**	**£38,357**	**£265,204**

Around 11.7 per cent of the total investment provided by the HSC Board, to trusts, was invested in specialist hospitals, notably Muckamore Abbey Hospital which serves three trusts with total costs of £22.3 million. The HSC Board reported commissioning 147 beds in 2015-2016, across the region which gives a cost per bed of £203,497 for hospital services (excluding ECR investment). However the number of beds should reduce as the resettlement of long stay patients continues, although it is not yet complete.

Community and Personal Social services costs accounted for around 88 per cent of the total investment. It is not possible to calculate an average cost per person in receipt of community services as the numbers of people in receipt of such services is not available.

The trusts in their financial returns provide a further breakdown of the monies spent on community services (i.e. AHPs expenditure, nursing costs, day services, residential accommodation, community medical/dental expenditure, grants, goods and services step up step down facilities, incontinence products) and on personal social services.

Usage of Social Care Services

The number of people availing of various social care services across the trusts is shown in Appendix 1 Table A1. Although information on costs per place was not available to the review, this data could perhaps account for the variation in trust's investment in learning disability social care services.

Supported Accommodation

There is a marked differential in the proportion of people in residential and nursing homes, with the highest in the Western Trust (23 per cent) and lowest in the Southern Trust (12 per cent). The variation was less marked for people in supported housing. However, taken together, these figures would suggest that most adults with a learning disability, using social care services are living with family carers or independently, with the Southern Trust having the highest proportion (76 per cent) and the lowest noted in the Western Trust (65 per cent).

Day Centres and Day Opportunities

Overall, around two-thirds of people with a learning disability, use day services, although the proportion that do so, is markedly higher in the Western Trust compared to the Southern Trust. The provision of day opportunities places compared to day centre places is most equal in Belfast and Southern trusts. Day opportunities in further education courses, horticulture and gardening enterprise schemes, or in catering establishments are procured by the trust to provide experiences leading to upskilling of people with a learning disability, to enable them to apply for work. A greater use of day centre places, solely run by the trusts was evident in the Western and South Eastern trusts as shown in Appendix 1 Table A2.

Family Support Services

Adults with a learning disability who live at home with carers may require additional support to help them live a full life in their community. Trusts provide a range of family support services including short break services, domiciliary care and direct payments.

Appendix 1 Table A3 shows the number and percentage of people in receipt of family support services in 2013-2014. Some disparity was evident in the use of family support services across the trusts. More families availed of short breaks in the Northern Trust with least doing so in the Western Trust. Domiciliary Care was provided to higher percentages of people in the South Eastern and Southern trusts but fewer in the Belfast and Northern trusts. Direct payments provided to either the person or family and carers were noted to be highest in the Belfast Trust, with a lower but similar proportion across the other trusts.

The variation in both the financial investment and services provided across the five trusts suggests that inequities persist across Northern Ireland in provision of these services for people with learning disabilities.

Recommendation 1	Priority 1
The commissioner should ensure effective use of resources through accountability meetings and seek evidence based improvements in learning disability services across trusts. The investment in learning disability hospital provision should also be kept under review given the current resettlement target set for achievement in 2016.	

2.2 Standards Reviewed Relating to SAFE Care

The review aligned specific standards for adults contained in the service framework to RQIA's four key stakeholder outcomes selected for use in 2016 – 2017. These are described in Table 4.

Table 4: Four RQIA Stakeholder Outcomes.

Is care **safe**?	Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.
Is care **effective**?	The right care, at the right time in the right place with the best outcome.
Is care **compassionate**?	Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.
Is the service **well led?**	Effective leadership, management and governance which creates a culture focused on the needs and experiences of service users in order to deliver safe, effective and compassionate care.

Questionnaires were sent to the five trusts and the line of questioning during discussions with staff focused on these four areas.

Findings

Safeguarding

All trusts had a safeguarding policy in place with a named safeguarding lead, who oversees the learning disability programme. A designated non-executive director with a particular responsibility for safeguarding was in place, with the exception of the Northern Trust, where the non-executive directors assume responsibility collectively. A new regional policy, Adult Safeguarding: Prevention and Protection in Partnership[14], was published in July 2015. Trusts await further operational guidance from the HSC Board before they can finalise their procedures. Currently all trusts are following the extant HSC policy and procedures.

[14] https://www.dhsspsni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership

All trusts had their own whistle blowing policy, the implementation of which is subject to a separate review by RQIA.

Equality of Access to Health Services

The HSC Board provided the following information from their 2015 file audit:

- 100 per cent of GPs have a system for identifying people with a learning disability.
- Over 70 per cent of the files had evidence that people with a learning disability and their family and carers have been involved in making choices or decisions about their individual health and social care needs.

A directed enhanced service (DES) for general practitioners to undertake health checks had a good uptake by GP practices across four trusts, except the Belfast HSC Trust.
A higher uptake of health checks by people with a learning disability was noted in the Northern Trust. The review was informed that some practices were more difficult to engage with. Where there is proactive engagement by a health facilitator, with local GP practices, better outcomes are evident.

A separate review was undertaken by the HSC Board in 2013 of The Enhanced Service Specialising in Health Care for Adults with a Learning Disability Provided by General Medical Services (GMS) Practices and of the effectiveness of Health Facilitators provided by HSC trusts.[15] The report shows there is significant variation across the trusts in relation to the uptake of health checks with the Belfast Trust GPs providing fewer health checks than other trusts.

This may be due to their lower levels of staff in this service. The review noted that the HSC Board has provided the Belfast Trust with temporary additional funding for one year to drive improvement in this area.

Employment of Health Facilitators

Health Facilitators are funded across the five trusts using GMS monies. The trusts were able to produce a wide range of examples ranging from easy read health screening materials to evidence of service users consenting to the health care facilitators undertaking their health checks.

There were examples of all HSC organisations making information accessible to people with a learning disability. Despite this, progress around the implementation of individual Health Action Plans (HAP) has been slow, with no agreement across trusts as to the form these might take. HAPs are an easy read plan for an adult with a learning disability to keep, usually formatted into a table that lists goals for better health and engagement with healthcare staff. In those instances where a plan was in place, there was also no demonstrable evidence of the trust demonstrating improvements in health outcomes arising from the HAPs.

[15] Professor Roy McConkey. University of Ulster and HSC Board. October, 2013

The Regional Health Facilitators Forum, a sub group of the Regional Learning Disability Health Care Improvement Forum chaired by PHA, has been developing guidance on the regional implementation of health and wellbeing plans (formally known as health action plans). These are currently out with trusts for comment. The guidance will be agreed by the Bamford Monitoring Group and disseminated to trusts.

The development and use of health action plans for adults with a learning disability needs to be reassessed, with agreement as to their final format and a method of recording health outcomes arising from their use.

A process also needs to be agreed regionally by the PHA for implementing the recommendations arising from the health screening as this differs from trust to trust.

Recommendation 2	**Priority 1**
The Regional Learning Disability Health Care and Improvement Steering Group, set up by the Public Health Agency should ensure each trust has a plan that can demonstrate measureable evidence of health improvements for adults with a learning disability.	

The trusts all advised of a range of staff who provide support and advice, including community learning disability nurses, speech and language therapists, epilepsy nurses, district nurses and a wide range of AHPs. A number of examples or specific initiatives undertaken with small groups or on specific topics were provided.

The review was advised of a number of regional screening programmes that trusts promote and utilise for adults with a learning disability.

In meetings with service users across all five trusts, adults with learning disabilities advised the review that they had received information on smoking cessation, healthy eating, levels of physical activity and alcohol consumption from health facilitators and general practitioners. The review was given limited examples of improvements in fitness of adults with a learning disability across the region, or in e.g. reduction of obesity to promote better health.

Health Related Outcome Measures

In 2014, a Regional Learning Disability Health Care and Improvement Steering Group was established by the PHA, to agree a regional approach to health screening and improving health and social care outcomes.

Trust databases in relation to adults with a learning disability, involved in regional screening programmes, do not contain health related outcome measures. There is no plan to collate the health outcome measurement information gathered about individuals, or to record details of action required in the future, to ensure improved health outcomes, although the Belfast Trust indicated their intention to review this in the future.

Development of a Clinical Quality Dashboard

A clinical quality dashboard is a tool, developed to provide clinicians, with relevant and timely information to inform daily decisions that improve quality of patient care.

Although the trusts provided examples of their dashboards, these were used to demonstrate e.g. figures for delayed discharges, admissions to specialist hospitals and staff absences. There was an absence of data which demonstrated for example a reduction in smoking, obesity, diabetes or a reduction in challenging behaviours. Dashboards had not been designed to capture information on health outcomes or service users' health improvements. This makes it difficult to gauge the effectiveness of clinical interventions, for adults with a learning disability.

Trusts reported using other reporting tools such as a RAG (red, amber, green) rating to report on their general activity in learning disability services, to senior management and to the HSC Board.

Other reports included local facility plans, statutory function reports, risk registers, incident databases and monitoring reports to ensure their managers have access to quality checks in a timely manner.

Recommendation 3	**Priority 1**
The PHA in conjunction with trusts should develop a regional dataset of information in relation to outcome measurement in 2016-2017 across two key areas to drive improvement in the health status of people with a learning disability. Targets should be considered in relation to the reporting of a reduction in smoking and obesity in the 2017-2018 year.	

Development of Interfaces between Services

All trusts described progress in improving their interfaces with mental health and older peoples' services; this work, however, remains at an early stage. The Northern Trust Rapid Assessment Intervention and Discharge (RAID) Team indicated they had developed a learning disability pathway and co-working arrangements with learning disability teams. Individuals with a learning disability within an acute hospital or presenting at an emergency department are assessed and supported by the RAID Team who help provide them with direct support at times of crisis. Some examples were provided by the Northern Trust of access to mental health services for people with mild learning disability. The other trusts described difficulties in getting an adult with a mild learning disability into mental health services. The pathway used by the Northern Trust should be reviewed by other trusts to see if it can be applied elsewhere.

There is also little interface with older peoples' services except in respect of people with dementia.

Some progress however appears to have been made with forensic and palliative care teams – possibly because of the small number of people involved in these more specialised areas.

The Belfast Trust stated that service users have access to psychological and psychiatric services provided by both specialist learning disability and primary mental health teams. The Northern Trust confirmed its PROMOTE team provides specialist learning disability interventions for people with complex mental health needs. PROMOTE is a treatment service for adults with a learning disability with additional forensic and or mental health needs.

The RQIA review found that there had been slow progress in relation to adults with a mild learning disability accessing mainstream mental health services. Further collaboration across teams is required to ensure appropriate access to mainstream mental healthcare services for patients with a mild learning disability.

Recommendation 4	**Priority 2**
The HSC Board should set an access target for inclusion of people with a mild learning in mental health services in order to achieve the standard set up in the service framework.	

2.3 Standards Reviewed Relating to EFFECTIVE Care

Findings

Provision of a Community Service

The review team looked at the composition of learning disability teams and models of service provision, developed since the last review.

Learning disability services continue to sit within different directorates across the five trusts. Broadly, teams include the same range of professionals identified in the initial RQIA review e.g. social work, learning disability nurses, specialist occupational therapists and speech and language therapists. The multidisciplinary team composition was being reviewed by each trust and deemed by trusts to be appropriate to the discharge of their functions.

A continued disparity exists since the last RQIA review, in the composition and in the description of roles across community teams that make comparisons of effectiveness difficult. A positive development since the last review is that the psychiatrists are now working directly in learning disability teams.

The Belfast Trust informed the review team that it had fully reviewed its community treatment and support services, agreed a new model of service provision and is in the final stages of implementing their new structures and processes. The trust visited services in Scotland in 2013 and out of hours

behaviour support services in England. The new model of service provision is based on prevention and early intervention. It was described as being multi-disciplinary with co-ordinated working, with the aim of creating a person centred, flexible and responsive service.

The Northern Trust has moved from a locality management model to a multidisciplinary model of management that delivers services according to their functions. A service improvement project commenced in September 2015, to build on progress already made, with a focus now on consolidating their new team structures for service delivery across all their learning disability services.

In the action plan provided to the review the South Eastern Trust did not clearly provide information on the overall outline of their adult community learning disability team, but rather described how services are delivered through a tiered process and the types of professionals involved in the adult learning disability teams.

The Southern Trust reported that a review of their team structures has been recently completed. A new model of service delivery has been agreed that includes clearer multi-disciplinary roles and responsibilities for staff.

The Western Trust has restructured its teams and now operates a social worker led service, supported by a multi-disciplinary team model as required. At the time of the review, recruitment for social workers, occupational therapists, family support workers and team leaders was nearly complete. The trust acknowledges that further work is required to secure the investment needed to enhance its new model in working with adults with a learning disability.

The review team notes that the leadership of the teams in each of the trusts and their lines of accountability varies as do referral procedures and the criteria for access to learning disability services.

Despite the changes made by the trusts in the delivery of learning disability services, the review found limited evidence of trusts actively seeking information about new service models beyond Northern Ireland.

There was very little evidence of trusts learning from other trusts' experiences or of those of the voluntary sector in the revision of their structures.

Recommendation 5	**Priority 2**
The HSC Board should review the current models of service provision in place in the five trusts in terms of evidence of best practice and ensure that this is disseminated regionally.	

Delivery of an Extended Hours Service by Community Learning Disability Teams

The review found little evidence of Community Learning Disability Teams (CLDT) operating outside of 09.00 to 17.00. Four trusts had plans to extend their intensive support services, particularly for people who are at risk of breakdown in the community from 17.00 to 20.00 or 22.00 on weekday evenings. While a welcome development, this leaves weekends uncovered except by out of hours social services.

At the time of the review, the Western Trust had no plans to extend the CLDT hours of service.

The South Eastern Trust has recently commenced a pilot of an out of hours intensive support service which will operate Monday to Friday 17:00 to 21:00.

This service was set up to support service providers outside of normal working hours and to help manage individuals with challenging behaviours, to prevent hospital admission and placement breakdown. On call practitioners advise and support service providers and if appropriate will refer patients to the trust community team for follow up the next working day.

Establishment of Challenging Behaviours/Specialist Teams

Positive changes were noted in the development of challenging behaviour teams in each trust since the review in 2013. However, the five trusts are developing their own unique teams and models to deal with challenging behaviours. The trusts have been provided with financial resources by the HSC Board, to enable challenging behaviour teams to be strengthened.

All trusts had increased the support services that staff in the community teams can offer. There was evidence in four trusts of consultant psychiatrists working in a more integrated way as part of the community teams. The review lacked clarity in terms of their role in community teams which should be reviewed by each trust. It was unclear to the review how they were involved in leading service changes to become more effective, especially for clients with challenging behaviours and or mental health problems who are on psychotropic medications.

Recommendation 6	**Priority 2**
Each trust should review the specific role of the consultant psychiatrist in their community team in terms of how best they can assist in the delivery of improvements in clinical outcomes for people with a learning disability.	

The Belfast Trust is providing positive behaviour interventions support to address challenging behaviours using a stepped model of intervention. Part of the trust's community infrastructure development plan has resulted in an increased capacity in services for prevention and earlier intervention. The introduction of behaviour practitioners to community teams and the integration

and enhancement of psychology services within their community teams is designed to support this approach.

The trust advised that when recruitment is complete, all the trust's day and residential/supported living services will have a behaviour support link person who will work with them to develop effective positive behaviour support models. Individual behaviour support for service users can be provided by a range of and combination of practitioners in the community teams, depending on the nature of the presenting problem. An intensive support service is also available.

The Northern Trust's clinical psychology learning disability services are available to adults with a learning disability, offering interventions for a range of psychological difficulties. These include offering assessment, support and advice in relation to behaviours that challenge.

If service users have behaviours that severely challenge, more intensive support is provided by the Positive Behaviour Support Service (PBSS), which operates at Tier 3 of the stepped care model. This service consists of a consultant clinical psychologist, supported by behavioural specialists, behavioural associates and a speech and language therapist. All those referred to the PBSS have been identified as either displaying high risk behaviour or having their community placement deemed at risk. The PBSS completes comprehensive assessments, develops, implements and supports behaviour support plans. They may offer training to staff teams, carers and families in order to increase their understanding and skills and how to follow specific behaviour support plans.

The South Eastern Trust has developed a behaviour support service (BSS) to assess those with challenging behaviour, to identify their needs and determine how they can be supported by the service.

The service consists of a skill mix of behaviour nurse therapists, psychology assistants and clinical psychologists. A number of band 6 behaviour practitioner posts, and band 3 behaviour assistant posts, were being recruited at the time of the review.

Referrals can be made to this team by any professional working with an individual with challenging behaviours.

The BSS works in partnership with families, community learning disability teams, statutory, voluntary and private service providers, schools and others to provide advice, support and behaviour support plans to meet the needs of the individual. Service users are reviewed at least annually, but more frequently as necessary.

The trust expects that this team will provide a more intense and flexible service to individuals with challenging behaviours, their families and service providers as required. The service is led by a senior manager and a consultant clinical psychologist. A speech and language therapist is also employed to provide advice and support, in relation to communication and swallowing assessments.

The Southern Trust community learning disability BSS comprises a team with a wide range of professional backgrounds including clinical psychology, nursing and social work. This team works collaboratively with a range of community learning disability staff, including AHPs, clinical psychologists, psychiatrists, day care, supported living and respite staff, as well as parents or carers and independent sector providers.

Comprehensive behavioural assessments are carried out, depending on the needs of service users, from which appropriate interventions are developed. To enhance the service, new protocols and proformas were developed to ensure collection of relevant information. The BSS team has developed a number of visual strategies and evidence based resources for use in direct work with service users and their families, in order to enhance the effectiveness and the likelihood of positive behavioural outcomes.

The Southern Trust advised that to manage increasing referral rates, it is developing a Tier 2 and Tier 3 level of intervention as required and provides a variety of training programmes for staff. The aim of this approach is to build capacity both in the BSS team and within community teams and the wider multidisciplinary service including service users, parents and carers. To further build capacity within the team, a number of BSS staff are currently pursuing further training in Positive Behaviour Management Support.

The Western Trust reported that service users with challenging behaviours are supported by both staff and carers to ensure that they are managed safely and that agreed strategies are in place to provide support. Intensive support workers have recently been appointed in the Western Trust. Their role is to provide rapid and intensive support in cases where there are significant challenges in managing behaviour, with a risk of breakdown of the family or placement.

They also have a behavioural support service which plays a key role, ensuring that people are properly assessed and that behaviour plans are in place. This service provides direct support and advice to staff on these issues. Advice and support is also provided through the sensory occupational therapy (OT) service on a case by case basis.

The Northern Trust is the only trust which has a comprehensive database of outcomes in the positive behaviour support service for over 11 years and their psychology services have outcome data on all their service users. The review team considers that this model should be reviewed by other trusts for effectiveness.

The review found that there is no agreed uniform model for behavioural support services across the five trusts. Some of the teams established with new funding are more expensive than others. An evaluation of the effectiveness of these teams would be valuable. The review was not told of any plans to do this by the five trusts. The Belfast Trust is collecting a range of data in preparation for a review of their Intensive Support Services, including outcome measurements for individual service users.

Given the extra financial investment provided to the trusts, it would be prudent for the commissioner to commission research on the outcomes and effectiveness of these teams, as well as review the costs of each of these teams. The commissioner should also gain insurance that policies are aligned with the principles of positive behaviour management.

Recommendation 7	**Priority 2**
An assessment of the activity and effectiveness of challenging behaviour teams should be undertaken by the commissioner. The outcome model used by the Northern Trust should also be reviewed to see if it could be applied regionally.	

Carers and Public Actively Involved in the Planning and Delivery

The five trusts described in their written submission to the review, how they involve service users and carers in meetings, forums, public consultations and also in some reviews of services, for example day opportunities or short breaks.

Meetings called 'Carers Voice' occur two to three times a year in the Western Trust. These meetings have included presentations on self-directed support, reporting on outcomes of the day care review or short breaks services.

Every trust had various parents and carers groups some of whom met with the review team. The review did not routinely find robust evidence that parent and carer groups were actively involved in the planning, delivery and monitoring of health and social care at all levels. Rather, meetings seemed to focus more on informing carers about trust plans to modify service provision. This does not meet the Service Framework for Learning Disability, Standard 3 (all patients, clients, carers and the public should have opportunities to be actively involved in the planning, delivery and monitoring of health and social care at all levels). This has resulted in some carers groups stating to the review that they considered their views are not valued.

Developing a Personalised Pathway of Care for Learning Disability Services

All five trusts advised that they completed service users' assessments and reviews in an individualised and person centred way.

Recommendation 8	**Priority 1**
Each trust, as part of their Personal and Public Involvement (PPI) Strategy, should proactively involve people with a learning disability and their carers in the planning of change to service delivery or in creating new service developments.	

Each trust described to the review individual pathways of care for assessments, care planning, monitoring and reviews of the needs of an adult with a learning disability.
However, these care pathways were not necessarily inclusive of all services provided to the person, such as residential care, day services and short breaks, even when provided by the trusts and also do not include non-statutory provision.

Direct Payments

All trusts reported that they were progressing the implementation of self-directed support and had updated their information for carers and service users in relation to accessing direct payments. It was reported to the review that this information is now in an easy read or an accessible format. The trusts provided training for their staff in arranging self-directed support.

The Belfast, Northern and Southern trusts are not paying the HSC Board recommended minimum rate of £10.00 per hour for self-directed support as suggested in November 2014 by the HSC Board senior management team. This was communicated to the HSC trusts in a letter to the chief executives in January 2015.

The uptake of direct payments and self-directed support in Northern Ireland lags behind the rest of the United Kingdom[16]. The trusts claim they are unable to fund direct payments from existing budgets and further monies cannot be extracted from ongoing service provision. The current limitations on the amount paid through direct payments and what it can be used to buy requires to be urgently reviewed. The existing disparities across trusts also need to be addressed. Consistency of provision of direct payments between child and adult services is also variable.

A number of carers stated to the review that the services they were provided with, in terms of meeting the needs of young people under 18 years cannot be replicated by adult learning disability services. This makes the transition difficult for many families who stated that on reassessment of their young person's needs by adult services, they were not provided with services at a similar level.

Recommendation 9	**Priority 2**
The commissioner should review the regional disparity in the uptake of direct payments and continue to monitor the consequences of trusts paying below the directed standard rate.	

Assessment of Clinical and Social Care Needs

All trusts advised the review of the information they gather from a wide range of areas including day opportunities, outcomes from service user

[16] Community Care Statistics, Social Services Activity, England 2013-14

assessments, directed enhanced services (DES) and engagement with carers. The Belfast Trust reported they were carrying out a needs assessment in the areas of accommodation needs, transitioning from children's to adult services and short breaks usage.

The Northern Trust reported on completing audits of their screening process and care management. The Western Trust has completed a review of day care and short breaks and is currently working on the first draft of a day care review report. They have also completed a five year projected accommodation needs analysis.

Trusts advised that they are using other forms of assessment tools and not the Northern Ireland Single Assessment Tool (NISAT) to assess the need of adults with a learning disability, over 65 years of age. The DoH has not introduced the NISAT tool for adult learning disability services as a requirement.
However, the Southern Trust reported using the NISAT after making some modifications to it, but not an electronic version. The Belfast Trust uses its own easy read assessment tool About You, which it developed in line with the content of NISAT.

The appropriateness of the use of NISAT within learning disability services needs to be addressed urgently at a regional level and revised regional guidance issued by DoH to HSC trusts concerning their expectation about the use of this tool in the future.

Recommendation 10	**Priority 1**
The Department of Health should review the appropriateness of NISAT for use within adult learning disability services and issue guidance to trusts in respect of the trusts' use of this tool to assess needs regionally.	

Information Systems

Many trusts described the manual collection of information, which is time consuming, can create errors in reporting of information and does not make bench-marking easy for the commissioner. No trusts were using an identical system. Trusts reported there are many limitations to existing systems, resulting in a lack of robust information to inform trusts and commissioners about clinical and social care needs of adults with a learning disability.

There is no agreed single regional information database system to record activity, performance or outcomes in community learning disability services. There was some evidence of collaboration commencing across trusts, to seek a single unified community information system that would capture information about adults with a learning disability in the community, whether attending hospital or general practice. A community informatics group had been recently formed to review information requirements and current databases used by trusts.

Patient Record Information System (PARIS) is a community information system used in adult learning disability services in the Belfast Trust. The Western and Southern trusts will change to PARIS in the future. The South Eastern Trust prefers to retain its own community information systems. The Northern Trust would prefer one regionally agreed information system.

The review team considers this is an area that must be addressed at a regional level in order that accurate and up to date information is available for meaningful planning of service delivery, investment and monitoring of outcomes.

Recommendation 11	**Priority 3**
The regional informatics group should consider and agree how best to capture information in a single unified regional IT solution, to ensure meaningful planning and consistency of reporting on learning disability services and outcomes across the five trusts.	

Day Services and Day Opportunities

Current thinking in relation to most school leavers with severe learning difficulties is to move away from traditional day centres towards other options such as college, vocational training, work experience and supported employment. Service users availing of directly provided day services require an annual review by the trust. This provides an opportunity to discuss their ongoing needs and aspirations.

Each trust had different schemes and a range of different opportunities for the provision of day services and day opportunities.

The Belfast Trust described to the review a range of day opportunities and appropriate employment opportunities provided through direct payments or contractual arrangements with the independent sector. These included buildings based day opportunities, community day services and a number of activity clubs. The trust contracts with Mencap, NOW[17] and Orchardville to provide work and training opportunities and works closely with the Belfast Metropolitan College in relation to further education. The trust also purchases individual day-care and day opportunity packages from the independent sector. Adults with a learning disability are referred for trust day support services using the About You tool, which outlines the specific needs and aspirations of the individual in relation to their day opportunities requirements.

The Northern Trust reported that it has invested in its day opportunities programme to develop a range of community-based day opportunities in four service areas, leisure; vocational; volunteering and further education. These opportunities are processed using a 'Railtrack' Model ensuring individual need

[17] NOW – a training and employment social enterprise group in Belfast

is met in line with assessed need, using local provision. A range of opportunities are in place, which are monitored and reviewed.

The trust advised that it has developed social enterprise vocational training provision across its 12 sites, involving four voluntary sector partners and also a trust-wide supported employment scheme, in partnership with the Department for Employment and Learning (DEL) and two voluntary sector providers. Individual employment progression is tracked, from training to paid employment, through monthly provider meetings.

As part of its Widening Choice and Opportunities Strategy, the Northern Trust has developed a number of satellite facilities, staffed by trust employees, which provide adults with a learning disability with a structured day service, in a smaller setting, in their local community away from larger adult centres. A satellite can also provide an assessment centre in order to prepare individuals, where appropriate, for community based day services such as employment and further education. The Northern Trust had positively evaluated the outcome of provision of care in one of their satellite units. The South Eastern Trust's adult learning disability services had a range of contracts with providers of day care and day opportunities, to provide support in order to access volunteering and employment based opportunities. Ongoing contract monitoring by staff ensures service delivery is provided against agreed targets and activity levels.

The South Eastern Trust advised that it has reviewed all current day care and day opportunities provision and is working actively with key stakeholders, including service users, carers, provider organisations and community groups to develop a range of options to increase choice for individuals. Adult services are also offering self-directed support as a means of delivering person centred day opportunities. Sector based day opportunity panels provide a local approach, which links service users with their local community. At the time of the review, a number of people with a learning disability and their carers had raised concerns with the trust about the trust's plans for the future development of their day care services.

The Southern Trust described to the review how community key workers seek to access appropriate day opportunities, to meet individual service users needs within their local community. These opportunities may be leisure based, volunteering, training, educational, full and part time or supported employment. The trust has directly employed two support workers and is in the process of recruiting a third, to ensure that every service user assessed as needing support to avail of day opportunities, is provided with appropriate support.

The Southern Trust is also in the process of procuring an independent brokerage system, which will be responsible for creating and expanding the range of day opportunities available to service users in each locality and for maintaining an online resource listing these opportunities. The trust already holds a number of contractual agreements with voluntary organisations including Clanrye Developments, Mencap and Appleby Print It Employment Services to promote supported employment opportunities for service users

with a learning disability. A number of patients spoke to the review team and expressed concern about the trust's management of the change process.

A draft directory of partners was supplied by the Southern Trust to some parents and carers which in terms of supplying information was expected to be a positive development. However, it caused some anxiety for carers, as prospective providers when telephoned by carers, were not aware of the inclusion of their respective services in the directory. This emphasises the need for information to be reviewed and updated as required, given the service availability in the community by a range of providers.

The Western Trust reported that it is continuing to develop its approach and a review of care and day opportunities is yielding useful information which they are using to make service improvements. Community teams and day care managers continue to work proactively with service users and their carers, to assess need and source appropriate opportunities for day services for each individual. This is undertaken as a normal part of care and support planning and results in access to a range of trust, voluntary, independent and other statutory provision. The Western Trust also stated that it is participating in a review of day care and day opportunities, which will assess the projected needs for the next five to 10 year period.

The trust also has a new dedicated community access worker whose role through the New Directions Service is specifically to source bespoke packages, where requested, including day care, supportive employment opportunities or college placements. This is working effectively for 27 service users on a trust-wide basis and is continuing to develop.

There was no evidence of the trusts having evaluated the effectiveness of their different schemes in relation to provision of day services and day opportunities.

Recommendation 12	**Priority 2**
Each trust should annually update their directories of services for people with a learning disability to ensure they provide information about current services.	

Recommendation 13	**Priority 3**
Each trust should evaluate the benefits and effectiveness of outcomes for adults with a learning disability of the various models of day care and day support. This should be reviewed by the HSC Board regionally in terms of their future commissioning plan for day care and day support services.	

Development of Partnership Arrangements

The trusts advised the review of close working partnerships with a range of providers of day care and day opportunities. These were in the areas of education, leisure, employment and vocational training for adults with a learning disability.

In addition, there is ongoing work involving supported employment and social enterprises with the Department for Education and Learning and volunteering with the Department of Social Development and the voluntary sector.

Although all trusts outlined their involvement with the non-statutory sector, the review team considered that there was no real sense of sustained partnership around broader service development plans but rather engagement takes place on a specific project basis as required.

All five trusts advised the review of close working relationships with a range of partners, in particular Northern Ireland Housing Executive (NIHE), but also the Department of Social Development (DSD) and a range of housing associations. A move towards tendering of services runs the risk of setting up competition among non-statutory providers with the lowest price becoming the most significant factor, which should be monitored by the HSC Board.

Supported Employment Opportunities

There are some very good examples of innovative and possibly very cost-effective schemes taking place in individual trusts, such as the Rail Track model in Northern Trust. This model illustrates a clear process from referral through to allocation of services.

It illustrates a person centred approach commensurate with the HSC Board's regional day opportunities model and Equal Lives report for vocational opportunities and educational opportunities. The review notes this good practice was not replicated by other trusts and types of service models were not routinely shared across trusts.

The proportion of people with learning disability even in part-time employment remains very low. Unpaid work experience placements still dominate, which run the risk of trainee exploitation.

Protection of their social security benefits may be a contributory factor in the low percentage in full time employment, but the review team saw evidence of a number of people who could graduate to paid employment. Some people subsequently reported that they had not been provided with an opportunity to do so. The review noted that trusts had employed very few people with a learning disability. The trusts as large employers should consider providing paid employment opportunities for people with a learning disability, as this would serve as an example to other statutory agencies and private businesses.

Recommendation 14	Priority 3
The trusts, as large employers should, as part of their organisational development strategies, seek to provide a model of positive discrimination by promoting more employment opportunities for people with a learning disability.	

Managing Transitions from Children's to Adult Services

None of the five trusts were approaching transition planning in the same way. All trusts reported that a regional protocol or pathway for children transitioning to adult services is in place. In some trusts the protocol is still in draft.

A number of families reported experiencing difficulties, when transitioning to adult services, particularly with continuing provision of short break services, therapeutic input and alternative options to school.

Many families indicated that they face a significant reduction in services yet with no change in the person's needs. It was reported to the review team by carers that they understand that this is solely driven by capacity of trusts to provide services.

Carers are finding it difficult to manage the interfaces between services in the absence of a lead medical consultant, especially where a young adult has a number of complex needs which cover more than one medical speciality. Up until a young person was 14 years old their needs were coordinated under paediatric services.

In the Belfast Trust, the learning disability service has engaged the Orchardville Society and NOW[18] to provide two transition officers to support young people, from the age of 14, to plan their transition from children's to adult services. The transition officers work routinely with education, children's and adult services.

The Belfast Trust has updated its policy on transition pathways; relevant managers from children's and adults services meet bi-monthly to share information, plan and track progress on plans made by the trust.

The Northern Trust has recently completed a baseline report, detailing potential known transitions for the next five years. Using a Transition Co-ordinator and working in partnership with children's services and education transition services, the trust now has incorporated transition work as part of the community learning disability team rather than as a separate transition team.

The South Eastern Trust reports that they hold a monthly community integration meeting. One aspect of this is to specifically consider children with

[18] NOW – a training and employment social enterprise group in Belfast

complex needs or who have been looked after by the trust, who will require placements within adult services.

The Southern Trust reported to the review team that a scoping exercise is underway to identify all young people from age 14 years so that a transition database may be collated. The trust is prioritising young people who turn 18 in 2016 and young people on an extra contractual referral who will return to the trust.

The Western Trust is currently managing transition from children's to adult services on a case by case basis. There is joint working by children's and adult services, in most cases, in advance of a young person's 18th birthday.

Arrangements are in place with local schools, to co-ordinate efforts to manage effective transitions for children from school to day care and day opportunities placements.

In the Western Trust, transition from children's to adult services has seen some improvement since the last review, due to the appointment of two people within adult teams.

They have a remit to work with children's services, to develop a transition plan for school leavers and to help adults make a transition to other services in the trust e.g. older peoples services. However, resources do not normally follow young people in transition and are often not available to adult services to maintain the levels of support provided in children's services.

Transition planning needs to be consistent with legislative requirements, guidance and best practice standards.

An options appraisal needs to be undertaken of how resources could follow the person across service boundaries in order to maintain services following their transition to adult services. It was unclear to some trust staff, if the transition funding for Looked After Children could be made available to cover services from 14 to 25 years and if funding is drawn from both children's and adult services.

Recommendation 15	**Priority 1**
Each trust involved in making transition arrangements should ensure that they follow legislative requirements and best practice standards and that the criteria for the continuity of service provision are made clear to people with a learning disability and their carers.	

The review team noted that the proportion of school leavers with more complex physical and behavioural needs continues to rise. This will create further pressure in adult services in the future.

Recommendation 16	Priority 3
All trusts should carry out an assessment of the needs of school leavers over the next five-year period to enable financial projections to be made for the increased resources required to maintain adults with a learning disability in the community adequately.	

Managing Transitions from Hospital to Community

All trusts were asked to provide information regarding their arrangements for adults transitioning from specialist hospitals. Resettlement of patients from Muckamore Abbey Hospital remains incomplete. The Belfast Trust has a dedicated care manager attached to Muckamore Abbey Hospital who works closely with the hospital and community teams in relation to all resettlement and delayed discharge patients.

The Northern Trust has developed effective alert and discharge planning arrangements with their hospital social workers, to ensure suitable planning for adults transferring from general hospital to the community. The Northern Trust's senior staff responsible for learning disability services meets quarterly to review all admissions to and discharges from Muckamore Abbey Hospital to assist in identifying any patterns and gaps in services.

The South Eastern Trust reports it has two dedicated transition workers who provide in reach services for patients in Muckamore Abbey Hospital, to help facilitate person centred discharge planning arrangements. The Southern Trust follows the pathway agreed with Belfast Trust for patients from Muckamore Abbey Hospital who are transitioning from hospital into the community. Trusts are continuing to work with patients who refuse to leave hospital despite a number of placements being identified. One trust is awaiting advice from the HSC Board and DoH in this matter. The Western Trust has completed its original resettlement strategy. At the time of the review they had only two patients on the delayed discharge list to relocate. This was expected to be completed by July 2016.

The review team looked at the number of beds in Muckamore Abbey Hospital in 2013-2014 and the number of people continuing to require resettlement in the community, as shown in Appendix 3 Table A7. Twenty beds are available for treatment, ten beds each in the Southern and Western Trusts. The trusts have been unable to fully meet the expectation of the DoH in terms of all long stay hospital patients being discharged to the community by March 2016, due to some of the above factors. It is anticipated that the patients referred to in Appendix 3 awaiting resettlement, will leave in November 2016, January 2017 and June 2017. Placements are provided mostly in nursing homes or other group living arrangements, when indicated by the person's assessment of need.

Number of Patients in Active Treatment and Delayed Discharge

There is a concerning trend of new patients experiencing delays in their discharge to the community. A snapshot of the position at the end of January 2016 is set out in Table 5.

Table 5: Numbers of Patients by Trust in Active Treatment and Delayed Discharge at the 31 January 2016.

	Inpatient Treatment	Delayed Discharge
Belfast Trust	15	18
Northern Trust	10	16
South Eastern Trust	9	14
Total in Muckamore	**34**	**48**
Southern Trust	5	3
Western Trust	2	7

Figures in Table 5 are based on end of month positions as reported in the returns for Muckamore Abbey Hospital to the HSC Board.

By 16 May 2016 the position was 68 patients were delayed in their discharge, 29 from Belfast Trust and 39 from the other trust areas in Muckamore Abbey Hospital.

Supported Accommodation and Support Services

The South Eastern Trust has worked with the NIHE, Supporting People and Housing Associations to create new and extended supported living schemes.

The HSC Board expressed concern about continued availability of funding from the DSD to support adults with a learning disability in supported living accommodation, if, in the future, they do not strictly meet their criteria, in the future. Discussions are being held with NIHE and trusts about the future of commissioning of these services and the intentions of NIHE.

Accommodation Needs of Adults with a Learning Disability

The Belfast Trust has reviewed the likely accommodation needs for people with a learning disability for the next four years. This information is used for financial and accommodation planning purposes. Individual accommodation plans are progressed through their care management processes which assess need, source accommodation and commission and review the service.

The Northern Trust has undertaken a similar exercise to examine the current and future accommodation needs of young adults in residential care, including individuals living with their parents long term and adults awaiting resettlement or involved in a delayed hospital discharge.

The Western Trust has carried out a five year needs analysis of accommodation and is anticipating accommodation needs of various types for 222 people between 2015 and 2019. This is more likely to increase than decrease based on changing needs within families. Most service users are

living in residential, nursing care, and supported living with day care support or 24 hours seven days a week support needs as required.

The availability of emergency accommodation in the community, for a short period, to support the work of behaviour support teams was commonly noted as a means of avoiding unnecessary hospital admissions. Sometimes patients whose placements break down in a crisis have returned to Muckamore Abbey Hospital. They risk becoming a new category of delayed discharges. However no trust to date has been able to provide such a crisis facility. The Northern Trust provides two stepdown beds in two separate facilities at Hollybank and Woodford Park to assess patients at risk of their placements breaking down and work with them intensively in the community.

Recommendation 17	**Priority 2**
The HSC Board, supported by the five trusts, should review the models of best practice in preventing hospital admissions and consider the feasibility of developing a pilot of a regional crisis admission house.	

Placements Out of Own Trust Area

The review was aware of a number of people who are placed out of their own area due to the lack of suitable care options in their home trust.

This creates funding implications for host trusts as new community services are needed to support the person in the new trust area. In the Northern Trust, in one new facility, 19 out of 20 beds were being purchased by other trusts.

Recommendation 18	**Priority 3**
Each trust should review the impact of the transfer of people to other trust areas in relation to the consequences for their learning disability team's infrastructure, the cost to the receiving trust and the possible disruption to family relationships and share their findings with the HSC Board.	

Review of Needs of Older Parents

All trusts informed the review of identifying, profiling, recording or reviewing older carers and their needs. This was frequently undertaken as part of other work, such as Transforming Your Care respite projects, review of short breaks or an exercise in scoping future accommodation needs. In addition to annual reviews and direct payments, all trusts advised that, based on the assessment of need and eligibility criteria, adults with a learning disability parents, carers and families are supported with short breaks. These take many different forms, such as day sitting, night sitting, flexible respite or direct payments.

The uptake of assessments by carers remains low across all trusts. Trusts advised that some carers have declined the recording of their needs. The

trusts all reported that they continue to offer carers assessments; in 2015, one trust wrote to all carers offering an assessment.

The HSC trusts advised that some families had declined to discuss future planning and reported that it is a subject that some families find difficult to talk about.

A number of families involved in the focus groups, stated they were unaware that support was available from the trust, to assist with future planning and would welcome this input. Set rules about when future planning should commence will not suit every family, although trusts should try to encourage this discussion during the review of the care plans for adults with a learning disability. This may help in reducing crisis intervention planning in the future.

Recommendation 19	**Priority 1**
The carer coordinator in every trust should report to the HSC Board about the reasons given by carers specifically not wishing to progress with a carer's assessment. The HSC Board should consider if any further action should be taken by trusts to increase the uptake of assessment.	

Recommendation 20	**Priority 2**
Each trust should monitor and ensure that effective future planning is taking place and monitor crisis admissions to care annually and disseminate any lessons for learning.	

Developing Capacity to Give or Refuse Consent

The trusts advised the review that staff have undertaken capacity and consent training. Where the service user has been assessed and does not have capacity, advocates can be used by the trust to ensure the best interests of the service user are considered. The majority of trusts also advised that leaflets explaining consent are made available for service users. Trusts currently await the implementation of the new Mental Capacity Act (Northern Ireland) 2016 and further guidance in relation to assessing capacity.

Advocacy

All trusts made advocacy services, funded regionally by the HSCB, available during the resettlement process. Four trusts advised of a contracted arrangement with an independent advocacy service, provided by ARC, Bryson House, Disability Action or VOCAL. The Northern Trust is undertaking a review of their current advocacy arrangements and developing a paper to confirm their future model. The Western Trust had just ended a contract with VOCAL and will now negotiate a new contract, although their funding to do so is very limited. TILII is used by the Belfast and South Eastern trusts to provide peer and self-advocacy.

The Belfast Trust is also supported by MENCAP to assist in the development of advocacy skills, which has led to significant improvements in the services provided by the transport department.

The Belfast Trust commissions separate advocacy services for the hospital and community.

The contract for community advocacy services prioritises cases where the trust is seeking some form of legal authority in relation to the service user and cases where there is some form of conflict between the trust and the service user.

The Southern Trust has used independent advocacy services for adults involved in the resettlement process and for adults living in trust supported living schemes. Speech and language therapy input was dedicated to this to ensure as many views as possible were captured, by assisting with service user communication. A number of service users and carers said they did not like group sessions, so the trust changed its plans. People are met in their own homes on an individual basis. The Western Trust has invested £20,000 in the provision of advocacy services.

Commissioned advocacy schemes seem to be more focussed on resettlement in other trusts.

The review team did not detect any initiatives to promote advocacy for persons with learning disability more widely; rather they are available on demand, although the Southern Trust stated that self-referral and referral from other agencies can be made to this service. The trust has doubled its investment in this service in the past two years. Advocacy may be especially crucial for the successful uptake of direct payments and other new service options. All trusts indicated that they promote people's human rights, although few specific instances were provided to the review as to how this occurred.

Recommendation 21	**Priority 3**
Each trust should review their investment in advocacy services and ensure it is available to a wider group of people, other than just those involved predominately in resettlement from hospital.	

Appropriate Support for Service Users in Contact with the Criminal Justice System

All trusts referred to advocacy services as part of the support available to adults within the learning disability service that come into contact with the criminal justice system. The Belfast and South Eastern trusts advised that they provide both peer and self-advocacy using the TILII group. The Southern Trust is using Disability Action to provide an independent advocacy service. The Northern, Southern and Western trusts have social work support available in their forensic teams to support people in contact with the criminal justice system.

Increased Staff Training and Awareness

Generally, trusts responded to this question by describing training for learning disability staff that includes the previous RQIA recommended areas of human rights and good communication. The Belfast and Western trusts reported that, where possible, service users had input into staff training.

The review notes that the Belfast Trust's two day induction programme for learning disability staff was shortlisted for a social work award in the learning and development category in 2013.

2.4 Standards Reviewed Relating to COMPASSIONATE Care

Findings

All trusts described to the review that they have established a carers' forum and carers' groups in their respite units to allow carers to freely express their views. Others ways in which the carer's voice was heard were described: during carers' assessments, annual satisfaction questionnaires, surveys, reviews of services users and during the care and support planning processes.
In addition, the Belfast Trust contacts two carers per day centre every month to seek feedback on their level of satisfaction with services.

Engaged through Effective Communications

In addition to the groups and structures that the trusts had previously described, they all made reference to the provision of some easy read material and accessible formats.

The Belfast Trust informed the review of service user committees in each of its day services. Each committee sends a representative to the trust wide service user forum.

The Northern Trust has provided information in accessible formats, and described the speech and language therapists training provided to other trust staff to promote better communication with service users. A pilot has been established using social media to share information with a wider group of service users and carers. The trust has also produced a DVD of the last 10 years provision of day opportunity services, to help promote uptake of this service.

The South Eastern Trust uses trust wide speech and language therapy services and has devised a person centred template titled How Best to Support my Communication. The trust provides accessible information about Promoting Quality Care assessments, videofluroscopy, numerous health appointments and the use of a hospital passport.

The Western Trust reported using communication plans, has developed easy read material and has some accessible information on the trust's website.

While supporting all initiatives described above, the review found that the trust websites are not very user friendly and have limited information available instead of specific easy to read information.

Recommendation 22	**Priority 1**
Each trust should have an identified area on their website for people with a learning disability which has more easily accessible information in terms of easy to read material with more use of signs / symbols for ease of access to information.	

End of Life Care Needs

All service users in nursing and residential homes should have end of life or dignity plans in place. The review found that community staff engage with families to produce end of life plans when requested.

Many positive examples were provided to the review from across Northern Ireland, which provided evidence of trusts supporting service users requiring palliative care with person centred care, in their home at the end of their life. All trusts described working with GPs, hospital staff, community nursing, rapid response teams, psychology, hospices and Macmillian nursing care to provide appropriate end of life care.

In the Northern Trust, learning disability services are represented on the trust's Palliative Care, End of Life Programme and the Bereavement Forum. The Belfast and Northern trusts described palliative care training opportunities available to their staff.

Care plans are agreed with service users, carers and families and updated following service user reviews. The Western Trust advised that its staff identify people with learning disabilities with no relatives, to ensure dignified end of life plans and arrangements are in place.

2.5 Services are Well Led

Findings

This review assessed the effectiveness of the leadership, management and governance of services while focusing on the needs and experiences of service users. Levels of leadership were assessed at both team and senior management levels in focus groups and from written responses to self-assessment questionnaires which were analysed by the review team. In addition, a meeting was held with the HSC Board as commissioner, to validate some of the information provided about actions taken by trusts.

Use of Service Framework by Trusts as a Tool for Improvement

Following the 2013 Phase I, Review of Community Services for Adults with a Learning Disability, all trusts reported in their action plans that they were progressing the service framework and contributing through regular reports, to monitoring by the HSC Board.

All trusts described their structures, confirmed the governance arrangements in place for learning disability and demonstrated linkages across their own trust with other directorates. Professional leads have responsibility to ensure that staff remained up to date with contemporary theories, interventions and best practice guidelines. Trusts advised the review of the types of processes in place, to gain assurance as to performance against the Service Framework for Learning Disability, including contributing to the HSC Board's monitoring of key performance indicators (KPIs) and participation in the HSC Board's file audit. The trusts provided a list of their internal audits of practice; for example audits of safeguarding, staff supervision, direct payments and carers assessments.

Proposals for gathering evidence to demonstrate improved outcomes for service users were reported to the review by three trusts, Belfast, Northern and Western. The Belfast Trust is introducing a Health Equality Framework as an outcome measurement tool.

This will be piloted across part of adult learning disability services later in 2016. The Northern Trust has an outcome evaluation framework for people in receipt of psychological services.

The Northern Trust reported increased numbers of direct payments, increased opportunities in supported living and day services and described their bespoke packages for resettlement.

The Western Trust similarly demonstrated an increase in supported living placements for resettlement of patients out of hospital, increased numbers of direct payments and developments in self-directed support.

The review team noted that most staff they met were familiar with the content of the service framework, although the review team received assurances that the Service Framework for Learning Disability has been rolled out across trust staff.
The Service Framework for Learning Disability should guide service developments, monitor outcomes and underpin the formulation of annual disability service development plans. The approach used by trusts in applying the standards varied across trusts.

Recommendation 23	**Priority 2**
The formulation of annual learning disability service development plans in trusts should be consistently underpinned by the standards set out by DoH in the Service Framework for Learning Disability.	

Use of Best Practice Evidence and Guidelines

All trusts advised that they use best practice evidence and that appropriate guidelines were available. Sources listed by the trusts included National Institute for Health and Care Excellence (NICE), Royal Colleges, external reviews and RQIA Quality Improvement Plans. The Belfast Trust is currently exploring membership of the National Health Service Bench Marking Network of Learning Disability Services.

Transferability of Skills between Mental Health and Learning Disability Teams

The Belfast Trust reported that their teams are working closely together in a number of ways such as audit forums and in monthly monitoring meetings with independent providers. The Northern Trust is developing opportunities for co-working with their RAID and Promote teams. The South Eastern Trust described the link between the CLDT's approved social worker, who engages directly with mental health services through a forum. The Western Trust advised that learning disability staff share knowledge and expertise on a case by case basis.

The Department of Health advised that students on the Approved Social Work Course (who are already experienced social workers) have to undertake a placement in mental health and or learning disability depending on their specific learning needs. Mental health social workers will undergo a Learning Disability placement in order to widen their experience and vice versa. However the review was not advised of any placements of learning disability staff in mental health services and vice versa to encourage experiential learning, or consideration of secondments of staff to learn more about mental health or learning disability services.

The trusts did not provide any data to quantify any skills exchange between mental health and learning disability teams. Limited improvement has been noted in this area.

There continues to be reluctance for mental health services to take people with a mild learning disability into their services, despite the standard set out in the Service Framework for Learning Disability.

Leadership of Services, Governance and Service Improvements

All trusts advised the review of a wide range of ways in which their staff are supported. Staff have regular supervision, attend team and MDT meetings, professional forums, knowledge and skills framework (KSF) appraisals, participate in staff surveys, complete induction training and specialised training for existing staff is available.

The trusts described regular learning disability team meetings, MDT meetings, supervision and visits by senior managers and directors. This demonstrates that staff are supported, able to make suggestions, have a team approach to addressing key concerns and is included in decision making.

Additionally, the review was advised that workshops are held in the Northern and Southern trusts to enable staff to offer suggestions for improving the service.

Trusts had service plans, directorate plans and corporate plans in place for adult learning disability services. Managers are described as having an open door policy when listening to their staff; staff were encouraged in many ways to be involved in decision making, for example the Southern Trust Assistant Director wrote to all learning disability staff asking them to identify any ineffective or inefficient practices.

Learning from incidents is disseminated across the teams during de-briefings by managers, in MDT meetings and regular incident review meetings. The trusts have incident review forms, Datix processes and risk registers, to ensure that learning is captured and shared. All trusts provided evidence of numerous audits carried out within learning disability services; files and care plans are regularly audited to ensure services users' notes are current and that relevant information is recorded. The Northern Trust continues to have leadership walk arounds involving both the Assistant Director and the Director and promotes staff engagement across all services.

All trusts have complaint, compliment and feedback systems and indicated that they reviewed the outcomes.

The chairman, non-executive directors, directors or heads of service conduct walk around visits to services. In the Southern Trust, this was developed further into a patient and staff safety leadership walk around programme. All trusts reported having person centred planning processes with Promoting Quality Care (PQC) risk assessments being completed with service users.

Difficulty in Implementation of the Service Framework for Learning Disability

Trusts stated that there is still a need to update the service framework, and amend the language in some parts to ensure trusts are meeting the KPIs consistently. The review noted that trusts have not all interpreted the KPIs in exactly the same way. Further work is required by the commissioner to agree definitions to ensure accuracy of reporting and comparability of outcomes.

Trusts described their difficulty in obtaining data, as it was not readily available or accessible. This has resulted in some cases in estimates being submitted. This can lead to inaccuracies if comparisons are made about performances of trusts. There are concerns therefore that this potentially inaccurate information is being used to measure performance by the HSC Board.

All trusts expressed concerns about the lack of specificity in some of the standards set out in the service framework and consider that the information provided to date, is unlikely to have enough reliability or validity to make accurate comparisons between trusts. However the HSC Board advised the review team that they consider the comparative data to be sufficiently robust.

The following benchmarking information of the KPIs to date, has been provided by the HSC Board to the RQIA review.

Table 6: Status of key performance indicators (KPIs) from Service Framework for Learning Disability

The Service Framework for Learning Disability contains 34 standards, 4 are specific to children and there is a set of 10 that are identified as generic. These essentially are intended to apply to all the population, or all HSC professionals or all service users, regardless of their health condition or social grouping.

The HSC Board is monitoring performance against the 20 standards that specifically relate to adults with a learning disability. The HSC Board reports separately on the generic and children's standards to the Department of Health.

Within the 34 standards there are 85 KPIs, however within the 20 standards relating to the adults with a learning disability there are only 56 KPIs.

Status of KPIs	Green	Amber	Red	Total number
Number of KPIs	27	25	4	56

This indicates that at the time of the review 27 KPIs were achieved, 25 KPIs were with an acceptable tolerance and four KPIs were not met.

Given that the Service Framework for Learning Disability is now in its third year, the review concluded that a higher level of achievement should have been evident. Closer partnership working by trusts would have been helpful to achieve a more consistent approach across Northern Ireland.

Recommendation 24	**Priority 3**
The DoH should assess the progress and the implementation of the standards contained in the Service Framework for Learning Disability.	

Recommendation 25	**Priority 1**
Each trust should produce action plans to demonstrate how they meet the KPIs in the Service Framework for Learning Disability and present this to their Trust Board for monitoring and to evidence their demonstration of improvement.	

Section 3: Stakeholder Consultations

The review team met with over 200 adults with a learning disability, from all of the HSC trusts across Northern Ireland, in 17 separate groups and in a range of one to one meetings with service users. The composition of the groups included adults with learning disabilities, adults with a learning disability who advocate for others, parents, carers and advocates. The review team met adults in settings ranging from their own homes, to day centres and trust facilities. Some groups were organised by the trusts, others by the voluntary sector, such as ARC, Destined, Positive Futures, TILII and VOCAL.

Generally, information obtained from this consultation process agreed with findings from interviews with trust staff. Annual health reviews were experienced by everyone with a learning disability, in general practice settings involving both nurses and GPs. However, parents wanted to receive a copy of appointment letters as the adult with a learning disability easily forgot the appointment and the family might not be aware of the date and time. GP practices also provided most of the health promotion advice regarding smoking cessation, healthy eating and exercise to service users who were also able to describe the process of consent and knew they could say no. The general consensus across the groups was that GPs were flexible and understanding of the needs of adults with a learning disability.

There were several examples of available work opportunities all unique to the services user's particular circumstances. Some people with a learning disability said they would like to be paid for work undertaken but as they relied on their social security benefits, they could not risk losing these as they were vital to them managing in the community. The cost of transport to attend day opportunities was raised by service users and parents as an issue.

Future planning was an area that was difficult to approach for people with a learning disability and their carers. There was a low level of acknowledgment of any plans in place. Parents and carers were quite concerned that plans have not been developed and that emergency planning would be the only fall-back position when carers were ill or no longer able to manage. Other parents whose current situation was more stable reflected that they would like to commence planning for the future, although no discussions had taken place with trust staff.

Transitioning to adult services was not a recent experience for most people we interviewed, but for the few adults who had experienced this, they described being offered one choice of activity or one choice of accommodation at resettlement. No service user interviewed described being offered two or more alternatives for either a day activity or accommodation. When children with a mild learning disability are in mainstream education, they were not identified as needing to make the transition into adult learning disability services until they finished their education. Consequently no planning and preparation was in place for these young people. A lack of structure and drift in the engagement by trusts was experienced by some carers.

Whilst the South Eastern Trust had examples of effective engagement with parents and carers, a number of parents and carers in the South Eastern Trust and Southern Trust also expressed their frustration to the review at the lack of engagement in ongoing development of learning disability services. Lack of contact and lack of support were both expressed by parents who felt that they were not being heard. Parents explained that they know their own son or daughter's needs best and found it difficult when trust staff did not take their views into consideration. Parents described being offered services that were very different and in their opinion, irrelevant to what their young person needed.

A group of parents and carers in the Southern Trust expressed dissatisfaction with communication from the trust in respect of day opportunities and respite. In Londonderry, parents and service users commented on the lack of contact with social workers. Most service users who met the review team did not have a social worker. A number were living fairly independent social lives and may not necessarily have required a social worker but stated they would value a telephone number to ring for advice if required. They believed the trust had difficulties in recruiting social workers who did not stay in employment very long.

Day centres and their satellite units were praised by service users and the parents. The staff were highly thought of and local community involvement was recognised as providing a significant contribution towards their success.

GPs highlighted that referrals made to learning disability services were managed well, however a referral to other secondary care services often required a second referral. Some adults with a learning disability did not understand the trusts' letters from partial booking systems. When no action is taken by an adult with a learning disability, because they do not know to phone the hospital to make an appointment or share the letter with someone who would understand the appointment process, they are discharged without having attended an appointment. Some concern was expressed by voluntary organisations, around the small but growing numbers of adults with a learning disability whose first language was not English, and the requirement for translators.

In Londonderry a group called Destined was very proactive in providing classes and services for a wide range of adults with learning disabilities. Activities and sports were developed for different age groups. Young adults were provided with classes and opportunities more appropriate to their age, while more mature adults had their preferred activities at alternative times of the day. Adults with a learning disability were supported to become involved in a wide range of activities across the city.

This scheme demonstrated an excellent model of community integration and also provides placements for young people who are considering a career in social work or social care services. Grant aid had been obtained from the European Union which has enabled a multiplicity of day options and services for young people with a learning disability to be developed.

Section 4: Conclusion

It is estimated that there is approximately 26,500 people with a learning disability in Northern Ireland, of whom; half are aged between zero to 19 years[19].

The Service Framework for Learning Disability was disseminated to all HSC trusts in September 2013. It contains 34 standards to provide guidance to trusts on how to improve the health and wellbeing of people with a learning disability.

This review assessed the quality of services delivered to adults with a learning disability against 30 standards. The standards relating to children will be reviewed at a later stage by RQIA. The processes established by the HSC Board to monitor and seek assurances regarding the delivery of safe, effective, compassionate and well led services were also reviewed. The review found evidence of improvements in a number of standards. In particular, the regionalisation of adult safeguarding practices, the enhancement of health promotion and screening undertaken by GPs, and the establishment of specialist teams to manage behaviours that challenge staff and carers.

In addition, a large array of creative day opportunities have been offered in place of the previous more limited choice of attendance at a day centre in each trust.

An evaluation of the effectiveness of different models of day opportunities in terms of improved outcomes for service users would be helpful regionally. Whilst there have been very welcome developments, trusts are still on an improvement journey and gaps remain in the full implementation of the standards in many areas.

Multiple information systems exist in very trust, to record activity, with a heavy reliance on paper based files. A more collaborative approach is required by trusts to develop and agree one single unified community based information system that will enable the commissioner to compare and contrast the effectiveness of outcomes in relation to the funding invested in learning disability services.

Guidance was delivered by the HSC Board in November 2014 regarding the introduction of a minimum payment rate of £10 per hour for direct payments as Northern Ireland considerably lags behind the rest of the United Kingdom. To date, only the Western Trust and the South Eastern Trust are paying this amount per hour. The review recommends this should be reviewed by the commissioner.

The uptake of carers' assessments continues to be low in Northern Ireland, as does the number of people with a learning disability in paid employment.

[19] Bamford Action Plan, Dhssps (2009-2011)

However, a number of people we spoke to expressed fear about losing their entitlement to their social security benefits.

This factor needs to be reviewed further by trusts, to ensure that people who can work daily can progress without fear into more meaningful employment opportunities.

There were examples of more consultations being held by each trust, with service users and carers, but less evidence of trusts actually developing services jointly or in direct partnership with service users, in keeping with the standard.

Transition planning between children and adult services continues to be problematic. Clearer projections of numbers and costs are required across all five trusts to identify the financial resources required to meet the known physical and behavioural needs of young people who have now entered adolescent services.

A low number of people with a mild learning disability are able to access mental health services which is not in keeping with the expectations set out in the standard.

Community learning disability teams continue to have a similar composition of professionals, as in 2013. Due to the varied range of roles, tasks, job descriptions, size and types of teams, it was difficult to compare and contrast teams for effectiveness. It is surprising given the small size of Northern Ireland, that such a variance is required to deliver essentially the same type of service provision.

Despite numerous targets being set by the HSC Board, the resettlement target of all long stay patients leaving learning disability hospitals by June 2017 may not be achieved.

The review noted a limited access to advocacy apart from those living in supported living schemes or transitioning from long stay hospitals. This inequality should be reviewed to ensure that all people who require this service can access this in the future more equitably.

In relation to the achievement of the key performance indicators contained in the service framework, the HSC Board demonstrated to RQIA that 27 of these have been fully achieved, 25 are in progress and 4 have not been achieved. The review concluded that a higher level of achievement should have been evident. Closer partnership working across trusts would have been helpful to achieve a more consistent approach to delivery of the standards across Northern Ireland.

Section 5: Recommendations

Recommendation 1	**Priority 1**
The commissioner should ensure effective use of resources through accountability meetings and seek evidence based improvements in learning disability services across trusts. The investment in learning disability hospital provision should also be kept under review given the current resettlement target set for achievement in 2016.	

Recommendation 2	**Priority 1**
The Regional Learning Disability Health Care and Improvement Steering Group, set up by the Public Health Agency should ensure each trust has a plan that can demonstrate measureable evidence of health improvements for adults with a learning disability.	

Recommendation 3	**Priority 1**
The PHA in conjunction with trusts should develop a regional dataset of information in relation to outcome measurement in 2016-2017 across two key areas to drive improvement in the health status of people with a learning disability. Targets should be considered in relation to the reporting of a reduction in smoking and obesity in the 2017-2018 year.	

Recommendation 4	**Priority 2**
The HSC Board should set an access target for inclusion of people with a mild learning in mental health services in order to achieve the standard set up in the service framework.	

Recommendation 5	**Priority 2**
The HSC Board should review the current models of service provision in place in the five trusts in terms of evidence of best practice and ensure that this is disseminated regionally.	

Recommendation 6	**Priority 2**
Each trust should review the specific role of the consultant psychiatrist in their community team in terms of how best they can assist in the delivery of improvements in clinical outcomes for people with a learning disability.	

Recommendation 7	**Priority 2**
An assessment of the activity and effectiveness of challenging behaviour teams should be undertaken by the commissioner. The outcome model used by the Northern Trust should also be reviewed to see if it could be applied regionally.	

Recommendation 8	**Priority 1**
Each trust, as part of their Personal and Public Involvement (PPI) Strategy, should proactively involve people with a learning disability and their carers in the planning of change to service delivery or in creating new service developments.	

Recommendation 9	**Priority 2**
The commissioner should review the regional disparity in the uptake of direct payments and continue to monitor the consequences of trusts paying below the directed standard rate.	

Recommendation 10	**Priority 1**
The Department of Health should review the appropriateness of NISAT for use within adult learning disability services and issue guidance to trusts in respect of the trusts' use of this tool to assess needs regionally.	

Recommendation 11	**Priority 3**
The regional informatics group should consider and agree how best to capture information in a single unified regional IT solution, to ensure meaningful planning and consistency of reporting on learning disability services and outcomes across the five trusts.	

Recommendation 12	**Priority 2**
Each trust should annually update their directories of services for people with a learning disability to ensure they provide information about current services.	

Recommendation 13	**Priority 3**
Each trust should evaluate the benefits and effectiveness of outcomes for adults with a learning disability of the various models of day care and day support. This should be reviewed by the HSC Board regionally in terms of their future commissioning plan for day care and day support services.	

Recommendation 14	**Priority 3**
Each trust, as large employers should, as part of their organisational development strategies, seek to provide a model of positive discrimination by promoting more employment opportunities for people with a learning disability.	

Recommendation 15	**Priority 1**
Each trust involved in making transition arrangements should ensure that they follow legislative requirements and best practice standards and that the criteria for the continuity of service provision are made clear to people with a learning disability and their carers.	

Recommendation 16	**Priority 3**
Each trust should carry out an assessment of the needs of school leavers over the next five-year period to enable financial projections to be made for the increased resources required to maintain adults with a learning disability in the community adequately.	

Recommendation 17	**Priority 2**
The HSC Board, supported by the five trusts, should review the models of best practice in preventing hospital admissions and consider the feasibility of developing a pilot of a regional crisis admission house.	

Recommendation 18	**Priority 3**
Each trust should review the impact of the transfer of people to other trust areas in relation to the consequences for their learning disability team's infrastructure, the cost to the receiving trust and the possible disruption to family relationships and share their findings with the HSC Board.	

Recommendation 19	**Priority 1**
The carer coordinator in every trust should report to the HSC Board about the reasons given by carers specifically not wishing to progress with a carer's assessment. The HSC Board should consider if any further action should be taken by trusts to increase the uptake of assessment.	

Recommendation 20	**Priority 2**
Each trust should monitor and ensure that effective future planning is taking place and monitor crisis admissions to care annually and disseminate any lessons for learning.	

Recommendation 21	**Priority 3**
Each trust should review their investment in advocacy services and ensure it is available to a wider group of people, other than just those involved predominately in resettlement from hospital.	

Recommendation 22	**Priority 1**
Each trust should have an identified area on their website for people with a learning disability which has more easily accessible information in terms of easy to read material with more use of signs / symbols for ease of access to information.	

Recommendation 23	**Priority 2**
The formulation of annual learning disability service development plans in trusts should be consistently underpinned by the standards set out by DoH in the Service Framework for Learning Disability.	

Recommendation 24	**Priority 3**
The DoH should assess the progress and the implementation of the standards contained in the Service Framework for Learning Disability.	

Recommendation 25	**Priority 1**
Each trust should produce action plans to demonstrate how they meet the KPIs in the Service Framework for Learning Disability and present this to their Trust Board for monitoring and to evidence their demonstration of improvement.	

Glossary

BPS - British Psychological Society

BSS - Behaviour Support Service

CLDT - Community Learning Disability Teams

DEL - Department for Employment and Learning

DES - Directed Enhanced Services

DHSSPS – Department of Health Social Services and Public Safety

DoH – Department of Health

DSD - Department for Social Development

EPEX – Electronic Information database

GMS - General Medical Services

GP – General Practitioner

HSCB – Health and Social Care

KPIs - Key Performance Indicators

LCID – Local Community Information Database

NIHE - Northern Ireland Housing Executive

NISAT - Northern Ireland Single Assessment Tool

OT – Occupational Therapist

PARIS – Patient Record Information System

PBSS – Positive Behaviour Support Services

PHA – Public Health Agency

RAID - Rapid Assessment Intervention and Discharge

RCP - Royal College of Psychiatrists

SLT – Speech and Language Therapist

TILII - Tell It like It Is (An ARC advocacy group)

TYC - Transforming Your Care

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DHSSPS (2015) Service Framework for Learning Disability. Belfast: DHSSPS.

United Nations. Convention on the Rights of Persons with Disabilities. Ratified by UK 2009.

Appendices

Appendix 1

Table A1: The number and percentage of people in receipt of various social care services in 2013-2014

Supported accommodation	Belfast	Northern	South Eastern	Southern	Western	Total
Residential / Nursing Home	313	282	281	234	253	1363
% in Residential / Nursing Homes	**17**	**15**	**19**	**12**	**23**	**16**
Supported Housing	238	265	234	243	129	1109
% Supported Housing	**13**	**14**	**15**	**12**	**12**	**13**

Note percentages are calculated as a proportion of the total number people in receipt of social care service.

Table A2: The number and percentage of people using day services 2013-2014

Day Services	Belfast	Northern	South Eastern	Southern	Western	Total
Day Centres	673	823	696	509	680	3381
% use day centres	**37**	**43**	**46**	**26**	**63**	**41**
Day Opportunities	604	542	402	402	295	2245
% day opportunities	**33**	**28**	**27**	**20**	**27**	**27**
Total Day Services	1277	1365	1098	911	975	5626
% day service	**70**	**71**	**72**	**46**	**90**	**68**

Table A3: The number and percentage of people in receipt of family support services in 2013-2014

Family Support Services	Belfast	Northern	South Eastern	Southern	Western	Total
Short breaks	470	563	406	515	177	2131
% short breaks	**26**	**29**	**27**	**26**	**16**	**26**
Domiciliary Care	167	179	459	530	162	1497
% domiciliary care	**9**	**9**	**30**	**27**	**15**	**18**
Direct Payments	201	148	101	132	91	673
% Direct Payments	**11**	**8**	**7**	**7**	**8**	**8**

Appendix 2

Standards from the Service Framework for Learning Disability grouped by RQIA's four key stakeholder outcomes.

Table A4: Standards reviewed relating to SAFE care

Standard	
1	All HSC staff should ensure that people of all ages are safeguarded from harm through abuse, exploitation or neglect.
19	All people with a learning disability should have equal access to the full range of health services including services designed to promote positive health and wellbeing.
20	All HSC staff, as appropriate, should advise people who smoke of the risks associated with smoking and signpost them to well-developed specialist smoking cessation services.
21	All people with a learning disability should be supported to achieve optimum physical and mental health.
22	All people with a learning disability who experience mental ill health should be able to access appropriate support.
23	All HSC staff, as appropriate, should provide people with healthy eating support and guidance according to their needs.
24	All HSC staff, as appropriate, should provide support and advice on recommended levels of physical activity.
25	All HSC staff, as appropriate, should provide support and advice on recommended levels of alcohol consumption.

Table A5: Standards reviewed relating to EFFECTIVE care

Standard	
2	People with a learning disability should as a matter of course make choices or decisions about their individual health and social care needs. These needs to be balanced with the individual's ability to make such decisions and then the views of their family, carers and advocates should be taken into account in the planning and delivery of services, unless there are explicit and valid reasons to the contrary agreed with the person.
3	All patients, clients, carers and the public should have opportunities to be actively involved in the planning, delivery and monitoring of health and social care at all levels.
14	Young people with a learning disability should have a transition plan in place before their 15th birthday and arrangements made for their transition to adulthood by their 18th birthday.
16	Adults with a learning disability should be able to access support in order that they can achieve and maintain employment opportunities in productive work.
17	All adults with a severe or profound learning disability should be able to access a range of meaningful day opportunities appropriate to their needs.
26	All people with a learning disability whose behaviour challenges should be able to get support locally from specialist learning disability services and other mainstream services, as appropriate, based on assessed need.
28	HSC professionals should work in partnership with a variety of agencies in order to ensure that the accommodation needs of people with a learning disability are addressed.
31	All people with a learning disability should have the impact of ageing taken into account in having their future needs assessed and proactively managed.
32	All people with a learning disability should have access to dementia services at whatever age it becomes appropriate for the individual.

Table A6: Standards reviewed relating to COMPASSIONATE Care

Standard	
4	Adults with a learning disability should be helped by HSC professionals to develop their capacity to give or refuse informed consent.
5	All patients, clients, carers and the public should be engaged through effective communications by all organisations delivering health and social care.
6	People with a learning disability should expect effective communication with them by HSC organisations as an essential and universal component of the planning and delivery of health and social care.
7	People with a learning disability should receive information about services and issues that affect their health and social wellbeing in a way that is meaningful to them and their family.
8	People with a learning disability, or their carer, should be able to access self-directed support in order to give them more control and choice over the type of care and support they receive.
9	Service users and their carers should have access to independent advocacy as required.
15	People with a learning disability should be supported to have meaningful relationships, which may include marriage and individual, unique, sexual expression within the law, balancing their rights with responsibilities.
18	All parents with a learning disability should be supported to carry out their parenting role effectively.
27	All people with a learning disability who come into contact with the Criminal Justice System should be able to access appropriate support.
29	All HSC staff should identify carers (whether they are parents, family members, siblings or friends) at the earliest opportunity to work in partnership with them and to ensure that they have effective support as needed.
30	All family carers should be offered the opportunity to have their needs assessed and reviewed annually.
33	All people with advanced progressive incurable conditions, in conjunction with their carers, should be supported to have their end of life care needs expressed and to die in their preferred place of care.
34	All people with a learning disability being assessed for supportive and palliative care should have their learning disability taken into account in consultation with them, their carers and learning disability services when appropriate.

Appendix 3

Table A7: Muckamore Abbey Hospital Indicative Beds and the number of patients still awaiting resettlement into the community

Indicative position	Wards -	Total - Inpatient Beds		
		2013 - 2014	1 April 2015	31 March 2016
Core Treatment Phase 1	CP Cranfield (PICU)	6	6	6
	CM Cranfield (Men)	14	14	14
	CM Cranfield (Women)	15	15	15
	Sixmile (Assessment)	3	3	3
	Sixmile (Treatment)	16	16	16
	Donegore	9	9	9
	Killead	24	24	24
Total Muckamore Assessment & Treatment		**87**	**87**	**87**
Children's Services, under 18	Iveagh Centre	8	8	8
TOTAL Assessment & Treatment Beds		**95**	**95**	**95**
MAH -Resettlement	Erne	10	17	21
	Greenan	15	0	0
	Moylena	19	16	7
	Ennis	15	0	0
	Rathmullan	12	0	0
	Oldstone	23	3	0
Total Muckamore Resettlement Beds		**94**	**36**	**28**

Table A8: Southern Trust Learning Disability Hospital Beds

Assessment & treatment	Dorsey	10	10	10

Table A9: Western Trust Learning Disability Hospital Beds

Assessment & treatment & PICU	10	12	8

Appendix 4

RQIA Published Reviews

Review	Published
Review of the Lessons Arising from the Death of Mrs Janine Murtagh	October 2005
RQIA Governance Review of the Northern Ireland Breast Screening Programme	March 2006
Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	September 2007
Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	February 2008
Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	March 2008
Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	April 2008
Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	June 2008
Review of The "Safeguards in Place for Children And Vulnerable Adults in Mental Health and Learning Disability Hospitals" in HSC Trust	June 2008
Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	August 2008
Review of General Practitioner Appraisal Arrangements in Northern Ireland	September 2008
Review of Consultant Medical Appraisal Across Health and Social Care Trusts	September 2008
Review of Actions Taken on Recommendations From a Critical Incident Review within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	October 2008
Review of Intravenous Sedation in General Dental Practice	May 2009
Blood Safety Review	February 2010
Review of Intrapartum Care	May 2010
Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	July 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Follow-Up Review of Intravenous Sedation in General Dental Practice	December 2010
Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	February 2011
RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	February 2011
A Report on the Inspection of the Care Pathways of a Select Group of Young People who Met the Criteria for Secure Accommodation in Northern Ireland	March 2011
An Independent Review of Reporting Arrangements for Radiological Investigations – Phase One	March 2011

Review	Published
Review of Child Protection Arrangements in Northern Ireland	July 2011
Review of Sensory Support Services	September 2011
Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	October 2011
Revalidation in Primary Care Services	December 2011
Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	February 2012
RQIA Independent Review of Pseudomonas - Interim Report	March 2012
RQIA Independent Review of Pseudomonas - Final Report	May 2012
An Independent Review of Reporting Arrangements for Radiological Investigations – Phase Two	May 2012
Mixed Gender Accommodation in Hospitals	August 2012
Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home	October 2012
Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	October 2012
Review of the Northern Ireland Single Assessment Tool - Stage Two	November 2012
Review of the Implementation of the Cardiovascular Disease Service Framework	November 2012
RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	December 2012
Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	February 2013
Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	March 2013
Independent Review of the Management of Controlled Drug Use in Trust Hospitals	June 2013
Review of Acute Hospitals at Night and Weekends	July 2013
National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	July 2013
A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	August 2013
A Baseline Assessment and Review of Community Services for Children with a Disability	August 2013
Review of Specialist Sexual Health Services in Northern Ireland	October 2013
Review of Statutory Fostering Services	December 2013
Respiratory Service Framework	March 2014
Review of the Implementation of NICE Clinical Guideline 42: Dementia	June 2014
Overview of Service Users' Finances in Residential Settings	June 2014
Review of Effective Management of Practice in Theatre Settings across Northern Ireland	June 2014
Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	July 2014
Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	July 2014

Review	Published
Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	August 2014
Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	November 2014
Discharge Arrangements from Acute Hospital	November 2014
Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	December 2014
Review of Stroke Services in Northern Ireland	December 2014
Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014
Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	December 2014
RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	December 2014
Review of the Care of Older People in Acute Hospitals	March 2015
Review of the Diabetic Retinopathy Screening Programme	May 2015
Review of Risk Assessment and Management in Addiction Services	June 2015
Review of Medicines Optimisation in Primary Care	July 2015
Review of Brain Injury Services in Northern Ireland	September 2015
Review of the HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	December 2015
Review of Eating Disorder Services in Northern Ireland	December 2015
Review of Advocacy Services for Children and Adults in Northern Ireland	January 2016
RQIA Review of the Implementation of the Palliative and End of Life Care Strategy (March 2010)	January 2016
Review of Community Respiratory in Northern Ireland	February 2016
An Independent Review of the Northern Ireland Ambulance Service	March 2016
RQIA Review of HSC Trusts' Readiness to comply with an Allied Health Professions Professional Assurance Framework	June 2016
Review of Quality Improvement Systems and Processes	June 2016
RQIA Review of Governance Arrangements Relating to General Practitioner (GP) Services in Northern Ireland	July 2016
RQIA Review of the Operation of Health and Social Care Whistleblowing Arrangements	September 2016

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

The Regulation and Quality Improvement Authority

Review of Emergency Mental Health Service Provision across Northern Ireland

September 2019

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Glossary

ASW	Approved Social Worker
ASD	Autism Spectrum Disorder
BHSCT	Belfast Health and Social Care Trust
CAIT	Crisis Assessment and Intervention Team
CAMHS	Child and Adolescent Mental Health Services
CBYL	Card Before You Leave
CDU	Critical Decision Unit
CPN	Community Psychiatric Nurse
CRHT	Crisis Resolution and Home Treatment
DoH	Department of Health
GHQ	General Health Questionnaire
GP	General Practitioner
HSC	Health and Social Care
HSCB	Health and Social Care Board
HTAS	Home Treatment Accreditation Scheme
ISS	Intensive Support Services
IT	Intensive Home Treatment Service
MATT	Multi Agency Triage Team
MDT	Multidisciplinary Team
MH	Mental Health
NHSCT	Northern Health and Social Care Trust
NICE	National Institute for Health and Care Excellence
NISRA	Northern Ireland Statistics and Research Agency
PCC	Patient and Client Council
PHA	Public Health Agency
PPI	Personal and Public Involvement
PSNI	Police Service of Northern Ireland
RAID	Rapid Assessment Interface Discharge Service
RCPsych	Royal College of Psychiatrists
RESWS	Regional Emergency Social Work Service
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust
SHIP	Self-harm Intervention Programme
SHSCT	Southern Health and Social Care Trust
ST	Speciality Trainee
WHSCT	Western Health and Social Care Trust

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services in Northern Ireland. RQIA's reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Reviews are supported by a core team of staff and by independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Department of Health (DoH) and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting against 4 key outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

These outcomes are aligned with Quality 2020 [(1)] and define how RQIA demonstrates its effectiveness and impact as a regulator.

Membership of the Review Team

Dr John Simpson	Retired Consultant Psychiatrist and Medical Director, Health and Social Care, Northern Ireland
Dr Sinead McAree	Consultant Psychiatrist, NHS Greater Glasgow and Clyde Board, Scotland
Ms Marjorie McMurray	Retired Community Psychiatric Nurse and Cognitive Behavioural Therapist, Health and Social Care, Northern Ireland
Dr Ruth Thornbury	ADEPT Clinical Leadership Fellow 2017/18 Programme, Psychiatry, Specialist Trainee (ST6) Doctor
Dr Judy Curran	ADEPT Clinical Leadership Fellow 2017/18 Programme, Psychiatry, Specialist Trainee (ST6) Doctor
Mrs Theresa Nixon	Director of Assurance (previously Director of Mental Health and Learning Disability), Regulation and Quality Improvement Authority
Mr Hall Graham	Assistant Director of Improvement (retired December 2018), Regulation and Quality Improvement Authority
Mr Ronan Strain	Project Manager, Regulation and Quality Improvement Authority
Mr Dean McAllister	Project Administrator, Regulation and Quality Improvement Authority

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We would particularly like to thank:

- Service Users
- Voluntary Organisations: Aware NI, Inspire, CAUSE, and Lifeline
- Royal College of Psychiatrists (RCPsych)
- Health and Social Care (HSC) Trusts
- Health and Social Care Board (HSCB)
- Public Health Agency (PHA)
- Integrated Care Partnerships (ICPs)
- Regional Emergency Social Work Service (RESWS)
- General Practitioners (GPs)
- Patient and Client Council (PCC)

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Executive Summary

This review was undertaken as part of the 2015-18 Programme in order to make an assessment of the provision of emergency mental health services in the 5 HSC Trusts across Northern Ireland. The fieldwork for this review was completed in April 2017.

Services were assessed in accordance with the principles detailed in the Regional Mental Health Care Pathway for Northern Ireland [(2)] and across ages applicable for mental health services (see below):

- Adult Mental Health Services (for patients aged 18-65 years);
- Older People's Services (for patients aged 65 years and over);
- Child and Adolescent Mental Health Services (CAMHS) (for patients aged 0-18 years);
- Learning Disability Services (for children and young people and adults with a learning disability); and
- Emergency Departments.

The Care Pathway was developed by the HSCB and PHA and endorsed by the DoH in October 2014. The pathway was modelled on the National Institute for Health and Care Excellence (NICE) clinical guideline 136 - "Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services" [(3)]. The overarching aims of this pathway were to provide HSC Trusts with clarity regarding the standards expected from their mental health services and to support consistency in service delivery throughout Northern Ireland. The pathway detailed a Stepped Care model with respect to how services are organised and the level of support to be provided at each of the 5 steps and applicable settings.

This review identified issues which may affect the delivery of a quality service for mental health service users, their families and carers. Nine recommendations for future improvements in the provision of emergency mental health services have been included in the report (Section 3). The review also identified a number of quality improvement initiatives which should be considered for implementation across the region.

Findings from the Review

Time of Presentation

Within working hours (Monday to Friday 9:00am to 5:00pm) all 5 HSC Trusts have systems and processes in place to provide emergency mental health services for patients of all ages. Outside normal working hours, all 5 HSC Trusts find it a challenge to provide dedicated specialised services for their local population during out-of-hours periods. This was particularly evident in relation to CAMHS, learning disability and older people's services.

Communication

Communication systems between mental health teams in each Trust and across the region have not been fully developed and there is a potential risk of information loss when patients transfer in an emergency context.

Specific Service Findings (Age Applicable)

Adult Services (patients aged 18 – 65 years)

All 5 HSC Trusts have developed systems and processes to deliver a service 24 hours a day, 7 days a week for service users who experience an emergency mental health problem. The specialist mental health teams which were established over 10 years ago are known as Crisis Resolution Home Treatment (CRHT) teams and have been established in line with the Royal College of Psychiatrists (RCPsych) Home Treatment Accreditation Scheme (HTAS) standards [(4)]. The CRHT teams are working well in each Trust. Challenges in the availability of acute beds and in the capacity of core community mental health teams have begun to impact upon the provision of this emergency service and recommendations are made in relation to these challenges.

Older People's Services (patients aged 65 years and over)

Challenges were identified in some Trusts with regard to providing this service during the out-of-hours period. We were informed by these Trusts that they are in the process of reviewing or restructuring their adult CRHT teams to ensure a specialist mental health service is provided for their over 65 population during the out-of-hours. A recommendation is made that each Trust should provide the same emergency mental health service during the out-of-hours period for the over 65 years population as is currently provided for the adult (patients aged 18-65 years) population.

Child and Adolescent Services (patients aged 0-18 years)

Developments and expansions of CAMHS provision and various specialist mental health teams across the Trusts were acknowledged. It was identified however, that all HSC Trusts remain at different stages of development in providing an emergency mental health assessment and treatment for children and young people in line with the CAMHS stepped care model [(5)], particularly during the out-of-hours period. More work is required to ensure a robust system is in place for these patients and consequently a recommendation is made to reflect this.

Learning Disability Services (children, young people and adults)

Effective provision of an appropriate service during the out-of-hours period was identified as a challenge for some HSC Trusts due to a lack of available resources.

The development of various specialist mental health teams across the Trusts for both adults and children with a learning disability was acknowledged. It was identified, however that all 5 HSC Trusts remain at different stages of development in providing emergency mental health assessment and treatment for these service users. Continued pressure on regional hospital acute beds (Muckamore Abbey Hospital for adults and Iveagh Centre for children) was reported, and, in conjunction with the lack of suitable community learning disability placements (including rehabilitation services, supported accommodation and respite) this will continue to pose a challenge Trusts. A recommendation that the current provision of core community learning disability services for adults is reviewed has been made.

Emergency Departments

In all 5 HSC Trusts, Emergency Departments are dealing with increasing numbers of patients with complex mental health needs. These include patients with concurrent mental and physical health and care needs and patients who abuse alcohol and drugs. There is a lack of dedicated psychiatric liaison provision into general acute hospital wards during the out-of-hours period. Additionally there is a lack of appropriate physical space to interview patients experiencing a mental health crisis in Emergency Departments. While some Trusts did provide evidence of a number of initiatives to alleviate some of these challenges, a recommendation in relation to arrangements for appropriate physical space in Emergency Departments is made.

Quality Improvement

HSC Trusts continue to develop and implement a number of quality improvement initiatives across emergency mental health services. The CRHT Regional Forum is a useful Forum to share learning about quality improvement across the region. This Forum is a voluntary arrangement with no formal governance processes, but has been valuable in the dissemination of good practice. To date, the Forum has focused mostly on adult teams and we would encourage the Forum to strengthen its governance arrangements and to expand further to involve the CAMHS, Learning Disability and Older People’s Services, as learning is likely to be transferable across all services.

Service User Experience

Trusts have mechanisms in place to gather service user experience. Service users spoken to during this review highlighted both positive and negative experiences of emergency mental health services.
It was concluded that each Trust could widen its approach to co-production with service users, carers and the public, in accordance with the regional Personal and Public Involvement (PPI) approach and Department of Health co-production guidance.

Throughout this review, all Trusts provided examples of specific pieces of work to demonstrate their commitment to improving their provision of emergency mental health services for service users of all ages. This commitment to improvement was acknowledged and encouraged. Pressure on available resource continues to be a significant challenge for all 5 HSC Trusts in relation to provision of a safe and effective service during out-of-hours periods.

Recommendations

Nine recommendations are made which will support the continuing improvement of emergency mental health services across Northern Ireland. The recommendations are made with a view to ensuring appropriate emergency mental health assessment and treatment for all who need it. The recommendations have been prioritised according to the timescales in which they should be implemented.

Section 1 – Context for this Review

1.1 Introduction and Context

Mental illness is a major public health issue in Northern Ireland and is the single largest cause of ill health and disability [6]. Northern Ireland has higher levels of mental ill health than any other region in the United Kingdom (UK). In Northern Ireland, 1 in 5 adults has a mental health condition at a given point in time, which is a 25% higher overall prevalence of mental illness compared to England [6].

Mental illness can affect anyone in society irrespective of age, gender, socio-economic status, or ethnic background. A range of biological, psychological, and social factors have been identified as contributing to the development of such illness. These include stressful or traumatic life events, abuse, lifestyle behaviours, deprivation, conflict, unemployment, bereavement, financial concerns and physical illnesses [6].

In the 2017-18 Northern Ireland Health Survey 18% of respondents scored highly on the general health questionnaire, suggesting they may have a mental health problem [7]. The survey also indicated that a quarter of respondents (26%) had concerns about their own mental health. Three-fifths of these (58%) sought help, with 82% of these seeking help from their General Practitioner (GP) and 44% from a family member. Of those who did not seek help, three-quarters (74%) stated that they were able to self-manage.

Whilst epidemiological data on the prevalence of mental ill health in children and young people in Northern Ireland is scarce, it is estimated that:

- Around 45,000 children and young people have a mental health need at any one time [6].
- More than 20% of young people are suffering “significant mental health problems” by the time they reach the age of 18 [6].

Suicides provide an indicator of mental health within a population. According to the Northern Ireland Statistics and Research Agency (NISRA) the figure for deaths as a result of suicide in Northern Ireland in 2017 was 305 [8]. Northern Ireland has the highest suicide rate compared to any other region in the UK. In addition, there is a gendered aspect to suicide with men 3 times more likely to die by suicide than women. Males aged 20 to 50 years old have the highest rate of suicide.

Over the past 25 years mental health services in Northern Ireland have continued to move from provision of acute hospital based care to community based care and treatment. Community based treatment teams have been established to respond more quickly and more flexibly to people with mental health difficulties and help to promote earlier recovery and more effective rehabilitation.

The shift in acute mental health services from inpatient care to a community based model of service delivery in Northern Ireland has been influenced and directed by the Bamford Review [9] and other publications such as Transforming Your Care [10], the Donaldson Report [11] and Health and Wellbeing 2026 Delivering Together approach [12].

In 2015-16, the Patient and Client Council (PCC) [13] and the HSCB [14] both undertook reviews of CRHT services across Northern Ireland highlighting that the development of such services was successful in providing an alternative to hospital admission. These reviews highlighted that moving towards a more community based model has resulted in a number of issues including:

- confusion about how services can be accessed and by whom;
- lack of continuity of staff – service users do not see the same person during each home visit;
- uncertainty about whether the necessary level of input can be achieved in brief visits from the home treatment teams; and
- the need for better processes to support service users after their discharge from services.

1.2 Terms of Reference

The terms of reference for this review were:

1. To examine emergency mental health service provision across all age ranges with regard to:
    - Assessment and management of patients referred to emergency mental health services from Emergency Departments, General Practice and General Practice out-of-hours services;
    - Access and referral pathways to specialist mental health teams or acute hospital admission;
    - Interfaces with General Practice and General Practice out-of-hours services, Emergency Departments, other mental health services and the voluntary sector;
    - Quality improvement processes, both within HSC Trusts and regionally; and
    - Effectiveness of services provided.

2. To explore the experience of users of emergency mental health services in Northern Ireland.

3. To report on findings, identify areas of good practice and, where appropriate, make recommendations for improvements in emergency mental health services in Northern Ireland.

Exclusions

This review excluded patients detained under the Mental Health (Northern Ireland) Order 1986 [15], services for Autism Spectrum Disorder (ASD), services for Dementia patients and Prison Mental Health Services.

1.3 Review Methodology

Comprehensive methodology which gathered information, evidence and facts from a wide range of sources was utilised to inform this review. This included those who use emergency mental health services in Northern Ireland, as well as from those responsible for commissioning and providing the services across the region.

Literature Review

A review of relevant literature was completed to understand the context for the review and to identify appropriate lines of enquiry. Following the literature review, a mixed approach was employed, comprising the following:

Engagement with Policy Strategy Leads for Mental Health Services

This included:

- Representatives from the DoH in the context of their policy role;
- Representatives from the HSCB in the context of their commissioning role; and
- Representatives from the PHA in the context of their strategic public health role.

This engagement enabled the Review Team to understand the strategic direction and regional context for the current and future provision of emergency mental health services across Northern Ireland.

Engagement with Service Providers

A structured questionnaire was developed and issued to the 5 HSC Trusts which was based on the RQIA 4 key domains of safe, effective, compassionate and well-led care. This ensured that a description of the services delivered in each of the Trusts was obtained, as well as information about the systems, processes and pathways Trusts employ to deliver their emergency mental health services.

Engagement with Staff

Staff working across frontline HSC Trusts were engaged through pre-arranged focus groups which were held across all mental health services. Focus Groups included staff from:

- Adult Mental Health Services (for patients aged 18-65 years);
- Older People's Services (for patients aged 65 years and over);
- Child and Adolescent Mental Health Services (CAMHS) (for patients aged 0-18 years);
- Learning Disability Services (for children and young people and adults with a learning disability); and
- Emergency Departments.

Focus groups included staff providing mental health services across both acute and community settings such as nurses, psychiatrists, social workers, allied health professionals, managers, GPs and administrative / support staff.

Engagement with Service Users

In order to ensure that the views of service users were included a focus group was held with Aware NI, Inspire and CAUSE. This focus group was hosted by Aware NI and brought together service users who had previously accessed emergency mental health services. Additionally service user experiences shared with the PCC were also included in this review.

Engagement with Lifeline

Lifeline is the Northern Ireland crisis response helpline service for people who are experiencing distress or despair. Meetings with their representatives provided an insight into Lifeline's roles and the nature of emergency activity and demand the organisation encounters on an ongoing basis.

Engagement with Royal College of Psychiatrists

Engagement with the RCPsych allowed us to understand its' role as the professional body responsible for education, training and setting and raising standards in psychiatry in Northern Ireland.

Review Meetings with HSC Trusts

Fieldwork concluded with a week of focused and targeted meetings with each of the HSC Trusts. Key lines of enquiry for these meetings were developed from a detailed analysis of each of the Trust's structured questionnaires, the main themes from staff and service user focus groups, and engagement with Lifeline and the RCPsych. Meetings were held with each of the Trust's executive management teams and senior clinicians across mental health services to discuss emerging findings, areas of concern and potential areas for improvement.

Section 2 – Findings from the Review

This section presents the key findings of the review, and is divided into 9 sub-sections (2.1 – 2.9). Each sub-section describes the provision of emergency mental health services for a particular age group (see below) during usual working hours, Monday to Friday, and also during the out-of-hours period, covering weekdays after 6.00pm and over weekends.

- Adult Mental Health Services (for patients aged 18-65 years);
- Older People's Services (for patients aged 65 years and over);
- Child and Adolescent Mental Health Services (CAMHS) (for patients aged 0-18 years);
- Learning Disability Services (for children and young people and adults with a learning disability); and
- Emergency Departments.

Evidence and facts described related to the provision of emergency mental health services across Northern Ireland in accordance with the Regional Mental Health Care Pathway [(2)]. We have commented on the teams in operation and also on the access to, and availability of, services. Examples of good practice are highlighted, as are areas where improvements are needed.

2.1 Mental Health Services in Northern Ireland

In October 2014, the Regional Mental Health Care Pathway [(2)] developed by the HSCB and PHA, was endorsed and implemented across Northern Ireland. The Pathway provided guidance on how mental health care should be delivered, whilst endeavouring to support consistency in service delivery throughout Northern Ireland. The Pathway detailed a stepped care model.

The Regional Care Pathway covered:

- How services could be accessed from time of referral to the point where care is no longer needed;
- The standards of care which should be in place; and
- How care decisions should be made - all the time ensuring that the service user and/or their relatives, partners, friends (as appropriate) remained at the centre of the decision making.

The Pathway utilised a 5-step care approach, whereby the service user's needs would be matched with the right level of support and the service user would 'step up' to intensive / specialist services as they needed. The 5 steps are:

- Step 1: Self-directed help and health and wellbeing services
- Step 2: Primary care talking therapies
- Step 3: Specialist community mental health services
- Step 4: Highly specialist condition specific mental health services
- Step 5: High intensity mental health services

The Pathway advocated timely access to services and included a number of regional targets in relation to response times as detailed below:

- Emergency response - appointment required within 2 hours of referral;
- Urgent response - appointment required within 5 days of referral; and
- Routine response - appointment within 9 weeks and 13 weeks of referral for psychological therapies.

The Care Pathway also provided a guide for people who feel mentally unwell, indicating that they should discuss their mental health problems / needs with their GP in the first instance and, depending on the severity of their problems, their GP would follow the 5-step care approach.

Emergency Mental Health Services

During this review evidence demonstrated that each Trust had developed, and continues to develop, its' emergency mental health services in line with the Regional Care Pathway. For example, we found that each Trust had developed specialist mental health teams (within core mental health services) to ensure they provided emergency mental health assessment and treatment for people who presented in a crisis or who were referred by General Practice or other secondary care services.

While we also found that Trusts recognised that all treatment and care needed to be personalised and recovery-orientated, we noted that each Trust found it challenging to deliver a consistent emergency mental health service in line with the 5-step care approach outlined in the Care Pathway. For example, 3 Trusts provided a specialist mental health service for their population aged over 65 during the out-of-hours period, and 2 Trusts did not (SEHSCT and WHSCT).

Within adult mental health services (patients aged 18-65 years) evidence was found that all 5 HSC Trusts had developed systems and processes to enable specialist mental health teams to undertake crisis assessments 24 hours a day, 7 days a week. However, we were informed that providing access 24 hours a day, 7 days a week in other services, such as those for children and young people, those for learning disability and older people services, remains a challenge.

During focus groups, adult service users (patients aged 18-65 years) highlighted that having intensive treatment from CRHT teams in their own home helps with their recovery and reduces stress. These adult service users also felt empowered and actively involved in their care and treatment plans, and reported that throughout their treatment these specialist mental health teams showed compassion, inclusiveness and good communication.

At the time of this review, Trusts highlighted that they are increasingly challenged with regard to achieving the targets detailed within the Care Pathway (for access to urgent and routine appointments) due to a demand and capacity mismatch.

For example, we were told by some Trusts that they are reporting on achievement of urgent responses within 10 days rather than the 5 day target set out for the region in the Care Pathway.

Throughout this review, evidence was found in each Trust that patients are still being referred to Emergency Departments, due to limited access to specialist mental health teams and other services, such as rehabilitation services, supported accommodation (including respite and voluntary) and community support services during the out-of-hours period. Evidence demonstrated that this is the case particularly within children and young people services and older people services.

Due to gaps in access during the out-of-hours period, some Trusts informed us that they rely at times on the other specialist services such as the Regional Emergency Social Work Service (RESWS) to provide emergency mental health services. RESWS staff clarified that filling such gaps in relation to access for patients with an emergency mental health problem is beyond their remit as their service is to provide an emergency social work response.

We also found that clear and comprehensive regional communication systems between all mental health teams have not been developed fully. We learnt that each Trust uses different communication systems, in some instances continuing to rely on photocopies, scanned documents and faxes to share information. This was concerning to the Review Team, as information may be lost or not transferred in a timely manner when patients move between Trusts in an emergency context.

We were informed that this issue has been raised informally within the adult CRHT Regional Forum; a voluntary Forum established by the adult CRHT teams to provide an opportunity for communication and shared learning across the region. The Forum, however, advised that this issue remains unresolved and that this concern has also been highlighted in recent inquests into deaths by suicide in Northern Ireland.

The Review Team agreed that this issue may be alleviated by the introduction of the new Encompass System, an HSC-wide initiative, which aims to introduce a single digital integrated care record to Northern Ireland. The proposed integrated care record will have the potential to improve the communication among healthcare professionals for individuals who experience an emergency mental health crisis, and will allow HSC professionals to access the right information, at the right time, in the right place securely.

Recommendation 1	**Priority 1**
I. The Health and Social Care Board should convene a short life working group, to include appropriate representation from each Health and Social Care Trust, in order to develop a regional information transfer protocol.	

II. Implementation of this protocol should ensure patient information is transferred securely and in a timely manner when patients transfer between Health and Social Care Trusts in an emergency mental health context.

III. The Health and Social Care Board should ensure information transfer between Health and Social Care Trusts in an emergency mental health context is considered as part of the Encompass programme for Northern Ireland.

2.2 Adult Mental Health Emergency Services

Table 1 summarises the provision of emergency mental health services for adults (patients aged 18-65 years) across the 5HSC Trusts at the time of this review.

Table 1: Adult Mental Health Emergency Services (patients aged 18-65 years) in Health and Social Care Trusts in Northern Ireland

Health and Social Care Trust	Specialist Mental Health Teams	Hours/Days
Belfast	• Unscheduled Care Team • Home Treatment Team	24/7 Service
Northern	• Crisis Resolution and Home Treatment Team (integrated team) • Rapid Assessment Interface and Discharge Service	24/7 Service
South Eastern	• Home Treatment Team	24/7 Service
Southern	• Crisis Resolution and Home Treatment Team (integrated team)	24/7 Service
Western	• Crisis Resolution and Home Treatment Team (integrated team)	24/7 Service

Within adult services (patients aged 18-65 years), evidence was found that all HSC Trusts have developed systems and processes to deliver a service 24 hours a day, 7 days a week for adult service users who experience an emergency mental health problem, which is in line with the RCPsych Home Treatment Accreditation Scheme standards [(4)].

HSC Trusts reported that these adult services have evolved at different rates in each Trust over the years. There is now a significant degree of similarity in what is provided 24 hours a day, 7 days a week.

HSC Trusts advised that specialist mental health teams have been established to deal with emergency crises and are known as CRHT Teams. In the BHSCT the Crisis Resolution Team is known as the Unscheduled Care Team and in NHSCT, SHSCT and WHSCT, their CRHT teams operate as integrated teams.

We were informed by HSCB and Trusts that the specialist mental health teams for adults were introduced more than 10 years ago, during transformation of the inpatient and community mental healthcare system, to help to facilitate a shift from acute hospital based services to more community based services.

Each Trust has established a single point of access for emergency, urgent and routine mental health referrals, and these referrals can be made by telephone, email or post, depending on the situation. All referral details are taken, and immediately transferred to a senior CRHT clinician for triage within 24 hours of receipt (or sooner). Following triage, patients are directed to the most appropriate service, such as an acute inpatient service, CRHT service or core community mental health services, so that care and treatment can commence immediately. As part of their Care Pathway, all emergency referrals to the CRHT service will have a face-to-face assessment within 2 hours, or at a time agreed with the patient. Emergency referrals can be made by a GP or other healthcare professional such as a member of a community mental health team, a liaison service, a Consultant Psychiatrist, a member of the Forensics Team, a member of the Eating Disorder Team and by members of the Emergency Department Team.

During focus groups with staff and service users, we heard that CRHT teams provide intensive support to people at the time when they most need help, aiming to avoid further deterioration and to alleviate distress as quickly as possible. Where appropriate, the CRHT teams also provide an alternative to hospital admission, enabling people to receive treatment and care in their own home. Service users explained that, by remaining in their own home, the disruption to their lives and the lives of those caring for them is minimised. GPs welcomed the availability of mental health expertise during the out-of-hours period.

HSC Trusts advised that the introduction of specialist mental health teams such as CRHT teams within adult services has positively impacted on hospital admissions, and this has correlated with a reduction in the need for acute hospital beds.

For example, NHSCT evidenced that since the introduction of adult CRHT teams in 2002, acute hospital beds have reduced from 178 (2002) to 93 (2017), a reduction of 47% through offering an alternative to hospital care. The Review Team was encouraged by this.

HSC Trusts also explained that demand for beds is once again increasing and, despite implementation of the Regional Bed Management Protocol for Acute Psychiatric Beds (2016) [16] through which Trusts are able to share beds regionally as/if available, accessing acute beds is becoming increasingly difficult. A number of variables are likely to impact upon the availability of acute beds, including varying length of inpatient stays and delayed discharges.

An example of good practice which has reduced the length of inpatient stay was demonstrated in WHSCT, where the inpatient Consultant Psychiatrist is also the CRHT Consultant. This has reduced the number of interfaces and has facilitated better flow of information between teams and services.

CRHT staff explained that longer length of inpatient stays and delayed discharges may result in CRHT teams in some areas having to retain high risk patients on their caseload, when it would be preferable to admit these patients to an acute inpatient bed. We heard that this can also impact on the team's capacity to take on new cases. During focus groups some service users highlighted a lack of availability of adult CRHT teams and felt that, at times, they could not access these teams when needed. The Review Team was concerned about the impact that the length of inpatient stays and delayed discharges were having on the availability of the CRHT resource.

SEHSCT Home Treatment Team reported that, due to capacity issues in the core community mental health teams, they are challenged in getting patients discharged to these teams. Staff informed us that this is having an impact on the Home Treatment Teams' ability to take on new cases, as they are retaining patients on their caseload who may be appropriately referred to a community mental health team.

Other Trusts reported that they too experienced capacity challenges in that it was difficult to discharge patients to their core community mental health teams, which was hindering their ability to offer 7 day follow-up for patients following treatment by CRHT teams. For example, SHSCT informed us that, due to the development of Step 2 services such as the mental health and well-being hubs, the complexity and risks held within their CRHT service have increased. We heard that there are also increasing demands year-on-year for 'higher risk' Step 3 assessments and this has also impacted on waiting times for patients to access CRHT services.

During focus groups staff also told us of a shortage in community services (including rehabilitation services, supported accommodation and respite) to enable patients with ongoing mental health difficulties to be cared for appropriately. Trust senior management teams concurred with this.

The Review Team agreed that adult emergency mental health services are now well established. All 5 HSC Trusts provide a 24 hour, 7 days a week service through the establishment of CRHT teams which are working well and providing a good service.

Current models of inpatient emergency mental health care, however, vary considerably with regard to length of stay and the availability of acute beds, which is also impacted by delayed discharges. The capacity of core community mental health teams has also begun to impact on the provision of the adult emergency mental health service. Improvements in the provision of these core community mental health services would help to stabilise the provision of emergency mental health care for the adult population.

Recommendation 2	**Priority 2**
The Health and Social Care Board should work collaboratively with each Health and Social Care Trust to help reduce the length of inpatient stays in those HSC Trusts where there is significant variation in relation to their peers, allowing for differing demographics and profile of patients. Learning should be shared across the region to ensure patients receive care appropriate to their assessed needs in the most appropriate location, delivered by the most appropriate professional(s).	

Recommendation 3	**Priority 2**
The Health and Social Care Board, together with the Health and Social Care Trusts, should review the current provision of core community mental health services (including rehabilitation services, supported accommodation and respite) and act on the findings of that review in order to: I. Ensure adult patients are cared for in the most appropriate setting; and II. Alleviate pressures currently experienced within acute mental health services.	

2.3 Older People Mental Health Emergency Services

Table 2 summarises the provision of emergency mental health services for older people (patients aged 65 years and over) across the 5 HSC Trusts at the time of this review.

Table 2: Older People Mental Health Emergency Services (patients aged 65 years and over) in Health and Social Care Trusts in Northern Ireland

Health and Social Care Trust	Usual Working Hours (Monday to Friday 9:00am to 5:00pm)	Out-of-Hours (Weekdays after 6:00pm and at weekends)
Belfast	• Adult Unscheduled Care Team • Adult Home Treatment Team	• Adult Unscheduled Care Team • Adult Home Treatment Team which includes a Psychiatry of Old Age Consultant
Northern	• Adult Crisis Resolution Home Treatment Team • Rapid Assessment Interface and Discharge Service	• Rapid Assessment Interface and Discharge Service
South Eastern	• Adult Home Treatment Team	• No Service
Southern	• Adult Crisis Resolution Home Treatment Team	• Adult Crisis Resolution Home Treatment Team
Western	• Adult Crisis Resolution Home Treatment Team	• No Service

During normal working hours (Monday to Friday 9:00am to 5:00pm) all 5 HSC Trusts deliver an emergency mental health service for older people. However, during our fieldwork, we found that within out-of-hours periods (weekdays after 6:00pm and at weekends), 3 Trusts (BHSCT, NHSCT, SHSCT) use various other teams to provide mental health services to people aged 65 years and over when they experience an emergency mental health problem. Both SEHSCT and WHSCT have no services during out-of-hours periods.

When a patient aged over 65 years presents with an emergency mental health problem in SEHSCT and WHSCT during the out-of-hours period, they are referred to the respective Emergency Department, and hence these patients may not be seen by an appropriate professional or in a suitable environment. Following our fieldwork both Trusts informed us that they are now working towards expanding the scope of their CRHT team to include patients aged 65 years and over. The Review Team welcomed this.

Feedback from staff and service users attending our focus groups confirmed that the service for people aged 65 years and over works well in each of the Trusts during normal working hours; however, staff also told us that demand is increasing which may impact on the quality of the service for older people in terms of access, response times and meeting patient need.

These findings highlighted a gap in service provision during out-of-hours periods, which may disadvantage the elderly.

This review included examination of mental health liaison services for older people who are inpatients in mental health services in acute hospitals in Northern Ireland. The RCPsych Standards for Inpatient Mental Health Services recommend that liaison services should be provided throughout an acute hospital with resources and skills needed to support all age groups [17].

Some Trusts have developed limited specialised liaison services for their population aged 65 years old and over, to cover the both the normal working hours and out-of-hours periods. This service is provided mainly by their adult CRHT teams. For example, in NHSCT this specialised liaison service is delivered by the Rapid Assessment Interface and Discharge (RAID) Service 24 hours a day, 7 days a week. The RAID service provides specialist mental health assessment to patients who present having self-harmed, used alcohol and drugs in a harmful hazardous way or who have mental health difficulties associated with old age.

BHSCT has a dedicated general hospital liaison service during normal working hours, and during out-of-hours periods this service is delivered by the Trust's Adult Unscheduled Care Team. SHSCT has a dedicated adult liaison team during normal working hours and its' Adult CRHT Team provides liaison services during the out-of-hours period.

The Review Team agreed that there is no comprehensive dedicated or specialised service within mental health services to specifically deal with emergencies for older people (aged 65 years and over) across all HSC Trusts.

The Review Team commends Trusts who have extended their CRHT service to their older populations and would encourage other Trusts who are in the process of reviewing or restructuring their adult CRHT teams to ensure a specialist mental health service is provided to their over 65 population.

Recommendation 4	**Priority 2**
Each Health and Social Care Trust should provide the same emergency mental health service during the out-of-hours period to their over 65 population as is currently provided to their adult (patients aged 18-65 years) population.	

2.4 Child and Adolescent Mental Health Services (CAMHS)

Table 3 below summarises the provision of emergency mental health services for Child and Adolescent Mental Health Services (CAMHS) to patients aged 0-18 years across the 5 HSC Trusts at the time of this review.

Table 3: Child and Adolescent Mental Health Services (CAMHS) provided to (patients aged 0-18 years) in Health and Social Care Trusts in Northern Ireland

Health and Social Care Trust	Usual Working Hours (Monday to Friday 9:00am-5:00pm)	Out-of-Hours (Weekdays after 6:00pm and at weekends)
Belfast	• Core Child and Adolescent Mental Health Service • Crisis Assessment and Intervention Team	• An on-call service provided by one Band 7 senior mental health practitioner to cover both Belfast and the South Eastern HSC Trusts
Northern	• Child and Adolescent Mental Health Service Crisis Response Team	• Child and Adolescent Mental Health Services Crisis Response Team and the Rapid Assessment Interface and Discharge Service operate a joint interface protocol for assessment of children and young people, under 18 years old, who present to Emergency Departments in the Trust
South Eastern	Delivered by the Belfast Trust: • Core Child and Adolescent Mental Health Service • Crisis Assessment and Intervention Team	Delivered by the Belfast Trust: • An on-call service provided by one Band 7 senior mental health practitioner to cover both Belfast and the South Eastern HSC Trusts
Southern	• Core Child and Adolescent Mental Health Service • Assessment Crisis Team and Community Intensive Intervention Service	• Adult Crisis Resolution Home Treatment team • Assessment Crisis Team and Community Intensive Intervention Service • Emergency Department, Regional Emergency Social Work Service and out-of-hours General Practitioner Service

Health and Social Care Trust	Usual Working Hours (Monday to Friday 9:00am-5:00pm)	Out-of-Hours (Weekdays after 6:00pm and at weekends)
Western	• Core Child and Adolescent Mental Health Services which includes a clinician on-call rota • Intensive Home Treatment Service and currently developing and resourcing a Crisis Assessment Team	• Child and Adolescent Mental Health Services 'Card Before You Leave' Scheme [19] for low risk patients • For high risk patients treatment provided by Adult Crisis Resolution Home Treatment team supported by the Family and Childcare on-call rota and dedicated senior manager out-of-hours rota

The Review Team found that each Trust is working in line with the CAMHS stepped care model Child and Adolescent Mental Health Services: A Service Model, July 2012 [5]. This approach is patient-focused and aims to deliver the appropriate level of care at the earliest point that best meets the assessed needs of the child or young person, while also enabling them to move up or down the steps as their needs change.

The 5 steps within the CAMHS model are listed below:

- Step 1 Prevention
- Step 2 Early intervention
- Step 3 Specialised intervention
- Step 4 Intensive intervention (Community)
- Step 5 Intensive intervention (Inpatient)

All HSC Trusts provide services for children and young people if they experience a mental health problem during normal working hours from Monday to Friday 9:00am to 5:00pm. However, at the time of this review, it was clear that during the out-of-hours period provision of an appropriate service can be a challenge due to a lack of available resources for all 5 HSC Trusts.

It was evidenced, however, that each Trust is in the process of developing their out-of-hours services in this regard. For example, during focus groups staff across all of the Trusts highlighted that that they are working collaboratively with their adult CRHT teams and have now extended their core services for children into the evenings to 9:00pm, including weekend day-time periods on Saturdays and Sundays from 9:00am to 5:00pm.

The HSCB and BHSCT told us that an Independent Regional Review of Acute CAMHS had been undertaken [18]. This independent review was commissioned by HSCB, in conjunction with BHSCT as the provider of the regional inpatient service at Beechcroft, and was published in September 2014.

This review recommended that a regional managed care network should be established and fully operational by September 2016 to ensure that services are responsive and consistent, to provide better co-ordination and an opportunity to develop learning and practice.

During fieldwork for this review Trusts told us that, despite a commissioning direction issued by the HSCB, this managed care network had not been established. At the time of fieldwork, we were advised that terms of reference and membership of the managed care network have been agreed and the network was currently recruiting an Operational Manager, a Clinical Director and administrative support, to ensure the network becomes fully operational. The Review Team welcomed this development.

All 5 HSC Trusts highlighted increases in complexity of cases which may require additional clinical input for joint assessments, intensive home support and robust multidisciplinary and interagency care planning, to ensure appropriate risk assessment and safety planning. Trusts explained that this increase in complex cases may lead to an increased likelihood of out-of-hours emergencies, as services during usual working hours will have less capacity.

Due to these anticipated increases and limited dedicated out-of-hours community services (including rehabilitation services, supported accommodation and respite services), Trusts reported that they may have to admit children and young people to paediatric or general medical wards in order to access next day assessments.

Despite these ongoing challenges, we found evidence that the Trusts are working to expand their CAMHS provision. For example, BHSCT provides CAMHS for children and adolescents resident in the SEHSCT area. BHSCT has developed a specialist team known as the Crisis Assessment and Intervention Team within their core CAMHS to deal with emergency crises. This team provides a service from 8:00am to 9:00pm, 7 days per week, accepting referrals from GPs, Social Services and Emergency Departments for same day or next day assessment.

During out-of-hours in BHSCT, an on-call service is provided by a senior practitioner (Band 7) who covers both BHSCT and SEHSCT. The out-of-hours Crisis Assessment and Intervention Team rota is also supported by Speciality Trainee Doctors (STs) in child and adolescent psychiatry.

Staff and senior management in NHSCT told us of the development of a specialist crisis response service which offers rapid mental health assessment and intervention to children and young people aged under 18 years. Children and young people can access this service by referral from the core CAMHS, through their GP, or by presenting to the Emergency Department at either Antrim or Causeway hospitals. The service operates 7 days per week, from Monday to Friday 9:00am to 9:00pm, 10:00am to 2:00pm on Saturdays and Bank Holidays, and 9:00am to 5:00pm on Sundays.

Outside of these hours, the CAMHS Crisis Response Team operates a joint interface protocol, working collaboratively with the RAID Service at Antrim and Causeway Hospitals. The RAID Service will provide an initial preliminary mental health assessment of those children and young people aged under 18 years, who present to the Emergency Department outside CAMHS working times. A specialist CAMHS assessment will then take place within 24 hours, either in hospital or in the community.

SHSCT has developed specialist teams within CAMHS to deal with emergency crises, these teams are the Assessment Crisis Team and the Community Intensive Intervention Service in-hours. The Assessment Crisis Team also provides a hospital liaison service from 9:00am to 5:00pm Saturday, Sunday and Bank Holidays and outside of those hours the patient is either admitted overnight for next day assessment or allowed home with appropriate arrangements for follow up.

WHSCT told the Review Team that it had established an Intensive Home Treatment Service during normal working hours from Monday to Friday 9:00am to 5:00pm in addition to their core CAMHS. The Trust is also in the process of developing and resourcing a Crisis Assessment Team. We heard from staff and senior management that during the out-of-hours period there is a Card Before You Leave (CBYL) scheme [19] in place for low risk referrals, this operates from 9:00am to 5:00pm Saturday, Sunday and Bank Holidays. High risk patients are assessed and managed by the Adult Mental Health CRHT team, supported by the Family and Childcare on-call rota and a dedicated senior manager's out-of-hours rota. Assessment by core CAMHS is provided the following day Monday-Friday from 9:00am to 5:00pm. WHSCT informed the Review Team that they are currently in the process of developing and resourcing a Crisis Assessment Team and arrangements for a CAMHS out-of-hours on-call service.

The Review Team was encouraged by, and welcomed, the development of Crisis Assessment Teams across the HSC Trusts. The Team agreed that all 5 HSC Trusts remain at different stages of development in providing an emergency mental health assessment and treatment for children and young people in line with the CAMHS stepped care model, particularly during the out-of-hours period. The Review Team concluded that more work is required to ensure a robust system is in place for this group of patients.

Recommendation 5	**Priority 2**
Each Health and Social Care Trust must ensure a robust system is in place 7 days a week, 24 hours a day, to provide an emergency mental health assessment and treatment service for all children and young people, in line with the Child and Adolescent Mental Health Services stepped care model (Child and Adolescent Mental Health Services; A Service Model, July 2012, Department of Health, Social Services and Public Safety, Northern Ireland) [4].	

2.5 Adult Learning Disability Services

Table 4 summarises the provision of emergency mental health services for adults with a learning disability across the 5 HSC Trusts at the time of this review.

Table 4: Mental Health Services for Adults with Learning Disability in Health and Social Care Trusts in Northern Ireland

Health and Social Care Trust	Usual Working Hours (Monday to Friday 9:00am-5:00pm)	Out-of-Hours (Weekdays after 6:00pm and at weekends)
Belfast	• Specialist Intensive Support Service	• Regional Emergency Social Work Services, Emergency Department and out-of-hours General Practitioner service • Referral to Adult Unscheduled Care Team
Northern	• Specialist Community Treatment Service	• The Rapid Assessment Interface and Discharge Service • Emergency bed provision linked to specialist respite services to provide an alternative to hospital admission
South Eastern	• Specialist Intensive Support Service	• Regional Emergency Social Work Services, Emergency Department and out-of-hours General Practitioner service • Adult Home Treatment Team
Southern	• Specialist Adult Learning Disability Crisis Response Team	• Adult Crisis Resolution Home Treatment Team
Western	• Specialist Intensive Support Service	• Regional Emergency Social Work Services, Emergency Department and out-of-hours General Practitioner service • Adult Crisis Resolution Home Treatment Team

During focus groups with staff and meetings with senior management, we evidenced that each Trust has established specialist teams to respond to adult learning disability patients who experience an emergency crisis during normal working hours, Monday to Friday from 9:00am to 5:00pm. These specialist teams include a Specialist Community Treatment Service in NHSCT, a Specialist Adult Learning Disability Crisis Response Team in the SHSCT and Specialist Intensive Support Services in BHSCT, SEHSCT and WHSCT.

During the out-of-hours period there are various arrangements to include access to Approved Social Workers in the RESWS, out-of-hours GP services, Emergency Departments, Adult CRHT Teams, Adult Unscheduled Care Team and the RAID Service in the case of NHSCT.

With respect to the provision of Step 5: High Intensity Mental Health Services of the Regional Mental Health Care Pathway [(2)], we were informed by HSCB that these inpatient services are provided by BHSCT in Muckamore Abbey Hospital, which is a commissioned regional specialist service for adults with a learning disability. At the time of fieldwork we were informed by both senior management and staff that continued pressure on regional hospital acute beds at Step 5 (Muckamore Abbey Hospital), in conjunction with the lack of suitable community learning disability placements (including limited rehabilitation services, supported accommodation and respite) is, and will continue to be, a challenge for the Trusts.

Despite these challenges, it was evident that Trusts are working to develop adult learning disability services for emergency mental health. For example, SHSCT has established a Specialist Adult Learning Disability Crisis Response team which provides services 7 days a week from 9:00am to 1:00am. Part of this service, includes an internal Trust agreement with the adult mental health CRHT team (which operates 24 hours a day, 7 days a week) to arrange any referrals after 1:00am. This new development, which effectively supports adult patients with a learning disability to remain in their own home and avoid unnecessary admission to hospital during an emergency, has received national recognition as an example of Positive Practice in the 'Strengthening the Commitment: Living the Commitment' National Report [(20)]. The Review Team commended this development.

In relation to the other 4 HSC Trusts (BHSCT, NHSCT, SEHSCT and WHSCT), evidence was found that each has established specialist teams known as Intensive Support Services or the NHSCT Community Treatment Service which play a central role in the management of people with a learning disability who present in crisis due to mental health issues.

Similar to SHSCT, these teams work closely with social work services and the Police Service of Northern Ireland (PSNI) to support adult patients with a learning disability to remain in their own home and avoid unnecessary admission to hospital. These teams also provide limited in-reach liaison services to Emergency Departments. We heard, however, that these teams are not funded to provide a 24 hours a day, 7 days a week service.

At the time of the fieldwork, we were also informed that a regional out-of-hours Consultant Psychiatrist Support service had been developed which is accessed through on-call rotas; however WHSCT reported that this service is not always available.

Throughout our examination of the emergency mental health services for adults with learning disabilities, we found evidence that the vast majority of patients with a learning disability are well known to services and that the numbers of adult patients with learning disability who experience crises are small.

The Review Team agreed that there are good mechanisms in place to ensure information about patients with a learning disability follows the patient. For example, all Trusts provided evidence that they are using a 'Hospital Passport System' [21]. Significant work has been undertaken to develop this system for service users with a learning disability. Passports are presented to hospital staff if service users are taken to hospital and they provide hospital staff with critical information regarding the individual patient. Feedback from service users and families during focus groups highlighted that the use of the passport system has enabled them to communicate more effectively without having to repeat their relative's information to staff when they present to services at a time of crisis.

The Review Team evidenced that all Trusts are working to develop their adult learning disability services for emergency mental health and agreed that pressures within acute learning disability services for adults could be assisted by enhancing core community learning disability.

Recommendation 6	**Priority 1**
The Health and Social Care Board, together with each Health and Social Care Trust, should review the current model and provision of core community learning disability services for adults (including rehabilitation services, supported accommodation and respite) and act on the findings of that review in order to: I. Ensure adult patients with a learning disability are cared for in the most appropriate setting; and II. Alleviate pressures currently experienced within acute learning disability services for adult patients.	

2.6 Children's Learning Disability Services

Table 5 summarises the provision of emergency mental health services for children with a learning disability across the 5 HSC Trusts at the time of this review.

Table 5: Mental Health Services for Children with Learning Disability Services in Health and Social Care Trusts in Northern Ireland

Health and Social Care Trust	Usual Working Hours (Monday to Friday 9:00am-5:00pm)	Out-of-Hours (Weekdays after 6:00pm and at weekends)
Belfast	• Core Children's Disability Service • Intensive Support Service	• Regional Emergency Social Work Services, Emergency Department and out-of-hours General Practitioner service • Admission to Iveagh Centre (Step 5)
Northern	• Children with mild learning disability access crisis services through core Child and Adolescent Mental Health Services • Children with severe learning disability access the Dual Agency Behaviour Support Service • Psychiatry services for children with Learning Disability are provided by Belfast Trust as part of a regional agreement	• Rapid Assessment Interface and Discharge Service • Emergency bed provision linked to specialist respite services to provide an alternative to hospital admission • Admission to Iveagh Centre (Step 5)
South Eastern	• Core Children's Disability Service • All age specialist Intensive Support Service	• Regional Emergency Social Work Services, Emergency Department and out-of-hours General Practitioner service • Admission to Iveagh Centre (Step 5)
Southern	• Extended its core Child and Adolescent Mental Health Services to include children and young people with an intellectual disability	• Assessment and Crisis Team (Step 4) • Out-of-hours Consultant Psychiatrist Rota • Admission to Iveagh Centre (Step 5)

Health and Social Care Trust	Usual Working Hours (Monday to Friday 9:00am-5:00pm)	Out-of-Hours (Weekdays after 6:00pm and at weekends)
		• Emergency Department, Regional Emergency Social Work Services and out-of-hours General Practitioner service
Western	• Core Children's Disability Service • Intensive Treatment Service (Step 4)	• Regional Emergency Social Work Services, Emergency Department and out-of-hours General Practitioner service • Intensive Treatment Service for Step 4 • Admission to Iveagh Centre (Step 5)

As mentioned previously in this report (Section 2.4) this review found evidence that each Trust is working in line with the CAMHS stepped care model (Child and Adolescent Mental Health Services; A Service Model, July 2012, Department of Health, Social Services and Public Safety, Northern Ireland) [5] for children with a learning disability.

The 5 Steps within this CAMHS model are listed below:

- Step 1 Prevention
- Step 2 Early intervention
- Step 3 Specialised intervention
- Step 4 Intensive intervention (Community)
- Step 5 Intensive intervention (Inpatient)

During the review of services for children with learning disabilities, we found evidence that each Trust has established services for children with a learning disability who present in an emergency mental health crisis, during normal working hours and also in out-of-hours periods.

We found that Trusts have either established a specialist service known as core Children's Disability Services or they have integrated their Children's Learning Disability Service into core CAMHS, which means children with a learning disability will receive services from the core CAMHS.

Evidence was found that each Trust delivers effective interventions at Steps 1, 2 and 3. It remains a challenge however for all Trusts to develop their services at Step 4 with specialist teams. During focus groups staff informed us that they can step up the level of support to Step 4 to respond to an individual child's needs, if required. This is a resource intensive process however, and staff highlighted that stepping up clinical staff's level of support may impact on their capacity to undertake assessments for other children and deliver effective interventions at Steps 2 and 3.

At the time of fieldwork, WHSCT reported that it has a dedicated intensive treatment service that is designed to 'wrap around' children with a disability in an emergency crisis. It can provide an emergency response or step up to acute inpatient care if required (Crannog Lodge). Crannog Lodge is an assessment and treatment ward for children with a learning disability, providing 24 hour care. Senior Trust management reported that Crannog Lodge provides a unique opportunity for continuity of care between community and hospital, allowing children to be treated in their local area and minimising the duration of inpatient stay. However, the Review Team was concerned that the Trust (at the time of this review) was operating outside the agreed regionally commissioned specialist service in operating this ward.

However, at the time of writing we understand that this service has been decommissioned by the HSCB and that Crannog is no longer in use for admitting children. The WHSCT now admit children to the regional inpatient service which is provided by the BHSCT in the Iveagh Centre (Step 5) which is adhering to the regionally commissioned specialist service.

In relation to Step 5, each Trust informed us that should a child or young person require admission to the Iveagh Centre in Belfast, this decision is reached on a planned basis, following assessment and intervention by the key services, in consultation with the inpatient service in Iveagh. The adult learning disability intensive support teams will also provide step down support for children and young people transitioning out of Iveagh. However, some Trusts reported they experience difficulties with admissions due to high bed occupancy in Iveagh. HSC Trusts may have to admit children or young people to Beechcroft (CAMHS mental health inpatient unit) to ensure timely access to appropriate care and treatment. During senior management meetings and focus groups with staff, we heard about difficulties with delayed discharges from Iveagh given the lack of available appropriate settings (including respite facilities and accommodation) at completion of acute assessment and treatment.

Similar to adults with a learning disability, we found evidence of the 'Hospital Passport System' in place within all Trusts for children and young people with a learning disability, who may present in a mental health crisis to an acute hospital setting. Feedback from staff highlighted that the passport system works well and provides staff with vital information as to how to care for the child or young person during their assessment and treatment. Feedback from service users and families also highlighted that they felt safe and secure when they had their child's passport with them.

The Review Team found that services for children with a learning disability are effective and the review team commended the use of the hospital passport system. Similar to adult mental health services; the Review Team considered that delayed discharges are influenced by a shortage of appropriate community services (including rehabilitation services, supported accommodation and respite) to enable children with ongoing learning difficulties to receive care from appropriate skilled staff in the most appropriate

setting. The Review Team agreed that pressures within acute learning disability services for children and young people could be significantly assisted by enhancing core community learning disability services.

Recommendation 7	**Priority 1**
The Health and Social Care Board, together with each Health and Social Care Trust, should review the current model and provision of core community learning disability services for children (including rehabilitation services, supported accommodation and respite) and act on the findings of that review in order to: I. Ensure children and young people with a learning disability are cared for in the most appropriate setting; and II. Alleviate pressures currently experienced within acute learning disability services for children and young people.	

2.7 Emergency Departments

Throughout this review, we were informed by all Trusts that pressures on Emergency Departments continue to arise in relation to mental health. This was also highlighted in the Public Health Agency's 2015 report on the extent of self-harm in Northern Ireland over a 3 year period (2012/13 to 2014/15) [(22)].

During focus groups, frontline staff confirmed that increasing numbers of patients with more complex needs are attending Emergency Departments. These include children and young people with mental health difficulties, complicated by drug and alcohol abuse, and elderly patients with concurrent mental, physical and social care needs.

An additional challenge identified by Emergency Department staff is the lack of dedicated psychiatric liaison service provision into general acute hospital wards during out-of-hours periods.
Emergency Department staff reported that they rely on adult CRHT teams and other specialist teams, however these teams may not be particularly specialised in the provision of liaison services.

The 2012 report of the "Joint Commissioning Panel for Mental Health - Guidance for Commissioners of Liaison Mental Health Services to Acute Hospitals" [(23)] recommends that liaison services should be provided throughout acute hospitals, including to the Emergency Department. The Review Team acknowledged implementation of the RAID model in NHSCT and highlights the model (or parts of the model) as potentially helpful for the development of liaison services in other Trusts.

Emergency Department staff expressed their concerns in relation the increased number of patients attending Emergency Departments who are escorted by the PSNI.

HSCB advised that a number of initiatives are ongoing to reduce the pressure on the service by offering alternatives to Emergency Department attendance. For example, an interagency protocol between the HSC system, the PSNI and the Northern Ireland Ambulance Service was issued in October 2015 [(24)].

Within this protocol, the PSNI is advised to consider other options, for example, '*The person's own home may be a suitable Place of Safety providing there is a responsible person willing to keep the person safely until the GP and Approved Social Worker can attend'.*

In order to reduce the length of time required by police officers to stay with patients in Emergency Departments, a joint risk assessment tool for the PSNI and Emergency Department staff has also been developed. This allows the police officer in agreement with Emergency Department staff to leave the person in the Emergency Department. In addition, we were told that an Alcohol Recovery Centre is in operation at weekends in the Belfast locality, which allows the PSNI to take people who are intoxicated to this facility rather than to the Emergency Department.

SEHSCT told us of a further development in the form of a pilot of a Multi-Agency Triage Team (MATT), which has the aim of improving user experience and preventing Emergency Department attendances. This Triage Team involves mental health practitioners, the PSNI, the Northern Ireland Ambulance Service and Emergency Department staff. The Review Team welcomed development of the MATT.

Despite the challenges outlined in relation to Emergency Departments, evidence was found for each Trust of service improvement initiatives and arrangements, such as collaborative working with various Specialist Mental Health Teams, Critical Decision Units (CDU), Alcohol Addiction Liaison Nurses, Self-Harm Intervention Programmes (SHIP) [(25)] and the Card Before CBYL scheme [(19)].

All Trusts reported a lack of appropriate physical space to interview patients in a mental health crisis within their Emergency Departments. This is not in line with the RCPsych Standards (Standard 19.1-19.42, Ward / Unit Environment) [(17)].

Recommendation 8	**Priority 3**
Each Health and Social Care Trust must ensure that an appropriate physical space to undertake mental health assessments is available 24 hours a day, 7 days a week within the Emergency Department setting.	

2.8 Quality Improvement

All Trusts demonstrated that they are continuing to develop and implement a number of quality improvement initiatives to improve the provision of emergency mental health services for their local population(s).

For example, the WHSCT's combined inpatient and home treatment service has embedded Clinical Microsystems quality improvement methodology into the design of its service. Multidisciplinary Teams (MDTs) meet weekly and apply quality improvement methodology to address problems at the frontline. The overall aim is to improve the consistency and reliability of structures and processes through which care is delivered, to improve the effectiveness of care and to enhance service user and carer experience.

Service developments in emergency mental health which have been supported by a quality improvement approach include physical health monitoring of patients on anti-psychotic medication, development of individualised therapeutic plans for inpatients, introduction of safety briefs and development of reflective practice. A culture of continuous improvement has been developed across the MDTs, which includes the views of service users.

The RAID Service which was established in NHSCT in 2015 works with staff in the Trust Direct Assessment Unit, Emergency Departments and wards 24 hours, 7 days a week. This service provides specialist mental health assessment for patients who may have self-harmed, used alcohol and drugs in a harmful or hazardous way or who have mental health difficulties associated with old age.

The NHSCT informed us that this service model has resulted in a more timely assessment and increased availability of specialist expertise to support the treatment and management of patients with mental health problems. By supporting ward teams, the service aims to enhance discharge planning and to reduce length of stay. Through early intervention and detection, the RAID team supports early recovery and discharge from hospital. Referrals are taken from both Emergency Departments and hospital wards.

The Crisis Assessment and Intervention Team, which was established within BHSCT in 2016, provides rapid assessment and intervention for children and young people who present at Emergency Departments or to their GP with acute mental health challenges and self-harm or suicidal ideation, on a 24 hours a day, 7 days a week basis. The Team also provides intensive treatment in the community to support children and young people and their families, thus preventing hospital admission.

An adult CRHT Regional Forum provides a valuable opportunity for sharing and learning across the region. Whilst this Forum operates under a voluntary arrangement, participants highlighted it has been invaluable in the sharing and dissemination of good practice.

The Review Team did have some concern about the lack of formal governance processes in relation to operation of the CRHT Regional Forum and recommended that the Forum must ensure it has robust governance processes in place. To date, the Forum has focused mostly on adult CRHT teams and the Review Team would encourage the Forum to engage a wider group of participants, to include CAMHS, Learning Disability and Elderly teams.

The Review Team were also informed of the involvement of the Home Treatment teams in a Regional Safety Collaborative which has led to the introduction of reflective practice groups, safety briefs and the use of the SBAR (situation, background, assessment and recommendation) approach in support of effective communication.

Recommendation 9	**Priority 2**
The Regional Crisis Resolution Home Treatment (CRHT) Forum should: I. Establish formal governance arrangements to ensure there are defined terms of reference, clear roles and responsibilities, and effective operating processes underpinning its work; and II. Consider widening its remit to include Child and Adolescent Mental Health Services, Learning Disability Services and Older People Services.	

2.9 Service User Experience

Seeking the life experiences of service users who have accessed emergency mental health services provided by specialist mental health teams was an important part of our overall methodology for this review. We engaged with service users from Aware NI, Inspire and CAUSE during a focus group which was hosted by Aware NI. We were also able to use service user experiences which the PCC shared with us to inform our work.

All 5 HSC Trusts have mechanisms in place to gather service user experiences such as service user groups, regular questionnaires, surveys and user engagement forums. Service user experiences are shared both internally and via the regional CRHT Forum. Trusts told us that service user experiences help staff to improve, change and modernise service delivery, where appropriate.

All Trusts confirmed their commitment to co-production and co-design of services. Trusts told us they encourage their service users and carers to participate in various initiatives and projects such as 10,000 Voices [(26)]. 10,000 Voices is a PHA initiative which gives people an opportunity to provide feedback on their experiences of accessing HSC services by asking for members of the public to ‘tell us their story’.

The Trusts have implemented several other initiatives to gather feedback on service user experience. These include dedicated independent peer advocacy through the voluntary sector, employment of staff with care experience backgrounds, and stakeholder engagement events to facilitate information sharing.

Trusts also highlighted the importance of capturing important learning from incidents, complaints and compliments and advised they have mechanisms in place to share and disseminate learning arising from these incidents, complaints and compliments.

A number of service users highlighted the excellent service they received from their specialist mental health teams and said this service had helped to prevent a hospital admission and assisted with their recovery.

Service users also highlighted the importance of being treated within their own home or as close to home as possible and told us that teams showed compassion toward them when providing services.

Service users identified several challenges in relation to the availability of services including:

- Concerns about a lack of continuity of care – having to explain their experience several times to different members of staff in different locations;
- A lack of available community services and support groups; and
- Challenges in accessing emergency mental health services when required.

The Review Team concluded that the Trusts were involved in various initiatives to harness the experience of service users and to ensure active and effective involvement of service users, carers and the public in the design and development of emergency mental health services. However, this could be strengthened by increasing the use of a co-production approach under the regional Personal and Public Involvement (PPI) framework [(27)] and co-production guidance [(28)].

Section 3 – Conclusion and Recommendations

3.1 Conclusion

Emergency mental health services are provided by 5 geographically located HSC Trusts in Northern Ireland. Each Trust is required to deliver their service in line with the Regional Mental Health Care Pathway [2] using a stepped care approach to ensure that anyone who experiences a mental health problem receives appropriate care in accordance with their mental health needs.

In general, all HSC Trusts have systems and processes in place to provide emergency mental health services for patients of all ages if they present in normal working hours (i.e. from Monday to Friday 9:00am to 5:00pm). However, it remains a challenge for all Trusts to provide dedicated specialised services to their local population during out-of-hours periods. This was particularly evident in relation to children and young people, people with learning disability and older people's services.

Throughout this review, all Trusts provided us with specific pieces of work to demonstrate their commitment to improving their provision of emergency mental health services for service users of all ages. There still remains however a significant challenge for the Trusts in relation to providing a safe and effective service during out-of-hours and within the community due to limited resources.

We believe good progress has been made in each of the Trusts in relation to developing specialist mental health teams over the past 10-12 years and in accordance with the Regional Mental Health Care Pathway [2] which was endorsed in October 2014.

Communication systems between mental health teams in each Trust and across the region have not been developed to their full potential. The Review Team was concerned that patient information could be lost or not transferred appropriately when a patient transferred to another Trust in an emergency context. A regional transfer protocol would strengthen current arrangements for sharing information.

Adult Mental Health Emergency Services (patients aged 18-65 years)

Adult emergency mental health services within all Trusts are now well established and provide a 24 hour service, 7 days a week. Each Trust has established CRHT teams in line with the RCPsych Home Treatment Accreditation Scheme (HTAS) [4]. These CRHT teams are providing a good service.

Factors such as the availability of acute beds and capacity of core community mental health teams have begun to impact on the provision of this emergency service.

Delayed discharges and longer lengths of stay in hospital have resulted in CRHT teams in some areas holding onto high risk patients, when it would be preferable to admit these patients to an acute inpatient bed. This may also have an impact on CRHT teams' capacity to take on new cases.

A review of the model and provision of community mental health services, to include rehabilitation services, supported accommodation and respite services, would help to stabilise the provision of emergency mental health care for the adult population.

The Review Team concluded that collaborative work by the HSCB and all Trusts to address variation in inpatient length of stay, to share learning and ensure patients receive care appropriate to their assessed needs in the most appropriate location, delivered by the most appropriate professional(s), would help.

Older People Mental Health Emergency Services (patients aged 65 years and over)

While all 5 HSC Trusts have arrangements in place to deliver an emergency mental health service for people who are aged 65 years and over during normal working hours, Trusts experience challenges providing this service during the out-of-hours period. Trusts are reviewing and/or restructuring their adult CRHT teams to ensure a specialist mental health service is provided to their over 65 population during out-of-hours. A variety of arrangements are in place in relation to mental health liaison services for older people who are inpatients in acute hospitals.

The Review Team commends those Trusts who have extended their adult CRHT teams to provide a service to their older populations during the out-of-hours period and recommends that each Trust should provide the same emergency mental health service during the out-of-hours period to the over 65 population as is currently provided to the adult (patients aged 18-65 years) population.

Child and Adolescent Mental Health Services (patients aged 0-18 years)

Each Trust is working in line with the CAMHS stepped care model (Child and Adolescent Mental Health Services: A Service Model, July 2012 [(5)] to provide services for children and young people during normal working hours. During the out-of-hours period provision of an appropriate service can be a challenge due to a lack of available resources. There are various examples of how each Trust is developing their out-of-hours services. An independent regional review of Acute CAMHS had recommended establishment of a regional managed care network; the Review Team commends this recommendation.

There are challenges with increasingly complex cases which may lead to an increased volume of out-of-hours emergencies.

The Review Team found evidence that Trusts are working to expand their CAMHS provision and acknowledged development of various specialist mental health teams across the Trusts.

All 5 HSC Trusts are at different stages of development of emergency mental health assessment and treatment services for children and young people (in line with the CAMHS stepped care model) during the out-of-hours period. The Review Team concluded that more work was required to ensure a robust system is in place for this group of patients.

Mental Health Services for Adults and Children with Learning Disability

Development of various specialist mental health teams across the Trusts for both adults and children with a learning disability is welcomed; however all Trusts are at different stages of development of emergency mental health assessment and treatment services for adults and children with a learning disability.

There are good mechanisms in place to ensure information about patients with a learning disability follows the patient. All Trusts provided evidence that they are using the 'Hospital Passport System' [21].

The Review Team heard about continued pressure on regional hospital acute beds (Muckamore Abbey Hospital for adults and Iveagh Centre for children). In conjunction with the lack of suitable community learning disability placements (including rehabilitation services, supported accommodation and respite) this will continue to be a challenge for the Trusts. The Review Team recommends that the current model and provision of core community learning disability services for adults and children with a learning disability is reviewed.

Emergency Departments

More patients with complex mental health needs are attending Emergency Departments. These include children and young people with mental health challenges complicated by drug and alcohol abuse and elderly patients with concurrent mental and physical health and social care needs. There is a lack of dedicated psychiatric liaison provision into general acute hospital wards during out-of-hours periods. There is also a lack of appropriate physical space to interview patients in mental health crisis in Emergency Departments. Some Trusts did provide evidence of a number of initiatives to address some of these challenges.

Quality Improvement

Each Trust demonstrated they are proactive and continue to develop and implement a number of quality improvement initiatives to improve the provision of emergency mental health services for their local population.

A CRHT Regional Forum (adult service) is operating and provides a valuable opportunity for sharing learning across the region. The Review Team agreed this Forum could involve teams from across the mental health services and recommend that formal governance arrangements are established for this Forum.

Service User Experience

Service users reported both positive and negative experiences of emergency mental health services. Some complimented their specialist mental health teams in preventing a hospital admission, assisting with recovery and engaging with compassion; while some service users highlighted concerns about challenges in accessing emergency mental health services.

There are mechanisms in place to gather service user experience. The Review Team concluded that each HSC Trust could widen its' approach to co-production with services users, carers and the public.

3.2 Recommendations

The recommendations identified during the review have been prioritised according to the timescales in which they should be implemented.

Priority 1 – completed within 6 months of publication of report
Priority 2 – completed within 12 months of publication of report
Priority 3 – completed within 18 months of publication of report

Implementation of the recommendations will improve the services delivered in each HSC Trust.

Number	Recommendation	Priority
1	I. The Health and Social Care Board should convene a short life working group, to include appropriate representation from each Health and Social Care Trust, in order to develop a regional information transfer protocol. II. Implementation of this protocol should ensure patient information is transferred securely and in a timely manner when patients transfer between Health and Social Care Trusts in an emergency mental health context. III. The Health and Social Care Board should ensure information transfer between Health and Social Care Trusts in an emergency mental health context is considered as part of the Encompass programme for Northern Ireland.	1

Number	Recommendation	Priority
2	The Health and Social Care Board should work collaboratively with each Health and Social Care Trust to help reduce the length of inpatient stays in those HSC Trusts where there is significant variation in relation to their peers, allowing for differing demographics and profile of patients. Learning should be shared across the region to ensure patients receive care appropriate to their assessed needs in the most appropriate location, delivered by the most appropriate professional(s).	2
3	The Health and Social Care Board, together with the Health and Social Care Trusts, should review the current provision of core community mental health services (including rehabilitation services, supported accommodation and respite) and act on the findings of that review in order to: I. Ensure adult patients are cared for in the most appropriate setting; and II. Alleviate pressures currently experienced within acute mental health services.	2
4	Each Health and Social Care Trust should provide the same emergency mental health service during the out-of-hours period to their over 65 population as is currently provided to their adult (patients aged 18-65 years) population.	2
5	Each Health and Social Care Trust must ensure a robust system is in place 7 days a week, 24 hours a day, to provide an emergency mental health assessment and treatment service for all children and young people, in line with the Child and Adolescent Mental Health Services stepped care model (Child and Adolescent Mental Health Services; A Service Model, July 2012, Department of Health, Social Services and Public Safety, Northern Ireland) [(4)].	2
6	The Health and Social Care Board, together with each Health and Social Care Trust, should review the current model and provision of core community learning disability services for adults (including rehabilitation services, supported accommodation and respite) and act on the findings of that review in order to: I. Ensure adult patients with a learning disability are cared for in the most appropriate setting; and II. Alleviate pressures currently experienced within acute learning disability services for adult patients.	1

Number	Recommendation	Priority
7	The Health and Social Care Board, together with each Health and Social Care Trust, should review the current model and provision of core community learning disability services for children (including rehabilitation services, supported accommodation and respite) and act on the findings of that review in order to: I. Ensure children and young people with a learning disability are cared for in the most appropriate setting; and II. Alleviate pressures currently experienced within acute learning disability services for children and young people.	1
8	Each Health and Social Care Trust must ensure that an appropriate physical space to undertake mental health assessments is available 24 hours a day, 7 days a week within the Emergency Department setting.	3
9	The Regional Crisis Resolution Home Treatment (CRHT) Forum should: III. Establish formal governance arrangements to ensure there are defined terms of reference, clear roles and responsibilities, and effective operating processes underpinning its work; and IV. Consider widening its remit to include Child and Adolescent Mental Health Services, Learning Disability Services and Older People Services.	2

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The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Public Accounts Committee

Report on the Safety of Services Provided by Health and Social Care Trusts

Together with the Minutes of Proceedings of the Committee Relating to the Report and the Minutes of Evidence

Ordered by the Public Accounts Committee to be printed 27 February 2013
Report: NIA 102/11-15 (Public Accounts Committee)

REPORT EMBARGOED UNTIL 00:01 AM on 17 April 2013

Membership and Powers

The Public Accounts Committee is a Standing Committee established in accordance with Standing Orders under Section 60(3) of the Northern Ireland Act 1998. It is the statutory function of the Public Accounts Committee to consider the accounts, and reports on accounts laid before the Assembly.

The Public Accounts Committee is appointed under Assembly Standing Order No. 56 of the Standing Orders for the Northern Ireland Assembly. It has the power to send for persons, papers and records and to report from time to time. Neither the Chairperson nor Deputy Chairperson of the Committee shall be a member of the same political party as the Minister of Finance and Personnel or of any junior minister appointed to the Department of Finance and Personnel.

The Committee has 11 members including a Chairperson and Deputy Chairperson and a quorum of 5.

The membership of the Committee since 23 May 2011 has been as follows:

Ms Michaela Boyle[1] (Chairperson)
Mr John Dallat (Deputy Chairperson)
Mr Trevor Clarke[2]
Mr Michael Copeland
Mr Sammy Douglas[3]
Mr Paul Girvan
Mr Ross Hussey
Mr Mitchel McLaughlin
Mr Dathí McKay[4]
Mr Adrian McQuillan[5]
Mr Seán Rogers[6]

1 With effect from 2 July 2012 Ms Michaela Boyle replaced Mr Paul Maskey

2 With effect from 1 October 2012 Mr Trevor Clarke replaced Mr Alex Easton

3 With effect from 1 February 2013 Mr Sammy Douglas replaced Mr Sydney Anderson

4 With effect from 11 September 2012 Mr Daithí McKay was appointed to the Public Accounts Committee

5 With effect from 24 October 2011 Mr Adrian McQuillan replaced Mr Paul Frew

6 With effect from 10 September 2012 Mr Seán Rogers replaced Mr Joe Byrne

7 With effect from 23 January 2012 Mr Conor Murphy replaced Ms Jennifer McCann

8 With effect from 1 July 2012 Mr Conor Murphy resigned from the Public Accounts Committee

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List of Abbreviations used in the Report

the Committee	Public Accounts Committee
C&AG	Comptroller and Auditor General
the Department/DHSSPS	Department of Health, Social Services and Public Safety
HSC	Health and Social Care
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NRLS	National Reporting Learning System
RAIL	Regional Adverse Incident Learning
RQIA	Regulation Quality and Improvement Authority
SAI	Serious Adverse Incident

Executive Summary

Introduction

1. Health and social care services affect every member of society at some stage in their lives. Each year, there are in excess of 15 million key interactions between health and social care staff and healthcare patients and social care clients. The public expects, and deserves, that services are delivered safely. However, one guarantee that the health and social care services cannot give patients and clients is that they will not be harmed by the system meant to look after them. The challenge for the health and social care services is to ensure their patient safety systems minimise the risk of harm and to take steps to maximise the competence, knowledge and skills of health and social care professionals.

2. Two recent reports[1] on unsafe care at Mid Staffordshire NHS Foundation Trust in England bring into particularly sharp relief just how crucial it is that the health and social care system treats patients as human beings and is open, transparent and accountable when things do go wrong. It is important that Trusts here learn from what happened in Mid-Staffordshire to ensure nothing like the events there could possibly happen here.

3. Adverse incidents are incidents that occur in a health or social care setting that could have resulted, or do result in the harm, or even death, of the patient or client. Around 83,000 incidents are reported by the Health and Social Care Trusts each year – around 250 of these are classified as serious adverse incidents. The Department told the Committee that of the 2,084 serious adverse incidents reported between July 2004 and March 2012, 813 individuals died in circumstances related to these incidents. The Committee acknowledges that deaths reported may not be a reflection of issues with the care delivered by health and social care services: for instance 488 of the fatalities reported relate to suicides, whether proven or suspected. However, while recognising such caveats, the Committee considers that the number of deaths still suggests that the standard of care being delivered by health and social care bodies requires continued close scrutiny.

4. Patient harm arising from adverse incidents is both a systemic and a human problem. While individual responsibility for adverse incidents should not be played down, systemic solutions to the problem are needed. Patient safety systems should include effective reporting and learning systems, effective remedial mechanisms and the active dissemination and implementation of evidence-based knowledge aimed at reducing adverse incidents.

5. Some, probably a very small proportion of, patients and clients who are dissatisfied with the care or treatment they receive, seek redress either by lodging a complaint or taking legal action against the provider. The latter can have significant financial implications — in the past five years, settling health and social care negligence cases has cost the Department of Health, Social Services and Public Safety (Department) £116 million. A significant proportion of this (around 35 per cent) related to legal and administrative costs.

Overall Conclusions

6. The Committee's overall conclusion is that, despite the introduction of a number of safety policies and initiatives, there is no reliable evidence to show that people receiving health and social care are any safer today than they were a decade ago. The Department still lacks a reliable means of tracking the progress of the health and social care services in improving

1 The Mid Staffordshire NHS Foundation Trust Inquiry, Chaired by Robert Francis, 24 February 2010, HC 375, London: The Stationery Office; Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC, February 2013, HC 947, London: The Stationery Office

the safety of those receiving care or in holding service providers accountable for minimising preventable harm.

7. The Committee was disappointed by the Department's reluctance to undertake research to estimate the potential level of harm caused to patients and clients. In the absence of a robust measure of the level of patient and client harm, it will be difficult for the Department to demonstrate improvement over a period of time. The Committee considers that evidence of progress is a vital step in spurring Trusts to improve safety levels across both the health and social care sectors.

8. The Committee also considers that patients and clients must be provided with much more detail on the performance of individual Trusts. In practical terms, this will involve notifying those individuals involved in adverse incidents and routinely making sufficient information publicly available to enable comparisons of safety levels across Trusts and to create external pressure for improvement.

9. The Committee recognises that the year-on-year increases in the number of reported incidents indicate some progress in developing a more open and fair reporting culture. However, on the basis of evidence given by the Department, it considers that organisational culture does not always support reporting, while fear of the consequences in terms of job security and personal repercussions still exist. The Department told the Committee that under-reporting continues to be a widespread issue, particularly in the acute sector. On the basis of this, the Committee concludes that Trusts are not maximising the potential to learn when things go wrong. As a direct consequence of this, public trust in the extent to which Trusts are providing safe and effective care can be seriously undermined.

10. The Committee is extremely concerned that nurses within the health and social care sector have reservations about raising patient safety concerns. While the Department acknowledged that staff must feel empowered to speak up, challenge and share in the responsibility for patient safety, it confirmed that, to date, it has not actively engaged with nursing representative bodies to devise a methodology for reassuring nurses. The Committee considers that there is a strong link between the culture of an organisation and the willingness and capability of staff at all levels to report and learn from adverse incidents. The Department and Trusts must do more to embed a widespread culture of safety in which honest reporting is encouraged and genuine learning can take place.

11. The quality of treatment and care provided will, to an extent, depend on the competence of staff in post. Regularly appraising the performance of staff can identify gaps in knowledge or experience and identify potential training needs. The Committee is astounded that the lack of appraisal in some areas within the sector, which was identified in 2010, has yet to be addressed. While the Committee acknowledges that appraisal exists to help health and social care professional consolidate and improve on good performance, it is also its expectation that it will provide a formal system for identifying poor performance.

12. It is important that patients and clients with valid claims against the health and social care services understand their rights and have access to a range of timely remedies including an explanation, an apology, remedial treatment and, where justified, financial compensation. In the Committee's view patients find the complaints and claims procedures confusing and difficult to navigate and can too easily and too quickly find themselves in a position where they have to seek legal remedies.

13. The Committee concluded that the absence of formal dispute resolution procedures which offer a viable alternative to litigation causes additional stress and expense for those dissatisfied with their care and treatment. Alternative dispute resolution, including mediation, can assist both Trusts and patients in reaching the non-financial remedies which patients often say they seek. The Committee urges the Department to consider how best to channel compensation to eligible patients and clients and has determined that the Northern Ireland Ombudsman is well-placed to offer advice in this area.

Summary of Recommendations

Recommendation 1

The Committee recommends that the Department undertakes research to produce robust estimates of the extent and cost of patient harm which includes both commissioning errors (where patients receive poor quality, unsafe care) and errors of omission, where the harm is attributable to a lack of access to care. The Committee also considers that the Department should develop a range of safety-related indicators to routinely evaluate the safety performance of Trusts and to use this information to set challenging safety targets. The Committee considers that, based on experiences in other high risk industries such as aviation, targeted improvements in the rate of adverse incidents can be achieved. The Committee expects the Department, in six months' time, to provide it with: an action plan which sets out how it intends to establish a baseline measure of the incidence of harm caused to patients within the health and social care services; and how it intends to use this information for setting priorities for harm reduction efforts throughout the system.

Recommendation 2

All health and social care adverse incidents have the potential to generate learning across the sector. The Department should ensure that its data systems have the capability to identify the underlying causes of adverse incidents, with a view to preventing their repetition. In particular, it is important that the Department establishes an effective reporting and learning system for near misses (where the patient or client was unharmed) in an attempt to avoid more serious incidents in the future.

Recommendation 3

The Committee welcomes the Department's commitment to improving its management information through the RAIL system but is concerned with the timescales involved. The Committee recommends that interim arrangements are put in place as a matter of urgency to ensure regional collection of relevant information and calls on the Department to provide it with a progress report in six months' time.

Recommendation 4

The Committee notes the Department's preference to develop a regional management information system rather than join with England and Wales in the NRLS. Given the obvious risks involved in such IT projects, the Committee recommends that the Department's business case gives full consideration to all other options, particularly the NRLS option, and clearly explains why each of these is unacceptable.

Recommendation 5

The public has a right to sufficient information on individual Trusts in order to assess relative quality across service providers. The Committee recommends that the current reports produced by the HSC Board are enhanced by providing data on all adverse incidents, that they are made publicly available on a timely basis, and that they are sufficiently detailed to allow the public to get a regional and local picture of the safety of the treatment and care provided.

Recommendation 6

In the Committee's view, the open and fair culture to which the Department aspires must extend to the increased participation of patients in their treatment. The Committee recommends that health and social care providers are advised of the need to inform those involved in any adverse incidents. Information provided should include the nature of the incident, the circumstances giving rise to the incident, the possible impact for the patient or client and details of learning arising from the incident.

Recommendation 7

The Committee sees considerable merit in learning lessons from health care experiences elsewhere. It therefore expects the Department to independently verify the extent of compliance with NRLS safety alerts across the health and social care sector. Further, the Committee considers that sanctions should be imposed where health and social care bodies fail to implement action on a timely basis.

Recommendation 8

In terms of learning lessons, the Committee welcomes the recommendations of the Francis Reports on Mid Staffordshire Hospitals NHS Trust, many of which have implications that could apply to any health and social care trust here. The Committee calls on the Department to work closely with the HSC Board and the Trusts to consider the full implications of the Francis Reports and recommends that it reports back to the Committee in six months' time outlining what actions have been taken, or need to be taken, to address the concerns raised.

Recommendation 9

In the Committee's view the reluctance of nurses to report safety concerns indicates there is a real need to challenge the existing culture in which errors are concealed. Failure to report incidents prevents learning. A positive culture would result in improvements in safety practices through better communication, teamwork and knowledge. The Committee recommends that the Department engages with all staff groups within the sector and takes urgent steps to ensure a more open and proactive reporting culture.

Recommendation 10

The recipients of health and social care services must be assured that their views on the safety and quality of the services they receive are important. The Committee recommends that Trusts become more proactive in obtaining feedback on the services they provide, encouraging patients and clients to identify areas for potential improvement or to highlight good practice. Improving links between data on complaints with other safety data, such as risk and incident reporting data, can lead to complaints being taken more seriously as a source of information and feedback on the standard of service or care being provided.

Recommendation 11

Ensuring the competence of staff is crucial in creating a safe environment for patients receiving treatment and care from the health and social care services. The Committee finds it unacceptable that so little regard has been given to assessing, maintaining and improving the competency of staff – particularly among medical staff in the Northern Trust. While the Department's reminder to Trusts of their requirements in this area is encouraging, the Committee considers that action should have been taken as soon as

weaknesses were identified. The Committee recommends that the Department follows up on its reminder to Trusts by carrying out annual verification checks on staff appraisal and development plans. The Committee also asks that the Department provides it with an update, in six months' time, on the progress of Trusts in completing staff appraisals.

Recommendation 12

The Committee recommends that the Department continues to track the outcome of initiatives to speed up claims handling and that it provides the Committee with an update on the performance of long running cases up to September 2012.

Recommendation 13

The Committee considers that the current "fault-based" approach adopted across health and social care services can place additional, unnecessary stress and expense on those who suffer injury and on health and social care providers. The Committee recommends that the Department gives serious consideration to the feasibility of developing robust formal dispute resolution procedures which could offer a real alternative to litigation. The Committee considers that the Department should consult with the Northern Ireland Ombudsman in determining an appropriate way forward.

Recommendation 14

The Committee recommends that the Department assesses the relative merits of continuing to meet the compensation costs of clinical negligence settlements rather than requiring HSC bodies to assess their relative risks and contribute, on the basis of these risks, to a central pool from which compensation costs are met.

Introduction

14. The Public Accounts Committee (the Committee) met on 14 November 2012 to consider the Comptroller and Auditor General's report "The Safety of Services Provided by Health and Social Care Trusts". The main witnesses were:

- **Dr Andrew McCormick**, Accounting Officer, Department of Health, Social Services and Public Safety;
- **Dr Paddy Woods**, Deputy Chief Medical Officer, Department of Health, Social Services and Public Safety;
- **Ms Julie Thompson**, Senior Finance Director, Department of Health, Social Services and Public Safety;
- **Mr Kieran Donnelly**, Comptroller and Auditor General; and
- **Ms Fiona Hamill**, Treasury Officer of Accounts.

15. Health and social care services are available to all people in Northern Ireland in a range of settings, such as hospitals and care homes. It is estimated that each year, there are in excess of 15 million interactions between health and social care providers and patient or clients. The vast majority of these patients and clients receive care or treatment which is effective and safe. Errors, which can and do cause harm, occur. In each year, around 83,000 incidents which caused, or could have caused, harm are reported by health and social care staff. Around 250 of these incidents are classified as serious. In the period from July 2004 to March 2012, 2,084 serious adverse incidents (SAIs) were reported. (Appendix 1 provides definitions of adverse/serious adverse incidents.) Although it can be difficult to determine the exact cause (or responsibility) for death, the Department told the Committee that 813 individuals died in circumstances related to these SAIs.

16. Where an individual considers that the care or treatment they received was not appropriate, they may seek redress. Redress may take the form of a complaint or, in more serious cases, may result in a claim for negligence. Around 60,000 complaints are lodged each year against health and social care providers. Around 600 new negligence claims are taken each year.

17. Negligence cases in the past five years have cost the taxpayer £116 million. The Department estimates that it could cost taxpayers a further £140 million to settle cases currently being processed. Other, less visible costs, such as the cost of providing care and treatment following an adverse incident, are not quantified but are likely to be substantial.

18. The Comptroller and Auditor General reported on the arrangements for settling clinical negligence claims in 2002. At that time, he recommended that action was required to ensure that cases were processed on a more timely basis. The Committee considered that this had the potential to minimise additional stress on injured patients and clients and to reduce the legal costs incurred in these cases. Progress in resolving negligence cases was unacceptably slow until the Assembly raised the issue again in 2010. The renewed interest resulted in initiation of an exercise to resolve long-standing cases which has seen a significant reduction in the number of cases running for over five years.

19. Despite a plethora of policy initiatives, there is little evidence that the Department or Trusts have made progress in making services safer. Recent cases, such as the pseudomonas outbreak in the Western Trust and subsequently the Belfast Trust and the death of a patient waiting on a trolley at the Accident and Emergency Department of the Royal Victoria Hospital, do little to provide assurance that safety is indeed a top priority.

20. In taking evidence, the Committee wished to explore how approaches to patient and client safety could help to reduce the burden of adverse incidents on heath and social care services. It focused on four key areas, as follows:

- The extent to which safety is measured;
- The culture within which care and treatment is provided;
- The competence of heath and social care professionals; and
- How the needs of those harmed as a result of receiving care can be fairly addressed.

The extent of harm caused by HSC providers must be measured and Information on the safety of Trust services made available to the public

There will always be risks in providing health and social care services. In order to mitigate against these risks, it is essential to have reliable estimates of the extent of harm caused to patients or clients

21. While no health and social care system will ever be risk free, adequate systems must be put in place to minimise the risk that patients or clients are harmed. As a first step in supporting efforts to make patient safety a standard of care in Trusts it is necessary to have reliable information on the extent and cost of harm caused. While it is difficult to estimate the extent and cost of harm accurately, available research suggests that, in England, around 10 per cent of patients admitted to hospital suffer some form of harm, much of which is avoidable.

22. The Committee is adamant that such a statistic should not be considered to be simply an unfortunate consequence of providing health and social care, particularly given the Department's evidence that adverse incidents have been linked to the deaths of hundreds of patients over the last eight years. In addition to the misery caused to patients and their families, adverse incidents negatively affect the health and social care system due to the increased costs of prolonged hospitalisation to treat complications. Currently these costs remain unmeasured. In the Committee's view, the Department's efforts to tackle patient safety effectively have to be based on a better understanding of the true extent of adverse incidents and the level of costs incurred in their treatment.

23. No research has been undertaken to estimate the likely level and cost of harm in Northern Ireland. The Department told the Committee that it sees little value in commissioning such research. Rather, in its view, efforts would be better focused towards making improvement. The Committee agrees that action is required to make improvements but considers that the vague notion that reducing patient harm should logically reduce costs and improve the outcomes of patient care is an unsound basis for developing a coherent approach to patient safety. Improvements cannot be measured unless a soundly based estimate of the extent of harm and the attendant financial costs is produced. The Department should set out clearly what it is trying to achieve and develop performance measures which can be used to assess its effectiveness in addressing patient safety issues.

Recommendation 1

24. **The Committee recommends that the Department undertakes research to produce robust estimates of the extent and cost of patient harm which includes both commissioning errors (where patients receive poor quality, unsafe care) and errors of omission, where the harm is attributable to a lack of access to care. The Committee also considers that the Department should develop a range of safety-related indicators to routinely evaluate the safety performance of Trusts and to use this information to set challenging safety targets. The Committee considers that, based on experiences in other high risk industries such as aviation, targeted improvements in the rate of adverse incidents can be achieved. The Committee expects the Department, in six months' time, to provide it with: an action plan which sets out how it intends to establish a baseline measure of the incidence of harm caused to patients within the health and social care services; and how it intends to use this information for setting priorities for harm reduction efforts throughout the system.**

Information on all adverse incidents must be collated and used to facilitate learning

25. Information on the circumstances leading to adverse incidents is extremely valuable, and learning lessons from individual incidents can prevent future harm. While the Committee recognises that the Belfast HSC Trust is one of the largest in the UK and provides various regional treatments, it does not agree with the Department that these factors should exempt it from comparison against other Trusts. The Committee considers that data on adverse incidents relating to regional (or specialist care) should be separately identified. As a result, the incidence of adverse incidents occurring in "routine" treatment or care could be fairly compared against the incidence in other Trusts.

26. In analysing data on adverse incidents, less attention has been focused on the detection and analysis of near misses, and the Committee believes that this neglect represents a missed opportunity. Near miss reports are a particularly good source of data for managing risk. Regionally, systems are in place to collate information on serious adverse incidents, but information on incidents deemed by Trusts to be less serious is retained within individual Trusts. Achieving substantial improvements in patient safety will require a management information system which captures data on all adverse incidents and near misses and uses this information to design care delivery systems.

27. A National Reporting and Learning System (NRLS) has been operating across England and Wales since 2003. The NRLS is a centralised database which supports development of improved patient safety solutions nationally. While, initially, the Department had considered the possibility of joining NRLS it told the Committee that it now plans to introduce a new Regional Adverse Incident Learning (RAIL) management information system. The Department informed the Committee that the outline business case for the RAIL system has not been finalised and, therefore, the anticipated full cost of the project is not yet known. However, to date, the system has cost just over £380,000. In the Department's view this system will provide comprehensive patient safety information which can be collated on a regional basis. Subject to approval of the business case, the Department expects that its RAIL system will be piloted in one health and social care organisation over a twelve-month period and, subject to the results of the pilot, will be rolled out across the sector.

28. The Committee notes that the RAIL pilot is not scheduled until 2014 and is concerned that prior to its full introduction, comprehensive information on adverse incidents will continue to be unavailable. Despite assurances by the Department, the Committee remains unconvinced of the need to embark on the development of a stand-alone Northern Ireland-specific management information system and expects the RAIL business case to fully explore all other available options.

Recommendation 2

29. **All health and social care adverse incidents have the potential to generate learning across the sector. The Department should ensure that its data systems have the capability to identify the underlying causes of adverse incidents, with a view to preventing their repetition. In particular, it is important that the Department establishes an effective reporting and learning system for near misses (where the patient or client was unharmed) in an attempt to avoid more serious incidents in the future.**

Recommendation 3

30. **The Committee welcomes the Department's commitment to improving its management information through the RAIL system but is concerned with the timescales involved. The Committee recommends that interim arrangements are put in place as a matter of urgency to ensure regional collection of relevant information and calls on the Department to provide it with a progress report in six months' time.**

Recommendation 4

31. **The Committee notes the Department's preference to develop a regional management information system rather than join with England and Wales in the NRLS. Given the obvious risks involved in such IT projects, the Committee recommends that the Department's business case gives full consideration to all other options, particularly the NRLS option, and clearly explains why each of these is unacceptable.**

The information provided to the public on the safety of care is inadequate and does not engender confidence in the health and social care services

32. Information on serious adverse incidents across the health and social care sector is collated by the Health and Social Care Board (HSC Board). The HSC Board considers the reported incidents and provides feedback to health and social care bodies. In addition, the HSC Board identifies lessons from individual incidents and communicates these across the sector. Information on all other adverse incidents is retained by individual Trusts.

33. The Committee acknowledges the work done by the HSC Board to ensure learning from serious adverse incidents. However, in the Committee's view, these reports must be extended to cover all adverse incidents and must be presented in a way that gives the public a clear picture of the safety of care available. Further, the Committee considers that, as the people who use health and social care services deserve to know about the risks they face on all aspects of safety, the reports should be sufficiently detailed to allow the public to compare safety performance across Trusts. The Committee expects that once the RAIL system is up and running this should go some way to ensuring that comprehensive information on patient safety is readily available so that the reporting needs of the public can be properly addressed.

Recommendation 5

34. **The public has a right to sufficient information on individual Trusts in order to assess relative quality across service providers. The Committee recommends that the current reports produced by the HSC Board are enhanced by providing data on all adverse incidents, that they are made publicly available on a timely basis, and that they are sufficiently detailed to allow the public to get a regional and local picture of the safety of the treatment and care provided.**

35. Individuals who suffer a serious adverse incident, or their representatives, are likely to be aware that they have suffered some form of harm. Even where this is not the case, procedures within Trusts dictate that, as part of the required investigation process, these individuals are informed.

36. The Committee was disappointed to learn that, in less serious cases, the individual will not always be informed. The public expects and deserves safe care, and those who do not receive this have a right to know.

Recommendation 6

37. **In the Committee's view, the open and fair culture to which the Department aspires must extend to the increased participation of patients in their treatment. The Committee recommends that health and social care providers are advised of the need to inform those involved in any adverse incidents. Information provided should include the nature of the incident, the circumstances giving rise to the incident, the possible impact for the patient or client and details of learning arising from the incident.**

38. Information on patient safety incidents is reported confidentially to the NRLS by healthcare staff across England and Wales. Clinicians and safety experts analyse submitted reports to identify any common patient risks and highlight opportunities to improve patient safety. Alerts

take the form of Rapid Response Reports, Patient Safety Alerts or Safer Practice Notices. Although Northern Ireland health and social care bodies do not provide incident data to the database, the Department told the Committee that arrangements are in place to ensure that NRLS messages are cascaded to all relevant organisations and clinical specialties for consideration and dissemination.

39. The Department told the Committee that individual Trusts are required to report on the extent to which they have implemented NRLS safety alerts. However, while the Department could provide evidence that safety information was provided to Trusts, it failed to convince the Committee that it routinely monitored the extent to which individual safety notices resulted in procedural improvements within Trusts. In the Committee's view, it is essential for the Department to independently verify the extent of Trust compliance with patient safety alerts and to impose sanction for failure (or unacceptable delay) in implementation.

Recommendation 7

40. **The Committee sees considerable merit in learning lessons from health care experiences elsewhere. It therefore expects the Department to independently verify the extent of compliance with NRLS safety alerts across the health and social care sector. Further, the Committee considers that sanctions should be imposed where health and social care bodies fail to implement action on a timely basis.**

Recommendation 8

41. **In terms of learning lessons, the Committee welcomes the recommendations of the Francis Reports on Mid Staffordshire Hospitals NHS Trust, many of which have implications that could apply to any health and social care trust here. The Committee calls on the Department to work closely with the HSC Board and the Trusts to consider the full implications of the Francis Reports and recommends that it reports back to the Committee in six months' time outlining what actions have been taken, or need to be taken, to address the concerns raised.**

Trusts must completely eliminate the blame culture if the reporting of incidents is to improve

Staff and those accessing care or treatment must be reassured that raising potential or actual patient safety concerns is welcomed

42. An open and fair culture encourages the willingness and capability of of staff to report and learn from adverse incidents. A failure to report incidents precludes learning across the sector and prevents identification of patterns and trends in causing harm. The Department acknowledges that there is likely to be significant under-reporting of incidents, particularly within the acute sector. In addition, the Committee highlighted that some cases of harm, for example those cases where the failure to provide treatment or care resulted in death, are unlikely ever to be captured. Against this background, the Committee was shocked to discover that nurses — or any medical staff who are well placed to advise on patient safety — should have reservations about raising concerns.

43. The Department acknowledged that an open and fair culture would ensure that individuals feel free to speak up and challenge the safety of treatment or care provided. It told the Committee that all health and social care staff have been reminded that the leadership within their organisation should promote a culture in which everyone can challenge everyone else.

44. Given the Department's views, the Committee was disappointed that it has not met with nursing representatives to discuss how the existing culture can be improved.

Recommendation 9

45. **In the Committee's view the reluctance of nurses to report safety concerns indicates there is a real need to challenge the existing culture in which errors are concealed. Failure to report incidents prevents learning. A positive culture would result in improvements in safety practices through better communication, teamwork and knowledge. The Committee recommends that the Department engages with all staff groups within the sector and takes urgent steps to ensure a more open and proactive reporting culture.**

46. Users of health and social care services are well placed to assess the quality and safe of the care or treatment they receive. Feedback from patients and clients can be useful in identifying good practice and highlighting areas where improvement in services is required.

47. Around 60,000 complaints are received about health and social care services each year, but with users fearing reprisal, it is likely that several others who are dissatisfied do not raise their concerns. Given the value of such information the Committee was disappointed that many health and social care patients and clients feel reluctant to complain about the quality or safety of the care they receive. The public must have confidence in the health and social care system and the attitude of staff responding to complaints is crucial to building this confidence.

Recommendation 10

48. **The recipients of health and social care services must be assured that their views on the safety and quality of the services they receive are important. The Committee recommends that Trusts become more proactive in obtaining feedback on the services they provide, encouraging patients and clients to identify areas for potential improvement or to highlight good practice. Improving links between data on complaints with other safety data, such as risk and incident reporting data, can lead to complaints being taken more seriously as a source of information and feedback on the standard of service or care being provided.**

The competence, performance and training needs of all staff must be regularly assessed

49. The Committee recognises that, whilst systems in place to support delivery of safe care make things happen, it is people that make systems work. Ensuring the competence of the staff and addressing training needs, therefore, are important steps in ensuring the safety of health and social care services. A survey in 2010 identified that a significant number of staff (over half of those who responded) had received no annual appraisal in the preceding twelve months and did not have a personal development plan in place. The Committee considers that the performance of all staff must be regularly assessed if poor performance is to be identified and addressed. Further, it considers that, in the absence of personal development plans, important training needs may be overlooked.

50. The Department agreed that the lack of compliance with appraisal practice is a major concern and informed the Committee that each Trust had been reminded of the need to ensure that the performance of staff is assessed regularly. Despite such an assurance statistics provided to the Committee by the Department following the evidence session indicate that there continues to be a problem in this area. The Table below sets out the percentage of staff who did not receive a formal appraisal in the latest performance period. This shows, for example, that in the South Eastern HSC Trust, an alarming 85 per cent of non-medical staff did not receive a formal appraisal in 2011-12. Similarly, in the last reporting period, 36% of medical staff within the Northern HSC Trust did not receive a formal appraisal.

HSC Trust	**Percentage of staff NOT appraised in latest performance period**	
	Medical	**Non-Medical**
Belfast	11%	14%
Northern	36%	53%
Southern	9%	65%
South Eastern	15%	85%
Western	48% (no breakdown provided)	

Recommendation 11

51. **Ensuring the competence of staff is crucial in creating a safe environment for patients receiving treatment and care from the health and social care services. The Committee finds it unacceptable that so little regard has been given to assessing, maintaining and improving the competence of staff – particularly among medical staff in the Northern Trust. While the Department's reminder to Trusts of their requirements in this area is encouraging, the Committee considers that action should have been taken as soon as weaknesses were identified. The Committee recommends that the Department follows up on its reminder to Trusts by carrying out annual verification checks on staff appraisal and development plans. The Committee also asks that the Department provides it with an update, in six months time, on the progress of Trusts in completing staff appraisals.**

Arrangements for addressing the needs of individuals who are dissatisfied with their care need to be improved

52. A small number of those who are dissatisfied with the treatment or care they received from a health and social body will take legal action in an attempt to obtain an explanation of, or an apology for, their experience or to seek financial compensation for injury suffered as a result of their experience. To be successful, these individuals must prove, in a court of law that a

practitioner or organisation failed to adhere to accepted standards of care or treatment. In other words, the individual must prove that no competent practitioner from the same specialty would support or endorse the care or treatment provided.

53. This "fault-based" approach has been the subject of criticism in England[2], because it places considerable additional stress on patients or clients, is time consuming, engenders a culture of secrecy across providers and results in substantial legal and administrative costs - which can often exceed the value of compensation awarded. For example, in 2011-12 across the Trusts, 139 closed cases resulted in the award of damages of less than £50,000. In 73 per cent of these settlements, total legal costs exceeded the level of damages.

54. Delay in clearing claims for clinical negligence causes uncertainty for all those involved, particularly those patients who have suffered and their families. The C&AG has reported that progress is being made and more claims are now being closed than opened. In particular he reported a decline in the number of long running cases between September 2010 and September 2011. While the Committee acknowledges this progress it considers that there are still unacceptable delays in clearing many negligence cases and further action is required.

Recommendation 12

55. **The Committee recommends that the Department continues to track the outcome of initiatives to speed up claims handling and that it provides the Committee with an update on the performance of long running cases up to September 2012.**

56. In 2002, in response to a report by the Northern Ireland Audit Office[3], the Department advised individual HSC bodies of the potential benefits of intervening early in cases where a clinical negligence case may arise. However, the Department has taken little action to measure the extent to which individual bodies have complied with the guidance.

57. The Committee considers that there are viable alternatives to litigation, such as conciliation, mediation and arbitration, which would ensure more satisfactory resolution in cases where patients or clients have suffered injury as a result of treatment or care. Such alternatives would ensure that compensation is provided to eligible patients and clients in an equitable and timely manner, would maximise learning across the sector and would incentivise HSC staff working towards improving the quality of treatment and care. Creating such an environment is essential to efficiency in an era of limited resources, and ultimately, in advancing patient safety and saving lives.

Recommendation 13

58. **The Committee considers that the current "fault-based" approach adopted across health and social care services can place additional, unnecessary stress and expense on those who suffer injury and on health and social care providers. The Committee recommends that the Department gives serious consideration to the feasibility of developing robust formal dispute resolution procedures which could offer a real alternative to litigation. The Committee considers that the Department should consult with the Northern Ireland Ombudsman in determining an appropriate way forward.**

59. In Northern Ireland, the cost of settled clinical and social care negligence claims falls to the Department rather than to the Trust or HSC body which provided the treatment or care. By contrast, in England and Wales, NHS bodies contribute to a central compensation pool on the basis of the assessed risk of the services they provide. The Committee considers that

2 Criticisms were expressed by the National Audit Office Report in May 2001 in its report , *Handling Clinical Negligence Claims in England HC 403* and subsequently by the House of Commons Public Accounts Committee who took evidence on that report.

3 *Compensation Payments for Clinical Negligence,* Northern Ireland Audit Office, July 2002, NIA 112/02.

the arrangements in England and Wales provide NHS bodies with some financial incentive to improving the safety of treatment or care.

Recommendation 14

60. **The Committee recommends that the Department assesses the relative merits of continuing to meet the compensation costs of clinical negligence settlements rather than requiring HSC bodies to assess their relative risks and contribute, on the basis of these risks, to a central pool from which compensation costs are met.**

Appendix 1

Adverse/Serious Adverse Incidents

Any event or circumstance that could have, or did, lead to harm, loss or damage to people, property, environment or reputation" is defined as an adverse incident. This definition acknowledges that not all incidents result in harm, but some do. Where an incident is prevented or avoided, resulting in no harm, this is called a 'near miss'. Adverse incidents can be, but are not always, related to individual human error. Often they are linked to system faults, work environments, technological failures or the complex characteristics of the individual patient's or client's condition or circumstance. Serious adverse incidents are a subset of adverse incidents.

A serious adverse incident, rather than an adverse incident, has occurred where there is:

- serious injury to, or the unexpected/unexplained death (including suspected suicides and serious self–harm) of: a service user; a service user known to Mental Health Services (including Child and Adolescent Mental Health Services or Learning Disability) within the last two years;
- serious injury to a staff member in the course of their work; or 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 the provision of services and/or the maintenance of business continuity;
- a serious assault (including homicide and sexual assaults) by a service user on other users/staff/members of the public occurring within a healthcare facility or in the community care setting; or
- a serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

Northern Ireland Assembly

Appendix 1

Minutes of Proceedings of the Committee Relating to the Report

Wednesday, 7 November 2012
The Senate Chamber, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr John Dallat (Deputy Chairperson)
Mr Sydney Anderson
Mr Trevor Clarke
Mr Michael Copeland
Mr Paul Girvan
Mr Daithí McKay
Mr Mitchel McLaughlin
Mr Seán Rogers

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mr Darren Weir (Clerical Officer)
Ms Antoinette Bowen (Clerical Officer)

Apologies: Mr Ross Hussey
Mr Adrian McQuillan

2:00 pm The meeting opened in public session.

4. Briefing on Northern Ireland Audit Office Reports on 'The Safety of Services Provided by Health and Social Care Trusts'

The Committee considered the above report on 'The Safety of Services provided by Health and Social Care Trusts'.

Mr Kieran Donnelly Comptroller and Auditor General; Mr Sean McKay, Director; Ms Claire Dornan, Audit Manager; and Joe Campbell, Audit Manager briefed the Committee on the report.

2:18 pm The meeting went into closed session after the C&AG's initial remarks.

2:31 pm Mr Girvan declared an interest stating that he has family members in the medical profession and nursing.

3:09 pm Mr Copeland left the meeting.

3:10 pm Mr Anderson declared an interest stating that he has family members who are employed by Social Services.

3:15 pm Mr Dallat left the meeting.

3:17 pm Mr Copeland entered the meeting.

3:18 pm Mr Dallat entered the meeting.

3:24 pm Mr Girvan left the meeting.

3:26 pm Mr Copeland left the meeting.

3:27 pm Mr Clarke left the meeting.

3:27 pm Mr Girvan entered the meeting.

3:46 pm Mr Clarke entered the meeting.

The witnesses answered a number of questions put by members.

[EXTRACT]

Wednesday, 14 November 2012
The Senate Chamber, Parliament Buildings

Present: Mr John Dallat (Deputy Chairperson)
Mr Sydney Anderson
Mr Trevor Clarke
Mr Michael Copeland
Mr Paul Girvan
Mr Mitchel McLaughlin
Mr Seán Rogers

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mr Darren Weir (Clerical Officer)
Ms Andrienne Magee (Clerical Officer)

Apologies: Ms Michaela Boyle (Chairperson)
Mr Ross Hussey
Mr Daithí McKay
Mr Adrian McQuillan

2:04 pm The meeting opened in public session.

4. Evidence on the Northern Ireland Audit Office Report 'The Safety of Services provided by Health and Social Care Trusts'.

2:08 pm Mr Anderson declared an interest stating that he has family members who are employed by Social Services.

The Committee took oral evidence on the above report from:

- Dr Andrew McCormick, Accounting Officer, Department of Health, Social Services and Public Safety (DHSSPS);
- Dr Paddy Woods, Deputy Chief Medical Officer, Department of Health, Social Services and Public Safety (DHSSPS); and
- Ms Julie Thompson, Deputy Secretary, Resource and Performance Management Group, Department of Health, Social Services and Public Safety (DHSSPS).

Agreed: The Committee agreed to request further information from the witnesses.

2:14 pm Mr Girvan entered the meeting.

2:19 pm Mr Girvan left the meeting.

2:28 pm Mr Girvan entered the meeting.

3:13 pm Mr Clarke left the meeting.

3:15 pm Mr Girvan left the meeting.

3:16 pm Mr Clarke and Mr Girvan entered the meeting.

3:19 pm Mr Copeland left the meeting.

3:21 pm Mr Rogers left the meeting.

3:22 pm Mr Anderson left the meeting.

3:24 pm Mr Copeland entered the meeting.

3:26 pm Mr Rogers entered the meeting.

3:44 pm Mr McLaughlin left the meeting.

3:52 pm Mr McLaughlin entered the meeting.

3:59 pm Mr Copeland left the meeting.

4:11 pm Mr Copeland entered the meeting.

4:26 pm Mr Copeland left the meeting.

4:28 pm Mr Clarke left the meeting.

4:39 pm Mr Clarke entered the meeting.

4:49 pm Mr Copeland left the meeting.

The witnesses answered a number of questions put by the Committee.

[EXTRACT]

Wednesday, 21 November 2012
Room 29, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr John Dallat (Deputy Chairperson)
Mr Sydney Anderson
Mr Trevor Clarke
Mr Michael Copeland
Mr Paul Girvan
Mr Ross Hussey
Mr Daithí McKay
Mr Mitchel McLaughlin
Mr Adrian McQuillan
Mr Seán Rogers

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mr Darren Weir (Clerical Officer)
Ms Andrienne Magee (Clerical Officer)

2:00 pm The meeting opened in public session.

3:22 pm The meeting went into closed session after the C&AG's initial remarks.

8. Issues Arising from the Oral Evidence Session on 'The Safety of Services provided by Health and Social Care Trusts'

The Committee considered an issues paper relating to the previous week's evidence session.

[EXTRACT]

Wednesday, 30 January 2013
Room 144, Parliament Buildings

Present: Mr John Dallat (Deputy Chairperson)
Mr Sydney Anderson
Mr Trevor Clarke
Mr Michael Copeland
Mr Paul Girvan
Mr Ross Hussey
Mr Daithí McKay
Mr Mitchel McLaughlin
Mr Adrian McQuillan
Mr Seán Rogers

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Miss Maria Magennis (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Ms Michaela Boyle (Chairperson)

2:03 pm The meeting opened in public session.

2:07 pm The meeting went into closed session.

2:07 pm Mr McKay left the meeting.

4. Issues Paper on 'The Safety of Services Provided by Health and Social Care Trusts'

Correspondence from the Department of Health, Social Services and Public Safety

The Committee noted correspondence from Dr Andrew McCormick, Accounting Officer, Department of Health, Social Services and Public Safety providing the information sought by it following its evidence session on 14 November.

2:15 pm Mr McKay entered the meeting.

Agreed: Following consideration of an issues paper reflecting the additional information the Committee agreed the outline of its draft report.

[EXTRACT]

Wednesday, 27 February 2013
Room 29, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr John Dallat (Deputy Chairperson)
Mr Paul Girvan
Mr Daithí McKay
Mr Mitchel McLaughlin
Mr Adrian McQuillan
Mr Seán Rogers

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Miss Maria Magennis (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Mr Trevor Clarke
Mr Michael Copeland
Mr Sammy Douglas
Mr Ross Hussey

2:04 pm The meeting opened in public session.

2:25 pm The meeting went into closed session after the C&AG's initial remarks.

6. Consideration of Draft Committee Report on 'The Safety of Services Provided by Health and Social Care Trusts'

The Committee considered its draft report on 'The Safety of Services Provided by Health and Social Care Trusts'.

Paragraphs 1 - 34 read and agreed.

Paragraph 35 - 36 read, amended and agreed.

Paragraphs 37 – 41 read and agreed.

Paragraph 42 read, amended and agreed.

Paragraphs 43 – 52 read and agreed.

Paragraphs 53 read, amended and agreed.

Insertion of a recommendation agreed.

Paragraphs 54 – 58 read and agreed.

Appendix 1 read, and agreed.

Consideration of the Executive Summary

Paragraph 1 – 13 read and agreed as per the main report.

Agreed: The Committee agreed the correspondence to be included within the report.

Agreed: The Committee ordered the report to be printed.

[EXTRACT]

Northern Ireland Assembly

Appendix 2

Minutes of Evidence

14 November 2012

Members present for all or part of the proceedings:

Mr John Dallat (Deputy Chairperson)
Mr Sydney Anderson
Mr Trevor Clarke
Mr Michael Copeland
Mr Paul Girvan
Mr Mitchel McLaughlin
Mr Sean Rogers

Witnesses:

Dr Andrew McCormick	*Department of Health, Social Services and Public Safety*
Ms Julie Thompson	
Dr Paddy Woods	

In attendance:

Mr Kieran Donnelly	*Comptroller and Auditor General*
Ms Fiona Hamill	*Treasury Officer of Accounts*

1. **The Deputy Chairperson**: Today we are considering the Comptroller and Auditor General's report on the safety of services provided by health and social care trusts. Does any member wish to express an interest?

2. **Mr Anderson**: I have a family member who works in Health and Social Care (HSC).

3. **The Deputy Chairperson**: Dr Andrew McCormick, accounting officer for the Department of Health, Social Services and Public Safety (DHSSPS), is here to respond to the Committee today. Dr McCormick, you are very welcome. Please introduce your team.

4. **Dr Andrew McCormick (Department of Health, Social Services and Public Safety)**: Thank you, Chairman. With me this afternoon are Paddy Woods, deputy chief medical officer, and Julie Thompson, senior finance director.

5. **The Deputy Chairperson**: Thank you. Given that the Audit Office report covers a wide area, I would be grateful if the witnesses could ensure that any responses are succinct. I repeat: succinct. Dr McCormick, I understand that you wish to make some introductory comments.

6. **Dr McCormick**: Thank you for the opportunity, Chairman. This is a very interesting and important topic, and we give top priority and attention to it all the time. If I may, I will just make one or two comments to set the scene and draw out the context.

7. The oversight of safety is a fundamental responsibility for me as accounting officer and for the accountable officers in each of the organisations, primarily the trusts, and it is the top issue on which we engage. We expect to be able to provide, and patients readily expect that they will get, the best possible care, and that that will be safe. However, as I have said before in this room in evidence sessions to the Health Committee, the best health systems, the best hospitals and the best doctors in the world have avoidable deaths, and the health service in Northern Ireland is not an exception. The key question for us all is how to minimise and manage risk to patients while still providing risky treatments.

8. Professor Cyril Chantler said:

"Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous."

9. That is a very good thing, because medicine is much more effective than it used to be. However, it involves expecting professionals to undertake procedures, to carry out activities and to manage a whole range of things that are inherently risky. The question then is how to minimise and manage that risk. We need to make sure that we have the best possible organisational leadership, strong governance systems, good policies and processes, a good work environment and good communication.

We need to measure and handle the complexity of work. We need to do all those things while ensuring that we maximise the knowledge, skills and motivation of staff. Clinical governance is the top corporate responsibility of each and every HSC organisation, and each chief executive is personally responsible to me for clinical governance.

10. We have a range of research on how unintended harm and unnecessary death arise in the worst cases. Most of the time, it is a result of a combination of circumstances in a system rather than the failings of an individual. Patient safety demands that we design effective systems. We need to minimise the risk of a single mistake or error — we are all human — leading to a bad outcome. We have undertaken a range of initiatives, going back to Best Practice, Best Care in 2002. In 2006, there was a framework for sustainable improvement in health and personal social services called Safety First. We have had a regular series of reports on the learning arising from serious adverse incidents (SAIs). Most recently, and very importantly, in November 2011, there was the publication of 'Quality 2020', which is a strategy designed to ensure that we do everything possible to promote quality and safety across the system.

11. However, we are not complacent, and we cannot possibly afford to be. What we have to do is create and nurture a learning culture and a systems approach. We need to ensure that our accountability is fair but not punitive. So, balancing the culture is very important. We need proper individual accountability, so that if an individual is not performing or does something that is outside the standard of professional practice, their professional regulator will act on that. That has to be part of what happens. However, the wider context is more complex and subtle, as I am sure will come out more fully in the questioning.

12. I hope that that was helpful by way of setting the scene.

13. **The Deputy Chairperson**: Thank you, Dr McCormick. I am sure that members will want to develop those themes. In turn, members will be putting their own questions, and I am sure they will want to pick up on some of the things you said.

14. I will begin along the lines of your introductory remarks. High-profile cases of patient harm strongly influence our views of the health and safety and social care services, but the report shows that the problem goes far beyond the headlines. Paragraph 1.5 of the report refers to the fact that 83,000 adverse incidents are reported each year. The truth is that we still know far too little about how often patients are being harmed by hospital treatment. Would you like to comment on that?

15. **Dr McCormick**: I understand and accept that we need to do further work to improve the information systems. To put that number of 83,000 in context, there are 2·8 million interactions a year between the service and individual patients, so the vast majority of what happens in the service is safe and effective. We are clear that we have a good information base that we have developed in relation to the more serious aspects of the things that go wrong. So the process for serious adverse incidents is clear and good. We are developing, and will introduce next year, the fully fledged system for bringing together, at regional level, all the information on learning from all adverse incidents. To complete that into 2014 will be a very important step, and that will place us, as a small, relatively simple region, ahead of other jurisdictions in the information that we will have. We accept that there is more to be done, and that will improve the handling and understanding of information. The whole essence of this is to learn from what goes wrong and make sure that we act to minimise recurrence. The hardest thing to defend is the same thing going wrong again, so we have to learn from the things that go wrong. We have a good system for learning from the serious incidents, and we are working further to improve that. That is part of the priority that we are giving to the issue.

16. **The Deputy Chairperson**: Dr McCormick, in your introductory remarks, you made reference to Safety First, from 2006. The Department was before the Public Accounts Committee 10 years ago, and we had loads of promises. Today, you have an opportunity to demonstrate that patients in Health and Social Care are safer than they were when you previously reported 10 years ago. How can you do that?

17. **Dr McCormick**: It is important to say that we have made a range of particular interventions to improve safety. It needs to be put in the context of the fact that medicine has changed in that period, so there are things that are done now that would not have been possible 10 years ago. They are well worth doing because they can extend life or improve quality of life in a very significant way, but that may mean that there are more things going wrong because more risky things are being undertaken. The key point far beyond any increase in such incidents is the increase in benefit. I would focus on the increase in the benefit of a better and improving healthcare system to patients, clients and the public in Northern Ireland. That is worldwide, of course. We are following through with applying innovations that are developed across the world, including here, and making sure that those are available, so that we have an improving standard of care and significant research-based interventions that improve safety. I can give details on that. However, we are still seeing a level of adverse and serious adverse incidents. At one level, it is inevitable that there will be some. Our job is to minimise them and to make sure that we learn from them.

18. **The Deputy Chairperson**: At this stage, two members, Trevor Clarke and Michael Copeland, have indicated their intention to ask questions.

19. **Mr Clarke**: You covered my question, sorry. That is OK.

20. **Mr Copeland**: You are very welcome, Andrew. I would like clarification. Are the 83,000 adverse incidents that the Chair referred to only adverse incidents that occurred within health service facilities, involving health service staff? A tremendous number of procedures are carried out in private clinics, paid for by the health service and, in some cases, using health service staff. Is the 83,000 the total number of adverse incidents concerning anyone receiving medical treatment? Or is there another figure paid for by the public, but outside that remit?

21. **Dr McCormick**: It embraces all activities that are the responsibility of the public sector. Even if it is carried out on behalf of the public sector by an independent sector provider, if it is contracted in that way, it will be covered by the statistics and will be required to be reported. Certainly, a significant proportion of the 83,000 come from the independent care home sector, and those are reported through the Regulation and Quality Improvement Authority (RQIA) as part of its functions. We would not pick up incidents in which an individual has sought private service, without that being within the governance of the public sector.

22. **Mr Copeland**: Is the public purse indemnified from claims arising from a procedure that has been carried out on behalf of, but not by, the health service?

23. **Dr McCormick**: The contracts that are drawn up with independent sector providers include provision to ensure that there is a proper handling of risk. Julie has the details in front of her. The model contract that we have with independent sector providers who are, say, undertaking a waiting list initiative or whatever, provides for the proper handling of the risk.

24. **Ms Julie Thompson (Department of Health, Social Services and Public Safety)**: They have to ensure that they cover the cost of that within their own arrangements. That is part of the standard contract arrangements that we have with the independent sector for clinical negligence claims, for example.

25. **Mr Copeland**: That is the potential cost of settlement of claims.

26. **Ms Thompson**: Yes, that it has to cover effectively.

27. **Mr Copeland**: That is not included in the figures that we have for those that are settled by the health service.

28. **Dr McCormick**: By definition, that will be excluded.

29. **Mr Clarke**: Dr McCormick, you said that a big proportion of the 83,000 relate to the independent sector. It is easy for us to accept that, but we have no evidence of it. Can you give us the figures that indicate that?

30. **Dr McCormick**: We can provide a breakdown of the figures per trust.

31. **Mr Clarke**: Proportionally, then, in the numbers that were referred in the independent sector versus the number that turned into actual negligence claims, as opposed to the number that you process yourselves versus actual claims. Even without looking at those figures, the proportion probably suggests that there is a bigger possibility of a claim against you than against an independent. I will stand corrected if you can provide me with evidence that proves otherwise.

32. **Dr McCormick**: I am not sure how much detail is available. We will give the Committee a breakdown of what is available. Of the 83,000, nearly 13,000 were reported by RQIA. My understanding is that the majority of those are from the independent care home sector. There are very limited independent hospital services in Northern Ireland. The majority of independent sector activity is in social care, nursing homes and residential care.

33. **Mr Clarke**: You referred to Northern Ireland. We are all aware of the pressures here in Northern Ireland, but some of this carries outside Northern Ireland. Let us not exclude that from the figures that you present to us. We are all aware that people travel to Dublin, Cardiff and other places for specialist surgery. Let us look at the broader picture. That is all part of the work that you have contracted out and part of the statistics. You made what I thought was a bit of a loose comment in your first response to Michael when, without coming armed with the evidence, you suggested that the figures might be higher proportionately.

34. **Dr McCormick**: I did not intend to imply that. I am sorry. I did not mean to convey that.

35. **The Deputy Chairperson**: Let us develop the theme a little bit. Members may be keen to ask about their own individual cases, but please do not do that.

36. Paragraph 3.5 mentions arrangements for promoting regional learning from serious adverse incidents through various patient safety reports. Dr McCormick, you will know that people are much more interested in how their local trust is performing. I am sure that you would agree with that. I am sure that you would also agree with the Committee that the public have a right to know how their local trust compares to other trusts in respect of patient safety. Do you accept that?

37. **Dr McCormick**: Yes.

38. **The Deputy Chairperson**: What steps have you taken to ensure that someone reading HSC patient safety reports can easily compare performance across different trusts and specialities?

39. **Dr McCormick**: It is important that there is an understanding of the context facing each individual organisation. That will vary between the organisations because of their different functions. We have available, and can provide for the Committee, a fuller breakdown of the incidence of serious adverse incidents by trust.

40. It is important to recognise that the trusts are unified organisations. Although they provide services on individual sites, they are coherent and unified organisations with medical staffing organised in networks. There is a mutual dependency between, for example, a larger hospital and a smaller hospital. Look at the relationship between, for example, Craigavon

hospital and Daisy Hill. They both have their particular staff present on site, but they also have an inherent and well-planned mutual dependency. It is important to focus only on information at trust level, and we can provide that. We have details of, and can answer questions on, the incidence of adverse incidents across the six trusts, if you include the Ambulance Service as a regional organisation. We can talk about that.

41. It is important to recognise that there are also important differences in context and the mix of services that are provided. By no means all, but many of the regional specialities are provided in the Belfast Trust. Those are often higher risk. It is important to recognise that if a hospital is providing higher-risk services, there might be a larger incidence of adverse incidents. That does not mean that the standard of care is lower. On the contrary, it might well be evidence that the standard of care is higher because that is where the specialist staff are available to take on the more difficult, more serious cases.

42. So, it is very important to look at this in context. However, I accept entirely that there is great local interest. It is important that there is confidence throughout the community that all services are as safe as they can be. I am very clear from all my dealings with the trusts that they accept the statutory obligation to provide safe services and that where there is a risk to that, we hear about it and act on it.

43. **The Deputy Chairperson**: Dr McCormick, I could not agree more. Indeed, you have encouraged me to ask a question that is not in the script. You will be aware that, recently, one man died in the A&E department of one of the Belfast hospitals. When a so-called independent team was set up to inquire into that, it was made up of members of the other trusts. Is that something that you would want to look at in the future when trying to rebuild confidence among members of the public?

44. **Dr McCormick**: It is very important for confidence that every part of the service is subject to scrutiny and accountability that is open and transparent. Good practice says that it is very important that an investigation of something that has gone wrong involves peers in Northern Ireland or, in more complex cases, experts from outside this jurisdiction. That shows a clear attitude among the leadership teams that people are in this business to learn from what goes wrong, identify the learning points and apply those conscientiously and systematically. I agree entirely with you that there should be that independent scrutiny.

45. **The Deputy Chairperson**: That is very important for the record. We appreciate your honesty on that.

46. **Mr Clarke**: Thanks for your indulgence again, Deputy Chairperson. In response to one of your earlier points, Dr McCormick, a bit like the Comptroller and Auditor General last week, was fairly defensive of the Belfast Trust, given it is accepted that it deals with more complex cases.

47. Dr McCormick, what information did you provide to the Audit Office on the level of these cases and the nature of the complaints? It is easy to lift this report and suggest that the Belfast Trust looks the worst. It is easy to make a defence that they deal with the most complex cases. However, there is nothing in here to convince me that these may not have been routine operations or procedures. There is nothing here to convince me that we are talking about complex cases. What information did you offer the Audit Office in relation to the nature of the cases that are referred to in the report?

48. **Dr McCormick**: That is an inherently complex point. I am very willing to engage further if there is further information that we can provide. We sought to bring to the Audit Office, as part of its development of the report, the relevant and available information. There is plenty of detail available on each of the individual cases. There is a record

in relation to each SAI, for example. Going through those exhaustively and undertaking an analytical scrutiny of the context in which they arose is at the heart of your point, and it is a very important point. Is more going wrong in complex areas of work, or are there too many things going wrong in relatively straightforward and routine contexts? We do need to get to that.

49. **Mr Clarke**: I appreciate that the Audit Office can work on the information only in numbers but not in detail. If you are taking this seriously, as you said you were in your opening remarks, you are bound to appreciate how difficult it is for us to accept this, even with respect to your answer, as did the Audit Office last week, when it suggested — possibly in your defence — that the Belfast Trust deals with the complex cases. However, there is nothing here that is evidence of that.

50. We listened to the media last week — thankfully it was not in Northern Ireland — and heard about a practitioner who was involved in many cases. If there are numbers of opportunities to do something when there have been complaints against an individual or individuals, something should be done. We should not just rest on the fact that they are working in a complex area or on complex cases, and that that is acceptable. To my mind, it is not acceptable. We saw evidence last week in the media, when someone was disciplined on the mainland.

51. I think that we need to have more drilling down on the figures. We see 35% in the Belfast Trust, but that is all it is telling us. It does not actually tell us what areas are involved. Indeed, reading the report regarding any of the trust areas, it does not tell me whether there are repeat cases or whether the same individuals are involved, and it does not tell me whether there is a pattern. I think we need to get more information in order to drill down into this in further detail.

52. **Dr McCormick**: I am happy to engage in that. It is a very important line of thinking. What I can point to is that we are seeking to learn from each case, and that many cases lead to particular follow-up by way of learning letters. An overview is then taken by the HSC Board, which is the manager of the SAI process. It looks for common themes coming out of the series of incidents that it is looking at.

53. We have details of the learning communications that have been issued in relation to safety and quality, which I can provide to the Committee. Several times a year, messages are sent out as issues arise, either within this jurisdiction or elsewhere, when something needs to be communicated. It is hard to use statistics to generalise.

54. The most important thing is to understand what has happened on a case-by-case basis, what underlay that, and, where we can, take corrective attention and draw it to the attention of those working in the particular field affected. Some themes are very general. For example, we have intervened in relation to how to assess a patient who might be deteriorating. If someone is deteriorating, and that is not noticed quickly enough, intervention might not be made in time to save them. We have had a number of cases of that nature in the past. So, we have early warning systems and systematic ways in which vital signs are monitored to ensure that intervention happens in time. Those are ways of learning lessons, and that draws out the point.

55. **Mr Clarke**: The only difficulty I have is that although that is a good sound bite as regards what you are trying to do, statistics — and statistics are all that we have here — show that over the past number of years, there has been no evidence of improvement. Although the sound bite concerns what you want to do to improve the service, the statistics do not back up what you are saying. I stand to be convinced about what your Department is doing to improve things because, statistically, there is no improvement.

56. **Dr McCormick**: Indeed. I have to acknowledge that. We have not yet touched on the level of reporting, although I am sure the point is coming. Several variables affect the total number of incidents reported. There is the actual level of harm happening and then there is the propensity to report, which varies. We know that this is a cause for concern and we cannot be complacent about it. We have to encourage a context in which every member of staff, families and individuals can feel free to challenge. That has to be the culture. In that context, some rise in the number of incidents could include some improvement in reporting, which would be a good thing. It is possible that we could have a steady or improving level of actual patient safety but with more incidents coming through. I am speaking hypothetically. I am not saying that that is the case. Our focus has to be on prevention. Once an incident has happened, it is vital to learn from it. The really important thing to do is maximise prevention.

57. **Mr Clarke**: The danger with that is that we have all been involved with the district policing partnerships, and we know how incidents are reported. In the past, when we saw a rise in crime, the police told us that it was due to more people reporting crimes. I am afraid of coming back here in a couple of years time and the health trusts saying that the reason there has been an increase is because they made it easier for people to report the problems. That is not drilling down to find the root of the problems. From sitting on the district policing partnerships, we all know that when there is a spike in crime the standard response from the senior civil servants involved is that it is because more people are reporting crimes.

58. **Dr McCormick**: I am not going to argue with that. It is a potential point; I will not make it more strongly.

59. **The Deputy Chairperson**: At this stage, I feel the need to remind myself, the witnesses and members of my opening remarks. We have to be succinct. It is a long report, and we have to get through it in reasonable time.

60. Moving on conveniently, the Audit Office approached the Royal College of Nursing (RCN) about its views. That was very important, because all of us agree that nursing staff are the backbone of any hospital or institution and that their views are very important. Turning to paragraph 3.14 of the report, I was shocked at the response from the RCN. The report states:

"While it assured us that Northern Ireland nurses are fully aware of their professional responsibility to raise concerns about patient safety and standards of care, it told us that, in its view, there remains a certain level of reluctance about raising concerns among nursing staff."

61. This is very serious, coming as it does from a prestigious organisation, the RCN. How do you intend to address that, Dr McCormick?

62. **Dr McCormick**: I share the concern about those remarks and I recognise that they are very serious. We will do all that is possible to promote a culture in which every individual feels free to raise concerns, and is protected and supported. Clinical governance is all about empowering every individual to speak up, challenge and share in the responsibility for patient safety. The Minister issued a circular to all staff throughout the health and social care system earlier this year. The substance of the letter was about whistle-blowing, but the first section said that whistle-blowing should not be necessary if the leadership in every organisation creates and promotes a culture in which everyone can challenge everyone else.

63. I react with considerable concern to what has been reported. It is important to emphasise the professional responsibility that everyone has to act in a way that promotes patient safety. I undertake to continue to convey the message to my chief executive colleagues that that has to be the culture that we promote.

64. **The Deputy Chairperson**: Dr McCormick, I am glad that you mentioned the word "culture" because there is a culture that does not encourage such behaviour. The general public and those who use the health service will judge you by your actions. Have you met representatives of the RCN?

65. **Dr McCormick**: I meet them regularly. I have not had —

66. **The Deputy Chairperson**: I am sorry, my question was very specific. Have you met representatives of the RCN in relation to the reluctance of their staff to assist you in identifying the serious problems in the health service, namely the 83,000 adverse incidents that we talked about earlier?

67. **Dr McCormick**: I have not had that specific meeting but I will do so. My colleagues in the Department have discussed the issue with RCN representatives. I need to follow through on that and I undertake to do so.

68. **The Deputy Chairperson**: Appendix 2 of the report provides a summary of the action taken by the Department on the recommendations in its 2002 report. The fourth recommendation refers to the need to be proactive to reduce the projected future costs of negligence cases. The Department responded by advising HSC bodies that patients affected by an adverse incident are less likely to sue when they are provided with an expression of sympathy and a full and factual explanation and, if appropriate, offered early corrective treatment. That is, in fact, good practice globally. Dr McCormick, did the Department follow up with the HSC bodies to establish whether the policy had been adopted?

69. **Dr McCormick**: We have regular engagement with the service on that. We probably need to do further follow-up as a result of this hearing to ensure that further evidence is produced of fulfilment of the undertakings given by the Department to the Committee and, in turn, by the trusts to us. They have responded acknowledging that it is the right thing to do, but we recognise and understand that further assurance is required regularly. It is not sufficient for this to be a one-off exercise following 2002. It has to be regular and consistent on a daily basis to pursue that point.

70. **The Deputy Chairperson**: Which HSC bodies did not adopt the policy?

71. **Dr McCormick**: I am not aware of any of them not adopting the policy as such. Undoubtedly, there will be some variation in performance against it and the extent to which it has been fully delivered, but I need to pursue that further and secure some further evidence for you on that point.

72. **The Deputy Chairperson**: We may return to that. No doubt, members will be aware from their constituency work of individual cases in which the standards of care have not lived up to what was expected.

73. **I repeat what I said earlier**: I ask members to keep their supplementary questions brief and clear. I will be keeping an eye on the time today, and I want everyone to remain focused. I have no doubt that they will. The first member is Paul Girvan.

74. **Mr Girvan**: I will let Mr Anderson ask his question.

75. **Mr Anderson**: I thank my colleague for allowing me to ask my question at this stage as I have another meeting to attend. Thank you for coming along. There are many very important issues, and some of them have been drawn out and debated in the initial questioning. My colleague Trevor touched on reporting. In paragraph 3.10, attention is drawn to the low level of adverse incidents reported in the acute sector. However, paragraph 4.5 states that 60% of complaints each year relate to the acute sector, most of which concern poor quality of care or treatment, staff attitude or the quality of communication. Typically, what redress is offered to a patient or client whose complaint is upheld?

76. **Dr McCormick**: There is a very clear procedure for handling complaints, and as the Venn diagram in the report draws out, not every complaint turns into a claim for compensation. The approach that we have taken in revising the complaints procedure over the past few years is to promote the maximum effort by each organisation to engage with the person who feels aggrieved and feels that they have not been provided with the appropriate standard of care at an early stage, to offer discussion, explanation and, where appropriate, an apology and to do those things straightforwardly and easily at local level. There should not be any reluctance or defensiveness, and the system should be very human in facing up to the fact that people will be in distress for one reason or another. They should receive a compassionate and caring response. The complaints procedure talks about local resolution being the first and best way forward.

77. We then have, as a second stage, the availability of access to the ombudsman. The ombudsman takes us to task firmly and fairly on a range of issues and will, at times, require action to be taken, including some financial redress on his recommendation. That is certainly part and parcel of how things work, and it is entirely appropriate. It is also fully provided for in our complaints procedure. Should the person affected still feel that they have further issues to pursue, they are not precluded from taking forward a claim for compensation through the courts. We want those procedures to be applied fairly and humanely, with genuine humanity and compassion throughout the process. That is vital, because we recognise that the system can appear intimidating. It is an enormous and complex system, and it can be forbiddingly technical. So it is very important that it is reduced to a straightforward engagement at a human level.

78. **Mr Anderson**: You kept saying "should" throughout your answer. I think that it should be "must". I do not know whether that is the case, so perhaps you can tell us.

79. **Dr McCormick**: It is what is expected. It is the only right thing that can be done. I regularly meet the chief executive of the Patient and Client Council (PCC) and the chief executive of the RQIA and I listen to what they are saying, because their job is to understand what is going in the system and bring to light what should be and must be applied that is not being applied.

80. If there is a consistent pattern of complaints or evidence emerging from inspections or reviews undertaken by the RQIA, I need to understand that and speak, as appropriate, to the chief executives of the organisations, be they the trusts or whoever else, and say, "I am hearing that things are not going as they should. That needs to change." We have regular accountability discussions with all the organisations that are accountable to the Department. That is routine, and we make sure that that agenda provides for any appropriate or necessary challenge to the patient experience and the quality and standard of care. I accept what you say: these things must be applied. If there is a departure from the acceptable standard, we need to draw together the evidence and intervene and act on that. That is part of our responsibility, and it is what we do.

81. **Mr Anderson**: So why are there 60%? Do you agree that the standards are not being applied, given the high level of 60% in acute cases?

82. **Dr McCormick**: It is understandable that acute services have a higher incidence of complex and risky activities and there is, therefore, more risk of something going wrong. Also, there is the risk that, in the heat of that context, something inappropriate might be said or done. So I would not say that I am surprised that 60% of the complaints are in the acute sector. That is reasonably understandable. It means that we need to make sure that the attitudes and standards of care in that sector

are given particular and consistent attention.

83. **Mr Anderson**: That being so, if 60% is understandable, what percentage do you think is — for want of a better word — acceptable? We are trying to get to zero, but what, to your mind, is acceptable?

84. **Dr McCormick**: I think that the objective is to get to a place in which the number of complaints, in absolute terms, is reduced. If the proportion from the acute sector were lower, that would imply that the proportion from some other sector was increasing, which would be no more acceptable. What we have to focus on is seeking to improve the standard of care that is being provided and reduce the risk or probability of something happening that gives rise to a complaint. So, we have to bear down on the issues. Therefore, the focus of our attention is on raising standards, promoting good practice and sharing evidence of how to do things effectively in order to ensure that time is available for the kind of explanation that helps people to have confidence that they are receiving the best possible care. So, there is a range of things that we can do. However, it is difficult to get at that percentage, to be honest.

85. **Mr Anderson**: What is that range of things?

86. **Dr McCormick**: It is promoting the application of good professional standards, ensuring that people are trained regularly in both the specifics of their clinical responsibilities and with regard to patient experience, and every other aspect of care. So, promoting good practice is the best thing that we can do in this context.

87. **Mr Anderson**: The Chair referred to something 10 years ago, before my time, which, probably, has not been acted upon. So, we are still looking for action in many areas and on many points in order to make inroads into this matter and reduce the number of complaints.

88. **Dr McCormick**: We always will be. In a service provided by 60,000 to 70,000 individuals, there is a continual turnover of staff. We know the right message to get across and the right leadership to apply. However, it has to be applied continuously. Realistically, we can never expect to reach the stage where the problem is solved. It requires continuous attention, refreshing of training and drawing out of new good practice as it emerges.

89. **Mr Anderson**: Are we getting that? Are we doing that?

90. **Dr McCormick**: Sorry: an immense effort goes into that. Generally, a very high standard of service is being provided. We are looking at a number of complaints and adverse incidents. Those are to be regretted. We are not at all complacent about the fact that they happen. To eliminate them completely would be unrealistic because there is an element of human error that arises. We have to simply ensure that there is consistent and steady leadership, so that —

91. **Mr Anderson**: So, how long has that been going on? You say that it is continuous. Has that procedure been continuous since 10, five or two years ago or is it beginning now?

92. **Dr McCormick**: The general effort to provide a high standard of care has been inherent in the health service since its inception. Part of what is happening is that there is more systematic awareness of the issues and, therefore, more responsibility on us as a leadership team to apply and promote good practice. Many features of that would have come to light in the past 10 years. There is no doubt that, in the next 10 years, there will be further things that could and should be done. We will have to pursue that. That will be an ongoing responsibility. I do not think that we can expect it ever to be solved completely unless we could have care provided by perfect people.

93. **Mr Anderson**: It could get a lot better.

94. **Dr McCormick**: Yes. I agree. That is our aspiration and determination.

95. **The Deputy Chairperson**: I will bring in Trevor Clarke in a second. Sydney Anderson, it is interesting that you said that it was before your time. It was not before my time, sadly.

96. Dr McCormick, we have heard all of this before. We have had all the promises before. Is there a monitoring system in place that quickly identifies where the clusters of complaints come from? What kind of early action can you promise the Committee that you will take to ensure that we do not have 83,000 complaints in 10 years' time, when I certainly will not be here? I think that anyone who listens to this today will be looking for answers. We have had the standard-issue promises. We get them from other accounting officers as well. The Health Department has been here before, 10 years ago. You had your own report in 2006. Really, you have failed. Today, you need to put on record what has changed because the media has not been good to you in the past year. There have been too many front-page stories, and we really need to know what system is in place to identify the problem hospitals and institutions and what action you can take to stop this immediately and not when the next Audit Office report comes out.

97. **Dr McCormick**: The things that are happening continuously include the clear monitoring of complaints and adverse incidents in each trust. So, there is a significant role for the board and the non-executive directors. Most trusts have a committee, which is chaired by a non-executive director, and which draws together information, challenges the leadership team in the organisation and asks why certain things are happening. The committee will have information along the lines you are describing; that is, where the clusters and patterns are. Individuals in each organisation are responsible for drawing that information together, understanding it and interpreting it. So, that is the first line of defence. The first responsibility has to be within each organisation, and they are accountable to me in fulfilling that responsibility.

98. The second line of defence is through the PCC, which is an individual organisation responsible, as the name suggests, for assisting patients and clients. If they are not getting satisfaction from a trust or a provider organisation, they can seek and receive assistance. Part of that facilitates the joining together of information by the PCC about the pattern of complaints or things that are causing problems or are going wrong. The PCC has direct access to the Department, which is why I meet its chief executive regularly to hear and understand what is going on. I can then use my authority, which comes from you, of course, as I am accountable to you. Therefore, I am accountable to you, and they are accountable to me: that is how it works. As I am vulnerable to criticism and challenge from you, I then say to the trusts, as accountable officer, that they must answer to me to secure improvement.

99. We have a process of accountability that is being developed and refined continuously to make sure that we are delivering. However, I am not going to promise that I can eliminate adverse incidents. That would be an unfair and unrealistic promise to make. What I can promise is that we will do everything in our power to promote patient safety, good practice, and improvement.

100. However, it needs to be accepted and recognised that there is inherent risk: medicine is risky. The only way to reduce the number of incidents of this nature is to stop intervening and let people die of their conditions. If someone dies without medical intervention, it would not be deemed to be an adverse incident, but it would be a very wrong thing to happen. We have a responsibility to intervene and to take risks. I recognise that we have a challenge in the context of the media reporting what we do, but I have no complaint about that. We need to make sure that there is support for people in the clinical teams who say to themselves, "If I do this, I am taking a risk and it might go wrong, but I am going to do it." We need people who are prepared to do that. I was talking

to a team this morning, and they know that in one in 100 cases, one of their patients will die. However, I need them to keep doing what they are doing, because we need the 99 other patients to do better than they would otherwise. That is a risk that society has to live with. There will always be adverse incidents; there will always be serious adverse incidents, and there will always be avoidable deaths. It would be wrong of me to promise otherwise.

101. **The Deputy Chairperson**: You referred to the media. In recent times, we have learned that even the media cannot escape responsibility, which we have seen in the case of the BBC. People are asking at what stage those in the health service will take responsibility. When will the heads roll when things systematically fail?

102. **Dr McCormick**: As you say, it would be if and when things systematically fail. It is clear that if there is a pattern in which the same thing goes wrong time and again, that would require a more serious level of intervention and accountability, and there are clear responses to that.

103. **Mr Clarke**: This is probably a good time for me to come in. You have left me a nice opening. In response to what you said, Dr McCormick, about us holding you to account, I am actually the new boy here — I am the youngest. We talked about a couple of dinosaurs a few minutes ago.

104. **The Deputy Chairperson**: Youngest?

105. **Mr Clarke**: I am the youngest here, and probably have the least experience, but when I read about you, I found out that you have been in post for seven years. I think I have a job to do to hold you to account, and I think that, in seven years, you have failed. To my colleague, you used the words "defensive" and "intimidating", and the phrase "show compassion". During the five years I have been in this job, I have had many people coming in — and I am sure that my colleagues have had individuals coming in — referring to complaints about the health trusts. I suggest that every word you have used is continuing practice. I have always found the Department to be "defensive". I have seldom seen it "show compassion", but it is certainly "intimidating". Those were your words, and I think they were well chosen. I accept that there can be human error.

106. As regards the length of time that you have been in post, I would like to be back here in the future, but I would not like to be back with you sitting there and with no change made. If it has taken you seven years, and we are reading the report that the Audit Office has for us today, dear help us.

107. **Dr McCormick**: I am convinced that many things are safer now than they were seven years ago. Many things are being done that could not have been done seven years ago because medical science has advanced. I think that the statistic that is invisible is the improving benefit of the interventions throughout the health and social care system. To me, that vastly outweighs the level of harm. There is a level of harm that is inherently unavoidable, because we provide services through human beings. We can show a series of interventions on —

108. **Mr Clarke**: I think that that point is acceptable, but there are cases when it is not. To go back to your use of the word "defensive"; in many cases, if the Department put its hand up and said that it made a mistake, that would prevent complaints, but you continue to defend your position right up until the matter goes to court, which does not convince me that this is not leading to statistics increasing, and it will not correct the mistakes that have been made. We all accept that there is human error, but there is no excuse for defending something over a period of years, getting to court and then settling, with an admission that you were wrong. There is a culture of defensiveness in your Department, which has to change. There has to be an acceptance that you can make mistakes and you have to be more upfront in that acceptance to the

general public. Then, I do not think we would be talking about 83,000 cases.

109. **Dr McCormick**: I accept and agree entirely that the right approach we should be taking is to be open and transparent, to be responsive and to engage in a way that says that something has happened here, it should not have happened, we want to acknowledge mistakes and apologise upfront. That is there.

110. In preparation for this hearing, I have seen internal documents in one of the trusts that say exactly that. It is not always easy to promote the application of that behaviour throughout a big system, and I acknowledge that there have been strong degrees of defensiveness in the past, including up to the present. We need to continually work at that.

111. My undertaking to the Committee is that my message to the service is that it should be open, transparent, responsive and human. I have been seeking to do that over the past number of years. That is the consistent approach taken by the chief executive group that I lead. We have more to do. I recognise and accept that, but I am determined to go forward and continue to do it.

112. **The Deputy Chairperson**: Can we go back briefly to Sydney Anderson? Apologies. We all make mistakes. I forgot that you were asking the questions, Sydney.

113. **Mr Anderson**: This is an area in which many questions can be asked and should be asked. Paragraph 4.7 refers to patients' fear of reprisal if they complain, which is similar to the views expressed by some health and social care workers about reporting errors. We have heard many things here today about clinical governance, best possible patient care, minimising risk in a culture of making services as safe as can be achieved. We have had all the fancy words and phrases. However, the situation is not good when you have patients and staff in fear of making a complaint. How will you persuade individuals that health and social care organisations see complaints not as something to run away from but an opportunity to learn from?

114. **Dr McCormick**: The scenario that you described is totally unacceptable to me. Having a situation in which a patient or member of staff is afraid to speak up or to complain can never be tolerated and must be rooted out. I am convinced that no chief executive in Northern Ireland would tolerate such an attitude. We need to continue to reinforce that message persistently and to point to and publicise the fact that there is a complaints procedure that is designed to open the access door to trust management and, if needs be, to the ombudsman. There must be a welcoming and positive response throughout the culture of the organisations. I am happy to use your expressions of concern in this hearing to take that message to some speaking opportunities at health service management conferences next week, and I undertake to speak out. This issue matters immensely in ensuring that we learn from things that go wrong rather than suppress or oppose, which are completely wrong and unacceptable responses.

115. **Ms Thompson**: The report points out that the regional board reviewed the complaints process, and one of its recommendations was about how to deal with cultural issues across the service and, equally, how to increase user satisfaction. Those recommendations that have come through will need to be implemented, and it is planned to do so as we move forward. So, the two issues that you drew out were picked up as part of that regional learning on the complaints process and are to be improved on as we look forward.

116. **Mr Anderson**: I will be brief, Chair, because I know that there is a lot of work to be done here today. Would you say that the situation is improving? It was, or may still be, that management did, or does, not always listen to staff. If there was a fear culture; why? If there was a fear culture, it must have been

triggered by something that may go back to management. Is there a fear of reprisals? Was or is there something going on? Do you agree that such a culture was there and may still be there in places?

117. **Dr McCormick**: I detect the features of it. At times, organisations can tend to regard reputational damage as a bad thing. Part of our consistent engagement with the trusts at present is to say that the interest of the patient, the safety of the service provided and the patient's experience and human interaction come first and foremost, and well ahead of an organisation's reputation. Somebody can get very good care but have a bad experience, and we need to fix and sort out both aspects. I think that there is a commitment across the leadership team to achieve that.

118. However, at times, there has been a view that organisational reputation is important, which is unsurprising in that we create, and give responsibilities to, organisations that, at some time and on some level, inherently compete with one another. They want to be seen as being the best, and, therefore, bad news or negative stories can take away from that. So, there is a human element there, but the message from me to them has to be, and is, that it is the patient first. Nobody is reluctant to take that message on board. The leadership teams get that point.

119. **Mr Anderson**: The clear message going out from here today is that the culture needs to change. It is good to hear from Julie that in a few weeks' time, you will speak at a conference. So, the message must go out that things need to change.

120. **The Deputy Chairperson**: We are an hour into the meeting, and only one member has asked questions. I will move on to Mitchel McLaughlin, but before that Sean Rogers and Michael Copeland have supplementary questions to ask. I ask you to be brief.

121. **Mr Rogers**: In response to what the Deputy Chair said earlier, you said that there was clear monitoring of adverse incidents. However, looking at the report, a wide category of adverse incidents are not collected or analysed. There is a conflict between what you are saying and what is in the report.

122. **Dr McCormick**: We have an established and systematic approach to serious adverse incidents. They are compiled, handled and managed, and there is then appropriate follow-up to lessons learned at that level. Also, each organisation will look at the full range of adverse incidents and draw information together. That way of doing things is broadly in line with the practice in other parts of the UK. So, we are not out of line in that approach to handling the issue.

123. We have the plan to develop and introduce the regional adverse incident learning (RAIL) system to provide a more comprehensive regional and systematic drawing together of all kinds of adverse incidents. That is on track, it is planned and it is being worked through. That will complete the process of information handling in the best possible way.

124. **Mr Rogers**: You mention RAIL, which came out of recommendation 5 in the 2002 report. That was to facilitate improved learning and sharing of lessons for all adverse incidents, including near misses. Granted, it was for criminal negligence, but, like my colleagues across the table, I question the promise you are making now, because in 2002, an action was recommended, yet 10 years later we are still talking about it.

125. **Dr McCormick**: The direct follow-up to the 2002 report included the creation and implementation of the system to deal with serious adverse incidents. That way of doing things began in July 2004, so there was a period of scrutiny and consideration of how to do it, but there was direct action following the 2002 report. That was a very important step. As I said, our practice is broadly in line with that in other parts of the UK, so we are not behind the game in that sense.

126. When the RAIL system is introduced, we will have a smoother and more systematic handling of that information than anywhere else. So, at that stage, we will be better off. There was definitely an effective response when it came to drawing together information directly on the issue of clinical negligence, which is where the report and hearing in 2002 focused. However, we have undertaken systematic work to develop and apply handling and learning from serious adverse incidents. That system came into being in July 2004.

127. **Mr Rogers**: The 2002 report talks about all adverse incidents, including near misses. We still do not have a situation in which information on all adverse incidents is collected or analysed. I am looking at the bottom of page 47 of the report.

128. **Dr McCormick**: As regards the summary of the recommendation, mechanisms have been introduced to facilitate learning and the sharing of lessons learned. The term used in 2002 was, "adverse clinical incidents". The definition of "serious adverse incidents" was only introduced in our response of July 2004. So, we did make a genuine response.

129. I acknowledge that we had hoped that the RAIL system would have moved more quickly. We had certainly set in train the action to introduce it from around 2010. It is on track to come into being and to provide the full and complete response. We also have a genuine ability in each organisation to draw together the information from all incidents, including near misses.

130. **Dr Paddy Woods (Department of Health, Social Services and Public Safety)**: It is fair to say that there has been an incremental exercise, arising from 2002, mainly focused on clinical negligence cases. Some, all, or a limited number of them may result from serious adverse incidents. With the RAIL project, we will go beyond serious adverse incidents and include all adverse incidents, which will take us beyond arrangements in any other jurisdiction in the developed world. The preparation for that has been quite extensive, because we are breaking new ground.

131. As well as that, there were attempts in the mid-2000s to link up with the National Patient Safety Agency's (NPSA) national reporting and learning system, which ultimately proved fruitless and introduced delay. At that time, it was felt that that might be the optimal way of dealing with the problem.

132. **The Deputy Chairperson**: I have misled members. The supplementary questions were only supposed to relate to the issues arising from Sydney Anderson's questions. You will get your turn to ask your own questions.

133. **Mr Rogers**: My question was a direct result of the response to the question about the closer monitoring of adverse incidents.

134. **The Deputy Chairperson**: I accept that.

135. **Mr Copeland**: To the best of my memory, my supplementary question relates to Sydney's questions. You will probably want to reply to this in writing because it is a bit convoluted. You said that the processes that you are employing are "under continual improvement and review", which I accept. However, as the Deputy Chairperson said, the process goes back over 10 years. Would it be possible to get a chronology of the process of continual improvement and review so that we can assess how it is relevant to where we are now? There seem to be some quite serious questions around this issue. We are charged with asking those questions, but it is not fair to ask you to give that information off the top of your head, so I am quite happy to take a reply in writing, if that is satisfactory.

136. **Dr McCormick**: I am happy to do that, and I can give a brief summary of some of the main points, which we will develop more fully in writing.

137. Best Practice, Best Care was in 2002. In 2003, there was a major piece of legislation taken through the Health and Personal Social Services (Quality,

Improvement and Regulation) (Northern Ireland) Order 2003, which led to the creation of the RQIA as a statutory regulator and included a statutory duty of quality. So, entrenched in legislation is the obligation on every organisation to provide quality services; and, believe me, chief executives take that obligation very seriously.

138. The reporting system for SAIs came in 2004, Safety First was in 2006, as were the quality standards. In 2006, we developed links with various UK-wide organisations, including NPSA. We had the creation of the HSC safety forum in 2007. The further piece of legislation that took forward the RPA further entrenched the obligations on the promotion of health and well-being. We revised the complaints procedure in 2009. The initiation of the RAIL process kicked-off in 2010, and we had a quality strategy in 2011.

139. So, almost every year, there has been some specific initiative designed to improve the system and secure a focus and attention on patient safety. We can elaborate on that in writing.

140. **The Deputy Chairperson**: For the record, I accept that Sean Rogers' question did relate to that of Sydney Anderson.

141. **Mr Mitchel McLaughlin**: Good afternoon. It has almost been like waiting for an appointment to see —

142. **Dr McCormick**: Oh dear.

143. **Mr Mitchel McLaughlin**: Turning to paragraphs 1.11 and 1.12 of the report, they are very interesting in that they discuss 'Safety First: A Framework for Sustainable Improvement in the HPSS'. They set out how we can create an informed safety culture in our hospitals and identify four main components. I will not read out the paragraphs — I am sure you have read them — but the four main components of an informed safety culture they identify are a reporting culture, a just culture, a flexible culture and a learning culture.

144. The paragraphs go on to discuss separating the actions of individuals involved in adverse incidents by examining the systems approach and recognising that there might be a chain of events that leads to particular circumstances. As far as it goes, that seems to be a fair approach, expect that does not really discuss the role, if any, of the clients or patients. Do you accept that this approach, as described, is inward looking?

145. **Dr McCormick**: I take the point. Part of what we have focused on more recently is the recognition that engagement with individuals is a vital part of how we go forward. Our 2009 legislation and our further interventions since then have emphasised the responsibility of organisations to secure patient and public involvement. They need to have schemes that provide for engagement, consultation and an open and transparent context of working. It is a point that we accept and recognise —

146. **Mr Mitchel McLaughlin**: We are describing a seamless regional approach across all trust areas. They all take the same approach. When an adverse incident is reported, are clients or patients notified automatically? Is it possible that a patient or client could be involved in an adverse incident and never know?

147. **Dr Woods**: By definition, it is possible. It is certainly the case that in serious adverse incidents, there is a requirement to undertake a root-cause analysis of what gave rise to the incident. Intrinsic to that is the involvement of patients and their carers. That is a critical perspective in determining what happened and the course of events from all the perspectives relevant to the incident.

148. **Mr Mitchel McLaughlin**: That is quite interesting. It seems to indicate that there is a very conscious policy in other circumstances not to tell patients. Is that what you just told us?

149. **Dr McCormick**: No.

150. **Dr Woods**: No. I am saying that it is very conscious. First, there is a requirement

to undertake a root-cause analysis when there is a serious adverse incident, and —

151. **Mr Mitchel McLaughlin**: Yes, the informing and involvement of patients and clients in an investigation into a serious adverse incident is de rigueur. That seems to make it clear that a distinction is made, and as a matter of conscious policy, you would not always automatically inform patients or clients who were involved in an adverse incident that is not regarded as a serious adverse incident. In those cases, it seems that the policy is that it is not necessary to inform patients or clients. Who makes that judgement call?

152. **Dr McCormick**: The attitude and responsibility has to be to engage with patients. The reason why the answer is not black and white is because the range of things that are classified as adverse incidents is very wide. It includes aspects that would affect individuals, but it could also include aspects of the management and organisation of the trust, and so on. It may not be essential to communicate with patients in each and every case. It depends on the context and effect of what has happened, and something could happen that would not have any major consequence for an individual.

153. I think that it is fair enough to look at this in a sensible way. However, if there is any doubt or there could be any effect on an individual, the attitude and the culture has to be that there should be communication with patients as a matter of principle.

154. The 83,000 incidents are very diverse. There may be some evidence from internal trust documentation that shows the kind of message that is given by trusts to their staff on how to do those things. Julie may have that to hand.

155. **Ms Thompson**: That is picked up in our guidance to trusts, particularly on how they should deal with apologies and explanations. It advises that each trust should consider how and when to express sympathy, and if things go wrong, that they should provide as full and as factual an explanation as possible. That goes alongside looking at the correct treatments. It is then picked up in individual trust policies and is recommended and endorsed to staff that they should carry that through. The guidance is not prescriptive about the standard, style or level of an incident. It is a wide-ranging response to deal with patients and users appropriately.

156. **Mr Mitchel McLaughlin**: Thank you for that. Dr McCormick, you did not address the question of who makes the judgement call. I am trying to understand — I do not understand — the difference between a serious adverse incident and an adverse incident. Is there a written code or specification?

157. **Dr McCormick**: Yes.

158. **Mr Mitchel McLaughlin**: In this fair and just culture we are talking about, you are trying to encourage staff to report issues that go wrong so that you can learn lessons and address the level of incidents that occur.

159. Paragraph 1.12 describes the circumstances in which disciplinary action could follow. Clearly, that would be a disincentive for staff to report incidents. You have a policy that, as far as it goes, seems to be an acceptable approach, but I am concerned that if there are obvious shortcomings in it, why those have not been recognised and picked up. A patient could be involved in an adverse incident, and someone else will decide whether it is a serious adverse incident and whether the patient will be informed if they were unaware of it. That does not seem to follow through on the principles that underlie the Safety First policy.

160. **Dr McCormick**: I understand what you are saying. When a patient has been affected by something like that, the principle should be to inform as the norm. In many cases, patients will be very well aware of the incident, but if they are not aware that something nearly went wrong that might have hurt them, an open and transparent culture would mean sharing that with them. In many

cases, and if there were no serious impact, it may just involve telling them that no harm was done.

161. The decision about what an adverse incident is as opposed to a serious adverse incident is a matter of frequent and live debate at senior level. However, clear criteria are used and we can share those with the Committee. There is a clear responsibility on each organisation to deal with those incidents transparently, and if there is a pattern of reluctance to record incidents in the proper way in an organisation, we will take action. We have a lot of reporting and scrutiny, and incidents will emerge. There is no point in anyone trying to hold back and not classify something that meets the criteria, because, thankfully, we have a context in which there is a lot of openness and scrutiny. Again, I acknowledge the positive benefit from whistle-blowing and from some media reporting. That can be beneficial, and it should ensure that nobody can say, "I will not report that as a serious adverse incident because I will get away with it and nobody will ever know". Thankfully, most times, people do know, and, specifically, we will take action against an organisation if a pattern of under-reporting emerges. We require organisations to be transparent, and that includes, as we have drawn out, the principle and obligation to be direct and frank with individuals. I am not saying that we are at a place where that is fully achieved, but our determination is that this is the right culture and the only culture that we will promote and tolerate.

162. **Mr Mitchel McLaughlin**: We will move on to paragraphs 1.16 and 1.17. They tell us that the actual scale of harm caused to patients and the true cost of that harm are unknown and talk about research in England that demonstrates that around 10% of patients treated are likely to suffer harm and that half of those incidents should have been avoidable. That rate of damage or harm would not be tolerated in the nuclear industry, and we are talking about the health service. If we cannot get the accurate data, and you tell me that there is a reporting culture and lots of information is gathered, how will we manage to deliver on the safety programme?

163. **Dr McCormick**: The correct response to that is to identify evidence-based understanding of scope to make improvement and to require organisations to apply evidence-based good practice. That is part of the general approach that we take to working with the organisations, and a lot of that comes from within them because the reason why doctors, nurses and the other professionals who work in the health service get up every morning is to provide a safe service. Many times, the ideas to promote safety come from them, and we need to make sure that evidence-based good practice is being applied.

164. I would focus on seeking to ensure a culture of service improvement, and that is why we follow, for example, the evidence that we obtained from the Institute for Healthcare Improvement in the US, which has a very good system to quickly identify where a change in practice can lead to saving lives. There was a 100,000 Lives campaign in the US. The leader of that was challenged, within his family, on the point that some improvement is not a number and soon is not a time, and the objective of securing actual numbers of lives saved within a number of years was undertaken. We seek to follow that pattern and ensure interventions that will actually save lives, such as reducing surgical site infections and dealing with ventilator-associated pneumonia. A range of evidence-based interventions will save lives, and the focus should be on that. Requiring organisations to apply evidence-based good practice is, to me, the right thing to do to bear down on the risk that is inherent in modern medicine.

165. **Mr Mitchel McLaughlin**: You will have read the report and maybe even the original research that demonstrated the level of casualty or adverse incident that could affect patients. The statistic of 10% prompts a question. If 10% of

people who get on an aeroplane get hurt, you would not get on a plane.

166. **Dr McCormick**: I am aware of the research from 2001. It was derived from two hospitals in the London area and based on a study of about 1,000 records over a period of about six months. So, it is quite a limited evidence base, and the authors of the paper acknowledged that there were real difficulties in extrapolating. I absolutely acknowledge that adverse incidents happening in the health service is a serious problem. In questioning the figure of one in 10, I am pointing out that it was from one context and at one time over 10 years ago. It is not the figure that is important but the recognition that there is a real issue that we have to address systematically and continuously. I do not advocate taking time to research exactly what is happening. I would rather research what we can do to improve patient safety and focus leadership attention and professional engagement on that, because that is how we make the best possible difference.

167. **Mr Mitchel McLaughlin**: Would you see no benefit in having a local or regional retrospective?

168. **Dr McCormick**: I question the value of it. There is lots of knowledge about how to make improvements. The problem is applying that knowledge systematically and achieving the change in culture on which I was challenged earlier. That is the difficult bit that it is well worth focusing our leadership energy on. Further research is likely to confirm that we have a problem. I am saying that we know that we have a problem, so I would rather not undertake research to confirm something that we are sure of already. I would rather focus on how to make improvement.

169. **Mr Mitchel McLaughlin**: On the next page, figure 2 shows us that the number of new clinical and social care negligence claims has increased in each of the past three years. What does that say about the priority given to safety?

170. **Dr McCormick**: It is important to see the clinical negligence numbers in figure 2 and throughout the report in the context of what has been happening. There is a fairly steady level of claims and significant expenditure in that area. However, as the report acknowledges, we have undertaken a lot of work to seek to accelerate the process. Good work has been done by the directorate of legal services to deal with old cases. Indeed, the number of old cases was challenged in an Assembly debate, and it is not right for justice to be delayed. That is wrong in principle. So, considerable effort has gone into bringing forward the rate of addressing claims in the courts. A significant number of those are listed to seek resolution in the courts well into next year. That led to higher expenditure this and last year and in recent years than would reflect the steady state. We are partly dealing with expenditure related to old cases because of the determined effort to clear old cases. That is an important point of context that the report fully acknowledges.

171. **Mr Mitchel McLaughlin**: Are you saying that that is the reason for the increase?

172. **Dr McCormick**: A significant part of the increase is down to clearing the backlog.

173. **Ms Thompson**: You are quite right to point out that the number of new cases is increasing each year. That trend is ongoing across the UK. For example, into 2011-12, we had a 4% increase in our new claims. England experienced a 6% increase and Wales, the previous year, a 10% increase in levels of new claims. The increase in the number of claims lodged is happening across the UK, and it goes back to the issues around the increasing complexity of what is happening in the health service and the work being performed. So, in the broader context, claims are increasing right across the UK on an ongoing basis and our level is slightly lower than those experienced across the rest of the UK.

174. **Mr Clarke**: Again, we have complacency from the Department. It is as if we should be giving it a gold star because

we are doing better than the rest of the UK and we have only a 4% increase in our claims. Honestly, I do not really care what is happening on the mainland; I am concerned with what is going on here in Northern Ireland. I think that it was a very complacent answer to suggest that we have only a 4% increase when others have 10%. That is not acceptable. I would rather you were telling us today that we had a 4% decrease. It is very defensive.

175. I also think that Dr McCormick's response to my colleague about why they did not want to drill down and did not think that there was any worth in doing so was a terrible indictment on your Department, because if you drill down into that, you might find out where some of the failings in your own Department are.

176. **Dr McCormick**: I think that we acknowledge the need to understand better where things are going wrong.

177. **Mr Clarke**: I do not think that you do appreciate that there is a need for an understanding because you said that the time would be better spent looking at ways of improving things as opposed to accepting that there has been wrongdoing in your Department. I am going back to when Mitchel asked the question initially. I do not think that Mitchel touched on the total cost of the claims; I think that he clearly stayed away from that. It was clearly the rise. However, you wanted to draw a parallel with the cost of the claims, which was fair enough. The total cases closed will bring rise to the overall cost. I think that you failed to answer the question, albeit Julie did not do any justification by trying to suggest that a 4% increase was very good in comparison with the mainland.

178. **Dr McCormick**: Sorry, I would not say that.

179. **Mr Clarke**: Well, that is how it came across.

180. **Dr McCormick**: If that is the case, I want to withdraw it.

181. **Mr Clarke**: We sit here today with 83,000 cases on the books, as it stands, and that is the attitude of the Department. You are drawing a comparison between yourselves and your counterparts in GB. You are suggesting that you are doing a good job, just because they have 10% and you have a 4% increase. I would say that you are doing a very bad job.

182. **Dr McCormick**: I am not claiming that; I do not want to claim that.

183. **The Deputy Chairperson**: For the sake of justice, I should give Dr McCormick one brief opportunity to clarify the position for Trevor Clarke and for anyone else.

184. **Dr McCormick**: We need to make sure that we are doing everything possible to bear down on claims. To me, the important thing to do is to promote patient safety and a culture in which people feel free to claim. It is possible that improving the culture could mean more claims. That would be an indictment in itself, but it would be a good thing to happen. We are also prepared to undertake any analysis that the Committee might recommend in relation to investigate why things are going wrong. We are entirely open to that. Ultimately, we are subject to your authority; we are accountable to you. We are offering our views in good faith, but we are subject to what you recommend. We are prepared to look at the balance between action to apply what we know will make a difference in improving patient safety and understanding root causes. Understanding root causes is vital. I think that we need to look at that very carefully and seriously.

185. **The Deputy Chairperson**: I call Mr Paul Girvan, who has shown remarkable patience.

186. **Mr Girvan**: Dr McCormick, thank you very much for coming along. I want to go back to the point that Mitchel raised about severe adverse incidents. Each and every one of us sitting round the table deals with constituents, day and daily. We hear about cases, some of which would make your hair stand on end. There are people who have no one to voice their complaint and, therefore,

no mechanism for bringing it forward. Some of those people may be senile, and many are buried. Sometimes, a case can be buried and never comes to light. Sometimes, the cases involving people who have passed away, due to something that went wrong, never come to light.

187. Of the 83,000 cases that are mentioned, how many are taken for inaction because nothing was done and the person never even got to hospital? By that, I mean that, in a number of cases, people never actually had treatment but were waiting to have treatment. I am talking about the likes of people who, perhaps, were on a waiting list for cardiac surgery but died. Some of the families have said that they died simply because they were kept on a waiting list and were delayed and became another one off the list. It is not that they were ever off the list, because the person, having passed away, is no longer a statistic. Are any of those included in the 83,000 complaints, or would some of those never have made it to the complaint list?

188. **Dr McCormick**: I will need to come back to you on the specific point that you have raised on the inclusion of non-events or things that should have happened. I follow and accept, clearly, the point that you are making. It is one reason why, from my point of view, ensuring timely access to service is a fundamental obligation. That is why our position on waiting times in a number of specialties is not defensible at present. Considerable effort is being made to improve, but we have to do better on access times. Thankfully, there is a clear clinical prioritisation so that waiting times for treatment to deal with life-threatening conditions is prioritised. We need to research on the point that you have made and come back. We need to make sure that, whatever about the fact at present, going forwards, there is a recognition that action that should have happened needs to be identified and recorded and be seen as part of our system, if it is not already. I need to check the facts on that.

189. **Mr Girvan**: Maybe you can respond to the Committee on that. Some of the patients have no voice, so no complaint would ever be lodged. I do not know whether it is because of the culture in it. Trevor talked about the need to hold the hands up and say that something went wrong and this is what happened. In a lot of the cases, some of the people who I spoke to said that all that they required was a sympathetic apology. Because they never got that, they hardened their position, so it went on and progressed to ending up in court. Instead of, in the early stages, hearing one sympathetic word from staff, they came up against what they deemed to be stonewalling in a system that was designed to restrict them from hearing what happened to their relative or their loved one. As a result, they decided that they were not going to let it drop and pursued the issue. That has added to the workload that you as a Department have had as well as probably lining the coffers of many expensive lawyers in the legal system in Northern Ireland.

190. **Dr McCormick**: I accept the point that you make entirely.

191. **Mr Girvan**: That leads me on to my main question. Paragraph 2.4 refers to the tracking process. The final bullet point in that paragraph refers to the systems that have been established by the trusts to track progress and action taken in response to patient safety alerts. Based on the information from those systems, how effective are the trusts at complying with safety alerts? What steps have been taken to validate the systems? What sanctions are placed on trusts where they fail to comply with safety alerts in the implementation of good practice? I appreciate that that is quite a convoluted series of questions, but there are very clear examples. The pseudomonas outbreak that we had in early 2012 had already been identified in Altnagelvin. I do not know what was going on — perhaps someone was living in a silo. Because they did not want to make this publicly aware, it was kept there. We had another outbreak in a Belfast Trust hospital, and, as

a result, the pair were not linked up. There seems to be a definite culture of trying to suppress what had been identified as a problem. We could maybe — I do not say definitely — have saved lives because of an intervention on something that had happened in another trust area where a problem and what had caused it had been identified. So, by taking on board some of the recommendations of that, they could have probably implemented changes throughout the whole organisation.

192. **Dr McCormick**: I am happy to respond both to the general point that you make about the handling of safety alerts and the specifics. We learned some very important lessons from pseudomonas and from the very penetrating insights in the two reports that RQIA, led by Pat Troop as an independent leader, brought together and brought to the Assembly and the Health Committee in the spring.

193. On the general point, we follow up safety alerts, and we require trusts to tell us whether they have complied with them or not. We have recently recognised the need to specify. If compliance is complete, that is fine. We had a requirement for them to refer to partial compliance, but that is too broad. We need to be specific and ask whether they have substantially complied, so that most of the important things are in place even if it is not total and complete. That is the place we want them to get to as a minimum. That is policed and monitored by the team that Paddy leads in our safety, quality and standards directorate. That is then brought to the twice-yearly accountability meetings, where we ask whether they have complied. If we have information in relation to non-compliance on any important safety alert, that is specifically discussed. What is going on and why? Those questions are asked. Trusts are well aware that if there is a safety incident in an area where they have been the recipient of a safety alert, that is bad for them. It is not quite as bad as the same thing recurring in the same organisation, but it is a bad point. It would lead to criticism and challenge, privately in my accountability meetings with them, and they know that there is a risk of that being very serious in the public domain as well.

194. On pseudomonas in particular, the Minister and I both said, in evidence sessions to the Health Committee in this very room, that we expected every safety alert to be taken seriously and every circular to be read, understood, channelled and handled. We know, and Pat Troop's report confirmed, that every organisation has a system for receiving, interpreting and disseminating the various alerts that come from the Department and from other sources. One of our penetrating points was to be more formal and official in our communications and to recognise that it is not sufficient to say that everybody knows because Northern Ireland is a small place and everybody talks to each other. Yes, people do talk a lot, and there was a level of awareness between the Belfast Trust and Western Trust about what had happened, but there was also a series of circumstances in relation to the taps especially. What came out scientifically about the taps was very unfortunate. People had introduced new taps that they thought would be safer, but it turned out that, scientifically, they were less safe. That was ironic and very unfortunate. People had been trying to improve things, but the very step taken to improve things had turned out to create a risk. We discovered that and acted on it. There was a problem with communication and with responsiveness, which came out very clearly in Pat Troop's report. We need to police it and see it through.

195. **Mr Girvan**: It just brings you back to the point of when something is identified as causing a major problem, such as pseudomonas. I know that comments have been made in relation to the nuclear industry and how a problem would be identified. I think back to something that happened with Boeing, when the board and the director of Boeing were going to be charged with manslaughter simply because a memo from a junior engineer who

saw a problem had not been adhered to. The director of Boeing was up on a manslaughter charge in, I think, the Italian courts. The same thing happened with a Formula 1 motor racing team, where certain people were held responsible because they had not paid attention to something. That did not even involve a serious incident in which people lost their life; rather, a potential risk was identified that senior officials had not acted on. When a major problem was identified at Altnagelvin, sufficient action was not taken to ensure that that came to the fore immediately. The Minister, therefore, had to stand in front of the House and answer questions, as did you, along with John Compton, in front of the Health Committee. I think that we have now identified a mechanism, but I want to ensure that that is in place, so that we will not have to revisit this in years to come.

196. That leads me nicely on to my next one. Paragraph 2.15 is to do with routine staff appraisals across the health service. It seems that there is a fairly low rate of reappraisal — 5% in some cases — and that staff development needs are not often assessed. Do those figures concern you? How do you intend to improve upon the situation? How can you have confidence that the care provided to patients and clients is safe when so little regard is given to assessing, maintaining and improving the competency of staff?

197. Some staff are very competent but their people skills are sadly lacking. Look at the number of complaints received about A&E. I am not necessarily blaming front line staff for that. Sometimes, management fail front line staff, because they give inadequate attention to the stress and strain that those staff are under. I know of one case — I do not want to go into any detail on it — where there was a major complaint about the blasé attitude of staff, which was, "There are a lot of sick people in here, so tough". That is not the way to deal with something. Those who complained were not being abusive or nasty, but they came back thinking that perhaps that was the right way to get action, because the people who were abusive got all the attention. It ended up that their family member passed away two or three days later. The first line at A&E was the problem, as was the attitude to patient safety and the way that staff responded to that. I am not one to blame front line staff, because sometimes they are under such pressure, and management sometimes cause that pressure. I am just wondering about paragraph 2.15 and how you feel that some of those areas can be dealt with.

198. **Dr McCormick**: I understand that that is a major concern arising from the report. I wrote to the trusts specifically on that point seeking a response before this hearing. I took very seriously the evidence presented on staff appraisal. Before coming to that specifically, I can give an important level of assurance on this aspect of work, in that appraisal is an essential part of good management, but continuous supervision and assessment are part of what is happening day and daily. So, the Committee can have confidence that, on a day-to-day basis, professional staff are being supervised and assessed. We should not wait until an annual appraisal to challenge someone. Annual appraisals are important, but more important, if things are going wrong or someone is not quite up to the mark, is challenging that person in the context of their normal work. If we have a supportive and learning culture, a supervisor can say, "You did the following things well, but you could improve on this". If that is happening all the time — and it is happening all the time — it provides assurance. The clinical staff take safety issues very seriously. If there is a risk, they will nip it in the bud. Nipping it in the bud and dealing with things in a daily context is the right thing to do.

199. Appraisal is also important. We have good information in relation to medical and dental staff. As we move towards revalidation, that will be cemented and secure. There will be a continuous

refreshment and revalidation. Paddy can talk about the detail of this if you wish.

200. The lower numbers, the more concerning numbers, are in the wider groups of staff. The context is that the Agenda for Change terms and conditions of service require the application of the knowledge and skills framework. That requires an assessment of individuals' training requirements on a regular basis; that is an inherent part of the system. We are looking to improve. Some of the percentages are unacceptably low. We are engaging with the Ambulance Service, in particular. The staff groups referred to in the report involve relatively small numbers, but they are still very important staff. It is important that there is both regular supervision and the application of the knowledge and skills framework approach in Agenda for Change to secure the right outcomes. The letter that I sent highlighted to the service the need for organisations to ensure that the performance of all staff is assessed regularly. I said that; I did not qualify it or put any subordinate clauses around it. That is a requirement on the organisations that we will pursue. We have had accountability meetings with two trusts in the past two days. We raised that point at those meetings and have had assurances that improvement is being made.

201. **Mr Girvan**: Does the Department ever engage in something that goes on in the private sector day and daily, namely a mystery shopper going in to carry out an assessment? The family that I am talking about were in A&E with their loved one, with the same condition, on two Friday afternoons. It was similarly busy on both occasions, but there was a sea change in the level of service from one occasion to the other. It could be identified that there were definitely staff who were creating a problem on a specific shift, and that needs to be focused on. That should be done. Does the Department go in as a fly on the wall to assess and observe what is going on?

202. **Dr McCormick**: We do not do that systematically. It has been done occasionally, and some quite important points have been made as a result. It is not done systematically, but we are certainly open to looking at it. It is important not to undermine confidence by giving the appearance of trying to catch people out. However, some unannounced inspections are carried out. For example, some of the RQIA hygiene inspections were planned on the basis of being unannounced, surprise visits. That is also part of what we talked about with the Committee in relation to the inspection of the independent sector homes. It is important to follow up that point and assess the value and effect that this would have. Getting an honest recognition of genuine problems is important. We need to find ways to make sure that there is good and effective challenge of — I am sure that it is not systematic bad intention — any pattern of behaviour that is not within the culture that we seek to promote. We need to take your suggestion seriously.

203. **Mr Girvan**: I think back to a problem that we had some time ago involving a number of ladies who had been brought in for mammograms. A problem was identified with how some of those mammograms were carried out. It seemed that a large number of cases had been missed. Why did it take so long for some of those things to be picked up? So many cases went through before a problem was flagged up. This is about the flagging up of issues, retraining and ensuring that the reporting comes back. The next thing that we heard was a headline on the Radio Ulster morning news that 1,400 women were being called back. The fear that that sort of thing causes in the community is horrendous. What happened that it took so long for some of those issues to be picked up? It is the sort of thing that does not give the public much confidence. Some of them will read a report like this and say, "I am safer not bothering going. I will just stay at home and take my chances." I am not saying that that is the case, but a lot of people will highlight that point.

204. **Dr McCormick**: If I recall correctly, the breast radiology case that you describe was in a difficult context. The vulnerability is where a service is being carried out by a single-handed practitioner, as was the case there. There are a number of areas in Northern Ireland where we have to provide services on that kind of basis. The important thing is to ensure that there is systematic peer involvement and that if someone is trying to keep something going but working in isolation, all the more attention is given to double-checking. That should be done without judging or making people feel that they are under unfair scrutiny. However, there should be a degree of peer challenge and a supportive network to maximise the safety services. We had an RQIA report on that case. It drew out some very important learning points in respect of timeliness of intervention and how to secure safety. It is a very important learning case for us.

205. **The Deputy Chairperson**: For the record, members and witnesses, we are now past the two-hour stage. Paul mentioned Formula One, although I am not trying to influence you. Sean Rogers has kindly given way to Mitchel McLaughlin, who has to leave shortly.

206. **Mr Mitchel McLaughlin**: I will remember your stricture about Formula One when I go to my next appointment.

207. At paragraph 4.13, figure 4 sets out the costs of settling claims. It is quite a stupendous figure really: £116 million. On a ratio of 2:1, the legal costs were £39 million. I just wonder how many hospitals you could build for that kind of money or how other Departments could use that kind of money if it were available. Will you talk to us about the changes that have been introduced in the past number of years — that five-year period, say — to reduce the costs of defending negligence claims and to reduce the time that it takes to process them?

208. **Dr McCormick**: A lot of important work has been done in the past number of years — the past five years, as you say — to seek to bear down on those costs. Lead responsibility for that lies with the director of legal services in the Business Services Organisation, which provides support to the health service bodies on this issue. So, action has been taken to seek to reduce the defence costs. We have looked at the way in which we contract for counsel and the way that that works. There has been significant work to standardise and put caps on that kind of cost. We look at what is necessary to benchmark and minimise our defence costs. Plaintiff costs fall to us as well, and it is important to challenge, without being unreasonable, the bills that come in and make sure that they are fair and acceptable given that we are responsible for public money in that context. We are seeking to do what is possible. It is quite a complex field, and quite a lot of factors go into the make-up of it. There are some important differences with elsewhere, but we are seeking to apply what we can to bear down on the legal costs and, as you said, increase timeliness and accelerate the process.

209. We welcome the view taken by the courts that procedures should be more timely and that we should seek to find alternatives to going to court, where possible. Given that harm has happened in the service, we cannot prevent or deny the right of access of a complainant to the courts, so we have to do what we can to minimise their need to go there. A range of things are being done to accelerate the process and bring forward and resolve some of the longer claims that are outstanding. That has been quite systematic. For example, in the financial year 2010-11, there was a significant drive to bear down on costs. The table shows a trend that, towards the end of financial year 2010-11, a significant number of cases were settled. Some of the plaintiff legal costs may have fallen into 2011-12, and you can see that it is not the most natural time series; 2010-11 looks a bit low, and 2011-12 looks a bit high. We have looked at that and think that there is probably some distortion of that trend. However, all that is about our

efforts to accelerate the processing of claims to meet our obligations and to try to contain cost where we can.

210. **Mr Mitchel McLaughlin**: I am slightly confused, looking at that, about the difference between 2009-2010 and 2010-11. Are you saying that 2010-11 was a blip?

211. **Dr McCormick**: It is probably most helpful to look at the trend and the percentages. The key point is that in 2010-11 and 2011-12, there was a concerted drive to clear old cases. So, some of the increase in compensation paid relates to old cases being cleared as well as the ongoing normal business. That partly explains the increase in expenditure in 2010-11 and 2011-12. The pattern across the years is that plaintiff costs run on average at 20% and defence costs on average at 10%. Most of the years are consistent with that. The 2010-11 figure shows a plaintiff cost of 13%, and that is probably a bit low against the normal trend. We think, perhaps, that some of that is because some of the plaintiff costs related to claims settled in 2010-11, because quite a few claims were settled late in the financial year. The claim may have been settled in January, February or March, but the plaintiff costs may not have been paid until 2011-12.

212. **Mr Mitchel McLaughlin**: What is the impact of the involvement of those in the directorate of legal services (DLS)? Do they arrange the defence for the Department, help in the assessment process or both?

213. **Dr McCormick**: They give advice and deal with the processing of the case through the court. They draw together the evidence on behalf of the trust and then secure counsel services in processing through the court. Part of their job is to seek to secure a fair outcome from the point of view of fulfilling our obligations to people who have suffered harm while also protecting the public purse. Their job is to find that balance and to be fair to both sides.

214. **Mr Mitchel McLaughlin**: Has the involvement of the directorate of legal services impacted on the percentage of cases that actually go to court, as opposed to, for example, negotiation between claimants' legal representatives and the Department that results in agreed settlements?

215. **Dr McCormick**: Some of that is down to earlier stages in the process whereby trusts are encouraged to seek to resolve issues without the need to go to court. Again, that is where the kinds of behaviours that we talked about earlier are so important, and we must do better on that.

216. **Mr Mitchel McLaughlin**: OK. I may just have presented that question in a misleading way. I did not intend to do so. I assume that a judgement call is always made somewhere. The decision was that you really needed to defend that case because you believed that you could defend it. That resulted in going to court. Obviously, you cannot guarantee the outcome. I am interested in how the involvement of the directorate of legal services has materially improved the process, because once you are committed to court, you lose control of the timetable. Lawyers and barristers will take their own sweet time in working their way through that process. Is there a material impact? What is the benefit of using the directorate of legal services if you still have to get external legal expertise to help you to defend your case?

217. **Dr McCormick**: They will provide essential expertise in processing responses and identifying when it is right to settle out of court and when it is right to let the process go through to the final stages. So, they have expertise and consistency in processing those cases.

218. **Mr Mitchel McLaughlin**: Does that not mean in practice that you will actually continue with that factor of 2:1 with regard to settlement awards and the cost of legal services, both for the complainant and yourselves?

219. **Dr McCormick**: There is some degree to which the process is not within our —

220. **Mr Mitchel McLaughlin**: I am trying to give you the opportunity to explain how you have improved, but I have to say that I am not getting it.

221. **Dr McCormick**: We are seeking to make sure that we process things smoothly in timing and that we do all that we can. DLS is doing what is possible to bear down on costs. So, improvement has been made. The underlying numbers are still as they are because a large number of claims have to be settled, including some very old ones. Some of the old high-cost cases would be in the realms of damages for birth injuries, and things like that, where you are talking about compensation, care and loss of earnings. There are lots of things that amount to large amounts of money. The right thing to do is to be responsible and handle those issues properly and fairly, and to seek to make maximum improvement. We are doing what we can to improve.

222. **Mr Mitchel McLaughlin**: Have you detected any impact from the review of legal aid?

223. **Dr McCormick**: Not directly.

224. **Mr Mitchel McLaughlin**: So, we are still dealing with high-cost cases?

225. **Dr McCormick**: Some aspects of cost are outside our control, as the report draws out. With the historic trend, courts locally are likely to make higher awards for personal injury than courts across the water. That is just a difference of fact. It is not within our sphere of influence. That is a matter for the courts.

226. **Mr Mitchel McLaughlin**: Paragraph 4.17 and figure 7 show that the majority of settlements result in compensation of £50,000 or less. Is that mainly as a result of court judgements or of negotiated settlements?

227. **Ms Thompson**: As the report points out, around 24% of claims result in compensation being paid, but you are quite right; that is not necessarily paid through the courts system. It can be agreed outwith the courts system. The report also points out that we need to look more at the smaller-value claims and maybe do something in a more cost-effective manner with them.

228. The court is actively advocating the use of mediation and alternative dispute resolution. We need to provide evidence on an ongoing basis of how that happens in cases. That is something that DLS will be working on with the Courts and Tribunals Service. So, we have acknowledged that we need to look at that recommendation, particularly as regards the smaller-value cases, to see whether there is a more cost-effective way of managing the legal side.

229. **Mr Mitchel McLaughlin**: There is an underlying issue. If the majority of settlements are £50,000 or less, are any statistics being thrown up on cases in which the legal costs exceed the amount awarded?

230. **Dr McCormick**: That is a genuine issue that needs to be looked at. Therefore, as Julie said, we accept the need to look hard for alternative means of resolution. We are aware of the approach being taken in other parts of the UK. I would not say that anywhere has this problem totally resolved. It is possible that some of the approaches taken might produce almost a perverse incentive to make low-value payments, which might then create a culture of wanting to make claims as there would be an automatic, or a semi-automatic, payment. We need to watch out for that, particularly given our responsibility to protect the public purse.

231. **Mr Mitchel McLaughlin**: Are you indicating that, at the moment, you do not monitor that?

232. **Dr McCormick**: We monitor things in the context of the way in which our system works, and we are satisfied that there is scrutiny of, and attention paid to, each settlement. So, each one is individually justifiable. What I am saying is that my understanding of what is being proposed in other jurisdictions is that if we were to follow that pattern, there could be some value in accelerating the process

but there would also be some risk of an unintended consequence.

233. **Mr Mitchel McLaughlin**: I understand that.

234. **Dr McCormick**: We need to watch out for that.

235. **Mr Mitchel McLaughlin**: There are probably more examples, but it occurs to me that there are three obvious examples: a negotiated settlement; the classic on-the-steps-of-the-court arrangement; and the outcome of a full court process. Do you have a statistical breakdown of that?

236. **Dr McCormick**: We will get some more details on that for the Committee.

237. **Mr Mitchel McLaughlin**: I accept that there may be other classes of compensation claims or settlements, but I would have thought that an analysis of those categories would inform your consideration of where the value-for-money aspect can be addressed.

238. Finally, I presume that the directorate of legal service's costs are just costed into the overall figures for legal services, compensation claims and settlements.

239. **Dr McCormick**: Yes, the figures that show the costs will include the relevant attribution of costs from DLS.

240. **Mr Clarke**: Following on from Mitchel's last point, I take it that we are going to get a paper detailing the cases that you won and the ones that you lost.

241. I am wee bit unclear about the legal costs. In figure 7, it is quite clear that legal costs are not included.

242. **Dr McCormick**: That was intended to present the scale of the compensation paid, but the figure —

243. **Mr Clarke**: Can you furnish us with a copy of the statistics for the legal costs in each of those categories?

244. **Ms Thompson**: Yes, we can; absolutely.

245. **Mr Clarke**: That would bear some weight and would help to answer some of Mitchel's questions.

246. **Mr Rogers**: I want to take you back to figure 3, "Reported Serious Adverse Incidents". Surely, valuable patient safety lessons are to be learned from an evaluation of all adverse incidents, and even the near misses. Focusing on just the serious adverse incidents could create a tolerance of near misses and low-grade harm. Why are we not maximising the potential to learn by collating all the information?

247. **Dr McCormick**: The intention is to do exactly that. We have drawn significant value from the existing reporting system, and we will continue to do so because there are very significant lessons to be drawn from serious adverse incidents. Once the RAIL system is in place, it is intended that it will provide exactly what you are asking for, namely a comprehensive pulling together of information, systematically and analytically, so that patterns can be more clearly identified and acted on. Paddy will provide more detail on the benefits that will result from the completion of the RAIL system.

248. **Dr Woods**: Even at this point in time, trusts will draw together all their adverse incidents, draw lessons from them and produce reports on adverse incidents in their organisations. As part of the accountability process, we will ask them to assure us that that is happening and that, very importantly, they are sharing more widely in the system any lessons that they have learned that are applicable elsewhere.

249. The expectation with the RAIL process is that all adverse incidents will be drawn together and analysed and that the lessons learned from the totality of adverse incidents will be drawn together and disseminated for learning across the piece. The expectation is also that, in addition, there will be learning from issues that arise from clinical negligence cases and complaints. As the Venn diagram in the report shows, they are separate but interrelated: they overlap in some respects, but they all present the opportunity for learning and the avoidance of repetition.

250. That is a fundamental element of the RAIL project. It also points to the complexity involved in pulling all those things together, because, when we do that, we will be the first jurisdiction in the developed world to pull those things together across a jurisdiction. There are states in the United States and parts of Australia that do it, but nowhere else in the world has done it for health and social care, which is a further factor. All the other systems in the world confine themselves to healthcare adverse incidents.

251. **Mr Rogers**: Mitchel made a point earlier about a systems approach. There has really been a breakdown in the systems approach up to now.

252. **Dr Woods**: There has been an incremental build in the systems approach in that we have concentrated on regional learning arising from serious adverse incidents. We have not neglected adverse incidents, although they are not collated on a region-wide basis. However, we expect trusts to aggregate their adverse incidents to learn the lessons from them and share them where wider learning opportunities arise.

253. **Mr Rogers**: Figure 3 shows that over 2,000 serious adverse incidents have been reported. Obviously, the ultimate price that patients pay when they are harmed is losing their life. Can you give us the number of cases from those 2,000 that involved fatalities?

254. **Dr Woods**: I do not have that figure to hand. We can produce them for you.

255. **Mr Rogers**: My other point is about paragraphs 4.35 and 4.36. You answered the question about paragraph 4.36 with regard to the level of damages. You said that it was a matter of fact that the English system awards more money. Will you comment on paragraph 4.35, which states that trusts here do not contribute to compensation claims? How do you feel about that, given that so much money comes from trusts in England?

256. **Dr McCormick**: This is partly a factor of different stages of the system's evolution. It also links to the fact that we have had within the process some delayed cases. So when the new trusts came into being in 2007, and we went from 17 to 5, it would have been potentially destabilising to have given the new trusts delegated responsibility for managing a volatile and significant level of expenditure. We have tried to form a balanced judgement. There is a case, as is drawn out in the report, for aligning responsibility for this cost with all the causal factors. In principle, that is the right thing to do, and, in looking at it a couple of times, our financial review groups have said that we should move in that direction. We did not do so in 2007 because it would have burdened new organisations with the legacy of past failings from other sources, so we thought that it was not the right thing to do at that time. We are keeping it under review, and we can see the arguments of principle. There are some advantages to us at present in that it is simpler and smoother to manage the budget centrally. That is not without some advantage, but we are very open to changing that. We can look at that again to see what is the best thing to do.

257. **Ms Thompson**: It is partly related to the number of outstanding cases. As that number falls, as one of the figures in the report shows, you then come down to a less volatile way of dealing with cases. That means that we should be able to reach a point with the trusts at which it is understood how much each should pay into a pool, which is how the system operates across other elements of the UK. So you have to have some understanding and an ability to forecast to enable you to put the costs through to the trusts in that way. We would be happy to look at that to see whether the time is now right, or would be right in the near future, to look towards doing that.

258. **Mr Rogers**: Finally, paragraphs 4.42 to 4.45 relate to alternative dispute resolution. Rather than facing court proceedings, patients and their families have a right to expect a full explanation, an apology and an undertaking that if harm has been done, it will not be

repeated. Keeping that in mind, do you think that it would be prudent to develop some alternative to legal action, which could reduce the costs and stress and perhaps result in a more positive outcome for the patient?

259. **Dr McCormick**: As the report states, we have accepted that recommendation from the Audit Office. We are looking at finding an alternative way forward and looking carefully at what is being applied elsewhere. Other parts of the UK are at different stages. There is also some potential learning from other jurisdictions. We have not yet identified a model from any other jurisdiction where this is a solved problem. Everyone is still learning, but the reason for seeking alternatives is very strong. If it is possible to provide a better, more responsive system at a lower legal cost, that is devoutly to be pursued. We are committing to work on that to identify alternatives, and if that means finding a compromise among other models and applying it, that is what we will do. Therefore, I accept the point and the recommendation.

260. **The Deputy Chairperson**: We have come a long road since Brangam and Bagnall and those who ripped off the health service. However, as I listen to you this afternoon, despite improvements in technology, record keeping, and so on, you seem still to be discussing ways in which you can reduce clinical negligence and better link the whole service. Have some people been sitting on their hands?

261. **Dr McCormick**: I would not say so. Rather, there is a strong motivation to take forward initiatives on patient safety. There are two parts to what you said. On patient safety, Paddy and the team in the Department's safety, quality and standards directorate and Michael McBride as Chief Medical Officer have shown strong personal commitment and leadership in introducing patient safety initiatives and exploring, developing and applying good practice. So we have strong leadership there and from many across the trusts who contribute to the patient safety forum. John Compton chaired that for a while, and that position is now with the Public Health Agency. There has been strong input and leadership from many across the service. There is a strong commitment to patient safety.

262. In response to your question on cost, we had to address the damage that was done through what happened in the Brangam Bagnall episode, which had very serious consequences, including recommendations from the Committee on dealing with that issue. We learned major lessons. A highly motivated team in the directorate of legal services is dealing with and clearing a caseload backlog. That has been a priority, and if that has limited all of our capacity, including mine, to change the system, I accept that we have not done all that we possibly could, but that is not through complacency or an absence of motivation. We are not complacent about this area of work. We know how much could be saved and that bearing down on this cost, including legal costs, would provide money for front line care. The previous Minister made strong statements about that in the Assembly a couple of years ago, and the current Minister wants to secure as much money as possible for the front line, so the motivation is inherent. I appreciate that it is difficult to satisfy you. Rightly, you place high demands on us to improve, and we undertake to seek to respond as positively as we can.

263. **The Deputy Chairperson**: Dr McCormick, if it is any help to you when you are dealing with the health trusts, and I am sure that I speak for all the members, patience is totally exhausted. We do not and cannot tolerate people living in fear of going into hospital and the public then paying out to meet horrendous compensation bills with money that should be going into public services.

264. **Mr Copeland**: I have four questions, three of which I am happy to talk to the Committee Clerk about and have answered by letter in the interest of expediency. I will start with a question that is not in front of me. It is widely accepted that we now live in a society that is more litigious than it used to

be. Is that factored into your thinking anywhere along the line and, if it is, in what context? Does there automatically exist in the back of your mind the thought that you will be sued? If so, does that have an impact on the way in which services are provided? I ask because my son is at Queen's medical school, and I am considering telling him to think again. People are now more inclined to go to law. I am not saying that there is a claims industry exactly but is there some outside influence? That is not to suggest for one minute that people are not entitled to lodge claims when they feel that such incidents have happened. However, is there any suggestion of people being led to law by commercial interests that lie outside the service?

265. **Dr McCormick**: It is difficult to produce hard evidence of that. We are concerned that the tendency to go to law in Northern Ireland is greater than in other jurisdictions. I understand that there is some reluctance in the legal profession to move to more specialist panels, as is the case in England. There are also no win, no fee provisions in England. Together, they have some effect in limiting the propensity for smaller claims to go forward. There are probably some cultural factors involved but those are beyond our control. You asked us what we do about this, and the answer is that we need to anticipate the issue. You mentioned medical school, and I think that it is absolutely right for there to be a clear understanding of risk management. That is part of how life works. I go back to what I said at the very beginning. I think that, as a society, we need to support those prepared to take risks. If I am in need of medical treatment, I want someone who has the courage to do what needs to be done, even knowing that something may go wrong, unintentionally, and despite the best of efforts. Again, I think of people working in highly stressed contexts in emergency departments or highly specialist services. As a society, we need to be behind those prepared to take risks, not create the consequence of people saying that they better not do something in case they are sued. That would be a very bad outcome. We need to promote and handle that very carefully. From our point of view, anticipating things going wrong and determining how to manage risk in a systematic way is a clear part of our responsibilities and something that we need to address smartly. We must really apply ourselves to this.

266. **Mr Copeland**: Thinking back to a previous career, which involved military service, I know that, when under fire, if you can get the casualty out of the killing area and back to the hospital, the survival rate is extremely high. I just wonder whether there is a cultural difference in there somewhere.

267. **Dr Woods**: There is a bit, from the point of view of healthcare practitioners. Those in the military appreciate that the environment in which they work is high risk and dangerous. For many years, probably until the past decade, the expectation was the rather unrealistic one that the practice of healthcare did not entail risk or a propensity for harm. A realistic approach is a start, and a big part of that is acknowledging that and then, as we have been discussing for most of this afternoon, systematically recording, analysing and learning from it. That is a relatively new perspective for the healthcare professions. In that regard, I do not worry so much about your son; it is the older generation like me who came up in a different culture. Part of the ongoing day-to-day push towards openness is recognising and managing risk. The first element in dealing with risk adequately is appreciating that it exists in the first place. That is not always the case. It is certainly a common theme throughout much of the material that we have been discussing today.

268. **Mr Copeland**: Andrew, paragraph 3.26 states that the latest policy document, 'Quality 2020', contains an undertaking to:

"devise a set of outcome measures, with quality indicators focused on safety, effectiveness and patient/client experience."

269. I am slightly puzzled that such indicators were not already in use, or were they but their name has changed? I become concerned when I see passé phrases, because I see so many of them, and they all originate in the same sort of psyche. Without such benchmarking information — that is on the assumption that you have not been using it to date — how have the trusts and the Department been able to set explicit, challenging and measurable goals for improving safety performance year on year?

270. **Dr McCormick**: The background is that a systematic approach to quality and safety with the kind of metrics being developed is relatively new. It is consistent with the recognition, which I mentioned a short time ago, of the degrees of risk that apply. The Quality 2020 strategy systematically brings together thinking that has been evolving over the past few years to ensure that we apply ourselves to this in a very systematic way and that it is given a strong leadership message. If you look back to, say, 2006, 2007 and 2008, the only show in town, and the metric on which attention was entirely focused, was access times in elective care. We had been singled out as having the longest waiting times in the UK for elective care, and that was the only thing that mattered. Shifting the attention in a more balanced way to a mature view of quality is a very good thing. I do not claim originality, nor do I say that we dreamed this up, but we have sought to give it really strong leadership. I appreciate that some of the phraseology can appear broad-brush and bland, but not when applied in a systematic and rigorous way, and I assure you that the statutory duty of quality gets people's attention and that the risk of being charged with corporate manslaughter is a live topic of conversation among chief executives. We know that this matters, so applying ourselves to sorting out these issues is very important.

271. **Mr Copeland**: I would like to raise a further point of information for my and the Committee's consideration. If one of these incidents occurs, a set series of steps kicks into place. Are those set by the trusts independently, and are they fine as long as they conform to the broad set of departmental guidelines? Is there a standard method of reporting that is instantly identifiable and transferable from one trust to another so that, at the end of a given period, the information comes to you in the form in which you need it and can be put to the purpose for which it was collated?

272. **Dr McCormick**: There is a prescribed and standard format for the reporting of SAIs to the Health and Social Care Board (HSCB) and for early alerts to the Department. There are some basic requirements. However, some detail has to vary according to the context because quite a broad range of categories apply. Paddy, do you want to say something about that?

273. **Dr Woods**: In broad terms, it is fair to say that the manner in which these are reported and followed up on is consistent across the piece.

274. **Mr Copeland**: Is the manner in which they are interpreted the same?

275. **Dr McCormick**: That is one of the key advantages of their being dealt with at a regional level by the Health and Social Care Board, which has the responsibility for collating SAIs across Northern Ireland. The HSCB wants, seeks and secures consistent information that it can turn into learning letters that are sent out into the system. Such letters will state: "In light of the following SAIs, the HSCB has reached the following conclusions." The letters then advise which points need to be attended to. Again, we have significant advantages in being a relatively small system.

276. **The Deputy Chairperson**: Michael, will you let Paul in at this point?

277. **Mr Copeland**: Yes.

278. **Mr Girvan**: My question is really about information and how it is passed through the organisation. Problems sometimes occur when information is not passed through.

279. I appreciate that you said that you will put together the RAIL database mentioned in paragraph 3.24. My point links in exactly with what Michael said. There are other software systems in operation, and there are risks involved in introducing any new software. We saw that previously when we paid a lot of money for software. That software ended up being owned by another company, not the people who paid for it to be developed, and it was then sold to other governments to run their systems. Given the risks involved in developing any new IT system, why were options such as joining the national reporting and learning system or purchasing an off-the-shelf package not considered? They could have delivered the same results.

280. **Dr McCormick**: I understand what you are saying. Paddy, do you want to take that question?

281. **Dr Woods**: Quite some time was devoted to trying to establish a link with the national reporting and learning system. However, that system does not cover social care, which would have been an issue for us. Subsequent events and the dispersal of NPSA across various organisations in England would suggest that, unfortunately, a link with that system was never going to be a realistic prospect. The history of the production of all singing, all dancing IT systems in the public sector, particularly in the health service, is not a happy one. However, the aim with the RAIL system is to, first, pilot it in one organisation and then road test all the areas that we want to cover. We recognise that we will be breaking new ground and that this system is not replicated anywhere else in the developed world. On that basis, we will pilot the system in one organisation to mitigate the risk that you mentioned. Depending on the results of that pilot, we will then roll it out across Health and Social Care.

282. **Mr Girvan**: What is the time frame for that?

283. **Dr Woods**: Assuming that we get agreement for the Department's business case, the expectation is that the pilot will be completed by the end of 2013, with a view to the overall system being in place by the end of 2014.

284. **Mr Girvan**: What will the new system cost?

285. **Dr Woods**: I do not have that figure to hand. Apologies.

286. **Mr Girvan**: Could we get that? Sometimes, we see very expensive systems that are nothing more than databases that everyone in the health profession can access.

287. From the outside, it does not seem too complicated, but it might be very complicated. Sometimes, those who write such programmes want to make them seem complicated so that it appears as though they are the only people who can write them. Gone are the days when notes were put up on a noticeboard and passed around everybody that way. I would like you to come back to us with the projected cost of the system — by that, I mean realistic projections.

288. **The Deputy Chairperson**: Paul, you may have noticed that Mr Michael Copeland has now left the meeting. Do you have any further questions?

289. **Mr Girvan**: We could go on all night if you want.

290. **The Deputy Chairperson**: I have been trying desperately to persuade you not to do that. Are you finished?

291. **Mr Girvan**: OK, yes.

292. **The Deputy Chairperson**: This has been an extremely important session. Health and social care services affect every member of society at some stage in their lives, and patient safety, which we have focused on, must be at the heart of all health and social care provision. I welcome the Department's appreciation of that and look forward to future improvements in service delivery.

293. The Committee will consider the evidence and produce its report in due course. Of course, we may wish to write to you for further information. Thank you for your evidence today, and —

294. **Mr Clarke**: Chairperson, I do not have a question but I want to make a comment.

295. **The Deputy Chairperson**: I knew that I was not going to get off that easily.

296. **Mr Clarke**: It is a caveat to your closing embarks. There will be questions, and in the absence of satisfactory answers, I ask for your indulgence in reserving the right to call the witnesses back. Is that appropriate?

297. **The Deputy Chairperson**: Trevor, thank you for that. It was a very useful contribution. Of course there will be questions. I imagine that someone will look back at the 2002 recommendations, investigate why many of those have not been honoured and ask what can be done in future to ensure that there is not another case of déjà vu. The public must be assured that there should be no fear of health service provision and that the awful problem of compensation will be better handled. I thank the witnesses. I also thank Hansard for its coverage of today's discussion.

Northern Ireland Assembly

Appendix 3

Correspondence

MAHI - STM - 300 - 1570

Correspondence of 14 November 2012 from Ms Marie Anderson

Ombudsman Northern Ireland

Our reference: MMCA/NIAO 14 November 2012

Ms Michaela Boyle MLA
Chair, Public Accounts Committee
Room 371
Parliament Buildings
Ballymiscaw
Stormont
Belfast
BT4 3XX

Dear Ms Boyle

Northern Ireland Audit Report (NIAO): The Safety of Services Provided by Health and Social Care Trusts

I read with interest the above report produced by the NIAO and understand that the Public Accounts Committee (PAC) took evidence, on the report, last week. Given the comments made on the matter of 'alternative dispute resolution' I thought it may be useful to contribute to the Committee's enquiry by outlining the Northern Ireland Commissioner for Complaints[1]' statutory role in the handling of health and social care (HSC) complaints which operates as a means of alternative dispute resolution.

The Commissioner's role in Health and Social Care Complaints

The purpose of the Commissioner's office is to investigate complaints of maladministration. In doing so the Commissioner seeks to ensure the people of Northern Ireland are served by a fair and efficient public administration, including health and social care that is committed to accountability, openness and, quality of service. The service provided by his Office is independent, free and, confidential.

The governing legislation for the Commissioner for Complaints jurisdiction in health and social care matters is the Commissioner for Complaints (Northern Ireland) Order 1996. His jurisdiction which included complaints of maladministration about Health and Social Care Trusts was extended in 1997[2] to include matters of complaint which related to 'the merits of a decision taken in consequence of the exercise of clinical judgement'. As a result of this extension of jurisdiction, the Commissioner for Complaints was empowered to investigate complaints about the care and treatment of patients arising from the actions of General Health Service Providers, (these include General Practitioners, Dentists, and Pharmacists) as well as Independent Providers of Health Services, (eg Nursing Homes). Where an individual is dissatisfied with the outcome of their complaint to a Trust or other HSC body, having been investigated and responded to under the HSC complaints procedure, they are advised of their right to forward their complaint to the Commissioner.

1 The NI Commissioner for Complaints is also known to members of the public as the NI Ombudsman

2 The Commissioner for Complaints (Northern Ireland) Order 1996 as amended by article 7(10) of the Commissioner for Complaints (Amendment) (Northern Ireland) Order 1997

Legal Remedy

It should be noted that the Commissioner is an alternative to the courts and individuals who seek compensation arising from a claim for clinical negligence as referred to in the NIAO report will be directed by the Commissioner to pursue a legal route for the remedy they seek. Article 9 (3) (b) of the 1996 Order prevents the Commissioner from investigating any matter in which the person aggrieved has or had a remedy by way of proceedings in a court of law. This bar is not absolute, however, as a residual discretion is afforded to the Commissioner by virtue of Article (4) (a) which enables the Commissioner to investigate, where he is satisfied that in the particular circumstances it is not reasonable to expect the complainant to resort or have resorted to the legal remedy. The circumstances where such a discretion will be used is where the complainant may not have the financial resources to fund court proceedings.

The Commissioner's approach to deciding those complaints involving clinical care and treatment of a patient or deceased member of a complainant's family which he will investigate recognises that, in theory, every complainant could potentially have a legal remedy. The Commissioner, therefore, considers carefully the remedy being sought by the complainant in respect of their complaint. Often the complainant simply seeks an explanation of what happened and where failures in care or treatment have been identified an assurance that this will not happen again. In many instances a complainant seeks only an apology. These are remedies which a complainant will not obtain if he/she pursues the legal route. Although his evidence gathering powers are equivalent to those of a High Court judge, unlike the legal process, the Commissioner's investigations are conducted in private, are inquisitorial in nature and, are non adversarial.

Maladministration

The standard which is being tested is for 'maladministration'. Maladministration is not defined in the legislation in order to reflect the wide discretion afforded to the Commissioner for Complaints in determining whether maladministration has occurred based on the facts of the case. Maladministration is also the standard which is being tested in clinical cases; albeit that the term in itself may not, on the face of it, appear to the general public to have relevance to clinical judgement.

The Commissioner's approach is to assess whether the actions of a health professional are fair and reasonable and this is not the same as a finding by a Court that a duty of care has been breached.

Learning from HSC Complaints

Where maladministration is found to have caused an injustice to an individual the Commissioner can recommend a remedy which often includes a change in practice or service improvement. As a result the Commissioner's investigations will result in outcomes which are not only personal to the complainant but which also result in learning for the HSC sector and consequently improved service delivery. The Commissioner has a discretion to recommend a wide range of remedies in any case. These can include a fuller explanation of events leading to the injustice suffered by the complainant, an apology, service improvement recommendations and, in appropriate cases financial redress.

Health and Safety Risks in the HSC Sector

Given the extent of the Commissioner's jurisdiction in the HSC sector, he enjoys a unique and valuable insight into the experiences of individuals who may have been failed by the sector. Significantly, the Commissioner also has an express power to disclose information to any person or body where he considers that information should be disclosed in the interests of the health and safety of 'any person'. For example, this power of disclosure enables the Commissioner for Complaints to eg refer a concern about a particular General Practitioner to the General Medical Council, or to refer a nursing home to the RQIA where regulations or procedures, may on the face of it, appear to have been breached. To assist with this important

mechanism for sharing information in the interests of patient safety, the Commissioner is currently finalising a protocol with the Regulation, Quality and Improvement Authority (RQIA); the body charged with responsibility for monitoring and regulating the HSC Sector.

HSC Case Digest

By way of illustrating the nature of the cases that the Commissioner investigates in the HSC sector, I attach a link to a recent case digest which focused on the Commissioner's casework involving the HSC sector:

http://www.ni-ombudsman.org.uk/niombudsmanSite/files/1e/1e645890-7740-4039-8edb-c88cc1447ab6.pdf

Alternative Dispute Resolution

The Commissioner's office, along with the Law Centre (NI), and Queens University's School of Law, published a public information booklet in September 2011 entitled 'Alternatives to Court in Northern Ireland'. The booklet, which has been circulated widely to advice and advocacy bodies in Northern Ireland, outlines the range of alternative dispute mechanisms.' The booklet also makes clear that alternative dispute resolution schemes are not meant to replace the courts in all cases but that such schemes do have some clear advantages over litigation. The booklet can be accessed at http://www.lawcentreni.org/publications/other-publications/831.html

Further Information

I trust the Committee will find the above information of assistance in their consideration of the need to establish an alternative to legal proceedings for clinical negligence, as highlighted by the Comptroller and Auditor General in his report on the safety of services provided by HSC Trusts. I would, of course, be available to provide further clarification on the Commissioner's role if you would consider that this would assist the Committee's inquiry.

Yours sincerely

Marie Anderson

MARIE ANDERSON
Deputy Commissioner for Complaints

Chairperson's Letter of 26 November 2012 to Dr Andrew McCormick

Dr Andrew McCormick
Accounting Officer
Department of Health, Social Services
and Public Safety
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Room 371
Parliament Buildings
Ballymiscaw
BELFAST
BT4 3XX
Tel: (028) 9052 1208
Fax: (028) 9052 0366
E: pac.committee@niassembly.gov.uk
Aoibhinn.Treanor@niassembly.gov.uk

26 November 2012

Dear Andrew,

Evidence Session on the Safety of Services provided by Health and Social Care Trusts

Thank you for your participation in the Committee's evidence session in this inquiry.

As the Committee agreed I would be grateful if you could provide the following information.

1) A breakdown of figures into claims made against Trusts which relate to care provided by independent healthcare providers, including those undertaken at locations outside Northern Ireland.

2) A summary of the number of serious adverse incidents by specialty for each Trust.

3) A breakdown of live negligence cases in the Belfast Trust which would be attributed to complex cases and a summary of the information recorded and how it is used in order to mitigate the risk of repeated failures by individuals.

4) A summary of the individual processes to categorise and record adverse and serious adverse incidents.

5) A sample of the learning communications disseminated by the HSC Boards to staff in response to its review of serious adverse incidents.

6) In response to the 4th recommendation at Appendix 2 of the 2002 Audit Office report, having issued guidance recommending that individual HSC bodies consider how to adopt the policy to proactively reduce potential negligence claims by early intervention, please confirm what action the Department took to follow up with each of the HSC bodies to establish whether this policy was adopted – and the number of HSC bodies without such a policy in place.

7) A chronology from 2002 of the reviews and continuous progress measures implemented by the Department to improve the safety of services.

8) Paragraph 3.10 of the Audit Office report highlights that the acute sector here has an adverse incident rate half that reported in England and Wales (35 % compared with 75%). Notwithstanding the different health and social care structures here, you have accepted that this suggests that there is under-reporting in the Northern Ireland acute sector.

What assurances can the department give to the public that open, honest reporting is part of the culture of health and social care services?

9) In terms of under-reporting, what assurances can you give that it is not the more serious type of adverse incident which is not reported given that cases of this nature would attract most public attention and possible litigation?

10) An analysis of the 83,000 adverse incidents that led to harm, loss or damage to people or property, environment or reputation and a summary detailing how many of the individuals were notified.

11) Your assessment of the number of adverse or serious adverse incidents that go unreported as a result of issues arising from senility/mental illness where the patient does not have an advocate to complain, or people having died due to having been deferred from a waiting list repeatedly.

12) A breakdown by Trust and specialty of the number of outstanding staff appraisals for each of the last 3 years.

13) A breakdown by specialty summarising the number and percentage of cases where the legal costs exceeded the agreed settlement of less than £50,000. Please also indicate the average legal costs for each specialty.

14) Confirmation of the number of fatalities that relate to the 2084 serious adverse incidents referred to at paragraph 3.5 of the Audit Office report.

15) A summary of the steps the Department is taking to drive improvements in the collation of information on all incidents across the entire sector prior to the implementation of any new management information system.

16) The Department's projected timeframe for the pilot and for the full implementation of the Regional Adverse Incidents and Learning System; a detailed summary of the realistic, projected costs of its design and build; and confirmation of whether the intellectual property rights to the system will be retained by the Department.

I would appreciate receipt of your reply by 10 December.

Yours sincerely,

Michaela Boyle
Chairperson
Public Accounts Committee

Correspondence of 8 January 2013 from Dr Andrew McCormick

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

From the Permanent Secretary
and HSC Chief Executive

Dr Andrew McCormick

Michaela Boyle
Chairperson
Public Accounts Committee
Room 371
Parliament Buildings
Ballymiscaw
BELFAST
BT4 3XX

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Tel: 028 90 520559
Fax: 028 90 520573
Email:
andrew.mccormick@dhsspsni.gov.uk

Our Ref: AMCC 4217
SECCOR/387/2012
DH3-12-8582

Date: 8 January 2013

Dear Michaela,

Evidence Session on the Safety of Services provided by Health and Social Care Trusts

Further to your letter of 26 November 2012, please find attached supplementary information in relation to the Committee's additional queries in relation to the above report. Responses in relation to queries 3, 12 and 13 are currently being finalised and will be sent to you by the end of this week.

I trust this is helpful. If you have any further queries, please contact Paul Gibson on 028 9052 0288 in the first instance.

Yours sincerely

ANDREW McCORMICK

1) A breakdown of figures into claims made against Trusts which relate to care provided by independent healthcare providers, including those undertaken at locations outside Northern Ireland.

The following table sets out the total number of current live claims made against the HSC which relate to care provided by independent healthcare providers including those from outside Northern Ireland.

Private Provider		No of Current Claims
Classic/Spire Health	Eng	13
BMI Woodlands	Eng	2
352 Group	NI	4
North West Independent Hospital	NI	8
Balmoral Clinic	NI	2
Mater Private Hospital Dublin	RoI	1
Guys and St Thomas	Eng	2
Sports Surgery Clinic Ltd Dublin	RoI	1
Orthoderm	NI	1
Medinet	Wales	1
Vita Clinics	Eng	1
Medica Group	Eng	1
Birkdale	Eng	46
Total		**83**

2) A summary of the number of serious adverse incidents by specialty for each Trust.

For the period 1 May 2010 to 31 March 2012, the HSCB received 523 SAI **notifications** from HSC organisations / Special Agencies or commissioned service providers.

However, SAI report notifications can be based on limited information at the time of reporting and on further investigation the degree of severity may become clear. This can result in the incident no longer meeting the criteria of an SAI and it can subsequently be de-escalated. Transferred SAIs can also occur which relate to duplicate notifications being received from one or more organisation but relating to the same incident.

The actual number of SAI's for the period 1 May 2010 to 31 March 2012 is therefore **475**, as 46 were de-escalated and 2 were transferred.

The number of SAI's reported from HSC Trusts for this period was **457**. The difference of 18 relates to non HSC Trust organisations and is set out below.

SAIs by POC and Org for Non HSC Trust organisations 1 May 2010 - 31 March 2012

Programme of Care	BSO	HSCB	Primary Care	Voluntary Sector	Total
Mental Health	0	0	0	1	1
Primary Health and Adult Community (includes GP's)	0	0	13	0	13

Programme of Care	BSO	HSCB	Primary Care	Voluntary Sector	Total
POC - Corporate Business / Other	2	2	0	0	4
Totals:	**2**	**2**	**13**	**1**	**18**

The 457 SAIs reported by HSC Trusts are not categorised by specialty (as these relate only to hospital services) but by Programme of Care in line with DHSSPS Data Administration Bulletin Programme of Care definitions.

Period 1 May 2010 to 31 March 2012

Programme of Care	BHSCT	NHSCT	NIAS	SEHSCT	SHSCT	WHSCT	Total
Family and Childcare (inc CAMHS)	11	17	0	5	13	1	47
Acute Services	48	12	1	2	14	9	86
Maternity and Child Health	4	1	0	1	5	2	13
Elderly	3	10	0	2	3	7	25
Mental Health	58	44	0	61	46	32	241
Learning Disability	2	2	0	3	7	3	17
Physical Disability and Sensory Impairment	1	0	0	0	1	0	2
Health Promotion and Disease Prevention	2	0	0	0	4	0	6
Primary Health and Adult Community (includes GP's)	1	1	0	0	1	3	6
POC - Corporate Business / Other	7	3	0	1	1	2	14
Totals:	**137**	**90**	**1**	**75**	**95**	**59**	**457**

4) A summary of the individual processes to categorise and record adverse and serious adverse incidents.

All HSC Trusts have a suite of extant incident policies and procedures in place which set out arrangements for categorising, recording, investigation and management of incidents including Serious Adverse Incidents (SAIs). All incidents and SAIs are recorded on Datix (the Trusts Risk Management System) and are coded and categorised by the use of the Common Classification System (CCS) codes contained within Datix and adopted by all HSC Trusts. The system also allows for the addition of specific Trust codes, if required. Datix also provides for incidents/SAIs to be recorded according to categories set up by the Trust for eg, by Directorate, sub Directorate, Specialty and Ward/Department/Facility.

All incidents and SAIs are coded on a central basis for actual and potential risk in line with the Risk Management Controls Assurance Standard using the Trusts Risk Matrix; this is also used for the purposes of determining the level of investigation to be undertaken.

Set out below are two flowcharts which illustrate firstly, the procedure for recording and reporting incidents and secondly, the procedure for identifying and processing serious adverse incidents. The examples used have been taken from the Northern HSC Trust's Incident management Policy and Procedures but these will reflect the position across all Trusts.

In addition, SAIs are specifically recorded and categorised in accordance with the criteria for reporting SAIs as set out in the HSCB procedure for the reporting and follow up of Serious Adverse Incidents (April 2010).

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

The Procedure for the Reporting and Follow up of SAIs outlines the criteria for reporting organisations to determine whether or not an adverse incident constitutes a SAI. The criteria used are as follows:

- serious injury to, or the unexpected/unexplained death (including suspected suicides and serious self harm) of :
  - a service user
  - a service user known to Mental Health services (including Child and Adolescent Mental Health Services, (CAMHS) and Learning Disability (LD) within the last two years
  - 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 assault (including homicide and sexual assaults) by a service user
  - on other service users,
  - on staff or
  - on members of the public

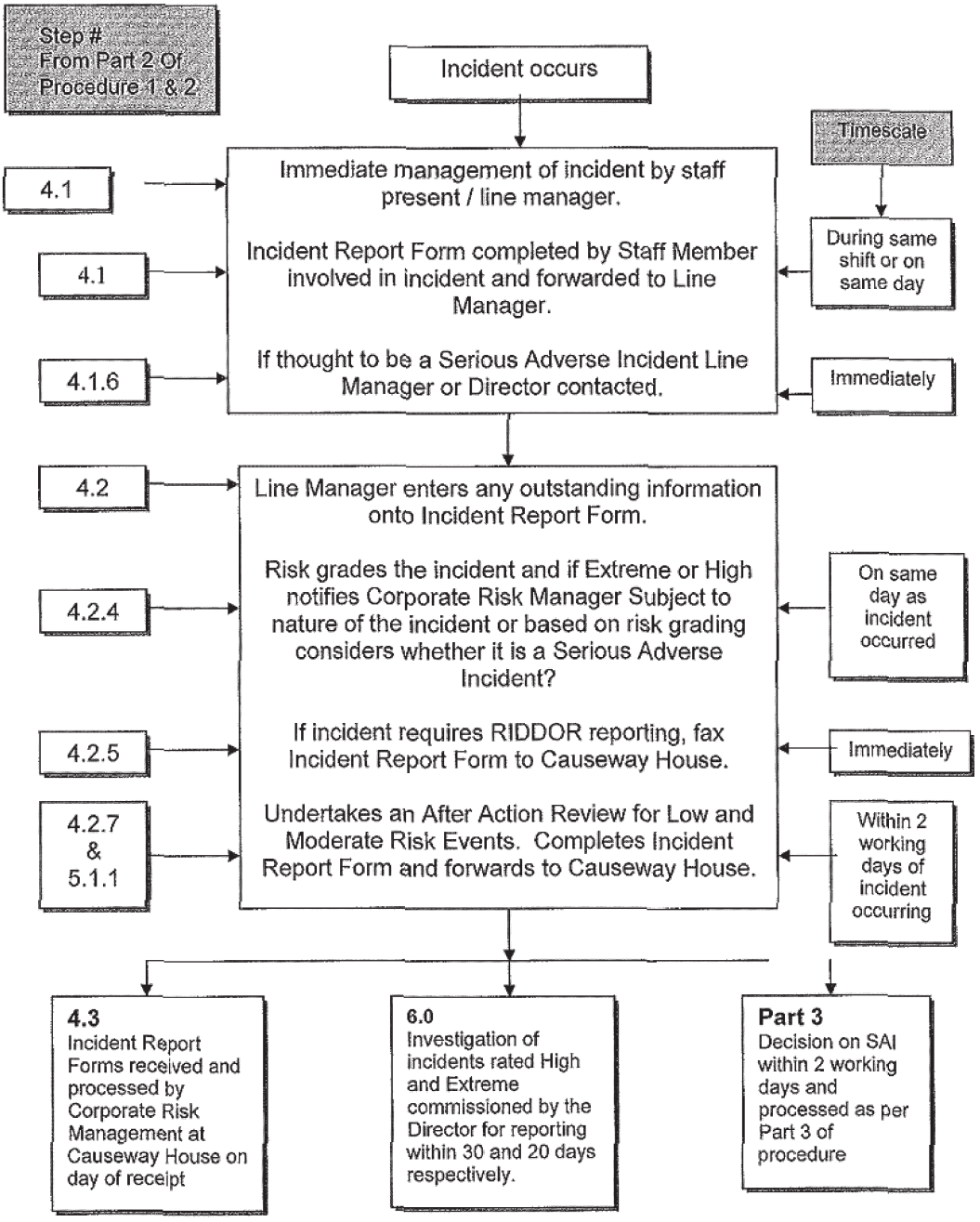
occurring within a healthcare facility or in the community (where the service user is known to mental health services (including CAMHS) or learning disability services within the last two years[1]).

- serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

When SAIs are received by the HSCB they are recorded on the DATIX risk management system; they are categorised under the nine programmes of care in line with DHSSPS Data Administration Bulletin (Programme of Care definitions) and also by a set of Common Classification System (CCS) codes. These codes are consistent with the DATIX risk management system which is used by all Trusts across the HSC.

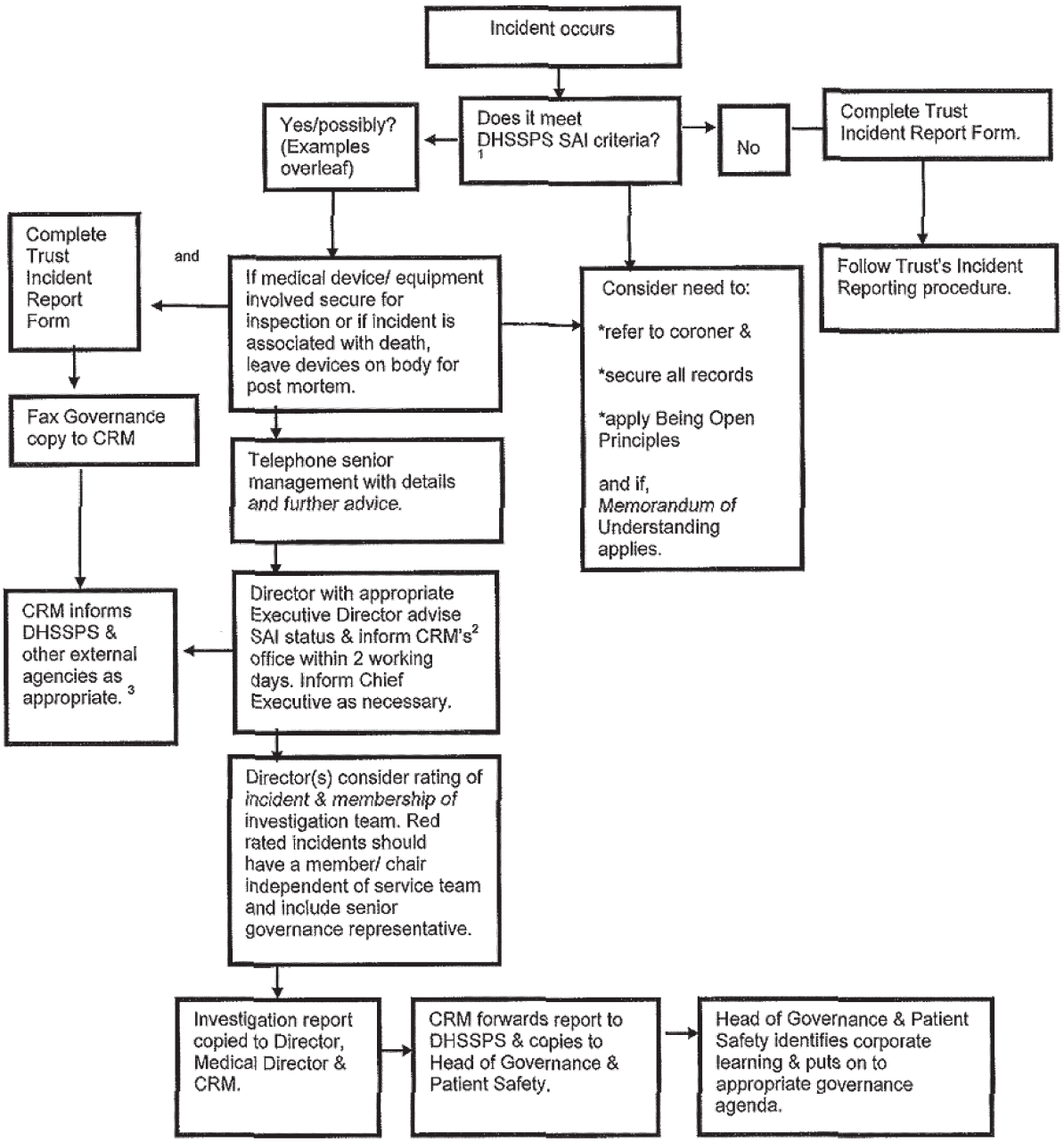
Appendix 1

Procedure for recording and reporting incidents



Appendix 2

PROCEDURE FOR IDENTIFYING & PROCESSING SERIOUS ADVERSE INCIDENTS



1.DHSSPS for SAI
* resulted in death
* regional learning
* media interest
ref to trigger list

2. CRM, Corporate Risk Manager, Alex Lynch
Tel: 028 9442 4635

3. Other agencies including:
MHC – Mental Health Commission
NIAC – re error using or in equipment/ medical devices
RQIA – regulated services other
NHSSB – Northern Health and Social Services Board

5) A sample of the learning communications disseminated by the HSC Boards to staff in response to its review of serious adverse incidents.

The two bi-annual learning reports produced by the HSC Board covering the periods 1 April 2011 – 30 September 2011 and 1 October 2011 – 31 March 2012 are attached below.

A third bi-annual learning report has been drafted and is pending approval. It will be forwarded to DHSSPS by the HSCB within the next few weeks.

In addition, the HSC Board also issues learning letters and recent examples are also attached.

- Letter dated 4 May 2012 - Learning from recent adverse incidents in maternity services
- Letter dated 22 May 2012 – Regional learning from a serious adverse incident (SAI) – Death following an accidental overdose of Warfarin
- Letter dated 22 May 2012 – Regional learning from a Serious Adverse Incident (SA) – Patients enrolled in a clinical trial
- Letter dated 28 June 2012 – Regional learning from a serious adverse incident (SAI) – flushing of a central line with the incorrect strength of heparin sodium injection

In addition to the HSC Board, the Department has also issued learning communications and examples of these are set as follows.

Supporting Safer Services Reports

Learning Communications - examples

Safety and Quality Learning Communication 02/11: Reducing the Risks Associated with Patients Taking Medication in Hospital Other Than That Prescribed as an Inpatient

http://www.dhsspsni.gov.uk/learning_communication_02_11

- issued following an incident involving the failure to recognise that a patient was taking medication
- linked to a Serious Adverse Incident
- to consider the best practice for their setting and take appropriate steps to minimise the risk to their patients of a similar incident occurring

Safety and Quality Learning Communication 01/09: Patients with Mental health Needs in the Acute Sector- Learning Lessons

http://www.dhsspsni.gov.uk/s___q_learning_communication_01_09.pdf

- issued (Jan 09) following the identification of a number of learning points arising from an investigation by a HSC Trust into the events surrounding the tragic death of a patient with mental health needs
- linked to a Serious Adverse Incident
- the recommendation from the investigation report related to: detaining & restraining patients under the Mental Health Order; staff training; communication among staff; and security access

Safety and Quality Learning Communication 05/09: Risk to patient safety of not using the H+C Number as the regional identifier for all patients and clients

http://www.dhsspsni.gov.uk/sqs_learning_communication_05_09_-_use_of_health_and_care_number_.pdf

- issued following NPSA highlighting the risk to patient safety of not using the NHS number as the national identifier for all patients. Reports to the NPSA about incidents arising from reliance on local hospital numbering systems demonstrate that there is real danger to patients of serious harm or death.
- linked to a Serious Adverse Incident
- with the introduction of the Health + Care Number (HCN) in Northern Ireland, similar patient/client safety considerations apply

National Learning Communications - examples

HSC (SQSD) 21/07: National Patient Safety Agency: Slips, trips and falls in hospital (PSO3)

http://www.dhsspsni.gov.uk/hsc__sqsd__21-07.pdf

- issued following the launch of NPSA's comprehensive report on patient falls in hospital
- to help assist in the practical implementation of falls prevention policies and to improve learning from falls

HSC (SQSD) 02/10: Preventing harm to children from parents with mental health needs

http://www.dhsspsni.gov.uk/hsc-sqsd02-10.pdf

- issued (March 2010) following a report undertaken by The National Confidential Inquiry into Suicides and Homicides (NCISH) – Filicide: A Literature Review.
- links with HSC (SQSD) 01/09 Patients with Mental health Needs in the Acute Sector-Learning Lessons(above)

HSC (SQSD) 28/07: NPSA Safe medication Alerts issued (June 2007) in response to NPSA's safer practice work programme (2007/2008)

http://www.dhsspsni.gov.uk/hsc__sqsd__28-07.pdf

- Actions that make anticoagulant therapy safer
- Promoting safer measurement and administration of liquid medicines via oral and other enteral routes
- Promoting safer use of injectable medicines
- Safer practice with epidural injections and infusions
- NPSA Alert 22 on reducing the risk of hyponatraemia when administering intravenous fluid therapy to children is highlighted in circular HSS(SQS)20-2007
- The NPSA Safe Medication Alerts have been designed to promote good practice and reduce the risk of harm. They are linked to the outcomes of the National Reporting and Learning System which has highlighted areas of high risk

HSS (MD) 17/2010: Physiological Early Warning Systems

HSS (MD) 39/2012: Physiological Early Warning Systems (PEWS) and the management of the deteriorating patient

http://www.dhsspsni.gov.uk/hss-md-17-2010.pdf

http://www.dhsspsni.gov.uk/hss-md-39-2012.pdf

- issued (April 2010) following a GAIN audit of the use of physiological early warning systems
- Consistent recording of physiological measurements (ie respiratory rate, pulse, blood pressure, temperature, alertness etc) being recorded as part of each set of observations.

- Escalation action to be performed and recorded when indicated by score.
- All observations for each patient to be recorded on an early warning system chart thus avoiding duplication.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

NCEPOD – A mixed bag report: An enquiry into the care of hospital patients receiving parenternal nutrition http://www.ncepod.org.uk/2010pn.htm

- Published by the National Confidential Enquiry into Patient Outcome and Death June 2010
- The enquiry reviewed the hospital care of 877 adult and 264 neonatal patients who were given parenternal nutrition (PN) and found good practice in less than a quarter of all cases
- Shared with HSC to note the report and its key findings and recommendations, to bring these to the relevant staff in your organisation & to consider the report and develop action plans to address the recommendations

National Confidential Inquiry into Suicides and Homicides (NCISH)

HSC (SQSD) 08/2007: National Confidential Inquiry: 5 year report into suicide and homicide by people with Mental Illness (NICISH)

http://www.dhsspsni.gov.uk/ncish-hss_sqsd_08_2007.pdf

- Issued (Jan 2007) following the publication of NCISH five year report into suicide and homicide by people with mental illness

HSC (SQSD) 51/2008: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Lessons for Mental Health Care in Scotland.

http://www.dhsspsni.gov.uk/hsc__sqsd__51-2008.pdf

- Issued (Oct 2008) Although specific to Scotland, the report's findings and recommendations will be of interest to those involved in the provision and delivery of mental health services in Northern Ireland.

Learning Communications (as a result of local intelligence)

Regulation and Quality Improvement Authority (RQIA) Reports

RQIA Report of Blood Safety Review – Issued February 2010.

http://www.rqia.org.uk/cms_resources/RQIA%20Blood%20Safety%20Report%2010%20Feb%202010.pdf

The RQIA was commissioned by the DHSSPS to carry out a review of the implementation in trusts and independent hospitals of DHSSPS Circular HSC (SQSD) 30/2007 dated 13 June 2007 and the addendum 02/08 dated 8 July 2008. These circulars relate to the National Patient Safety Agency (NPSA) Notice 14: Right Patient Right Blood.

Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children – Issued July 2010

http://www.rqia.org.uk/cms_resources/Hyponatraemia%20Report%207%20Jul%2010.pdf

The review team found there was evidence of improvement and commitment to achieving full compliance with the recommendations made in NPSA Safety Alert 22 and in the RQIA Hyponatraemia Review 2008.

6) **In response to the 4th recommendation at Appendix 2 of the 2002 Audit Office report, having issued guidance recommending that individual HSC bodies consider how to adopt the policy to proactively reduce potential negligence claims by early intervention, please confirm what action the Department took to follow up with each of the HSC bodies to establish whether this policy was adopted – and the number of HSC bodies without such a policy in place.**

Departmental circular HSS (F) 20/2002 entitled Clinical Negligence – Prevention of Claims and Claims Handling was issued in September 2002. The purpose of the circular was to advise HPSS Boards, Trusts and certain agencies of developments in the management of clinical negligence claims. HPSS bodies are asked: (i) to ensure that all claims managers and other relevant staff have access to the pre-action protocol; (ii) to examine their caseload to check the level of compliance with the time limits shown in it and rectify instances where the limits have been exceeded; and, (iii) to confirm in writing that their staff are actively taking its contents into account in processing cases. The circular contained an annual statement to be signed by Chief Executives confirming or otherwise that these and a number of other new obligations are being met. The statement was to be submitted by 30 June of each year.

A summary of returns received is set out below (2003 being the earliest year still held).

Year	Statements received
2003	15 out of 23 (4 Boards and 19 Trusts)
2004	16 out of 23 (4 Boards and 19 Trusts)
2005	17 out of 23 (4 Boards and 19 Trusts)
2006	15 out of 23 (4 Boards and 19 Trusts)
2007	6 out of 9 (4 Boards and 5 Trusts)
2008	9 out of 9 (4 Boards and 5 Trusts)
2009	4 out of 6 (4 Boards and 5 Trusts)

The requirement to provide this statement ceased with the issue of revised guidance on claims handling (HSS(SQSD) 05/10), as it was felt that equal assurance was already provided through Arms Length Bodies Governance Controls Assurance Standard and Risk Management Controls Assurance Standards. The handling of legal claims was also centralised in DLS who consider how and if early intervention would potentially reduce negligence claims, as part of ongoing case handling.

The Department's approach is to discharge its role in line with Managing Public Money NI reflecting that for 'Arms Length' Bodies it is the Board of the ALB and in particular the Chair and Non-Executive Directors who are charged with responsibility for ensuring that the ALB delivers on its statutory responsibilities and Ministers' priorities within the resource and policy framework set by the department

A significant component of any ALBs Governance arrangements connected to the safety of patients and clients will focus on how ALBs respond to and learn from instances where things have gone wrong and harm has occurred or could have occurred. However, overwhelmingly the main mechanism by which ALBs are required to ensure the safety of patients and clients is through ongoing good governance which provides assurances with regard to for example the estate e.g. the testing and safe handling of equipment and fire safety; Human Resources e.g.

regulation of the workforce, CPD, supervision, appraisal and revalidation; Quality of Services e.g. through regulation, audit and review

The Department is continuously seeking to strengthen the effectiveness of Governance within its ALBs and the Department's own role of sponsoring ALBs.

7) A chronology from 2002 of the reviews and continuous progress measures implemented by the Department to improve the safety of services.

The following sets out a chronology from 2002 of the reviews and continuous progress measures implemented by the Department to improve the safety of services

Best Practice Best Care (2002)

Published in May 2002, Best Practice Best Care (BPBC) aimed to put in place a framework to raise the quality of services and tackle issues of poor performance. BPBC has made an important contribution towards:

- Setting robust standards (through links with NICE and SCIE)
- Improving clinical and social care governance
- Improving regulation of the HSC workforce
- Introducing a Duty of Quality
- Establishing the Regulation and Quality Improvement Authority (RQIA)

Clinical and Social Care Governance (CSCG) (2003)

Guidelines to begin the process of developing and implementing clinical and social care governance (CSCG) arrangements across the HSC issued in January 2003. (HSS (PPM) 10/2002 refers)

The CSCG framework is intended to build on and strengthen existing activity relating to the delivery of high quality care and treatment. This includes: -

- continuing professional and personal development;
- audit;
- risk assessment and risk management;
- complaints management;
- evidence based practice;
- user involvement;
- identifying, promoting and sharing good practice, learning lessons from best practice as well as poor performance;
- significant event auditing; and
- professional regulation.

PSS (Quality, Improvement & Regulation) (Northern Ireland) Order 2003

Introduced a statutory duty of quality which placed a statutory requirement on the HSC Board and Trusts to put and keep in place arrangements for improving and monitoring the quality of HSC services they provide, that is, to put and keep in place a system of clinical and social care governance(CSCG).

The 2003 Order also established the Regulation and Quality Improvement Authority (RQIA). It has responsibility for regulating, inspecting and monitoring the standard and quality of HSC services provided by independent and statutory bodies in Northern Ireland.

Serious Adverse Incident Reporting System (2004)

The SAI Reporting System was introduced in 2004 – its purpose is to ensure an agreed approach to reporting, managing, analysing and learning from adverse incidents. (HSS (PPM) 06/2004 refers)

Service Level Agreement with the National Clinical Assessment Service (NCAS) (2004)

NCAS is a national service. It works to resolve concerns about the practice of doctors, dentists and pharmacists by providing case management services to health care organisations and to individual practitioners. It works with all parties to clarify the concerns, understand what is leading to them and make recommendations to help practitioners return to safe practice.

The Regulation and Quality Improvement Authority (RQIA) (2005)

RQIA took up its responsibilities on a phased basis from 1 April 2005.

Safety First: A Framework for Sustainable Improvement in the HPSS (2006)

Safety First was published in March 2006. It placed a particular focus on patient and client safety and led to further important developments which have ensured improved safety of services, such as the HSC Safety Forum and formal links with the National Patient Safety Agency in London

The Quality Standards for Health and Social Care (2006)

The Quality Standards for Health and Social Care was published in March 2006. The standards are designed to:

- give the HSC and other organisations a measure against which they can assess themselves and demonstrate improvement;
- help service users and carers to understand the quality of service to which they are entitled
- help to ensure implementation of the duty the HSC has in respect of human rights and equality of opportunity for the people of Northern Ireland; and
- enable formal assessment of the quality and safety of health and social care services.

External links established (2006)

On 1 July 2006, the Department established links with the National Institute for Health and Clinical Excellence (NICE) whereby all Clinical Guidelines and Technology Appraisals published by the Institute from that date are locally reviewed for their applicability in NI and, where appropriate, endorsed here. Under this arrangement, Northern Ireland also joined England, Scotland and Wales as full participants in the Interventional Procedures Programme.

Links were also established with the National Patient Safety Agency (NPSA) which issues regular safety alerts for action in the health service and which the DHSSPS communicates to HSC organisations for implementation. In addition, the DHSSPS participated along with the other countries in the UK in the Clinical Outcome Review Programme (which encompasses Confidential Enquiries) which conducts national confidential enquiries, and from which important learning is derived for application in Northern Ireland.

Memorandum of Understanding (MOU) between The DHSSPS (On behalf of the HSC) and the PSNI, HSENI and Coroner's Office on Investigation of Unexpected Death or Serious Harm (2006)

Developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations are required into a serious incident. (HSS (MD) 06/2006 refers)

Guidelines and Audit Implementation Network (GAIN) (2007)

GAIN was established in August 2007 as an amalgamation of the Clinical Resource Efficiency Support Team (CREST), Regional Multi-professional Audit Group (RMAG), and the Northern Ireland Regional Audit Advisory Committee (NIRAAC).

GAIN has an important safety and quality improvement role in HSC services throughout Northern Ireland through the commissioning of regional guidelines and audits as well as the promotion of good practice through the dissemination of audit results, and the publication and facilitation of implementation of regional guidelines.

HSC Safety Forum (2007)

The Forum was established in June 2007 to support organisations in their provision of safe, high quality care. The Forum has a number of aims:

- to be a regional resource for shared learning
- to proactively support the promotion of a safety culture
- to facilitate education and learning on improvement science and methodology
- to work to decide which interventions to implement in the future
- to promote collaborative working and facilitate shared learning
- to encourage the necessity of top table leadership
- to promote clinical and social care involvement
- to promote the involvement of patients.

Service Frameworks Programme (2007)

The Service Framework Programme began in 2007. The overall aim: to improve the health and well-being of the population, reduce inequalities and improve the quality of care. Service Frameworks set out the standards of care that patients, clients, their carers and wider family can expect to receive. The first round of Service Frameworks focused on the most significant causes for ill health and disability - cardiovascular health and wellbeing; respiratory health and wellbeing; cancer prevention, treatment and care; mental health and wellbeing; and learning disability. Work has also commenced to develop Service Frameworks for children and young people and older people.

Personal and Public Involvement (2007)

Guidance on strengthening Personal and Public Involvement (PPI) issued to assist HSC organisations improve the quality and effectiveness of user and public involvement as an integral part of good governance arrangements and to support the development of a more patient and user-centred HSC envisaged by the reform programme. (HSC (SQSD) 29/2007 refers)

Care Standards

The HPSS (Quality, Improvement and Regulation) (NI) Order 2003 allows for the regulation of a range of health and social care services, and for the development of minimum standards for these services. These standards focus on the safety, dignity, wellbeing and quality of life of service users. They are designed to address unacceptable variations in the standards of treatment, care and services and to raise the quality of services. To date the following standards have been developed:

- Nursing Homes Standards (2008),
- Residential Care Homes Standards (2008)
- Nursing Agencies Standards (date)
- Domiciliary Care Agencies Standards (2011)
- Residential Family Centres Standards (2011)
- Day Care Settings Standards (2012)
- Childminding and Day Care Standards (2012)

These will be used by RQIA, alongside the requirements of regulations, in making decisions on regulation of establishments and agencies.

The Health and Social Care (Reform) Act (NI) 2009

Introduced a specific duty on HSC Trusts to improve the health and social well-being of, and reduce health inequalities between those for whom it provides, or may provide, health and social care.

Complaints in HSC: Standards and Guidelines for Resolution and Learning (2009)

Effective from 1 April 2009 this introduced a new single-tier process for complaint handling (placing a renewed emphasis on the need for effective and robust local resolution). Complainants have access to the NI Commissioner for Complaints (the Ombudsman) where they remain dissatisfied with the outcome of the HSC Complaints Procedure. Complainants may also avail of independent help and advice from the Patient and Client Council (PCC).

Regional Adverse Incident Learning (RAIL) System (2010)

The development of a Northern Ireland wide, centralised database began in 2010. It is intended that the RAIL system will store, analyse and report on aggregated data emanating from all AIs (including SAIs and near misses) from across all HSC organisations so that the causal and contributory factors in patient and client safety can be assessed. RAIL will aim to address the gap in regional patient and client safety data by:

- maximising the reporting of adverse incidents (including near misses);

- ensuring that learning from all incidents and near misses, where relevant, is identified across the HSC;
- providing a mechanism to share learning from adverse incidents in a meaningful way within the HSC; and
- ensuring that learning from adverse incidents is put into practice in a timely manner.

The RAIL outline business case was passed to the Department in July 2012 and recommends a phased approach to implementation, with the first phase being a 12-18 month pilot to test and refine the system in practice, and determine the staffing, processes and system infrastructure required for RAIL to operate effectively in the longer term. The outline business case is revised following comment by Departmental advises. However, it is intended that the RAIL system will be fully operational by April 2014 subject to positive evaluation of the pilot phase, and approval of a future separate business case for the recurrent long term staffing and infrastructure.

Quality Strategy (2011)

Quality 2020 – A 10 Year Strategy to Protect and Improve Quality in health and Social Care in Northern Ireland was launched by Minister 17 November 2011. It defines quality for health and social care in terms of three key components: safety; effectiveness and patient/ client focus. It presents a clear Vision for the future, in which we aspire to be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care.

The implementation of Quality 2020 has commenced with the launch of the first tranche of projects in October 2012. These will focus on key areas for improvement and pave the way for further project work during the life of the strategy. It is intended that the implementation provide both a strategic 'agenda' and 'context' for quality improvement. It is not simply about a programme of new projects or strategic initiatives, important as they will be in driving forward necessary change and innovation. It is also about recognising and, where appropriate, endorsing the often self-initiated activity of HSC bodies across a multitude of quality improvement initiatives which they all undertake on an on-going basis in seeking to fulfil their Statutory Duty of Quality.

8) **Paragraph 3.10 of the Audit Office report highlights that the acute sector here has an adverse incident rate half that reported in England and Wales (35 % compared with 75%). Notwithstanding the different health and social care structures here, you have accepted that this suggests that there is under-reporting in the Northern Ireland acute sector.**

What assurances can the department give to the public that open, honest reporting is part of the culture of health and social care services?

The Department acknowledges that the data provided by the NRLS on reporting across England and Wales would suggest that there is under-reporting in the Northern Ireland acute sector.

However, comparisons between countries or healthcare systems are not straightforward as:

- the definitions of incident vary and therefore it is difficult to know if countries are reporting using similar definitions; e.g. suicides are reported under NI's SAI system
- the criteria for reporting may vary from country to country;
- Northern Ireland has an integrated Health and Social Care system which is unique. Throughout the UK, local councils are responsible for delivering components of Health and Social Care.

In relation to the NI Audit Office finding regarding the comparable rate of serious adverse incidents, acute SAIs account for approximately 20% of the total SAI activity reported from

across health and social care for the period 1 May 2010 – 31 March 2012. However, in attempting to draw a comparison with England and Wales, when social care SAIs are excluded from overall activity, the percentage of acute sector SAIs is in the region of 65%.

The Department is committed to the highest possible standards of conduct, openness, honesty and accountability in HSC services. The Department, HSC Board and Trusts will continue working to improve their safety culture and are encouraging the timely and open reporting of incidents at all levels - organisational and individual level through:

- The SAI Reporting System
- Whistle blowing policy
- HSC Complaints Procedure
- Clinical and social care governance and risk management arrangements

Reporting is promoted through the promotion of an informed safety culture across the HSC. The DHSSPS takes a "systems" approach to preventing incidents. Rather than blaming individuals, this approach seeks to indentify the underlying causes of incidents, learn from them, and take action to put things right. This approach promotes a culture of openness and transparency and encourages staff to acknowledge errors, investigate the events leading to the error and to disseminate any learning gained as a result of the investigation.

All Trusts are taking proactive steps to implement the web based datix adverse incident reporting system across their organisations. This means that all staff will be able to report incidents on a real time web based system from any Trust computer. The training that was rolled out with this implementation specifically focussed on appropriate reporting and feedback mechanisms to ensure learning. This requires on-going, targeted work to ensure confidence and participation by staff.

All staff are actively encouraged to report incidents and this practice is continuing to be promoted through corporate, directorate and divisional governance structures.

In addition, each Trust has a whistleblowing policy which encourages staff to report concerns, and provides a variety of options for staff to report outside line management arrangements if they feel their concerns are not being listened to.

The Department through the Trusts actively promotes an open culture, in which errors or service failures can be reported and discussed; and to ensure that, where lessons are identified, the necessary changes are put into practice. Staff are expected to, and must, make themselves fully aware of the relevant incident policy and procedures and the arrangements in place for the reporting, investigation and management of incidents.

9) In terms of under-reporting, what assurances can you give that it is not the more serious type of adverse incident which is not reported given that cases of this nature would attract most public attention and possible litigation?

The Department through Trusts actively encourages the reporting of all adverse incidents and SAIs. However, it is not possible to provide an absolute assurance in this regard but Trusts have confidence that systems are sufficiently robust to pick up on all or most cases. However, if a Trust becomes aware of an incident through other means rather than a formal notification of an adverse incident (eg, complaint, legal claim, coroners case or media enquiry) each case would be considered on an individual basis and investigated in accordance with the relevant policy. It would also be escalated and reported as an adverse incident/SAI or Early Alert, as appropriate and the reasons why it was not previously reported would be identified.

The Department requires all arm's-length bodies to have effective policies in place to deal with whistle-blowing at a local level. Recently, Minister wrote to all staff in the HSC to highlight the importance of their having the confidence to blow the whistle where they have genuine concerns, particularly around patient safety.

The aims and objectives of this policy are to promote a culture of openness, transparency and dialogue which at the same time should reassure staff that they will not be penalised for raising a genuine concern and gives them a process to follow that upholds patient confidentiality and should not unreasonably undermine confidence in the service. This policy enables the HSC to demonstrate to staff and the public that it is ensuring its affairs are carried out ethically, honestly and to high standards.

10) An analysis of the 83,000 adverse incidents that led to harm, loss or damage to people or property, environment or reputation and a summary detailing how many of the individuals were notified.

The following table provides a breakdown by organisation of the 83,000 adverse incidents reported in 2011/12.

Organisation	Number of adverse incidents
Belfast HSC Trust	22,682
Northern HSC Trust	10,771
South Eastern HSC Trust	15,574
Southern HSC Trust	8,422
Western HSC Trust	8,523
NI Ambulance Service HSC Trust	2,254
RQIA	14,742
Total	**82,968**

An analysis by each organisation of adverse incidents is provided in the attached spreadsheets.

Belfast HSC Trust

BHSCT Incidents by Sub Category and Category
Incident date: 1/4/11 to 31/3/12

Sub Category (CCS Level 2)	Category (CCS Level 1)																	
	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Abdominal organs other than digestive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3
Placental abruption	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0	5
Administration of assessment	0	0	0	0	37	0	0	0	0	0	0	0	0	0	0	0	0	37
Administration or supply of a medicine from a clinical area	0	0	0	0	0	0	0	0	0	0	0	0	903	0	0	0	0	903
Admission	103	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	103
Advice	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Anaesthetic problem connected with labour or delivery	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3
Leaking abdominal aortic embolism	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Appointment	99	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	99
Arteries and veins	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	11

	Sub Category (CCS Level 2)	Category (CCS Level 1)																		
		Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
	24-hour monitoring of "at risk" mental patients	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
	Born before arrival	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	6
	Transfusion of Blood related problem	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	276	276
	Bones or joints other than skull or spine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
	Breech presentation	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0	5
	Abuse by the staff to the patient	0	54	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	54
	Cancer - Dx failed or delayed	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
	Communication between staff, teams or departments	0	0	0	0	0	396	0	0	0	0	0	0	0	1	0	0	0	397
	Communication with the patient (other than consent issues)	0	0	0	0	0	55	0	0	0	0	0	0	0	0	0	0	0	55
	Confidentiality of information	0	0	0	0	0	58	0	0	0	0	0	0	0	0	0	0	0	58
	Consent	0	0	0	0	0	31	0	0	0	0	0	0	0	0	0	0	0	31
	Cord prolapse	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3

Sub Category (CCS Level 2)	Category (CCS Level 1)																		
	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Elective Caesarean Section	0	0	0	0	0	0	0	0	0	0	20	0	0	0	0	0	0	20
Emergency Caesarean Section	0	0	0	0	0	0	0	0	0	0	32	0	0	0	0	0	0	32
Upper Digestive tract	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Difficult delivery	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	7
Discharge	833	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	833
Patient's case notes or records	0	0	0	0	0	0	0	0	372	0	0	0	0	0	0	0	0	372
Patient's case notes or records	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Shoulder dystocia	0	0	0	0	0	0	0	0	0	0	33	0	0	0	0	0	0	33
Ectopic or other complications of pregnancy	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Environmental matters	0	0	0	0	0	0	0	0	0	150	0	0	0	0	0	0	0	150
Electronic Patient Record	0	0	0	0	0	0	0	0	11	0	0	0	0	0	0	0	0	11
Equipment related	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Security issue related to Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	46	0	46
Eye (OPCS4 - C01-C086)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2

	Sub Category (CCS Level 2)	Category (CCS Level 1)																		
		Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
	Lack of/delayed availability of facilities/equipment/supplies	0	0	0	0	0	0	0	0	0	314	0	0	0	0	0	0	0	314
	Slips, trips, falls and collisions	0	0	5375	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5375
	Lower female genital tract	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	7
	Upper female genital tract	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3
	Pathological or suspicious CTG or other fetal distress	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	7
	Financial Loss	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
	Fires, fire alarms and fire risks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	193	0	193
	Inadequate maintenance of fluids	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
	Labour assisted by forceps	0	0	0	0	0	0	0	0	0	0	16	0	0	0	0	0	0	16
	Fracture - Dx failed or delayed	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	3
	Exposure to electricity, hazardous substance, infection etc	0	0	184	0	0	0	0	0	0	0	0	0	0	0	0	0	0	184
	Operations on the Heart	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4
	Unplanned homebirth	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
	Staff records or information	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3

Sub Category (CCS Level 2)	Category (CCS Level 1)																	
	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Hysterectomy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3
Images for diagnosis (scan / x-ray)	0	0	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	14
Scans / X-ray images	0	0	0	0	0	0	0	0	12	0	0	0	0	0	0	0	0	12
Infection control	0	0	0	0	0	0	0	0	0	0	0	0	0	127	0	0	34	161
Injury or damage connected with Anaesthesia	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Delivery using more than one instrument	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Intrapartum haemorrhage	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Information Technology	0	0	0	0	0	0	0	0	0	120	0	0	0	0	0	0	0	120
IUGR or placental insufficiency	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Laboratory investigations	0	0	0	0	229	0	0	0	0	0	0	0	0	0	0	0	0	229
Lifting accidents	0	0	135	0	0	0	0	0	0	0	0	0	0	0	0	0	0	135
Prolonged first or second stage of labour	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Male genital organs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Medical device/equipment	0	0	0	0	0	0	0	0	0	0	0	926	0	0	0	0	0	926

	Sub Category (CCS Level 2)	Category (CCS Level 1)																	
		Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
	Some other medical condition	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
	Possible delay or failure to Monitor	0	0	0	0	0	0	0	0	0	0	0	0	0	176	0	0	0	176
	Monitoring or follow up of medicine use	0	0	0	0	0	0	0	0	0	0	0	0	38	0	0	0	0	38
	Injury or poor outcome for the mother	0	0	0	0	0	0	0	0	0	0	113	0	0	0	0	0	0	113
	Mouth	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	8
	Neurological factor	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Abuse etc of Staff by patients	0	2860	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2860
	Public order, Protests, Bomb scares,Riot, Disorder	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0	8
	Supply or use of Over The Counter medicines	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4
	Abuse - other	0	1028	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1028
	Accident caused by some other means	0	0	813	0	0	0	0	0	0	0	0	0	0	0	0	0	0	813
	Appointment, Admission, Transfer, Discharge - other	14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14

Sub Category (CCS Level 2)	Category (CCS Level 1)																		
	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Anaesthesia - other	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Assessment - other	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4
Consent, Confidentiality or Communication - other	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0	8
Diagnosis - other	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	6
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	131	0	0	131
Infrastructure or resources - other	0	0	0	0	0	0	0	0	0	35	0	0	0	0	0	0	0	35
Information - other	0	0	0	0	0	0	0	0	29	0	0	0	0	0	0	0	0	29
Labour or delivery - other	0	0	0	0	0	0	0	0	0	0	136	0	0	0	0	0	0	136
Other medication error	0	0	0	0	0	0	0	0	0	0	0	0	20	0	0	0	0	20
Implementation of care or ongoing monitoring - other	0	0	0	0	0	0	0	0	0	0	0	0	0	137	0	0	0	137
Security - other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	61	0	61
Treatment, procedure - other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70	70
Patient complains of inadequate pain management	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Patient factor	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3

	Sub Category (CCS Level 2)	Category (CCS Level 1)																	
		Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
	Patient's reaction to Medication	0	0	0	0	0	0	0	0	0	0	0	0	50	0	0	0	0	50
	Abuse etc of patient by patient	0	1502	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1502
	Post-partum haemorrhage > 1,000ml	0	0	0	0	0	0	0	0	0	0	29	0	0	0	0	0	0	29
	Security incident related to Premises, Land or Real Estate	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	120	0	120
	Preoperative factor	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	Preparation of medicines / dispensing in pharmacy	0	0	0	0	0	0	0	0	1	0	0	0	233	0	0	0	0	234
	Medication error during the prescription process	0	0	0	0	0	0	0	0	0	0	0	0	492	0	0	0	0	492
	Placenta praevia	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	4
	Security incident related to Personal property	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	264	0	264
	Pulmonary embolism postoperatively	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	4
	Problems following radiation therapy	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1

Sub Category (CCS Level 2)	Category (CCS Level 1)																	
	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Patient's case notes or records	0	0	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9
Problem with the referral from primary to secondary care	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Respiratory factor	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Respiratory Tract	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	10
Ruptured uterus	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	4
Self-harm during 24-hour care	0	709	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	709
Self harm in primary care, or not during 24-hour care	0	165	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	165
Needlestick injury or other incident connected with Sharps	0	0	293	0	0	0	0	0	0	0	0	0	0	0	0	0	0	293
Skin	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	35	35
Bones and joints of skull and spine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Soft tissue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Adverse events that affect staffing levels	0	0	0	0	0	0	0	0	0	607	0	0	0	0	0	0	0	607
Abuse of staff by other staff	0	33	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	33

	Category (CCS Level 1)																				
Sub Category (CCS Level 2)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Injury caused by physical or mental strain	0	0	21	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21
Connected with the management of operations / treatment	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	447	448
Test results / reports	0	0	0	0	0	0	0	0	124	0	0	0	0	0	0	0	0	124
Transfer	125	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	125
Pressure sore / decubitus ulcer	0	0	0	0	0	0	0	0	0	0	0	0	0	358	0	0	0	358
Urinary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3
Security issue related to Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	26	0	26
Delivery assisted by ventouse	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Totals:	**1181**	**6351**	**6821**	**12**	**293**	**548**	**13**	**2**	**549**	**1226**	**433**	**926**	**1741**	**810**	**131**	**721**	**924**	**22682**

NHSCT Incidents opened between 01/04/2011 and 31/03/2012

	STAGE OF CARE (CCS LEVEL 1)														
DETAIL (CCS LEVEL 2)	**AATD**	**ABUSE**	**ACCID**	**ASSESS**	**CCCP**	**INFO**	**INFRA**	**LABOUR**	**MEDDEV**	**MEDIC**	**MONIT**	**OTHER**	**SECRTY**	**TMTPRO**	**Total**
Abdominal organs other than digestive	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Placental abruption	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Administration of assessment	0	0	0	15	0	0	0	0	0	0	0	0	0	0	15
Admission	31	0	0	0	0	0	0	0	0	0	0	0	0	0	31
Appointment	10	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Arteries and veins	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Born before arrival	0	0	0	0	0	0	0	7	0	0	0	0	0	0	7
Transfusion of Blood related problem	0	0	0	0	0	0	0	0	0	0	0	0	0	13	13
Breech presentation	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Abuse by the staff to the patient	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5
Communication between staff, teams or departments	0	0	0	0	172	0	0	0	0	0	0	0	0	0	172
Communication with the patient (other than consent issues)	0	0	0	0	56	0	0	0	0	0	0	0	0	0	56
Confidentiality of information	0	0	0	0	19	0	0	0	0	0	0	0	0	0	19
Consent	0	0	0	0	3	0	0	0	0	0	0	0	0	0	3
Elective Caesarean Section	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Emergency Caesarean Section	0	0	0	0	0	0	0	21	0	0	0	0	0	1	22
Lower digestive tract	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1

	STAGE OF CARE (CCS LEVEL 1)														
DETAIL (CCS LEVEL 2)	**AATD**	**ABUSE**	**ACCID**	**ASSESS**	**CCCP**	**INFO**	**INFRA**	**LABOUR**	**MEDDEV**	**MEDIC**	**MONIT**	**OTHER**	**SECRTY**	**TMTPRO**	**Total**
Upper Digestive tract	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Difficult delivery	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Discharge	569	0	0	0	0	0	0	0	0	0	0	0	0	0	569
Patient's case notes or records	0	0	0	0	0	107	0	0	0	0	0	0	0	0	107
Shoulder dystocia	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Environmental matters	0	0	0	0	0	0	21	0	0	0	0	0	0	0	21
Electronic Patient Record	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Security issue related to Equipment	0	0	0	0	0	0	0	0	0	0	0	0	6	0	6
Lack of/delayed availability of facilities/equipment/supplies	0	0	0	0	0	0	41	0	0	0	0	0	0	0	41
Slips, trips, falls and collisions	1	0	3856	0	0	0	0	0	0	0	0	0	0	0	3857
Pathological or suspicious CTG or other fetal distress	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Fires, fire alarms and fire risks	0	0	0	0	0	0	0	0	0	0	0	0	45	0	45
Inadequate maintenance of fluids	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Labour assisted by forceps	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3
Exposure to electricity, hazardous substance, infection etc	0	0	91	0	0	0	0	0	0	0	0	0	0	0	91
Images for diagnosis (scan / x-ray)	0	0	0	7	0	0	0	0	0	0	0	0	0	0	7
Scans / X-ray images	0	0	0	0	0	30	0	0	0	0	0	0	0	0	30
Infection control	0	0	0	0	0	0	0	0	0	0	8	0	0	2	10
Laboratory investigations	0	0	0	55	0	0	0	0	0	0	0	0	0	0	55

	STAGE OF CARE (CCS LEVEL 1)														
DETAIL (CCS LEVEL 2)	**AATD**	**ABUSE**	**ACCID**	**ASSESS**	**CCCP**	**INFO**	**INFRA**	**LABOUR**	**MEDDEV**	**MEDIC**	**MONIT**	**OTHER**	**SECRTY**	**TMTPRO**	**Total**
Lifting accidents	0	0	105	0	0	0	0	0	0	0	0	0	0	0	105
Prolonged first or second stage of labour	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Medical device/equipment	0	0	0	0	0	0	0	0	218	0	0	0	0	0	218
Possible delay or failure to Monitor	0	0	0	0	0	0	0	0	0	0	17	0	0	0	17
Injury or poor outcome for the mother	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3
Mouth	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Abuse etc of Staff by patients	0	1344	0	0	0	0	0	0	0	0	0	0	0	0	1344
Abuse - other	0	178	0	0	0	0	0	0	0	0	0	0	0	0	178
Accident caused by some other means	0	0	459	0	0	0	0	0	0	0	0	0	0	0	459
Appointment, Admission, Transfer, Discharge - other	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Assessment - other	0	0	0	4	0	0	0	0	0	0	0	0	0	0	4
Consent, Confidentiality or Communication - other	0	0	0	0	34	0	0	0	0	0	0	0	0	0	34
Other	0	0	0	0	0	0	0	0	0	0	0	1068	0	0	1068
Infrastructure or resources - other	0	0	0	0	0	0	10	0	0	0	0	0	0	0	10
Information - other	0	0	0	0	0	54	0	0	0	0	0	0	0	0	54
Labour or delivery - other	0	0	0	0	0	0	0	58	0	0	0	0	0	0	58
Other medication error	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2
Implementation of care or ongoing monitoring - other	0	0	0	0	0	0	0	0	0	0	50	0	0	0	50
Security - other	0	0	0	0	0	0	0	0	0	0	0	0	12	0	12

	STAGE OF CARE (CCS LEVEL 1)														
DETAIL (CCS LEVEL 2)	**AATD**	**ABUSE**	**ACCID**	**ASSESS**	**CCCP**	**INFO**	**INFRA**	**LABOUR**	**MEDDEV**	**MEDIC**	**MONIT**	**OTHER**	**SECRTY**	**TMTPRO**	**Total**
Treatment, procedure - other	0	0	0	0	0	0	0	0	0	0	0	0	0	47	47
Patient's reaction to Medication	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2
Abuse etc of patient by patient	0	570	0	0	0	0	0	0	0	0	0	0	0	0	570
Post-partum haemorrhage > 1,000ml	0	0	0	0	0	0	0	4	0	0	0	0	0	0	4
Security incident related to Premises, Land or Real Estate	0	0	0	0	0	0	0	0	0	0	0	0	73	0	73
Security incident related to Personal property	0	0	0	0	0	0	0	0	0	0	0	0	66	0	66
Patient's case notes or records	0	0	0	4	0	0	0	0	0	0	0	0	0	0	4
Problem with the referral from primary to secondary care	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Ruptured uterus	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Self-harm during 24-hour care	0	265	0	0	0	0	0	0	0	0	0	0	0	0	265
Self harm in primary care, or not during 24-hour care	0	33	0	0	0	0	0	0	0	0	0	0	0	0	33
Needlestick injury or other incident connected with Sharps	0	0	106	0	0	0	0	0	0	0	0	0	0	0	106
Skin	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Adverse events that affect staffing levels	0	0	0	0	0	0	104	0	0	0	0	0	0	0	104
Abuse of staff by other staff	0	13	0	0	0	0	0	0	0	0	0	0	0	0	13
Connected with the management of operations / treatment	0	0	0	0	0	0	0	0	0	0	1	0	0	38	39
Test results / reports	0	0	0	0	0	39	0	0	0	0	0	0	0	0	39

	STAGE OF CARE (CCS LEVEL 1)														
DETAIL (CCS LEVEL 2)	**AATD**	**ABUSE**	**ACCID**	**ASSESS**	**CCCP**	**INFO**	**INFRA**	**LABOUR**	**MEDDEV**	**MEDIC**	**MONIT**	**OTHER**	**SECRTY**	**TMTPRO**	**Total**
Transfer	7	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Twin delivery or multiple birth	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Pressure sore / decubitus ulcer	0	0	0	0	0	0	0	0	0	0	127	0	0	0	127
Security issue related to Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	10	0	10
Delivery assisted by ventouse	0	0	0	0	0	0	0	4	0	0	0	0	0	0	4
MEDICATION STAGE															
Administration/supply of a medicine from a clinical area	0	0	0	0	0	0	0	0	0	218	0	0	0	0	218
Advice	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Monitoring/follow-up of medicine use	0	0	0	0	0	0	0	0	0	7	0	0	0	0	7
Other	0	0	0	0	0	0	0	0	0	74	0	0	0	0	74
Preparation of medicines/dispensing in a pharmacy	0	0	0	0	0	0	0	0	0	28	0	0	0	0	28
Prescribing	0	0	0	0	0	0	0	0	0	78	0	0	0	0	78
Supply or use of over-the-counter (OTC) medicine	0	0	0	0	0	0	0	0	0	8	0	0	0	0	8
Totals:	**624**	**2408**	**4617**	**85**	**284**	**231**	**176**	**114**	**218**	**422**	**204**	**1068**	**212**	**108**	**10771**

South Eastern HSC Trust

South Eastern
Incidents by Sub category and Type
1 April 2011 to 31 March 2012

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
Acute transfusion reaction	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Administration	404	0	0	0	0	0	0	0	0	0	0	0	0	404
Alleged assault/abuse by other	0	0	0	0	0	0	0	0	0	0	0	6	0	6
Alleged assault/abuse by pt/clt/res	0	0	0	0	0	0	0	0	0	0	0	13	0	13
Alleged assault/abuse by pt/clt/res (weapon)	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Actual Assault/abuse by other (weapon involved)	0	0	0	0	0	0	0	0	0	0	0	3	0	3
Actual Assault/abuse by pt/clt/res (weapon involved)	0	0	0	0	0	0	0	0	0	0	0	7	0	7
Assisted to floor	93	0	0	0	0	0	0	0	0	0	0	0	0	93
Actual Assault/abuse by other	0	0	0	0	0	0	0	0	0	0	0	24	0	24
Actual Assault/abuse by pt/clt/res	0	0	0	0	0	0	0	0	0	0	0	1210	0	1210
Awaited	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Bed Management	2	0	0	0	0	0	0	0	0	0	0	0	0	2

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
Delay in obtaining bleep holder or on-call staff	36	0	0	0	0	0	0	0	0	0	0	0	0	36
Bruising noted (cause unknown)	15	0	0	0	0	0	1	0	0	0	0	0	0	16
CDI	9	0	0	0	0	0	0	0	0	0	0	0	0	9
Incorrect documentation - Consent details incorrect/omitted	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Contact with electricity	0	0	0	0	0	0	0	7	0	0	0	0	0	7
Choking/Potential to choke	21	0	0	0	0	0	0	0	0	0	0	0	0	21
Contact with hot or very cold surface, object or substance	0	0	0	0	0	0	0	64	0	0	0	0	0	64
Collection or Delivery of blood from/to wards/lab/blood bank	7	0	0	0	0	0	0	0	0	0	0	0	0	7
Community Acquired Pressure Ulcer (Trust Patient)	59	0	0	0	0	0	0	0	0	0	0	0	0	59
*Breach of Confidentiality	16	0	0	0	0	0	0	0	0	0	0	0	0	16
Item dirty/contaminated - foreign body	149	0	0	0	0	0	0	0	0	0	0	0	0	149
Cut/Contact with sharp material/object (not needlestick)	0	0	0	0	0	0	0	86	0	0	0	0	0	86
Item dirty/contaminated - tissue	28	0	0	0	0	0	0	0	0	0	0	0	0	28
Item dirty/contaminated - not specified	10	0	0	0	0	0	0	0	0	0	0	0	0	10

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
Possible fall from bed (bedrails not specified)	142	0	0	0	0	0	0	0	0	0	0	0	0	142
Incorrect documentation - consent form not signed by pt/doctor	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Theatre list incorrectly typed by secretary	7	0	0	0	0	0	0	0	0	0	0	0	0	7
Arrival at theatre without correct consent documentation	6	0	0	0	0	0	0	0	0	0	0	0	0	6
Incorrect consent documentation - wrong body part/side listed	5	0	0	0	0	0	0	0	0	0	0	0	0	5
Incorrect consent form used	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Delayed Discharge/Transfer	24	0	0	0	0	0	0	0	0	0	0	0	0	24
*Delay in obtaining records	5	0	0	0	0	0	0	0	0	0	0	0	0	5
Delayed Sample	15	0	0	0	0	0	0	0	0	0	0	0	0	15
Disposal (sharps bin)	0	0	0	0	0	0	0	0	0	14	0	0	0	14
Disposal of sharps/biological agent (improper)	0	0	0	0	0	0	0	0	0	11	0	0	0	11
Dispensing	195	0	0	0	0	0	0	0	0	0	0	0	0	195
Damaged/wet packaging	9	0	0	0	0	0	0	0	0	0	0	0	0	9
Dog Bite	0	0	0	0	0	0	0	3	0	0	0	0	0	3

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
*Breach of DPA Legislation	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Failure to comply with EU Directive (eg traceability)	13	0	0	0	0	0	0	0	0	0	0	0	0	13
Exposed to infection	19	0	0	0	0	0	0	0	0	0	0	0	0	19
Expected death	6	0	0	0	0	0	0	0	0	0	0	0	0	6
Exposure to radiation	6	0	0	0	0	0	0	0	0	0	0	0	0	6
Fall from bed (bedrails up)	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Fall from bed (bedrails down)	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Possible fall from bed (bedrails down)	26	0	0	0	0	0	0	0	0	0	0	0	0	26
Possible fall from bed (bedrails up)	59	0	0	0	0	0	0	0	0	0	0	0	0	59
Possible fall from chair height	332	0	0	0	0	0	0	0	0	0	0	0	0	332
Fall from bed	27	0	0	0	0	0	0	0	0	0	0	0	0	27
Fall from height	0	0	0	0	0	0	0	17	0	0	0	0	0	17
Fall whilst mobilizing (assisted)	39	0	0	0	0	0	0	0	0	0	0	0	0	39
Possible fall while mobilizing	588	0	0	0	0	0	0	0	0	0	0	0	0	588
Fall whilst mobilizing (unassisted)	91	0	0	0	0	0	0	0	0	0	0	0	0	91
Item faulty/broken	7	0	0	0	0	0	0	0	0	0	0	0	0	7
Use of firearms	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Fall from chair/commode/toilet etc	62	0	0	0	0	0	0	0	0	0	0	0	0	62

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
Failure to act on results	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Found on floor - cause unknown	888	0	0	0	0	0	0	0	0	0	0	0	0	888
Hanging	22	0	0	0	0	0	0	0	0	0	0	0	0	22
Hit by moving vehicle	0	0	0	0	0	0	0	3	0	0	0	0	0	3
Road Traffic Accident	0	0	0	0	0	0	0	0	0	0	55	0	0	55
Hospital Acquired Pressure Ulcer	143	0	0	0	0	0	0	0	0	0	0	0	0	143
Exposure to or contact with harmful substance	0	0	0	0	0	0	0	5	0	0	0	0	0	5
Incorrect blood/component transfused	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Insufficient Information to allow coding by Pharmacy	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Issue of blood or blood products from blood bank	7	0	0	0	0	0	0	0	0	0	0	0	0	7
Jumping/multiple injuries	1	0	0	0	0	0	0	0	0	0	0	0	0	1
*Documentation - incorrect patient labels used or in file	14	0	0	0	0	0	0	0	0	0	0	0	0	14
Lifting/lowering (general)	0	0	0	0	0	22	0	0	0	0	0	0	0	22
Lifting/lowering (waste handling)	0	0	0	0	0	3	0	0	0	0	0	0	0	3
Lost Sample	10	0	0	0	0	0	0	0	0	0	0	0	0	10
Manoeuvring equipment with pt/client	0	0	0	0	0	7	0	0	0	0	0	0	0	7

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
Possibly due to medical condition	61	0	0	0	0	0	0	0	0	0	0	0	0	61
Due to medical condition	19	0	0	0	0	0	0	0	0	0	0	0	0	19
For Medication	13	0	0	0	0	0	0	0	0	0	0	0	0	13
Document/Labels misfiled	45	0	0	0	0	0	0	0	0	0	0	0	0	45
Documentation - incorrect/missing/ inadequate/illegible records	76	0	0	0	0	0	0	0	0	0	0	0	0	76
Mislabelled or wrong patient ID	45	0	0	0	0	0	0	0	0	0	0	0	0	45
*Missing Records	18	0	0	0	0	0	0	0	0	0	0	0	0	18

Southern HSC Trust

Incidents by Adverse event and Stage of care

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Absconder/missing patient - detained	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Absconder/missing patient - voluntary	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Admission could not be arranged / failure to admit	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Adverse reaction when drug used as intended	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Affray, fights, disorderly behaviour	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
False fire or intruder alarm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	47	0	47
Medication prescribed to which p. had a known allergy	0	0	0	0	0	0	0	0	0	0	0	12	0	0	0	0	12
Ambulance was late or failed to show up	14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14
Wrong quantity	0	0	0	0	0	0	0	0	0	0	0	17	0	0	0	0	17

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Appointment recording error	17	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	18
Cardiac arrest	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Actual or suspected Arson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	5
Inadequate assessment	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Delay / difficulty in obtaining clinical assistance	1	0	0	0	4	0	0	0	0	0	0	0	3	0	0	1	9
Awareness / dreaming / nightmare	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Lack of/delayed availability of beds (general)	4	0	0	0	0	0	0	0	12	0	0	0	0	0	0	0	16
Lack of/delayed availability of beds (high dependency/ICU)	0	0	0	0	0	0	0	0	9	0	0	0	0	0	0	0	9
Stretching or bending injury, other than lifting	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Exposure to biological hazard	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	15
Failure to answer bleep	0	0	0	0	0	9	0	0	0	0	0	0	0	0	0	0	9
Bomb threat/scare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	5

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Breach of patient confidentiality	0	0	0	0	0	19	0	0	0	0	0	0	0	0	0	0	19
Other breach of security or public order	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	0	10
Breathing system problem / failure	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Contact with very hot or very cold surface	0	0	35	0	0	0	0	0	25	0	0	0	0	0	0	0	60
Inadequate check on equipment	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	4
Exposure to chemical	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Injury from clean sharps	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Collapse of a structure or fitting	0	0	34	0	0	0	0	0	0	0	0	0	0	0	0	0	34
Collision with an object	0	0	116	0	0	0	0	0	0	0	0	0	0	0	0	0	116
Delay/failure in acting on complication of treatment	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
Simple complication of treatment	0	0	0	0	0	0	0	0	0	3	0	0	41	0	0	0	44

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Contra-indication to the use of the medication	0	0	0	0	0	0	0	0	0	0	0	11	0	0	0	0	11
Healthcare associated cross infection	0	0	0	0	0	0	0	0	0	0	0	0	12	0	0	42	54
Unintended injury in the course of an operation or clin task	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	18
Delay	23	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25	48
Delay in diagnosis for no specified reason	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	3
Delay in administering medicine	0	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	7
Failure/delay in collection/ delivery systems	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	7
Lack/unavailability of device	0	0	0	0	0	0	0	0	5	0	36	0	0	0	0	0	41
Wrong device/equipment used	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	3
Diathermy burn	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Injury from dirty sharps	0	0	64	0	0	0	0	0	0	0	0	0	0	0	0	0	64

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Equipment disconnection	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Absconder / missing patient	247	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	247
Patient does not attend appointment	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Documentation - delay in obtaining healthcare record / card	10	0	0	0	0	0	0	13	0	0	0	0	0	0	0	0	23
Healthcare record / card - mislabelled	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Documentation - no access to	5	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	10
Dose or strength was wrong or unclear	0	0	0	0	0	0	0	0	0	0	0	152	0	0	0	0	152
Unsafe / inappropriate clinical environment	56	0	0	0	0	0	0	0	12	0	0	0	1	0	0	0	69
Unsafe environment (personal safety, light, temp, noise, air)	0	0	0	0	0	0	0	0	34	0	0	0	0	0	0	0	34
Expiry date wrong, omitted or passed	0	0	0	0	0	0	0	0	0	0	0	14	0	0	0	0	14

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Failure or overload of IT or telecommunications system	0	0	0	0	0	0	0	0	18	0	0	0	0	0	0	0	18
Fire - Accidental	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0	18
Failure to follow up	4	0	0	0	1	0	0	0	0	0	0	0	3	0	0	0	8
Formulation of medication was wrong	0	0	0	0	0	0	0	0	0	0	0	18	0	0	0	0	18
Sharps or needles found	0	0	62	0	0	0	0	0	0	0	0	0	0	0	0	0	62
Frequency for taking of medication was wrong	0	0	0	0	0	0	0	0	0	0	0	78	0	0	0	0	78
Haemorrhage / haematoma, anaes.	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Inadequate handover of care	0	0	0	0	0	12	0	0	0	0	0	0	0	0	0	0	12
Fall from a height, bed or chair	0	0	234	0	0	0	0	0	0	0	0	0	0	0	0	0	234
Breach of confidentiality of staff records or information	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	3
Slips on ice or snow	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	7

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Diagnostic images / specimens - inadequate / incomplete	0	0	0	0	14	0	0	0	0	0	0	0	0	0	0	0	14
Discharge - inappropriate	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Hazardous and avoidable exposure to infection	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Infusion injury (extravasation)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Injury caused by medical device	0	0	0	0	0	0	0	0	0	0	8	0	0	0	0	0	8
Injury - cause unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	194	0	0	194
Communication failure within the team	0	0	0	0	0	11	0	0	0	0	0	0	0	0	0	0	11
Intruders, Break-ins, Trespassers, Intruder alarms	0	0	0	0	0	0	0	0	0	0	0	0	0	0	32	0	32
IT/telecommunications failure/ overload	0	0	0	0	0	7	0	0	0	0	0	0	0	0	0	0	7
Wrong / transposed / omitted medicine label	0	0	0	0	0	0	0	0	0	0	0	8	0	0	0	0	8

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Lifting in the course of moving a load	0	0	24	0	0	0	0	0	0	0	0	0	0	0	0	0	24
Records missing, believed lost, damaged or stolen	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	8
Moving machinery	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Other IT malfunction	0	0	0	0	0	0	0	0	13	0	0	0	0	0	0	0	13
Failure of a device or equipment	0	0	0	0	0	0	0	0	0	0	146	0	0	0	0	0	146
Failure to discontinue treatment	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4
Refusal of medication	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Documentation - misfiled	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	0	7
Mismatch between patient and medicine	0	0	0	0	0	0	0	0	0	0	0	39	0	0	0	0	39
Missing, inadequate or illegible healthcare record	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	3
Missing young person	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4

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Methicillin Resistant Staphylococcus Aureus	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	4
Missing needle/swab/ instrument	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3
Inadequate or no consent to treatment or procedure	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Supply failure (gas or power)	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4
Medicine not administered	0	0	0	0	0	0	0	0	0	0	0	95	0	0	0	0	95
Failure to note relevant information in patient's record	0	0	0	0	1	0	0	10	0	0	0	0	0	0	0	0	11
Omitted medicine or ingredient	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	6
Omitted medicine or ingredient	0	0	0	0	0	0	0	0	0	0	0	65	0	0	0	0	65
Operative site not marked	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Communication failure - outside of immediate team	0	0	0	0	0	44	0	0	0	0	0	0	0	0	0	0	44
Abuse - other	0	489	0	0	0	0	0	0	0	0	0	0	0	0	0	0	489
Accident of some other type or cause	0	0	284	0	0	0	0	0	0	0	0	0	0	0	0	0	284

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Access, admission, transfer, discharge other	23	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23
Anaesthesia - other	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Other incident to do with assessment	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	3
Consent, Confidentiality or Communication - other	0	0	0	0	0	16	0	0	0	0	0	0	0	0	0	0	16
Medical device/equipment - other	0	0	0	0	0	0	0	0	0	0	17	0	0	0	0	0	17
Documentation (including records, identification) other	0	0	0	0	7	0	0	30	0	0	0	0	0	0	0	0	37
Other - please specify in description	0	0	0	0	0	0	0	0	0	0	0	0	0	104	0	0	104
Other incident related to the Infrastructure	0	0	0	0	0	0	0	0	23	0	0	0	0	0	0	0	23
Other - Infection control incident	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	5	6
Labour or delivery - other	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3
Other medication incident	0	0	0	0	0	0	0	0	0	0	0	155	0	0	0	0	155

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Implementation & ongoing monitoring/review - other	0	0	0	0	0	0	0	0	0	0	0	0	26	0	0	0	26
Preoperative - other	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Other incident related to Security	0	0	0	0	0	0	0	0	0	0	0	0	0	0	50	0	50
Self-harming behaviour - other	0	43	0	0	0	0	0	0	0	0	0	0	0	0	0	0	43
Treatment, procedure - other adverse event	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	50	50
Communication failure with patient, parent or carer	0	0	0	1	0	21	0	0	0	0	0	0	0	0	0	0	22
Patient incorrectly identified	0	0	0	0	35	2	0	20	0	0	0	1	0	0	0	6	64
Lifting or moving a patient or other person	0	0	37	0	0	0	0	0	0	0	0	0	0	0	0	0	37
Physical abuse, assault or violence	0	1160	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1160
Discharge - planning failure	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Transfusion policy error	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	128	128

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Postponed or cancelled surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	52	52
Racial	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Adverse reaction to blood product	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Unexpected re-admission or re-attendance	15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15
Failure in referral process	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Patient refuses/fails to take/ discontinues medication or TMT	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Inappropriate use of control and restraint	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Retained needle/swab/ instrument	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	5
Wrong route for administration of medication	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Road Traffic Accident in the course of employment or care	0	0	36	0	0	0	0	0	0	0	0	0	0	0	0	0	36

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Attempted suicide, whether proven or suspected	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12
Self discharge, or against medical advice	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Sexual	0	60	0	0	0	0	0	0	0	0	0	0	0	0	0	0	60
Operation or procedure wrongly sited	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Self harm	0	158	0	0	0	0	0	0	0	0	0	0	0	0	0	0	158
Fall on level ground	0	0	1354	0	0	0	0	0	0	0	0	0	0	0	0	0	1354
Smoking related	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0	18
Hazardous exposure to smoke or fire	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Hazardous exposure to electricity or electric shock	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Wound or Surgical Site Infection	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	5
Lack of suitably trained / skilled staff	0	0	0	0	0	0	0	0	86	0	0	0	0	0	0	0	86

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Failure of sterilisation or contamination of equipment	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	5	6
Medication incorrectly stored	0	0	0	0	0	0	0	0	0	0	0	23	0	0	0	0	23
Stress-related illness possibly arising from employment	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Person struck by a projectile	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	0	14
Suicide (completed), whether proven or suspected	0	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11
Wrong method of preparation or supply	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Suspected fall	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Proven, alleged or suspected theft	0	0	0	0	0	0	0	0	0	0	0	0	0	0	57	0	57
Treatment/procedure - inappropriate/wrong	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Treatment / procedure - failed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Transfer - delay/failure	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Trapped in lift, locked in a room, other traps	0	0	19	0	0	0	0	0	0	0	0	0	0	0	0	0	19
Tripped over an object	0	0	42	0	0	0	0	0	0	0	0	0	0	0	0	0	42
Test results / reports - failure / delay to receive	0	0	0	0	23	0	0	0	0	0	0	0	0	0	0	0	23
Test results / reports - missing	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2
Test results / reports - mislabelled	0	0	0	0	8	0	0	1	0	0	0	0	0	0	0	0	9
Test request form - none/ incomplete	0	0	0	0	18	0	0	0	0	0	0	0	0	0	0	0	18
Unplanned admission / transfer to specialist care unit	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Urgent appointment not available when required	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
User error	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	7
Damage caused by vandalism (other than ARSON)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	28	0	28
Verbal direction to patient was wrong or omitted	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Verbal abuse or disruption	0	685	0	0	0	0	0	0	0	0	0	0	0	0	0	0	685
Connected with clinical waste	0	0	0	0	0	0	0	0	6	0	0	0	1	0	0	0	10
Connected with domestic waste	0	0	0	0	0	0	0	0	15	0	0	0	0	0	0	0	15
Assault etc with a weapon	0	24	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24
Wrong drug / medicine	0	0	0	0	0	0	0	0	0	0	0	81	0	0	0	0	81
Test results/ images - available but inaccurate	0	0	0	0	8	0	0	1	0	0	0	0	0	0	0	0	9
Failure to act on adverse test results or images	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Accidental or malicious use of an Alarm System	0	0	0	0	0	0	0	0	0	0	0	0	0	0	50	0	50
Diagnostic images or Lab tests not available when required	0	0	0	0	3	1	0	0	0	0	0	0	1	0	0	0	5
Blood product not available	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	37	37
Diagnostic images / specimens missing	0	0	0	0	20	0	0	1	0	0	0	0	0	0	0	0	21

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Diagnostic Images / specimens - mislabelled / unlabelled	0	0	0	0	34	0	0	0	0	0	0	0	0	0	0	0	34
Theatre list details incorrect	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	14	15
Cross-matching error	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Delay or failure to monitor	0	0	0	0	0	0	0	0	0	0	0	0	9	0	0	0	9
Failure/delay to order correct tests, image etc	0	0	0	0	14	0	0	0	0	0	0	0	0	0	0	0	14
Failure to act on adverse symptoms	0	0	0	0	2	0	1	0	0	0	0	0	1	0	0	0	4
Totals:	465	2648	2414	18	198	145	4	102	272	6	217	802	106	298	321	406	8422

Western HSC Trust

STAGE OF CARE (CCS LEVEL 1)																					
ADVERSE EVENT (CCS LEVEL 3)		Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total	
Unauthorised access or use of password		0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1		
Admission could not be arranged / failure to admit		8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8		
Adverse reaction when drug used as intended		0	0	0	0	0	0	0	0	0	0	0	0	20	0	0	0	0	20		
Affray, fights, disorderly behaviour		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	4		
False fire or intruder alarm		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	0	10		
Medication prescribed to which p. had a known allergy		0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4		
Ambulance was late or failed to show up		2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2		
Wrong quantity		0	0	0	0	0	0	0	0	0	0	0	0	41	0	0	0	0	41		
Apgars <6 at 5 mins		0	0	0	0	0	0	0	0	0	0	11	0	0	0	0	0	0	11		
Appointment recording error		4	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	5		

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Cardiac arrest	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	6	8
Actual or suspected Arson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	29	0	29
Delay / difficulty in obtaining clinical assistance	2	0	0	0	2	0	0	0	0	0	5	0	0	3	0	0	10	22
Lack of/delayed availability of beds (general)	2	0	0	0	0	0	0	0	0	19	0	0	0	0	0	0	0	21
Lack of/delayed availability of beds (high dependency/ICU)	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	4
Stretching or bending injury, other than lifting	0	0	16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16
Exposure to biological hazard	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Failure to answer bleep	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	3
Bomb threat/scare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Breach of patient confidentiality	0	0	0	0	0	13	0	0	0	0	0	0	0	0	0	0	0	13
Other breach of security or public order	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24	0	24
Breathing system problem / failure	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1

STAGE OF CARE (CCS LEVEL 1)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
ADVERSE EVENT (CCS LEVEL 3)																		
Contact with very hot or very cold surface	0	0	50	0	0	0	0	0	0	0	0	0	0	0	0	0	0	50
Catheter-related urinary tract infection	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Inadequate check on equipment	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	4
Injury from clean sharps	0	0	28	0	0	0	0	0	0	0	0	0	0	0	0	0	0	28
Collapse of a structure or fitting	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Collision with an object	0	0	144	0	0	0	0	0	0	0	0	0	0	0	0	0	0	144
Delay/failure in acting on complication of treatment	0	0	0	0	0	0	0	0	0	0	3	0	0	6	0	0	15	24
Simple complication of treatment	0	0	0	0	0	0	0	0	0	0	82	0	0	225	0	0	0	307
Contra-indication to the use of the medication	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	3
Cord PH < 7.15	0	0	0	0	0	0	0	0	0	0	20	0	0	0	0	0	0	20
Healthcare associated cross infection	0	0	0	0	0	0	0	0	0	0	0	0	0	21	0	0	2	23
Unintended injury in the course of an operation or clin task	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	35	35

STAGE OF CARE (CCS LEVEL 1)																				
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Delay	4	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	18	23
Delay in diagnosis for no specified reason	0	0	0	0	0	0	4	0	0	0	3	0	0	0	0	0	0	7
Failure/delay in collection/delivery systems	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	7
Lack/unavailability of device	0	0	0	0	0	0	0	0	0	8	0	17	0	0	0	0	0	25
Wrong device/equipment used	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	4
Diagnosis - wrong	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Delayed diagnosis of infection	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Injury from dirty sharps	0	0	103	0	0	0	0	0	0	0	0	0	0	0	0	0	0	103
Absconder / missing patient	406	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	406
Patient does not attend appointment	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Documentation - delay in obtaining healthcare record / card	5	0	0	0	0	0	0	0	19	0	0	0	0	0	0	0	0	24
Healthcare record / card - mislabelled	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	3
Documentation - no access to	3	0	0	0	1	0	0	0	16	0	0	0	0	0	0	0	1	21

STAGE OF CARE (CCS LEVEL 1)																				
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Dose or strength was wrong or unclear	0	0	0	0	0	0	0	0	0	0	0	0	31	0	0	0	0	31
Eclamptic fit	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Unsafe / inappropriate clinical environment	12	0	0	0	0	0	0	0	0	9	0	0	0	0	0	0	2	23
Unsafe environment (personal safety, light, temp, noise, air)	0	0	0	0	0	0	0	0	0	13	0	0	0	0	0	0	0	13
Expiry date wrong, omitted or passed	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Extended stay / episode of care	0	0	0	0	0	0	0	0	0	0	5	0	0	3	0	0	2	10
Failure or overload of IT or telecommunications system	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0	6
Fetal abnormality detected at birth	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Financial Loss	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	0	0	7
Fire - Accidental	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15	0	15
Failure to follow up	5	0	0	0	2	0	0	0	0	0	0	0	11	8	0	0	8	34
Formulation of medication was wrong	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4
Sharps or needles found	0	0	87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	87

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Frequency for taking of medication was wrong	0	0	0	0	0	0	0	0	0	0	0	0	23	0	0	0	0	23
Inappropriate handling of the patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	5
Inadequate handover of care	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	5
Unplanned homebirth with good outcome	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Fall from a height, bed or chair	0	0	202	0	0	0	0	0	0	0	0	0	0	0	0	0	0	202
History insufficient or symptoms unaccounted for	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Breach of confidentiality of staff records or information	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	4
Slips on ice or snow	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Diagnostic images / specimens - inadequate / incomplete	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6
Discharge - inappropriate	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Hazardous and avoidable exposure to infection	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8

STAGE OF CARE (CCS LEVEL 1)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
ADVERSE EVENT (CCS LEVEL 3)																		
Patient information leaflet wrong or omitted	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Infusion injury (extravasation)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	5
Injury caused by medical device	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	5
Communication failure within the team	0	0	0	0	0	13	0	0	0	0	0	0	0	0	0	0	0	13
Intruders, Break-ins, Trespassers, Intruder alarms	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	30	0	30
Wrong / transposed / omitted medicine label	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4
Lack of clinical or risk assessment	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Diagnosis not normally possible at the time of the incident	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2
Lifting in the course of moving a load	0	0	18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18
Records missing, believed lost, damaged or stolen	0	0	0	0	0	0	0	0	16	0	0	0	0	0	0	0	0	16
Equipment malfunction / failure	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Other IT malfunction	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0	6

STAGE OF CARE (CCS LEVEL 1)																		
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Failure of a device or equipment	0	0	0	0	0	0	0	0	0	0	0	120	0	0	0	0	0	120
Failure to discontinue treatment	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
Cardiac ischaemia / infarction	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Documentation - misfiled	0	0	0	0	0	0	0	0	18	0	0	0	0	0	0	0	0	18
Mismatch between patient and medicine	0	0	0	0	0	0	0	0	0	0	0	0	22	0	0	0	0	22
Missing, inadequate or illegible healthcare record	0	0	0	0	1	0	0	0	2	0	0	0	0	0	0	0	0	3
Methicillin Resistant Staphylococcus Aureus	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0	0	1	19
Missing needle/swab/instrument	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4
Neonatal death	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Unexpected admission to Neo-Natal Unit	0	0	0	0	0	0	0	0	0	0	56	0	0	0	0	0	0	56
Inadequate or no consent to treatment or procedure	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	6
Medicine not administered	0	0	0	0	0	0	0	0	0	0	0	0	49	0	0	0	0	49

STAGE OF CARE (CCS LEVEL 1)																	
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Failure to note relevant information in patient's record	0	0	0	0	4	0	0	0	11	0	0	0	0	0	0	0	0	15
Lifting or moving an object other than a load	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Omitted medicine or ingredient	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Communication failure - outside of immediate team	0	0	0	0	0	46	0	0	0	0	0	0	0	0	0	0	0	46
Abuse - other	0	213	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	213
Accident of some other type or cause	0	0	275	0	0	0	0	0	0	0	0	0	0	0	0	0	0	275
Access, admission, transfer, discharge other	32	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	32
Disruptive, aggressive behaviour - other	0	52	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	52
Anaesthesia - other	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Other incident to do with assessment	0	0	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	15
Consent, Confidentiality or Communication - other	0	0	0	0	0	36	0	0	0	0	0	0	0	0	0	0	0	36
Medical device/equipment - other	0	0	0	0	0	0	0	0	0	0	0	17	0	0	0	0	0	17

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Diagnosis - other	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Documentation (including records, identification) other	1	0	0	0	5	0	0	0	21	0	0	0	0	0	0	0	0	27
Other - Clinical Trials	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22	0	0	22
Other incident related to the Infrastructure	0	0	0	0	0	0	0	0	0	17	0	0	0	0	0	0	0	17
Other - Infection control incident	0	0	0	0	0	0	0	0	0	0	0	0	0	20	0	0	3	23
Labour or delivery - other	0	0	0	0	0	0	0	0	0	0	16	0	0	0	0	0	0	16
Other medication incident	0	0	0	0	0	0	0	0	0	0	0	0	52	0	0	0	0	52
Implementation & ongoing monitoring/ review - other	0	0	0	0	0	0	0	0	0	0	0	0	0	46	0	0	0	46
Other incident related to Security	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	49	0	49
Self-harming behaviour - other	0	92	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	92
Treatment, procedure - other adverse event	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	29	29
Communication failure with patient, parent or carer	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	5

STAGE OF CARE (CCS LEVEL 1)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
ADVERSE EVENT (CCS LEVEL 3)																		
Patient incorrectly identified	0	0	0	0	13	1	0	0	11	0	0	0	0	0	0	0	5	30
Patient injury or damage	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Lifting or moving a patient or other person	0	0	29	0	0	0	0	0	0	0	0	0	0	0	0	0	0	29
Physical abuse, assault or violence	0	1054	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1054
Discharge - planning failure	27	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	27
Transfusion policy error	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70	70
Postponed or cancelled surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4
Post-partum haemorrhage > 1,000ml	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	6
Racial	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Unintended exposure to radiation	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Respiratory arrest	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Adverse reaction to blood product	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	7
Unexpected re-admission or re-attendance	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Failure in referral process	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7

STAGE OF CARE (CCS LEVEL 1)																				
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Missing, inadequate, illegible referral letter	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
Patient refuses/fails to take/ discontinues medication or TMT	0	0	0	0	0	1	0	0	0	0	0	0	4	0	0	0	3	8
Maternal resuscitation	0	0	0	0	0	0	0	0	0	0	12	0	0	0	0	0	0	12
Failure to return from authorised leave	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Wrong route for administration of medication	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Road Traffic Accident in the course of employment or care	0	0	39	0	0	0	0	0	0	0	0	0	0	0	0	0	0	39
Attempted suicide, whether proven or suspected	0	44	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	44
Self discharge, or against medical advice	9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Sexual	0	58	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	58
Operation or procedure wrongly sited	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Self harm	0	212	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	212

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Fall on level ground	0	0	385	0	0	0	0	0	0	0	0	0	0	0	0	0	0	385
Hazardous exposure to smoke or fire	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Hazardous exposure to electricity or electric shock	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Wound or Surgical Site Infection	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	4	6
Lack of suitably trained /skilled staff	0	0	0	0	0	0	0	0	0	90	0	0	0	0	0	0	0	90
Failure of sterilisation or contamination of equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Stillbirth	0	0	0	0	0	0	0	0	0	0	14	0	0	0	0	0	0	14
Medication incorrectly stored	0	0	0	0	0	0	0	0	0	0	0	0	15	0	0	0	0	15
Person struck by a projectile	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Suicide (completed), whether proven or suspected	0	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25
Wrong method of preparation or supply	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	6
Suspected fall	0	0	1645	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1645
Third or fourth degree tears	0	0	0	0	0	0	0	0	0	0	30	0	0	0	0	0	0	30

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Proven, alleged or suspected theft	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70	0	70
Lack of/delayed availability of operating theatre	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Unplanned return to theatre	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	3	4
Treatment/procedure - inappropriate/ wrong	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	9	11
Treatment / procedure - failed	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	5	11
Transfer - delay/failure	16	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	17
Trapped in lift, locked in a room, other traps	0	0	47	0	0	0	0	0	0	0	0	0	0	0	0	0	0	47
Tripped over an object	0	0	52	0	0	0	0	0	0	0	0	0	0	0	0	0	0	52
Test results / reports - failure / delay to receive	0	0	0	0	9	0	0	0	3	0	0	0	0	0	0	0	0	12
Test results / reports - missing	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	4
Test results / reports - mislabelled	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	3
Test request form - none/incomplete	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Unplanned admission / transfer to specialist care unit	59	0	0	0	0	0	0	0	0	0	8	0	0	0	0	0	1	68
User error	0	0	0	0	0	0	0	0	0	0	0	14	0	0	0	0	0	14
Damage caused by vandalism (other than ARSON)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	74	0	74
Verbal abuse or disruption	0	429	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	429
Connected with clinical waste	0	0	0	0	0	0	0	0	0	4	0	0	0	1	0	0	1	6
Connected with domestic waste	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	2
Assault etc with a weapon	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Incorrect blood product given	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Wrong drug / medicine	0	0	0	0	0	0	0	0	0	0	0	0	69	0	0	0	0	69
Test results/ images - available but inaccurate	0	0	0	0	8	0	0	0	2	0	0	0	0	0	0	0	0	10
Failure to act on adverse test results or images	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4
Accidental or malicious use of an Alarm System	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0	11

STAGE OF CARE (CCS LEVEL 1)																				
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total	
Diagnostic images or Lab tests not available when required	0	0	0	0	5	0	0	0	4	0	0	0	0	0	0	0	0	9	
Diagnostic images / specimens missing	0	0	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0	11	
Diagnostic Images / specimens - mislabelled / unlabelled	0	0	0	0	75	0	0	0	2	0	0	0	0	0	0	0	0	77	
Theatre list details incorrect	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	9	14	
Delay or failure to monitor	0	0	0	0	0	0	0	0	0	0	0	0	32	31	0	0	26	89	
Treatment not clinically indicated	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	2	5	
Failure/delay to order correct tests, image etc	0	0	0	0	4	0	1	0	0	0	0	0	0	1	0	0	0	6	
Failure to act on adverse symptoms	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	2	
Totals:	**615**	**2188**	**3160**	**9**	**171**	**133**	**11**	**7**	**139**	**192**	**286**	**177**	**402**	**394**	**22**	**317**	**300**	**8523**	

Adverse Incidents by Category and Incident date grouped by Stage of care
NIAS

	2011 04	2011 05	2011 06	2011 07	2011 08	2011 09	2011 10	2011 11	2011 12	2012 01	2012 02	2012 03	Total
	139	104	106	125	97	91	114	133	259	199	153	122	1642
Assault	3	1	0	1	1	0	1	1	6	4	2	3	23
Asset loss, damage etc	0	0	0	0	0	4	2	3	0	6	5	0	20
Late Meal Break	30	14	24	35	32	17	26	56	119	100	69	57	579
Building-Land	0	2	4	4	3	1	2	2	4	2	3	1	28
Confidentiality	0	0	0	0	0	0	0	1	0	0	0	0	1
Contact with something	2	1	2	3	0	0	4	3	3	3	2	0	23
Hazardous Substance	0	0	0	0	1	0	0	5	1	1	2	0	10
Drug	22	27	13	12	18	13	14	11	16	12	7	6	171
Equipment	27	28	32	34	21	29	30	28	33	26	22	24	334
Ergonomic	1	1	0	1	0	1	0	0	0	0	2	0	6
Harrassment	1	1	3	0	0	0	1	0	1	3	1	0	11
Manual Handling	4	2	4	5	3	0	9	1	10	5	11	4	58
Organisational	12	13	8	5	6	6	7	6	20	14	5	8	110
Records Management	1	0	0	0	1	0	0	2	3	2	0	1	10
Sharp Object	2	0	1	1	0	1	2	1	1	0	1	2	12
Slip, trip or fall	3	1	0	2	2	1	2	1	6	2	3	1	24
Treatment	3	1	0	3	1	1	1	2	2	1	0	1	16
Vehicle	28	12	15	19	8	17	13	10	34	18	18	14	206

MAHI - STM - 300 - 1647
Correspondence

	2011 04	2011 05	2011 06	2011 07	2011 08	2011 09	2011 10	2011 11	2011 12	2012 01	2012 02	2012 03	Total
	139	**104**	**106**	**125**	**97**	**91**	**114**	**133**	**259**	**199**	**153**	**122**	**1642**
Access, Appointment, Admission, Transfer, Discharge	10	19	16	20	9	16	12	5	6	10	12	12	147
Assault	0	0	0	0	0	0	0	0	0	0	0	1	1
Asset loss, damage etc	0	0	0	0	0	0	1	0	0	0	0	0	1
Drug	2	1	1	0	1	2	0	0	0	0	0	0	7
Equipment	1	4	6	9	4	4	4	0	0	2	1	4	39
Manual Handling	1	1	0	0	1	0	2	0	0	0	1	0	6
Organisational	4	11	6	6	2	6	3	5	4	7	8	7	69
Slip, trip or fall	1	0	1	0	1	0	0	0	0	0	0	0	3
Treatment	0	0	1	4	0	2	0	0	1	1	1	0	10
Vehicle	1	2	1	1	0	2	2	0	1	0	1	0	11
Abusive, violent, disruptive or self-harming behaviour	18	20	26	31	22	16	17	19	26	18	18	20	251
Assault	18	17	26	30	21	16	15	19	26	18	18	20	244
Asset loss, damage etc	0	0	0	0	0	0	1	0	0	0	0	0	1
Equipment	0	2	0	0	0	0	0	0	0	0	0	0	2
Harrassment	0	1	0	1	0	0	0	0	0	0	0	0	2
Vehicle	0	0	0	0	1	0	1	0	0	0	0	0	2
Accident that may result in personal injury	15	10	16	19	25	22	13	16	17	10	18	28	209
Building-Land	0	0	0	0	0	0	0	0	0	1	0	0	1
Contact with something	5	0	3	2	4	3	2	1	0	3	2	5	30

	2011 04	2011 05	2011 06	2011 07	2011 08	2011 09	2011 10	2011 11	2011 12	2012 01	2012 02	2012 03	Total
	139	104	106	125	97	91	114	133	259	199	153	122	1642
Hazardous Substance	0	0	0	0	1	1	0	0	0	0	0	2	4
Equipment	0	0	0	0	0	0	0	0	0	0	0	2	2
Manual Handling	1	5	7	6	3	6	3	2	1	2	3	5	44
Sharp Object	2	0	0	0	1	0	1	0	0	0	0	2	6
Slip, trip or fall	1	1	4	2	6	7	4	4	1	2	3	5	40
Vehicle	6	4	2	9	10	5	3	9	15	2	10	7	82
Medication	0	0	0	1	1	0	0	0	0	0	0	0	2
Treatment	0	0	0	1	1	0	0	0	0	0	0	0	2
Other - please specify in description	0	0	0	0	0	0	0	0	0	0	1	1	2
Contact with something	0	0	0	0	0	0	0	0	0	0	0	1	1
Hazardous Substance	0	0	0	0	0	0	0	0	0	0	1	0	1
Security	0	0	0	0	0	1	0	0	0	0	0	0	1
Equipment	0	0	0	0	0	1	0	0	0	0	0	0	1
Totals:	**182**	**153**	**164**	**196**	**154**	**146**	**156**	**173**	**308**	**237**	**202**	**183**	**2254**

RQIA

Under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and associated regulations, regulated services are required to report certain adverse incidents to RQIA. These include: deaths; serious injury; accidents; outbreaks of infectious disease; allegations of misconduct; incidents involving the police; and a range of other incidents. During 2011-12, 14,551 such incidents were reported to RQIA. In addition, under The Mental Health (Northern Ireland) Order 1986 as amended by the Health and Social Care (Reform) Act (Northern Ireland) 2009, certain categories of serious adverse incidents must be reported to RQIA by HSC trusts. These include: actual or alleged assault; sexual assault or allegation; death; suspected suicide; other incidents. During 2011-12, 191 such incidents were reported to RQIA.

The following tables provide a breakdown of reportable incidents by category across all regulated services and mental health and learning disability services. It should be noted that these figures should be considered in light of the age and health profile of the care population.

All Regulated Services

Category	Number
Death	2,982
Accident	2,229
Serious injury	1,449
Serious illness	960
Allegation of misconduct	795
Incident involving the police	633
Outbreak of infectious disease	227
Other incidents	5,276
Total	**14,551**

Mental Health and Learning Disability Services

Category	Number
Suspected suicide	90
Death	59
Actual/alleged assault	9
Actual/alleged sexual assault	9
Other incidents	24
Total	**191**

While it is not possible to provide a composite regional analysis at this stage it is expected that the implementation of the RAIL project will allow the analysis and monitoring of adverse incidents on a regional basis similar to that which is applied to Serious Adverse Incidents.

All investigations within the HSC follow the principles of the NPSA's guidance: *Being Open – Communicating Patient Safety Incidents with Patients, their Families and Carers (Revised 2009)* http://www.nrls.npsa.nhs.uk/alerts/?entryid45=65077

HSS (SQSD) 34/2007 HSC Regional Template and Guidance for Incident Review Reports draws attention to the principles outlined in Being Open.

http://www.dhsspsni.gov.uk/hsc__sqsd__34-07.pdf

Criteria 5.3.2(d) of the Quality Standards for Health and Social Care (2006) requires the HSC to have "systems in place that promote ongoing communication with service users and carers when treatment or care goes wrong". The Quality Standards are used by RQIA to assess the quality of care provided by the HSC. http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health___social_care.pdf

Trust policies and procedures state that the patient/client should be notified at the earliest opportunity if a serious near miss or adverse incident occurs and a note documented in their medical/health and social care record. However, from the Trust's database it is not possible to identify how many individuals were actually notified that an adverse incident had occurred.

With regard to SAIs, it is Trust practice to involve the patient/client and/or family member in the investigation and the outcome of this is documented in a section of the report entitled 'Involvement/contact with patient/client and/or family member'. However, it must be recognised that not all patients/clients and/or family member/s wish to participate in investigations.

11) Your assessment of the number of adverse or serious adverse incidents that go unreported as a result of issues arising from senility/mental illness where the patient does not have an advocate to complain, or people having died due to having been deferred from a waiting list repeatedly.

Trust staff are encouraged to advocate for patients/clients and raise concerns on their behalf. Trusts also engage with a number of independent/voluntary organisations to provide advocacy services for clients/patients who do not have capacity, or who feel unable to raise concerns directly with HSC staff. Within Learning Disability services there are also a number of appointed advocates for individual clients who cannot represent themselves. In addition, Trusts have robust complaints system, which operate at local and corporate level. In addition, there are a number of systems in place throughout Trusts whereby patients/clients are given the opportunity raise concerns.

There are requirements within legislation which require regulated services and trusts to report certain categories of incidents to RQIA. It is not possible to quantify the number of incidents that go unreported. However, where there is an identified failure to report incidents in line with relevant legislation, RQIA may take enforcement action against a regulated service (see note below), or in the case of a trust RQIA may escalate its concerns to the relevant chief executive.

Note: Under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, the following health and social care services are required to register with RQIA, and are subject to regulation:

- Adult placement agencies
- Children's homes
- Day care settings
- Domiciliary care agencies
- Independent clinics
- Independent hospitals (including private dental practices) *Nursing agencies Nursing homes *Residential care homes *Residential family centres Voluntary adoption agencies

14) Confirmation of the number of fatalities that relate to the 2084 serious adverse incidents referred to at paragraph 3.5 of the Audit Office report.

A SAI notification that documents a death does not necessarily imply that the circumstances relating to the adverse incident contributed to the cause of the death. Information from SAI notifications are captured at the time of reporting and it is not possible to determine causes (or responsibility) until all investigatory processes are completed.

Death Related SAI's - Period July 2004 to 31 March 2012

Suicide (completed), whether proven or suspected	488
Other death related	325
Total	**813**

The figure of 813 - is death related SAI's for the total notification received and **not** individual deaths as a SAI may be received relating to one incident but may involve one or more deaths e.g. maternal / neonatal death.

Deaths are reported where the individual is known to HSC services e.g. mental health services, children's services, community care, etc. The table includes deaths reported as a result of road traffic accidents, homicide, filicide, drowning, etc.

It should be noted therefore that deaths reported may not be a reflection of issues with the care delivered by health and social care services.

15) A summary of the steps the Department is taking to drive improvements in the collation of information on all incidents across the entire sector prior to the implementation of any new management information system.

Departmental circular HSC (SQSD) 8/2010 Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services was issued following the transfer of reporting arrangements from DHSSPS to HSCB. This provides guidance to HSC bodies on revised reporting roles and responsibilities as a result of the transfer.

Section 2 sets out the roles, responsibilities and accountability arrangements for incident reporting pending the establishment of RAIL.

The Public Health Agency/HSC Board have also established a number of regional groups which include the following:

- Regional commissioning indicators
- Regional Key Performance Indicators for Nursing
- Regional Quality Improvement Groups e.g. Falls and Pressure Ulcers.
- Regional governance leads meeting.
- Regional Patient Safety Officer Meeting

All these groups take forward work which will include improvements in the collation of information on all incidents across the entire sector prior to the implementation of any new management information system.

The HSCB/PHA are in the process of carrying out a review of the SAI system with a view to improving reporting mechanisms. The review will involve meetings with individual Trusts. Following completion of the review, the HSCB/PHA intend to issue revised guidance on the SAI process.

PAC may wish to note that in addition to reporting on AIs there are other local and national reporting arrangements (with statutory or mandatory reporting obligations) that operate

in tandem with serious adverse incident reporting process. These include, for example, notifications to:

- Coroners Service for Northern Ireland – sudden or unexplained death (such as industrial diseases) should be referred to the coroner;
- Health and Safety Executive Northern Ireland (HSENI) – incidents are required to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 (RIDDOR);
- Northern Ireland Adverse Incident Centre (NIAIC) – incidents involving medical devices, non-medical equipment, plant and building items used in HSC services;
- DHSSPS, Pharmaceutical Advice and Services - drug alerts; and
- Medicines & Healthcare Products Regulatory Agency (MHRA) – for safety problems with medicines, medical devices and blood.

In relation to the development of the RAIL system, all Trusts are actively represented on both the Project Team and the Project Board. However, in the interim period until the new system is approved and implemented at Trust level, work is continuing to further embed an open culture and philosophy for adverse incident reporting, investigation and management. Examples of this work include:

- Review and update of the extant Incident Policies and Procedures;
- Awareness and training sessions on Incident Reporting;
- Approved project mandate to roll-out Datix web; draft project plan to implement Datix Web on an organisational basis is currently under development;
- Provision of quarterly reports (and other ad hoc reports) to Assistant Directors and 4th line staff in respect of adverse incidents, claims and litigation;
- Newsletter published following each Lessons Learnt Sub Committee meeting containing articles generated from the reports provided to the subcommittee to ensure dissemination of organisational learning at Directorate level;
- Further embedding of Safety, Quality & Experience programme via the Corporate and Directorate Management plan which includes governance issues relating to incidents, complaints and litigation.
- Provision of information for the purposes of appraisals viz medical staff on adverse incidents, complaints and claims that they have been involved in, on a yearly basis;
- Regular monitoring of open incidents and lessons learnt from SAIs through Directorate Governance Fora meetings, Monthly Performance Improvement Meetings and the Chief's Executives Mid and End of Year Accountability Review meetings; Governance Assurance Meetings, Corporate Control and Safety & Quality Committee meetings (and sub committees aligned to each area).

16) The Department's projected timeframe for the pilot and for the full implementation of the Regional Adverse Incidents and Learning System; a detailed summary of the realistic, projected costs of its design and build; and confirmation of whether the intellectual property rights to the system will be retained by the Department.

The Regional Adverse Incident Learning System (RAIL) Outline Business Case (OBC) is going through the Department's assurance process. The Public Health Agency (PHA) has been asked to address several queries and we expect a revised OBC within the next few weeks.

The total estimated cost associated with the preferred option (a twelve month pilot) is £383,771 as set out in the original OBC. The pilot will then inform a full business case.

With regards to Intellectual Property Rights (IPR) it is anticipated that within the pilot, members of the RAIL team will be utilising software products with which they are already or will become familiar with e.g. DATIX, INFRA, MS Access, MS SQL etc.

Assuming RAIL proceeds beyond the pilot it is most likely that the PHA will select a software product(s), or link two or more software products and configure the product(s) to meet requirements. It will only be in the event of PHA developing a solution from scratch that IPR will be considered. It will not be an issue if PHA configure a procured software product, as the product would be used under licence and subject to its own terms and conditions.

The issue of IPR has been logged on the pilot's "Issues Register" and will be revisited during the latter stages of the pilot.

Correspondence of 21 January 2013 from Dr Andrew McCormick

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

From the Permanent Secretary
and HSC Chief Executive

Dr Andrew McCormick

Michaela Boyle
Chairperson
Public Accounts Committee
Room 371
Parliament Buildings
Ballymiscaw
BELFAST
BT4 3XX

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Tel: 028 90 520559
Fax: 028 90 520573
Email:
andrew.mccormick@dhsspsni.gov.uk

Our Ref: AMCC 4226
SECCOR/387/2012
DH3-12-8582

Date: 21 January 2013

Dear Michaela

Evidence Session on the Safety of Services provided by Health and Social Care Trusts

Further to my letter of 8 January 2012, please find attached the remaining supplementary information in relation to the Committee's additional queries in relation to the above report.

I trust this is helpful. If you have any further queries, please contact Paul Gibson on 028 9052 0288 in the first instance.

Yours sincerely

ANDREW McCORMICK

3. **A breakdown of live negligence cases in the Belfast Trust which would be attributed to complex cases and a summary of the information recorded and how it is used in order to mitigate the risk of repeated failures by individuals.**

The Belfast Health and Social Care Trust advised that, as at November 2012, there were 931 live negligence cases. The table below sets out the number of cases where the estimated value of compensation would be in excess of £500,000 which would relate to the more complex cases.

Specialty	Number of Active Cases
Paediatrics/Cardiology	2
Obstetrics	5
Obstetrics/Midwifery	2
A&E/Orthopaedic Surgery/Vascular Surgery	3
Neurosurgery/Orthopaedic Surgery/Ophthalmics	3
Intensive Care/Nursing	2
Other (Anaesthetics/Psychiatric/Orthopaedics/General Medicine)	5
Total	**22**

Information as at 03/01/13

The process the Trust has developed to learn from claims and mitigate against risk is applied against all claims regardless of "complexity". The Trust uses a commercial risk management software system 'Datix' to record information for each case. Each case is logged onto Datix and a number of fields are completed. A screen shot to demonstrate the data that is held is set out below.

Summary reports are provided on a quarterly and ad hoc basis to the Assurance Committee of Trust Board, the Governance Steering Group and to the Directorates. The Assurance Committee, on behalf of Trust Board, is responsible for seeking assurance that a robust system of risk management, including claims management is in operation. The Assurance Group of Executive Team is required to review data on incidents, including claims, from which to extrapolate trends and areas of concerns, including evidence of emerging risks. These are then brought to the attention of the Assurance Committee to which it reports.

The Trust has a Claims Review Group to oversee the management of all claims and to provide assurance that any deficiencies identified in existing Trust policy, procedures, systems of work or control measures have been brought to the attention of the Directorates and any lessons learned disseminated and implemented. This group meets four times per year. In order to ensure that appropriate actions required and lessons learned are implemented, the Assurance Committee will receive timely summary progress reports on all

claims, in addition to which, the Legal Services Manager will ensure that relevant details of the assessment are shared across the Trust to achieve optimum learning; e.g. by the provision of post-case summary reports to Trust Governance Managers and discussion of same at Trust Case Review meetings. An Annual Report is also produced.

Datix Screen shots

Figure 1 – Showing typical fields for inputting general claim information

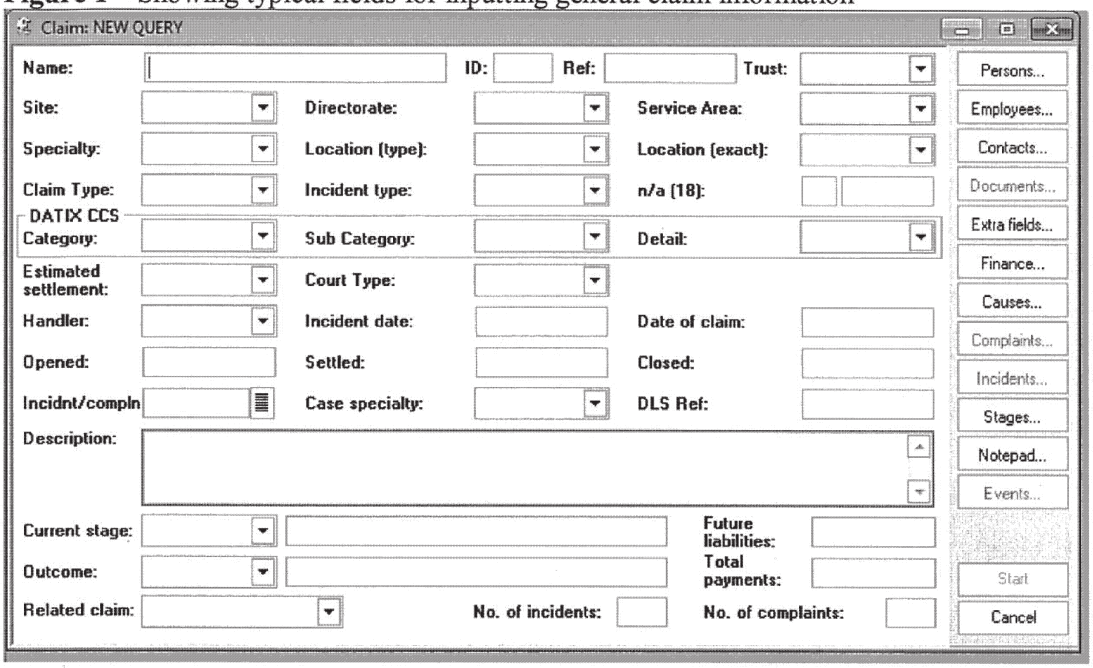
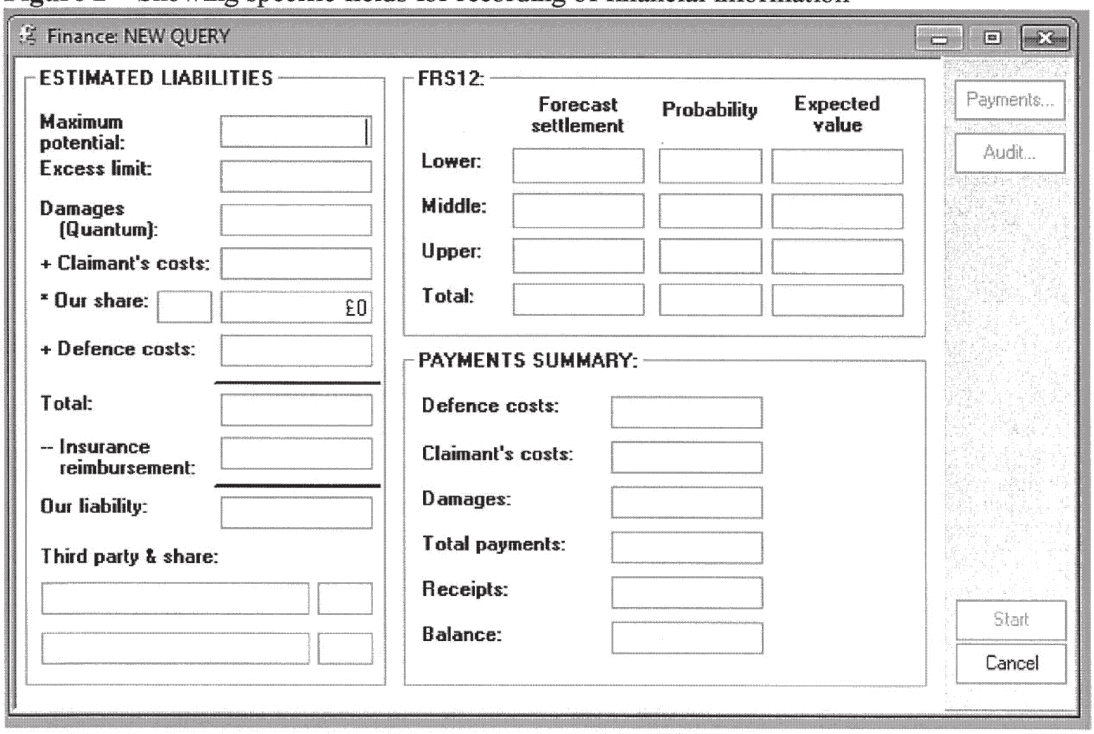


Figure 2 – Showing specific fields for recording of financial information



12. A breakdown by Trust and specialty of the number of outstanding staff appraisals for each of the last 3 years.

It is recognised that effective appraisals are good employment practice, leading to improved staff performance, higher staff satisfaction and better patient outcomes.

However, appraisal is only one element in a suite of management activities which are aimed at both improving the service and maintaining safety standards. To isolate appraisal in this context would not reflect the overall position. Appraisal itself is a formative process the outcome of which should be the development of a Personal Development Plan for the member of staff. If there were concerns about a member of staff it would be entirely inappropriate to wait until the next appraisal meeting to deal with these.

The key element in management which relates to the safety issues are on-going monitoring of all staff by their line managers and action taken quickly to resolve concerns when they arise. Concerns may be identified through managerial observation, complaints, legal cases or concerns reported to management by other members of staff. The Trusts have established Whistleblowing Policies to facilitate this. Good management techniques and close involvement with staff can identify issues early which in turn can allow action to be taken before anything serious develops. In the event a serious issue has been identified staff may be suspended from work or have their work restricted as a patient protection measure. In all cases of concern the issue is investigated and appropriate action taken, this can range from no action if the concern is unfounded to developmental training or through the use of disciplinary or capability procedures formal action, up to and including dismissal.

As part of the Agenda for Change Agreement, a Knowledge and Skills Framework was developed for non-medical staff as a tool for describing the knowledge and skills staff need to apply at work in order to deliver high quality services; it includes an annual review and development for staff. The output from the Knowledge and Skills Framework for an individual job is a list of descriptions and/or standards (KSF post outline) specifying the minimum applied knowledge and skills required for a job and how this should develop during a person's time in post.

As an integral part of the implementation of Agenda for Change KSF post outlines are being developed by individual employers. A KSF Organisational Leads group meets on a bi-monthly basis and is working in partnership to develop and disseminate guidance to ensure good practice and consistency of application of KSF post outlines across all HSC Organisations.
It is only when a post has a KSF outline that an effective review process of the skills attained by an individual can take place and where the skills fall short of the required standard for the post, a Personal Development Plan put in place.

During the last six years employers have been concentrating HR resources in delivering the pay and grading parts of the Agenda for Change Agreement to over 64,000 staff. Although work on KSF outlines has been ongoing as part of that implementation process, progress on this is varied across the HSC.

In relation to medical appraisal we should see a substantial improvement across all trusts over the next reporting period for the reasons outlined below:

1. Medical appraisal has been a long standing contractual requirement for doctors working in the HSC. While there have been historic variances in the uptake of appraisal for doctors, planning for the commencement of revalidation has had a significant impact in increasing participation, with the 2009 HSC Staff Survey reporting that 70% of medical and dental staff had been appraised in the preceding 12 months.

2. All doctors who wished to continue to practise medicine were issued with a Licence to Practise in November 2009. Medical revalidation, which commenced on the 3rd December 2012, is the process by which doctors will regularly renew their licence to practise, and will assure patients and the public that they are keeping up to date and continuing to practise to the appropriate professional standards. Doctors will be unable to revalidate if they do not to demonstrate that they have participated in a robust annual appraisal process that covers the totality of their practice.

The breakdown by each Trust setting out the percentage numbers of staff who did not receive a formal annual appraisal is set out below.

Belfast Health and Social Care Trust

Medical		Non-medical staff	
2008/2009	28%		
2009/2010	17%	**2009/2010**	23%
2010/2011	11%	**2010/2011**	Not available
		2011/2012	14%

Northern Health and Social Care Trust

Medical		Non-medical staff	
2009	5%		
2010	18%	**Sept 2010**	43%
2011	36%	**Sept 2011**	55%
		Sept 2012	53%

Southern Health and Social Care Trust

Medical		Non-medical staff	
2008/2009	2%		
2009/2010	1%	**Dec 2010**	77%
2010/2011	9%	**Dec 2011**	59%
		Nov 2012	65%

South Eastern Health and Social Care Trust

Medical		Non-medical staff	
2010	1%		
2011	Not available	**2010/2011**	83%
Sept 2012	15%	**2011/2012**	79%
		To Nov 2012	85%

Western Health and Social Care Trust

All Staff	
2009/2010	68%
2010/2011	60%
2011/2012	48%

Northern Ireland Ambulance Service

NIAS Paramedics undertake and must successfully complete the Trust's Paramedic-in-Training Programme which meets the Health Professions Council (HPC) Standards of Education and Training and Standards of Proficiency for Paramedics to enable them to apply for registration as a Paramedic with the HPC.

NIAS Ambulance Care Attendants undertake and must successfully complete a nationally accredited training programme (formally an Exexcel/IHCD qualification and now moved to an Edexcel/BTEC qualification).

Paramedics, by virtue of being a registered professional, are required to maintain Continuing Professional Development (CPD) portfolios of evidence. Furthermore, Paramedics, Emergency Medical Technicians and Ambulance Care Attendants are required to undertake mandatory annual reassessment of essential clinical skills. They are also required to undergo regular work-based observational assessments by Clinical Support Officers (CSOs). In addition, CSOs carry out audits on a regular basis, for example hand hygiene, patient experience, completion of PRFs. CSOs also hold regular CPD events for frontline staff.

KSF went 'live' within NIAS on 3 October 2012 and individual Directorates now have responsibility to roll-out Personal Development Reviews to staff within their area of responsibility. This is in line with the Regional KSF Action Plan.

Notwithstanding the above, it is important to note that the Trust has robust management procedures and policies in place to address any issues of concern that may arise with a member of staff, for example Capability, Disciplinary, Harassment and Attendance Management procedures and policies, with related performance management arrangements and reporting on each areas. The NIAS Assurance Framework includes details on all these areas and is presented at each Assurance Committee and Trust Board meeting.

The Trust had developed a Capability Procedure which is designed to deal with those cases where an employee is lacking in some area of knowledge, skill or ability, and is consequently unable to carry out some, or all of the duties required of them to an acceptable standard. The procedure is used where there is evidence of a genuine lack of capability rather than a deliberate failure on the part of the employee to perform to the standards of which he/she is capable.

The Trust also has a Disciplinary Procedure which is designed to help and encourage all employees to achieve and maintain appropriate standards of conduct, performance and behaviour.

13. A breakdown by specialty summarising the number and percentage of cases where the legal costs exceeded the agreed settlement of less than £50,000. Please also indicate the average legal costs for each specialty.

The tables below provides a breakdown of the number of clinical / social care negligence cases, which were closed during each year, and where the amount awarded in damages was less than £50,000. It excludes cases closed with no monies paid in damages or legal costs.

Table 1: Total number of cases closed during 2009/10, where the amount in damages was less than £50,000

Specialty	2009/10					
	Legal Costs Greater than Damages		Damages Greater than Legal Costs		Cases with Damages < £50k	Mean Legal Costs on Cases with damages < £50k
	No.	%	No.	%		
Obstetrics & Gynaecology	24	82.8%	5	17.2%	29	£6,340.69
Accident & Emergency	18	72.0%	7	28.0%	25	£7,542.01
General Surgery	9	75.0%	3	25.0%	12	£8,758.44
Trauma & Orthopaedics	5	100.0%	0	0.0%	5	£590.14
General Medicine	7	77.8%	2	22.2%	9	£9,453.92
Paediatrics	2	100.0%	0	0.0%	2	£159.25
Other Specialties	20	74.1%	7	25.9%	27	£14,865.64
Unknown	3	75.0%	1	25.0%	4	£8,135.01
Total	**88**	**77.9%**	**25**	**22.1%**	**113**	**£8,559.81**

Table 2: Total number of cases closed during 2010/11, where the amount in damages was less than £50,000

Specialty	2010/11					
	Legal Costs Greater than Damages		Damages Greater than Legal Costs		Cases with Damages < £50k	Mean Legal Costs on Cases with damages < £50k
	No.	%	No.	%		
Obstetrics & Gynaecology	21	80.8%	5	19.2%	26	£10,132.44
Accident & Emergency	16	66.7%	8	33.3%	24	£5,070.09
General Surgery	16	69.6%	7	30.4%	23	£9,490.98
Trauma & Orthopaedics	5	45.5%	6	54.5%	11	£15,154.51
General Medicine	7	77.8%	2	22.2%	9	£19,180.01
Paediatrics	4	80.0%	1	20.0%	5	£3,336.98
Other Specialties	20	57.1%	15	42.9%	35	£7,304.21
Unknown	2	66.7%	1	33.3%	3	£17,138.89
Total	**91**	**66.9%**	**45**	**33.1%**	**136**	**£9,312.40**

Table 3: Total number of cases closed during 2011/12, where the amount in damages was less than £50,000

Specialty	2011/12					
	Legal Costs Greater than Damages		Damages Greater than Legal Costs		Cases with Damages < £50k	Mean Legal Costs on Cases with damages < £50k
	No.	%	No.	%		
Obstetrics & Gynaecology	24	75.0%	8	25.0%	32	£19,937.15
Accident & Emergency	20	83.3%	4	16.7%	24	£8,902.80
General Surgery	10	62.5%	6	37.5%	16	£10,179.32
Trauma & Orthopaedics	6	60.0%	4	40.0%	10	£18,489.06
General Medicine	10	76.9%	3	23.1%	13	£13,919.04
Paediatrics	3	75.0%	1	25.0%	4	£16,600.84
Other Specialties	28	71.8%	11	28.2%	39	£8,158.55
Unknown	1	100.0%	0	0.0%	1	£1866.75
Total	**102**	**73.4%**	**37**	**26.6%**	**139**	**£12,710.91**

The information detailed in this response has been derived from the DHSSPS annual information collection on clinical / social negligence cases. The information refers to the number of cases which were closed during each of the financial years listed, with the financial information relating to the total amount paid during the period of time which the case had been open. For the purposes of the DHSSPS information collection, HSC Trusts are provided with clear definitive guidance on how to complete the return, i.e. a case is recorded as closed when the letter has been received by the HSC Trust that all monies (damages and legal costs) have been paid.

Northern Ireland Assembly

Appendix 4

Other Papers Submitted to the Committee but not included within the Report

Health and Social Care Board

Criteria for Reporting SAIs

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

Learning Communications

April 2011 – September 2011 - Learning Report

October 2011 – March 2012 - Learning Report

4 May 2012	Letter of Learning from Recent Adverse Incidents in Maternity Services
22 May 2012	Letter of Learning from a SAI Following an Accidental Overdose of Warfarin
22 May 2012	Letter of Learning from a SAI re Patients Enrolled in a Clinical Trial
28 June 2012	Regional Learning from a SAI re Flushing of a Central Line with the Incorrect Strength of Heparin Sodium Injection

http://www.dhsspsni.gov.uk/learning_communication_02_11
http://www.dhsspsni.gov.uk/hsc-sqsd02-10.pdf
http://www.dhsspsni.gov.uk/hsc__sqsd__28-07.pdf
http://www.dhsspsni.gov.uk/hss-md-17-2010.pdf
http://www.dhsspsni.gov.uk/hss-md-39-2012.pdf

Supporting Safer Services

June 2006	Report
December 2007	Report
September 2011	Report

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Report on Care of Hospital Patients Receiving Parenternal Nutrition
http://www.ncepod.org.uk/2010pn.htm

Report on 5 Year Report into Suicide and Homicide by People with Mental Illness
http://www.dhsspsni.gov.uk/ncish-hss_sqsd_08_2007.pdf

Report on Suicide and Homicide by People with Mental Illness: Lessons for Mental Healthcare in Scotland
http://www.dhsspsni.gov.uk/hsc__sqsd__51-2008.pdf

Regulation and Quality Improvement Authority (RQIA) Reports

February 2010 Report of Blood Safety Review

http://www.rqia.org.uk/cms_resources/RQIA%20Blood%20Safety%20Report%2010%20Feb%202010.pdf

July 2010	Reducing the Risk Hyponatraemia When Administering Intravenous Infusions to Children

http://www.rqia.org.uk/cms_resources/Hyponatraemia%20Report%207%20Jul%2010.pdf

National Patient Safety Agency Guidance

Being Open – Communicating Patient Safety Incidents with Patients, their Families and Carers
http://www.nrls.npsa.nhs.uk/alerts/?entryid45=65077

Regional Template and Guidance for Incident Review Reports
http://www.dhsspsni.gov.uk/hsc__sqsd__34-07.pdf

Quality Standards for Health and Social Care
http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health___social_care.pdf

Departmental Circular

Learning from Adverse Incidents and Near Misses Reported by HSC Organisations and Family Practitioner Services
HSC (SQSD) 8/2010

Northern Ireland Assembly

Appendix 5

List of Witnesses Who Gave Oral Evidence to the Committee

List of Witnesses Who Gave Oral Evidence to the Committee

1) Dr Andrew McCormick, Accounting Officer, Department of Health, Social Services and Public Safety (DHSSPS);

2) Dr Paddy Woods, Deputy Chief Medical Officer, Department of Health, Social Services and Public Safety (DHSSPS);

3) Ms Julie Thompson, Senior Finance Director, Department of Health, Social Services and Public Safety (DHSSPS);

4) Mr Kieran Donnelly, Comptroller and Auditor General; and

5) Ms Fiona Hamill, Treasury Officer of Accounts, Department of Finance and Personnel (DFP).

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STRATEGIC MANAGEMENT GROUP:

REVIEW OF RETROSPECTIVE SAMPLING EXERCISE IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS

FINAL REPORT

DECEMBER 2013

CONTENTS:

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1. BACKGROUND

A retrospective review of patient case files within Muckamore Abbey Hospital was completed between 2005 and 2009 by the Eastern Health and Social Services Board (EHSSB) and North and West Belfast Health and Social Services Trust. Following this the Department of Health Social Services and Public Safety (DHSSPS) instigated a retrospective sampling exercise in June 2007 across all 5 Health and Social Services Trusts to identify if there were concerns, significant prevalence or similar findings within any other mental health or learning disability inpatient hospital.

The DHSSPS required the retrospective sampling exercise to focus on those people most at risk especially minors (children under the age of 18 years) admitted to mental health and learning disability hospitals over a twenty year period between 1985 and 2005. A 10% sample of relevant files was agreed.

The retrospective sampling exercise encompassed long stay wards in adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital which had already been reviewed) and regional child and adolescent inpatient mental health services (which included a specific investigation of Lissue and Forster Green Hospitals commissioned by the EHSSB and latterly the Health and Social Care Board (HSCB) as a result of a complaint detailing serious allegations made when the above exercise was being planned).

Each Trust was asked to follow the methodology applied in the Muckamore Abbey Review which characterised the incidents as follows:

- Category 1: Sexualised behaviour between adult and minor
- Category 1a: Sexualised behaviour between minor and minor
- Category 2: Sexualised behaviour between adult and adult (non-consenting)
- Category 3: Sexualised behaviour between adult and adult (consent unclear)
- Category 4: Sexualised behaviour (consenting)
- Category 5: Suspected sexualised activity (general details unknown)
- Category 6: Physical abuse involving actual bodily harm and above
- Category 7: Sexualised behaviour query significance
- Category 8: Issues noted and dealt with thoroughly using recognised procedures

Between April 2008 and August 2009 eight reports were submitted to the DHSSPS covering ten sites. In late 2011 these reports and other reporting documents (thirteen in total) were handed over by the DHSSPS to the PSNI for further investigation under Operation Danzin.

The PSNI analysis noted that in some of the reported incidents no further police action was required. Other incidents required more detailed information to enable the PSNI to determine what further action, if any, was required.

It was also evident from the PSNI analytical review that the scale and scope of the sampling had been interpreted by Trusts in different ways. This resulted in significant inconsistencies and variances in both methodology and sampling applied within the commissioned reports.

The DHSSPS subsequently requested that the HSCB and PSNI review the retrospective sampling process. The purpose of this review was to provide assurance to the DHSSPS that, where incidents of abuse were noted in the retrospective sampling exercise reports, these had been appropriately identified and dealt with.

After a series of discussions with the DHSSPS, HSCB and PSNI it was agreed to set up a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland (2004), Although established under the provisions of the Protocol in relation to children, in this case the remit of the SMG was extended to include vulnerable adults.

2. STRATEGIC MANAGEMENT GROUP

The SMG was chaired by Fionnuala McAndrew, Director of Social Care and Children, HSCB and Brian Hanna, Detective Superintendent, Serious Crime Branch, PSNI.

The terms of reference for the SMG are included in Appendix 1

A list of members of the SMG is contained in Appendix 2.

The SMG met for the first time on 25 April 2012, and met on a total of 5 occasions. A calendar of meetings is attached in Appendix 3.

The SMG ensured the active cooperation and coordination of all relevant agencies, agreed a joint communication plan (See Appendix 4) and a Human Resources flowchart (See Appendix 5) to assist in the review process. At each meeting of the SMG progress was reviewed. It was agreed that at the conclusion of the SMG process a report would be submitted which addresses the key issues that emerged from the review of the retrospective sampling exercise.

The SMG set up two subgroups to progress the work, one in relation to adult services and the other in relation to children's services.

Each sub-group met on a number of occasions and the terms of reference of each sub-group are contained in Appendix 6 (Adults) and Appendix 7 (Children's).

Health and Social Care Trusts identified senior members of staff to participate in both the Children's and Adults' Sub-groups. They completed audit documentation in relation to either the Children's or Adults Sub-groups on behalf of the Trust and also acted as key liaison individuals in reviewing the information presented within each of the Trust reports.

The PSNI identified a Detective Inspector who participated in both the Children's and Adults Sub-groups and provided advice and guidance in relation to the potential for criminal proceedings in specific cases.

Given the complexity and number of facilities which were subject to the review, members of both the SMG and the relevant sub-groups signed a "Declaration of Interest" indicating whether or not they had managerial or any other type of involvement with the various facilities during the time period under investigation.

A copy of the Declaration of Interest pro forma is included at Appendix 8.

3. HISTORICAL INSTITUTIONAL ABUSE INQUIRY

On 31 May 2012 the First Minister and Deputy First Minister announced an Inquiry into historical institutional abuse in Northern Ireland. The Northern Ireland Executive Inquiry and Investigation into Historical Institutional Abuse Inquiry (HIAI) will examine if there were systematic failings by institutions or the state in their duties towards those children in their care between the years 1922 – 1995.

The Inquiry and Investigation will take the form of

- An Acknowledgement Forum;
- A Research and Investigative Team; and
- An Inquiry and Investigation Panel with a statutory power which will submit a Report to the First Minister and the Deputy First Minister.

A number of cases of interest to the HIAI have already been referred to PSNI for investigation.

As the HIAI has indicated that Lissue and Foster Green will be included in its consideration it is anticipated that the SMG report will be made available to the HIAI to assist where possible.

4. METHODOLOGY:

Given the complexity of the previous exercise and the apparent inconsistencies which had been identified by both the DHSSPS and the PSNI, it was agreed that, in order to provide a more consistent analysis of the exercise, the SMG would develop audit templates to quality assure and analyse the available information.

Audit Template 1 was applied across all the original retrospective sampling exercise reports to ensure that any childcare or adult safeguarding concerns have been identified and addressed, either within Trusts policies and procedures and/or Protocols for Joint Investigation processes with the PSNI.

The template considered the following:

1. Has the Trust complied with the initiating request from DHSSPSNI to undertake a retrospective sampling exercise? If not, what gaps have been identified and what steps is the Trust taking to address these gaps?

2. Have individuals identified as victims been referred to the PSNI for further investigation?

3. Have members of staff in any of the institutions about whom concerns have been expressed been subject to police referral and/or referral to the relevant regulatory and/or professional bodies? If so, when and who took lead responsibility for progressing the concerns within the Trusts?

4. Where investigations were completed at the time of the original allegations, was reference made to the relevant policy and procedures as they pertained at that time and were the investigations carried out in line with the legislation, policy and best practice in place at that time?

5. Were appropriate safeguarding arrangements in place in each of the institutions at the time?

6. What actions, if any, has the Trust set in place following the retrospective sampling exercise and how are these being progressed?

A copy of Audit Template 1 is included in Appendix 9.

The SMG also developed **Audit Template 2** which was designed to capture key information across all Trusts and asked:

- Are the terms of reference included in the report?
- Does the report address the timescale 1985-2005?
- Does the report confirm the 10% sample was reviewed?
- How many files were reviewed in total?

- Does the report address children's files?
- Are specific incidents referred to which identify the victims as adults?
- Is an action plan referenced in the report?
- If yes is it available?
- Are any actions outstanding?
- Does the report fully address the terms of reference?

Each Trust was required to complete this audit template in order to provide a consistent analysis across the five Trust areas in relation to the reports that have been produced. A copy of Audit Template 2 is included in Appendix 10.

Finally, the SMG developed **Audit Template 3** in order to capture specific details on individual cases. A copy of Audit Template 3 is included in Appendix 11.

5. ANALYSIS - ADULT SUB-GROUP

Following the establishment of the SMG, the Adult Sub-group met on 7 occasions. In addition, 2 joint meetings were held with the Children's Sub-group.

5.1 Terms of Reference:

The Sub-group has addressed the Terms of Reference agreed by SMG, that is, to:

- Quality assure the retrospective review process and reports in relation to adults;
- Ensure any issues or concerns in relation to individual adults have been actioned appropriately;
- Ensure that any criminal concerns or issues have been referred to PSNI; and
- Ensure that any Human Resources and regulatory issues have been taken forward by the appropriate Trust or employer.

5.2 Cases involving children:

The initial review of the reports of retrospective sampling exercise indicated that a number of cases involving children had been reported on by adult services. These cases were extracted from the Adult Sub-group return and referred to the Children's Sub-group for their consideration.

5.3 Western HSCT

The retrospective sampling exercise identified **10** incidents where an in-patient or visitor to the hospital may have been subjected to abuse. 1 incident where the victims were noted as being under the age of 18 was passed to the Children's Sub-group for their consideration. Of the adult patients, 6 were identified as female, with gender unspecified for the remainder. All 9 incidents involving adults were described as being of a sexual nature, ranging from alleged indecent exposure to rape.

- 3 incidents occurred in Mourne House (a unit for people with learning disabilities) and involved the same alleged perpetrator ;
- 3 incidents involved patients in the Tyrone and Fermanagh Hospital. One of these patients made 2 allegations of abuse;
- 2 incidents were reported from Gransha Hospital; and
- 1 incident did not indicate which facility was involved.

In all 9 cases, these matters were referred to the PSNI at the time of the original retrospective sampling exercise. 7 were subsequently noted as requiring no further police action, and 2 required further police consideration.

All but one case was closed following review by the PSNI. This case required police investigation but, following careful consideration the victim was assessed as being unfit to engage in any criminal or other investigative process. The case has now been closed by the PSNI.

No members of staff were named as either alleged perpetrators or victims in any of these allegations.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Western Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
    - At the time of the original incident;
    - As a result of the retrospective sampling exercises; or
    - As a result of the SMG review process
- any criminal concerns or issues identified were referred to PSNI; and
- no Human Resources or regulatory body issues were identified

5.4 South Eastern HSCT

The methodology adopted by the South Eastern Trust at the time of the retrospective sampling exercise identified a total of 45 incidents for consideration. 39 of these involved patients identified as female, 4 were male, and the patient's gender was unspecified in 2 cases. 1 incident involving a child was referred to the Children's Sub-group for their consideration.

All incidents were categorised as of a sexual nature, ranging from allegations of common assault and indecent exposure to gross indecency. All incidents were reported from the Downshire Hospital.

- 39 of the total of 45 incidents involved 10 alleged perpetrators. Of these, 3 were involved in 2 separate incidents; 3 individuals were involved in 3 separate incidents; 1 was involved in 4 incidents; 1 was involved in 5 incidents; 1 was involved in 6 alleged incidents and 1 was involved in a total of 9 incidents;
- 6 patients alleged that they had been subjected to unwanted sexual advances on more than 1 occasion, ranging from 2 to 8 incidents;
- 1 incident involved the alleged rape of a 76 year old woman. This was reported to the police at the time, and was subject to an initial police investigation. Unfortunately however, due to the circumstances of the offence and the frailty of the victim, it was not possible to pursue a criminal investigation any further;

- Records indicated that on 7 occasions, staff members were subjected to alleged sexual assaults by patients.

No members of staff were named as alleged perpetrators in any of these incidents.

Following the SMG review, a total of **38** incidents, including those incidents where staff may have been subjected to assault, were passed to the PSNI for review. On review of the full papers, all but 5 of these were closed.

Of these 5, which were deemed to require police investigation, 3 have been closed as, following careful consideration, the victims have been assessed as being unfit to engage in any criminal or investigative process. The other 2 relate to cases where the victims are staff members rather than patients and identification details are required to progress the matters any further.

The Trust states that no specific Down Lisburn Trust policies covering the early period of the original retrospective sampling exercise were found, with the earliest extant policies dating from 2002.

Reference was also made by the Trust review team to Eastern Health and Social Services Board policies that were extant in the mid years of the audit, i.e. EHSSB Guidance on Abuse of Vulnerable Adults (1996 and 1997).

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the South Eastern Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human Resources or regulatory body issues were identified

5.5 Northern HSCT

Due to problems with the original methodology, the Northern Trust took the decision to review all available patients notes considered as part of the retrospective sampling exercise, with the exception of one young person where the Trust could not identify the original incident. This re-audit identified **10** incidents involving adults which required further consideration. 1 of these patients was identified as male. All incidents were categorised as of a sexual nature and were reported from Holywell Hospital.

- An additional incident was identified which involved a 17 year old. To date the Trust has not been able to trace the identity of this young person. Nevertheless, this was referred to the Children's Sub-group for their consideration.
- In 3 of these incidents it is alleged that a member of Trust staff was involved.
- In 1 incident the staff member was named. Trust records show that this incident was investigated on the ward at the time, in that the patient was interviewed by a Consultant Psychiatrist and a Senior Nurse. No contact was made with the PSNI, and the allegation was withdrawn by the patient on the same day. The Trust review team has not been able to find any record either of the allegation or any subsequent investigation.
  The member of staff named was not subject to any internal disciplinary processes, and remained in employment. The staff member resigned from the Trust to work for another provider, but was re-employed by the Trust shortly afterwards. He has since worked in a variety of roles within the Trust, including the provision of community-based care. This matter has now been investigated by the PSNI and the Trust under the Protocol for the Joint Investigation of Cases of Alleged and Suspected Cases of the Abuse of Vulnerable Adults (2009) and the relevant Human Resources procedures. Both investigations have now concluded and no further action will be taken.

The PSNI reviewed a total of 7 incidents. Upon full review, only one case required police investigation. This has now been investigated by the police and has been closed.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Northern Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

5.6 Belfast HSCT

The retrospective sampling exercise identified a total of **8** incidents for further consideration, all of which were reported from Knockbracken Healthcare Park. Of these, 5 were categorised as physical, 2 of a sexual nature and 1 case of theft. 6 patients were female.

It was noted that 6 incidents appeared to involve 5 children under the age of 18 years. All of these were referred to the Children's Sub-group for consideration.

One allegation of physical assault was reported to the PSNI and investigated at the time of the incident.

The retrospective sampling exercise also identified one incident which involved the suspected theft of a patient's handbag. Records indicate that this was not referred to the PSNI but was dealt with within the hospital. The PSNI have indicated that no further action is required in relation to this matter.

No members of staff were named or identified as alleged perpetrators in any of these incidents.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Belfast Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human resources or regulatory issues were identified.

5.7 Southern HSCT

The retrospective sampling exercise in relation to adult patients identified a total of **14** incidents for further consideration. 13 of these were drawn from wards in Longstone Hospital (a facility for people with learning disabilities) and 1 was from St Luke's Hospital. 10 cases were categorised as being of a sexual nature, 1 of a physical nature and 3 were uncategorised. 8 cases involved male patients, 2 involved females and in 4 cases the gender of the patient was not specified.

- One incident of physical assault involved a member of staff. The matter was referred to the police. The staff member was subsequently dismissed and was later convicted of assault occasioning actual bodily harm. The individual had been employed as a Nursing Assistant and so was not a member of any regulatory or professional body.
- 1 female patient alleged she had been abused on more than 1 occasion. Insufficient detail is available within the records to clarify if either of these incidents constituted a crime
- 1 male patient alleged he had been abused on 2 occasions. One incident involved an allegation of physical assault resulted in a prosecution and conviction of a staff member. The records do not contain sufficient detail of the second incident to assess if a possible crime may have been committed.

- The retrospective analysis indicates that 3 cases were subject to Strategy Discussions under the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults. However, the outcome of those discussions is not recorded in the hospital notes.

Two incidents remain outstanding, none of which involved members of Trust staff as either alleged perpetrator or victim. In both cases, the alleged abuse occurred within the patients' homes prior to their admission to hospital and, as such, fall outside the remit of the retrospective sampling exercise. However, the Trust and the PSNI continue to work together to investigate these incidents and this work is almost complete.

The Trust notes that the original retrospective sampling report did not make any comment on whether the practice noted was in accordance with policy or best practice guidance at the time.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Southern Trust:

- any issues or concerns identified in relation to individual adults have been actioned appropriately; either
  - At the time of the original incident ;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

6. ANALYSIS: CHILDREN'S SUB-GROUP

Children identified through information contained within the relevant reports were subject to discussion within the Children's Sub-group and information forwarded to PSNI for their consideration. While the PSNI will report on their deliberations in a separate section of the report (See Chapter 7), it is clear that a number of cases should have been reported to PSNI either at the time of the incident or during the retrospective sampling exercise.

6.1 Western HSC Trust

Only one incident in the Western Trust was reviewed in the retrospective sampling exercise. The incident involved an adult male patient from Tyrone and Fermanagh Hospital in 1989 and involved 2 child victims. The incident was not referred to police but was referred during the retrospective review. The victims were not known to social services and were not referred for social work intervention at the time. The Protocol for Joint investigation only came into place in 1991 and was therefore not relevant. There will be no further investigation as the victims' identities are not known and cannot now be confirmed.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Western Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
    - At the time of the original incident;
    - As a result of the retrospective sampling exercises; or
    - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human Resources or regulatory issues were identified.

6.2 South Eastern HSC Trust

One incident was reviewed under the retrospective sampling exercise which involved sexualised behaviour between an adult patient and a minor. It was reported at the time and police were involved. The alleged offender self-referred to police and subsequently signed the Sex Offenders Register in 1999. The offender was a patient in Downshire Hospital. There is no further follow up required.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the South Eastern Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
    - At the time of the original incident;

  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- no Human Resources or regulatory issues were identified.

6.3 Northern HSC Trust

One incident was reviewed under the retrospective sampling exercise. The incident involved a 17 year old female patient in Holywell Hospital and involved sexualised behaviour between an adult and a minor. The Trust is unable to identify the original case file so little information is available about the case, and no further information is available that could assist in identifying the case.

In these circumstances therefore, SMG cannot be completely satisfied that in relation to the retrospective sampling exercise in the Northern Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercises; or
  - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

6.4 Belfast HSC Trust

At the time of the original retrospective sampling exercise, Belfast Trust reviewed **30** sample incidents, 10 from Lissue Hospital, 10 from Forster Green Hospital and 10 from the Young People's Centre. The audit was undertaken by 2 senior staff from outside the Child and Adolescent Mental Health Service (CAMHS). The audit did not include the 8 point classification used by the Muckamore Audit Team and it remains unclear why this classification was not used.

6.4.1 *Lissue Hospital*

The review of 10 cases within Lissue did not present with any new concerns. A number of former patients have, however, already made contact with the PSNI in relation to historical allegations of abuse. These are being investigated by the PSNI and sit outside the SMG process.

6.4.2 *Young People's Centre*

As part of the retrospective sampling exercise the Trust reviewed facility files but did not review fieldwork or other files. 10 cases were reviewed, none of which identified issues of concern from within the facility. 7 of the cases referenced contextual

issues that involved allegations of abuse prior to admission to the Unit. Whilst outside the scope of the SMG these incidents are being reviewed by Trust staff to ensure that any allegations of abuse have been appropriately identified and responded to within agreed protocol and procedures. This includes further discussions with the PSNI to determine if these cases should be referred to the Public Prosecution Service. HSCB will seek assurance from the Trust that this has been completed.

6.4.3 *Forster Green Hospital*

Examination of the files from Forster Green revealed that in all but one case, concerns were in respect of overall family functioning or allegations of mistreatment within the wider family circle. One file referenced a young person's allegation of sexual mistreatment by a "doctor"- with another young person in the Forster Green site. This allegation was reviewed by the Children's Sub-group.

The Belfast Trust confirmed that this incident was investigated following the original retrospective sampling exercise. The incident was referred to both the PSNI and the General Medical Council, the professional and regulatory body for doctors. The matter has now been fully addressed and no further action is required.

6.4.4 *Knockbracken Healthcare Park*

As a result of the SMG process, the Belfast Trust identified a further **6** cases in the Knockbracken facility where children and young people may have been involved in incidents which required further investigation. These cases were referred to the PSNI for consideration, and the police concluded that there are no outstanding policing issues and no further police involvement is required. However, it should be noted that while limited information was available to the original retrospective review exercise, the original case papers in relation to these cases were destroyed in line with the procedures and timescales set out in Good Management Good Records (DHSSPS 2011) and so were not available for further inspection and analysis. As a result, additional details of the incidents are unknown and cannot be progressed by any police investigation.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Belfast Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
    - At the time of the original incident;
    - As a result of the retrospective sampling exercises; or
    - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and

- any Human Resources and regulatory issues identified have been taken forward by the Trust.

6.5 Southern HSC Trust

There were **19** incidents identified within the Southern HSCT area involving 10 victims. Two victims were involved in two separate incidents, one was involved in three incidents, and one was involved in 5 separate incidents. 6 of the alleged perpetrators' identities are not known and 13 of the alleged perpetrators are recorded as patients.

- One incident from 1997 involved a staff member. The records indicate that the staff member allegedly discussed pornographic material with a 16 year old (male) patient. This case is being reviewed by police and Trust personnel. The staff member is no longer employed by the Trust. In reviewing the files in relation to this case, the police identified a further allegation by the victim of rape when he was aged 5 and living in a Children's Home This had not been previously reported to Police but is now subject to further investigation by police and Trust personnel. This part of the investigation is not part of the SMG process.

- One alleged perpetrator is involved in two incidents; another is involved in 4 incidents.

- One alleged perpetrator offender is deceased and one victim is believed to be deceased.

- The police are actively reviewing Trust files to further investigate 15 of the incidents to determine if they can be cross referenced and additional information obtained.

- 6 incidents are recorded as category 1 with a further 2 considered as category 1. There are 5 deemed as category 5 with a further 1 considered as category 5. There is one case noted as category 7 and a further case assessed as possibly category 8. There are 3 incidents where it is not recorded.

In a number of the noted incidents the information available to the retrospective sampling exercise was limited. As a consequence, the Trust set up a process to review information contained in other files not considered by the retrospective sampling exercise, such as field work files to determine if further investigations or actions may be required.

Following full review of the available information by the PSNI, 4 cases were identified as requiring police investigation. These 4 cases all involve the same victim. 2 of the cases require additional information from the Trust to enable the PSNI to determine if

any further investigations are required. The remaining 2 have been referred to local PSNI for investigation.

SMG can, therefore, be satisfied that in relation to the retrospective sampling exercise in the Southern Trust:

- any issues or concerns identified in relation to individual children have been actioned appropriately; either
    - At the time of the original incidents a result of the retrospective sampling exercises; or
    - As a result of the SMG review process
- any criminal concerns or issues identified have been referred to PSNI; and
- any Human Resources and regulatory issues identified have been taken forward by the Trust.

7. PSNI ANALYSIS FROM AUDIT RETURNS

The PSNI provided the following report for the SMG:

7.1 Adult Sub-Group

Police were handed documents relating to the Belfast and Western Health & Social Care Trusts on 16th November 2012 during a meeting with Ms Joyce McKee, Regional Adult Safeguarding Officer, Health and Social Care Board. The remainder of the Trusts then submitted reports via email following internal audits.

7.1.1. Belfast Health & Social Care Trust

Belfast Health & Social Care Trust referred 8 cases as part of their audit.

Of these 8 cases 2 (one relating to a physical assault and the other to a theft) were reviewed and no police investigation was required.

The remaining 6 cases all involved a child victim and, as such, were referred to the Children's Sub-group for comment.

7.1.2. Western Health & Social Care Trust

Western Health & Social Care Trust referred 10 cases as part of their audit.

Of these 10 cases only 1 was reported to Police at the time however there were a further 7 cases which contain reference to having been reported to Police at a later date as part of a retrospective review and Police recommended no further action at that stage.

In the remaining 2 cases one case was closed during review. One case was identified as requiring police investigation. However, the victim had been assessed as unfit to engage in any investigation and therefore the case has been closed.

There is 1 case reported by Western Health & Social Care Trust which has been duplicated on the Child return – this case is one of those which were retrospectively reviewed by Police and no further action was recommended.

7.1.3. Southern Health & Social Care Trust

Southern Health & Social Care Trust referred 14 cases as part of their audit.

Of these 14 cases there were 3 cases which had previously been reported to Police and therefore no further report is required.

Following an initial review 8 cases have been identified as requiring further information. Full papers are awaited so that decision can be made as to whether a police investigation is required.

There are also 4 cases included in Southern Health & Social Care Trust's Child Return which involve an adult injured party but where the suspect in the case is a minor. These four cases require further information in order that Police can make a formal decision whether to investigate the matter or not.

7.1.4. South-Eastern Health & Social Care Trust

South-Eastern Health & Social Care Trust referred 45 cases as part of their audit.

Of these 45 cases there were 2 cases which were reported to Police at the time of the alleged offence and therefore no further report is required.

Following an initial review, 38 cases were identified as requiring further information. Papers in these cases have now been reviewed and 5 were identified as requiring police investigation.

Of these 5 cases, 3 have been closed as the victims have been assessed as unfit to engage in any investigative process. The remaining 2 cases involve members of staff as victims rather than patients. Identification and contact details are required to progress these details.

There is one duplication of a case with the Child return. However this was one of the cases which were reported to Police at the time of the alleged offence and therefore no further report is required.

7.1.5. Northern Health & Social Care Trust –

Northern Health & Social Care Trust referred 11 cases as part of their audit.

Of these 11 cases there were 4 cases which were reported to Police at the time of the alleged offence and therefore no further report is required.

There are a remaining 7 cases where further information was required in order that Police could make a formal decision whether to investigate the matter or not. Following this review only one case required police investigation. This was passed to the relevant department and an investigation was initiated. This has now concluded and no further action is required.

7.2 Children Sub-Group

7.2.1 Belfast Health & Social Care Trust

Belfast Health & Social Care Trust referred 6 cases as part of their audit. All of these 6 cases had previously been raised under the Adult SMG return.

Of these 6 cases there was only 1 case reported to Police at the time of the alleged offence and therefore no further action is required.

Papers for the remaining 5 cases have been destroyed and therefore none of these matters could be fully progressed or reviewed. A specific query was raised by Belfast Health & Social Care Trust in relation to a complaint against a doctor attached to Forster Green In-Patient Unit in 1993. A report was prepared as the case had come to light following an audit of files in October/November 2009. The report has been reviewed and no further action is required.

A further 7 cases have been referred from the Young People's Centre. These relate to matters occurring outside of a care environment but which had been reported or disclosed whilst the victims were in care. These cases all require police investigation. However, current contact details need to be confirmed before this matter can be progressed.

7.2.2. Western Health & Social Care Trust

Western Health & Social Care Trust referred 1 case as part of their audit. This case had already been highlighted as part of the Adult return and, whilst the matter was not reported to Police at the time of the alleged offence, the papers comment that the case was the subject of a retrospective review and was discussed with Police at that time and no further action was recommended.

7.2.3. Southern Health & Social Care Trust

Southern Health & Social Care Trust referred 19 incidents as part of their audit. One of these cases has already been highlighted within the Adult return.

Of these 19 incidents there were 3 cases which were reported to Police at the time of the alleged offence and therefore no further report is required (although it is believed one of these may be a duplication).

There are 4 cases included in the return which involve an adult injured party but where the suspect in the case is a minor.

All the referred cases have been reviewed and a police investigation is required in relation to 4 cases. These 4 cases all involve the same victim. 2 of the cases have been referred to the relevant department for investigation and the matters are on-going. The remaining 2 cases await information from the Trust in order to progress.

7.2.4. South-Eastern Health & Social Care Trust

South-Eastern Health & Social Care Trust referred 1 case as part of their audit. This case had already been highlighted as part of the Adult return. The case had previously been reported to Police and therefore no further report is required.

7.2.5. Northern Health & Social Care Trust

No papers were received from Northern Health & Social Care Trust as part of the Child return. However one case was identified within the Adult return involving a

female aged 17 at the time of the alleged offence. This case could not be progressed as no papers were available and therefore no review can be carried out.

7.2.6. Current Investigations

As of 1 January 2013, there are a further 69 cases which have been reported directly to the police or have been referred by the Historical Institutional Abuse Inquiry. All of these cases involve injured parties who were children at the time of the alleged offence(s). The date range of these complaints is far wider than that of the SMG audit, with complaints ranging from 1953 to 2007.

Police decisions on these matters will take into account the evidence and documentation available at this time; the injured party and the time of the alleged offence. There will also be consultation with the Public Prosecution Service and, prior to recommending any prosecution, consideration will be given as to whether it is in the public interest to pursue some of the alleged cases.

8. CHANGES IN POLICY AND PROCEDURES:

The agreed time period for review was a twenty year period between 1985 and 2005. However, some of the incidents considered in the retrospective sampling exercise occurred as far back as 1971, with others having taken place as recently as 2004.

Over that period there have been significant changes in clinical practice as well as legislation, policy and procedures on how to respond to and investigate allegations of abuse.

There has also been recognition that effective treatment and care for people with mental health problems or learning disabilities can be provided in community settings or in smaller group living arrangements. As a result, fewer people are living in or being admitted to mental health and learning disability in-patient facilities.

These and other developments such as improvements in professional and in-service training have contributed to a positive change in the culture of mental health and learning disability in-patient facilities since the 1970s. Both processes and practice across a range of settings and professional groups have been significantly enhanced so as to afford greater protection to children and vulnerable adults. These developments include but are not restricted to:

- The United Nations Convention on the Rights of the Child 1989
- The Children (Northern Ireland) Order 1995, supplementary legislation and associated volumes of guidance
- Revision of DHSSPS Children 'Sharing to Safeguard (Revised HSCC 3/96
- The Human Rights Act 1998
- Co-operating to Safeguard Children (DHSSPS 2003) (currently being revised)
- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Children (2004)
- The Bichard Inquiry Report 2004
- Equal Lives (2005)
- Strategic Framework for Adult Mental Health Services (2005)
- UN Convention on the Rights of People with Disabilities (2006)
- SSI Overview Report 'Our Children and Young People - Our Shared Responsibility' (Dec. 2006) ("SSI Overview Report 2006")
- Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance (2006)
- Criminal Justice (Northern Ireland) Order 2008 and Guidance on Public Protection Arrangements Northern Ireland (NIO) 2008
- Independent Review Report on Agency Involvement with Mr Arthur McElhill, Ms Lorraine McGovern and their Children - Henry Toner QC (June 2008)
- The Sexual Offences (NI) Order 2008
- Understanding the Needs of Children in Northern Ireland (UNOCINI) DHSSPS 2008

- The Protection of Children in England - A Progress Report - Lord Laming (March 2009)
- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009)
- Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements (2010)
- Manual of Practice: Public Protection Arrangements in Northern Ireland (December 2010)
- Reporting and Follow up of Serious Adverse Incidents (HSCB 2010)
- Achieving Best Evidence Guidance on interviewing victims and witnesses, the use of special measures, and the provision of the pre-trial therapy (2011)
- Justice Act (Northern Ireland) 2011
- Records Management: Good Management Good Records (DHSSPS 2011)
- Safeguarding Board for Northern Ireland - Policy Framework Safeguarding Board (Northern Ireland) Act 2011
- RQIA Review of the Effectiveness of the Safeguarding Arrangements in place for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland (2012)

In addition, Trust governance and information management systems now record incidents involving individual service users or staff members and ensure that these are escalated to the appropriate senior managers for action.

9. RECORDS MANAGEMENT

In 2011 the DHSSPS published “Good Records Good Management” as a guide to the required standards of practice in the management of records.

This guidance provides a framework for consistent and effective records management based on advice and publications from the Ministry of Justice and the Public Records Office of Northern Ireland. In establishing this guidance the DHSSPS took account of current practice followed by a wide range of organisations in both the public and private sectors, recommendations emanating from reviews, guidance from professional organisations and bodies, and importantly what the law requires.

“Good Records Good Management” applies to both adult and children’s services and to all services, whether delivered in the community or in a hospital, and includes guidance on the retention and destruction of records.

Some of the records from the period of the original retrospective sampling exercise have been destroyed by Trusts in keeping with this guidance. This is particularly relevant in the Northern and South Eastern Trusts.

It also became evident through the work of the SMG that while each service area and specialism maintains its own record of contact with individual service users, these are not routinely cross-referenced. As a result, it is clear that each Trust considered only records from within mental health and learning disability facilities and did not examine individual service user’s community-based records. For example, hospital staff were not always aware that a safeguarding investigation was underway in the community, and community staff were not always aware that an allegation of abuse had been made by a hospital in-patient.

Reference has already been made to the lack of formal Terms of Reference for the original retrospective sampling exercise. The SMG acknowledges that, given the time scale for reporting on the original retrospective sampling exercise, it would simply not have been possible for audit teams to examine all records for each individual, even if this had formed part of the original Terms of Reference.

The amount of time that has elapsed and the absence of a central repository of Trust internal operational policies have meant that it has not been possible for the SMG to examine some issues in any detail. For example, issues of ethnicity, race and diversity were not routinely recorded in the 1970’s and 80’s. It has not, therefore, been possible for the SMG to comment on these areas.

10. SUMMARY OF FINDINGS:

The PSNI and the Adult and Children's Sub-groups reviewed the available information against the Terms of Reference set for the SMG using specially designed audit templates to analyse the information. In relation to each of the Terms of Reference, the Sub-groups would make the following comments:

- Quality assure the retrospective review process and reports in relation to adults

The methodological challenges with the retrospective sampling exercise have already been noted elsewhere and include:

- Inconsistent application of time frames;
- Inconsistent sampling including numbers of cases and records considered;
- Variation in recording of the audit findings; and
- Variation in the analysis of the findings.

A further variation has arisen in relation to the quality assurance of the original sampling exercise and the assessment of whether the actions taken at the time of the original incident were in accordance with best practice. This has varied from a reliance on the knowledge and integrity of the original auditors, through to a complete re-audit of patient files.

The Sub-groups were unable to identify all the policies, procedures, protocols and good practice guidance that regulated practice during the time period considered by the retrospective sampling exercise. A limited list has been compiled, but it is believed to be incomplete. It is therefore difficult to assess whether practice as noted in the contemporaneous notes available to the retrospective sampling exercise, was always in accordance with the policies, procedures and best practice guidance of the time.

- Ensure any issues or concerns in relation to individuals have been actioned appropriately

All issues which have been identified in relation to individuals have been actioned, either:

- At the time of the original incident;
- As a result of the retrospective sampling exercises; or
- As a result of the SMG review process.

These actions included a review by PSNI of any incidents where it is alleged or suspected that a criminal offence may have taken place although a small number of inquiries are continuing. Where appropriate, referral to the relevant Trust Human Resources process or regulatory body.

- Ensure that any criminal concerns or issues have been referred to PSNI

It is clear from the retrospective sampling exercise reports that a number of incidents involving individuals should have been passed to the PSNI for further investigation at the time the incident occurred. Where it has been possible to identify either the victim or the alleged perpetrator, this has now been done. All completed audit templates have been shared with PSNI.

However the PSNI have identified the following challenges in relation to any investigations:

- The criminal law has changed since the timeframe covered by the original sampling exercise and some offences have been de-criminalised;
- Trusts have not been able to identify either the alleged victim or the alleged perpetrators in some cases;
- Due to the lengthy period of time that has elapsed since the alleged incidents took place, it may not be possible to establish if the threshold for criminal activity has been reached;
- A number of the incidents are now statute barred;
- Some of the relevant patient records will have been destroyed in accordance with Records Management: Good Management Good Records **(**DHSSPS 2011).

- Ensure that any Human Resources and regulatory issues have been taken forward by the appropriate Trust or employer

Adult Sub-group:

A total of 4 incidents within the Adult Sub- group (1 from the Southern Trust and 3 from the Northern Trust) have been identified where it is alleged that abuse took place and where the alleged perpetrator was a member of Trust staff. These instances of alleged abuse were all identified in patient records at the time of the alleged incident and were highlighted by the retrospective sampling exercise.

In one of these incidents, the staff member concerned was subject to both criminal and employer investigations and was dismissed from Trust employment on conviction.

In one incident, the Trust has determined there are no grounds to take forward an internal disciplinary procedure or for referral to a professional or regulatory body.

However, in 2 incidents (from the Northern Trust), it has not been possible either to identify the alleged perpetrators or victims, or to determine if the conduct warranted referral to a professional or regulatory body. Consequently it has not been possible

for the Trust to take forward any HR or regulatory matters in relation to these individual members of staff.

Children's Sub-group:

A total of 4 incidents within the Children's Sub-group have been identified where it is alleged that abuse took place and where the alleged perpetrator was a member of Trust staff or other statutory organisation.

3 of these were from the Belfast Trust. In one case a referral was made to the relevant regulatory body and Trust HR procedures were implemented. This case is now concluded with no further action required. In two other incidents the allegations were investigated and no further action is required.

1incident from the Southern Trust involved a member of staff who is no longer employed by the Trust.

11. Learning and Next Steps:

The SMG has identified a number of areas of learning through the course of this review.

1) It was difficult to reconcile the processes and methodologies used by the different Trusts in the original retrospective sampling exercise. In any future reviews the following should be considered in order to ensure consistency of reporting:
    - agreed, clear Terms of Reference from the start which set out the required reporting timescales should be available;
    - the establishment of a Monitoring Group (including representation from the PSNI) to oversee the review process and agree the final Report ; and
    - the methodology along with any appropriate audit tools should be based on the Terms of Reference and should be available from the beginning of any investigation.

    The procedures for the establishment of a Strategic Management Group set out in the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse (2004) were particularly helpful for this review, and could be used as a model for any future reviews of this kind.

2) The SMG only considered the findings of the original retrospective sampling exercise which in turn reflected on practice between 1985 and 2005. While there has been significant progress in safeguarding arrangements, processes and practice in the interim period, there is a need for constant vigilance to ensure that the systems in place to protect vulnerable children and adults are as robust as possible. The SMG is aware that the Regulation and Quality Improvement Authority (RQIA) has recently completed an inspection on this theme. The SMG recognises that the HSCB and PHA have a responsibility to ensure that the recommendations contained in the RQIA report “Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland – Overview Report (2013)” are fully implemented. The HSCB and PHA have established a formal reporting process on the implementation of these recommendations, which includes individual reports from and meetings with Trusts, plus a schedule of reports to the DHSSPS.

3) It was apparent that information relating to allegations of abuse during an admission to an in-patient facility was noted on facility files, but it was not clear if these were subject to proper process, including referral to the PSNI under the Joint Protocol arrangements. Nor was it clear from the records that clinical teams in in-patient facilities were always aware of new or continuing safeguarding investigations in community settings. It is important that in all cases other relevant

Trust records, including fieldwork files, Looked After Children records and community services files are cross-referenced so that all relevant information be considered to ensure a more consistent and holistic assessment of a safeguarding concern.

4) The original retrospective sampling exercise considered only 10% of files from the period 1985 to 2005. The SMG recognises that there may be incidents falling outside the audit period or sample size where former patients of mental health or learning disability facilities believe that they were subjected to inappropriate or abusive behaviours during their stay in hospital. The SMG would encourage any former or current patient who feels that they are in this position to contact the PSNI, HSCB or relevant HSC Trust who may then need to consider what actions, if any, may be required. To promote a culture of openness and transparency, it would be necessary to establish a point of contact for individuals and their families or carers who may wish to raise concerns and to have them addressed on an individual level. The promotion of the HIAI will also afford further opportunity for individuals to come forward if they consider that the care afforded to them when in an institution was of an abusive nature and they wish this to be explored further.

5) Throughout this review it has been difficult to access internal legacy Trust and Board policies and procedures which applied at different times throughout the sampling period. A central archive would allow any future inquiry or investigation to access the relevant policies and procedures quickly and easily. This in turn would allow for a clearer and quicker determination as to whether best practice and policy guidance was adhered to at the time. The HSCB will discuss this with the DHSSPS to consider the value of creating such a regional archive

12. CONCLUSIONS:

The Strategic Management Group (SMG) was set up to take forward a specific piece of work, that is, to consider issues arising out of the retrospective sampling report carried out by the 5 Health and Social Care Trusts and to provide assurance to the DHSSPS that, where incidents of alleged abuse were noted in the retrospective sampling reports, these have been appropriately identified and dealt with.

The retrospective sampling exercise encompassed long stay wards in adult mental health hospitals, learning disability hospitals (excluding Muckamore Abbey Hospital) and regional child and adolescent inpatient mental health services and covered the period 1985 - 2005.

To progress this work, the SMG set up two sub-groups, one in relation to adult services and one in relation to children's services. A number of audit tools were devised and applied to the retrospective sampling exercise reports provided by each Health and Social Care Trust. This work is now complete.

The findings from the audit process were analysed by both sub-groups and shared with colleagues in the PSNI. A total of 77 incidents were referred to the PSNI for consideration and comment. Two incidents led to referral to an appropriate regulatory and/or professional body.

In addition, Belfast and Southern Trusts are reviewing additional files that were not part of the original retrospective sampling exercise, to provide assurances that any contextual issues or concerns have been appropriately followed up.

The SMG is able to provide assurance to the DHSSPS that, with one exception in the NHSCT, where incidents of alleged abuse were noted in the retrospective sampling reports, that

- Any issues or concerns in relation to individuals have been actioned appropriately; either
  - At the time of the original incident;
  - As a result of the retrospective sampling exercise; or
  - As a result of the SMG review process
- Any criminal concerns or issues have been referred to PSNI; and
- Any Human Resources and regulatory issues have been taken forward by the appropriate Trust or employer.

APPENDIX 1 – SMG TERMS OF REFERENCE

STRATEGIC MANAGEMENT GROUP

TERMS OF REFERENCE

Introduction

The Department of Health, Social Services and Public Safety (DHSSPS) have engaged in a series of discussions with the Health and Social Care Board (HSCB) to set up a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland (2004) (the Protocol).

Although established under the provisions of the Protocol in relation to children, in this case its remit will be extended to include vulnerable adults.

The SMG will conduct a Review of the work undertaken by the 5 Health and Social Care Trusts (HSCTs) which sampled case records of patients in Mental Health and Learning Disability hospitals in the period 1985 to 2005. The purpose of this limited retrospective sampling exercise was to provide assurance to the DHSSPS that. Where incidents of abuse had occurred in the past, these had been appropriately identified and dealt with.

The Review will also include consideration of the conclusions of investigations relating to Lissue and Forster Green Hospitals.

The Regulation and Quality Improvement Agency (RQIA) have been commissioned by the DHSSPS to review the effectiveness of the current safeguarding arrangements for children and vulnerable adults within Mental Health and Learning Disability Hospitals in the Trusts. The SMG will therefore not address current safeguarding arrangements. The SMG will liaise closely with RQIA to address any potential safeguarding issues which may emerge during the course of its review and

to follow up issues identified in the Overview Report prepared by RQIA at the conclusion of its process.

Definition of Abuse:

The SMG will use the definition of organised abuse contained in the Protocol, and extend the definition to both children and vulnerable adults.

The Protocol defines organised abuse in three main settings, families, communities and institutions. Section 6.3 of the Protocol refers to institutions where an adult or adults, employed in the public, private or public sector, abuses the children he or she works with. Section 6.8 of the Protocol states that:

"Institutional abuse is abuse by adults working in a position of trust, either in an employed or voluntary capacity, in an organisation or association that has responsibility for or provides activities for children. The organisation or association acts as the organisational base bringing adults and children together which provides the opportunity for exploitation by abusers. Institutional abuse often involves abuse of many children over a long period of time".

Membership:

The SMG will be Co-Chaired by the Police Service of Northern Ireland (PSNI) and Health and Social Care Board (HSCB).

Membership will include:-

Fionnuala McAndrew HSCB	Aidan Murray HSCB
Tony Rodgers HSCB	Philip Moore HSCB
Paula Smyth BSO	Alphy Maginnis BSO
Donald Glass PSNI	Paul Darragh PHA
Lesley Walker BHSCT	Marie Roulston NHSCT
Oscar Donnelly NHSCT	Trevor Millar WHSCT
Brice McMurray SHSCT	Michael Hoy SEHSCT

Mary Hinds PHA	Marian Hall HSCB
Brian Hanna PSNI	Kieran Downey WHSCT
Paul Morgan SHSCT	Ian Sutherland SEHSCT
Francis Rice SHSCT	Brendan Whittle SEHSCT

In addition the SMG will extend an invitation to one or more recognised experts from outside Northern Ireland who can also act as independent persons to provide professional oversight and ensure greater transparency during the review.

Functions of the Strategic Management Group

The SMG will fulfil the following functions: -

- Develop policy relating to the Review;
- Establish the principles of the conduct of the Review
- Address the issue of resourcing of the Review which will fall into two categories:-
  - Logistical resources - transport, accommodation, staff cover, etc; and
  - Staff resources –which includes administration support
- Act on a consultative basis to professionals involved in the audit of the retrospective sampling exercise
- Ensure co-ordination between the key agencies, which have an interest in the progress of the Review
- Provide regular updates to the DHSSPS on the progression of the Review
- Draw up a communication strategy.

The SMG will **not** be responsible for any Human Resource issues that may be identified within any of the institutions involved but will refer these directly to Senior Management in the respective Trusts for consideration and action as appropriate. It will be a matter for Senior Management in those agencies to actively consider referral to regulatory bodies and/or the professional associations of any staff identified during the course of the review about which concerns have been

expressed either in relation to their professional conduct and or ongoing criminal investigations.

Process

The SMG will meet within agreed timescales and as often as deemed necessary to discuss the progress of the Review and will take forward the following: -

a) Consideration of the retrospective sampling exercise undertaken by all five HSC Trusts and identify any particular gaps/issues which may require a further review of particular cases by developing and applying an audit tool.
   The audit template will consider the following:
   1. Have Trusts complied with the initiating request from DHSSPS to undertake a retrospective sampling exercise? If not, what gaps have been identified and what steps is the Trust taking to address these gaps?
   2. Have individuals identified as victims been referred to the PSNI for further investigation?
   3. Have members of staff in any of the institutions about whom concerns have been expressed been subject to police referral and/or referral to the relevant regulatory and/or professional bodies? If so when and who took lead responsibility for progressing the concerns within the Trusts?
   4. Were investigations completed at the time allegations were made with reference to policy and procedures as they pertained at the time and were they in line with extant legislation, policy and best practice at the time?
   5. Were safeguarding arrangements appropriate in each of the institutions at the time?
   6. What actions if any have Trusts set in place following the retrospective sampling exercise and how are these being progressed?
b) The information technology and administrative support in order to take forward the investigation; and
c) Identify any specialist advice which is required such as legal, medical, psychiatric, cultural or special needs;

Children and adults who may require support and who are identified through the process of this review will be offered support and/ or counseling by an appropriate

organization. Any children or adults named by others, regardless of whether they have made statements or not, who may require individual help will be offered support or advice as appropriate. Individuals, both victims and alleged perpetrators, may also be referred to PSNI who will be responsible for undertaking any criminal investigations

It is recognised that the Review cuts across a number of Trust and PSNI boundaries and the following key points will be considered at all times.

- The continuing safety of children and vulnerable adults;
- Appropriate sharing of information; and
- Lack of contamination of evidence.

The SMG will ensure that lines of communication are well established between the Review Work Groups and the Trusts that have carried out the retrospective sampling exercise and which have responsibility for Lissue and Forster Green Hospitals.

At each meeting the SMG will:

- Review progress
- Review all aspects of the strategy
- Provide advice on the appropriate strategic direction;
- Ensure the continuing active co-operation of all relevant agencies;
- Agree a joint approach to media interest; and
- Produce an accurate record of all meetings held.

In particular, the SMG will consider the following:

- The aims of the investigation: -
  - Protection of Children and vulnerable adults
  - Identification of possible criminal offences
  - Evidence gathering; and
  - Consideration of other possible victims.
- The context of the investigation: -
  - The culture of the institutions
  - Ethnicity, race and diversity issues

- Consideration of resource implications;
- Possible community interest and reaction;
- Media/union/professional association interest; and
- Public profile/status of alleged abuser(s) or victim(s).

- Handling Information: -
  - Arrangements for handling information obtained in the Review
  - Managing confidentiality; and
  - The need to make other organizations aware of abuse allegations concerning their staff in order that they can take steps necessary for child or vulnerable adult protection within their respective organizations and other Human Resource considerations where appropriate.

Work Groups

Two work groups will be established to consider issues relevant to adult and children's services arising from the retrospective sampling exercise and the Lissue and Forster Green Hospital reports, and will make comment on the quality and appropriateness of Trust responses.

Welfare Principle

As with all investigations of abuse of children or vulnerable adults, care must be taken to ensure that the welfare of the child and vulnerable adult remains paramount. Whilst the gathering of criminal evidence is important, it must not be to the detriment of any child or vulnerable adult's welfare. Although investigations to establish the standard of evidence for criminal proceedings are important, the need to protect the child or vulnerable adult, which requires a lesser standard of proof, should not be delayed. Individual/group support to children, vulnerable adults and their families as appropriate should always be considered.

The SMG recognises that whilst some children may have been subjected to abuse or inappropriate treatment, they are now adults and may not wish to have or require ongoing social work involvement. All cases in which abuse is suspected will be referred to PSNI for criminal investigation.

Conclusion

At the conclusion of the Review the SMG will meet to discuss the salient features of the Review and make recommendations for improvements either in policy or in practice. Recommendations should be communicated to the Chair of the Regional Child Protection Committee (RCPC) or Safeguarding Board for Northern Ireland (SBNI) (if established), the Chair of the Northern Ireland Adult Safeguarding Partnership and the PSNI for further consideration and any necessary action.

A written report will also be sent by the SMG to the DHSSPS to inform future strategic and policy developments.

APPENDIX 2 –SMG MEMBERSHIP:

Fionnuala McAndrew, HSCB Co-Chair
Brian Hanna, PSNI, Co-Chair
Tony Rodgers, HSCB
Paula Smyth, BSO
Donald Glass, PSNI
Lesley Walker, BHSCT (subsequently replaced by Cecil Worthington)
Oscar Donnelly, NHSCT
Bryce McMurray, SHSCT
Aiden Murray, HSCB
Phillip Moore, HSCB
Alphy Maginness, BSO (Legal Department)
Paul Darragh, PHA
Cecil Worthington, NHSCT (subsequently replaced by Marie Roulston)
Trevor Millar, WHSCT
Michael Hoy, SEHSCT
Mary Hinds, PHA
Paul Morgan, SHSCT
Francis Rice, SHSCT (subsequently replaced by Miceal Crilly)
Marian Hall, HSCB
John Doherty, WHSCT (Later replaced by Kieran Downey)
Ian Sutherland, SEHSCT
Don Bradley, SEHSCT

In attendance:

Martin Quinn, HSCB
Joyce McKee, HSCB

APPENDIX 3 – SMG CALENDAR OF MEETINGS:

The SMG met on the following occasions:

- Wednesday 25 April 2012
- Friday 21 September 2012
- Friday 23 November 2012
- Thursday 24 January 2013
- Thursday 21 March 2013

ADULT SUB-GROUP: MEETING DATES

- 9 July 2012
- 14 September 2012
- 9 November 2012
- 7 December 2012
- January 2013
- 1 February 2013
- 29 March 2013

CHILDREN'S SUB-GROUP: MEETING DATES

- 22 August 2012
- 25 September 2012
- 26 October 2012
- 27 November 2012
- 19 December 2012
- 22 January 2013

- 21 February 2013
- 25 March 2013

ADULT AND CHILDREN'S SUB-GROUPS: JOINT MEETING DATES

- 12 October 2012
- 19 December 2012

APPENDIX 4 – COMMUNICATIONS PLAN

Strategic Management Group – Communications Plan

Introduction

The Department of Health, Social Services and Public Safety (DHSSPS) have engaged in a series of discussions with the Health and Social Care Board (HSCB) to set up a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland (2004) (the Protocol).

Although established under the provisions of the Protocol in relation to children, in this case its remit will be extended to include vulnerable adults.

There is intense public concern surrounding the issue of organised and institutional abuse. It is essential that there is an effective communications strategy in place which ensures that information is released into the public domain in a timely, balanced, victim centred and appropriate way.

This will require a co-ordinated approach with all relevant organisations including the HSCB, Police Service of Northern Ireland (PSNI) and HSC Trusts.

The historical abuse inquiry due to commence in the Autumn and other associated pieces of work may have an impact on this plan, so there will also need to be a close link with OFMDFM, DOJ and DHSSPSNI in relation to a co-ordinated communications approach.

It is important that the communications plan remains fluid and is developed as the work of the Strategic Management Group (SMG) progresses.

The purpose of this brief plan is to provide a very broad template from which to start the communication process; a list of the key stakeholders; communications options and a list of the key information needed in due course.

Objectives

The communications plan aims to:

- Support the overall aims and objectives of the Strategic Management Group

- Provide a co-ordinated communications approach with key partners.

- Ensure that no information is released into the public domain that will compromise or prejudice enquiries.

- Ensure that as far as possible all communications are sensitive to the needs of victims and where appropriate ensure that victims are briefed on any statements being issued into the public domain.

- Provide wider public reassurance that all appropriate steps are being taken by the SMG, within their remit, to effectively address issues relating to children and adults.

- To build confidence in the Strategic Management Group which will be essential for ensuring the review and any investigations are as effective as possible.

- To monitor all media and social media coverage and stakeholder statements, and effectively address any concerns at an early stage; providing necessary information and reassurance; and where the criticism is unfair, inaccurate and unfounded to robustly rebut it.

Partners and Stakeholders

Below is a list of key partners and stakeholders – the list is not exhaustive and can be added to as the work of the SMG progresses.

Key partners

- Health and Social Care Board

- Police Service of Northern Ireland

- HSC Trusts
- DHSSPSNI
- Dept of Justice
- Office of First and Deputy First Minister
- Regulation and Quality Improvement Authority
- Safeguarding Board Northern Ireland
- Public Health Agency

Key Stakeholders

- Victims
- Victim Groups
- Staff
- General public
- Local politicians
- Health Committee
- Justice Committee
- Local and national media
- NI Social Care Council
- Religious organisations
- Statutory organisations
- Charity organisations
- Regional Voluntary and Community Organisations
- Independent Contractors
- Trade Unions
- Care Providers
- BMA

- RCN

Key Communications channels

It is essential that there is effective communication both internally and externally to ensure that staff, stakeholders, and the public are kept fully informed as appropriate.

Whilst not exhaustive communications options include:

Internal

- Intranet
- Email
- Staff Publications
- Face to face briefings

External

- Media Briefings
- Press releases
- Interviews/feature articles
- Lines against enquiry
- E-briefings for stakeholders
- Updates on websites
- Briefings for Health and Justice Committees
- Assembly written and oral statements
- Letters to the editor

Key Communication Principles:

- The PSNI have primacy over all communications in relation to specific investigations. This is essential in ensuring that nothing is issued that could potentially jeopardise an investigation.

- Each organisation should identify a senior representative to approve media statements and lead on interviews as required.

- It is essential that all media enquiries, interview bids and any responses are shared amongst all relevant partner organisations.

Action Points

In order to ensure that we have an effective communications plan in place the following information will be required from the SMG as and when available:

- As appropriate and following close liaison with PSNI, details of alleged offences under investigation, including any protection issues.

- Where appropriate a brief on safeguarding and investigative steps taken at the time the offences occurred.

- Where appropriate a brief on safeguarding arrangements in place now to minimise the risk of this occurring again. There will also be a need to explain how these arrangements compare to protocols and polices in place at the time of any alleged abuse.

- As appropriate and following close liaison with PSNI, details of any progress in the investigation, arrests, charges, court appearances.

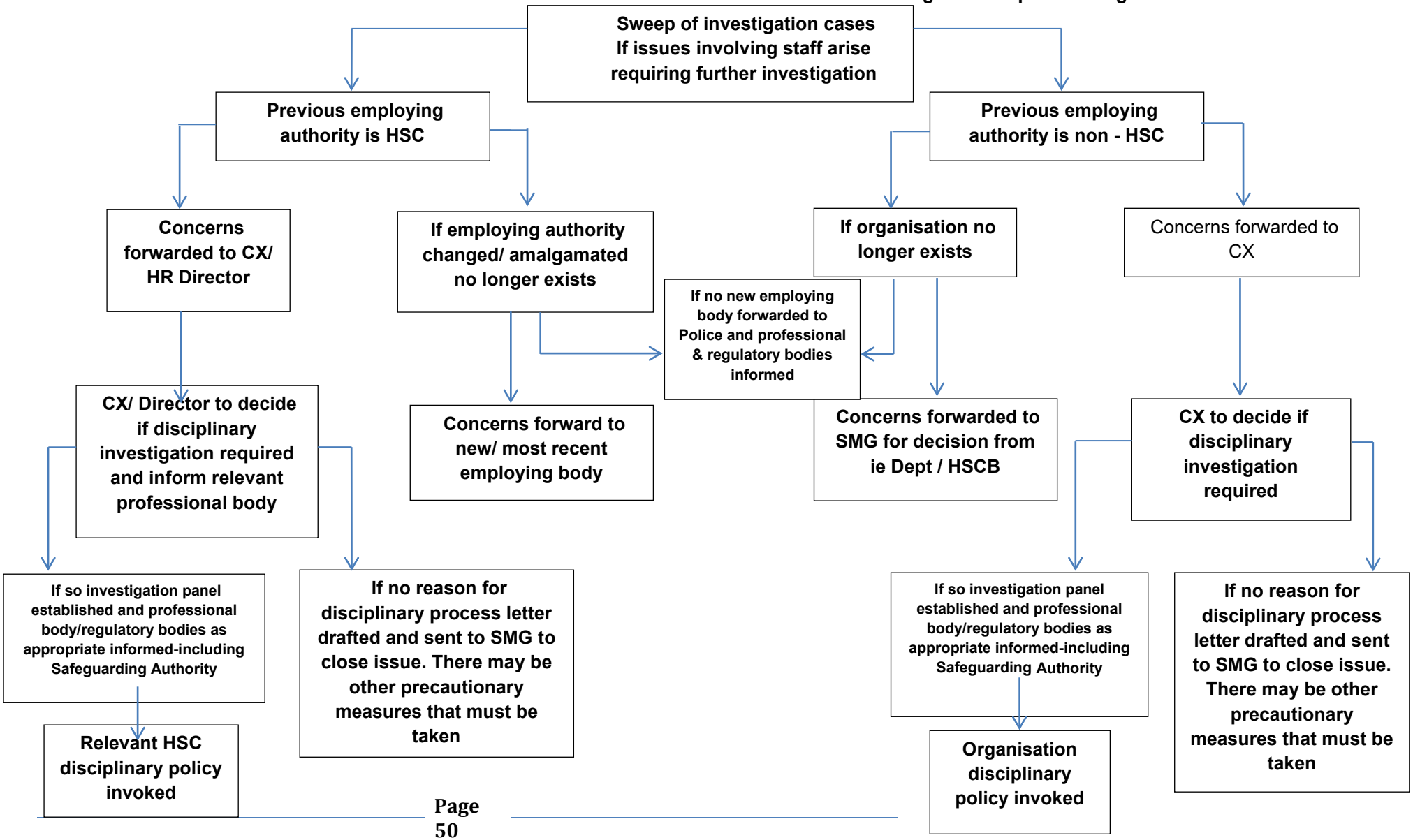
Next steps

SMG to advise on timings for communications activity. At this stage a detailed timetable of communications activity will need to be developed and agreed by all the relevant partner organisations.

APPENDIX 5 – HR PROTOCOL

HR Protocol for Non – Criminal Actions

This Protocol is established for non -criminal issues for all HSC staff discovered during the sweep of investigation cases.



APPENDIX 6 – ADULT SUB-GROUP TERMS OF REFERENCE

STRATEGIC MANAGEMENT GROUP

ADULT SUB- GROUP TERMS OF REFERENCE

Background:

- The Department of Health Social Services and Public Safety (DHSSPS) is engaged in on-going discussions with the Health and Social Care Board (HSCB) in relation to the establishment of a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland.
- Although established under the provisions of the Protocol in relation to children, in this instance the SMG's remit extends to consideration of how to proceed with regard to any concerns that may arise in relation to the historic care of vulnerable adults emerging from the recent retrospective sampling work undertaken by each of the 5 Health and Social Care Trusts (HSCT).
- In order to ensure optimal co-ordination at a regional level, Social Services input is from the HSCB and the Police Service for Northern Ireland (PSNI) involvement is provided at a Detective Superintendent level.
- The SMG has established two sub-groups to take forward the work in relation to adults and children. The Sub-groups are chaired by the HSCB Adult Safeguarding Officer and Children's Safeguarding Officer respectively.

Purpose of Adult Sub-group:

The purpose of the Adult Sub-group is to:

- Quality assure the retrospective review processes and reports in relation to adults;
- Ensure any issues or concerns in relation to individual adults have been actioned appropriately;
- Ensure that any criminal concerns or issues have been referred to the PSNI; and

- Ensure that any Human Resources and professional regulatory issues have been taken forward by the appropriate Trust or employer

Regulation and Quality Improvement Agency:

- The Regulation and Quality Improvement Agency (RQIA) have been commissioned by the DHSSPS to carry out a review of the effectiveness of current safeguarding arrangements within Mental Health and Learning Disability Hospitals in the five HSCTs.
- This review will become the baseline to assure HSCB of the effectiveness of current safeguarding arrangements in these facilities, and formal discussions with RQIA are required to clarify this process.

Reporting Arrangements:

The Chair of the Adult Sub-group will report directly to the SMG on the sub-group's deliberations on an on-going basis and will, at a minimum, provide written reports to each SMG meeting.

The Chair of the Adult Sub-group will also contribute to the final report which will be submitted by the SMG to the DHSSPS, PSNI, SBNI and NIASP.

Membership of the Adult Sub-group:

J McKee (HSCB) Chair	
T Millar (WHSCT)	M Ó Maoláin (SHCT)
J Veitch (BHSCT)	T Fleming (NHSCT)
M Mannion (BHSCT)	M Mitchell (BHSCT)
D Bradley (SEHSCT)	D/I Stephen Wilson PSNI

APPENDIX 7 – CHILDREN'S SUB-GROUP TERMS OF REFERENCE

STRATEGIC MANAGEMENT GROUP

CHILDREN'S SUB- GROUP TERMS OF REFERENCE

Background:

- The Department of Health Social Services and Public Safety (DHSSPS) is engaged in on-going discussions with the Health and Social Care Board (HSCB) in relation to the establishment of a Strategic Management Group (SMG) in accordance with the Protocol for Joint Investigation of Alleged and Suspected Cases of Child Abuse in Northern Ireland.
- Although established under the provisions of the Protocol in relation to children, in this instance the SMG's remit extends to consideration of how to proceed with regard to any concerns that may arise in relation to the historic care of vulnerable adults emerging from the recent retrospective sampling work undertaken by each of the 5 Health and Social Care Trusts (HSCT).
- In order to ensure optimal co-ordination at a regional level, Social Services input is from the HSCB and the Police Service for Northern Ireland (PSNI) involvement is provided at a Detective Superintendent level.
- The SMG is the appropriate vehicle to co-ordinate (a response to)(joint investigations of)any cases of a child protection nature which may emerge from the forthcoming Historical Abuse Inquiry to be set up by the Office of the First and Deputy First Minister.
- The SMG has established two sub-groups to take forward the work in relation to adults and children. The Sub-groups are chaired by the HSCB Adult Safeguarding Officer and Children's Safeguarding Officer respectively.

Purpose of Children's Sub-group:

The purpose of the Children's Sub-group is to:

- Quality assure the retrospective review processes and reports in relation to children;

- Ensure any issues or concerns in relation to individual children have been actioned appropriately;
- Ensure that any criminal concerns or issues have been referred to the PSNI; and
- Ensure that any Human Resources issues have been taken forward by the appropriate Trust or employer

Regulation and Quality Improvement Agency:

- The Regulation and Quality Improvement Agency (RQIA) have been commissioned by the DHSSPS to carry out a review of the effectiveness of current safeguarding arrangements within Mental Health and Learning Disability Hospitals in the five HSCTs.
- This review will become the baseline to assure HSCB of the effectiveness of current safeguarding arrangements in these facilities, and formal discussions with RQIA are required to clarify this process.

Reporting Arrangements:

- The Chair of the Children's Sub-group will report directly to the SMG on the sub-group's deliberations on an on-going basis and will, at a minimum, provide written reports to each SMG meeting.
- The Chair of the Children's Sub-group will also contribute to the final report which will be submitted by the SMG to the DHSSPS, PSNI, SBNI and NIASP.

APPENDIX 8 – DECLARATION OF INTERESTS PRO FORMA

SMG DECLARATION AND REGISTER OF INTERESTS

QUESTIONNAIRE

Name: _____

Have you had direct professional responsibility (as a practitioner or manager) in any of the following facilities?

	Yes / No	If "Yes" please give dates:
Lissue Hospital		
Forster Green Hospital		
Young People's Centre		
Stradreagh Hospital		
Tyrone and Fermanagh Hospital		
Gransha Hospital		
Knockbracken / Purdysburn Hospital		
Longstone Hospital		
St Luke's Hospital		
Holywell Hospital		
Downshire Hospital		

Have you any connections* with any of the following facilities?

	Yes / No	If "Yes" please give dates:
Lissue Hospital		
Forster Green Hospital		
Young People's Centre		
Stradreagh Hospital		
Tyrone and Fermanagh		

Hospital		
Gransha Hospital		
Knockbracken / Purdysburn Hospital		
Longstone Hospital		
St Luke's Hospital		
Holywell Hospital		
Downshire Hospital		

*The DHSSPS has no firm definition of "connection"; however it states that you should declare any relationship which could be deemed to influence your views on any matter which may be discussed by the SMG.

Signed: _____ **Date: _____**

Title: ____ **Organisation: _____**

APPENDIX 9 – AUDIT TEMPLATE 1

Strategic Management Group (SMG) Audit Template

1. Background

A retrospective review of patient files within Muckamore Abbey was completed by the Eastern Health and Social Services Board between2005 and 2009 following a patient complaint.

This led to the Department of Health and Social Services and Public Safety (DHSSPS) instigating a retrospective sampling exercise across all five Health and Social Care Trusts (HSCTs) to identify if there were concerns or significant prevalence of similar findings within any other mental health or learning disability in-patient hospitals within Northern Ireland.

It was agreed in June 2007 that the sampling exercise should focus on those most at risk, especially minors/children admitted to mental health and learning disability hospitals over a 20 year period 1985-2005. A 10% sampling of relevant files was agreed. Each HSCT was asked to follow the methodology applied in the Muckamore Abbey review which categorised the incidents as follows: -

Category 1 -	Sexualised behaviour between Adult/Minor
Category 1 (A) -	Sexualised behaviour between Minor/Minor
Category 2 -	Sexualised behaviour between Adult/Adult (Non-Consenting)
Category 3 -	Sexualised behaviour between Adult/Adult (Consent unclear)
Category 4 -	Sexualised behaviour (Consenting)
Category 5 -	Suspected sexualised activity (General details unknown)
Category 6 -	Physical abuse involving actual bodily harm and above
Category 7 -	Sexualised behaviour – query significance

Category 8 - Issues noted – dealt with thoroughly using recognised procedures

Between April 2008 and August 2009, 8 reports were submitted covering 10 sites. In late 2011 these reports and other reporting documents, 13 in total, were handed over to the PSNI for further investigation.

It was evident from the analytical review of the available information that the scale and scope of the sampling had been interpreted by HSCTs in different ways and this resulted in significant inconsistencies and variances in both methodology and sampling applied within the commissioned reports.

2. Terms of Reference

Fionnuala McAndrew, Director of Social Care, Health and Social Care Board requested a template be developed for the Senior Management Group (SMG) to address the following key areas:-

- What was the expectation at the time of responding to the described scenarios?
- What legislation policy and practice guidance was in place?
- Were the responses in line with expectations of best practice at the time?
- Was there appropriate liaison with police and child or adult protection services?
- Are there any situations that require further investigation by the PSNI?

The PSNI carried out an investigative analysis report to determine if additional information was required for the PSNI to carry out its investigation and noted the following gaps in the submitted reports:

TRUST/HOSPITAL	DATES 1985-2005	SAMPLING	SIZE / %	CHILDREN	ADULTS	CATEGORIES	INCIDENT DETAILS
EASTERN – Lissue, Foster Green	1970-1979 1990-1999	NOT CLEAR	NOT CLEAR	YES	NO	NO	YES

WESTERN – Stradreagh	**YES**	**YES**	**10%**	**YES**	**YES**	**YES**	**YES**
WESTERN – Tyrone & Fermanagh, Gransha	**YES**	**YES**	**37%**	**NO**	**YES**	**YES**	**YES**
BELFAST - Knockbracken	**1970-1986**	**NO**	**20% + 6**	**YES**	**YES**	**NO**	**YES**
SOUTHERN – Longstone	**YES**	**NOT CLEAR**	**25% + 10**	**YES**	**NO**	**NO**	**NO**
SOUTHERN - St Luke's, Craigavon	**YES**	**NOT CLEAR**	**25%**	**YES**	**NO**	**NO**	**LIMITED**
NORTHERN – Holywell	**YES**	**NOT CLEAR**	**10%**	**NOT CLEAR**	**NOT CLEAR**	**YES**	**LIMITED**
SOUTH EASTERN – Downshire	**YES**	**YES**	**10%**	**NO**	**YES**	**YES**	**LIMITED**

The PSNI report made the following comments: -

1. It is not possible to put a figure on the number of incidents reported on. This is due to some of the HSCTs reporting a number of incidents and others stating the number of patients affected.
2. It is not always clear where the patients involved are adults or children this means that the assessment of incident if criminal is difficult.
3. The lack of incident detail in some reports has made it difficult to make basic assessments of what has happened, when and where it happened and who was involved.
4. Information including patient names (whether perpetrator or victim), dates of birth, date of incident or whether the incident was reported to the police is not always recorded.
5. It has not been possible to complete the network analysis or analyse whether problems exist in particular wards or under certain staff members.

6. The main focus of many of the reports is on the process and policies that were in place at the time of the incidents and whether these were adhered to. They appear to overlook the vulnerable victims and perpetrators in some cases failed to emphasise the incidents where the police should have been involved and fully investigate why they were not.
7. In some of the reports it has been stated the police have advised on the findings of the report and are of the opinion that nothing further can be done.
8. There is no further information on who was consulted and whether these incidents were formally cleared.
9. Minutes of the reports assume a level of knowledge of the remit and the layout of the institution.

The police go on to identify information which is required in order to progress the analysis. The police indicate that much of the information required would have been captured at the time of completion of the individual reports and may still be readily available if the research has been retained.

Audit Template

TRUST:	**HOSPITAL SITE:**
REFERENCES: (Source Material, attached copies if possible)	
INCIDENT DATE:	**INCIDENT LOCATION:**
VICTIM:	**ALLEGED PERPETRATOR :**
Name or Unique Reference	Name or Unique Reference
Gender: MALE/FEMALE	Gender: MALE/FEMALE
DOB or Age:	DOB or Age:
Status (e.g. Inpatient, Outpatient, Staff, Other)	Status (e.g. Inpatient, Outpatient, Staff, Other)
RELEVANT LEGISLATION, POLICY AND PRACTICE GUIDANCE AT THE TIME:	
WERE THE RESPONES IN LINE WITH EXPECTATIONS OF BEST PRACTICE AT THAT TIME?	
CATEGORY	**Tick which is appropriate**

1. Sexualised behaviour between Adult/Minor	
1A. Sexualised behaviour between Minor/Minor	
2. Sexualised behaviour between Adult/Adult (Non-Consenting)	
3. Sexualised behaviour between Adult/Adult (Consent unclear)	
4. Sexualised behaviour (Consenting)	
5. Suspected sexualised activity (General details unknown)	
6. Physical abuse involving actual bodily harm and above	
7. Sexualised behaviour – query significance	
8. Issues noted – dealt with thoroughly using recognised procedures	
POLICE INVOLVEMENT	
Reported to Police	YES/NO
Police Advice	YES/NO
Further Details (e.g. Outcomes if known, Police Contact)	YES/NO
SOCIAL SERVICES INVOLVEMENT:	
Reported to Social Services	YES/NO
Social Services Advice	YES/NO
Further Details (eg Outcomes if known, referral to counselling, support services etc)	YES/NO

FORM COMPLETED BY:	
Name:	Job Title:
Signature:	Date:

APPENDIX 10 – AUDIT TEMPLATE 2

Strategic Management Group Audit Template 2

Name of Report	
Trust Name	
Signed off by	

Are the Terms of Reference included in the report?	☐	☐
Does the report address the timescale 1985 – 2005? If not what dates are covered?	☐	☐
Does the report confirm that a 10% sample was reviewed?	☐	☐
How many files were reviewed in total?	☐	
Does the report address children's files?	☐	☐
Are specific incidents referred to which identify either victims or adults? If yes can you complete template 2 for each case/file.	☐	☐
Is an Action Plan referenced in the report? If yes, is it available?	☐ ☐	☐ ☐
Are any actions outstanding? (Please attach a copy of Trust Action Plan)	☐	☐
Does the report fully address the Terms of Reference?	☐	☐
Comments		

APPENDIX 11 – AUDIT TEMPLATE 3

Strategic Management Group (SMG)

Monitoring Template – Audit Template 3

PSNI [i]					Social Services [ii]				
Initials or Identifying Reference	Nature of Alleged Offence	Statement of Complaint Yes/No	Investigating Officer	Update	Referred to Trust Yes/No *(if No enter N/A below)*		Lead Officer	Update	Criminal / Civil Legal Proceedings Update
					Name of Trust	Date of Referral			

APPENDIX 12 - SUB-GROUP MEMBERSHIP

Membership of the Adult Sub-group:

J McKee (HSCB) Chair	
T Millar (WHSCT)	M Ó Maoláin (SHCT)
M Mitchell (BHSCT)	T Fleming (NHSCT)
M Mannion (BHSCT)	D/I S Wilson (PSNI)
B Rhodes (SEHSCT)	

Membership of the Children's Sub-group:

M Quinn (HSCB) Chair	M Logan (SHSCT)
T Cassidy (WHSCT)	J Fenton (NHSCT)
T McAllister (BHSCT)	D/I S Wilson (PSNI)
A Garland (SEHSCT)	U Turbett (PHA)

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ
Tel: 028 9052 0561
Email: sean.holland@health-ni.gov.uk

Mr Martin Dillon
Chief Executive
Belfast Health & Social Care Trust
A Floor, Belfast City Hospital
Lisburn Road
BELFAST
BT9 7AB

Our Ref: SH5

Date: 20 October 2017

Dear Martin

We are writing to you in order to raise a number of significant issues around the recent allegations of abuse made against staff working in Muckamore Abbey Hospital, and the related suspension of staff.

You should take our decision to raise this directly with you as a measure of our growing concern as to the handling by your Trust of this very serious issue. This relates both to the way we became aware of this incident, and the partial and imprecise nature of information provided in response to a number of requests for information from Departmental officials.

As you will be aware, there is a clear procedure in place for the reporting of incidents such as this, as set out in Departmental Circular HSC (SQSD) 64/16: specifically criterion 7, which specifies incidents resulting in *'an immediate suspension of staff due to harm to patient/client'* and further stipulates that such incidents should be notified to the Department '*promptly (within 48 hours of the event in question)'.*

In light of this very clear guidance, it is wholly unacceptable that the Department was not made aware of these allegations through an Early Alert notification until 7th September. Indeed, this alert seems to have been raised only after the Department had been prompted to make enquiries following a phone call on 30th August to a senior official by an elected representative acting on behalf of the father of the patient in question.

It was further troubling to learn that there were also delays in the reporting of the incident within the Trust. Based on the information in the Early Alert received on 7th September, an adult safeguarding concern had been raised on 21st August regarding an alleged assault of a patient in the Psychiatric Intensive Care Unit in Muckamore Abbey hospital, which had actually occurred some nine days earlier on 12th August. This delay was separately explained to Departmental officials as due to a combination of a staff member who witnessed the incident going on leave, and some

INVESTORS IN PEOPLE

subsequent confusion over who was responsible for reporting the incident in their absence. It was on the basis of this advice from the Trust that the attached response was issued to Gavin Robinson MP who had initially alerted the Department to the incident.

The Early Alert also advised that the named staff member involved was not on duty on 21st August, but in their absence was placed on precautionary suspension on 22nd August pending the outcome of the investigation. In line with established safeguarding procedures, the allegation was referred to the designated Adult Safeguarding Officer and the PSNI, who we were advised were taking the lead in the investigation.

Subsequently, however, an update to the original EA notification from the Trust was received by the Department on 26th September, advising that CCTV footage of the incident had been viewed which had given rise to 'grave concerns'. The nature of these concerns was not specified, prompting the Department to again contact the Trust to request further details.

Indeed, it was in response to this further request for information that we became aware that a second patient was involved in the incident, and a second member of staff had been placed on precautionary suspension, as well the nurse in charge of the ward on the day of the incident. Information regarding the redeployment of two other staff nurses to another ward pending the outcome of the investigation was also referred to in this update. These were clearly significant developments, and given the Department's clear interest in the incident, we cannot understand why this information was not relayed to us in the early alert.

In addition the Department is deeply concerned to learn following contact with the HSCB/PHA that the incident was not reported as an SAI until 22 September 2017. Given the seriousness of the circumstances and potential public interest the Trust should have reported this incident with 72 hours as an SAI as outlined in the HSCB Procedure for the Reporting and Follow up of SAI Section 4.2 and Section 6. As this did not happen it is clearly a breach of agreed procedures. We also now understand that the investigation initiated by the Trust into the alleged assault that took place on 12th August is now not PSNI led as originally reported, but is a Joint Agency investigation and that an SAI Level 3 Root Cause Analysis review has also been instigated by the Trust.

In view of the foregoing, it was with some considerable alarm that that we learned, through subsequent enquires made by the Department, that there had been a separate safeguarding concern raised relating to a patient in another ward in Muckamore and also involving a nurse now on precautionary suspension.

Again we are profoundly disturbed that this further incident was not formally reported to the Department through the Early Alert notification system (indeed no such report has been made at the time of writing).

To be clear: the lack of comprehensive, accurate and timely information to date, as outlined above, has made it difficult for the Department to be assured that the relevant adult safeguarding policy and procedures have been appropriately implemented in relation to these incidents. This is a situation which we find both unacceptable and unsustainable.

We ask now that, as a matter of urgency, you provide comprehensive written accounts both of the incidents in question, the actions of the Trust in managing them and provide an explanation for the apparent non-compliance with the relevant guidance as set out above.

Yours sincerely

Sean Holland
CHIEF SOCIAL WORK OFFICER

Charlotte McArdle
CHIEF NURSING OFFICER

Exhibit 57

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ

Tel: 028 9052 0561

Email: sean.holland@health-ni.gov.uk

Our Ref: SH20

Date: 30 November 2017

Mr Martin Dillon
Chief Executive
Belfast Health & Social Care Trust
A Floor
Belfast City Hospital
Lisburn Road
BELFAST
BT9 7AB

Dear Martin

MUCKAMORE ABBEY HOSPITAL

We are writing following the meeting with Marie Heaney and Brenda Creaney on 17 November. As you will know, this meeting was to discuss the detail of your letter of 2 November and the subsequent briefing report which was prepared for the Trust's Quality Assurance Committee.

This letter now seeks further written assurances on the range of issues which were raised during the 17 November meeting and on related matters which have emerged in parallel.

The Department acknowledges the Trust's apology and the subsequent steps the Trust has taken to address our concerns. In particular, we note you have indicated that 'management and leadership behaviours would be subject to further investigation and action'. We would welcome clarity on the Terms of References and modality for this investigation.

Trust Briefing Paper

Turning to the briefing paper which was prepared for the Trust's Assurance Committee, regarding Incidents in Muckamore Abbey Hospital, the Department has a number of observations and areas requiring further clarification.

Whilst the Department acknowledges the issues with regards to resettlement and delayed discharged, we are concerned that this could be interpreted as a contributory factor. I am sure you would agree under no circumstances should resettlement and/or delays in discharge be considered a causal factor for abuse and mistreatment of patients. Muckamore Hospital as a regulated facility is required regardless of patient status to deliver safe and person-centred care and to ensure all staff act with the highest degree of professional conduct.

We also note with particular concern that the paper presented to the Trust Assurance Committee made no reference to the Department's concerns as outlined in our letter to you on 20th October 2017. We would therefore seek assurance that your Board Senior Management Team and Assurance Committee have received a full chronology about the circumstance and concern regarding the initial management of events.

The Trust paper provides data on the number of 'Abuse by Staff to patient incidents on the Muckamore Abbey Hospital Site April 16 – Oct 17' which indicates 18 incidents in just 18 months. Unfortunately no explanation about the nature of the abuse or staff involved was provided. The data presented in the charts shows a worrying pattern, therefore the Department is seeking assurance that all these incidents have been thoroughly and comprehensively investigated by the Trust and that a full trend analysis has been completed to ensure that there are not recurring themes emerging.

We also believe the Trust now needs to review all allegations of abuse by staff over the last five years and the action taken by the Trust as part of its investigation. We therefore ask that this is now incorporated into the Terms of Reference for the 'Level 3' SAI investigation. As part of this, we also ask that the TORs include and examination of the failures to communicate the incident with the Department as well as the subsequent difficulties we faced in securing timely information from the Trust.

Proposed Turnaround Team

On 27th October the Department was contact by the Directors of Nursing and Adults Services to advise additional information had come to light following the review of CCTV footage which give rise to further and serious cause for concern. At this stage both Brenda and Marie indicated that the Trust was considering installing a 'Turnaround Team'. Following a meeting with the Trust on 30th October it would appear the Trust adjusted its position. It would be helpful if you could clarify the factors which contributed to the Trust's change of position, and how the Trust is assuring itself, in light of a number of failures to report by staff, that the practice of staff including managers is of the highest standards.

Safeguarding Investigation

In respect of the current adult safeguarding and police investigation, we are aware that a number of staff have been suspended pending investigation whilst others have been redeployed to other wards with enhanced supervision. In terms of ensuring patient safety, it would be helpful to understand how the Trust is ensuring safe and effective practice from those staff for whom there are significant concerns regarding their failure to report abuse yet they remain working within the hospital.

It is also our understanding that the Adult Safeguarding Investigation by the Trust has been completed and a report has been presented to the Director of Adult services, we are therefore requesting that the findings be made available to the Department.

Other Issues

We also note the Trust initially proposed to review 25% of CCTV footage, however in light of our responsibly to safeguard the public we do not believe this is adequate. We therefore are requesting that 100% of the footage is reviewed. Can you confirm the Trust's commitment to review all the CCTV footage?

In relation to the various investigations the Department expects the highest standards of independence and therefore anticipates the Trust will source an independent team from outside of Northern Ireland. Given our concern we request that you share a copy of the Terms of Reference with the Department.

We further understand that another team has been appointed to provide assurance about Nursing and Care Practice and again we are requesting a copy of the Terms of reference for this review.

You will also be aware of specific comments being made on social media, which indicates that some ex-patients may have experienced abusive treatment and that senior Trust officials knew and failed to act. Given the seriousness of these allegations can you outline Trust plans to reach out to those making these comments?

Future Reporting

As we trust is clear from the foregoing, we consider that the issues raised here are of the utmost seriousness. We are being guided in our approach by the standards of accuracy, detail and timeliness that we anticipate would be required were a Minister in place. With this in mind, and as this is an evolving Investigation, we are formally requesting a fortnightly update. We are happy to be copied into any updated information being provided to you and your senior team.

You will also appreciate that it may well prove necessary to write to you further as more details emerge.

Yours sincerely

SEAN HOLLAND
Chief Social Work Officer

CHARLOTTE McARDLE
Chief Nursing Officer

Belfast Health and Social Care Trust

caring supporting improving together

Chief Executive
Mr Martin Dillon

Chairman
Mr Peter McNaney, CBE

22 December 2017

Mr Sean Holland/Prof Charlotte McArdle
Chief Social Work Officer/Chief Nursing Officer
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Dear Charlotte/Sean

I am writing in response to your letter of the 30 November 2017 to provide the further written assurance requested therein.

Like the Department, I expect and have requested the highest level of independence for the Level 3 SAI Panel and this review.

Trust Briefing Paper

With regard to the written update provided to the Trust's Assurance Committee, the Chairman had specifically requested that Board members be updated on the total number of patients currently residing in Muckamore, a profile of the various wards and an update on resettlement to include an update on the number of delayed discharge patients. Hence the inclusion of the context setting section.

The Trust did not seek to imply or infer – nor would it ever do such a thing – that the challenges of managing patients with complex needs and very challenging behaviours was or is in any way a contributory factor to or a mitigating factor for staff behaviours which were utterly unacceptable. Muckamore Hospital as a regulated facility is required to deliver safe and person-centred care with all staff acting with the highest degree of professionalism. This is what we expect and what we overwhelmingly find, the small number of recent serious incidents notwithstanding.

I can provide assurance that the DoH correspondence of 20 October was shared with the Chairman and Trust Board. The Assurance Committee were also fully informed of the initial chronology and management of events.

The data related to *'abuse by staff to patients'* on Muckamore Abbey Hospital between April 2016 and October 2017 is part of the collation of the regular key data used for trend analysis and monitoring.

Again, the purpose of the paper to the Trust's Assurance Committee where this data appears was not to provide detailed information on each of the incidents. I can provide assurance to the Department that all of these incidents have been investigated by Adult Safeguarding and any appropriate actions followed up.

Proposed Turnaround Teams

The Trust did initially consider the concept of an independent '*turnaround'* team however on reflection concluded that this was not feasible or likely to produce the outcome needed. They key reasons include the difficulties related to identifying and securing the appropriate expertise in a timely way. Furthermore the level of complexity involved in undertaking the necessary comprehensive investigation and analysis requires a multi-layered and sequenced approach.

Currently the Trust has put in place a number of additional supports which provide assurance that the current practice of staff and managers is of the highest standards.

These are detailed below.

a) Directors Oversight Group **-** A number of Directors *(Medical Director/Deputy Chief Executive, Director of Adult Social and Primary Care, Director of Nursing, Director of Social Work and Director of Human Resources)* have been meeting the Muckamore Abbey Hospital Multi-Disciplinary senior team on a weekly basis. This meeting is used to hold to account and monitor the implementation of the action plan which has been developed to provide the Trust with the assurance it requires in relation to patient safety. This Director' Group provides an open door invitation to all staff to directly engage in relation to any issues or concerns they wish to raise.

b) Enhanced Monitoring of Practice – This remains in place across all the wards at Muckamore Abbey Hospital.

c) Patient Protection Co-ordination Group - A group of senior managers with operational responsibilities meet on a weekly basis to monitor and review practice supervision arrangements for all wards. This group to date have had responsibility for viewing and reporting on the CCTV images. This group is responsible for implementing actions identified for the protection of patient's action plans and reporting progress to the Directors Oversight Group on a weekly basis.

d) Strategic Multi Agency Group - The second meeting of the multi-agency group is scheduled to meet on the 8 January 2018. This meeting ensures that all involved organisations are informed and actions co-ordinated.

This group includes:

- Northern HSC Trust
- RQIA
- HSCB
- PSNI
- DOH
- Belfast HSC Trust

e) External Support Team - The Trust has appointed an independent support team consisting of:

Yvonne McKnight – Senior Adult Safeguarding Specialist
Professor Owen Barr – University of Ulster
Frances Canon – NIPEC

This group has two key roles:

1. To review all actions taken to date by the Trust and provide feedback and advice

2. To support the Adult Safeguarding Investigations in respect of specialist nursing expertise

The Terms of Reference for this group are being developed and will be shared with DOH when agreed.

Adult Safeguarding Investigations

The Joint Agency Investigation remains ongoing in relation to the incidents of the 12 August and 1 October. The PSNI have indicated that they hope to complete their interviews with staff prior to Christmas.

The Trust's Adult Safeguarding is also ongoing and action plan is in place with HR and Adult Safeguarding processes closely aligned.

The two staff referred to in terms of their alleged failure to report have been returned to PICU ward on restricted practice and enhanced supervision. Their actions will be subject to a disciplinary investigation once PSNI have completed their interviews.

I can clarify that the Adult Safeguarding Investigation is not complete. Progress reports and action plans are developed and updated regularly. To date Adult Safeguarding investigation processes have focused on the individual incidents. The next step in this will be the screening interviews with staff, patients and relatives and this will require the additional support of the Trusts Adult Gateway Safeguarding Team. The Trust would wish to highlight that a further two staff have been suspended following a report of a historical allegation and the management of this matter. This is being investigated under Adult Safeguarding procedures.

Other Issues

I can confirm that in the interest of regaining public and other stakeholders' confidence the Trust intends to review all of the CCTV footage and is currently identifying additional independent support to complete this.

Independent Level 3 SAI

A fully independent panel is being appointed and is due to commence its work in late January 2018. The Terms of Reference are currently under consideration by the HSCB Designated Review Officer (DRO) and once agreed will be forwarded to you.

The panel members who have been appointed are as follows:

Name	**Role**	**Expertise**
Margaret Flynn	Chairperson	Significant experience in leading serious case reviews in Learning Disability including Winterbourne.
Professor Michael Brown	Policy Queens University	
Dr Ashok Roy	Consultant Psychiatrist, Coventry & Warwickshire Partnership Trust/Chair, Faculty of Intellectual Disability Psychiatry/Royal College of Psychiatrists	

The remaining members of the panel are being considered in consultation with the HSCB DRO to ensure full independence and will be confirmed in the coming weeks.

I can confirm that the Trust has included the need for a review of all allegations of abuse by staff over the last 5 years and the actions taken in response thereto in the Terms of Reference. I can also confirm that the Terms of Reference include an examination of the recent communication failures.

Social Media Comments

The Trust has examined the posts on social media, which mention a small number of previous patients (3). All of these patients have been cared for in Muckamore in the past, over 20 years ago. None have been recent In-patients. With regard to staff posts, there are no current staff posting, the individuals who posted are retired.

Further Reporting

I wish to assure Department colleagues that the Trust is actively aware of the seriousness of the concerns and are deeply committed to conducting this investigation to the highest standards of independence and competence.

The Trust will provide fortnightly updates from the date of this letter. In addition the Trust would like to suggest and extend an invitation to both of you to meet with the Directors Oversight Group at Muckamore Abbey Hospital to provide ongoing assurance.

Yours sincerely

Martin Dillon
Chief Executive

Copy Mr Peter McNaney, Chairman

Trust Oversight Group:
Dr Cathy Jack
Mrs Marie Heaney
Miss Brenda Creaney
Mr John Growcott
Mr Damian McAlister

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ

Tel: 028 9052 0561

Email: sean.holland@health-ni.gov.uk

Our Ref: SH139

Date: 4 December 2018

By email

Mrs Valerie Watts
Chief Executive
HSCB
12-22 Linenhall Street
BELFAST

Dear Valerie

MUCKAMORE ABBEY HOSPITAL SAI REPORT

As you will be aware, an independent Level 3 SAI review was commissioned earlier this year into the allegations of physical abuse of patients by staff at Muckamore Abbey Hospital.

This review came about as a result of the collective action taken by all parts of the system to what was emerging from the viewing of CCTV footage.

Given the seriousness of the allegations, and the level of public interest, it was our clear expectation that the SAI process would be handled without any unnecessary delay. It was therefore disappointing that, at a recent meeting with colleagues from HSCB and PHA, I was met with what I considered to be unconvincing arguments to my questions as to why this critical report has not yet been signed off.

It is of further concern that nearly two weeks on from that meeting we are no clearer about when this will happen.

It is my view that any further delays in this process have the potential to pose a significant risk to the credibility of the system and its ability to respond to what is a very serious matter in an effective and timely way.

I would therefore ask you for an urgent response indicating when the Department can expect this report to be signed off.

Yours sincerely

SEÁN HOLLAND
Chief Social Work Officer

INVESTORS IN PEOPLE

HSC SUMMIT ON MUCKAMORE SAI REPORT

30th January 2019- Castle Buildings

In attendance:

Richard Pengelly – Permanent Secretary DoH

Sean Holland – Chief Social Worker DoH

Dr Michael McBride – Chief Medical Officer DoH

Rodney Morton – Deputy Chief Nursing Officer DoH

Jerome Dawson – Director of MHDOP DoH

David Gordon – Director of Communications DoH

Alison McCaffrey – LDU (Note taker) DoH

Dr Lourda Geoghegan – Director of Improvement and Medical Director RQIA

Marie Roulston – Director of Social Care and Children HSCB

Paul Cummings – Director of Finance HSCB

Tony Stevens – CE NHSCT

Shane Devlin – CE SHSCT

Hugh McCaughey – CE SEHSCT

Martin Dillon – CE BHSCT

Anne Kilgallen – CE WHSCT (by phone)

Introductions/Expectations

1. After a round of introductions, Richard thanked everyone for attending at relatively short notice and opened the meeting by referring to the key commitment in his statement of 17th December that, within a year, no one should call Muckamore their home where there are better alternative options for their care. He emphasised that, while this must be the system's guiding principle going forward, he does not underestimate the scale and complexity of the challenges involved.
2. A discussion followed around the progress that had already been made in terms of the resettlement of hundreds of learning disability patients, and the complex

needs of the remaining population to be resettled that may require the deployment of new solutions/models, and significant resources.

3. Richard acknowledged these points, but made clear that the initial task for the system was to set out how we plan to deliver on the commitments and the recommendations in the report. He then set out his expectations in relation to the Action Plan.

Action Plan

4. Richard stated that it is his intention that the Action Plan will be the roadmap for change in the same way as Delivering Together has been for the wider HSC system. Funding implications will be for Ministers to consider in due course, and decisions would necessarily take into account the potential release of resources from different parts of the system as we change how care is provided to this group in the future.
5. At this point in the discussion, Richard also stressed that he was not concerned with symbolic or token gestures being mooted around, for example, the closure of Muckamore, and that the focus should be on moving forward on the basis of evidence-based and co-produced options for the future.
6. Rodney Morton referred to the work being led by the HSCB to review the provision of acute care in hospital and community settings for people with learning disability. Sean Holland also noted the need to complete on the aspirations in the Bamford Review around this, and to revisit current business cases to ensure appropriate provision is made for the future based on the outcomes of the current review.

Governance arrangements

7. The discussion moved on to governance arrangements. Marie Roulston made reference to the recently established structures around the transformation project to develop a new learning disability service model as a potential vehicle through which to drive and monitor progress. Michael McBride enquired about the current status of the Bamford cross-departmental group, and the need for something similar going forward.

8. Concluding this part of the discussion, Richard asked for all efforts to be concentrated on the development of the Action Plan at this stage. Once agreed, decisions could follow on the appropriate governance arrangements.

Cultural Issues

9. Richard also took the opportunity to raise concerns about the wider cultural issues exposed by the report, and the need to learn lessons and ensure that they are also addressed in the Action Plan. He mentioned a recent whistle-blowing letter relating to another unit that has recently been drawn to his attention.
10. There was general consensus around the table that addressing these issues would perhaps be the most challenging aspect of the work that lies ahead, but it was also acknowledged that there is already work ongoing in other areas of the Department in response to the Hyponatraemia Inquiry for example that would be relevant and these should be cross-referenced in the Action Plan. Sean Holland also emphasised the relevance of the Mental Capacity Act (enacted in 2016 but not yet commenced) given that it contains a range of new legislative safeguards that if implemented would help address many of the cultural issues highlighted in the report.
11. At this point, Sean Holland also updated the group on recent developments relating to the police investigation, including the searches of eight properties that took place earlier that day, and the expectation that further incidents will emerge from the ongoing viewing of the CCTV footage.
12. In light of this, Richard emphasised the need for clear and consistent messaging that conveys the unacceptable nature of what has happened and ongoing HSC support to those carrying out the police investigation, but also provides the necessary assurances to the public and crucially the families of those affected that current services are safe and action is being taken to ensure meaningful change in the future.
13. Appropriate support for those working in this field and dedicated to providing high quality and safe services was also emphasised by a number of attendees.
14. Paul Cummings raised the need for assurances also to be sought in relation to services currently being provided by the independent sector, and implications for this sector more widely. Lourda Geoghegan advised that the role of the independent sector was discussed at a meeting between the RQIA and the

BHSCT this week. Current challenges were also noted around the cost of current packages in the community, and the dynamic nature of the situation on the ground was highlighted by Tony Stevens who referred to the difficult reality of managing “placement breakdowns” in the community often leading to hospital admissions, and a growing numbers of delayed discharges.

Way forward

15. Richard acknowledged the complexity of the issues involved, and the need in the first instance for everything to be captured in the Action Plan before we begin to find solutions. As a starting point, Richard asked for a first cut of the Action Plan to be drawn up and submitted to Jerome early next week. This should start with the recommendations in the SAI report and his commitments, and be circulated to the group to ensure that all of the pertinent issues have been captured. Once this has been done, roles and responsibilities will be allocated; timeframes set in which to find solutions; and appropriate governance arrangements put in place.

Engagement with families, MLAs, charities

16. Martin Dillon outlined the extensive work carried out with families by the BHSCT to build relationships during the course of the resettlement process and more recently to emphasise their key role in making plans for any future models of care. Marie Roulston echoed this, and the need to think further about co-design arrangements and supports in this particular context. The important role of charities was also noted.
17. Richard reiterated the importance of keeping the families informed, and in line with the commitment he had given when they met in December, he asked for a further meeting to be arranged, as well as a letter to issue to them referring to today’s meeting and his commissioning of further work on the Action Plan which he would brief them on at the meeting.
18. Sean Holland advised that he and Charlotte McArdle are to meet Colm Gildernew MLA (SF) in February. Discussions had also taken place with Gavin Robinson MP (DUP). Martin Dillon indicated that a briefing for MLAs was planned for February also.

Alison McCaffrey – Learning Disability Unit, DoH

Exhibit 61

From: Jackie McIlroy
Deputy Chief Social Work Officer
Office Social Services

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

By e-mail

Ms Marie Heaney
Director of Adult, Social and Primary Care Services
Belfast Trust Headquarters
A Floor, Belfast City Hospital
Lisburn Road
BELFAST
BT9 7AB

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ

Tel: 028 9052 0704

Email: jackie.mcilroy@health-ni.gov.uk

Our Ref:

Date: 22 February 2019

Dear Marie

PUBLIC INTEREST DISCLOSURE

Thank you for the Trust's update report of 20th February 2019.

The report has raised some concerns about the current protection and safeguarding arrangements for patients in Muckamore Abbey Hospital (MAH) on which I require urgent assurance.

I should also advise that the Department has received separately a public interest disclosure that:

- Trust management made a decision before Christmas to suspend the work of the DAPO team who were responsible for following up the incidents of concern that had been identified by the CCTV viewers. It is not clear to the Department whether the work of the DAPO teams has restarted.
- Serious incidents of concern involving MAH staff members had been viewed on CCTV but that no further action had been taken in relation to them as yet, raising concerns that appropriate action to protect patients may not have taken in respect of staff who may still be working directly with patients.
- A very significant backlog of safeguarding referrals arising from the CCTV viewing had built up and
- Concerns about the ability of the DAPO team to cope with the safeguarding workload arising from the CCTV viewing had been raised repeatedly with Trust management, but that no additional capacity had been provided.

INVESTORS IN PEOPLE

The information provided in your report of the 20th February appears to corroborate some of this information. The report does seem to suggest that there are 158 reports of concern notified by the CCTV viewers that, apart from an initial triaging, have not been processed any further. Of those, 95 have been categorised as either urgent or Category A. It is the Department's understanding that until the DAPO team starts to process a referral from the CCTV viewers, no further action is taken to identify the staff and patients involved in the incident, no protection plan is put in place, the PSNI are not informed and staff and patients are not informed. Can you clarify urgently the actions that the Trust has taken in respect of the 158 reports of concern?

I note that your report states that only two DAPOs are involved in the process and that attempts to recruit other staff have been unsuccessful. This would appear to corroborate the information received by the Department that the Trust has not been able to put in place sufficient staff to respond to the safeguarding referrals in a timely fashion.

The Trust report also references members of staff who had been "bystanders" continuing to work with patients, but with enhanced supervision arrangements. It was my understanding that at least some "bystanders" had been suspended and I seek clarification on the approach taken by the Trust in relation to those who are believed to have witnessed incidents of concern but did not take any action.

I require an urgent response to this letter which addresses the concerns raised by the public interest disclosure and fully explains the current situation regarding the protection of patients from staff who have been identified as being involved in incidents of concern on CCTV.

The Department has other queries in respect of the latest report which we will address with you separately.

Yours sincerely

Jackie McIlroy
Deputy Chief Social Work Officer

Tel: 028 90 520704
Email: jackie.mcilroy@health-ni.gov.uk

Copied to:
Marie Roulston, Director of Children and Adult Social Care (HSCB)

Belfast Health and Social Care Trust

caring supporting improving together

Trust Headquarters
A Floor, Tower Block
Belfast City Hospital
51 Lisburn Road
Belfast, BT9 7AB

Wednesday 27 February 2019

Jackie McIlroy
Deputy Chief Social work Officer
Office Social Services
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 2SQ

Dear Jackie

RE: Public Interest Disclosure

Thank you for your letter of 22nd February 2019 and our meeting on Monday 25th February 2019 with Rodney Morton and Moira Mannion.

The purpose of the meeting was to discuss the public interest disclosure letter of 22nd February 2019 and the Trusts most recent update report to the Department of Health regarding Muckamore Abbey Hospital.

In relation to your letter's opening remark that the report has raised some concerns about the current protection and safeguarding arrangements for patients in Muckamore Abbey Hospital, I wish at the outset to firmly state that the assurance systems we have put in place in Muckamore Abbey Hospital are robust and we are confident that the level of scrutiny being delivered every day in Muckamore is providing a high level of assurance.

I would suggest that the Trust and Department of Health colleagues should meet formally on a monthly basis so that the Trust can provide the assurances sought given the level of operational detail and the evolving nature of this investigation.

Some of the most important and impactful assurances include:

- The installation of a CCTV system in every ward, in the day care centre and the swimming pool

- Contemporaneous programming of viewing areas, which has not revealed any current issues of concern. It has shown good practice and positive interactions between staff and patients often in very challenging circumstances
- We have a programme of external staff providing safety and quality leadership visits on a regular basis
- Provision of Positive Behaviour Support training to nurses on every ward
- Daily safety briefings on each ward
- Significant improvement in meaningful activities for every patient which reduces challenging behaviour
- Weekly live governance involving all sisters/charge nurses reviewing incidents and episodes of seclusion which has seen a significant reduction
- Collating weekly key governance data for close monitoring, including staffing levels, vacancy and absences
- Significant cross Trust focus on discharge over past 12 months with patients numbers reducing from 93 in September 2017 to 66 in January 2019. The majority of people delaying in Muckamore Abbey Hospital have a discharge plan
- Ongoing engagement with families to encourage feedback
- Continuing roll out of social work led 'keeping yourself safe' guidance for patients
- Further the Trust has placed on pre-cautionary suspension 19 staff whose practices were deemed to be of an unacceptable standard on the historic CCTV material and required further investigation and referral to the PSNI for consideration of criminal threshold
- Bi-weekly Directors Oversight Co-Ordination meeting

These measures provide assurance in the present time of the safety of patients and are part of the 'changing the culture' programme in Muckamore Abbey Hospital.

Your letter refers to the risk management of the historical CCTV material. I will provide some context and then address each of the points you make in your letter.

It is important to understand that the process set up to undertake the viewing and professional analysis of up to 420,000 hours of CCTV footage over approximately 31 weeks with 3 shifts in each 24 hour period approximately 3255 shifts was inevitably going to take a considerable period of time. This task was influenced by a number of factors;

- Recruiting and retaining suitable numbers of staff qualified to undertake the initial viewing of the footage. The Trust has successfully retained some 23 staff to work on this over the past 10 months. Inevitably availability of these staff has dipped at times.
- The analytic work of the Learning Disability DAPOs and the Learning Disability MAPA is much more specialised and for some time the preferred model of consistency was within a smaller team.

This approach was jointly reviewed in December 2018 by senior staff in the Trust and PSNI. It was agreed that the limitations of having only 2 viewing screens for a number of related functions needed to be examined. The PSNI were looking at copying the images from the hard-drives and taking this to the forensic imaging unit at Seapark. This action was agreed and a process of assessing the methodology and risks was commenced by IT staff from PSNI

in discussion with the specialist CCTV provider contracted by the Trust. The benefits of this action were that Seapark had 12 viewing screens and the PSNI were recruiting additional staff into this operation. This meant that the remaining viewing could be completed in a shorter period of time.

The PSNI at this time were seeking assurances that PICU viewing had been fully completed as they were in preparation for interviews with staff associated with the PICU incidents. They indicated that they saw PICU as phase 1 of their investigation with any further incidents from other wards as a further phase. The PSNI indicated that their priority at that point was the completion of PICU, the security of the viewing room at Muckamore and the plan to copy all of the hard-drives.

Over the Christmas holiday given the small team the viewing and DAPO analysis were temporarily paused. However, oversight arrangements were in place over the Christmas period led by the Director of Nursing and DASPC with situation reports to RQIA.

Following the Christmas break access to the viewing room was prioritised to;

- Security measures/PSNI IT assessment
- PICU viewing (following a validation process it was clear a number of weeks of night duty were outstanding
- Live viewing for real-time assurances
- DAPO and MAPA analysis when required
- Remaining viewing of other wards

The availability of the small team of viewers in the post-Christmas period impacted on the planned viewing schedule.

On the 05th February 2019 the ASG team assessed the incidents highlighted by the viewing team and applied a desk-top analysis of the incidents which was highlighted in the report to the DOH. The next step in the process requires DAPOs viewing the incidents with the MAPA specialist and onward report to the Management team consisting of Deputy Director of Nursing, Co-Director and Senior HR for decision making.

On the 08th February the PSNI decided to move the hard-drives to Seapark, This required a further pause in access to viewing of historical footage.

The Trust had been advised that access to viewing at PSNI facility could commence on Monday 25th February and staff have attended on this date to undertake the analysis of the priority incidents followed by the category A incidents.

PUBLIC INTEREST DISCLOSURE POINTS

- **Trust Management made a decision before Christmas to suspend the work of the DAPO team who were responsible for following up incidents of concern that had been identified by the CCTV viewers**

This is incorrect. The Trust in discussion with the PSNI who are leading this Adult Safeguarding investigation agreed the priorities for the viewing area as referenced earlier. The DAPO completed a desk-top initial analysis on 05th February. The PSNI were in discussions to copy the hard-drives which were removed on the 08th February and viewing of historical footage was paused to facilitate the transition to Seapark.

- **Serious incidents of concern involving MAH staff members had been viewed on CCTV but that no further action had been taken in relation to them as yet, raising concerns that appropriate action to protect patients may not have taken in respect of staff who may still be working directly with patients.**

This is incorrect. The Trust has been clear from the outset of this investigation that its first priority is the protection and safety of patients in the hospital. The measures outlined at the start of this letter demonstrate that the care of patients in Muckamore is being closely monitored and currently safe.

The protracted natured of the examinations of the very large volumes of historical footage and the associated processes mean that batching of processes is inevitable with the constraints outlined. The Trust is acutely aware that a number of urgent triaged incidents require immediate analysis and are actively working with the PSNI to ensure this is completed without further delay.

The temporary pausing of viewing whilst the hard-drives are transferred to PSNI facilities is designed to ensure that more rapid decision-making can occur in relation to any staff practices evidenced in the past. This decision-making must be thorough and informed by MAPA specialist viewers with decision-making being undertaken by the Management team as previously referenced.

This analysis and decision-making must be carefully processed following agreed processes which involve

- Initial identification
- Adult Safeguarding
- MAPA
- Care plan
- Decision making by senior team

Whilst there has been a logistical pause in viewing the historic CCTV this was a rational and justifiable decision. The DAPO viewing of all 158 incidents resumed on Monday 25th February.

- **A very significant backlog of safeguarding referrals arising from the CCTV viewing had built up and concerns about the ability of the DAPO team to cope with the safeguarding workload arising from the CCTV viewing had been raised repeatedly with Trust management, but that no additional capacity had been provided.**

The Trust is aware of the batching of incidents related to limited access to viewing screens and has addressed this fully in partnership with the PSNI.

I would acknowledge that the DAPOs involved to date have undertaken a significant amount of work which the Trust is deeply appreciative of. Expressions of interest advertisements for additional DAPOs have been advertised at least a couple of times with no success.

In response to this a number of actions have been agreed.

- Director Adult Social & Primary Care has been released from role to manage all work streams related to Muckamore Abbey Hospital.
- A number of Advanced Adult Safeguarding consultants and practitioners are being recruited at the moment to lead the Trust investigative work and manage the communication between PSNI, Disciplinary team and Operational Management team.
- Additional DAPO capacity has been identified by colleagues in Northern Trust which is being activated.
- Additional MAPA expertise has been secured.

This additional capacity is becoming available from next week.

Bystanders

I can confirm that the Trust made the determination that pre-cautionary suspension would be applied to these staff who had engaged in physical and psychological practices which required investigation and should be removed from the workplace as a protection plan.

Staff who appeared to witness incidents following the Management decision-making process are being managed with enhanced supervision as a protective measure.

There are no apparent witnesses or bystanders who have been placed on pre-cautionary suspension, however, the charge nurse for PICU was placed on precautionary suspension pending investigation for his role in assuring safety.

One member of staff who has moved to a position with South Eastern Trust is now receiving enhanced supervision.

I hope this addresses the concerns you have raised and request again that monthly meetings with the Department of Health are arranged to ensure the complexity and the evolving nature of the situation can be communicated more effectively and robust assurance provided.

Yours sincerely

M. Heaney.

Marie Heaney
Director of Adult Social & Primary Care

Exhibit 63

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ

Tel: 028 9052 0561

Email: sean.holland@health-ni.gov.uk

Our Ref: SH181

Date: 17 May 2019

Via email

Mrs Valerie Watts
Chief Executive
Health & Social Care Board
12-22 Linenhall Street
BELFAST

Dear Valerie

MUCKAMORE ABBEY HOSPITAL

As you know, RQIA undertook a further unannounced inspection of Muckamore Abbey Hospital (MAH) during 15 – 17 April. The RQIA then outlined their findings in a letter to the Department with issued on 30 April, setting out a range of continuing concerns, chiefly around staffing.

BHSCT have provided the Department with assurances as to the strenuous efforts being made to stabilise the position at MAH. At a meeting on held in DoH on 14 May, BHSCT was able to relay these assurances directly to RQIA. While at that meeting there was consensus that MAH was providing safe care in the immediate term, RQIA remained concerned about the pressures facing staff due to the working environment and surrounding context. Concerns that persisted despite the assurances on staffing numbers.

We must, therefore, give serious consideration to the possibility that, in the medium to long term, it may simply not be possible to sustain safe, effective and human rights compliant services at MAH.

In parallel, BHSCT has reported that further suspensions at MAH may be necessary as the criminal investigation progresses. Clearly, any additional suspensions of staff at MAH would reduce the Trust's capacity to continue to provide services and, beyond a certain point, would require services to cease for reasons of safety.

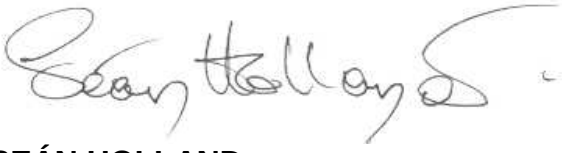
I understand that the Trust has begun work on contingency planning for this possibility and I am writing now to ask you to support this as a matter of urgency.

More generally, I appreciate the many competing pressures faced by HSCB and the strain this has placed on staff members. However, you will understand that, in view of the issues which have emerged from MAH, this must now be a priority for the HSC. I am therefore formally requesting that you identify a member of staff who can be dedicated full time to working with the Trusts on MAH.

In the first instance, the priority will be on stabilisation of the current position and contingency planning, however the ultimate aim remains the resettlement of residents in line with commitment of the Permanent Secretary and the deployment of a new model of care which address the issues identified in the MAH SAI.

As ever, happy to discuss.

Yours sincerely



SEÁN HOLLAND
Chief Social Work Officer

CHARLOTTE McARDLE
Chief Nursing Officer

Exhibit 64

MUCKAMORE ABBEY HOSPITAL – DEPARTMENT AND BELFAST TRUST LIAISON MEETING

6th September 2019

Castle Buildings

Attendees:

Richard Pengelly, DoH

Sean Holland, DoH

Charlotte McArdle, DoH

David Gordon, DoH

Mark Lee, DoH

Martin Dillon, BHSCT

Cathy Jack, BHSCT

Brenda Creaney, BHSCT

Marie Heaney, BHSCT

MINUTE

1. Belfast Trust started by updating on their meetings with PSNI and the number of additional suspensions that may be necessary. This was based on either a different interpretation of events which the Trust viewed and had made a judgement on or additional information (for instance, a staff member have witnessed a significant number of incidents of abuse rather than just 1 or 2). It was noted that the Trust made the final judgement, as the employer, about the appropriate action in each case. However, PSNI may feel the need to make public any disagreement with the Trust about judgements on patient safety.

2. The PSNI have identified 6 non-registrants for possible precautionary suspension but only one of those individuals was currently working in Muckamore. Of 8 registrants identified, 3 were currently working in Muckamore. The police have a further 10 names which they will be bringing forward to the Trust. It was noted that the police had set a lower threshold than the Trust for identifying incidents of concern – which had led to them identifying 450 incidents in PICU, compared to 150 by the Trust.

3. The Trust updated on progress towards discharge. Of 54 patients currently in Muckamore (of whom 14 are forensic) the Trust expect 22 discharges by Christmas and a further 5 in January or February.

4. The meeting agreed on the need to close Muckamore Abbey Hospital. The need for a policy statement to underpin this change was queried – however the approach was justified both by existing policy frameworks and potentially on health and safety grounds.

5. The ability to stabilise the site for the next 4-6 months was discussed. This would require sufficient progress with CCTV viewing to be confident there were no risks which had not been addressed – and sufficient staffing. It was noted that suspensions of staff often had a ripple effect, with other staff going on sick leave in addition to those who were suspended. While agency staff were available and already extensively used in the hospital, there was a risk to safety and stability if the ratio of agency staff to permanent staff became too high. Current risks were being mitigated by ensuring there was a mix of staff throughout shifts and continuity in agency staff. The additional cost of agency staff (and the impact of this on permanent staff morale) was noted.

6. In discussion, it was suggested that Muckamore's status as a hospital could be removed (given only 2 patients were under active treatment) which might allow a different staff mix to be deployed under a social care-style model. The Department would check the process for removing hospital status (**action**: ML). However, it was noted it was likely that significant input from doctors and nurses would still be needed to manage the risks which came from having such a significant number of challenging individuals together in one place.

7. The key question to be considered was whether to seek to close Muckamore immediately or to undertake a longer, more planned closure process. Advice should be put to the Permanent Secretary next week considering the risks associated with different approaches – an immediate closure, an approach over 4-6 months, or something in between (**action**: ML). It was noted that many of the staff might leave immediately if a closure was announced. We would also need to ensure that anywhere that patients were moved to had CCTV in place, in the same way there was at Muckamore.

8. The Trust were able to provide a reasonable assurance of safety in Muckamore at the moment – and confirmed that it was safer than it had ever been. Nonetheless, it was agreed that a stocktake of current safeguarding measures should take place – and that a process map for the existing safeguarding process should be completed (**action**: ML to liaise with HSCB). One additional action would be to consider requiring all HCAs working in Muckamore to be registered with NISCC. This would allow their removal from the register, if necessary.

9. The importance of engagement with families (recognising there could be no veto) on options for closing Muckamore was critical. The biggest worry was likely to be having a safety net in place for when placements broke down. Margaret Flynn (author of the SAI) had recently visited the Trust again and saw each of the current placing Trusts having some capacity in their own services for such

contingencies. Other jurisdictions would also have approaches we could consider – including crisis response teams and panels who had to agree any admission to an LD hospital. If consulted on an immediate move away from Muckamore or a slower change, many of the families were likely to prefer a single move rather than having their loved ones going through two settlement processes. While engagement with families and carers would probably have to be Trust by Trust – reflecting the differing contingency plans they would be developing – an overarching role for the PCC might be helpful to ensure consistency and inform policy decisions (**action**: CM to discuss with PCC).

10. A media strategy would need to be developed, and might take into account Margaret Flynn's current assessment of the service, and the approach to a 'big bang' announcement in due course (**action**: DG).

11. It was agreed to meet again next Friday.

Mark Lee

9th September 2019

MUCKAMORE ABBEY HOSPITAL – DEPARTMENT AND BELFAST TRUST LIAISON MEETING

13th September 2019

Castle Buildings

Attendees:

Richard Pengelly, DOH

Seán Holland, DOH

Charlotte McArdle, DOH

Mark Lee, DOH

David Gordon, DOH

Kim Burns, DOH

Máire Redmond, DOH

Marie Roulston, HSCB

Martin Dillon, BHSCT

Marie Heaney, BHSCT

1. Belfast Trust provided an update on the most recent 10 precautionary suspensions. One individual did not attend their meeting and were being spoken to today (13th). Six of the individuals were active in the workplace. Three of the individuals who had been based in six-mile forensic unit were on unspecified leave. A specialist forensic nurse had reviewed the CCTV for six-mile.

2. A further 8 staff are under active consideration because of new PSNI referrals with 2 of them likely to be placed on precautionary suspension this coming week. All of the 8 are working at Muckamore, bar one who is on sick leave, one who is working at Beechcroft and one who is a student. These 8 are new PSNI referrals although the Trust was aware of some (but not all) of them and the PSNI has been asked to supply further footage to the Trust.

3. 56 staff in total are on the Trust's radar to date; this includes the 29 already on precautionary suspension and 28 on supervision / protection plans. There are potentially 2-5 further suspensions per week going forward and there is still a lot of footage to be viewed; the PSNI is only 60% through PICU. The Trust advised that for those staff who had observed the abuse but not reported it, that a judgement would me made based on the seniority of staff involved, the number of observations made and level of abuse observed. .

4. MH advised that all staff including senior medics were tasked with steadying the team but that a number of bank staff have cancelled shifts and there were at least 6 staff who were anxious to leave MAH. She also advised that the staff situation today (13th) and over the weekend was safe but that the situation was examined twice daily.

5. In response to a question from DG asking if the patient / staff ratio had changed because of staffing issues MH advised that it had actually improved. CMcA highlighted that while the number of staff suspended was very concerning, a bigger problem may be the impact this has on the unit. MH advised that 29 staff on suspension is still a small number. It was hard to point to a tipping point at which point safety would be a major concern but if 40 staff were suspended this would cause major concern. The Trust is currently undertaking an exercise to assess how many permanent staff were working in Muckamore pre-2017, to give them a sense of the scale of the challenge that might be faced.
   Action: Daily Sit Rep to be shared with Department; this needs to include a clear assurance from Trust that service is safe / unsafe. (MH)

6. The group discussed how we could underpin the message that MAH is safe and the external assurances we have which include the work that Francis Rice is undertaking in MAH and the daily sit reps. CMcA advised that this work has commenced and Francis is working with staff on the ground in MAH to ensure there is clear communication between staff and management. RP highlighted the need to ensure very clearly and transparently that Francis is independent. SH also advised that decisions regarding safeguarding responses were being triangulated between PSNI, RQIA and the Trust – providing a greater level of assurance. MD offered to provide details of 10 or 11 changes that had been made to improve safety at Muckamore.
   Action: All the current assurance mechanisms in MAH and how these can be enhanced to be pulled together into one paper. DOH with input from Belfast Trust and HSCB (CMcA)

7. MD highlighted that there was no normative nursing model for LD, although this regional work was underway. One of the main concerns of the RQIA had been the ability to match the requirements of patients (including 1:1, 2:1 and 3:1 supervision) to staffing levels. CMcA advised that Brenda Creaney has carried out some work on developing an approach to support this using existing workforce models including Telford. It was noted that further work was needed to understand whether these staffing ratios were always necessary and proportionate.

8. MRou suggested that an analysis of the workforce requirements at MAH would be very helpful for all Trusts to see as it would help them to determine the staff they could supply to MAH in a contingency.
   Action: Workforce analysis of MAH to be developed by Belfast Trust.

9. RP asked if MAH is only perceived safe because of the CCTV in the hospital (although he recognised for privacy reasons this does not cover bedrooms and bathrooms). MD agreed this was the case and that there was a need to increase the contemporaneous viewing of the CCTV at MAH which is currently one shift per week. MD agreed that there is no doubt that there has been a change in staff behaviours since CCTV was introduced. RP was concerned about this reliance on CCTV, given it did not cover all areas and that it was arguable as to whether it prevented any incidents, as opposed to simply recording them.

10. It was noted there were a number of other factors driving change, beyond CCTV monitoring. CMcA advised that the culture and practice does appear to have changed and also that patient behaviours do indicate if something has happened. It was noted that Caring Cultures training had been undertaken and that IR1s were monitored.

11. SH acknowledged that no-one can absolutely guarantee that MAH is safe for patients but that some assurance can be taken from a combination of safety measures which include the CCTV, new staff, training and Francis Rice work. MH also added the increase of professionals visiting the unit, visible leadership from managers and 24 hour open access for families. She also advised that a co-director and a divisional nurse were starting in the Trust next week.

12. Contingency plans were discussed by the group with the 1st contingency being to import staff and the 2nd to export patients (in extremis). SH advised that creating a cohort of staff under each Trust had the potential to create discord and would be difficult to manage; it was agreed that this option was unlikely to work effectively. ML advised that at discussion with other Trusts it was concluded that it was almost always better to bring staff into MAH rather than move patients out at very short notice – although this approach could destabilise other services such as respite and community services which help to stop patients being admitted to MAH as an in-patient. Another option is to transfer staff into community providers to allow placements to start.

13. SH advised that a plan for rapid closure is still being firmed up while ML advised that the Department is pushing for clearance of capital bids which support resettlement. The feasibility of other capital works e.g. at Whiteabbey and Knockbracken is also being considered.

14. It was agreed that there would always be a need for a small inpatient unit and also that the forensic patients were a group for which a facility was required. There was consensus that there were benefits to placing a forensic LD unit on the same site as the forensic MH unit at Knockbracken, though this would need to be considered further and discussed with families. SH advised that this would require capital money so that some buildings could be brought up to standard quickly. Trust clinical and estate staff had recently been up and walked the site. MD highlighted that from a clinical point of view none of the vacant wards were suitable and that extensive work would likely be required. A firm sense of

timescales would have to await scoping work being completed but it was likely that at least a 12 month timescale would be required. MH advised that a business case for accommodation for the MAH forensic patients would need to be developed.

15. The cohort of 16 patients for whom places had been identified but no timescales agreed – and how to finalise these plans – was discussed. The potential to appoint a specific resettlement lead was discussed but MH advised that 2 senior managers had now been appointed to MAH; one to focus on communication and the other to focus to discharge of patients; while HSCB had appointed Lorna Conn to lead the regional work.

16. SH highlighted the challenge in creating a service that responds to the ongoing need for assessment and treatment and modelling a service that extends home treatment, peripatetic and crisis response but still needs a small in-patient unit. MH advised that 2/3 patients are being admitted per month into MAH but that stays are much shorter than before. She further highlighted the gaps in the medical fields which are needed to support home treatment and to prevent placements breaking down.

17. SH agreed to produce a paper on the way forward; setting out in the first instance why MAH can't continue as is although RP noted that any decision to close must only be taken after engagement with families and staff; this engagement to take place in the very near future. CMcA advised that Vivian McConvey from PCC had agreed to carry out engagement with families and that Vivian is trying to obtain the services of 1 or 2 advocates to support this. The importance of engagement with the RCN was noted and CMcA noted that Siobhan Rogan may be able to help the development of the nursing model in Muckamore.

    Action: SH to produce a paper on the way forward for MAH – by end of next week (20th Sept.)

    Action: CMcA to take forward development of an engagement plan – by end of next week (20th Sept)

18. It was agreed that a communication plan and statement on the immediate future of MAH and the direction of travel was required as soon as possible. This would emphasise that this is not any different to what has been planned for several years i.e. the resettlement of all patients from MAH to ensure that no-one has a hospital as their permanent address. It was not closure but a radical re-shaping of existing pathways. MRoul highlighted the key messages in this statement should also be around the opportunities for staff to be deployed in the community, different settings and have the opportunity of alternative pathways. DG advised that he is meeting with Belfast Trust comms staff to discuss the plan on 14th Sept.
    Action: Comms plan to be developed by DG and BT comms by end of next week (20th Sept)

Action: Draft statement on direction of travel for MAH by DG for middle of week i.e. 18th Sept

19. The need for a further meeting in a week would be kept under review, with a decision in the next couple of days.

20. To sum up, no decision on closing MAH immediately has been taken although this will be kept under review dependent on future suspensions and assurances given in daily Sit Rep.

MUCKAMORE ABBEY HOSPITAL – DEPARTMENT AND BELFAST TRUST LIAISON MEETING

25th September 2019

Castle Buildings

Attendees:

Seán Holland, DoH

Charlotte McArdle, DoH

Mark Lee, DoH

David Gordon, DoH

Kim Burns, DoH

Rodney Morton, DoH

Siobhan Rogan, DoH

Sean Scullion, DoH

Marie Roulston, HSCB

Cathy Jack, BHSCT

Marie Heaney, BHSCT

Brenda Creaney, BHSCT

Francis Rice, BHSCT

Tony Stevens, Northern Trust

Seamus McGoran, South-Eastern Trust

Apologies:

Richard Pengelly, DoH

Martin Dillon, BHSCT

Welcome/Apologies/Note of previous meeting

1. Sean Holland welcomed attendees and noted apologies. The note of the previous meeting on 13 September was agreed.

Update on current position

2. Sean Holland thanked the Belfast Trust for providing a daily SITREP and invited Trust reps to provide an update on the current position.

3. Marie Heaney advised that there are currently 55 in-patients in the hospital, with 10-12 of those on target for discharge by Christmas. Staffing levels at the hospital are safe at present, with the impact of 4 recent further staff suspensions being managed. Overall the site remains stable at present.

4. Francis Rice advised of work underway to look at the staffing profile across the site, and advised there are currently 39 Agency staff employed. He outlined a proposal to maximise this resource through measures that would enable agency staff to take charge of wards, and advised that discussions with relevant stakeholders were ongoing to progress this. A review of observation levels was also underway. He also advised that to create the headroom within the hospital to allow the improvement work required by RQIA to proceed, an estimated additional 23 registered nurses would be required, though this would be on a temporary basis, with this number expected to reduce proportionately as the resettlement programme progresses and the number of in-patients reduces. He also advised there was an ongoing issue with retention of registered staff, noting that 7 registered nursing staff had resigned in the past week.

5. Sean Holland queried the number of resettlement breakdowns. Marie Heaney advised there was extensive preparation before and after each resettlement, involving both in-reach and out-reach work with hospital and community staff. A lack of robustness in community services infrastructure also contributed to breakdown rates of placements. Marie Roulston noted current information on breakdown rates is not robust, and the HSCB had recently produced a SITREP report to enhance this information.

6. The meeting discussed options for sourcing the additional 23 nursing staff, including potential incentives, and agreed that measures to source this additional resource required a regional response involving all Trusts. Each Trust could be asked to provide 5 staff to support Muckamore, as a regional facility. Discussions on this were already underway. The impact on existing community and respite services was discussed and it was noted that Trusts were seeking to identify LD nurses currently in other roles (EDs, mental health etc.) who could be deployed without impacting on services that kept people out of Muckamore. Staff from other Trusts deployed in Muckamore would be released back as soon as staffing levels could be reduced.

7. It was noted that incentives might be needed to ensure staff were willing to work in Muckamore. Discussions with HR were underway. These incentives might need to extend to existing staff. It was also noted there were some recruitment challenges with the wider MDT team, for instance psychiatrists.
   Action: Trusts to continue to work regionally to identify staff to be deployed in Muckamore.

8. Sean Holland noted the Trust's assessment that services remained stable, despite the continuing pressures on the hospital. He also noted the proposals to increase the stability of services, including enhanced staffing arrangements, evolving governance arrangements and proposals to reduce levels of observation. He also stressed the importance of continued monitoring of resettlement success rates, and the collection of robust and consistent data to inform this.

9. Cathy Jack noted the potential for further staff suspensions as the police investigation progresses. The PSNI had made 35 new referrals of incidents, with 4 of these classified as priority. In addition a backlog of 9 incidents remained to be reviewed. She advised that improvements had been made to Trust ASG processes, and that decisions about which ward's CCTV footage would be viewed next would made on a risk stratification basis. Marie Roulston advised that the initial findings from Joyce McKee's overview of the Trust's ASG processes appeared to indicate these were compliant with guidance, and a report on this would be provided. It was noted that the involvement of PSNI and RQIA in safeguarding discussions provided an extra line of assurance.

   Action: Forward copy of Joyce McKee's report on ASG arrangements in MAH to DoH (Marie Roulston)

Update on contingency planning

10. Marie Roulston advised that the HSCB had now received contingency plans from 4 Trusts, with the Western Trust in the process of developing theirs. The plans set out Trust planning arrangements for their clients in MAH in the context of various scenarios for services at the hospital. She also clarified that the scope of the plans also encompassed the wider provision of in-patient treatment services.

Future of MAH

11. Mark Lee provided a summary overview of the content of the position paper on the future role of MAH, covering the policy context, other significant national and local service failures, cultural issues specific to MAH, the transformation project on the LD Service Model and review of acute in-patient care, provision for forensic patients and options for the MAH site.

12. Marie Heaney highlighted that the profile of the current in-patient population had changed considerably over the years, with an increase in the prevalence of behavioural issues and away from Mental Health presentation.

13. Sean Holland clarified that the optimal outcome for the current in-patient population at MAH would be a managed process of regional restructuring of acute in-patient treatment services over a time-period that would allow for the development and provision of adequate and robust community services and infrastructure. He described a model of local in-patient provision in each Trust supported by strong community services underpinned by an appropriately resourced workforce. He stressed the importance of a regional plan to co-ordinate the restructuring of acute treatment services across Trusts and the corresponding transfer of resource to support the development of the necessary infrastructure in each Trust.

14. Dr Stevens suggested the Northern Trust could put forward a proposal to develop an in-patient treatment unit at Whiteabbey Hospital, with potential to provide 10 in-patient beds.

15. Following discussion, the group agreed there was consensus around the broad direction of travel set out in the paper, with work to continue to deliver on the commitments to resettlement of the current MAH delayed discharge in-patient population in tandem with a wider project to deliver on the regional recommendations for the future of in-patient treatment services arising from the independent panel's review.

    Action: Develop a regional programme plan to oversee restructuring of acute LD in-patient treatment services through implementation of recommendations arising from independent panel's review, taking due account of regional work and governance structures already established to deliver the MAH HSC Action Plan (Mark Lee)

16. The group discussed a communications plan and options for engaging with patients, families and staff in the discussion around the future role of the hospital. Marie Heaney advised that the clear message emerging from her recent meetings with families was that they would wish to be consulted ahead of any decisions on the future role of services provided at the hospital being taken. It was also noted that any decisions on the way forward for provision of acute treatment services for the LD population would be taken in the context of the findings of the independent panels' review of acute in-patient services.

17. Sean Holland suggested a discussion on this at the scheduled MDAG meeting on Tuesday 1 October would be helpful, with a subsequent media statement to be issued on the work underway to review provision of regional arrangements for delivery of acute in-patient services. He also indicated it would be helpful to reinforce this with a media interview, and suggested that it might be useful to involve Margaret Flynn in this.

Action: Arrange for issue of statement and media briefing involving Sean Holland/Margaret Flynn to take place on Tuesday afternoon, following MDAG meeting at MAH at 11am (David Gordon)

Action: Belfast Trust to consider arrangements to brief families and check Margaret Flynn's availability to participate in media briefing (Marie Heaney)

MAHI – DoH Evidence Module 3d

Timeline for Safeguarding guidance and documentation

Year	Name	Guidance
1967	The Criminal Law Act (Northern Ireland)	Established an obligation on citizens, if they suspect a serious offence had been committed, to provide the police with any information they may have which is likely to help secure the arrest, prosecution or conviction of a suspect
1973	Health and Personal Social Services (Northern Ireland) Order 1972	Article 37 permitting the removal to suitable premises of persons in need of care and attention.
1986	Mental Health (Northern Ireland) Order 1986	Article 121 provides for an offence of ill treatment or wilful neglect of someone in hospital or a nursing home who is being treated for a mental disorder.
1996	**UNABLE TO SOURCE**	Guidance issued by the Department as the basis for the development of Board and Trust adult protection policies.
2002	Regional Adult Protection Forum established	To promote, develop and improve arrangements for the protection of vulnerable adults.
December 2003	Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults **[MMcG/68]**	Set out the roles and responsibilities of respective agencies and provided guidance about joint working arrangements and investigation and provided a framework for joint working. Designed in partnership with the PSNI, HSC Boards and Trusts and built on the 1996 guidance.
2005	Regional Adult Protection Forum received Departmental endorsement	To produce standardised regional procedures for the protection of vulnerable adults.
2006	Safeguarding Vulnerable Adults, a Regional Adult Protection Policy and Procedural Guidance **[MMcG/69]**	Detailed the processes to be followed in the event of a suspicion or allegation that a vulnerable adult is at risk of abuse, exploitation or neglect. Derived from best practice in NI and with reference to developments elsewhere in the UK.
July 2009	The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults **[MMcG/70]**	Developed in partnership between the Department, PSNI, RQIA the HSC Trusts and the former HSC Boards. Recognised the need for more co-ordinated interagency working to ensure that vulnerable adults, who are

Year	Name	Guidance
		at risk of abuse, receive protection, support and equitable access to the criminal justice system. Roles and responsibilities outlined and provided guidance on joint working and investigation arrangements.
2009	Consultation 'Reforming Northern Ireland's Adult Protection Infrastructure' issued.	Developed in conjunction with the Northern Ireland Office and other Gov. Departments.
2010	Adult Safeguarding in Northern Ireland – Regional and Local Partnership Arrangements **[MMcG/71]**	Response to the 2009 consultation. Established the Northern Ireland Adult Safeguarding Partnership and five Local Adult Safeguarding Partnerships. Collaborative partnerships with responsibility for adult safeguarding in NI and replaced the Regional Adult Protection Forum (established in 2002). Tasked with the delivery of improving ASG outcomes by way of a strategic plan, operational policies, procedures and effective practice.
2011	Department commissioned the RQIA to carry out a review of the effectiveness of safeguarding arrangements in MH & LD hospitals in NI	Covered all five HSC Trusts.
2011	Programme for Government 2011 - 2015	NI Executive identified safeguarding adults at risk as a priority in PfG 2011 – 2015.
February 2013	RQIA inspections report published 'Review of Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland'	Covered the period 2011 – 12, re 33 inspections and contained 2 recommendations to ensure the continued safeguarding and protection of children and vulnerable adults. These included the prioritisation of the publication of the Adult Safeguarding Policy Framework.
March 2015	Follow up report from RQIA on Safeguarding published 'Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland Regional Summary'	

Year	Name	Guidance
July 2015	Adult Safeguarding Prevention and Protection in Partnership **[MMcG/72]**	Further guidance developed and published in partnership with the DoJ as a response to the 2011-15 Programme for Government. Replaced the 2006 doc 'Safeguarding Vulnerable Adults, a Regional Adult Protection Policy and Procedural Guidance'. Aimed to improve safeguarding arrangements for adults at risk of harm from abuse, exploitation or neglect. Set out how NI Executive intended ASG to be taken forward across all Gov Depts., agencies and voluntary and community etc. orgs.
August 2016	Protocol for Joint Investigation of Adult Safeguarding Cases **[MMcG/73]**	This was the 3rd edition and replaced the July 2009 version. Aim of the joint protocol was to ensure that adults in need of protection were supported in a manner which upheld their rights – in particular their access to the criminal justice system and to prevent abuse through a collaborative multi-agency partnership.
2020	Minister for Health launched a public consultation on a range of legislative options on safeguarding	Launched following the widely publicised safeguarding failings at Dunmurry Manor and Muckamore Abbey which highlighted the need to review and improve ASG policy in NI.
April 2021	Consultation closed and Department progressing work to introduce an Adult Protection Bill	Consultation responses analysed and Adult Protection Bill being introduced to provide a statutory underpinning of safeguarding arrangements in NI.

MAHI - STM - 300 - 1784

			Trust Reference:	BHSCT/EA/21/057	
Initial call made to:	Heather Finlay (Deputy CNO)	**(DoH) on**	19/03/2021	**(DATE)**	

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name:	Brenda Creaney	**Organisation:**	BHSCT
Position:	Director of Nursing, User Experience and AHPs	**Number**	07767846162

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. urgent regional action	X
2. contacting patients/clients about possible harm	
3. press release about harm	
4. regional media interest	X
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.*

A letter has been received, via email, by the team in Muckamore Abbey Hospital (MAH) and the Chief Executive expressing “extreme concern” about the staffing levels in Erne Ward, by a family member of a patient who is being cared for there. This person is also a member of MDAG and has raised concerns with the management team, who have facilitated a number of meetings to address their concerns. A further meeting is scheduled for this afternoon to progress matters with this family.
The Trust, who report the staffing position in MAH to DOH weekly, are satisfied nurse staffing is currently safe, however we remain reliant on a large percentage of agency staff, which is an ongoing risk in respect of the stability of the staffing situation.
RQIA have been made aware of this correspondence.
There are currently 42 patients being cared for on the MAH site, 8 of whom are in Erne Ward.
I append the current staffing to this Early alert.
The professional officers will also contact their departmental counterparts to update them accordingly.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact:	Gillian Traub

Contact details:

Telephone (work or home):	07824877634

Mobile (work or home)	As above
Email address (work or home)	gillian.traub@belfasttrust.hscni.net

Forward pro forma to Corporate Governance Dept via BHSCT Early Alerts Inbox: EarlyAlertNotificationMedDir@belfasttrust.hscni.net

FOR COMPLETION BY DHSSPS:

Early Alert Communication Received by:		**Office:**	
Forwarded for consideration and appropriate action to:		**Date:**	
Detail of follow-up action (of applicable)			