BW-262

MAHI - STM - 184 - 1018

INVESTIGATION OF ADVERSE INCIDENTS – MASTERCLASS PROGRAMME

26h & 27th March 2019

Antrim Board Centre, 17 Lough Road, Antrim, BT41 4DH

DAY 1

9:00am Registration

9.30am Welcome and App Introduction

9.40am *How to get to on the Right Path* - Investigation Approach

Getting it Right from the Beginning – Initiating the Investigation

The Right People for the Right Job – The Investigation Team

11.00 am *Break*

11.15 am *Failing to Prepare, Prepare to Fail* - Preparing for Analysis

Tell Me What Happened? - Incident Chronology

What Exactly Happened? Fact Finding

12:30 pm *Lunch*

1.15pm *To Interview or Not to Interview* - Interviewing Approach

A Just Culture - Engaging and Supporting Staff

15:00 pm *Break*

I want to tell you how I Feel – Involving Patients/Service Users and their Families & Carers

Look Deeper, Look Further - Analysis Tools and Techniques (*Time Permitting*)

4.45 pm Reflection Day 1

CLS Educate
Healthcare Training

BW-262

INVESTIGATION OF ADVERSE INCIDENTS – MASTERCLASS PROGRAMME

26th & 27th March 2019

DAY 2

9:30am Reflection Day 1

9.45am *Find the Cause then Fix it* - Key Causal Factors

10:30 am *Break*

10:45 am *Find the Cause then Fix it* - Causal Factors

Change the Way you Look at Things - Contributory Factors

12:45 pm *Lunch*

1.30pm *What can we do to stop it happening again?* - Recommendations & Action Planning?

If you can't explain it simply, you don't understand it well enough - Report Compilation

15:00 pm *Break*

Take a Step Back - Take Time to Evaluate

Work Smart - Running Effective Incident Investigation Team Meetings

4.30 pm Reflection & Close

APPENDIX 4

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT

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

WHAT HAPPENED?

WHY DID IT HAPPEN?

WHAT HAS BEEN LEARNED?

WHAT HAS BEEN CHANGED?

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

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

THE INVESTIGATION TEAM :

INVESTIGATION TERMS OF REFERENCE:

APPENDIX 5

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT GUIDANCE

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

WHAT HAPPENED?

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

WHY DID IT HAPPEN?

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

WHAT HAS BEEN LEARNED?

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

WHAT HAS BEEN CHANGED?

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

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

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

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

HEALTH AND SOCIAL CARE BOARD / PUBLIC HEALTH AGENCY

SERIOUS ADVERSE INCIDENT REVIEW SUB-GROUP

TERMS OF REFERENCE

1. INTRODUCTION

The purpose of the Serious Adverse Incident Review Sub Group (SAIRSG) is to provide assurances that appropriate structures, systems and processes are in place within the Health and Social Care Board (HSCB) and Public Health Agency (PHA) for the management and follow up of serious adverse incidents arising during the course of the business of an HSC organisation/Special Agency or commissioned service.

The SAIRSG also has responsibility to ensure that trends, best practice and learning is identified and disseminated in a timely manner, in conjunction with the HSCB/PHA Quality and Safety Experience Group (QSE) and Safety and Quality Alert Team (SQAT).

2. ACCOUNTABILITY OF THE GROUP

The SAIRSG shall report to the HSCB/PHA QSE group.

3. OBJECTIVES OF THE GROUP

3.1 Review SAI Activity and Designated Review Officer (DRO) Learning summary reports, to identify learning and themes/trends arising from SAIs that require follow up / discussion / further action;

3.2 Ensure that themes/trends, best practice and regional learning from SAIs is identified to the QSE Group in a timely manner;

3.3 Make recommendations to the QSE Group on the commissioning of independent reviews in respect of specific SAIs;

3.4 Escalate, issues of concern and importance, in respect of SAIs to the QSE Group, as appropriate;

3.5 Provide a bi-annual SAI Learning Report to the Board of the HSCB and PHA and their respective Governance committees;

3.6 Provide assurances to SMT, AMT and the Boards of the HSCB and PHA and respective Governance Committees that SAIs are managed in an appropriate manner.

4. MEMBERSHIP OF THE GROUP

Core membership of the SAIRSG will consist of the following officers, or their nominated representative, from the HSCB and the PHA:

- Governance Manager, HSCB **(Chair)**
- Senior Manager: Safety, Quality and Patient Experience, PHA (Co-Chair)
- Consultant, Service Development & Screening, PHA (Medical Representative)
- Social Care Commissioner MH & LD, Social Services, HSCB (Social Care Representative)
- Pharmacy Lead - Medicines Governance and Public Health, HSCB (Integrated Care Representative)
- Patient Safety, Quality and Patient Experience Lead Nurse, PHA (Nursing & AHP Representative)
- Assistant Governance Manager, HSCB

(Names of current members of the group are included as an addendum to these TOR).

In Attendance:

- RQIA representatives (for items of mutual interest to both RQIA and HSCB/PHA)

    - Director of Regulation and Nursing
    - Director of Mental Health and Learning Disability and Social Work

The SAIRSG may also invite, as appropriate, the relevant HSCB/PHA Officers from the service area in which a serious adverse incident has arisen, to attend meetings where that incident is being considered. Equally, where the SAIRSG considers that it requires other specialist knowledge it is at liberty to invite/co-opt any relevant specialist to provide advice.

5. QUORUM

The SAIRSG shall be quorate by the attendance of four members of the Group, to include the Chair and/or Co Chair.

6. ADMINISTRATION

The SAIRSG will be supported by the Governance Team who will ensure:

- agreement of the agenda with Chairperson;
- collate and circulate all associated papers at least 3 working days in advance of each meeting;
- keep a record of matters arising and log of actions;

- take forward the work of the SAIRSG, in conjunction with group members, to ensure actions, learning and outcomes from each meeting are progressed.

The action log from each meeting shall be approved and considered at the following meeting.

7. RELATIONSHIP / LINKS WITH OTHER GROUPS

There are a range of other quality and safety groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SAIRSG will work in conjunction with the following groups:

- HSCB / PHA Regional Complaints Sub Group
- Patient and Client Experience Steering Group
- Safety and Quality Alerts Group
- Promoting Good Nutrition Implementation Steering Group
- Regional Falls Prevention for Acute Services Group
- Regional Pressure Ulcer Prevention Advisory Group
- Regional Project Steering Group Evidencing Care through key nursing performance indicators
- Medicines Governance Advisors Groups
- Regional Child Protection Committee (RCPC)
- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board

8. FREQUENCY OF MEETING

The SAIRSG meetings will take place monthly (prior to QSE meeting).

9. REVISION OF TERMS OF REFERENCE

The SAIRSG will review its Terms of Reference on a biennial basis or earlier as required.

Addendum

Current Membership of Group – February 2014

- Governance Manager, HSCB **(Chair)** – Mrs Anne Kane
- Senior Manager, Safety, Quality and Patient Experience, PHA (Co-Chair) – Mrs Oriel Brown
- Consultant, Service Development & Screening, PHA (Medical Representative) – Dr Paul Darragh
- Social Care Commissioner MH & LD, Social Services, HSCB (Social Care Representative) – Mrs Valerie McConnell
- Pharmacy Lead - Medicines Governance and Public Health, HSCB (Integrated Care Representative) - Dr Brenda Bradley
- Patient Safety, Quality and Patient Experience Lead Nurse, PHA (Nursing & AHP Representative) – Mrs Mary McElroy
- Assistant Governance Manager, HSCB – Mrs Jacqui Burns

In Attendance:

- RQIA representatives (for items of mutual interest to both RQIA and HSCB/PHA)
  - Director of Regulation and Nursing – Mrs Kathy Fodey
  - Director of Mental Health and Learning Disability and Social Work – Mrs Theresa Nixon

HEALTH AND SOCIAL CARE BOARD / PUBLIC HEALTH AGENCY

SERIOUS ADVERSE INCIDENT REVIEW SUB-GROUP

TERMS OF REFERENCE

1. INTRODUCTION

The purpose of the Serious Adverse Incident Review Sub Group (SAIRSG) is to provide assurances that appropriate structures, systems and processes are in place within the Health and Social Care Board (HSCB) and Public Health Agency (PHA) for the management and follow up of serious adverse incidents arising during the course of the business of an HSC organisation/Special Agency or commissioned service.

The SAIRSG also has responsibility to ensure that trends, best practice and learning is identified and disseminated in a timely manner, in conjunction with the HSCB/PHA Quality and Safety Experience Group (QSE) and Safety and Quality Alert Team (SQAT).

2. ACCOUNTABILITY OF THE GROUP

The SAIRSG shall report to the HSCB/PHA QSE Group.

3. OBJECTIVES OF THE GROUP

3.1 Review SAI Activity and Designated Review Officer (DRO) Learning summary reports, to identify learning and themes/trends arising from SAIs that require follow up / discussion / further action;

3.2 Ensure that themes/trends, best practice and regional learning from SAIs is identified to the QSE Group in a timely manner;

3.3 Make recommendations to the QSE Group on the commissioning of independent reviews in respect of specific SAIs;

3.4 Escalate, issues of concern and importance, in respect of SAIs to the QSE Group, as appropriate;

3.5 Provide a bi-annual SAI Learning Report to the Board of the HSCB and PHA and their respective Governance committees;

3.6 Provide assurances to SMT, AMT and the Boards of the HSCB and PHA and respective Governance Committees that SAIs are managed in an appropriate manner.

4. MEMBERSHIP OF THE GROUP

Core membership of the SAIRSG will consist of the following officers, or their nominated representative, from the HSCB and the PHA:

- **Co-Chairs**
  - HSCB Governance Manager
  - PHA Head of Nursing, Quality, Safety and Patient Experience

- **Members**
  - PHA Medical Representatives
  - HSCB Social Care Representative
  - HSCB Integrated Care Representative
  - PHA Nursing & AHP Representative
  - HSCB Assistant Governance Manager

In Attendance:

- RQIA representatives (for items of mutual interest to both RQIA and HSCB/PHA)

  - Director of Regulation and Nursing
  - Director of Mental Health and Learning Disability and Social Work

(Refer to attached addendum for current membership listing)

The SAIRSG may also invite, as appropriate, the relevant HSCB/PHA Officers from the service area in which a serious adverse incident has arisen, to attend meetings where that incident is being considered. Equally, where the SAIRSG considers that it requires other specialist knowledge it is at liberty to invite/co-opt any relevant specialist to provide advice.

5. QUORUM

The SAIRSG shall be quorate by the attendance of four members of the Group, to include the Chair and/or Co Chair and representation of two professional areas.

In exceptional circumstances, meetings can proceed without relevant professionals present this can be endorsed at the next meeting.

6. ADMINISTRATION

The SAIRSG will be supported by the Governance Team who will ensure:

- agreement of the agenda with Chairperson;

- collate and circulate all associated papers at least 3 working days in advance of each meeting;
- keep a record of matters arising and log of actions;
- take forward the work of the SAIRSG, in conjunction with group members, to ensure actions, learning and outcomes from each meeting are progressed.

The action log from each meeting shall be approved and considered at the following meeting.

7. RELATIONSHIP / LINKS WITH OTHER GROUPS

There are a range of other quality and safety groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SAIRSG will work in conjunction with the following groups:

- HSCB / PHA Regional Complaints Sub Group
- Patient and Client Experience Steering Group
- Safety and Quality Alerts Group
- Promoting Good Nutrition Implementation Steering Group
- Regional Falls Prevention for Acute Services Group
- Regional Pressure Ulcer Prevention Advisory Group
- Regional Project Steering Group Evidencing Care through key nursing performance indicators
- Medicines Governance Advisors Groups
- Regional Child Protection Committee (RCPC)
- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board

8. FREQUENCY OF MEETING

The SAIRSG meetings will take place monthly (prior to QSE meeting).

9. REVISION OF TERMS OF REFERENCE

The SAIRSG will review its Terms of Reference on a biennial basis or earlier as required.

Health and Social Care Board

Public Health Agency

ADDENDUM

Current Membership of Group – May 2015

- HSCB Governance Manager (Co-Chair) – **Mrs Anne Kane**
- Head of Nursing, Quality, Safety and Patient Experience (Co-Chair) – **Ms Lynne Charlton**
- PHA Consultant, Service Development & Screening (Medical Representative) – **Dr Paul Darragh**
- PHA Consultant, Service Development & Screening (Medical Representative) – **Dr Louise Heron**
- HSCB Social Care Commissioner Adult Services (Social Care Representative) – **Mrs Valerie McConnell**
- HSCB Pharmacy Lead - Medicines Governance and Public Health, (Integrated Care Representative) - **Dr Brenda Bradley**
- PHA Patient Safety, Quality and Patient Experience Lead Nurse, (Nursing & AHP Representative) – **Mrs Mary McElroy**
- HSCB Assistant Governance Manager - **Mrs Jacqui Burns**

In Attendance:

- RQIA Director of Regulation and Nursing – **Mrs Kathy Fodey**
- RQIA Director of Mental Health and Learning Disability and Social Work – **Mrs Theresa Nixon**

HEALTH AND SOCIAL CARE BOARD / PUBLIC HEALTH AGENCY

SERIOUS ADVERSE INCIDENT REVIEW SUB-GROUP

TERMS OF REFERENCE

1. INTRODUCTION

The purpose of the Serious Adverse Incident Review Sub Group (SAIRSG) is to provide assurances that appropriate structures, systems and processes are in place within the Health and Social Care Board (HSCB) and Public Health Agency (PHA) for the management and follow up of serious adverse incidents arising during the course of the business of an HSC organisation/Special Agency or commissioned service.

The SAIRSG also has responsibility to ensure that trends, best practice and learning is identified and disseminated in a timely manner, in conjunction with the HSCB/PHA Quality and Safety Experience Group (QSE) and Safety and Quality Alert Team (SQAT).

2. ACCOUNTABILITY OF THE GROUP

The SAIRSG shall report to the HSCB/PHA QSE Group.

3. OBJECTIVES OF THE GROUP

3.1 Review SAI Activity and Designated Review Officer (DRO) Learning summary reports, to identify learning and themes/trends arising from SAIs that require follow up / discussion / further action;

3.2 Examine themes/trends from SAIs and when identified ensure the themes/trends, best practice and regional learning are referred to the QSE Group in a timely manner;

3.3 Make recommendations to the QSE Group on the commissioning of independent reviews in respect of specific SAIs;

3.4 Escalate, issues of concern and importance, in respect of SAIs to the QSE Group, as appropriate;

3.5 Provide a bi-annual SAI Learning Report to the Board of the HSCB and PHA and their respective Governance committees;

3.6 Provide assurances to SMT, AMT and the Boards of the HSCB and PHA and respective Governance Committees that SAIs are managed in an appropriate manner.

4. MEMBERSHIP OF THE GROUP

Core membership of the SAIRSG will consist of the following officers, or their nominated representative, from the HSCB and the PHA:

- **Co-Chairs**
  - HSCB Governance Manager
  - PHA Head of Nursing, Quality, Safety and Patient Experience

- **Members**
  - PHA Medical Representatives
  - HSCB Social Care Representative
  - HSCB Integrated Care Representative
  - PHA Nursing & AHP Representative x 2
  - HSCB Assistant Governance Manager

In Attendance:

- RQIA representatives (for items of mutual interest to both RQIA and HSCB/PHA)
  - Director of Regulation and Nursing
  - Director of Mental Health and Learning Disability and Social Work

- Secondary Care Medicines Governance Lead (for items of mutual interest relating to medication issues)

(Refer to attached addendum for current membership listing)

The SAIRSG may also invite, as appropriate, the relevant HSCB/PHA Officers from the service area in which a serious adverse incident has arisen, to attend meetings where that incident is being considered. Equally, where the SAIRSG considers that it requires other specialist knowledge it is at liberty to invite/co-opt any relevant specialist to provide advice.

5. QUORUM

The SAIRSG shall be quorate by the attendance of four members of the Group, to include the Chair and/or Co Chair and representation of two professional areas.

In exceptional circumstances, meetings can proceed without relevant professionals present this can be endorsed at the next meeting.

6. ADMINISTRATION

The SAIRSG will be supported by the Governance Team who will ensure:

- agreement of the agenda with Chairperson;
- collate and circulate all associated papers at least 3 working days in advance of each meeting (*representatives in attendance for items of mutual interest will only to be circulated related papers*);
- keep a record of matters arising and log of actions;
- take forward the work of the SAIRSG, in conjunction with group members, to ensure actions, learning and outcomes from each meeting are progressed.

The action log from each meeting shall be approved and considered at the following meeting.

7. RELATIONSHIP / LINKS WITH OTHER GROUPS

There are a range of other quality and safety groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SAIRSG will work in conjunction with the following groups:

- HSCB / PHA Regional Complaints Sub Group
- Quality Safety and Experience Group
- Safety and Quality Alerts Team
- Promoting Good Nutrition Implementation Steering Group
- Regional Falls Prevention for Acute Services Group
- Regional Pressure Ulcer Prevention Advisory Group
- Regional Project Steering Group Evidencing Care through key nursing performance indicators
- Medicines Governance Advisors Groups
- Regional Governance Officers Group
- HSC Safety Forum
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board for Northern Ireland

8. FREQUENCY OF MEETING

The SAIRSG meetings will take place monthly (prior to QSE meeting).

9. REVISION OF TERMS OF REFERENCE

The SAIRSG will review its Terms of Reference on a biennial basis or earlier as required.

ADDENDUM

Membership of Group – January 2016

- HSCB Governance Manager (Co-Chair) – **Mrs Anne Kane**
- Head of Nursing, Quality, Safety and Patient Experience (Co-Chair) – **Ms Lynne Charlton**
- PHA Consultant, Service Development & Screening (Medical Representative) – **Dr Paul Darragh**
- PHA Consultant in Public Health, (Medical Representative) – **Dr Jackie Mc Call**
- HSCB Social Care Commissioner Adult Services (Social Care Representative) – **Mrs Valerie McConnell**
- HSCB Pharmacy Lead - Medicines Governance and Public Health, (Integrated Care Representative) - **Dr Brenda Bradley**
- PHA Patient Safety, Quality and Patient Experience Lead Nurse, (Nursing Representative) – **Mrs Mary McElroy**
- PHA Allied Health Professional Consultant, (AHP Representative) – **Mrs Geraldine Teague**
- HSCB Assistant Governance Manager - **Mrs Jacqui Burns**

In Attendance:

- RQIA Director of Regulation and Nursing – **Mrs Kathy Fodey**
- RQIA Director of Mental Health and Learning Disability and Social Work – **Mrs Theresa Nixon**
- Secondary Care Medicines Governance Lead – **Mrs Angela Carrington**

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY

(DRAFT) TERMS OF REFERENCE

QUALITY SAFETY AND EXPERIENCE GROUP (QSE)

1.0 Introduction

The Health and Social Care Board (HSCB) and the Public Health Agency (PHA) receive information and intelligence from a wide range of sources in relation to safety, quality and patient experience of services commissioned.

Whilst effective arrangements currently exist in relation to each of these areas, these arrangements could be further strengthened by the establishment of an over-arching group to identify themes, patterns and areas of concern emerging from all existing sources; and agree the actions to be taken to address these in order to improve the safety and quality of services commissioned.

2.0 Objectives of the QSE Group

2.1 To streamline and further enhance current arrangements in relation to Safety, Quality and Patient Experience;

2.2 To consider learning, patterns, themes or areas of concern from all sources of information and to agree appropriate actions to be taken, and follow up of agreed actions;

2.3 To provide an assurance to the Senior Management Team of the HSCB, the Agency Management Team of the PHA and the Governance Committees and Boards of both organisations that the QSE Group has an overview of all sources of information in relation to the safety, quality and patient experience of services and is co-ordinating appropriate action in response.

3.0 Working Arrangements between Existing Groups/Information Flow to QSE

3.1 The Regional Serious Adverse Incident Review Group (SAI) and the Regional Complaints Group (RCG) will be reconstituted as a Serious Adverse Incident Sub Group and a Regional Complaints Sub Group of the QSE Group.

3.2 The Complaints and SAI Sub Groups, which will be multi-disciplinary groups, will meet on a monthly basis, prior to each QSE group, to consider in detail issues emerging from SAIs and complaints and agree issues which require to be referred to the QSE, together with a recommendation for consideration.

3.3 Other existing groups relating to the Patient Experience, Medicines Management, SQAT, Safeguarding Board and Case Management Reviews and Quality 2020 will refer matters on an agreed basis to the QSE Group with an appropriate recommendation for consideration.

4.0 Membership of the QSE

Director of Nursing, Midwifery and Allied Health Professionals – (Chair)

Director of Performance and Corporate Services – (Co-Chair)

Director of Public Health/Medical Director

Director of Social Care;

Assistant Director of Social Care (Safety and Quality Lead);

Head of General Medical Services/Safety and Quality Lead;

Head of Pharmacy and Medicines Management;

Assistant Director of Nursing and Allied Health Professionals;

Assistant Director of Public Health Medicine (Safety and Quality)

Clinical Director, Safety Forum;

Governance Manager;

Complaints/Litigation Manager;

Head of Dental Services (co-opt as required);

Head of Optometry (co-opt as required);

Assistant Director of Allied Health Professionals (co-opt as required);

In Attendance:

Deputy Complaints Manager

Assistant Governance Manager

Consultant in Public Health Medicine (Safety and Quality lead)

Senior Nurse (Safety, Quality and Patient Experience)

5.0 Frequency of Meetings

Meetings of the Group will be monthly

6.0 Administrative Support to the QSE Group

6.1 The Action log shall be taken by the Director of Nursing Midwifery and Allied Health Professionals (or her nominated deputy)

6.2 The agenda and papers will be developed and circulated by Corporate Services staff.

6.3 Agreed actions will be followed up by Corporate Services staff.

6.4 Agenda items and papers should be forwarded to qse.team@hscni.net

7.0 Review of Terms of Reference

These Terms of Reference will be reviewed in 12 months.

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY

TERMS OF REFERENCE

SAFETY AND QUALITY ALERTS TEAM (SQAT)

1.0 Introduction

The Health and Social Care Board (HSCB) and Public Health Agency (PHA) are responsible for the co-ordination and implementation of regional safety and quality alerts (SQAs), letters and guidance issued by the DHSSPS, HSCB, PHA, RQIA and other organisations.

The Safety and Quality Alerts Team (SQAT) was formed in April 2012 to co-ordinate the implementation of regional safety and quality alerts, letters and guidance. A subsequent protocol was established and endorsed by the DHSSPS in July 2013 which outlines the management of the process. (See annex 1)

2.0 Accountability of the Group

The SQA Team shall report to the HSCB/PHA Quality and Safety Experience Group.

3.0 Objectives of the SQA Team

The SQA Team provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation. The Team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

4.0 Membership of the Group

Core membership of the SQA Team will consist of the following officers, or their nominated representative, from the HSCB and the PHA: (see annex 2 which details the current membership as at January 2015)

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services
- Assistant Director Nursing, Safety & Quality & Patient Experience
- Assistant Director Service Development & Screening
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Safety, Quality and Patient Experience Nurse, PHA

- Assistant Governance Manager, Safety and Quality, HSCB
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care, Head of GMS, HSCB when required
- Social Care and AHP input for Alerts relevant to those professions

5.0 Quorum

The SQA Team shall be quorate by the attendance of three members of the group; usually including representation of two professional areas. Where meetings proceed without relevant professionals present this can be endorsed at the next meeting.

6.0 Administration

- The Action log shall be taken by the Chair of the group (or nominated deputy)
- The agenda and papers will be developed by the Assistant Governance Manager and circulated by the PA to the Chair.
- The Assistant Governance Manager will oversee the process, maintain an up-to-date log, prepare for and support team meetings, and prepare an annual and mid-year report. They will be supported by the Governance Support Manager and a Governance Support Officer.

7.0 Relationship/Links with Other Groups

There are a range of other quality and safety groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SQA Team will work in conjunction with various groups which include the following list of groups which is not definitive:

- HSCB / PHA Regional SAI Review Sub Group
- HSCB / PHA Regional Complaints Sub Group
- Patient and Client Experience Steering Group
- Promoting Good Nutrition Implementation Steering Group
- Regional Falls Prevention for Acute Services Group
- Regional Pressure Ulcer Prevention Advisory Group
- Regional Project Steering Group Evidencing Care through key nursing performance indicators
- Medicines Governance Advisors Groups

- Regional Child Protection Committee (RCPC)
- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board
- Medicines Safety Sub-Group (MSSG)

8.0 Frequency of Meetings

Meetings of the Team will be fortnightly.

9.0 Review of Terms of Reference

The SQA Team will review its Terms of Reference on a biennial basis or earlier as required.

Annex 2

HSCB/PHA Protocol for Implementation of Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: 29 January 2015

1.0 Introduction

This protocol describes the process which the Health and Social Care Board (HSCB) and Public Health Agency (PHA) will use to oversee implementation of Safety and Quality Alerts (SQAs) by Health and Social Care (HSC) Trusts, including actions relevant to primary care providers. It applies to SQAs issued since 1 April 2012.

2.0 Context

SQAs may arise from a variety of sources, including serious adverse incidents, reviews by the Regulation and Quality Improvement Authority (RQIA), safeguarding reports, legislative changes, medicines regulators, equipment or device failures, national safety systems, and independent reviews. The volume of SQAs is challenging for providers and commissioners to manage. Some SQAs relate to substantive safety issues that require a high level of assurance, while others relate to risk which can be managed within existing clinical and social care governance and risk management arrangements. The information systems to measure clinical and social care safety and quality are limited at present. For some actions, it is more efficient and effective to have one regional process, rather than each provider taking action individually.

This protocol was designed in that context.

3.0 Scope of Safety Quality Alerts (SQAs)

This protocol covers SQAs and equivalent correspondence as outlined below. It applies to health and social care-related SQAs though the

vast majority relate to health care. Specific arrangements for the independent sector and for SQAs that relate mainly to primary care are described later.

Category 1 SQAs include:

- DHSSPS Safety Quality & Standards (SQS) guidance and letters/circulars;
- Learning Letters or Learning Reminders arising from serious adverse incidents (SAIs);
- National Patient Safety Alerting System (NPSAS) alerts;
- Safety or quality-related professional letters from DHSSPS;
- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports and equivalent robust other national enquiries/audits;
- Guidelines and Audit Implementation Network (GAIN) Reports.

Category 2 SQAs include:

- Medicines and Healthcare products Regulatory Agency (MHRA) notices;
- Safety Alert Broadcast System (SABS) notifications.

A separate process is in place for the following:

- NICE guidance. Appendix 1 gives a schematic overview of the interfaces between this process and the process for NICE guidance;
- Drug alerts and recalls;
- Professional In-Confidence alerts regarding individual practitioners.

4.0 Dissemination of Safety Quality Alerts (SQAs) issued by DHSSPS

If an SQA from DHSSPS includes an assurance template or other form of assurance loop, DHSSPS will send the SQA in Draft form to the lead

Director in PHA/HSCB for the SQA process (the Medical Director/DPH), copied to the HSCB lead Director for the HSCB/PHA Coordinating Office (the Director of Performance and Corporate Services). Through them, and with input from relevant health and social care professionals within HSCB and PHA, the nature and timing of the assurance required, and the distribution list, will be agreed. DHSSPS will then issue the final version of the SQA to the agreed distribution list. This approach is intended to ensure that the actions required of organisations are clear through a single communication. Under the arrangements to date, two communications are required on some occasions.

DHSSPS will issue SQAs that do not have an assurance loop directly to relevant organisations.

SQAs will be issued to the Chief Executive's office of relevant organisations, and copied to the HSCB/PHA Central Coordinating Office, the Governance Leads in Trusts and other relevant Directors. A standard distribution list is given in Appendix 2.

5.0 Dissemination of Learning Letters/Learning Reminders issued by PHA/HSCB

When regional learning is identified following the review of an SAI, complaint or other incident a learning letter/learning reminder may be issued to the appropriate HSC organisations for wider circulation, application of learning and assurance that learning has been embedded.

Prior to issue the Central Co-ordinating Office (CCO) (see section 6.0) will forward the draft Learning Letter/Learning Reminder and distribution list to DHSSPS Safety & Quality Standards Directorate for issue to relevant Policy Leads for review to ensure compatibility with DHSSPS policy in advance of SQAT meeting.

Following finalisation of the learning letter/learning reminder the HSCB/PHA will then issue the final version to the agreed distribution list. (see Appendix 2)

The Safety and Quality Alert Team will consider responses to learning letters/learning reminders and close the Alert when it is assured that actions have been implemented, or there is an existing robust system in place to ensure implementation.

6.0 HSCB Central Coordinating Office

SQAs where Trusts or the independent sector have a primary role in implementation will be logged by a central coordinating office (CCO) managed by the Governance Team within HSCB Corporate Services. All correspondence in relation to alerts will be channelled through the HSCB Alerts mailbox at Alerts.HSCB@hscni.net. The CCO will maintain a system to track progress on implementation. The CCO will also provide 6-monthly summary reports for the HSCB/PHA Safety Quality Alerts Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board and others as required.

A Programme Manager will oversee the process, maintain an up-to-date log, prepare for and support team meetings, and prepare an annual and mid-year report. They will be supported by a Database Officer, Administrative Officer, and members of the Safety Quality Alerts Team.

7.0 HSCB/PHA Safety Quality Alerts Team

HSCB and PHA will manage arrangements for the implementation and assurance of Category 1 SQAs through the Safety Quality Alerts Team (SQAT). Serious Adverse Incidents and Complaints are managed through their respective teams and reports to the Quality, Safety and Experience Group (QSE).

The SQA Team will include HSCB & PHA representatives from professional groups, and Corporate Services (Appendix 3). It will be sponsored, and chaired as necessary, by the Medical Director/Director of Public Health. It will report through the Senior Management Team of HSCB to the HSCB Governance Committee and Board at the frequency outlined in the HSCB safety quality reporting framework. To ensure timely processing of Alerts, the Team will meet every 2 weeks. HSCB/PHA will put arrangements in place to ensure that any immediate issues that need to be addressed are processed immediately.

8.0 Trust Input

To ensure input from Trusts, the SQA Team will seek advice from relevant Trust professionals. Each Trust has identified a first point of contact for queries regarding SQAs (Appendix 3).

9.0 Interface with other Safety/Quality-related organisations

To ensure coordinated action across the wider system, the HSCB/PHA SQA Team will also seek input from the range of organisations and bodies that contribute to safety and quality of health and social care (Appendix 3), as required.

10.0 Process for Determining Appropriate Arrangements

Category 1 Alerts will be reviewed by the Safety Quality Alerts Team to make an initial determination on

- Whether or not regional action is required to assist Trusts or primary care with implementation, and
- The nature of the assurance required regarding implementation.

The default position is for Trusts to take action locally. It is likely that regional action will be by exception, and only where it adds real value.

If regional action is required, the proposed actions will be discussed where necessary with Trusts and/other relevant organisations to agree the precise task. It is important to note that any regional actions do not in any way negate the responsibilities of Trusts or other organisations to take necessary actions to implement the Alert; immediate necessary action should not be delayed. However, it is recognised that some aspects of implementation may be more efficient, and may ensure a better outcome for patients, clients, staff and the public if they are developed in a standard way across the region. Training modules, quality improvement projects, regional procurement are examples of regional action that could help to ensure standardised good quality care within the NI context, taking account of resources and service configuration.

To take forward work for the region, the principle of using existing systems as much as possible, will apply. However, if necessary, a Task and Finish Group may be established, including all relevant professionals and managers from relevant providers, and as appropriate, service users and/or the public.

Category 2 Alerts will be implemented primarily through existing systems. If on occasion explicit assurance or other action is required, it will be identified by the Safety Quality Alerts Team and described to Trusts and primary care providers as outlined for Category 1 Alerts.

11.0 Criteria for Regional Action and Assurance Levels

To assist the assurance process and without cutting across existing systems, the Team will determine the detail of the method of assuring implementation of an Alert. The method of assurance will be proportionate to the assessed level of risk associated with the issue covered by the Alert and will work on a principle of using existing systems of assurance as much as possible. Options for assurance methods include:

- Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements;
- Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA;
- Level 3 – completion of an audit specified by HSCB/PHA.

The following criteria will be used to assess whether or not regional action is required to assist implementation, and to determine the level of assurance required:

- The risk to an individual patient, client, staff member or member of the public, is high (impact);
- The number of patients, clients, staff or public who may be exposed to the risk is high (likelihood);
- Aspects of implementation are complex and outwith the control of Trusts or relevant organisations (complexity);
- A regional approach is achievable (deliverability & stakeholder agreement);
- Regional action will not introduce undue delay (timeliness);
- The Alert relates to an issue with a high public/political profile (public confidence);
- Other reasons (professional judgment).

In making its decisions, the Team will take account of:

- Other Alerts relating to the service area in question;
- Common themes within a range of Alerts;
- Learning from Serious Adverse Incidents and Complaints;
- Existing safety and quality initiatives in health and social care.

12.0 Informing Trusts and Primary Care of the Outcome

On completion of the processes outlined above, if regional action or assurance is required, the Chair of the Safety Quality Alerts Team will inform Trusts, primary care, and other relevant providers or

stakeholders of the next steps or requirements. Communication will be to the Trust Chief Executive's office, copied to the Trust Governance Lead.

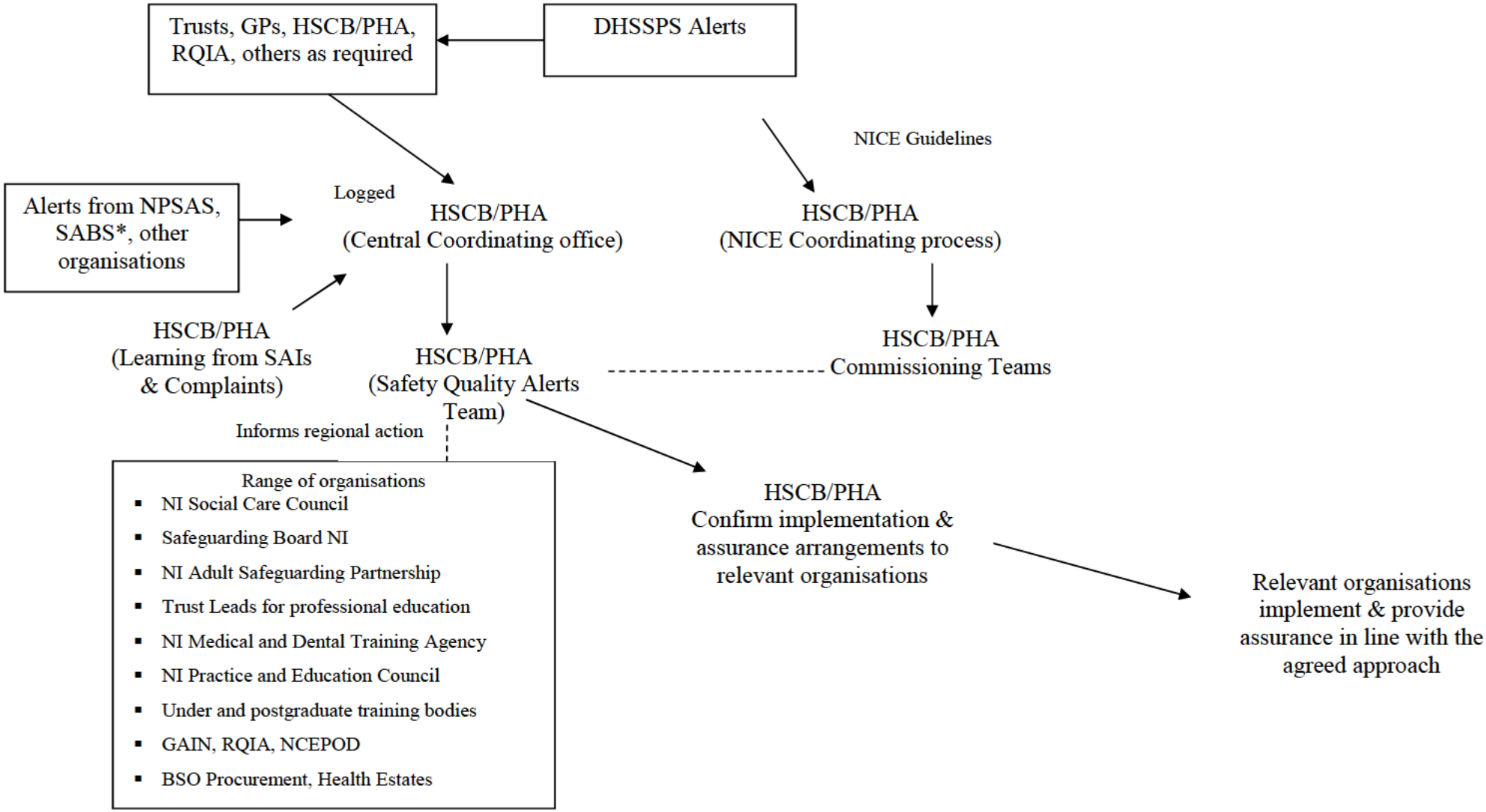
13.0 Alerts Relating to Independent Sector Providers

Independent providers are already required to respond to many of the types of Alerts covered by this protocol. In addition, DHSSPS or HSCB/PHA will send Alerts that they issue to RQIA for dissemination to relevant independent providers. DHSSPS also agree the annual work programme of RQIA which may include reviews of governance systems in independent providers, and/or assurance on implementation of specific SQAs.

14.0 Review of this protocol

This protocol will be refined on an on-going basis and not less than annually.

HSC System for Managing Safety and Quality Alerts – Structural Overview **Appendix 1**



MAHI - STM - 184 - 1050

Template Distribution List

Appendix 2

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs			CEX		
Medical Director			Medical Director/Director of Public Health		
Directors of Nursing			Director of Nursing/AHPs		
Directors of Social Services			PHA Duty Room		
Governance Leads			AD Health Protection		
Directors of Acute Services			AD Service Development/Screening		
Directors of Community/Elderly Services			AD Health Improvement		
Heads of Pharmacy			AD Nursing		
Allied Health Professional Leads			AD Allied Health Professionals		
NIAS			Clinical Director Safety Forum		
CEX			**HSCB**		
Medical Director			CEX		
RQIA			Director of Integrated Care		
CEX			Director of Social Services		
Medical Director			Director of Commissioning		
Director of Nursing			Alerts Office		
Director for Social Care			Dir PMSI & Corporate Services		
NIMDTA			**Primary Care (through Integrated Care)**		
CEX / PG Dean			GPs		
QUB			Community Pharmacists		
Dean of Medical School			Dentists		
Head of Nursing School			**Open University**		
Head of Social Work School			Head of Nursing Branch		
Head of Pharmacy School			**DHSSPS**		
Head of Dentistry School			CMO office		
UU			CNO office		
Head of Nursing School			CPO office		
Head of Social Work School			CSSO office		
Head of Pharmacy School			CDO office		
Head of School of Health Sciences (AHP Lead)			Safety, Quality & Standards Office		
Clinical Education Centre			**NI Social Care Council**		
NIPEC			**Safeguarding Board NI**		
GAIN Office			**NICE Implementation Facilitator**		
NICPLD			**Coroners Service for Northern Ireland**		

Membership **Appendix 3**

HSCB/PHA Safety Quality Alerts Team

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services
- Assistant Director Nursing, Safety & Quality & Patient Experience
- Assistant Director Service Development & Screening
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Safety, Quality and Patient Experience Nurse, PHA
- Assistant Governance Manager, Safety and Quality, HSCB
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care (Head of GMS) HSCB - when required
- Social Care and AHP input for Alerts relevant to those professions

SQA Team Roles

- Lead Social Worker – through Fionnuala McAndrew
- Lead AHP – through Michelle Tennyson
- Lead Public Health Doctor – Jackie McCall
- Lead Nurse – Mary McElroy
- Lead Pharmacist – Brenda Bradley
- Lead GP – Dr Margaret O'Brien
- Programme Manager – Margaret McNally
- Admin Support – Christine Thompson / Mareth Campbell

Trust Governance Lead Contacts

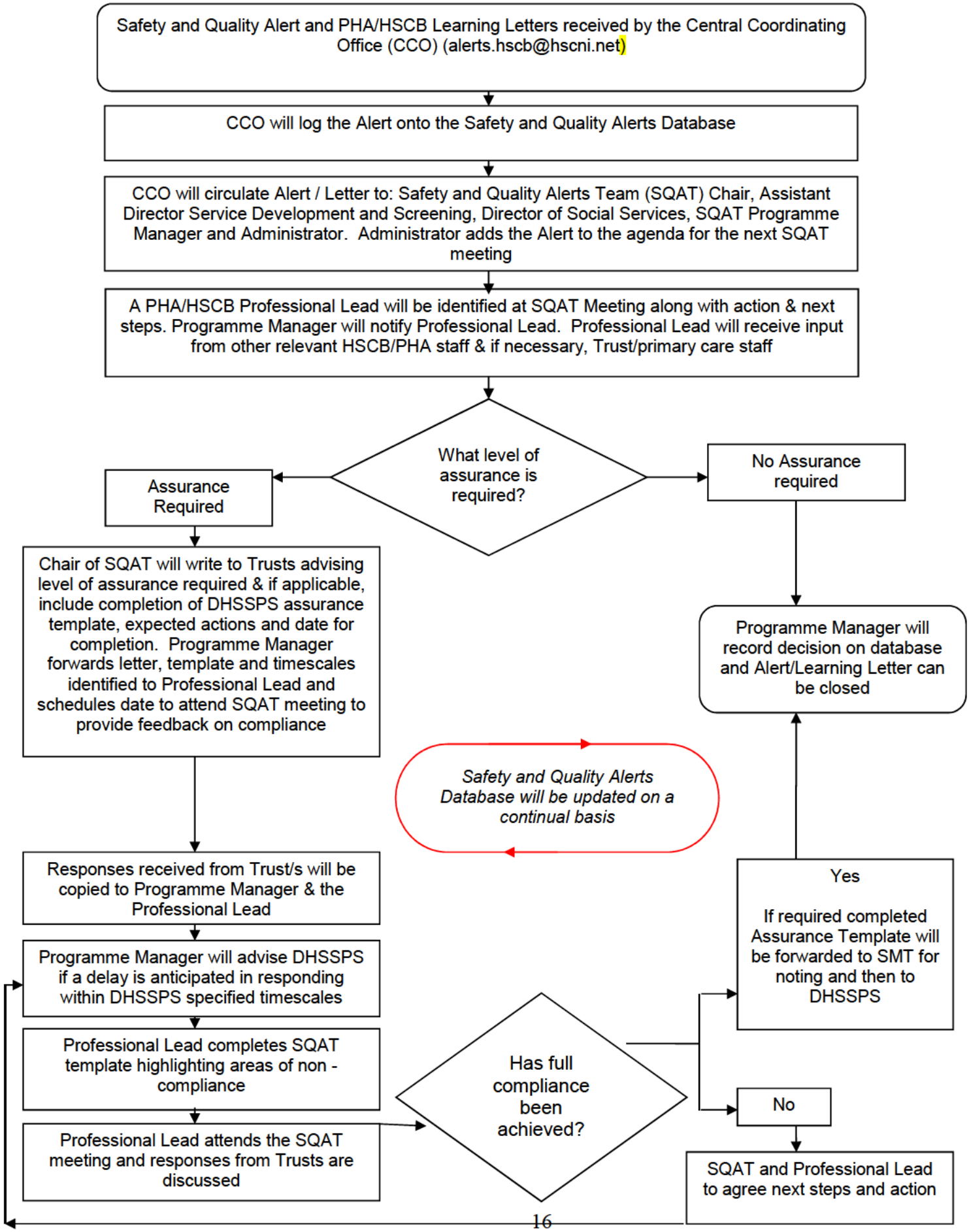
- Belfast – Dr Cathy Jack and Claire Cairns/Christine Murphy
- South East – Dr Charlie Martyn and Irene Low/Liz Campbell
- Southern – Dr John Simpson and Margaret Marshall/Dawn Mackin
- Northern – Dr Greg Furness and Suzanne Pullins/Ruth McDonald
- Western – Dr Alan McKinney and Therese Brown/Teresa Murray

Link as required with

- NI Social Care Council
- Safeguarding Board NI
- NI Adult Safeguarding Partnership
- Trust Leads for professional education
- NI Medical and Dental Training Agency
- NI Practice and Education Council
- Under and postgraduate training bodies
- GAIN
- RQIA
- BSO Procurement
- Health Estates, DHSSPS

Appendix 4

HSCB/PHA Process for the Management of Safety and Quality Alerts



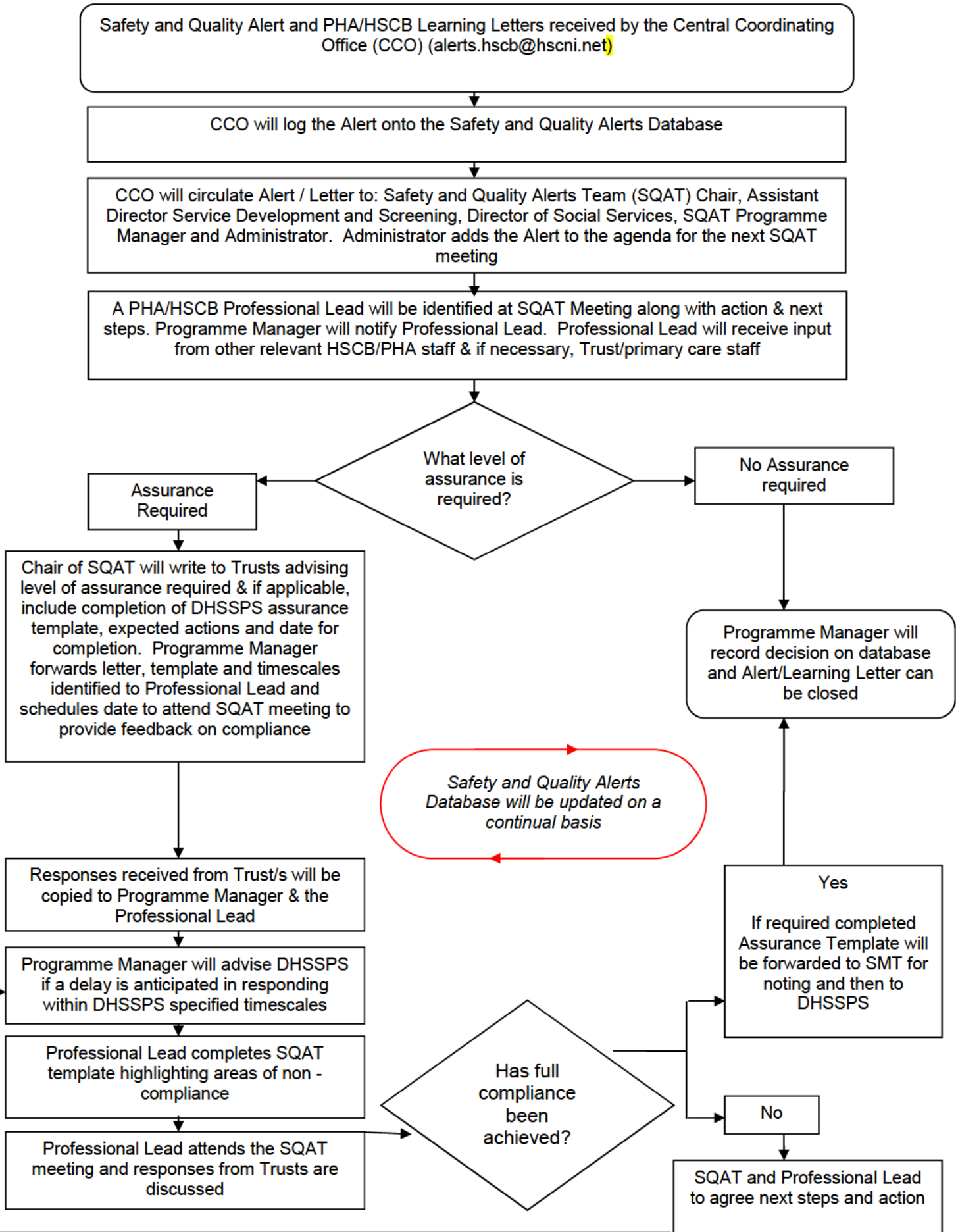
Annex 2

Current Membership of the Group – January 2015

- Dr Carolyn Harper, Medical Director/DPH, PHA (Chair)
- Michael Bloomfield, Director of Performance and Corporate Services
- Oriel Brown, Nurse Consultant, Safety, Quality & Patient Experience
- Dr Janet Little, Assistant Director Service Development & Screening
- Brenda Bradley Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Dr Jackie McCall, Consultant in Public Health, PHA
- Mary McElroy, Safety, Quality and Patient Experience Nurse, PHA
- Margaret McNally, Assistant Governance Manager, Safety and Quality, HSCB
- Dr Gavin Lavery, Clinical Director for Safety Forum, PHA
- Margaret O'Brien, Assistant Director of Integrated Care, Head of GMS, HSCB ***when required for GP input***

Appendix 4

HSCB/PHA Process for the Management of Safety and Quality Alerts



MAHI - STM - 184 - 1056

Health and Social Care Board

Public Health Agency

SAFETY AND QUALITY
REMINDER OF BEST PRACTICE GUIDANCE

Subject	Management and advice for patients/clients with swallow/dysphagia problems
HSCB reference number	SQR/SAI/2015/015 (OPS/MH/LD/AS)
Programme of care	Older People Services/Adult Mental Health/Learning Disability/Acute Services

LEARNING SOURCE			
SAI/Early Alert/Adverse incident	✓	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

There have been a number of serious adverse incidents related to choking on food. In one such incident, a resident in a residential care home had been resettled from a long stay hospital with active involvement from hospital and community services during and following resettlement.

Speech and Language Therapy (SLT) had assessed the resident as being at risk of choking and made detailed recommendations.

The SLT recommendations included:

- Soft mashed food;
- Full supervision at mealtimes; and
- Use of a personalised placemat as a visual reminder of the above.

Recommendations were documented in the resident's care plan prior to discharge from the long stay hospital, and following assessment whilst in the residential care home. The recommendations, however, were not followed and the resident subsequently choked on food and despite prompt administration of first aid, they very sadly died.

The contributory factors to this incident were:

- Staff caring for the resident where not fully aware of the SLT recommendations. Food of a hard consistency was served to the resident;
- At the time of the incident, only one member of staff was supervising a group of residents;
- The recommendation regarding use of a personal placemat was not put in place following the resident's transfer to the residential care home.

Health and Social Care Board

Public Health Agency

REQUIREMENTS UNDER CURRENT GUIDANCE

Managers of Residential Care and Nursing Homes:

- You should have robust systems in place, and working, to ensure that all staff involved in delivering care are fully aware, and reminded of, each resident's individual needs and care plans.

- You should ensure that relevant staff under your management are aware of the DHSSPSNI Care Standards for Nursing Homes (April 2015) - Standard 12, (Nutrition, Meals & Mealtimes)
  http://www.dhsspsni.gov.uk/nursing_homes_standards_-_april_2015.pdf - and the
  Residential Care Home Standards – Minimum Standards (August 2011) – Standard 12 (Meals & Mealtimes)
  http://www.dhsspsni.gov.uk/care_standards_-_residential_care_homes.pdf

For staff involved in the delivery of individual care plans:

- You need to make sure you know the detail of individual care plans of each resident under your care during a shift and you should adhere to each plan. This should include any speech and language therapy recommendations.

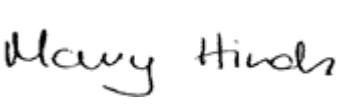
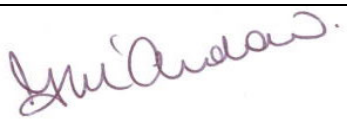
ACTION REQUIRED

HSC Trusts should:

1. Share this Reminder of Best Practice Letter with relevant staff.

RQIA should:

1. RQIA should disseminate this letter to relevant independent sector providers.

Date issued	1 October 2015		
Signed:			
Issued by	Dr Carolyn Harper Medical Director/ Director of Public Health	Mrs Mary Hinds Director of Nursing, Midwifery and Allied Health Professionals	Mrs Fionnuala McAndrew, Director of Social Care and Children

Health and Social Care Board

Public Health Agency

RE: Management and advice for patients/clients with swallow/dysphagia problems – Distribution List

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs	✓		CEX		✓
Medical Director		✓	Medical Director/Director of Public Health		✓
Directors of Nursing		✓	Director of Nursing/AHPs		✓
Directors of Social Services		✓	PHA Duty Room		
Governance Leads		✓	AD Health Protection		
Directors of Acute Services		✓	AD Service Development/Screening		
Directors of Community/Elderly Services		✓	AD Health Improvement		
Heads of Pharmacy			AD Nursing		✓
Allied Health Professional Leads		✓	AD Allied Health Professionals		✓
NIAS			Clinical Director Safety Forum		✓
CEX		✓	**HSCB**		
Medical Director		✓	CEX		✓
RQIA			Director of Integrated Care		✓
CEX	✓		Director of Social Services		✓
Medical Director		✓	Director of Commissioning		
Director of Nursing		✓	Alerts Office		✓
Director for Social Care		✓	Dir PMSI & Corporate Services		✓
NIMDTA			**Primary Care (through Integrated Care)**		
CEX / PG Dean		✓	GPs		
QUB			Community Pharmacists		
Dean of Medical School		✓	Dentists		
Head of Nursing School		✓	**Open University**		
Head of Social Work School		✓	Head of Nursing Branch		✓
Head of Pharmacy School			**DHSSPS**		
Head of Dentistry School			CMO office		✓
UU			CNO office		✓
Head of Nursing School		✓	CPO office		
Head of Social Work School		✓	CSSO office		✓
Head of Pharmacy School			CDO office		
Head of School of Health Sciences (AHP Lead)		✓	Safety, Quality & Standards Office		✓
Clinical Education Centre		✓	**NI Social Care Council**		✓
NIPEC		✓	**Safeguarding Board NI**		✓
GAIN Office		✓	**NICE Implementation Facilitator**		✓
NICPLD			**Coroners Service for Northern Ireland**		✓

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Health and Social Care Board

Public Health Agency

SAFETY AND QUALITY
REMINDER OF BEST PRACTICE GUIDANCE

Subject	Risk of serious harm or death from choking on foods
HSCB reference number	SQR-SAI-2021-075 (OPS/MHS/AS)
Programme of care	Older Peoples Services (OPS) / Mental Health Services (MHS) / Acute Services (AS)

LEARNING SOURCE			
SAI/Early Alert/Adverse incident	✓	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

Incident 1
A nursing home resident assessed as having swallowing difficulties, at risk of choking and on a texture modified diet was given two pancakes contrary to the guidance outlined in his Speech and Language Therapy (SLT) Eating, Drinking and Swallowing Recommendations, by a member of staff. The resident choked and died a short time later. The resident's nursing home care plan had not been updated with the SLT Eating, Drinking and Swallowing recommendations and the recommendations were difficult to source. The dietary information held in the kitchen for this resident was incorrect.

Incident 2
An independently mobile nursing home resident assessed as having swallowing difficulties and recommended an IDDSI texture modified diet (Level 5 food / Level 4 fluids) was seated at the nurses' station. The resident accessed a chocolate from an open box of sweets, not compatible with the recommendations. The resident started to cough, vomited brown coloured phlegm and their chest status deteriorated. The resident was transferred to hospital and died shortly after admission.

Incident 3
An inpatient with eating, drinking and swallowing difficulties, recommended a texture modified diet (IDDSI Level 4 foods) and assessed at being at risk of choking, choked on a biscuit which did not dissolve to IDDSI level 4 but remained IDDSI level 7 when mixed with hot tea. The SLT Eating Drinking and Swallowing Recommendations, care plan and risk assessment were up to date. Paramedics attempted to dislodge the obstruction however the patient suffered a cardiac arrest and died.

Incident 4
An inpatient diagnosed with a stroke, severe speech and swallowing difficulties was recommended 'Nil by Mouth' and a naso-gastric tube was placed. A miscommunication between domestic services staff and nursing staff resulted in a food tray being left in front of the patient, who ate from the tray. The patient's chest status and general condition deteriorated. The patient passed away. A Nil By Mouth sign was not placed at the entrance to the patient's room and a formal meal distribution process was not in place.

Incident 5
A review into a nursing home caring for a significant number of people with learning disabilities and swallowing difficulties was undertaken. The review found a lack of mapping to new IDDSI terminology in care plans, residents with swallowing difficulties were offered the wrong food textures, insufficient supervision at mealtimes and all of the information held by catering / kitchen staff did not correlate with SLT eating, drinking and swallowing recommendations due to old food consistency terminology being used.

REQUIREMENTS UNDER CURRENT GUIDANCE

In summary, these five SAI's relate to adults with eating, drinking and swallowing difficulties and the **failure to recognise and support their needs**. On each occasion there was a failure to confirm the eating, drinking and swallowing needs of the person, and a failure to communicate their needs to the wider team and ensure safe processes were in place.

Current guidance relevant to these incidents is noted below:

1. International Dysphagia Diet Standardization Initiative IDDSI – International Dysphagia Diet Standardisation Initiative

2. NHS Improvement issued Patient Safety Alert NHS/PSA/RE/2018/004 "Resources to support safer modification of food and drink" detailed at: HSC (SQSD) 16 18 - Resources to support safer modification of food and drink (hscni.net)

The reasons why people choke are complex and can have numerous contributing factors. Recognition of patients' difficulties, implementation of SLT Eating, Drinking and Swallowing Recommendations into a care plan, alongside coordinated multidisciplinary team efforts reduces the risk of serious harm or death.

Key learning points for all staff involved with supporting the care of adults who present at risk of eating, drinking and swallowing difficulties are highlighted below:

1. When a person has identified eating, drinking and swallowing difficulties this should be centered on an up to date Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet, within individual care plans.

2. Clear mechanisms for the communication of swallowing recommendations to those who are providing food or caring directly for individuals with swallowing difficulties should be in situ within the care setting, including when transferring between locations, include all staff (domestic and catering staff) and where appropriate families and visitors. Nil By Mouth signs should be clearly visible to all staff.

3. The needs of individuals with swallowing difficulties should be communicated at pivotal times; handover, meal and snack times, if people move facilities, attend day centers or go out in the care of others.

4. The development of a process for a safety pause before any meals and snacks should be considered e.g. “what patient safety issues for meal and snack times do we need to be aware of today?”

5. Ensure foods or fluids that pose a risk to individuals with eating, drinking and swallowing difficulties are stored securely.

6. The training and development needs of staff providing care for individuals with eating, drinking and swallowing difficulties should be identified and arrangements put in place to meet them.

Resources:

- Dysphagia Northern Ireland, Public Health Agency, practical resources to support staff: Dysphagia NI
- Online Dysphagia Awareness Training for health and social care staff providing the knowledge to manage and support people with eating, drinking and swallowing difficulties Leadership Center.
- Report on the Regional Choking Review Analysis – thematic review, HSCB & PHA (2018) Thematic Review

Health and Social Care Board

Public Health Agency

ACTION REQUIRED

HSC Trusts should:

1. Disseminate this letter to all relevant staff and discuss it at team meetings / safety briefings.

2. Review and as necessary update your Trusts policy and systems to reflect the information in the 'Requirements under Current Guidance' section of this letter.

3. Please provide assurances to the alerts mailbox at Alerts.HSCB@hscni.net by **3 March 2021** that you have appropriate audit processes in place to monitor points 1-6 as detailed in the 'Requirements under Current Guidance' section of this letter.

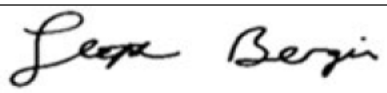
NIMDTA should:

1. Disseminate this letter to all relevant doctors in training.

RQIA should:

1. Disseminate this letter to relevant Independent Sector Providers.

2. Implement this learning through the normal RQIA monitoring processes for assurance of implementation of guidance.

Date issued	3 February 2021		
Signed:			
Issued by	Dr Stephen Bergin Acting Director of Public Health	Mr Rodney Morton Director of Nursing, Midwifery and Allied Health Professions	Mrs Marie Roulston Director of Social Care and Childrens Services

RE: SQR-SAI-2021-075 (OPS/MHS/AS) - Risk of serious harm or death from choking on foods – Distribution List

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs	✓		CEX		✓
First point of contact		✓	Director of Public Health		✓
			Director of Nursing, Midwifery and AHPs		✓
NIAS			Director of HSCQI		✓
CEX		✓	AD Service Development, Safety and Quality		
First point of contact		✓	PHA Duty Room		
			AD Health Protection		
RQIA			AD Screening and Professional Standards		
CEX	✓		AD Health Improvement		✓
Director of Quality Improvement		✓	ADs Nursing		✓
Director of Quality Assurance		✓	AD Allied Health Professionals		✓
			Clinical Director of HSCQI		✓
NIMDTA					
CEX / PG Dean	✓		**HSCB**		
QUB			CEX		✓
Dean of Medical School		✓	Director of Integrated Care		
Head of Nursing School		✓	Director of Social Services		✓
Head of Social Work School		✓	Director of Commissioning		
Head of Pharmacy School		✓	Alerts Office		✓
Head of Dentistry School			Interim Director of PMSI		
UU					
Head of Nursing School		✓	**Primary Care (through Integrated Care)**		
Head of Social Work School		✓	GPs		
Head of Pharmacy School		✓	Community Pharmacists		
Head of School of Health Sciences (AHP Lead)		✓	Dentists		
Open University			Dispensing GPs		
Head of Nursing Branch		✓	**BSO**		
			Chief Executive		
Clinical Education Centre		✓			
NIPEC		✓	**DoH**		
NICPLD		✓	CMO office		✓
NI Medicines Governance Team Leader for Secondary Care		✓	CNO office		✓
NI Social Care Council		✓	CPO office		
Safeguarding Board NI			CSSO office		
NICE Implementation Facilitator		✓	CDO office		
Coroners Service for Northern Ireland		✓	Safety, Quality and Standards Office		✓

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BW-271

EASTERN HEALTH AND SOCIAL SERVICES BOARD

A Model of Community Based Services for People with Learning Disabilities

Final Draft
16th August 1996

CONTENTS

INTRODUCTION

In September 1995 the Eastern Health and Social Services Board considered a paper concerning the future of services for people with Learning Disabilities. One of the decisions made, was that a multi-agency group should be set under the Chairship of the Director of Social Services, to consider an appropriate model of community based services for people with learning disabilities within the Eastern Boards area. Subsequently, a core development group consisting of Board representatives, representatives from the Community Trusts, Muckamore Abbey Hospital and the Voluntary Sector was set up (See Appendix 1 for the full group membership). This group met on a number of occasions, and their initial work culminated in June 1996, with a seminar. This seminar drew from best practice both in Ireland and in Great Britain, so that any proposals being made to the Board, would be based on such best practice. A programme of the event is included in Appendix 2. A commentary of the event has been written by the Director of Social Services, and is available in a stand alone format.

Following the event, the development group worked for a further full day with a facilitator, to draw up and agree the essential ideas which are contained in this report. Despite the diverse representation on the group, general agreement was reached to the ideas and proposals within this report.

The format of the report is somewhat different from previous reports presented to the Board. Firstly, the report provides an indication of where we would like to be in the year 2002 and beyond. This vision was created for us by those people attending both the seminar and the subsequent development group day. The report then provides some information on current service provision. It moves on to consider a number of life stages of people with learning disabilities, and begins to outline the appropriate responses to children and adults within those life stages. The report then outlines the principles which should be adopted to underpin service delivery. It makes clear what the commissioning framework should be, and finally proposes an implementation plan.

Clearly there is much work to be done, but the development group believe that the approach suggested within this report prevents polarisation of service delivery, and ideas about how services should be provided in the future. The proposals within the report puts the person

with the learning disability at the centre of the process. This we firmly believe is the right approach.

2002 AND BEYOND - A VISION

It is crucial in planning and developing services to create shared vision about what services may look like in the future. The development group in acknowledging this, asked what would be the expectations of various groups about the future of service delivery. These groups were: Users of services and carers, staff, purchasers/providers, and the wider community. Set out below are the visions of the groups described.

Service Users and Carers

Users (Children)

Children would have a priority of provision, in the acknowledgement that substantial inputs to children with learning disabilities can provide dividends at a later age, and reduce the need for some services in adulthood. Children would be afforded the basic rights associated with children without disabilities. They would mainly be living at home, and their needs would be met where they lived. They would have access to all those activities that non-disabled children have. At the same time their specific specialised needs would be recognised and met by whatever support systems were necessary. They would have access to advocacy, health promotion, and alternative holistic therapies. Children with learning disabilities would also have a voice in determining what happened to them in the future.

Carers of Children

Carers of children would be in shared care and supported care arrangements. They would have help with the management issues around caring for children with learning disabilities. Consideration would be given to other children within the family, and not simply focus on the child with learning disabilities. Advice would be readily available to carers, and they would be listened to. Their own needs will have been carefully assessed, and support provided to maintain them as the principal carers.

Users (Adults)

Adults with learning disabilities would have easy access to accommodation, to training, to education, to leisure and social activities. They would have the same access as everyone else to primary and

secondary health care to a specialist tertiary care when required. They would have access to information, and a nominated key worker to give them advice and support. They would also have access to advocacy arrangements, and a voice that was listened to by all relevant people.

Carers for Adults

Carers of adults with learning disabilities would have confidence that should anything happen to them, their family members would be well cared for in the future. In addition, carers would be certain that should it be necessary, they would be afforded support for and protection from the person with learning disabilities. Caring arrangements would be based on the principles of shared care and supported care. They would also have had their needs assessed, and received appropriate responses.

Purchasers/providers

For purchasers and providers, there would be a common understanding of the principles around the care and support of people with learning disabilities, and a commitment to put these into practice. There would be de-institutionalised services, offering genuine choice based on a person centred planning approach. There would be good effective interagency co-operation, which would be demonstrated by joint planning forums, and the optimum use of resources.

In recognition that people with learning disabilities access virtually all of the various health and social services programmes, explicit policies and protocols for such access would be agreed, and specialist input provided where required. In terms of contracting arrangements, central co-ordination would be strong, especially during the periods of change. The Board would facilitate responsiveness at a local level, probably through sub-purchasing via community trusts. In terms of funding arrangements, there would be adequate resources in place, and as importantly a flexibility as to the use of the total resources available. Monitoring arrangements would include users and carers, and ensure an independent view, all of which should be built into contracts.

Staff providing services

The vision for the future for staff, was considered under four broad themes: the profile of staff; clarity of roles and responsibilities; training and development requirements; job satisfaction.

In acknowledgement that services are likely to change, it was suggested that for supported living arrangements, there needed to be well trained staff, some of whom may be unqualified, but working alongside trained staff providing support. Flexibility of staffing arrangements would be a key factor, and consideration would have been given to terms and conditions of service. Staff would be demonstrating that they were providing a value for money service.

Staff would be engaging with other agencies for the provision of day time activities. The Health and Social Services responsibility, would be in care managing, key working and overseeing the individuals' package of activities.

Community support to people with learning disabilities would be provided be Psychiatrists, Nurses, GP's, Social Workers and the Primary Health Care Team. When necessary, other specialists would be involved.

The roles and responsibilities of HPSS staff when working alongside other agencies and within multi-disciplinary teams will have been clarified.

The training and development requirements would have been well worked out, which would maximise existing skills and commitment, and investment made in expertise.

All of the things previously identified, would lead to job satisfaction, fulfilment and commitment.

The wider community

The wider community would have accepted the integration of people with learning disabilities into communities. Knowledge of Care in the Community issues will have improved, through formal education and via the media. Elected Representatives both at a national and local level, will have made it clear that they support the integration of people with learning disabilities fully into society. Segregation in school life , work life, social and recreational life will have been substantially reduced.

Commentary

What has been presented in this section therefore a fairly modest vision for the future of people with learning disabilities from a number of different

perspectives. Clearly this cannot be a definitive list, but gives a flavour of what the future might look like. Being presented as a vision, it can remain a vision. What is important is that in the sections of this report to follow, the vision is borne in mind.

WHAT WE COMMISSION AT PRESENT

Within the Eastern Boards area, it is estimated that there are some 3,227 people with Learning Disabilities. This is likely to be an underestimate, as there will undoubtedly be people living within the area who have not been registered. DHSS prevalence rates would suggest a total of 3,575 in the Boards area.

The learning disability population is distributed between the Community Trusts in the following way:-

DL	25.87%
ND&A	20.30%
N&WB	27.09%
S&EB	26.74%

Of the 3,227 all but 299 currently live in the community. The 299 are cared for by Muckamore Abbey Hospital. Patients in MAH have been categorised in 2 ways: acute/forensic and long stay. The distribution of Eastern Board patients is as follows: acute/forensic - 76; long stay - 233; (analysis of patients as at May 1996).

Some hospital respite services are also purchased from Forest Lodge, Belvoir Park.

Currently the Board commissions a wide range of services from Community Trusts and the voluntary sector. Services include: statutory residential care, day services, learning disability nurses, social work and domiciliary services. Full details of the activity commissioned by the Board is included in Appendix 3(a) and (b).

Current expenditure on Learning Disability services (including Capital Charges but excluding estimated preserved rights expenditure) for EHSSB residents is estimated to be £31.5m. Appendix 3 analysis expenditure across the main programme areas taking account of pan services. Of this total £10.68m is spent in MAH. This is made up as follows:-

Acute/Forensic	£ 3,202,100
Continuing care	£ 6,198,750
Outpatients	£ 610,989
Revenue	£10,011,839
Capital Charges	£ 669,257
Total Contract	£10,681,096

LIFE STAGES AND APPROPRIATE RESPONSES

Introduction

This section considers what are the general needs of people with learning disabilities and their carers within four different life stages, these are:

- pre-birth to 5 years
- 5+ years to 19 years
- 19+ years to 64 years
- 65+ years

It also considers the appropriate services responses to those needs and by whom, and what inputs are necessary to make the system work.

The underpinning philosophy of this section is to help people with learning disabilities to lead ordinary integrated lives. In considering appropriate service responses, it should be recognised at the beginning of this process, that Health and Social Services will not be responsible for everything. Clearly other agencies are responsible for a wide range of inputs. A consequence of this analysis is that the roles of other agencies will be more clearly identified, and by necessity, change processes undertaken by them.

Pre birth to 5 years

Pre-birth can be divided into preconception and pre-natal care. It is important that those people who may be at risk of giving birth to a child with learning disabilities, are provided with full information, and genetic counselling. Should the parents be aware that they are to give birth to a child with learning disabilities, information, guidance and support should be given to them to help them to prepare for the birth of their child.

The principal professionals involved at this stage, are the Primary Care Team and the obstetric services. It is important that Mid-Wives, GP's and other members of the Primary Care Team have sufficient awareness, training and knowledge to enable them to respond fully to the needs of the parents at this stage. This applies particularly to when diagnosis is made, whether that be pre-birth or at birth. Parents should have access to accurate and full assessments, counselling and advice services and support from a choice of professionals or peer group. It is extremely important at this stage, that all the information required by parents is

supplied. This suggests that a comprehensive information service is available to parents.

During a child's development to the age of 5, it is important that parents and family members have access to ongoing counselling if required, continuous assessment, and the provision of services as appropriate. With regard to children's education, it seems important that wherever possible children should be integrated into pre-school play groups, nursery schools and primary schools with other non-disabled children. In recognition of their special needs however, the support to receive integrated services should be available. These will include:

- classroom assistants for helping with personal care
- back up speech therapy within the school setting
- communication support if necessary
- specialist equipment for those children with additional disabilities

It is recommended that wherever possible a child in this stage, lives within the family environment, which if necessary can be in adapted housing, and that they have access to not only a circle of friends, but family link schemes, fee paid fostering schemes, and other support services. Careful consideration should be given at this time to the parents needs for additional education and training in the management and support of a child with a learning disability.

In terms of health care and treatment, it is important that children should be catered for in mainstream services especially at the primary and secondary level. It has been demonstrated in other places, that in order for this to happen, considerable staff training and development needs to be undertaken. Without this a child's particular and special needs are often overlooked.

Sufficient resources need to be in place at the appropriate intensity to provide for those special needs. These will include psychological input, professionals allied to medicine, community nurses specialising in learning disability, paediatricians, dental services and ophthalmology. A 24 hour crisis intervention team should be available across the Boards area to provide appropriate support, and to prevent admission to tertiary services.

For this particular life stage, children need equal access to leisure services. This will require such services to make sure that at least some

of their staff are fully aware of the needs of children with learning disabilities, and can offer appropriate support when children and families are undertaking leisure activities.

5+ years - 19 years

Wherever possible children and young people within this life stage are expected to be able to live at home. This can only happen however with the provision of any physical and practical support, which has been assessed as being required. These may include aids and adaptations and environmental changes to the property, for example; access requirements.

For those living at home, respite services may be needed for the carers and/or the person with learning disabilities. These should be provided in a variety of different ways, and should be flexible enough to meet the persons needs. They should be child and young person centred, and age appropriate.

If it is not appropriate for the young person to have holidays with their family, these should be provided as far as possible in integrated settings, with the support needed for the individual to participate fully in the experience.

Should young people in this life stage be unable to live at home, ideally they should be provided support in a substitute family, or if needs require, a specialist child care provision.

In terms of education, it is important that wherever possible young people have integrated education. This will require considerable liaison and joint planning with DENI. It may also require changes in the school health agenda, ensuring that the therapies required by individuals can be met within the school health system.

When not at school, young people within this life stage need friends and leisure opportunities as do every other young person. It is important that choices are identified for these individuals which are integrated. Thus integrated summer schemes, holidays and friendship links are all to be promoted.

Young people with learning disabilities may have only the same health care needs as other children. However, when they have more

specialised health care needs, it is important that they have a person centred, multi-disciplinary assessment of need. Furthermore it will be important that GP's and the Primary Health Care Team have an awareness of the special needs of young people with learning disabilities. Dentists should also be trained in the basics of providing their services to people with learning disabilities.

The secondary health care services that may be required are a range of PAM services and within those, physiotherapy could well be a priority. Psychological input and the services of a Consultant Paediatrician and Psychiatrist may also be required. Health Care issues often related to young people with learning disabilities are sleeping disorders, eating problems, behavioural issues, epilepsy, enuresis and autism.

It is important that throughout the health and social care services, that integrated information systems are operating, especially for people with learning disabilities.

For adolescents, the issue of transfer to adulthood is of crucial importance. In particular the transitions include education to work, relationships and sexuality issues, possibility of leaving home, travel and risk taking. All of these things need to be considered by the individuals key worker, and plans made for the transition. This will require considerable liaison between a wide variety of agencies providing different types of input.

19 - 65 year olds

The main emphasis within this life stage for people with learning disabilities is to live ordinary lives. This means that they live in ordinary housing, have access to education, work and leisure. Real choices are offered as a way of accessing these things. Many people currently live in either Hospitals, Residential or Nursing Homes, Group homes or in parental accommodation. Many of these people may like to have homes of their own. Thus a primary responsibility to meet the needs of people within this life stage is to stimulate providers of housing, providers of education, providers of leisure and employers. It is only when other agencies or groups take responsibility for people with learning disabilities that the hopes and aspirations of people within this life stage will be realised. Clearly some people will need support in accessing the various choices available to them. Some of the support needs will be the responsibility of health and social services, other will be the responsibility

of the agencies providing these services. Such responsibilities need to be well documented, and recognition of these included within the implementation plan.

For those people within this life stage, access to health and social care is also of crucial importance. Once again the Primary Health Care team is likely to be the first contact point for people with learning disabilities who have health problems. In order that people can access these and be responded to sensitively and appropriately, greater awareness training and staff development needs to be undertaken within that staff group.

In order to prevent admission to hospital care, there needs to be in place a specialist/crisis intervention team (this mirrors the same development for children with learning disabilities). There should also be a key worker who is named for each individual person with learning disabilities. The use made of that key worker by individuals will be different, but at least people with learning disabilities should know that a key worker is there to help and support them.

65+ years

Once again in this life stage the service responses are similar to those that have been discussed above. Living in ordinary houses, in ordinary streets with the support that is needed is the prime consideration. As in other life stages, people within this stage, should have access to independent advocacy. They also need, as do other elderly people, regular health and sensory checks, preferably through their own GP, Dentist, Optician etc. Clearly if these professionals are not sufficiently trained to deal with people with learning disabilities they must be trained as soon as possible.

People with learning disabilities living in their own homes should have the same range of domicilary support services available to them as do non-disabled people. However, as they may have special needs, those people providing services should be sufficiently well trained and knowledgeable about learning disabilities.

Once again the range of opportunities available to non-disabled people should be available to elderly people with learning disabilities.

Commentary

What has been provided in this section is the consideration of the differing needs of people as they move through various life stages. It can clearly be seen that the needs of people with learning disabilities are very similar to those with no disabilities. The crucial difference is the support that is needed by disabled people to access those things that are taken for granted amongst non-disabled people.

Information from this section has been collated into a tabular form which is reproduced in Appendix 4. This list shows quite clearly what is needed within the different life stages. It also provides an important starting point for the planning and delivery of appropriate service responses.

THE PRINCIPLES THAT WILL UNDERPIN SERVICE DELIVERY

Objective

The overall objective for services for people with learning disabilities is to work with individuals to help them achieve and maintain a valued lifestyle. In order to achieve this basic objective services will work in ways which will enable people with a learning disability to increasingly:

- be recognised as a unique individual with opportunities for individual expression
- live and spend their time in ordinary community settings using common local facilities
- have opportunities to make both major life and day to day decisions with the appropriate support and information
- have opportunities to learn, grow and experience increasing capability
- be encouraged to present themselves in such a way as to promote their own self esteem
- experience a natural and positive progression in their lives with minimal disruption at times of change
- be part of the community with a network of friendships, family links and opportunities for more intimate relationships.

In order to translate these ways of working into action, the Eastern Health and Social Services Board will base their strategy on the five accomplishments as designed by John O'Brien. These are five accomplishments which will ensure the social inclusion of people with a learning disability into ordinary communities. These are outlined in Appendix 5, which demonstrates the accomplishment, the outcome, the implications and the challenges.

Social inclusion has implications for the way in which services are developed and run. These are that:

- people will not have to go outside their natural communities to receive the majority of services which will be local and comprehensive

- services will be designed and run for the interests of users

- users of services, their families and advocates will be provided with accurate and appropriate information.

THE COMMISSIONING FRAMEWORK

This section of the report sets out the commissioning framework adopted by Eastern Health Social Services Board in three main areas.

(i) Social Care
(ii) Specialist Health Care (Community based)
(iii) In-patient care.
(iv) Specialist Services for Children

Essentially this framework sets out the commissioning intentions of the Eastern Health and Social Services Board. By definition therefore, providers wishing to develop services must ensure that they do so within the confines of this framework. It will be seen that this framework draws upon the previous sections of this report.

Social Care

The overall philosophy associated with the commissioning of social care services is that of social inclusion, integrated services and care plans based on person centred planning and especially essential life style planning. It is unlikely that service development will be agreed if they do not meet this overall philosophy of care.

Accommodation

The principal type of accommodation likely to be developed in future, is supported living. This is defined by the NDT (1993) as follows:-

- Separate housing and support

  The agency that provides or co-ordinates supports is not the landlord nor does it have any organisational connection to the property owner.

- Focusing on one person at a time

  A process of person centred planning is used to find out what each individual wants and then to plan individually and assist them to secure the accommodation and supports that are right for them.

- Full user choice and control

  Individuals chose where they live, who they live with (if anyone), who supports them and how. Individuals hold their own tenancy or mortgage and are in control of their own money and household.

- Rejecting no-one

  There is an implicit assumption that everyone can live in the community. The fact that someone has complex needs does not mean that they should be denied the opportunity to choose their own life style. Attention is given to environmental adaptations and personally designed supports.

- Focusing on relationships: making use of informal supports and community resources

  The starting point is to build on a persons' existing relationships and connections. Paid help is only used when natural and informal support is not available. Paid supporters work to develop a social network alongside their other activities.

  As Kinsella (1993) says, one problem is that producing a definition immediately puts boundaries around supported living, implying that it is just another model in the continuum of residential services, with a danger of it being seen as an end, rather than a means to an end.

  Supported living is not just another model, but a process to enable people with learning disabilities to be included in their communities and be fully and actively involved in them.

Day Activities

Day activity services will only be commissioned if they are innovative and move forward traditional Day Centres. Day activities must be linked to other agencies and services including education, training and development, work skills and work. In respect of all of these, integration is the key. Integration with other non-disabled people in the activities that are being undertaken.

Existing day services provided by both the statutory and voluntary sector will wish to seek other partners with whom to develop imaginative and far

reaching schemes. These should include social and recreational leisure opportunities, vocational training, the development of co-operatives, the development of social firms, work skills, training programmes, and supported employment.

Respite/support services

The provision of respite and other support services in the Eastern Boards area is currently insufficient to meet the needs of all those living in the community. Respite care can be provided in individuals own homes, in host families, or in residential or nursing homes. In all schemes however, where respite care is offered, efforts must be made to ensure that a close link is developed between the family and the respite care givers. This is important, as the role of respite care is to support the efforts of the main carers and not to supplant them.

Other support services which need to be developed to assist people with learning disabilities are the development of self advocacy groups, citizen advocacy and friendship schemes.

Specialist health care (community based)

While a specialist in-patient service is provided at Muckamore Abbey Hospital, the Board would be willing to commission three specialist health care services (community based). These are: community learning disability teams, rehabilitation services and respite care provision. These are detailed below.

Community learning disability teams

As less people are admitted to Muckamore Abbey Hospital, and as more people are resettled in the community, the provision of effective and well structured community learning disability teams are essential to ensure that a range of peripatetic/domiciliary services are provided.

The community learning disability team would comprise of the following membership, each of whom will carry client caseloads:

Community learning disability nurses, Specialist social workers. A Consultant Psychiatrist, A Clinical Psychologist, Physiotherapists, Occupational therapists and Speech and language therapists.

The role of the community learning disability team will be to carry out multi-agency specialist assessments, to enable care managers to design packages of services tailored to meet the assessed needs of individuals. They will also provide a range of professional services in order to meet individual specialist needs. This will include the provision of advice, treatment, intervention, support, counselling, teaching and educational programmes.

The key areas in which team members will provide the above services are related to challenging behaviour, mental health, forensic, psycho-sexual needs, epilepsy, the promotion of continence, assisting individuals to access generic health care services, assisting individuals to access specialist health services, profound physical disabilities, severe language and communication needs, health related counselling and psycho-therapy, and health promotion.

The objectives of such a team would be to provide an easily accessible service for service users, carers and families; to work in partnership between health and social care colleagues; to develop working links with primary health care teams and general practitioners; and to link and liaise closely with other specialist health care services.

The outcomes for service users will be that there should be no delay in accessing support and intervention required for specialist services, and the provision of multi-disciplinary approach to individualised care.

Rehabilitation services

One of the difficulties faced by those people who are admitted as in-patients for mental health and emergency care, is that the rehabilitation services currently offered to them, are also hospital based. This does not provide the opportunity for rehabilitation within a home like and domestic style environment with close links to community amenities and services.

The Eastern Health and Social Services Board would wish to commission services which aid the quick discharge from hospital based services to the community, even for those people who need a period of rehabilitation.

The objectives of the service would be to provide facilities in order that independent living skills and community living skills can be assessed; to provide opportunities for people to learn new skills to prepare them for full re-integration back into the community; to provide, where required, fully

supervised after care in relation to the mental health order; to prevent inappropriate placement in secure provision or prisons for people diverted from the Courts, and to provide a time limited transitional facility where treatment can continue whilst living skills are developed.

The rehabilitation service staff will work closely with hospital based staff and members of the community learning disability team.

Respite care provision

A considerable amount of respite care is currently provided within a hospital setting. The Board is prepared to commission respite care provision developed within the community for adults with profound challenging behaviour, including people with complex autistic needs. The provision will provide replacement services to individuals who currently access hospital based services. The objectives of the service would be to provide planned respite for a person with defined health and social care needs living in the community; to provide care based around a persons usual routines and plans of care in their ordinary home; to provide (where requested by carers) assessment and new plans of care which can be continued in the ordinary home environment to address particularly challenging needs; to link with the key worker for each person; to maintain usual day care arrangements whilst in respite care, and to link with key workers within appropriate services.

It is suggested that should these three community based services be provided, then more people will be able to remain within the community, and the resettlement of patients from Muckamore Abbey Hospital will be enhanced.

In-patient Care

The Board is willing to purchase in-patient care only when it can be demonstrated that community based or out-patient treatment is either not available or not appropriate. The Board only wishes to commission and purchase specialist in-patient treatment services for people with learning disabilities who fall within the following categories:

- Mental illness
- Behavioural disturbance
- Offences (including those referred by the courts)
- Additional handicapping conditions

Mental Illness

All forms of mental disorder occur in people with learning difficulties, but with a significantly increased frequency when compared with the non-handicapped population. A prevalence of up to 10% suffering from psychotic illness has been generally accepted and is significantly higher than the general population.

Severe Behavioural Disturbances

Behavioural disturbances (including bouts of aggression, autistic behaviour, socially unacceptable behaviours, hazardous behaviour, self injurious behaviour, general over reactivity, restlessness and noisiness) varies widely in frequency and predictability. The most consistent estimates of prevalence of severely challenging behaviours is 20 per 100,000 general population. EHSSB could expect to have approximately 130 such people in the population.

Offences (ordered by the Courts)

Offending behaviour by people with a learning disability is uncommon (1% of the population) and is virtually confined to those with mild/moderate intellectual handicap. A person with learning disabilities who offends should not automatically enter the penal system and should be assessed and most often dealt with under the current mental health legislation. The Board will commission inpatient services for those people who require a degree of security for those ordered by the court, those who do not reach the courts and those who are referred for treatment before trial.

Additional Handicapping Conditions

It is common for intellectually disabled people to display other disabilities particularly if the intellectual disability is severe. Approximately 40% of people with a learning disability have an EEG abnormality. Frank epilepsy is significantly more common than in non-handicapped people (25-28% affected).

The Board will commission in-patient services for those people with learning disabilities who have additional handicapping conditions where it can be demonstrated that the multiplicity of nursing and care problems posed may not be met within the general acute hospital setting.

The Board views the purchasing of in-patient services from MAH solely as a tertiary service. People will go to the hospital from their usual accommodation, will receive the treatment they need and will be discharged as quickly as possible to the accommodation from where they came (or to a suitable alternative). It is expected that each admission will be subject to a detailed assessment, care/treatment plan and expected time frame from admission to discharge.

Specialist Services for Children

Much of what is written in this section refers equally to children and adults. However, there are some specific specialist services that the Board will wish to commission. All services commissioned must meet the philosophy and principles of the Children (NI) Order 1995, in particular, the following:

- The welfare of the child is paramount
- Wherever possible, children should be brought up and cared for within their own families
- Children should be safe and be protected by effective intervention
- Children should be kept informed about what happens to them and should participate when decisions are made about their future
- Parents continue to have parental responsibility even when their children are no longer living with them
- Parents with children in need should be helped to bring up their children themselves and such help should be provided in partnerships with parents
- services provided to children and families should draw on effective partnership between the Board, Trusts and other agencies.

The services the Board will commission are:-

Specialist non-admission assessment and diagnosis

It is expected that the majority of the work of assessment and diagnosis can be carried out by the Community Learning Disability teams. However, for some children this will not be possible and attendance at a specialist unit may be necessary. The Board is willing to commission a limited number of places within a community based setting meeting the requirements of the Children Order for domestic and home-like environments to be provided.

Specialist Assessment and Treatment

When this cannot be provided by the Community Learning Disability team, the Board will commission a limited number of places within a community based setting where children may either attend on a daily basis or live-in for an agreed period of time. Facilities should be available for a parent to be accommodated as well, should this be deemed in the best interest of the child's treatment plan.

Specialist respite/shared care

Ideally the Board would wish to commission such care in substitute family care. This would require having foster families fully trained to accept children and young people with complex needs and high demand for individual attention. Should these not be available the Board will commission residential placements, subject to them meeting the requirements of the Children Order (detailed above).

FINANCIAL MATTERS

It can be seen from a previous section that a considerable resource is tied up with hospital based services. It is acknowledged that there are some patients who would be more appropriately placed in the community if the human and financial resources were available. These resources can only come from a transfer from hospital to community.

The key element of any financial strategy must therefore involve the transfer of continuing care funds from the MAH baseline to community projects and infrastructure costs involving resettlement. The continuing care funds amount to £6,198,750.

To discover what "dowry" may be associated with individuals, the total available is divided by the agreed numbers of patients for resettlement. This dowry system has yet to be formally agreed with N&WBCT, but on a full cost basis it is likely to be in the range of £25,000 - £27,500 per patient. It is intended that funds associated with the purchase of continuing care beds will be transferred to the 4 community Trusts areas from 1997/8. This will help the Trusts to make plans for the patients who are their responsibility.

On the basis of current information on patient numbers in MAH funding to be transferred will be as follows:

	DLCT	ND&ACT	N&WBCT*	S&EBCT	Total
Patients	32	38	83	70	223
Finance	£0.890m	£1.042m	£2.388m	£1.879m	£6.199m
*assumes unallocated patients under N&WBCT responsibility					

There are 3 key financial pressures which need to be considered within the long term strategy:

(i) Recurrent revenue available to resettle continuing care patients from MAH

As noted above an average cost per patient of £25,000 - £27,500 should be seen as the financial constraint within which resettlement can take place.

(ii) Financing of MAH baseline over the resettlement

As recurrent funds are withdrawn from the MAH baseline bridging finance (non recurrent funding) will have used to provide short term as to the hospital. A fund of between £7-8m is likely to be required to complete this process. This is demonstrated in the table below:-

	97/8	98/9	99/2000	2000/1	2001/2
Assumed withdrawal of patients	20%	20%	20%	20%	20%
Recurrent funding withdraw	£1.24m	£1.24m	£1.24m	£1.24m	£1.24m
Fixed cost constraints	100%	90%	70%	£%%	-
N/R Alleviation	£1.24m	£2.23m	£2.6m	£1.74m	-

This is essentially a provisional estimate and will need to be discussed in detail with N&WBCT.

(iii) Community Developments outside MAH resettlement process

There is clear evidence that existing community provision is inadequate. It is difficult to envisage, however, significant additional resources being made available to address these matters. Alongside the resettlement process therefore two further issues need to be addressed:-

- re-alignment of community services within existing provision
- equity considerations

Both of these issues require an understanding of the needs of people with learning difficulties, an agreement to the principles underpinning service delivery and adherence to the commissioning framework which have already been addressed in this report.

IMPLEMENTATION PLAN

The implementation plan is divided into 2 parts: professional issues and financial issues. In order to put in place the vision created within this report professional and financial matters will need to have equal weight. Without this the plans for services for people with learning disabilities will flounder.

Professional Issues

1. To ensure that the Community Health and Social Services Trusts are fully conversant with the commissioning framework.

2. To request CHSST to examine their range of services for people with learning disabilities and to make proposals to the Board as to how the identified needs of individuals will be met either via existing or reconfigured services.

3. To ensure that each Trust has nominated individuals to manage the change process.

4. To draw up plans to raise the awareness of the needs of people with learning disabilities among:

   - G.P's and the Primary Health Care Team
   - PAM Services
   - Obstetrics and Paediatrics
   - Dentist/Ophthalmologists and hearing specialists
   - Health promotion staff
   - Other nominated professionals

5. To draw up plans to train and develop staff to use Essential Lifestyle Planning (ELP).

6. To ensure that Trusts undertake ELP for all patients in MAH who are the responsibility of the EHSSB.

7. To ensure that Trusts undertake ELP for all adults and children coming to the attention of the Trust.

8. To request Trusts to provide realistic timescales for providing ELP on **all** their existing clients.

9. To ensure the Board has at least one staff member dedicated to a central co-ordinating role over the next 5 years.

10. To set up a Board monitoring team to ensure that the required changes are happening.

11. To ensure that the Board has consultation time available from a nominated specialist in developing learning disability services.

12. To ensure that the other 3 Health and Social Services Boards (especially NHSSB) are conversant with the EHSSB approach.

13. To draw up a specification for information requirements irrespective of where people with learning disabilities live and from whom they receive services.

14. To ensure that Trusts maintain information in accordance with the specification.

15. To liaise with other agencies to ensure that they know the strategic direction proposed and their role within it.

16. To work closely with Consultants at MAH to determine how they and other specialist staff could help prevent admissions to MAH, by developing community alternatives.

17. To draw up a service specification for Specialist Treatment Services at MAH.

Financial Issues

1. To put in place arrangements for devolving purchasing funds for the continuing care element of MAH to Community Trusts.

2. To determine the size and cost of the acute element of MAH and to agree appropriate costings.

3. To project the recurrent costs of community developments to be used in resettlement. This process should be completed in consultation with the 4 CHSST. A key element of this process will be to establish whether the average cost dowry restraint of £25,000 - £27,500 per patient will be sufficient to cover scheme costs.

4. To agree with NWBCT the details of the dowry arrangements.

5. To ask NWBCT to project the long term need for non-recurrent support to the Hospital over the retraction period.

6. To consider if short term bridging support will be needed from DHSS and, if so, to plan and make an approach.

APPENDIX 1

Membership of Core Development Group

EHSSB
John Richards
Peter Gibson
Philip Donaghy
Maureen Dodd
Larry Blaney
Ciaran Doran

S&E Belfast Trust
Louanne Hempton

N&W Belfast Trust
Noel Rooney
Norma Hetherington

ND&A Trust
Cecil Worthington
Veronica Jackson

DL Trust
Sean O'Rourke
Miceal Crilly

Mencap
Maureen Piggott

LEAD
Gail McKibben

APPENDIX 2

Learning Disability Development Group Event
10th June 1996
Airport Hotel, Aldergrove

Introduction to the Day
- ⇨ John Richards

Person entered planning
- ⇨ Cecil Worthington, North Down and Ards HSS Trust
- ⇨ Peter Kinsella, Liverpool HA

Accommodations Options
- ⇨ Supported Living - Peter Kinsella
- ⇨ Village Community - representative of Camphill Communities (Neil Snellgrove)

Specialist Services
- ⇨ Mark Feinmann, North Mersey NHS Trust

Day Services/supported employment/social firms
- ⇨ Aidan Murray, North and West Belfast Trust
- ⇨ Tony Phillips, London Borough of Havering
- ⇨ Personal Department and Work Skills Programme

Overview of services in one authority
- ⇨ Gilly Gilmore, Stafford SSD
- ⇨ Michael Burns, carer from Staffordshire

Discussions and Conclusions

Core Learning Disability Development Group meet with presenters
- ⇨ The day was facilitated by Rob Williams

LEARNING DISABILITY			CORE CONTRACT	PEOPLE FIRST	TOTAL CONTRACT
Service Description			Indicative Volume	Indicative Volume	Indicative Volume
District Nursing		Face to Face Contacts	1,393	85	1,478
Nursing Auxiliaries		Face to Face Contacts	77	0	77
Health Visiting		Face to Face Contacts	168	0	168
Mental Handicap Nursing		Face to Face Contacts	16,069	0	16,069
Chiropody		Face to Face Contacts	868	0	868
Physiotherapy		Face to Face Contacts	9,583	0	9,583
Occupational Therapy		Face to Face Contacts	7,270	0	7,270
Clinical Psychology		Face to Face Contacts	0	0	0
Speech & Language Therapy		Face to Face Contacts	9,875	0	9,875
Dietetics		Face to Face Contacts	20	0	20
Community Medical Officer		Face to Face Contacts	437	0	437
Community Dental		Face to Face Contacts	1,934	0	1,934
Hospital Inpatient	Acute	Beds	57	0	57
	Continuing Care	Beds	222	0	222
	Rehabilitation	Beds	17	0	17
	Respite	FCEs	828	0	828
Hospital Outpatients		Attendances	1,221	0	1,221
Statutory Residential Care - Core		Occupied Bed Days	70,071	225	70,296
Statutory Residential Care - Cluster		Occupied Bed Days	37,121	0	37,121
Private Nursing Home		Purchased Bed Days	0	21,992	21,992
Private Residential Home		Purchased Bed Days	0	4,280	4,280
Voluntary Nursing Home		Purchased Bed Days	0	1,294	1,294
Voluntary Residential Home		Purchased Bed Days	0	21,292	21,292
Statutory Day Services		Attendances	217,733	532	218,265
Voluntary Day Services		Attendances	0	15,552	15,552
Home Help		Total Hours Worked	12,249	5,069	17,318
Independent Domiciliary Care Schemes		Total Hours Delivered	0	24,771	24,771
Domiciliary Respite Schemes		Total Hours Delivered	3,946	4,988	8,934
Social Workers		Active Caseload	2,585	47	2,632

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ANALYSIS OF RECURRENT REVENUE EXPENDITURE ON LEARNING DISABILITY

96/7 PRICES

		APPORTIONMENT OF FUNDS						
		DLCT	NDACT	NWBCT	SEBCT	UNALLOC	TOTAL	
HOSPITAL	CONTINUING CARE	£889,165	£1,041,593	£2,032,377	£1,879,949	£355,666	£6,198,750	
MAH	ACUTE/FORENSIC(MALLOW)	£478,270	£755,687	£935,038	£980,488	£52,617	£3,202,100	
	OUTPATIENTS	£48,966	£57,360	£111,923	£103,528	£19,586	£341,364	MAH
	PATIENTS IN REPUBLIC OF IRELAND					£269,625	£269,625	£10,011,839
GPT	FOREST LODGE GREEN PARK	£137,500	£93,500	£126,500	£192,500		£550,000	
COMMUNITY	*STATUTORY RESIDENTIAL CARE*	£1,131,148	£536,723	£1,089,580	£1,074,616		£3,832,067	
	DAY SERVICES	£1,277,671	£978,021	£1,702,774	£1,519,179		£5,477,645	
	MENTAL HANDICAP NURSING	£157,200	£86,032	£171,249	£116,565		£531,046	
	VOLUNTARY BODY	£293,525	£171,985	£18,136	£230,960		£714,606	
	SOCIAL WORK	£269,572	£177,925	£402,971	£300,778		£1,151,246	
	SERVICES	£356,158	£201,167	£371,466	£177,064		£1,105,855	
	CROSS BOUNDARY FLOW	£29,560	£60,275	£156,802	£267,176		£513,813	
	LINDSAY HOUSE	£157,196	£100,322	£73,542	£81,782		£412,842	
	ADMINISTRATION	£296,784	£250,477	£256,280	£239,182		£1,042,723	
	DOMICILARY RESPITE	£30,369	£9,503	£0	£0		£39,872	COMMUNITY
	MISCELLANEOUS ITEMS	£68,224	£84,467	£36,328	£57,100		£246,119	£15,067,834
	PEOPLE FIRST	£938,229	£1,095,797	£922,557	£1,138,040		£4,094,623	
	PRESERVED RIGHTS ESTIMATED	£797,525	£810,300	£855,195	£830,740		£3,293,760	
	REVENUE TOTALS	£7,357,062	£6,511,135	£9,262,718	£9,189,647	£697,494	£33,018,056	
	CAPITAL CHARGES COMMUNITY	£354,949	£144,228	£273,103	£361,566		£1,133,846	
	CAPITAL CHARGES HOSPITAL			£669,257			£669,257	
	REVENUE + CAPITAL CHARGES	£7,712,011	£6,655,363	£10,205,078	£9,551,213	£697,494	£34,821,159	
	EXCLUDE PRESERVED RIGHTS							
	CONTRACT TOTALS	£6,914,486	£5,845,063	£9,349,883	£8,720,473	£697,494	£31,527,399	

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A Compilation of what Responses/Services Might be Appropriate to the Different Life Stages of People with Learning Disabilities

	Life Stages			
What's Needed	*PB- 5yrs*	*5-19yrs*	*19-64yrs*	*65+*
Accommodation				
Ordinary Housing	✓	✓	✓	✓
Supported Housing			✓	✓
Tenanted Accommodation			✓	✓
Adult Placement			✓	✓
Foster Care with Families	✓	✓		
Residential Care		✓	✓	✓
Nursing Home Care			✓	✓
Village Communities			✓	✓
Health Care				
Skilled/Knowledgeable Primary Health Care Team	✓ ✓	✓ ✓	✓	✓
Skilled/Knowledgeable Obstetrics & Paediatrics	✓	✓	✓	✓
Skilled/knowledgeable PAMS	✓	✓	✓	✓
Skilled/knowledgeable Dentists/Opthamologist/Hearing Specialist	✓		✓	
Genetic Counselling		✓	✓	✓
Health Education/Promotion	✓	✓	✓	✓
Psychiatric Support	✓	✓	✓	✓
Psychological Support	✓	✓	✓	✓
Regular Health/Screening Checks		✓	✓	✓
Hospital In-patient	✓	✓	✓	✓
Hospital Out-patient				
Support				
Person Centred Assessment (ELP)	✓	✓	✓	✓
Creche	✓			
Fee-paid Fostering	✓			
Child Minding	✓			
Pre-School Playgroups	✓			
Family Link Schemes	✓	✓		
Summer Schemes	✓	✓		
Holidays	✓	✓		
Friendships	✓	✓	✓	✓
Advocacy	✓	✓	✓	✓
Key Worker	✓	✓	✓	✓
Access to respite Care	✓	✓	✓	✓
Domiciliary Support	✓	✓	✓	✓
Continuance Advisors/Services	✓	✓	✓	✓
Aids/Adaptions	✓	✓	✓	✓
Older Persons Clubs				✓
24 Hour Crisis Support Team (Multi-Professional)	✓ ✓	✓ ✓	✓ ✓	✓ ✓
Integrated Information Systems	✓	✓	✓	✓
Voluntary Organisations				

Social Care	MAHI - STM - 184 - 1101			
Social Work	✓	✓	✓	✓
Family Support	✓	✓	✓	✓
Counselling	✓	✓	✓	✓
Benefits Advice		✓	✓	✓
Accessing Services	✓	✓	✓	✓
Things To Do				
Access to Education: Primary	✓			
Secondary		✓		
Further		✓	✓	
Day Services			✓	✓
Vocational Training		✓	✓	
Work Skills		✓	✓	
Work		✓	✓	
Supported Work	✓	✓	✓	✓
Sport	✓	✓	✓	✓
Leisure		✓	✓	
Training/Development for Staff				
Primary Care	✓	✓	✓	✓
Secondary Care	✓	✓	✓	✓
Tertiary Care	✓	✓	✓	✓
Assessment/Care Management		✓	✓	✓
Traditional Service Providers	✓	✓	✓	✓
Specialist Staff	✓	✓	✓	✓

Accomplishment	Outcome	Implications	Challenge
Supporting Community Presence	All individuals sharing ordinary places	Everyone should live in their own house/flat/bungalow within a natural community. They should also as far as possible access ordinary places of education, training and work. Local facilities for general health care; leisure; spirituality; transport; etc. should be accessible and accessed when other people are using them.	To widen inclusion to as many people and as many activities as possible. This is especially challenging in relation to people with multiple disabilities or complex mental health needs.
Promoting choice	People having the opportunity to make as many choices as possible and the range of experiences to validate those choices	The three major implications of this accomplishment are individuality, risk can control. If people are to make their own choices it has to be done on an individual level and services have to be much more responsive to individual needs and wishes in relation to every aspect of life from choices to living companions, food to friendship. This must imply risk taking. Life is full of risks from crossing the road to developing relationships. It is vital that if life is to be fulfilling for people with learning disabilities, services and staff must be willing to let some people make mistakes, be hurt and achieve success. Everyone learns by making mistakes and no-one gets it right, first time, all the time. However, this does not imply abandoning a duty to care. Risks must be evaluated and reduced to sensible proportions. No-one climbs mountains without support and training appropriate to their needs and no-one should be denied the opportunity to take the first step. The other aspect of choice is bound up in the word "control". People with learning disabilities live lives controlled by others. If people are to have realistic choices then those who have the power and control have to ensure that choices are valid and based on real experience. This is very difficult because it implies denying choice to give experience; encouraging someone to try a new food or moving them out of a large institution, against their expressed wishes. This is done "for their own good" and it needs a whole system of checks and balances if it really is to be for the benefit of the individual service user.	If choices are to be valid they and the experiences must be specific to the needs of the individual. Of particular challenge to services is meeting the needs of people form the minority ethnic communities and offering them choices.
Improving competence	People having their gifts recognised and their abilities maintained and enhanced.	One of the major issues in relation to improving competence is to remember that ir applies to far more than practical skills. It is important for people to learn to feed themselves, catch a bus or manage their income. It is equally important to be encouraged to be competent in dealing with ones emotions and relationships; also in recognising incompetencies and developing stratifies for coping. To understand how best to help people and how to recognise the it is most important and relevant for them to acquire. To work hard to help people maintain the skills they have achieved and to help people understand that sharing and co-operating are skills that increase the competence of the community	To understand how best to help people and how to recognise the abilities it is most important and relevant for them to acquire. To work hard to help people maintain the skills they have achieved and to help people understand that sharing and co-operating are skills that increase the competence of the community.

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Promoting valued roles	People being respected and having status within their community	When a person has the key to their own front door, or gets paid for undertaking some work, that creates a massive sense of self-worth. When they are seen by others as having those and other rights and responsibilities their status is increased. The implications of this accomplishment are to increase the esteem shown to and felt by people with learning disabilities. This is most easily done in the wide range of relationships where people interact on a one-to-one basis.	Traditionally, people with learning disabilities in our society have been under valued and have lacked opportunities to take on the roles, such as employee or home-maker, that many people take for granted. The challenge is to provide services in such a way as to increase the range and number of positive roles that people with learning disabilities have. Services must show that people with learning disabilities give to society as well as receive from it.
Supporting community participation	People having a wide range of relationships with people not paid to be part of their loves	Community presence is not enough to provide real positive lives. People need to have friends, family, lovers and acquaintances in their lives to feel part of their community. Services must work hard to provide opportunities for relationships to grow and help to nurture them by avoiding, as far as possible, dis-continuity in people's lives. Links with people's past should be maintained when they move on. This means encouraging unpaid people into the lives of people with a learning disability. Perhaps someone form the congregation can accompany an individual to church, or becoming a member of the supports association can relieve the paid carer of the need to attend football matches that are of no interest. Such links in peoples lives can contribute vital stability when change occurs. None of this is a justification for leaving people with insufficient support not for ignoring the need to safeguard and protect people from, abuse, neglect or exploitation	The challenge is to find ways of building links. They do not happen automatically just because people live in ordinary house in the community. Nurturing is essential and the maintaining of life-long links with families and close friends as well as developing the new links. People whose behaviour can be seen as odd or aggressive will provide the greatest challenge to services in developing links and participation

MAHI SCTM 84 - 1103

With acknowledgement to:
Debbie Race, Planning & Development Officer
Staffordshire Joint Commissioning Group

BSW-271

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Safeguarding - Adults at Risk of Harm and Adult in Need of Protection Return.

Trust:

Month End:

	Adult in Need of Protection Activity	POC 1 (Acute)	POC 4 (Elderly Care)	POC 5 (Mental Health)	POC 6 (Learning Disability)	POC 7 (Physical & Sensory Disability)	POC 9 (Primary Health & Adult Community)	Total
2	No of APP1 referrals for adult in need of protection (APP1 section 3)							0
2.1	No of APP1 referrals screened out of protection							0
2.2	Total no of adult in need of protection risk assessments commenced							0
2.3	No of protection plans Implemented							0
2.4	No of initial strategy discussions/meetings							0
2.5	No of additional strategy discussions/meetings							0
	Of the total number recorded at 2.2, how many were managed as:							
2.6	No of Joint Protocol consultations							0
2.7	No of single agency Trust investigations							0
2.8	No of single agency PSNI investigations (PSNI only to complete)							0
2.9	No of Joint Protocol cases							0
2.10	Pre Interview Assessments							0
2.11	No of joint ABE interviews							0
2.12	No of single PSNI, ABE's (PSNI only to complete)							0
2.13	No of cases closed to adult in need of protection							0
	TOTAL	0	0	0	0	0	0	0
2.14	**Of the total no of adults in need of protection closed at 2.13, record the number who state they feel safer now as a result of the safeguarding investigation?**							
	a. I feel that I am not at all safer now							0
	b. I feel that I am not much safer now							0
	c. I feel that I am quite a bit safer now							0
	d. I feel that I am completely safe now							0
	Total	0	0	0	0	0	0	0
	Total Should equal 2.13	OK	OK	OK	OK	OK	OK	OK

2.15	No of adults in need of protection / carer's who have provided feedback at the point of closure							0

Please note an interim protection plan may be in place however the investigation has not commenced.

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Safeguarding - Adults at Risk of Harm and Adult in Need of Protection Return.

Trust:

Of the Number of concerns / referrals recorded at 2.0 (INITIALLY FOR PILOT) please detail the:

	Source/Origin of concern / referral	POC 1 (Acute)	POC 4 (Elderly Care)	POC 5 (Mental Health)	POC 6 (Learning Disability)	POC 7 (Physical & Sensory Disability)	POC 9 (Primary Health & Adult Community)	Total
3.1	*Self*							0
3.2	*Carer*							0
3.3	*GP*							0
3.4	*Learning Disability Hospital*							0
3.5	*Adult Mental Health Hospital*							0
3.6	*Acute / General Hospital*							0
3.7	*Non Acute Hospital*							0
3.8	*PSNI*							0
3.9	*MARAC*							0
3.10	*Prisons*							0
3.11	*Day Care worker*							0
3.12	*Home Care Worker*							0
3.13	*Other Trust*							0
3.14	*RESW*							0
3.15	*Housing Provider*							0
3.16	*Regulated Care Home*							0
3.17	*Supported Living*							0
3.18	*RQIA*							0
3.19	*Benefits Branch*							0
3.20	*Vol organisation*							0
3.21	*Anonymous*							0
3.22	*Other*							0
	Total	0	0	0	0	0	0	0
	Total Should equal 2.0	OK	OK	OK	OK	OK	OK	OK

Of the Number of concerns / referrals recorded at 2.0 (INITIALLY FOR PILOT) please detail the PRIMARY category of abuse, exploitation or neglect.

	Category of abuse	POC 1 (Acute)	POC 4 (Elderly Care)	POC 5 (Mental Health)	POC 6 (Learning Disability)	POC 7 (Physical & Sensory Disability)	POC 9 (Primary Health & Adult Community)	Total
4.1	*Physical Abuse*							0
4.2	*Psychological / Emotional Abuse*							0
4.3	*Sexual Abuse*							0
4.4	*Financial Abuse*							0
4.5	*Neglect*							0
4.6	*Exploitation*							0
4.7	*Institutional Abuse*							0
	Total	0	0	0	0	0	0	0
	Total Should equal 2.0	OK	OK	OK	OK	OK	OK	OK
	Of the numbers of concerns / referrals recorded at 2.0 (INITIALLY FOR PILOT), how many are being considered as -							
4.8	*Sexual/Domestic Violence*							0
4.9	*Human Trafficking*							0
4.10	*Hate Crime*							0
	Total	0	0	0	0	0	0	0

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Safeguarding - Adults at Risk of Harm and Adult in Need of Protection Return.

Trust:

Of the number of concerns / referrals at 2.0 (INITIALLY FOR PILOT), please detail the location where the incident took place

	Location of Incident	POC 1 (Acute)	POC 4 (Elderly Care)	POC 5 (Mental Health)	POC 6 (Learning Disability)	POC 7 (Physical & Sensory Disability)	POC 9 (Primary Health & Adult Community)	Total
5.1	*Own home*							0
5.2	*Day Care Settings*							0
5.3	*Public place*							0
5.4	*Nursing Home*							0
5.5	*Residential Home*							0
5.6	*Supported Living*							0
5.7	*Adult Placement*							0
5.8	*Short break*							0
5.9	*Adult Hostel*							0
5.10	*Adult Mental Health Hospital*							0
5.11	*Learning Disability Hospital*							0
5.12	*Acute / General Hospital*							0
5.13	*Non acute hospital*							0
5.14	*Prison/Police custody*							0
5.15	*Other*							0
	Total	0	0	0	0	0	0	0
	Total Should equal 2.0	OK	OK	OK	OK	OK	OK	OK

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Supplementary Guidance Notes

2.0 ***Total number of APP1 referrals for an adult in need of protection***
This figure relates to he total number of adult in need of protection referrals in the reporting period by Programme of Care, whether or not the referral was screened in or out of protection

2.1 **Number of APP1 referrals screened out of adult in need of protection**
This is the number of referrals that do not meet the threshold for a protec ion response and are referred for an alternative response.

2.2 ***Number of adult in need of protection risk assessments commenced***
This figures refers to the number of adult in need of protection risk assessments (APP3) that commence wi hin the reporting period

2.3 **Number of protection plans implemented**
The care and protection plan is a report agreed with the adult at risk (or the person representing them or their best interests) detailing the actions to be taken, with timescales and responsibilities, to support and protect he person from harm, this report will be produced by the Investigating Officer or/and the Designated Adult Protection Officer. This figure relates to the total number of protection plans hat are developed and implemented in the reporting period.

2.4 **Number of initial strategy discussions / meeting**
This includes all inititial strategy discussion, telephone stategies; face to face meetings

2.5 **Number of additional strategy discussions / meetings**
This includes all addititional mee ings / discussions / telephone strategies/ reviews / case discussions/ case conferences

2.6 **Total Number of Joint Protocol Consultations**
This figure is the total number of Joint Protocol consulations between the Trusts and PSNI in the reporting period, irrespective of outcome in line with the regional Joint Protocol.

2.7 **Total number of single agency Trust only investigations**
This figure relates to all HSC Trust investigations **commenced** during the reporting period. An Investigation is the process used by a single agency to establish the facts and contributing factors leading up to he referral. This process will be used to iden ify and manage risks for the patient/ client

2.8 **Total number of Single agency PSNI investigations (PSNI only to complete)**
This figure relates to investigations relating to an adult in need of protection **commenced** by PSNI in the reporting period

2.9 **Total number of Joint Protocol Cases**
This is the total number of cases that have commenced and are being join ly managed under he Joint Protocol arrangements. This will include cases where the PSNI are leading the single agency investigation and the HSC Trust is working collaboratively to support this process.This protocol relates to adults in need of protection where the harm caused by abuse, neglect or exploitation constitutes a criminal offence. It sets out requirements to ensure that the welfare and protection needs of the adult in need of protection are met as fully as possible. Throughout the Joint Protocol process HSC trusts and PSNI will work in partnership to take these needs into account.

2.10 . **Total number of Pre Interview Assessments**
This is an initial interview under the Joint Protocol arrangements with the vulnerable witness to determine their wishes in progressing with a statement of complaint through the criminal justice process.This is the total number of PIA's completed in the reporting period.

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2.11 . **Total number of Joint ABE interviews**
These are separate interviews required under Achieving Best Evidence conducted jointly by the PSNI and HSC Trust to assist an adult in need of protection to provide a full statement to the PSNI. This includes he number of ABE interviews conducted jointly by PSNI and SW. It is not the number of ABE cases, but aims to reflect the number of interviews that take place.

2.12 . **Total number of single PSNI ABE's (PSNI only to complete)**
Total number of ABE's interviews completed by 2 ABE police officers where the adult is deemed to meet he definition of an adult in need of protection

2.13. **Total number of cases closed to adult in need of protection**
This figure refers to the number of cases where the adult in need of protection activity ceases and the protection plan is terminated. Where a case is transferred to be managed through alternative safeguarding responses or monitored through o her Trust processes he case is deemed to be closed to adult protection.

2.14. **Total number of adults in need of protection cases closed at 2.13, record the number who state they feel safer now as a result of the safeguarding investigation?**
This figure relates to the number of individuals who have been through an adult protection process and whose case is now closed at 2.13. The return should indicate the number of individuals who record their response under a - d.

2.15. **Total number of adult in need of protection feedback survey's completed**
This figure refers to the number of completed surveys / questionaires etc. ie 10,000 Voices; where service user and / or carer feedback has been collated as part of a formal process for quality improvement and service development

3.0 **Source / Orgin of concern / referral**
This section refers to the service / team / dept / agency etc that is reporting the concern or making the referral and he total number recorded at 3.0 should equate to the total number of concerns / referrals recorded at 2.0 (INITIALLY FOR PILOT)

4.0 **Primary category of abuse**
It is acknowledged that abuse often occurs in multiple forms and is recorded on the referral forms as meeting the definitions of different types of abuse. In this section, please record the PRIMARY form of abuse that is being alleged in the concern / referral. Record each client only once, category of abuse should be recorded in order of severity. The total numbers recorded in 4.0 should equate to that recorded in 2.0 INITIALLY FOR PILOT

4.8 **Number of concerns / referrals recorded at 2.0 (INITIALLY FOR THE PILOT) that are being considered as Sexual /Domestic violence; Human Trafficking ; Hate Crime**
The numbers recorded here may also be recorded in 4.0 above reflecting the type of abuse reported hat are linked to o her definitions.

5.0 **Location of incident**
This refers to the place where the alleged harm / abuse occurred. The total number recorded here should equate to the total number of referrals recorded at 2.0 (INITIALLY FOR PILOT)

Programmes of Care

Programmes of Care are the broad categories of service users. Programmes of Care are used to target resources effectively and to help organise services.
The Main Programmes of Care for Adult Safeguarding are:
PoC 1 – Acute/Hospital care
PoC 4 – Elderly / Older people, including Dementia
PoC 5 – People with mental health issues, including Child & Adolescent Psychiatry
PoC 6 – People with a learning disability. This should include both adults and children with autism.
PoC 7 – People with a physical or sensory disability
PoC 9 – Primary Health and Adult Community - GPs, Dentists, Oph halmic Practitioners, Pharmacists and patients aged 16-64, with primary reason for contact o her than mental illness, learning disability or physical and sensory disability
Adult safeguarding is not applicable for POC 2 - Maternity and Child Health, POC - Family & Childcare, POC 8 Health Promotion and Disease Prevention

Belfast Health and Social Care Trust

caring supporting improving together

Belfast Local Adult Safeguarding Partnership (LASP)

Annual Report 2018/2019

CONTENTS

SECTION 1: Overview

The Belfast Health and Social Care Trust is committed to promoting the health, well-being and protection of all adults in receipt of its services across the spectrum of its universal and specialist provision including domicilliary and day care services, residential care, nursing home care, supported living and respite care provided by or commissioned on behalf of the Trust.

The Local Adult Safeguarding Partnerships (LASPs) are located within each of the Health and Social Care Trust areas. The role of LASPs is to implement Northern Ireland Adult Safeguarding Partnership (NIASP) guidance, policy and procedures at a local level. Membership is drawn from local statutory, voluntary, independent and community sectors, including representation from Criminal Justice Agencies, Local Commissioning Groups, Local Authorities and the Faith Community.

The annual LASP work plan is reviewed under the three core themes contained in Adult Safeguarding Prevention and Protection in Partnership (2015).

The report includes an update from each Trust service area in relation to adult safeguarding, with each service area detailing challenges, achievements and activity levels.

LASP partner organisations are also provided with an opportunity to detail adult safeguarding work undertaken within their organisation during the reporting year.

SECTION 2: Work plan for Reporting Period Achievements and Challenges

PROTECTION

Adult Safeguarding Structures within the Belfast Trust

Currently within the Belfast Trust each service area have their own separate arrangements in place for delivery of adult safeguarding. While these service area arrangements have been effectively delivering on adult safeguarding work for a number of years, it had been agreed that the current structures would be amended to reflect the requirements of the Prevention and Protection in Partnership Policy 2015. The Department of Health (DOH) Policy details the structures required within Trusts in terms of a single Adult Protection Gateway Service.

The Trust took the decision to develop a single Adult Protection Gateway Service and remains committed to delivering on this objective. This work has been delayed due to other operational priorities but the Trust remains committed to developing a Trust wide Adult Protection Gateway Service.

Work in relation to the development of this new Adult Protection Gateway Service will be progressed by the Trust Adult Safeguarding Specialist (TASS) and the three divisional social workers for each service area.

Adult at Risk of Harm work

The Trust recognises the importance of ensuring that there are robust arrangements in place in response to adults at risk of harm when the threshold for an adult protection investigation has not been met. The need for professional risk assessment/risk management strategies and alternative safeguarding responses is recognised as pivotal to the safety and welfare of this group of service users. There is also a need to ensure that effective governance and monitoring arrangements are in place for adults at risk of harm. As detailed in the Older Peoples Core team service area report, work is currently underway to develop the necessary tools to ensure that this important area of work is appropriately and effectively addressed.

Role of the Adult Safeguarding Champion (ASC)

The Belfast Trust ASC is accountable to the Executive Director of Social Work for the discharge of their role. Given the size of the Trust, the ASC role has been delegated down through the current reporting structures, with first line managers being responsible for the operational delivery of the role. Within social work, many of these line managers are already trained DAPOs and are therefore very familiar with the ASC role and where this fits within the wider adult safeguarding structures and reporting arrangements.

Adult safeguarding training for line managers has been amended to ensure staff are fully briefed on the ASC role and responsibilities. There is a need for widespread training of

line managers to ensure that they are fully briefed on their role as ASCs but given limited resources this is currently being managed on a phased basis. In the interim any adult safeguarding referrals received by a DAPO not meeting the threshold for an adult protection investigation will result in advice being given regarding the need for a professional assessment and alternative safeguarding response.

RQIA inspection in Hospital Outpatient Departments across the region

An RQIA Review of Outpatient Services in hospital settings identified a lack of knowledge among staff (medical and nursing) in relation to adult and child safeguarding. The Belfast Trust drafted an action plan in response to issues identified. Of particular note are proposals to develop a new Adult Safeguarding Nurse Specialist post similar to the current Specialist Nurse Child Protection posts. It is anticipated that this will help ensure adult safeguarding is embedded in the acute sector. Job descriptions are currently being drafted

Regional Joint Protocol

The primary aim of the regional Joint Protocol 2016 is to ensure that adults at risk of harm who have experienced harm which constitutes a criminal offence have equal access to the justice system. The Protocol further seeks to promote a rights based approach in relation to the individual's views and wishes. In this reporting period Trust adult safeguarding staff continue to view as positive the limited discretion within the Protocol which facilitates a sensitive and proportionate response. Trust staff have, however, also continued to report instances when there are differences between PSNI and Trust in relation to the interpretation and scope of the Protocol. The Protocol includes a process of escalation where there is a difference of opinion between Trust and PSNI and this has been used appropriately and effectively.

A review of the Joint Protocol is ongoing and practice issues identified are being addressed within the review process. The working group taking forward this review includes representatives from Trusts and PSNI. RQIA, as co-signatories to the Joint Protocol, have also provided an input into this review. The review had been put on temporary hold at PSNI's request and was further delayed as a result of the Belfast TASS sick leave. The working group has reconvened and has held a two-day workshop in Garnerville. It is hoped that a first draft of the revised Joint Protocol will be available for consultation in June/July 2019.

Scamwise

Scamwise Northern Ireland Partnership have produced the fourth edition of the 'Little Book of Big Scams' and have shared these books with Trusts for onward circulation. The Trust welcomes the opportunity to assist with this very significant area of financial abuse.

PSNI are also in their second year of a rolling programme to raise awareness of financial abuse and in particular scams. Year one focused on training Trust domiciliary care workers in order to heighten their awareness of potential scams, so that they could assist vulnerable service users in early identification and scam avoidance. Now in year two the

Trust are working with relevant PSNI scam prevention officers to facilitate training of independent sector domiciliary care staff. Feedback from Trust staff in year one was very positive and it is anticipated that this success will be mirrored in year two.

COPNI Report and Independent Review commissioned by Department of Health

The COPNI report Home Truths and the issues of concern highlighted within this report have formed the basis of an action plan at regional and local Belfast Trust level. Belfast Trust have participated fully in regional meetings to discuss and address issues raised and have also been looking at Trust practice at a local level.

The Trust has welcomed the independent review commissioned by DOH and have met with the Independent Review Panel to discuss its role in relation to Dunmurry Manor.

More recently DOH notified each Trust to submit an anonymised list of all adult safeguarding referrals commenced in nursing homes during the period 01.03.17.-28.02.19. They subsequently clarified that this list should include nursing, residential and supported living. Trusts were advised that CPEA would be conducting an audit in relation to 50 files which would be randomly selected from the list submitted. Belfast Trust have submitted lists as per DOH requirement and await clarification on files submitted for audit. In addition, on 12 March 2019 the CPEA independent review team held a working session for social work practitioners involved in adult safeguarding cases in Dunmurry Manor Nursing Home. Each Trust was asked to nominate 8 practitioner staff to attend this event. Belfast Trust practitioners in attendance at this session reported that it provided a useful opportunity to reflect on practice and consider areas for improvement.

The current culture is one of openness, reflection and learning and the Belfast Trust have embraced opportunities to reflect on current practice.

Belfast Trust Learning and Reflection Workshop

The Trust Adult Safeguarding Champion organised a Belfast Trust adult safeguarding workshop with a focus on reflection and learning. Margaret Flynn facilitated this workshop, which was well attended by adult safeguarding staff across all programmes of care. Members of the Trust collective leadership teams also attended, as did senior consultants and senior nurse colleagues. Margaret Flynn shared with the group the themes and issues that had emerged from her extensive portfolio of conducting high-profile reviews such as Winterbourne View and Operation Jasmine. The themes and initial learning from her review in relation to Muckamore Abbey Hospital were also discussed and she touched on some of the initial learning from the COPNI and DOH independent review in relation to Dunmurry Manor. The workshop was very interactive and allowed for a reflective discussion on adult safeguarding experience and practice within the Belfast Trust. The work from this session will inform Belfast Trust adult safeguarding practice going forward.

Pressure Ulcers within an Adult Safeguarding Context

HSCB and PHA gave a commitment to develop a regional Safeguarding Adults Protocol in relation to the interface between pressure ulcers and adult safeguarding. A regional working group was established and the Belfast TASS contributed to this by convening a

regional meeting to look specifically at the threshold/criteria for referral of pressure ulcers into an adult protection process. Specifically, the group were tasked with looking at the Department of Health (DOH) England 'Safeguarding Adults Protocol - Pressure Ulcers and the Interface with a Safeguarding Enquiry' (January 2018), to consider whether this would meet the needs in a Northern Ireland context. This group drafted initial views and this work helped inform a regional workshop on 10th October 2018. HSCB and PHA have since drafted a guidance document in relation to the management of pressure ulcers and this is currently out for consultation.

The Belfast Trust Adult Protection Gateway Team have previously made referrals to police under Article 121 of the Mental Health Act in relation to potential wilful neglect. As noted in the APGT service area report, the Public Prosecution Service have taken the decision in one case to refer to PHA. The Belfast Trust welcomes plans to reach a regionally agreed position in terms of the interface between adult safeguarding and pressure ulcers.

Capacity Assessments

In April 2019 the Trust received confirmation from the Royal College of Psychiatrists NI that a decision had been taken that Financial Capacity Assessments would not form part of core NHS work for Consultant Psychiatrists. The view taken was that financial capacity assessments can often be complex, requiring the obtaining and assimilation of much information in addition to detailed clinical assessments. The decision to deem a Patient incapable of managing their financial affairs can have far reaching consequences. In addition, there may be a perceived conflict of interest in cases where the Trust has asked for a Financial Capacity Assessment and a Psychiatrist is acting as an officer of that Trust.

The consensus view from the Royal College of Psychiatrists is that Financial Capacity Assessments are not part of core NHS work for Consultant Psychiatrists; rather they are special medico legal or category 2 work. As such, our opinion is that Consultant Psychiatrists are not obliged to carry out this work as part of their job plans. The only exception to this is when a Patient is detained as an inpatient under the Mental Health (NI) Order 1986, when a Consultant acting as RMO may carry out a Financial Capacity Assessment if necessary as part of that Patient's care. There may be other exceptional clinical circumstances when a Consultant may conduct a Financial Capacity Assessment in cases of immediate clinical need.

Trusts were advised of the need to make alternative provisions for these assessments. This will have significant implications for the Trust and for Adult Safeguarding in terms of financial abuse allegations. While the number of Trust assessments privately funded is currently quite low, it is anticipated as a result of this notification there will be a need for the Trust and Adult Safeguarding to be clear regarding arrangements in place going forward.

The issue of capacity to consent to and/or contribute to a police investigation is an important element of Adult Protection work and Joint Protocol. To date the Trust have provided these assessments when required and occasionally have needed to fund these privately. Police are of the view that Trusts are best placed to provide these assessments. In light of the Royal College of Psychiatrists' position in relation to financial capacity assessments, there will be a need to clarify their position in relation to capacity assessments for Joint Protocol.

Complex Investigations

Central to the work of Adult Protection is the management and co-ordination of complex investigations, many of which relate to large scale investigations in regulated services. These investigations are resource and time intensive and are managed within the context of competing priorities. The multi-agency nature of many of these large-scale investigations, along with issues associated with working across Trust boundaries, can be challenging. For the agencies who have staff subject to investigation, protection plans can also be resource intensive. **As detailed in the Learning Disability service area report, the Muckamore Abbey Hospital adult protection investigation is ongoing. The work involved in this investigation is critical to the safety and welfare of the patients and is a key priority for the Belfast Trust.**

Adult Safeguarding / Adult Protection Funding

The Trust welcomes the additional funding provided in relation to adult safeguarding work.

The non-recurrent funding of £39,400 was utilised to help fund the Muckamore Abbey Hospital adult protection investigation. It is important to note that this investigation is very time and resource intensive. Funding of this investigation and any subsequent investigations of this scale will require ring-fenced funding from DOH.

The recurrent funding of £112,000 is also welcomed and the Trust are currently considering how best to utilise this additional funding. There are competing priorities for this funding, as each service area could benefit from additional DAPOs to support their work in complex adult protection investigations.

The Trust had in previous reports highlighted the need for additional funding in relation to adult safeguarding training and delivery of adult safeguarding training continues to be a challenge for the Trust.

Data Returns

The Belfast Trust continues to collate HSCB monthly data returns manually and as in previous years this has proved challenging. Priority is understandably given to casework and this has resulted in collation of information being a secondary consideration. The Trust continue to struggle to ensure accuracy in collation of information and to avoid duplication in terms of statistical returns. **The new HSCB reporting template was implemented in October 2018 and is currently subject to regional review. It continues to be the aim of Belfast Trust to ensure that the new Adult Safeguarding Module on Paris will provide the necessary statistical collation. Work in relation to this is ongoing.**

PARTNERSHIP

Belfast LASP

The Belfast LASP normally meet quarterly but due to TASS extended sick leave, only three meetings were held within this reporting period. Attendance at LASP meetings has fluctuated this year, in part due to changes in named LASP representatives for partner organisations.

The LASP work plan for 2018-19 has also been impacted by TASS sick leave and TASS operational pressures associated with work in Muckamore and back-fill in the Adult Protection Gateway Team. There is a need to re-energise Belfast LASP in terms of membership, focus and an achievable work plan for 2019-20, which is inclusive of the aims and objectives set by NIASP and by LASP members.

Policing & Community Safety Partnership (PCSP)

The TASS continues to represent adult safeguarding on the South Belfast PCSP. Adult safeguarding continues to be an established area of work in terms of the PCSP Action Plan. There is currently a project in South Belfast - Growing Older Growing Safer, which aims to increase the safety of older people in South Belfast with access to prevention, early intervention and protection. The project supports community guardians who will provide support and information to organisations and individuals with regard to keeping themselves safe.

On 7 March 2019 the PCSP held a community event for seniors in the Finaghy Road area of Belfast. A local councillor and the Lord Mayor were in attendance. This event included a number of information stalls, one of which was a Trust-manned stall providing information on adult safeguarding, local Trust services and self-directed support. The event was well-attended and feedback received on the day was positive.

NIASP

The TASS continues to represent Belfast Trust at a regional level on NIASP. TASS attendance at NIASP facilitates the sharing of information from NIASP to LASP. LASP members view this as a key positive as it ensures they are kept updated on regional issues and regional developments.

Human Trafficking

In November 2018 Trusts were issued with an updated version of the Working Arrangements for the Welfare and Protection of Adult Victims and Potential Victims of Human Trafficking & Modern Slavery. This guidance document was jointly issued by DOJ, Police and HSCB and had been developed in discussion with DOH. As the NIASP representative on the DOJ Engagement Group, the Belfast TASS has been working with the Modern Slavery Strategic Training & Data Coordinator in the Protection & Organised Crime Division / Modern Slavery & Human Trafficking Unit, to look at raising awareness

of the guidance document and the role of Trusts. An initial information session has taken place with the regional TASSs and work is planned with the regional training group. It is anticipated that bespoke training for key staff will be devised. The conduit for taking forward this work is that it will fall within the remit of adult safeguarding. The Belfast TASS and the South Eastern Trust TASS are currently working on a proposal in relation to a Trust internal referral pathway.

Domestic & Sexual Violence and Abuse Partnership / MARAC

Trust Adult Safeguarding are represented on the Belfast Area Domestic & Sexual Violence & Abuse Partnership by the TASS. Attendance at meetings has been problematic due to sick leave and competing operational priorities. That said, there is relevant communication with the Chair of the Partnership. The TASS had chaired the MARAC work-stream but this had been put on hold following changes at regional level, which included the MARAC Operational Group being disbanded. It is understood that a new strategic MARAC Operational Board has been established with Terms of Reference and objectives set. The Belfast MARAC will reconvene to ensure delivery of regionally agreed objectives.

Domestic Violence & Abuse Disclosure Scheme

The Domestic Violence & Abuse Disclosure Scheme, launched in March 2018, continues to function following MARAC meetings. Issues around information sharing and the decision making forum continue to present challenges.

PREVENTION

Adult Safeguarding Training

The BHSCT delivers the 5 levels of Adult Safeguarding training as outlined in the NIASP Training Strategy and Framework (revised 2016). These 5 levels are designed to equip staff of different bands develop the knowledge and skills commensurate with their job role and experience to support adults in need of protection and to promote staff confidence and competence in effectively carrying out their adult safeguarding role. The Training Strategy is compatible with the Adult Safeguarding Policy 2015, Regional Operational Procedures, 2016 and the Joint Protocol, and all training materials are designed to raise standards, promote best practice and ensure consistent and proportionate responses to safeguarding issues. Training is provided for all levels and our specialist Investigating Officer/Designated Adult Protection Officer and Joint Protocol Trained staff are supported through quarterly support group workshops.

This year the Learning & Development service has continued to deliver to social work and social care staff and due to the high level of demand from other programmes of care, we reserve a number of places for any Belfast Trust employee whose primary role is work with adults. There continues to be requests from many different service areas and we have delivered some bespoke training to try to meet these demands. Lifeline staff became Belfast Trust employees and they received bespoke level 1 adult safeguarding training. Other examples include Estate services and Palliative Care staff. However, there remains concern that we continually have to turn down requests and in this last year, in particular from medical staff including staff from the GUM clinic, Geriatric services, psychiatry, nursing and OT services. While they access a limited number of places on the awareness raising courses concern remains that they do not appear to have access to Adult safeguarding training for the numbers required. This in turn highlights the potential that the implementation of the Regional Operational Procedures and Joint Protocol is not standardised across these different service areas.

There continues to be a high demand for Level 1 Adult Safeguarding awareness raising and mandatory refresher courses. The RQIA requirement for the social care workforce to attend Awareness Raising training is the primary driver supporting compliance. The requests for bespoke training for these service areas is considerable. The Learning & Development team continue to respond to requests for bespoke training. For example, this year we delivered bespoke awareness raising training to new staff in the Mental Health Assessment teams and a 2 day bespoke training for both investigating officers and designated adult protection officers within the mental health POC. A further example was 2 sessions in Muckamore Abbey regarding quality recording in the Adult Protection referral forms.

Several programmes of care are continuing to undergo reorganisation and it is anticipated that these programmes of care will require additional training to develop confidence and competence in relation to screening referrals at ASC/Line management level and in relation to quality recording in all APP forms. This will have an impact on resources within the training team.

Action 2019 – 2020:

- To ensure that all training material is contemporary and compatible with 2015 and 2016 Policy & Procedures to ensure staff are knowledgeable about roles and responsibilities in adherence to regional requirements.

- To continue to support staff through the quarterly facilitation of practice support groups for staff undertaking the roles of IO, DAPO and Achieving Best Evidence interviews. This ensures that staff are cognisant of the current NIASP strategy and that issues from a staff perspective are understood. It also involves inviting speakers and sharing relevant adult safeguarding research to ensure staff are aware of up-to-date developments related to adult safeguarding.

- To continue to sustain and develop effective relationships with PSNI and Regional Adult Safeguarding trainers in the delivery of the NIASP training strategy.

- Continue to be committed to meet workforce needs in working towards full implementation of the regional policy and procedures. It has been emphasized that these documents are 'live' documents' and therefore it is imperative that staff are kept updated in relation to on-going changes.

- To deliver bespoke training to reorganized POC's to ensure confidence / competence in relation to screening and thresholds that are compliant with the 2016 Regional Policy and that recording of required forms are of a high quality.

LASP Prevention Group

The focus of the LASP prevention group continues to be compatible with the NIASP strategic plan 2013 -2018. The group meets on a quarterly basis and membership of is derived from voluntary and statutory sectors. The group continues to increase awareness of adult safeguarding to communities through the well-established projects that have been developed and sustained.

A review of the Keeping You Safe project was completed in July 2018 and the outcome was that while large numbers received the training the number of active staff delivering the training was low due to a variety of reasons including staff moving to new posts, retiring or leaving the trust. Existing staff attended an update session in July and this was well received and achieved the aim of ensuing that Adult Safeguarding messages are standardized and consistent with current policy. The programme was evaluated positively and is viewed as a very useful resource for service users. This will continue to be delivered across a range of regulated facilities and in all service groups. There continues to be an additional session for new staff who want to deliver this training and this was likewise well attended and evaluated. This is a very important project as it is designed to empower service users to recognize abuse and know who to talk to if concerned. It is imperative that the current staff trained to deliver this programme to service users are supported and encouraged to continue to remain involved. It is equally important that new staff are recruited on a yearly basis to ensure that key adult safeguarding messages are far reaching and that service users are involved as co-facilitators.

Towards the end of the last year the group considered developing a DVD to assist in the delivery of adult safeguarding messages but subsequently decided against this project as a more regional one was being developed and there was a risk of duplication. This may be revisited, as the thought process was a DVD to be shown to service users as opposed to staff.

The group continues to meet on a quarterly basis and will focus on organizing workshops for ASC's in commissioned services who are now required to complete a yearly return position report. The aim of these workshops will be to establish the level of confidence in relation to completing these forms and will assess understanding of commissioned services understanding of the position report, what are the expectations and what support will they require going forward.

Adult Safeguarding Training Activity	No. of candidates attended	No. of courses held during the reporting period
ABE 5 Day	16	1
ABE 7 Day	2	1
ABE Practice Support Group	24	3
ABE Refresher	8	3
Adult Safeguarding Level 1 Awareness	424	20
Adult Safeguarding Level 1 Refresher	671	43
Adult Safeguarding Level 2	52	3
Adult Safeguarding Level 3 Investigating & Designated Officers	61	3
Adult Safeguarding Level 4 Joint Protocol	24	1
Chairing Skills for Designated Officers	22	3
Court Skills (IO/DAPO)	14	1
Designated Officers Practice Support Group	49	4
Investigating Officers Practice Support Group	181	4
Keeping You Safe for Facilitators	31	2
Keeping You Safe Review	12	1
LASP Prevention Group	26	4
MARAC	29	2

Period – 1st April 2018 – 31st March 2019

SECTION 3: Belfast Trust Adult Safeguarding Activity Returns

Chart 1: Belfast Trust Safeguarding Referral Rates April 2011 - March 2019

Chart 2: Belfast Trust Monthly Safeguarding Referral Rates by Service Area April 2018 – March 2019

Chart 3: Belfast Trust breakdown of Adult Safeguarding Activity by Service Area

Chart 4: Table of Percentage Increase / Decrease in Adult Safeguarding Activity

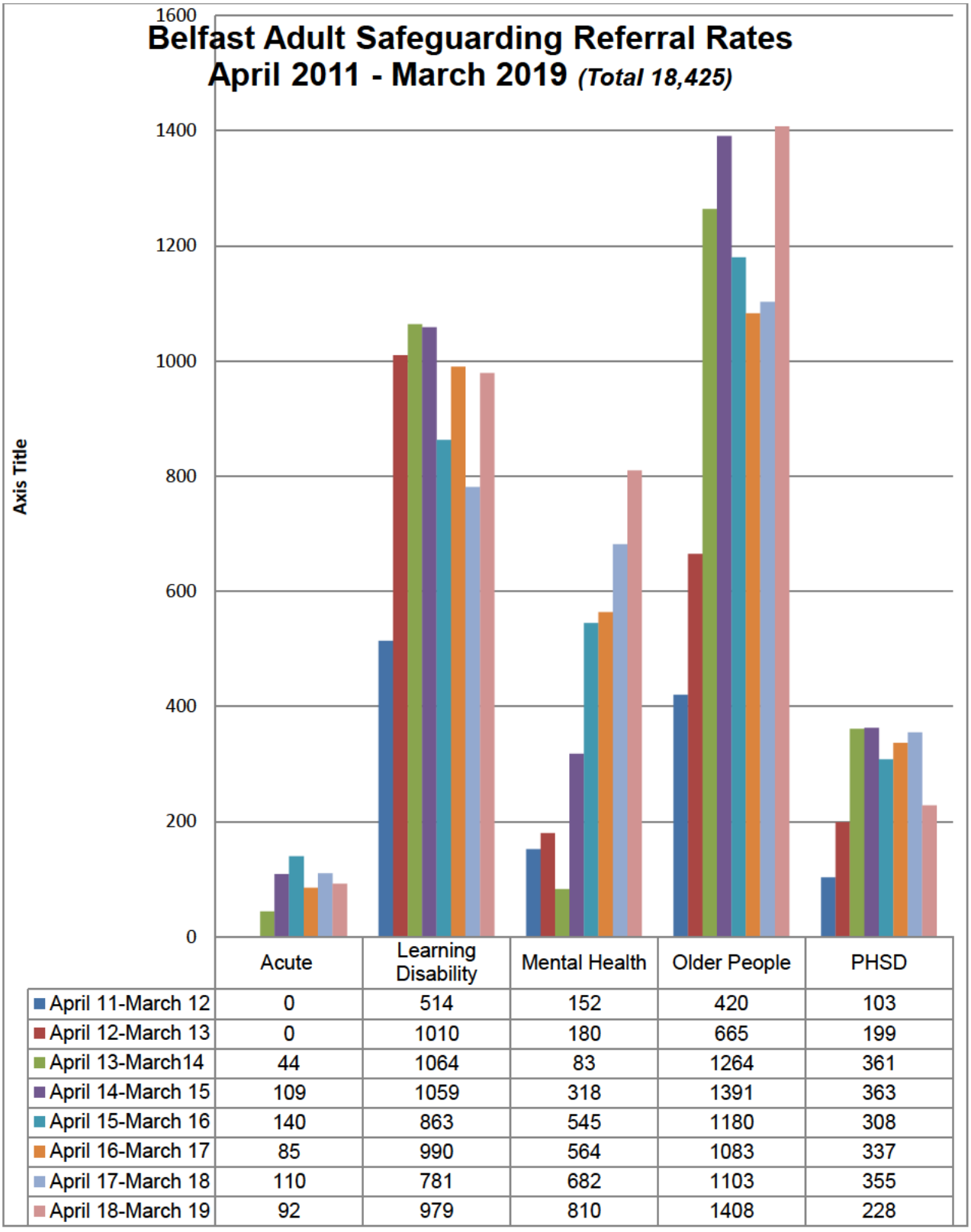
Data Returns

Analysis of data returns is included in each service area report. This section therefore focuses on the overall position in relation to the Belfast Trust statistical returns.

As detailed earlier in the report, the Belfast Trust continue to find the current system of manual collation challenging. The Trust are working with Paris developers to set up a system where in future this information can be collated directly from Paris.

In this reporting period April 2018 to March 2019 the Belfast Trust received a total of 3,517 referrals. 1,723 of these referrals resulted in an adult protection investigation. There is clearly significant work to be done to ensure more accurate reporting of adult protection cases. This will be a key piece of work for Belfast Trust in the coming year.

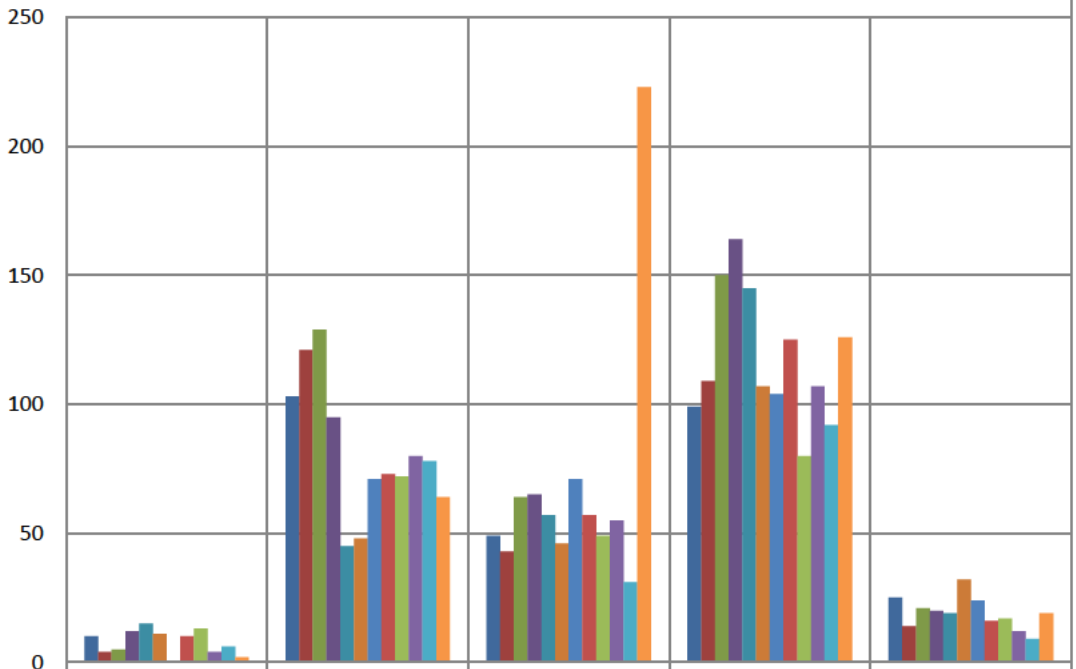
CHART 1



	Acute	Learning Disability	Mental Health	Older People	PHSD
April 11-March 12	0	514	152	420	103
April 12-March 13	0	1010	180	665	199
April 13-March14	44	1064	83	1264	361
April 14-March 15	109	1059	318	1391	363
April 15-March 16	140	863	545	1180	308
April 16-March 17	85	990	564	1083	337
April 17-March 18	110	781	682	1103	355
April 18-March 19	92	979	810	1408	228

Referral rates have continued to rise year on year.

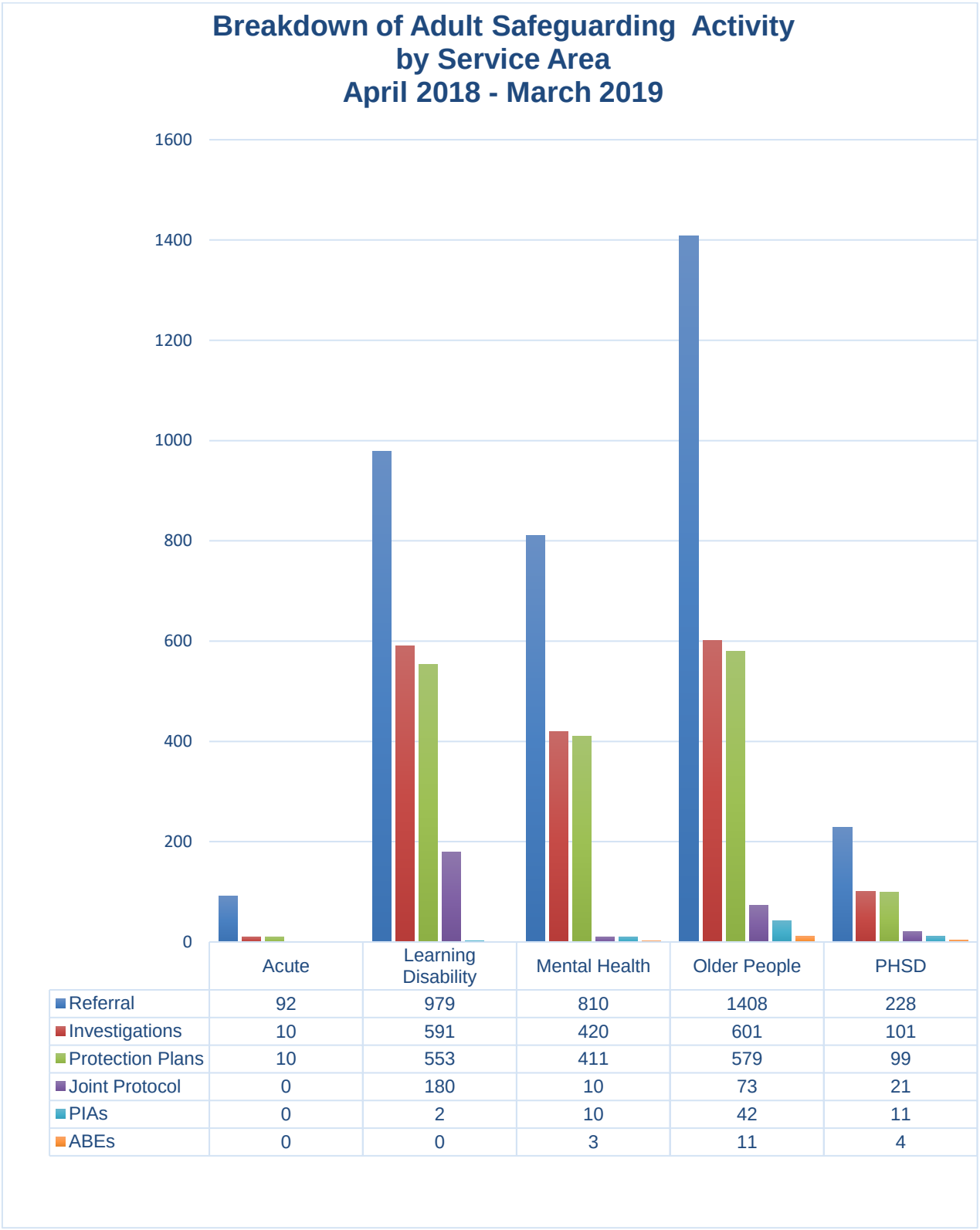
Adult Safeguarding Referral Rate by Month
April 2018- March 2019



	ACUTE	LEARNING DISABILITY	MENTAL HEALTH	OLDER PEOPLE	PHSD
April	10	103	49	99	25
May	4	121	43	109	14
June	5	129	64	150	21
July	12	95	65	164	20
August	15	45	57	145	19
September	11	48	46	107	32
October	0	71	71	104	24
November	10	73	57	125	16
December	13	72	49	80	17
January	4	80	55	107	12
February	6	78	31	92	9
March	2	64	223	126	19

Note: astronomical data point for MH, March 2019 is due to non-reporting of data by specific teams during the year, then reporting in a cumulative manner for March 2019. Unable to separate into individual months.

CHART 3



	Acute	Learning Disability	Mental Health	Older People	PHSD
Referral	92	979	810	1408	228
Investigations	10	591	420	601	101
Protection Plans	10	553	411	579	99
Joint Protocol	0	180	10	73	21
PIAs	0	2	10	42	11
ABEs	0	0	3	11	4

The differential between referrals and investigations across each of the service areas highlights that, in real terms, the numbers of adult protection investigations is significantly less than would first be perceived, e.g. Older People 1408 referrals, only 610 resulted in an adult protection investigation, meaning that less than 50% resulted in an adult protection investigation.

MAHI - STM - 184 - 1126

CHART 4

Table Of Percentage Increase/Decrease In Adult Safeguarding Activity Years 17/18 to 18/19

Service Area	Referrals		Investigations		Protection Plans		Joint Protocol		PIAs		ABE Interviews	
Years	17/18	18/19 +/- %	17/18	18/19 +/- %	17/18	18/19 +/- %	17/18	18/19 +/- %	17/18	18/19 +/- %	17/18	18/19 +/- %
Acute Sector	110	92 -16%	6	10 +67%	4	10 +150%	0	0 NC	0	0 NC	0	0 NC
Learning Disability	781	979 +25%	352	591 +68%	343	553 +61%	34	180 +429%	0	2 *	1	0 -100%
Mental Health	682	810 +19%	364	420 +15%	362	411 +41%	21	10 -52%	12 -	10 -17%	9	3 -67%
Older People	1103	1408 +28%	448	601 +34%	444	579 +30%	58	73 +26%	24	42 +75%	12	11 -8%
PSD	355	228 -36%	131	101 -23%	129	99 -23%	14	21 +50%	10	11 +10%	2	4 +100%

SECTION 4: Service Area Reports

PHYSICAL & SENSORY DISABILITY

Within the reporting period there have been 144 Adult Safeguarding referrals. 26% of this activity was assessed as not appropriate for the safeguarding frameworks. 43% were assessed and considered as level three activity and were subsequently managed by the Adult Protection Gateway Team with protection plans being implemented by that team. The remaining 31% were subject to investigation and protection planning from within the service area.

There has been a continued appropriate reporting of quality concerns with 33 referrals within the reporting period. This reflects the pattern in the previous reporting period and would suggest that professional staff continue to correctly utilise alternative safeguarding response processes.

All relevant staff in the community teams are trained to Designated Adult Protection Officer or Investigative Officer level. The updated Adult Safeguarding Operational Procedures were implemented in the service area in June 2017 and the Belfast Trust Training Team provided additional training to all relevant staff. Staff have continued to embed the Operational Procedures into practice.

The implementation of the Operational Procedures and the Designated Adult Protection Officer role has been positive within the service area. The Designated Adult Protection Officers in the service area make decisions upon the thresholds for all referrals and are responsible for activity relevant to situations involving adults at risk of harm, including the consideration of alternate safeguarding responses and the investigation of adult safeguarding concerns. Therefore, there are no referrals/consultation with the Adult Protection Gateway Team in relation to those adults as defined within the Operational Procedures as being 'at risk of harm'. The service area continues to find the transition positive for service users; it has reduced delay in decision-making, by eliminating the transfer of cases to the Adult Protection Gateway Team to await their decision-making and has improved service user experience by ensuring that the core team staff maintain involvement without interruption. However administrative demands continue, the service area has a limited number of minute takers and discussions continue regarding how this pressure can be relieved.

Across the reporting period, interface challenges with the Adult Protection Gateway Team remain. This primarily relates to consistency and clarity in decision making within referrals involving suspected criminal activity, wherein the Protocol for Joint Investigation is required; and cases being accepted for investigation involving 'adults in need of protection'. It is apparent that challenges remain regarding differences in operational understanding of this Protocol between the Belfast Trust and the PSNI. Such instances have caused delay, and it has been necessary for a small number of cases to be re-referred to the Adult Protection Gateway Team for further strategic discussion with colleagues in PSNI. The service area includes a number of trained Achieving Best Evidence interviewers; however, there are insufficient opportunities to embed this learning in practice and to meet NIASP requirements, given the lack of demand. This reduction on the demands of specially trained practitioners has been consistent with a rise in decision making within Joint Protocol strategy discussions between the Adult Protection Gateway

Team and PSNI which have resulted in single agency, PSNI only Achieving Best Evidence interviews. Staff within Physical & Sensory Disability service area continue to advocate on the behalf of those service users who may benefit in achieving equity to justice from the support available via 'special measures'. Additionally the levels of complexity of these cases being returned to core teams for investigation is very significant in terms of implementation of safety plans and responses to any emerging concerns.

With regard to user engagement within the safeguarding process, it is critical that we continue to ensure and demonstrate that individuals are fully involved in the interventions that bring about their desired outcomes. The 10,000 Voices project has provided a vehicle for important discussions and critical reflection upon the investigative process. The service area has continued to promote and encourage user participation within the survey.

The service area continues to utilise internal networks in terms of practice development. Furthermore, staff participate in the designated and investigating officer forums facilitated by the Training Team. Staff report positively on these opportunities.

The core teams continue to employ the community information system to record all activity. Unfortunately, the Regional Operational Procedures documentation is not yet available on PARIS, and availability of the updated administrative tools to record the investigative process will be welcome.

Throughout this reporting period the service area continues to foster a climate within which the implementation of the Adult Safeguarding Prevention and Protection Regional Policy (2015) and attendant regional procedures and joint protocol occurs. It continues to be essential that service users are equipped with the knowledge regarding what constitutes abuse and know the basic care standards. The Keeping You Safe programme is a priority for the service area and continues to be delivered to groups and individual service users by trained staff. This will enable and empower service users to assess risk, ensure quality and thwart detrimental behaviours developing. This labour intensive activity will increase demand upon the workforce but it is critical in assuring the prevention of harm. The Keeping You Safe programme recognises service users as experts in their own lives and provides the means to achieve contact with the right professionals if they so require it. It is vital in the effort to work preventatively regarding adult abuse and is a key objective for the service area. Work to continue the provision of this service user training programme is planned within the Day Centre forum.

ADULT PROTECTION GATEWAY TEAM

The Adult Protection Gateway Team (APGT), is now in its sixth operational year and continues to provide a gateway / protection response for the Older People (OP) service area and Physical and Sensory Disability (PSD) service area. In the APGT this two-tier function acts to provide a central point of contact for external referrals, for all internal safeguarding referrals for OP and for protection referrals forwarded by PSD. For referrals that require a protection response cases are allocated to APGT DAPOs and IOs for investigation. To provide this service the APGT has the following compliment of staff: 1 B8A Assistance Service Manager, 4 B7 DAPOs, 6 B6 IOs and 1 B6 Nurse Specialist. During this reporting period the rate of referrals, screened out, protection investigations and joint protocol investigations were as follows: -

	Older People Service		**Physical Health & Sensory Disability Service**	
	2017/2018	**2018/2019**	**2017/2018**	**2018/2019**
Total Referrals received	1103	1408	355	228
Total Level 3 Adult Protection Investigations	190	323	48	58
Total Screened Out referrals	351	429	135	84
Total Joint Protocol Investigations	58	73	14	21

Looking at a comparison from 2017/18 to 2018/19 there is an evident increase in Adult Protection L3 investigations and an increase in Joint Protocol Investigations over this period.

The task of screening referrals on duty continues to require a daily resource of one DAPO and one IO to manage. As noted above, the number of referrals forwarded to APGT continues to remain high in comparison to investigation figures. The level 3 adult protection investigations account for approximately 23% of the total number of referrals received by the APGT. However, the task of receiving and recording information, conducting screening processes and allocating referrals requires one quarter of the B7 resource within the team.

As reflected in previous reporting years, there remains a high number of inappropriate referrals sent to APGT for screening. Over the period of 2018/2019, approximately 32% of referrals were screened out of the adult safeguarding process. The APGT continue to receive a high number of inappropriate referrals from Care Homes and external agencies which include resident on resident incidents, quality issues, explained injuries, medication

errors etc. APGT have also noted a continuing trend whereby Care Homes report incidents to the Belfast Trust keyworkers, however they are then redirected to APGT to make a referral under Adult Safeguarding Policy and Procedures. This creates duplication for care homes who have referred the incident to RESWS or Community Teams/CReST and then directed to contact APGT, when on occasions many referrals are inappropriate and do not meet the Safeguarding Threshold.

Last year's report envisaged the requirement to work with Care homes to focus on thresholds for reporting adult safeguarding concerns. This action will be carried forward with the intention over the next few months to work with Care Homes which will focus on ensuring that the thresholds for reporting concerns are being applied appropriately and that the reporting pathways are clear.

This action is timely, as the statistical breakdown for OPS over the period of 2018/2019 reflected a significant increase in referrals to APGT for screening for Older Peoples Programme of Care. The statistics highlight a significant increase of 28% in referrals made to APGT for screening. The increase in referrals is most evident over the months of June 2018-August 2018 with referrals peaking at 164 in July 2018. The increase in referrals over this period can be linked to the release of the COPNI report mid-June 2018 which seen an increase in Adult Safeguarding referrals referred to APGT by Care Homes and external agencies.

Within the Belfast Trust there has been a phased approach to implementing the regional Safeguarding Policy & Procedures, with Older People service area being the last to be implemented. Significant organisational change and workforce challenges have resulted in delays in full implementation. Now that the CReST service is established it is anticipated that work with Care Homes and CReST will be carried out concurrently to ensure that there is further clarity regarding thresholds, reporting arrangements and referral pathways.

PSD implemented the new Procedures in June 2017. The ability for core services to screen their own referrals and to forward only protection referrals to APGT has been welcome and demonstrates a more appropriate use of the APGT gateway function. As both service areas are working within different safeguarding frameworks, APGT's ability to straddle two processes and pathways has been challenging. It is expected that current pressures will be alleviated when service areas are working within the same framework.

Followed on from the previous year, the Director of Adult Services determined that the Belfast Trust would move to one Trust wide Adult Protection Gateway service. This will require one team to act as a single point of contact and manage all adult protection cases. Given the current arrangements within the Trust, it is anticipated that Mental Health and Learning Disability services will join with the existing APGT. There has been some initial work in relation to the structure, function, role and remit of the new Trust wide protection team but further discussion and consideration of the remit of the team is required.

In addition to the gateway function, it is proposed that the APGT will also act as a central point of contact for all Human Trafficking, Female Genital Mutilation, Forced Marriage, No Recourse to Public Funds, Domestic Abuse and MARAC referrals. Within the framework of the new Trust-wide team the APGT will continue to hold responsibility for these areas

of practice, additional to this the development of audit and governance arrangements for both APGT and Core services will also be required.

The development of a Trust-wide team will require Core services to provide a screening and safeguarding response for those referrals that do not require a protection response.

Casework that requires a joint protocol, multi-professional or institutional investigation continues to be challenging, resource driven and time consuming. This is evident when regulated facilities particularly Nursing Homes are involved. The referral rates relating to abuse, exploitation and neglect in regulated facilities have remained consistently high with figures outlined highlighting a significant increase from the previous year. With the implementation of the new Policy and Procedures it has become evident that at times there has been a level of ambiguity in relation to the interpretation of cross Trust arrangements and the roles and responsibilities of host and placing Trusts. At times there also appears to be some variation in the role, function and remit of the Strategic Management Group across Trusts. This has been flagged with the NIASP Protection work-stream who are currently reviewing the Procedures. It is anticipated that the update of the regional Procedures will address the practice issues identified. In the interim, the Trust continues to work in partnership with other Trusts to ensure the safety and well-being of residents. This includes ensuring that investigations and protection plans are in place. In moving forward, further clarification regarding what is defined as an institutional investigation would also be helpful.

Over the reporting period of 2018/19 referrals and adult protection investigations vastly increased resulting in additional pressure on the staff within APGT. As a result, APGT were placed on the Risk Register in relation to an identified back log of case closure and recordings which fell outside the expected standards. This was subject to close monitoring and review by management of APGT.

In the last quarter of this period, APGT were subject to significant staffing changes with three senior members of the team, two DAPOS and the ASM/Team Manager, leaving the team to pursue temporary Expression of Interest Posts within the Trust. Additionally, APGT experienced the departure of Investigating Officers who left the team or moved into senior positions. The staff situation experienced by APGT has had a consequential impact on the team, APGT was placed on the Risk Register due to the staff shortages, however the void in the staff team remains ongoing despite actions from Senior Management to recruit and stabilise the service.

APGT were successful in recruiting B7 Social Workers/DAPOs, and partially successful in recruiting two B6 social workers, however the recruitment process is ongoing, with the pressing need to fill the empty posts. Due to the nature of the service delivered and the impact of recent staff changes within the team, APGT are now functioning with an inexperienced staff team, which requires enhanced monitoring and support from senior management for the foreseeable future.

Despite the practical challenges identified, APGT continue to function as the central point of contact for external agencies and continue to screen adult safeguarding referrals for OPS and investigate level 3 Adult Protection investigations for PSD and OPS. Additional challenges faced by APGT over this reporting period include APGT experiencing an increase in information requests from professional bodies such as NISCC & NMC. This is in addition to Freedom of Information (FOI) requests, subject access requests and Data

Protection requests from external managers, relatives and staff members subject to investigation. APGT continue to liaise with Data Protection and DLS when required to meet the requests outlined.

This has also highlighted the interface issues between Adult Protection Investigations and HR/Management Internal Investigations and the challenge faced when agencies attempt to use safeguarding reports as evidence during internal investigations. Responding to such information requests within specified timeframes places additional pressures on the team, this was evident over the past 12 months when APGT received numerous statistical data requests following the release of the COPNI report in June 2018. The collation of data and producing of reports exceeded the current staffing resource and created significant pressures within the team.

Over this reporting period, APGT experienced an increase in referrals for OPS resulting in an increase in level 3 adult protection investigation in care home settings. The impact on the team resulted in an increase number of complex investigations with multiple incidents of abuse subject to investigation at any one time. As a result, the b6 specialist nurse was subject to a change in case work allocation and activity, such as removal from duty and allocation of specialist case work due to the increased volume of investigations and activity within Care Home settings. The specialist nurse role continues to remain a vital component within APGT due to the complexity of care home and nursing/ care related investigations referred into the Trust. A fundamental service provided by the nurse specialist is the facilitation of bespoke education sessions with care homes, service providers and agencies in relation to the Role of APGT and function of Adult Protection investigations within the Belfast Health and Social Care Trust.

There has been an increase in the requests and demand for the education sessions by agencies in an attempt to increase the awareness within care settings in relation to Adult Protection and Adult Safeguarding. Additionally, the specialist nurse attends and contributes to the review of regional strategic developments for example the development of the NIPEC guidance on safeguarding training in the nursing profession, developments relating to investigating pressure damage and chairing of quarterly Regional NIPEC meetings attended by specialist nurses across the region.

Due to the expert clinical area of work undertaken by the specialist nurse in complex investigations which include Article 121 of the Mental Health Order, Pressure Damage and Institutional Abuse, APGT senior management have conducted a review of the skill mix within the team and has proposed the appointment of a temporary B7 Specialist Nurse within the APGT. There is the intention to pilot this post for a 6-month period and review it in relation to role, responsibility and outcomes.

It continues to be the case that none of the Joint Protocol investigations conducted by APGT with police under Article 121 of the Mental Health Order have reached the threshold for prosecution as determined by the Public Prosecution Service (PPS). What is of note is that investigation processes in this area of work are elongated and protracted with outcomes for the most part of no prosecution. It would be beneficial and informative if the PPS could provide a clearer understanding of what constitutes a criminal threshold for wilful neglect and provide guidance around investigations and threshold for referral to police. Currently it would appear that police are seeking advice from PPS about thresholds for prosecution before investigations are concluded. While this is welcomed, it would be preferable if PPS and police could agree thresholds for wilful neglect. The

review of the Joint Protocol will consider in detail the use of Article 121. Following the regional review of pressure damage investigations, APGT conducted an investigation under Adult Safeguarding and Joint Protocol policy and procedures with a recommendation by the PPS for prosecution under Health and Safety Legislation, this is the first of its kind in the Belfast Trust area, with the process and outcome eagerly anticipated.

The number of investigations agreed as Joint Protocol by police increased by 26% for OPS and 50% for PSD over the reporting period of 2018/19. This is a substantial increase, however the number of ABE interviews conducted for OPS decreased by 8% over this period, with PSD ABE interviews increasing from 2 to 4 demonstrating a 100% increase over this reporting period. Approximately only one third of referrals made to CRU are agreed as Joint Protocol. It is generally acknowledged that the new Joint Protocol is being interpreted very differently by respective agencies, hence resulting in a high percentage of referrals made by DAPOs not meeting Joint Protocol as determined by police. Given outcomes APGT find themselves querying decisions made by police and have on a number of occasions challenged decisions in support of vulnerable service users. APGT staff are experienced practitioners who frequently negotiate decision making with the police and use the escalation process as detailed in the Joint Protocol. Again, it is anticipated that the review of the Joint Protocol currently underway will address the concerns identified and will reach a consensus position in terms of definition and application of the Joint Protocol.

The reduced number of investigations agreed by police has had a substantial impact on the number of PIA and ABE interviews conducted. Aside from the implication of this on vulnerable service user groups, there has also been a significant impact on social work ABE interviewers who are unable to meet their practice requirements as outlined in the protocol. APGT note that police have advised DAPOs that referrals are being passed to uniformed Police Officers and Registered Intermediaries are being used as an alternative to ABE trained social workers. The review of the Joint Protocol will consider this and all related issues.

CORE TEAMS - Older People's Service Community Social Work Teams

The Adult Safeguarding Protection Team still retain the responsibility for receiving and screening all adult safeguarding referrals in Older People's Services. During this reporting period the Older People's Social Work Service continues to move ahead with structural and organisational change. The professional oversight has been strengthened with four 8a Team Leader posts across all Community Social Work and the service is pleased to report that this management structure is now stable. However, during this reporting period a vacancy rate of 50- 75% in team leaders in Community Social Work has prevented the full implementation of the Regional Policy. Adult Safeguarding referrals continue to be screened and thresholded by the Gateway Team. It is the view of the service area that this was the only way that we could ensure a consistent response and thresholding during this very unstable period. Whilst the service area intends to move forward with full implementation of the policy, we remain concerned that further work needs to be developed in relation to identifying standards and processes for managing adults at risk of harm and developing alternative pathways. This is a priority for the service area in the forthcoming year

The management of safeguarding concerns raised in the care home sector continue to present significant demands. The development of a preventative CREST model has ensured that early warning signs of a change in standards in a care home setting are identified with earlier interventions. The issues raised through the Dunmurry Manor investigation Home Truths Report continues to be a focus in the broader discussion of how risk is identified and managed across the Service Area. Staff have been involved in DOH and Trust facilitated workshop sessions reflecting on particularly how our current thresholds of risk and risk management plans are a critical to our broader responsibilities under Safeguarding.

The CREST model has been significant in ensuring the development of strategies which deliver timely reviews, responsive supports and prevention work in Residential and Care Home sector. The ASCOT tool along with the guidance and mentoring of Kent University is being introduced to the CREST team as a methodology to support and assure. Further training and development in this area is anticipated. This outcomes tool will both support the care homes in identifying particular areas for improvement and provide a mechanism to work together on improvements. Also, it will bring a rigour to the work carried out by our Social Work staff in observations, monitoring and reviewing within the sector to prevent safeguarding concerns arising.

Quality Improvement methodology has been applied to reviewing and improving the understanding of how older people and/or their family can feel safe in raising concerns or complaints within the care home setting. This again has at its core service improvement and also supports the prevention of concerns being raised later or not at all and escalating to the need for protection.

Staff have also benefited from being able to attend training and events held by partner agencies such as Women's Aid and Action on Elder Abuse.

Challenges

The service area is training staff to be able to bring a range of tools to the protection of our older citizens through a range of methodologies. Community Services have made use of the High Court to ensure the protection of those who lack the capacity to make decisions to protect themselves. This work will inevitably change as aspects of the Capacity Legislation is enacted. As a Service Area we are working to remain flexible and creative in how we respond to the circumstances of individuals to ensure their safety.

At present the Service Area is taking an action to the High Court in respect of a service user who has been subject to harm through the actions and interference by another. The service user lacks capacity to recognise and manage these harmful actions. The Trust are asking that the Court would make an order on behalf of the person, in the absence of their mental capacity, to exclude the perpetrator from interfering in the service user's property and care. This is a new approach and could be critical in shaping case law. This is a significant piece of work for staff both in terms of understanding and managing the day to day complexity but also in the number of reports and consultations ahead of any court appearance.

The importance of a competent and confident workforce who are well versed in early identification and intervention is essential.

Strategic Direction

We are confident that within the Care Home Sector the ASCOT methodology represents a welcome focus on quality of care and a supportive system of bring further strength to the prevention work which is ongoing. Within the Community Social Work Teams, we have appointed a governance post which will bring further assurances in the form of regular auditing of our safeguarding work to highlight areas of good practice through peer support initiatives. It will also help to identify areas of variance in practice. A Principal Social Worker has been permanently recruited in the Community Teams and a temporary equivalent post in our Hospital setting. This will bring a renewed focus to the training and development of our staff and the governance arrangements related.

As we progress to integrate the Regional Policy in the service we will have a renewed focus on the feedback from people who are supported through our safeguarding processes and look at how we improve the lived experience of safeguarding. Feedback from 10,000 Voices will help inform this work going forward.

HOSPITAL SOCIAL WORK

Processes and staff resources are in place to provide a response to Adult Safeguarding queries and referrals across the hospital sites in Belfast Health and Social Care Trust. These include: Royal Victoria Hospital, Belfast City Hospital, NI Cancer Centre, Mater Infirmorum, Musgrave Park Hospital and Meadowlands. Monthly returns are provided to the Adult Protection Gateway Team (BHSCT) by way of collection and monitoring of referrals for BHSCT referrals.

The Service has Designated Adult Protection Officers and Investigating Officers trained and available on each of the hospital sites and cover arrangements in place if required.

There have been a number of instances of residents from other Trust areas coming into regional hospital facilities in the BHSCT area (e.g. Royal Victoria Hospital or Musgrave Park Hospital) for care and treatment and disclosing Adult Safeguarding issues. The Service has worked with the Gateway Teams from other Trusts to ensure referrals are made to the appropriate area and immediate protection planning is done. The Service has initiated a new reporting process for 2019/20 to capture the number of referrals to other Trust Adult Protection Teams.

One of the challenges for the service is that service users can often have short admissions to hospital were Safeguarding disclosures are made. This can often be a vulnerable time for people due to injury and/or ill-health. Social Work staff in the Safeguarding roles provide a sensitive and professional response in these situations taking cognisance of issues such as capacity to engage in the investigatory process, what immediate protection response is required and how Adult Safeguarding issues may impact on discharge planning.

A recent RQIA Review report highlighted the issue of awareness of Adult Safeguarding within the outpatient departments on the hospital sites. An action plan has been put in place to provide these departments with Safeguarding posters and information for display in waiting areas.

LEARNING DISABILITY

The Service Area continues to have a number of dedicated Learning Disability Adult Safeguarding staff. This comprises of 9 DAPOs: 5 are SW Team Leaders in the hospital and community teams; 1x 8a Operations manager; 1x DAPO in Muckamore Abbey Hospital (MAH) who deals with patient on patient incidents; and 2x DAPOs in the Specialist Team who deal with allegations against staff or paid carers or where there are issues in relation to the quality of care provided in a group setting.

From September 2017 the Specialist team (2x Band 7 DAPOs) have been involved solely in the large-scale adult safeguarding investigation into Muckamore Abbey Hospital. This has involved dealing with the historical CCTV incidents and historical incidents. This meant that the work, usually undertaken by this Specialist Team, had to be dealt with by the core Community Learning Disability teams. This added additional pressure to their existing workloads.

The service area has 36 Investigating Officers who are embedded across the service area. There are now 3 ABE trained social workers.

Adult safeguarding (ASG) remains a major area of work for the Service Area. There has been an increase in the number of adult safeguarding referrals from 916 referrals last year to 977 this year with 560 investigations completed. 789 of these referrals were received from the hospital and 188 from the community. A large number of referrals have resulted from the large-scale adult safeguarding investigation in Muckamore Abbey Hospital. This includes 236 referrals generated from the viewing of historical CCTV footage that has been downloaded from April-September 2017 relating to 5 wards in Muckamore. In addition, there remains a high number (519) of patient on patient incidents across the hospital site.
The figures are as set out in table below.

Number of safeguarding adult referrals within the period	977
Of the referrals at 6.1, how many were received from acute settings?	789
Number of investigations commenced within the period	560
Number of investigations completed within the period	560
Of the completed investigations at 6.4, how many required a Multidisciplinary Agency Risk Assessment Conference (MARAC)?	1
Number of adult protections plans commenced within the period	536
Number of adult protections plans in place on 31st March	536

<u>Current allegations against staff in Muckamore Abbey Hospital</u>

There have been current ongoing incidents relating to allegations against staff within the hospital site. These allegations have been investigated by the community teams with the support of 1x Band 6 Investigating officer.

CCTV is now running across all the wards at Muckamore. The adult safeguarding team can therefore view CCTV as part of their investigation. The introduction of CCTV across all the wards has been extremely positive in that it has allowed for independent checking of allegations, which has aided in the ASG process. It has also provided reassurance to the families, senior management team, Trust Board and Department of Health. This helps to clarify information quickly and incidents can either be very quickly screened out or the CCTV can be used to provide details and evidence in relation to the allegations made. From viewing the CCTV learning can be achieved in relation to what precipitated the incident, the intervention of staff etc. This helps to set a context to the incidents. The adult safeguarding team now meet regularly with the Service manager, ward managers and operations managers to ensure there is good communication, shared learning and protection plans are reviewed.

There are significant resource implications for the ASG team given the length it time it takes to view the CCTV (as there are a large number of cameras in any given area), time to identify the staff, accurately record the viewing and at times to obtain input from the MAPA trainer in respect of any Physical Interventions used. A number of issues viewed would fall under staff conduct issues and would not reach the threshold for an adult at risk or an adult at need of protection. However, they would be matters of concern for the Adult Safeguarding team, which remains a challenge whether such matters should come under Adult Safeguarding.

The vast majority of the ongoing referrals made against staff relate to one particular patient who is very autistic and assessments of his communication have showed that he has limited use of expressive language.

As per the Regional policy, any incident deemed to meet a criminal threshold have been referred to the PSNI.

The CCTV policy has been reviewed. For assurance purposes contemporaneous CCTV is also underway across the site. Any good practice is documented and shared through the service manager to each ward area.

The Adult safeguarding team are now planning to complete a more in-depth audit of data to identify any trends or patterns. This will ensure the adult safeguarding responses are better informed and consider a range of factors including the skills mix, staff ratio, time of incident, environment, the patients presentation, etc. which may impact on the safety of patients. This will inform the entire multidisciplinary teams' decision making to improve patient safety.

<u>Historical CCTV allegations against staff in Muckamore Abbey</u>

This has continued to be an extremely challenging year for the service area in respect of adult safeguarding incidents reported because of viewing historical CCTV within the Hospital. The large-scale ASG investigation commenced in August 2017 following the delay in reporting an Adult safeguarding incident. CCTV was viewed at this stage in relation to this incident and during this viewing a number of other adult safeguarding incidents, which were not reported, were noted. This included mostly incidents of a physical nature on patients by staff and the inappropriate use of seclusion. These incidents were later reported as an early alert

to the Board. For assurance purposes a further 25% random viewing of CCTV took place across the Muckamore Abbey Hospital (MAH) site which revealed further incidents in one ward. Subsequently, an incident was reported by a patient against a staff member in another ward. Further allegations were made by a whistle-blower against 2 staff members. A number of these allegations resulted in a joint PSNI/ Social services investigation.

Following these incidents an independent Serious Adverse Incident Level 3 Investigation was commissioned focussing on adult safeguarding from 2012-17 including the above incidents. This panel was chaired by Margaret Flynn. The findings of this report 'A way to go' have now been shared with the affected families through workshops and individual meetings and with the staff across learning disability. A written copy of the report has been made available to families, including an easy read version for patients.

The main themes emerging from this report were as follows:-

- **The criteria for admission to the hospital was too low with patients being admitted for a large number of reasons including, those who required assessment and treatment, those whose placement had broken down, short breaks etc. In addition, once admitted these patients were extremely difficult to discharge and therefore the length of admission became protracted with many having no discharge plans.**
- **There was a high incidence of patients being bored in the hospital due to a lack of meaningful activity on and off the wards. This undoubtedly led to frustrations and an increase in patient on patient incidents but also of incidents of staff on patients.**
- **There was an inappropriate use of seclusion sometimes for long periods of time and poor recording detailing the rationale for the decision surrounding this.**
- **Despite a large number of RQIA inspections and a very high number of Adult safeguarding referrals, (even resulting in referral to the police) there was a lack of action taken which actually reduced the number of incidents or improved the safety for patients.**
- **Families were not allowed access to the patients' bedrooms or to the actual ward. This was particularly so in one ward.**
- **There was a lack of visible leadership across the site**

Some of the recommendations from the report that now form part of the Trust action plan are as follows-

- **People with learning disabilities should be able to live their lives with their families and in communities and the services provided should understand that ordinary lives require extraordinary supports – which will change over the life course.**
- **The hospital should review its criteria so that admission is for assessment and treatment only, for the shortest time possible.**

- **The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services.**
- **There should be better advocacy services.**
- **Development of a co-produced communication strategy with parents/carers/ appointment of carer consultant aimed as repairing and establishing relationships and trust with patients and with their relatives as partners. Families should have greater input in relation to decision-making.**
- **Families and advocates should be allowed open access to wards and living areas.**
- **Patients should be engaged in more meaningful activities during their admission.**
- **Patients and families should have better information in relation to how to complain.**
- **Families should receive regular progress updates.**
- **The families wanted an end to seclusion.**
- **There should be a review of Adult Safeguarding culture and practices at Muckamore so that the responses to safeguarding incidents and allegations are proportionate and timely, that the perception that people with learning disabilities are unreliable witnesses is changed and that the safeguarding documentation is substantially revised.**

Much progress has been made in relation to these action points but there is still a lot of work ongoing. Whilst this SAI investigation was ongoing it was agreed that all the downloaded CCTV (April-Sept 2017) be viewed for all 5 wards. This proved to be very challenging for all adult safeguarding staff in learning disability services. The Muckamore investigation has been unprecedented in terms of numbers of allegations and its complexity. This has resulted in a huge amount of work relating to the historical allegations and the historical CCTV incidents being undertaken by the 2 DAPOs in the community. This has had a knock on effect on the community teams as they had to take on the work previously covered by this specialised team.

Since the start of the investigation, the 2 DAPOs have processed 191 referrals for one ward with 177 of these being referred to the PSNI. 14 other incidents were not referred to PSNI. These incidents are all mostly of a physical nature and include inappropriate use of seclusion. In addition, a further 158 incidents relating to the other wards have been triaged by the ASG team. To date only a small number of these incidents have been viewed by the adult safeguarding team. However, of what has been viewed an additional 44 referrals have been forwarded to the PSNI. These incidents are again mostly of a physical nature and involved a number of staff who were either involved in actual physical incidents and or other staff who allegedly witnessed the incident and or failed to intervene.

The CCTV was taken by the PSNI in February 2019 and at this stage the percentage viewed for each of the 5 wards was as follows –82%,-64%, 66%, 48% and 46%. This clearly continues to create difficulties for families who know that there is further

historical CCTV to view. The Trust remain committed to the viewing of all CCTV during this specified period.

The PSNI have an identified taskforce dealing with this investigation and have a team of additional officers. They have been working very closely with the PPS and are looking at a whole range of potential offences in relation to this investigation including Article 121, wilful neglect, common assault and misconduct in a public office.
Unfortunately, over the reporting year attempts to recruit additional DAPOs to assist with this investigation have been largely fruitless resulting in the 2 DAPOs undertaking the viewing of CCTV, as well as preparing large voluminous files for the Police and HR department. This has been a hugely complex task and both the PSNI and the HR department have complimented the team for the complex work completed.
All the affected families have a nominated DAPO attached to them and with their agreement there were updated on a regular basis regarding any further developments as well as offered supports including psychological support from the Trust. The DAPOs have been working in close partnership with the PSNI and a number of visits to families were done jointly between the Trust and the PSNI. At the end of the reporting period the service area managed to secure a part time DAPO whose sole role is family liaison with some of the affected families.

As a result, of the current ASG investigations 20 staff have been placed on precautionary suspension and other staff are subject to protective measures. This along with staff sickness has given rise to a number of challenges for the service in ensuring that there is adequate staffing across the site to ensure patient safety.

There has also been ongoing liaising with the other Trusts to update them regarding the current investigation but also to address any specific issues relating to their service users.
Whilst the CCTV remains outstanding, there is also a feeling of uncertainty across the staff group at the hospital. Staff across the site have been supported at this difficult time through a large number of initiatives including a counsellor who provides 1:1 emotional support, reflective practice sessions, workshops with staff, massage sessions and support sessions with HR and OH. In addition, a health fair is planned and 'Bewell' sessions planned.

The Service Area has continued to work within the Adult Safeguarding Regional Policy, the HR disciplinary processes and Joint Protocol. This has resulted in many challenges balancing the requirements of each process and being proportionate in relation to staff but at the same time protecting patients.

The hospital SW staff have continued to roll out the ASG 'Keeping yourself safe programme' across MAH. There has also been further ASG training provided across the hospital site. There is further CCTV to view and the 2 DAPOs who had been doing the investigation are now due to be replaced by a new ASG team which was appointed at the end of March. This team currently comprises of 1x Band 8B and 3x 8A staff. There remit is take forward the remaining historical CCTV and provide support to the affected patients and families.

<u>Muckamore Abbey Hospital current patient on patient referrals</u>

The social work department in the hospital continues to lead in relation to safeguarding patient on patient incidents. In this reporting year, there have been 519 incidents in the hospital. Most of these incidents are of a physical nature. Many of these incidents include multiple incidents relating to the same patients either as alleging causing harm or and victims of alleged abuse. All these referrals are processed by one Band 7 Lead DAPO, who is supported by the Senior Social Worker and by 2 Investigating Officers. Together they support the Multi-disciplinary team in the development of risk management, alternative safeguarding responses and protection plans. Support is also provided to the patient and a referral to the PSNI if deemed appropriate, or at the request of patient or carers. As part of the screening and or as part of the investigation into the incidents CCTV will also be viewed by the DAPO.

As a result of staffing difficulties (suspensions and staff off sick) and also as a means of stabilising the hospital, the hospital has been closed to admissions. In addition, over the last year the hospital has been retracting as patients have been discharged and therefore the number of inpatients has significantly declined. However, there remains a high level of incidents of a physical nature between patients in the shared setting of the hospital. There are ongoing difficulties related to the physical environment and the mix of patients in the wards, many of whom have complex needs and present with challenging behaviours associated with autism and other conditions, communication difficulties and limited insight into the possible consequences of their actions or that of others. Very few of the patients have skills to protect themselves. Staffing levels can also often mean that patients are unable to avail of opportunities to be off the ward and this can increase the number of incidents on the ward.

Despite good multidisciplinary working including robust risk assessment and risk management plans, it continues to be a challenge implementing suitable protective plans to reduce the likelihood of further incidents. All these ASG incidents are now reviewed on a weekly basis at the multidisciplinary team but also the data forms part of the SITrep report, which allows the Senior Management team / Directors Oversight group the opportunity to understand trends and patterns in relation to this and consider what further steps can be taken to address the matter.

In order to reduce the number of patient on patient incidents in the wards considerable work has been done:

- **In Jan 2019 an activity Co-ordinator was appointed following a review of day care at the hospital. This has significantly improved the level of activities for inpatients across the Hospital Site. Therapeutic Day services are now also provided within the hospital at weekends and evenings activities on the ward and off the ward. This has helped to reduce contact between patients and thus reduce frustrations levels and the likelihood for incidents. Activities for patients ensures the holistic needs of patients is catered for with intervention, which may include recreational input, social input or skill development. By extending the frequency and range of appropriate and meaningful activity the mental, physical and emotional wellbeing and social needs of patients is promoted.**

- **Joint Therapy Aims and Free time Plan/Activity Boxes have been introduced which allows ward staff to work on individualised therapy aims with patients, which forms an important part of their treatment. The box can also be used to de-escalate a situation or redirect a patient from a difficult situation, which promotes the safety and well-being of patients.**
- **Plans are place to resettle a large number of patients whose discharge has been delayed. There has been work done by the service area with a large number of providers along with the other Trusts to put in place plans to successfully resettle patients in the community.**
- **The Trust has also developed a supported living scheme in Cherryhill, which is due to open in June 2019 and will be accommodating 9 patients who are to be discharged from the hospital.**
- **The hospital SSW and lead DAPO have regular meetings with the service manager and the 8a nursing operations managers to address any ongoing concerns in relation to patient safety.**
- **The hospital SW team are currently piloting real time feedback from patients and from carers prior to and post Adult safeguarding intervention to understand what would make them feel safer.**
- **Safeguarding procedures, including use of special observations, has been used to minimise targeting of vulnerable patients.**
- **The ASG team will now be auditing data in relation to ASG and identifying trends and patterns so that a collective understanding can be achieved in relation to the issues re ASG across the site and then identifying how this can be addressed.**
- **There continues to be discharge meetings convened to expedite community placements and notify Trusts of the number of safeguarding concerns for each patient remaining in hospital.**
- **Ongoing training of nursing staff in Muckamore regarding the thresholds, their responsibilities under adult safeguarding protocols, completing the forms correctly and developing robust interim protection plans.**
- **Viewing CCTV assists the ASG team to understand the factors precipitating/ leading up an ASG incident and the context of the incident, which is then shared with the ward managers/ management team.**
- **Positive behaviour practitioners provide support to reduce incidents of challenging behaviour.**
- **The Keeping You Safe Training to patients remains a key function of the SW team in the hospital. Within the last year, 21 patients have been provided with the training. Various methods have been used, group and individual sessions, depending on the ability of patients.**

Social Work staff in MAH are now aligned to each ward, which ensures there is a full MDT approach to address the issues and reduce the potential risk to patients e.g. through making environmental improvements, use of positive behavioural support, increased day activities etc.

In the last year, the service has implemented a new process in the management of safeguarding. This process is in keeping with the Adult Safeguarding Policy and provides opportunity for ward managers to become nominated Adult Safeguarding Champions. The vast majority of incidents managed through this process are minor in content and only require an Alternative Safeguarding response. The hospital SW department continues to provide support and advice to ward managers and nursing staff. The Senior Social Worker has been auditing this new initiative and raising any issues with hospital management.

Community based investigations

Allegations against staff

The service has continued to investigate concerns raised in nursing homes, residential homes and supported living projects. The referrals cover a range of abuse including alleged physical abuse, psychological abuse, financial abuse of service users and institutional practices.

The service remains concerned about quality issues which, while they do not meet the threshold for safeguarding, may have significant impact on the quality of life for service users. Many of these facilities continue to experience high turn overs of staff, low staff morale and poor resilience. The Trust continues to work with providers to build their capability and improve their resilience.

Allegations of service user on service user abuse

Most of these referrals relate to low level physical incidents of one service user on another which reflect the reality of group care for service users who can display behaviours, which challenge and have communication difficulties. As noted in previous reports, where the victim and person who is alleged to have caused harm have learning disabilities, behavioural issues and share the same space it can be difficult to put in place protective plans. Again, as noted in previous reports suitable alternative placements are required.

All group living services are aware of the need to review care plans, environments and the mix of service users in order to promote a safe living environment for all.

The Service Area believes that many preventative measures are required to address these issues such as good quality staff recruitment, retention, support and training.

MENTAL HEALTH

There continues to be a significant increase in the volume of Adult Safeguarding referrals, investigations and protection plans in the last twelve months with an increase in referrals by 20% and in investigations by 10%. The Mental Health Adult Safeguarding Team continues to provide the majority of DAPO cover and has endeavoured to continue to improve awareness of Adult Safeguarding procedures in recognising and reporting of abuse in community teams that are non-Social Work led. DAPO's from the Mental Health Adult Safeguarding Team continue to embed the process and knowledge of the procedures and to assist Team Leaders in fulfilling their responsibility for initial screening, implementing interim protection plans, governance responsibilities and onward referral to DAPO.

The Mental Health Adult Safeguarding Team currently consists of a PSW – who is also the named Adult Safeguarding Lead for the mental health service area in addition to the PSW role, 2 Band 7 Senior Practitioners/DAPO's, a Band 7 Senior Practitioner/Professional Social Work development lead and Think Family lead, who also provides sessions into Adult Safeguarding for DAPO. All DAPO's in the Mental Health Adult Safeguarding Team are ABE trained.

The Mental Health Adult Safeguarding team currently acts as a single point of contact for Adult Safeguarding referrals for mental health services who do not have trained DAPO's within their team. There are plans for all mental health referrals to be sent to the Adult Safeguarding Protection Gateway team in the future for screening and decision making on the level 3 cases to be taken forward for investigation, but to date the current process remains and there is no date for APGT screening of all referrals. The Adult Mental health team currently screen all referrals received and identify an IO and DAPO. They are also the point of contact for guidance and referrals from outside agencies and are advised on issues which would require a safeguarding investigation and arrange for the allocation of an IO and DAPO to commence the safeguarding process. The Mental Health Adult Safeguarding Team continues to act as the central point of contact for PSNI for PIA / ABE interview consultations and requests and allocates referrals to trained staff within the mental health service area. There continues to be well established support groups for IO, DAPO and ABE trained staff across the Trust and staff are encouraged to attend these groups to keep them updated regarding any changes or issues and is also a forum for shared experience and learning.

The Mental Health Adult Safeguarding Team meet weekly to review and discuss Adult Safeguarding investigations and management of cases. The team has a Band 7 Senior Practitioner for MARAC cases and referrals for MARAC process.

The Mental Health Adult Safeguarding Team also provides supervision and support to DAPO's and IO's across all services who are not line managed by a qualified Social Worker DAPO. They also provide an advisory and consultative role for all professional staff across the 41 mental health teams / services and outside agencies including voluntary organisations and PSNI.

Referrals are received from a wide range of service areas, including hospital settings, the medium secure facility, supported living facilities, nursing and residential settings, day

care and from a range of community mental health services – within acute, primary and recovery teams.

There has been an increase in the number of protection plans by 15%. The figures reflect a reduction in PIA/ABE interviews. The figures for 2018/2019 show a reduction of 50% in PIA interviews and a 70% decrease in the number of ABE interviews completed within mental health. This is largely due to the police thresholds for joint protocol investigation and a high proportion of referrals to CRU have been assessed by the PSNI as only requiring a single agency investigation. The PSNI thresholds assess domestic abuse, historical abuse, physical and sexual assaults as single agency investigations. The PSNI/CRU thresholds also assess any patient in receipt of 24 hour care in a hospital setting are not vulnerable adults in need of protection and will only agree this a single agency PSNI investigation. DAPO staff in their consultations with CRU continue to challenge these decisions and the need for a joint investigation with PSNI on a case by case basis. However, it remains our experience that the PSNI will make the final decision. It is predicted that there will continue to be a decline in PIA/ABE interviews under the new thresholds for assessment by PSNI. Given the reduction in joint protocol investigations mental health services will not be nominating social work staff to undertake the ABE training this year. Staff currently trained have reported that they are having difficulty meeting the two ABE interview requirements to continue with the role given the reduction in ABE interviews.

Within Mental Health services there is a significant deficit in DAPO's across the service as not all of the services are led by Social Work staff. There are 6 social work Team Leaders across the 41 mental health teams, 10 senior practitioner staff including the 3 Senior Practitioner DAPO'S in the Mental Health Adult Safeguarding Team and a two year time limited temporary addition of 2 CSM Social Work posts who will undertake a DAPO role within their service area if there is no Senior Social Worker/DAPO in post. An expression of interest has been circulated for an additional two temporary Senior Practitioner Social Work staff to undertake additional roles within the community teams – this will include a DAPO role along with other enhanced duties and there continues to be increased pressure on DAPO's within the mental health service area who also undertake a number of functions i.e. Team Lead, ASW, ASW assessors, Professional Social Work Supervision and DAPO. There is also a deficit of Band 6 staff due to vacancies within the community teams and of IO trained staff within nursing staff in mental health with Nursing staff declining to undertake the IO role supported by their unions, therefore Social Workers tend to undertake the majority of Adult Safeguarding investigations. In addition some community teams have AYE Social Work staff who are currently unable to undertake the IO role until they are at Band 6 level while other teams report only one Social Worker within their team and the remainder of staff are support staff who are also unable to undertake the IO role. This has continued to impact on Social Work front line services delivery and has placed considerable pressure on the Social Work workforce who also undertake all of the other statutory functions within mental health. There continues to be an increase in referrals from the voluntary sector and from the Leaving and After Care teams who have no provision of IO/DAPO within their service area and victims may not be currently open to mental health services. However as they meet the key definitions of an adult at risk of harm or an adult in need of protection an IO has to be sourced from the existing mental health IO trained staff which also increases pressure on their service delivery and caseloads.

There are on-going challenges within mental health services with the introduction of the Adult Safeguarding policy July 2015. Joint agency working with PSNI, RQIA, professional bodies regarding procedures, protocols and practice issues remains an ongoing priority. The mental Health Adult Safeguarding Team have implemented a database to capture the recording of Adult Safeguarding as an interim measure while plans continue to implement all of mental health safeguarding recording and investigations to the Trust information system – PARIS. All staff within mental health services will require some additional training for the implementation of recording of adult safeguarding referrals and investigations on PARIS, however there is no current timescale for this due to the new APP documentation which needs to be designed for PARIS but planning meetings continue with the PARIS implementation team. The service area remains committed to the delivery of adult safeguarding, while recognising significant workforce pressures. A priority for the service is to ensure that Band 6 non-Social Work staff are encouraged to undertake IO training and that there are suitable supervision and support arrangements put in place to support non-Social Work IO staff. Additional bespoke IO and DAPO training has been facilitated by the Learning and Development Team in addition to the IO/DAPO training offered twice per year to relieve pressures on community teams so that newly appointed staff could undertake the IO and DAPO roles.

Workforce planning continues to be encouraged with the Service Leads within each service area to ensure that appropriate levels of Band 6 staff and Band 7 Social work staff are recruited to undertake the assessed safeguarding requirements for their service. Consideration is also required of the capacity of Band 7 Senior social work practitioner staff to meet the demand within the service area and fulfil the statutory requirements of the Band 7 role to undertake the ASW and DAPO / ABE function.

The Mental Health Adult Safeguarding Team continue to offer essential support to all DAPO's and IO's within the Service Area and in quality assuring all aspects of Adult Safeguarding. The Mental Health Adult Safeguarding Team has completed an initial audit of safeguarding within the service area and plans to do this on an annual basis to ensure governance arrangements, appropriate safeguarding investigations are undertaken and review decision making, and alternative responses to safeguarding. Refresher training for IO/DAPO is also being planned with the Learning and Development Team which would be an addition to the IO/DAPO support groups currently in place so that IO/DAPO's can maintain and update their skills and knowledge in safeguarding. It is anticipated that the current level of DAPO/IO need within mental health services will remain at the same rate when the Adult Protection Gateway Team become the single point for referrals for mental health. The Adult Protection Gateway Team will take responsibility for level 3 investigations which include joint protocol investigation, institutional care investigations and investigations involving paid members of staff and have a team of DAPO and IO staff to manage the investigation. All other referrals will remain the responsibility of the mental health service to progress the investigation. Within mental health services the level 3 investigation for joint protocol and paid staff allegations of abuse have decreased due to the police thresholds for joint protocol investigation and the level of referral for institutional abuse referrals remains low, therefore the majority of referrals currently referred and dealt with by the mental health Adult Safeguarding team will remain at its current level.

SECTION 5: LASP Partner Updates

Belfast and Lisburn Women's Aid

- All the staff team are given Adult Safeguarding training which is Core. (every three years) Last training session 2018.
- Four staff 1. Board member, Two Senior managers, Outreach worker have completed Adult Safeguarding training Champion/Appointed persons.
- We have one Adult Safeguarding Champion Liz Brogan and three appointed persons.
- All staff and volunteers are aware and can identify the above.
- We have created a template for collating all adult safeguarding queries, discussions, referral activity.
- Each of our three refuges use the pro forma to record ASG activity.
- All information is sent to the ASC.
- All information gathered is used in the yearly ASG report.
- Adult Safeguarding is regularly on staff meeting agenda's; Senior Management team meetings, Board meetings, individual team meetings, and full staff meetings.
- We have an Adult Safeguarding policy which outlines procedures for dealing with Adult Safeguarding referrals etc.
- ASC attends all LASP meetings throughout the year.
- Our key worker in the Older Women's Project has had the following additional training/awareness raising sessions – Dementia Awareness – Advice NI – Integrated services for Older people-Action on elder abuse conference.

Cedar Foundation

Our Quality Improvement Plan included:

- Assurance that all staff and volunteers have the appropriate Level of 1,2,3 Safeguarding Training-Achieved 100%
- Continue to use ISO accreditation as the framework for ensuring systems and processes to monitor and evaluate our Safeguarding Practices; we updated our Policy to reference the European Convention on Human Rights, and to include our Complaints Procedure
- We reviewed incidents monthly and reported quarterly to the Executive Board
- We completed the Adult Safeguarding Champion Position Report for 18/19
- We participated in LASP and ARC Networks to ensure the currency of knowledge regarding best practice approaches to Adult Safeguarding

Lisburn & Castlereagh City Council

Please record your organisations/service activity under the Prevention, Protection, Partnership headings for the year 2017-18. This will be included in the LASP report. If you also know or plan to complete activity in the forthcoming year please also record in the 2019/20 section.

Activity	2018-19	2019-20
Prevention	• Reviewed all 14 SG Procedures • Produced New Procedure – 'Dealing with a Person in Crisis / at risk of suicide' • 4 In house LCCC Keeping safe trainers attended an up skilling/bridging course with Volunteer Now to add adults at risk training to Child protection training to ensure staff only have to be released once for training. • SG champions (SP and BT) Attended Appointed persons training and mental capacity training • SG Champions attend SG Champion network meeting re Position report • Completed the 18/19 Position report • Attended Elder Abuse Conference in February • SG Champions have both attended Mental Health First Aid training • February 2019 - Arranged a meeting with GRO (births, deaths and marriage registration) to discuss the sharing of personal information to ensure a referral can be made to the relevant statutory bodies if abuse is suspected. This was following concerns about a GRO Memo that was sent to Council staff. • Have now achieved Platinum membership of ONUS –	To review and update LCCC Safeguarding Policy - New CEO Revise the e learning management system for Safeguarding and roll out to all staff. Members of in-house working group to attend Appointed person training. SG champions to attend any relevant training

	workplace domestic Abuse. Have carried out a number of awareness raising session in community for businesses and churches	
Activity	**2018-19**	**2019-20**
Partnership	• Attend SET and Belfast Trust LASPS meetings • Elder Abuse day 15 June 2018 - Bow street mall - partnership with PCSP, SET LASP, Banks and Trading standards on scam awareness • SG champion on working group for action plan - 'accessing safeguarding services' • SG champions are active members of NI Safeguarding Network • PCSP now members of our internal working group	Work in partnership for Elder abuse day 2019 - loneliness theme

Volunteer Now

Core KAS Sessions

Throughout 2018-19 Volunteer Now has continued to work in partnership with the Health and Social Care Board and Belfast LASP to deliver free 'Keeping Adults Safe' training to participants from voluntary, community, independent and faith sector organisations in the Belfast Trust area.

The following courses were delivered:

- **3** full day **KAS M2** 'Keeping Adults Safe: Training for Staff and Volunteers'
- **2** full day **KAS M3** 'Keeping Adults Safe: Recruitment, Selection and Management'

There were **79** participants in total and the average participant evaluation score was **4.6** (on a scale of 1 to 5, where 5 is excellent).

Additional Activities

Volunteer Now has been actively involved with the Belfast LASP throughout the year, attending LASP meetings and events.

Volunteer Now Enterprises Ltd also continues to promote the 'Keeping Adults Safe: Adult Safeguarding Champion & Appointed Person' training through the LASP.

Core KAS Sessions – Break down

A full break down of the **core KAS sessions** in the Belfast LASP area is included below:

19th October 2018, Module 2: Keeping Adults Safe: Training for Staff and Volunteers
Belfast (Volunteer Now)
16 participants
Average Score: 4.6

Participant Comments: Enjoyed the group discussions, hearing people's different opinions on situations. / Invaluable to keep everyone up to date with expectations. / Nice relaxed refresher to safeguarding / lots of respect and space to discuss issues, plenty of clarity and guidance / Useful for my organisation.

8th November 2018, Module 3: Keeping Adults Safe: Recruitment, Selection and Management

Belfast (Volunteer Now)
11 participants
Average Score: 4.6

Participant Comments: Invaluable information, well organised and presented / Will go back and look at our policy / Excellent update / Found Access NI info particularly useful / Content of the training was very relevant.

17th January 2019, Module 2: Keeping Adults Safe: Training for staff and volunteers

Belfast (Knockbracken Health Care Park)
14 participants
Average Score: 4.9

Participant Comments: Very interesting training and in depth, really useful and has improved my knowledge greatly. / The training was very thorough – I enjoyed the discussions with the entire group to get different opinions. /

11th February 2019, Module 3: Keeping Adults Safe: Recruitment, Selection and Management

Belfast (Knockbracken Health Care Park)
21 participants
Average Score: 4.4

Participant Comments: Good level of interaction. [Trainer] made you feel very comfortable]. / Well put together course. Good interaction with the group. / Interactive group discussions, useful and informative. / Enjoyable interactive training which raised awareness and evoked thought. / Very well presented. / Trainer was knowledgeable. Room was cold in the morning, warmed up in the afternoon. / Excellent training – enjoyed all the interaction and group exercises. / Lots of food for thought for my organisation as we consider expanding the range of services that we provide. / The resource pack was great. Really enjoyed the case studies and discussions. / Good use of resources. / Good opportunity to revise and recap on existing knowledge and to network with others.

19th March 2019, Module 2: Keeping Adults Safe: Training for staff and volunteers Belfast (Knockbracken Health Care Park)

17 participants
Average Score: 4.7

Participant Comments: Room was cold. / Great lunch facilities, / Easy to understand, and use in my workplace. / Enjoyed the training – very informative and related to my work place. / A high standard of training, very informative and felt very comfortable and able to ask questions. / Trainer very good. / Well laid out training with experienced facilitator. / Very well delivered. / Room was freezing, everyone uncomfortable.

Core KAS Sessions – Analysis

Participant Feedback

The average participant evaluation score for the Belfast M2 sessions was **4.7**, and for the M3 session was **4.5** (on a scale of 1 to 5, where 5 is excellent).

As demonstrated by the participant evaluation comments included above, feedback has continued to be excellent with respect to the trainers, course content, delivery and interactive nature of the sessions.

Booking and Attendance Numbers

The 3 KAS M2 sessions were attended by 47 participants and the 2 KAS M3 sessions by 32 participants, giving a total of **79 participants across the 5 sessions.** This averages at 15 participants per session (the maximum is 25 per session).

A significant issue across all KAS sessions is ‘drop out’ of participants who have signed up for sessions and then failed to attend or made late cancellations. This can be difficult to manage due to the courses being free to book and has continued in 2018-19 despite our formal booking/confirmation process via our website and reminder emails being routinely sent to participants prior to delivery dates.

SECTION 6: Belfast LASP work plan 2019/20

There will be a strong emphasis on taking forward areas of adult safeguarding work within the Belfast Trust in response to regional and local learning.

There will be a review of adult safeguarding structures and local procedures to ensure that adult safeguarding is fully embedded across all areas within the Trust.

In addition, the Belfast LASP will work to deliver on the NIASP annual objectives for 2019/20 and will consult with Belfast LASP members regarding a local LASP work plan for 2019/20.

CONTROLS ASS RANCE EVIDENCE LIST

Standard Medicines Mgt. **Risk Assessor** **Date** **Score** 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
1 **Board level responsibility for the safe and secure handling of medicines is clearly defined and there are clear lines of accountability throughout the organisation, leading to the Board**	The Trust Chief Executive has overall statutory responsibility for the safe and secure handling of medicines.			0	
	The Chief Pharmacist is responsible for ensuring systems are in place to appropriately address all aspects of the safe and secure handling of medicines and reports directly to the Chief Executive.			0	
	The Trust's commitment to the safe and secure handling of medicines is clearly signalled.			0	
	Clear lines of accountability for the safe and secure handling of medicines throughout the organisation have been established. These define the relationships between the Trust Board, Risk Management Committee, Pharmacy Services Clinical Governance Committee and other relevant groups.			0	
	There is a Medicines Management Committee which reviews, analyses and monitors medicines use processes.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

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Standard: Medicines Mgt. Risk Assessor: Date: Score: 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
2 **Suitable controls are in place, which ensure that the principles of the se and Control of Medicines Report are met.**	The Trust complies with guidance on the Use & Control of Medicines (2004)			0	
	This addresses a wide range of issues but principally: - Prescribing - Administration - Record Keeping - Storage and Security - Supply, delivery and transfer - Labelling - Waste - Practice environments - Specific practitioners			0	
	Standards set in the Duthie report for the handling, administration, storage and custody of medicinal products in hospitals, community clinics, residential and nursing homes, community nursing or midwife units and the ambulance service form the basis of local policies & procedures.			0	

CONTROLS ASS RANCE EVIDENCE LIST

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Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
2 (cont'd)	At each step where a medicine changes hands there are clear procedures which document: - Where responsibility lies, whether it may be delegated and how far it extends. - What should be recorded, where, by whom and how long records should be kept. - How often stock reconciliation should take place and who should undertake the task.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
3 **Medicines are procured, stored and handled in an efficient and secure manner.**	Pharmacy staff are involved in replenishing, monitoring, and adjusting medicines stock control.			0	
	Appropriate procedures are in place for the ordering, stock control, storage, movement and safe handling of medical gases.			0	
	Under the management of Chief Pharmacists, wherever possible, corporate action is taken to ensure the efficient and effective procure-ment of all medicines, particularly in the context of the Pharmaceutical Contract Executive Group, established by Trust CEO & aligned to public procurement policy and strategy				
	Particular attention is paid to the following medicine security issues: - Storage of medicines, whether in bulk in the pharmacy or in smaller quantities elsewhere. - Methods of ordering medicines.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
3 (cont'd)	- Means of delivery. - Receipts procedures, including full records. - Methods of distribution both within and between hospitals. - Dispensing of medicines including patients' own medicines, dispensing for discharge and self administration. - Administration of medicines. - Disposal of medicines. - Where self administration schemes are in operation.				
	Physical security measures in place include: - Lockable cupboards, freezers and fridges for the storage of medicines, with temperature monitoring as appropriate. - Cabinets which meet the requirements as set in the Duthie report for all medicines. - Lockable medicine trolleys which are immobilised when not in use. - Lockable, immobilised bedside medicine storage cupboards (where appropriate).			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
3 (cont'd)	- Lockable, security sealed containers for transporting/moving medicines. - Entrances to pharmacies and other controlled areas have solid doors, fitted with security locks and intruder alarms. - Stationery including requisition books, order books and blank prescription forms are kept in a locked cupboard.				
	Staff handling medicinal products which are hazardous to health comply with COSHH regulations. Contact is either prevented or adequately controlled.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

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Standard: Medicines Mgt. Risk Assessor: Date: Score: 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
4 **The organisation conforms to HPSS Charges for Drugs and Appliances (Amendment) Regulations (NI) 2003**	Arrangements are in place for the collection of prescription charges as specified in source guidance taking into account exemption and remission from charges.			0	
	No charge is made for medication administered or supplied within hospital premises to HPSS patients and there is no charge liability for discharge medication.			0	
	Medication for the treatment of venereal disease (STDs) is dispensed free of charge.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

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Standard	Medicines Mgt.	Risk Assessor		Date		Score	0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
5 **nlicensed aseptic dispensing in hospital pharmacies complies with HSSE(OCE)1/97, and licensable activities are covered by a manufacturing "specials" licence.**	Aseptic preparation of medicines is only carried out under the supervision of a pharmacist.			0	
	Unlicensed aseptic dispensing facilities in hospital pharmacies undergo regular inspections by the RPLS every 24 months and they report to the Chief Executive and those commissioning health services.			0	
	Licensed activities are subject to regular audit by Departmental Inspectors.			0	
	There is a programme of regular internal audit.			0	
	There is a programme of capacity planning for equipment and staff.			0	
	Aseptic dispensing is carried out under the control of a pharmacist in suitable facilities to avoid the risk of microbiological contamination and medication errors sometimes associated with the preparation of parenteral medication at ward level.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard	Medicines Mgt.	Risk Assessor		Date		Score	See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
5 (cont'd)	Radiopharmaceutical dispensing activities take into account the registration of open sources by the Environment Agency, additional training requirements for staff, radiological implications for staff and a prospective programme for quality assurance of products.			0	
	Verification that users of radiopharmaceuticals are authorised to do so is sought prior to use.			0	
	Where products are transported to other sites, proper packaging is always used and the services of a safety advisor are employed.			0	
	Radiopharmacies are licensed unless operated under the direct supervision of a pharmacist.			0	
	When work to identify the capacity issues around workforce, workload and workplace in relation to aseptic preparation is completed, the Trust will be in a position to respond to the findings and recommendations.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: 0

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Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
6 **Prescription, supply and administration conform to the re uirements of relevant legislation. Prescription, supply and administration of medicines is undertaken only by appropriately ualified, competent staff.**	Prescription only medicines (POM) are only supplied to patients against the prescription or written direction of an "appropriate practitioner."			0	
	Doctors,dentists and independent nurse prescribers may prescribe,administer or supply Prescription Only Medicines in areas where they are competent directly to a patient. Supplementary prescribers may only prescribe in accordance with an agreed patient specific clinical management plan and the patient's agreement. Other nurses and healthcare workers,however,supply medicines under the direction of a Doctor.			0	
	Midwives may administer specified controlled drugs, under a supply order which is signed by an appropriate Medical Officer Doctor or Supervisor of Midwives and any of the substances that are specified in medicines legislation under midwives' exemption,provided it is in the course of their professional midwifery practice.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
6 (cont'd)	No-one can administer parenteral POM's otherwise than to himself unless he is a practitioner or acting in accordance with the directions of a practitioner although there are two exceptions: - Certain life saving drugs used in an emergency. - Medicines available to particular health professionals, e.g. paramedics, in the course of their professional practice.			0	
	Legislation is framed to ensure that the majority of clinical care should be provided on an individual patient-specific basis. Where the direction of a doctor is not patient specific, the Trust ensures that the appropriate patient group direction: - Is authorised by a senior doctor and senior pharmacist. - Is approved on behalf of the Trust. - Is undertaken by sufficiently competent, trained, experienced personnel and offers genuine benefit for patients, which cannot be fulfilled by the usual prescription route.			0	

CONTROLS ASS RANCE EVIDENCE LIST

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Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
6 (cont'd)	There is a clear audit trail, i.e. a secure system for recording, monitoring and reconciling medicines.			0	
	Appropriate protocols are in place to ensure that arrangements for comm-unication and transfer of patient informat-ion relating to medicines,prescribing and medication history support safe practice and confidentiality.				
	Medicine defects or safety alerts,including those relating to devices,must be imple-mented as appropriate.				
	Unlicensed medicines are only used where a licensed alternative is not available and pharmaceutical quality assurance has been demonstrated for both the procurement and use of such products.			0	
	Chemotherapy prescribing, supply and administration are in accordance with the policy of the local cancer network. In addition, prescribing, supply and administration of intrathecal chemotherapy complies with HSS(MD) 45/2003 and HSS (MD) 39-02.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
6 (cont'd)	A House Officer who holds the relevant qualification which allows him to be registered but does not yet have the required experience may issue prescriptions for POMs or CDs as part of his required duties or post. He may not order for private patients or for his own use.			0	
	BNF guidance on how to write prescriptions to ensure clarity and safety is followed.			0	
	Ward Pharmacy services are in place to ensure that prescriptions are safe, clear, legible, etc. and comply with local and national guidance.			0	
	In accordance with the EU directive patient information leaflets are supplied each time a medicine is dispensed to a patient.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. | Risk Assessor: | Date: | Score: 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
7 **The prescribing, supply, administration, safe custody and destruction of controlled drugs complies with the appropriate legislation.**	Possession,supply,storage and record keeping of controlled drugs meets the requirements of both the Medicines Act & the Misuse of Drugs Act & regulations made under the legislation.Comprehensive guidance is available in the BNF, and Ethics and Practice.			0	
	The pharmacy keeps a register in the form of a bound book for Controlled Drugs in Schedule 6 to the 2002 regulations.			0	
	All requisitions for controlled drugs comply with the legislation and contain: - Ward or department name and address. - Description of controlled drug required including the form. - Total quantity to be supplied. - Signature of the Nurse in Charge (or other approved departmental manager) - Signature of supplier. - Signature to receive goods for transit.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
7 (cont'd)	- Signature for receipt at ward or department. - Date.				
	Midwives and paramedics are also required to keep a record of controlled drugs received and drugs administered, in a book kept solely for that purpose.			0	
	There are documented systems and procedures in place for the destruction of all Controlled Drugs, including patients' own drugs, which adhere to regulations where these apply.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

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Standard: Medicines Mgt. Risk Assessor: Date: Score: 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
8 **All medicines no longer re uired are destroyed or otherwise disposed of in accordance with safety, legal and environmental re uirements.**	The Trust adheres to the following principles when disposing of medicines: - Witnessed accountability. - Secure transit. - Adequate documentation. - Legally authorised persons to carry out and, where necessary, witness the destruction. - Adherence to legislation.			0	
	The Trust applies all required controls to "special waste" under the Special Waste Regulations 1998.			0	
	Prescription-only medicines are classed as special waste and all movements are tracked using consignment notes and relevant records are kept for three years.			0	
	Those persons who keep records of Controlled Drugs under the Misuse of Drugs regulations only destroy them in the presence of an authorised person.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

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Standard Medicines Mgt. Risk Assessor Date Score 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
9 **The supply of medicines for clinical trials is undertaken in accordance with relevant legislation and best practice guidelines**	Clinical Trial Authorisatios are held for any trials sponsored by drugs companies.			0	
	All clinical trials involving medicines comply with Medicines for Human Use (clinical trials) Regulations 2004.			0	
	All trials identify a sponsor which takes responsibility for the initiation, management and/or financing of a clinical trial.			0	
	All trials are authorised by the Licensing Authority (LA), prior to commencement.			0	
	All trials conducted with a DDX granted before latest regulations notify the L.A. of intention to continue after01/05/04 and provide details of the current study sponsor,so as to be considered as having the necessary authorisation.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
9 (cont'd)	Clinical trials are carried out in accord-ance with the conditions and principles of good clinical practice as set out in the Medicines for Human Use Regulations 2004.			0	
	The manufacture of investigational medicinal products (including placebos & active comparators) is undertaken only at licensed manufacturing sites with an additional specific IMP license under GMP conditions.			0	
	Prior authorisation by the Licensing Authority is obtained for manufacture for importation from outside EU.			0	
	Procedures are in place for dealing with untoward events.			0	
	All medicines, or constituent ingredients, for clinical trials are ordered, stored and dispensed by the hospital pharmacy.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
9 (cont'd)	The Trust adheres to guidelines in respect of clinical trials in hospitals in the following ways: - A suitably trained and competent pharmacist has been designated as responsible for clinical trials supplies. - Pharmacist is responsible for ensuring that necessary certificate or exemptions are obtained before trials begin. -There is pharmaceutical input to the trial protocol. - There is pharmaceutical input to the local research ethics committee. - Ordering, storage and dispensing takes place in accordance with the requirements of "Good Clinical Practice for Trials on Medical Products in the European Community" and the guidelines provided in the Duthie report - Stock accountability. - Access to trial protocols. - Reimbursement of pharmacy costs.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard Medicines Mgt. **Risk Assessor** **Date** **Score** 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
10 **The organisation reports adverse incidents involving medicinal products and devices to the relevant agency, and appropriately manages any subse uent re uired action.**	The Trust identifies and learns from all patient safety incidents & demonstrates improvements in practice,based on locals & national experience and from the infor-mation derived from analysis of incidents			0	
	The Trust encourages the prompt reporting to the Medicines Control Agency of any suspected adverse reactions due to "black triangle" drugs and any serious or unusual suspected reactions to established products. The "yellow card" is used for reporting adverse drug reactions to the agency.			0	
	Adverse incidents arising from any medicinal product, thought to be defective, are reported to the Pharmac-eutical Branch, DHSSPS.			0	
	The Trust ensures that: - Drug incidents are reported and investigated locally. - Defective medicinal products are reported to the relevant agency.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard Medicines Mgt. **Risk Assessor** **Date** **Score** See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
10 (cont'd)	- Products are kept until the option of investigating the incident has been dismissed. - Staff are aware of the mechanisms for reporting an adverse reaction or a defect with a medicinal product. - An auditable procedure is in place in primary and secondary care relating to the management of drug recalls.				
	Procedures are in place to ensure the prompt reporting of adverse incidents relating to medical devices to the N. Ireland Adverse Incident Centre.			0	
	A liaison officer has been nominated to co-ordinate the reporting of incidents and for disseminating safety warnings from them.			0	
	Regular reviews are undertaken to ensure that the procedures are effective and are being followed.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
10 (cont'd)	A pharmacist has been nominated to co-ordinate the reporting defective medical products incidents and action resulting from a 'drug alert' letter. Regular reviews are undertaken to ensure that procedures are effective and are being followed.			0	
	The Trust has established a local, multi-disciplinary, medication error (prescribing, dispensing or administration) reporting and monitoring system as part of the Risk Management system.			0	
	Medication incidents are reported on existing clinical report forms or on the Medicines Governance Team form.			0	
	The Trust facilitates the online reporting of medication incidents.			0	
	Medication incident reports are monitored by a multi-professional management committee.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
(cont'd)	The Trust ensures that: -staff are aware of the process for reporting an adverse drug reaction & report suspected adverse reactions via the yellow card system. -Defective medicinal products are reported to the relevant agency -products are kept and, if necessary quarantined,until the option of invest-igating the incident has been dismissed. -staff are aware of the mechanisms for reporting a defect with a medicinal product - an auditable procedure is in place in primary & secondary care relating to the management of drug recalls			0	
	Staff are aware of the process for reporting medication incidents and the reported incidents are investigated locally.			0	
	-Incidents are also analysed for regional trends.			0	
	- The best practice policies and safety memos issued by the NI Medicines Governance Team are evaluated and implemented.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
11 **Supervision of pharmaceutical dispensing processes is undertaken in accordance with relevant legislation and current professional standards.**	Pharmacists discharge their legal and professional duty by ensuring the safe, accurate and clinically appropriate dispensing of medicines including those that are extemporaneously prepared.			0	
	Pharmacists directly supervise dispensing activities where the premises are registered pharmacies or outpatient prescriptions are being dispensed.			0	
	The dispensing of medicines for patients to take home and one stop dispensing for discharged are also supervised and there is appropriate clinical pharmacy input.			0	
	For in-patient medication, the accountable pharmacist makes sure that staff involved in dispensing are suitably trained and competent.			0	
	Suitable systems are in place to allow the accountable pharmacists to discharge their legal and professional duties of supervision.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard: Medicines Mgt. Risk Assessor: Date: Score: See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
11 (cont'd)	These systems are fully documented in Standard Operating Procedures which cover all aspects of dispensing and associated activities.			0	
	Standard Operating Procedures are reviewed at least annually.			0	
	The SOP's include a suitable system for reporting, recording and prompt review of known dispensing errors.			0	
	Pharmacists adhere to their responsibilities under the Code of Ethics & Standards with regard to extemporaneous preparation.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

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Standard: Medicines Mgt. Risk Assessor: Date: Score: 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
12 **The risk management process contained within the Risk Management System standard is applied to the safe and secure handling of medicines.**	Risks in respect of the safe and secure handling of medicines are systematically identified using: - Control self-assessment workshops. - Use of checklists. - Judgements based on experience and records. - Flow charts. - Systems analysis. - Scenario analysis. - Systems engineering techniques.			0	
	Historic data, including adverse event data, complaint and claim information, staff sickness/absence details are also used to identify risk.			0	
	All identified risks are documented in a "risk register" and systematically assessed and prioritised.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard Medicines Mgt. **Risk Assessor** **Date** **Score** See above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
12 (cont'd)	Risk treatment plans have been developed and implemented.			0	
	Risks and the effectiveness of implemented risk treatments are monitored and reviewed on a continuous basis.			0	
	Senior management and the Board are informed of any significant risks and associated risk treatment plans.			0	
	Upon induction all medical, nursing and pharmacy staff and other stakeholders receive information on systems in place to minimise risks associated with the safe and secure handling of medicines.			0	
	Ongoing staff training in the safe and secure handling of medicines is undertaken.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

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Standard Medicines Mgt. Risk Assessor Date Score 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
13 **All healthcare staff involved with medicines undertake continuing professional development to ensure that there are safe and secure handling processes in place.**	All staff involved with medicines ensure safe and secure handling of medicines through compliance with relevant legislation, DHSSPS guidance and Trust policies.			0	
	Staff are aware of and apply these requirements at all times.			0	
	As the requirements for safe and secure handling of medicines may change over time, all practitioners keep up to date with current practice through continuing learning and continuing professional development.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard Medicines Mgt. **Risk Assessor** **Date** **Score** 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
14 **The organisation, through the Chief Pharmacist, has access to up-to-date legislation and guidance relating to the safe and secure handling of medicines.**	As a minimum, staff have acccess to all the key references listed at the front of this standard.			0	
	Trust staff have access to up-to-date legislation and relevant guidance.			0	
	There are appropriate mechanisms in place for the dissemination of information.			0	
	Up to date DHSSPS guidance is accessed on the internet and equivalent NHS documents via the COIN database, the Medicines & Healthcare Regulatory Agency website, the Controls Assurance Support Unit website and the DHSSPS governance website.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

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Standard Medicines Mgt. Risk Assessor Date Score 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
15 **Ade uate resources support the safe, secure and appropriate use of medicines.**	All parts of the Trust where there is involvement in the safe and secure handling of medicines are adequately staffed with competent personnel and suitable facilities and equipment are available.			0	
	There is strong collaboration across Primary & Secondary care relative to the use of medicines and a Drug & Therapeutics Committee has been established to agree,implement & monitor adherence to prescribing guidelines across these sectors.			0	
	Consideration is given to developing these in line with HPSS modernisation plans.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard Medicines Mgt. **Risk Assessor** **Date** **Score** 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
16 **Key indicators capable of showing improvements in the safe and secure handling of medicines and the management of associated risk are used at all levels of the organisation, including the Board, and the efficacy and usefulness of the indicators is reviewed regularly.**	Indicators have been developed which demonstrate that medicines are being safely and securely handled and risks are minimised.			0	
	The indicators are designed to demonstrate improvement in the performance of pharmacy services and staff prescribing and handling medicines over time.			0	
	The number of indicators devised is sufficient to monitor all aspects of the process, including risk management.			0	
	The Board uses those indicators which are useful for ensuring that internal controls are working satisfactorily and medicines are being safely and securely handled.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

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Standard: Medicines Mgt. Risk Assessor: Date: Score: 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
17 **The system in place for the safe and secure handling of medicines, including risk management arrangements, is monitored and reviewed by management and the Board in order to make improvements to the system.**	Management and the Board monitor and review all aspects of the system for the safe and secure handling of medicines including: - Accountability arrangements. - Processes, including risk management arrangements. - Capability. - Outcomes. - Internal Audit findings.			0	
	The review is carried out by individuals with the relevant knowledge and expertise of the safe and secure handling of medicines and includes a review of any adverse incidents.			0	
	The Risk Management Committee monitors and reviews all aspects of the system as a basis for establishing significant information which should be presented to and dealt with by the Board.			0	
	The Audit Committee reviews internal audit findings.			0	
			TOTAL	0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard Medicines Mgt. **Risk Assessor** **Date** **Score** 0

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
18 **The Board seeks independent assurance that an appropriate and effective system for the safe and secure handling of medicines is in place and that the necessary level of controls and monitoring are being implemented**	Management has considered the range ofindependent internal and external assurance available and avoids duplication and omission.			0	
	The Board obtains independent assurance that the system for safe and secure handling of medicines is appropriate and effective.			0	
	Any review that takes place results in a report, recommendations for action and the retention of evidence of work undertaken.			0	
	Reports are made to the appropriate sub-committee of the Board.			0	
	Internal Audit and Clinical Audit functions are in place.			0	

CONTROLS ASS RANCE EVIDENCE LIST

Standard Medicines Mgt. **Risk Assessor** **Date** **Score** see above

Criterion No.	Evidence Re uired	Source	Ref:	Score age	Rationale Behind Score Awarded
18 (cont'd)	Internal Audit is required to give an opinion to the Board on the adequacy and effectiveness of the overall system of internal control. In doing so they will seek to work with, and rely on the work of other bodies e.g. RQIA.			0	
	More specific assurance for this standard is gained from visits by: - DHSSPS Medicines Inspectorate			0	
			TOTAL	0	

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OVERALL SCORE FOR MEDICINES MANAGEMENT STANDARD

Criterion Number	Score(S)
1	0
2	0
3	0
4	0
5	0
6	0
7	0
8	0
9	0
10	0
11	0
12	0
13	0
14	0
15	0
16	0
17	0
18	0
TOTAL	0

OVERALL SCORE FOR MEDICINES MANAGEMENT STANDARD 0

EB34/03

A RISK MANAGEMENT STRATEGY

FOR THE

EASTERN HEALTH

AND SOCIAL SERVICES BOARD

April 03

1. INTRODUCTION

1.1 The Eastern Health and Social Services Board is responsible for commissioning high quality health and social care for the community it serves. This Risk Management Strategy has been developed in order to ensure the Eastern Health and Social Services Board discharges its functions so as to ensure that risks are managed as effectively and as efficiently as possible and to acceptable standards of quality.

1.2 Risk management is recognised as an integral part of good management practice. It is an iterative process consisting of core elements which, when undertaken in sequence,and applied across the whole organisation enable continual improvement in decision making and in the quality of outcomes.

2. DEFINITIONS

2.1 In order to assist in understanding the different stages in the process of Risk Management, the following definitions are used for the core elements in the process.

2.2 **Risk management** is the term applied to a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring and reporting risks associated with any activity of the Board, in a way that will enable the Board to minimise losses and maximise opportunities. Risk management is as much about identifying opportunities as avoiding or mitigating losses, and it underpins all developments in Governance.

2.3 **Corporate Governance** is the formal system by which the Board is directed and controlled at its most senior levels in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

2.4 **Controls Assurance** is the process that enables HPSS bodies to demonstrate that they are doing their reasonable best to manage to meet their objectives and to protect users, staff, the public and other stakeholders against risks of all kinds. It is a means whereby the Chief Executive as Accountable Officer, discharges her responsibilities and can provide a public assurance that appropriate governance arrangements are being applied across the whole organisation.

2.5 Improved Governance in the Board is the prime objective of the elements outlined above.

3. PROCESS

3.1 Risk Management, is the underlying process of planning and identifying risk and the requirement for a control process which provides the ~~nescseeary~~ necessary assurance. The lead in this will be undertaken by the Board's Risk Management Group.

3.2 Corporate Governance has two strands. It has tended to be the term to describe procedures as set out in the Board Standing Orders for the control of the senior levels in the Board. The more generic use of the term Governance relates to the process of ensuring that risks, and the nescessary control framework, identified under the Risk Management process, are implemented across the whole organisation. This is a matter which requires corporacy across all unidisciplinary and multidisciplinary activities of the Board.

3.3 Controls Assurance is the process whereby the Chief Executive, as Accountable Officer, is enabled to make a public statement that the Board has discharged its responsibilities through controls assurance processes in each area of the Board's activities or where this is not the case, the potential effect of risks are identified.

3.4 All three elements are part of the wider governance agenda to which the Board is committed. While each element has its own processes and developing guidance, they are dependent on each other in order to give the final assurance that public funds are being used appropriately and that the best possible care is provided to the population we serve.

4. MAIN AREAS OF RISK

4.1 The Four Boards in N Ireland have recognised that there are four broad functional areas of risk

- the Board's strategic functions
- the Board's internal operational responsibilities

- the adequacy of risk management within the services commissioned by the Board
- the adequacy of risk management in collaborative/partnership working across HPSS organisations and with other organisations.

From these four broad functional areas the Board has determined that there are seven key strands which group the risks for the organisation. These are also set out in the diagram at the diagram at the end of this report.

- Clinical Care Governance
- Social Care Governance
- Primary Care Governance
- Corporate Governance
- Internal Financial Controls
- Organisational or Management Controls
- Other Statutory Requirements

5. RISK MANAGEMENT POLICY STATEMENT

5.1 The Eastern Health and Social Services Board follows and adopts best practice in the identification, evaluation and control of risks to ensure, as far as is reasonably practical, that risks are managed or reduced to an acceptable level. The Board accepts that risks exist and can never be eliminated. It is, however, important that all staff are aware of the nature of risk and the types of risk associated with their areas of work. Senior staff accept responsibility for dealing with risks in their service areas. Senior management provide support and assistance in the risk assessment and evaluation process.

6. OBJECTIVES IN RELATION TO RISK MANAGEMENT

6.1 The Board's objectives in relation to the management of risks are to:

- integrate risk management into the culture of the Board;
- manage risk in accordance with best practice;
- consider legal compliance and statutory duties as a minimum standard;

- anticipate and respond, wherever possible, to changing social, environmental and legislative requirements;
- raise awareness of the need for risk management.

7. RISK MANAGEMENT PROCESS

7.1 The Board will advance its risk management In line with the Australia/New Zealand Risk Management standard AS/NZS4360:1999 which has been adopted as the regional standard for the NIHPSS and for the NHS. The key stages of the Board's risk management process comprise:

7.2 Establishing the context

The Board will establish a strategic, organisational and risk management context in order to define the basic parameters within which risks must be managed and to provide guidance for decisions within more detailed risk management studies. The Audit and Controls Assurance Committee will decide the criteria against which risk is to be evaluated and define the structure for risk management.

7.3 Identifying risks

The Board will ensure that the risks to be managed are identified using a comprehensive, well structured, and systematic process. The Board's Audit and Controls Assurance Committee (see Section 8) will ensure that there is an ongoing programme of risk identification and that a rolling risk audit programme is developed. The approach used to identify risks will depend on the nature of the activities under review and the type of risk involved.

7.4 Analysing the risks

All identified risks will be analysed to separate minor acceptable risks from the major risks and to provide data to assist in the evaluation and treatment of risks. Risk analysis will involve consideration of the sources of risk, their consequences and the likelihood that those consequences may occur. Factors which effect consequences and likelihood will be identified and risk will be analysed by combining estimates of consequences and likelihood in the context of existing control measures. Formal assessment reports will be prepared and reviewed by the Risk Management Group and assessed by the Audit and Controls

Assurance Committee. An organisation wide risk register will be developed to ensure that significant risks are recorded, actions identified and implementation tracked. The Audit and Controls Assurance Committee will work to develop a methodology for prioritising risks based on severity, frequency and existing controls.

7.5 Evaluating the risks

Risk evaluation will involve comparing the level of risk found during the analysis process with the previously established risk criteria. The output of the risk evaluation will be a prioritised list of risks for further action. If the resulting risks fall into the low or acceptable risk category, they will be accepted with minimal further treatment. Low and accepted risks will be monitored and periodically reviewed to ensure they remain acceptable. If risks do not fall into the low or acceptable risk category, they will be treated as described below.

7.6 Treating risks

Where it is not practicable to avoid a risk entirely, all necessary steps will be taken to control the frequency and severity of the risk. Controls will be established to prevent risks (and therefore reduce likelihood of frequency of occurrence) and/or to mitigate loss should a risk materialise (and therefore reduce the impact of the risk). The Board's Risk Management Co-ordinator will provide expert assistance and advice to Board officers in identifying appropriate actions to treat risks.

7.7 Monitoring and reviewing

The Board through its Audit and Controls Assurance Committee will monitor risks, the effectiveness of the risk treatment plan and strategies and the management system set up to control implementation. Risks and the effectiveness of control measures will be monitored to ensure changing circumstances do not alter risk priorities as few risks remain static.

Ongoing review will take place to ensure that the management plan remains relevant.

7.8 Communication and consultation

Communication and consultation will be an important consideration at each step of the risk management process and stakeholders will be informed/communicated with at early stages and throughout the process.

7.9 Standard Training Programme

The Board will establish a standard programme of Risk Management awareness and training for staff to help them understand and carry out their Risk Management roles.

7.10 Reporting System

The Board will establish a reporting system on the extent to which controls identified are being effectively and consistently applied and will establish a mechanism for ensuring that risk assessments, audits and complaints are brought as appropriate to the attention of the Senior Management Team, the Audit and Controls Assurance Committee, Board staff and managers.

8. RISK MANAGEMENT STRUCTURES AND RESPONSIBILITIES

8.1 It is a fundamental tenet of this Strategy that, whilst overall accountability and responsibility for risk management lies with the Chief Executive as the Accountable officer all Directors and Heads of Department must accept that the management of risk in their service areas and Departments is one of their key operational and day to day responsibilities. The overall risk management responsibilities of managers and staff are broadly outlined below:

8.2 The Board

- designate a Senior Officer accountable to the Chief Executive with responsibility for risk management and for reporting to the Audit and Controls Assurance Committee. This will be the Head of Corporate Services.
- demonstrate commitment through endorsement of the Risk Management Strategy;
- ensure that responsibilities for the management and co-ordination of risks are clear;
- allocate resources on a prioritised basis;
- decide on the level of risk to be carried

- from time to time review the operation/effectiveness of Risk Management structures and Procedures

8.3 The Audit and Controls Assurance Committee

- ensure the appointment of the Risk Management Co-ordinator to co-ordinate activity across the Board and to liaise with the DHSSPS, other Boards and Trusts as appropriate;
- ensure the ratification of major risk management policies and procedures takes place through the appropriate structures;
- ensure the resources required to implement risk management initiatives are identified;
- ensure communication with health and social care organisations regarding problems of mutual concern.
- make recommendations on the level of risk to be carried
- ensure compliance with DHSSPS/DFP Guidance

8.4 Senior Management Team

- ensure the commitment of all Board staff to the Risk Management process
- ensure the effective integration of Clinical and Social Care Governance and Risk management .

8.5 Board Risk Management Group

- secure the effective implementation of the Risk Management Strategy
- ensure the implementation of the ongoing programme of Risk Audits agreed by the Audit and Controls Assurance Committee
- consider Directorate level risk assessments, assign priorities and identify proposed risk treatments
- develop and maintain the Board's Register of Risks
- monitor and report to the Audit and Controls Assurance Committee on the results of risk management activity
- ensure that training needs of Board staff are identified and met

8.6 Board Risk Management Co-ordinator will work closely with the Board Risk Management Group to

- Support and advise the Head of Corporate Services on reporting Risk Management to the Audit and Controls Assurance Committee.

- Co-ordinate all Risk Management activity across the Board and liaise with DHSSPS, other Boards and provider organisations
- Develop, monitor and update as necessary the Boards' Risk Management Strategy
- Work with Board Directorates to ensure that specific Risk Management programmes are developed and implemented within each core function / programme of care
- Develop and maintain an organisation–wide and up-to-date register of risks
- Support Directors and Directorate staff in establishing and maintaining Directorate Risk Management procedures, including risk assessment and incident reporting and in developing service/Directorate specific triggers for incident recording
- Demonstrate compliance with standards as required through internal and external assessments
- Review trends and incidents, claims and complaints
- Investigate trends and specific incidents
- Secure and/or designing and implementing effective education and training on Risk Management
- Provide support to the Board's Risk Management Group and to the Audit and Controls Assurance Committee.
- Liaise with other quality and safety-related initiatives and risk assessments across the Board and the wider HPSS, including those linked to Human Rights, Equality and other legislative requirements.

8.7 Directors, Heads of Departments and Board Managers

- identify Risk Management "lead/leads" for the Directorate
- implement the risk management procedures internally, including risk assessment and incident reporting;
- establish Directorate level risk management teams as appropriate;
- develop Directorate specific triggers for incident recording;
- ensure staff are aware of and adhere to appropriate risk management procedures, including continual risk self assessment;
- ensure the availability of risk management procedures and information for all staff within their area of responsibility;
- facilitate the training of staff to support the implementation of risk management procedures;

- stimulate the interest of their staff to participate in the risk management process by responding positively to the reporting of adverse incidents or general risk related concerns;
- develop and maintain up-to-date details of risks specific to the Directorate as part of the Boards overall Risk Register

8.8 Designated Directorate Risk Management Leads comprise the Board Risk Management Group

Within their Directorates they

- co-ordinate the risk assessment activity within the Directorate ensuring the completion of assessments and review of incident records in line with the Board's risk management strategy and other policy requirements;
- facilitate the flow of incident reports through the Directorate in line with Board policy.

8.9 Designated HSCG leads

- co-ordinate the risk assessment activity within the HSCG ensuring the completion of assessments in line with the Board's risk management strategy and other policy requirements;

- facilitate the flow of incident reports across the LHSCG in line with Board policy.

8.10 All other staff

- general risk awareness at all times;
- notify line managers of any identified risks;
- compliance with relevant incident reporting procedures;
- acceptance of personal responsibilities for maintaining a safe environment
- participate in regular awareness training in keeping with Board policy on training.

9.0 SPECIFIC RESPONSIBILITIES

The risk management structure in the Eastern Health and Social Services Board will include consideration of the risks associated with the maintenance of all statutory functions which are exercised

by individual Board Directors .These statutory functions are established through various pieces of legislation and up-to-date details of the relevant legislation are maintained by the Directors and are covered by Directorate Risk Management procedures.

The role of Non-Executive Directors in serving on the Audit and Controls Assurance Committee and on the Board will be fundamental in advancing Governance through organisation-wide Risk Management.

Designated Board Officers will work with Board officers from the other three HSS Boards to ensure that there is consistency in taking this agenda forward.

10. Review

Board processes for organisation wide Risk Management are represented in the flow diagram attached (Appendix 1). The context of the Risk Management in wider Governance developments is represented figuratively in Appendix 2 (attached). Essentially, Risk Management is a foundation for developing Controls Assurance and appropriate Governance to span all the areas of Board activity.

As NI HPSS specific Controls Assurance standards are issued to EHSSB, the structures and processes outlined above will deal with these and report on the assessed position of the Board on each.

This Strategy and the Board's progress with organisation wide Risk Management should be reviewed by March 2004.

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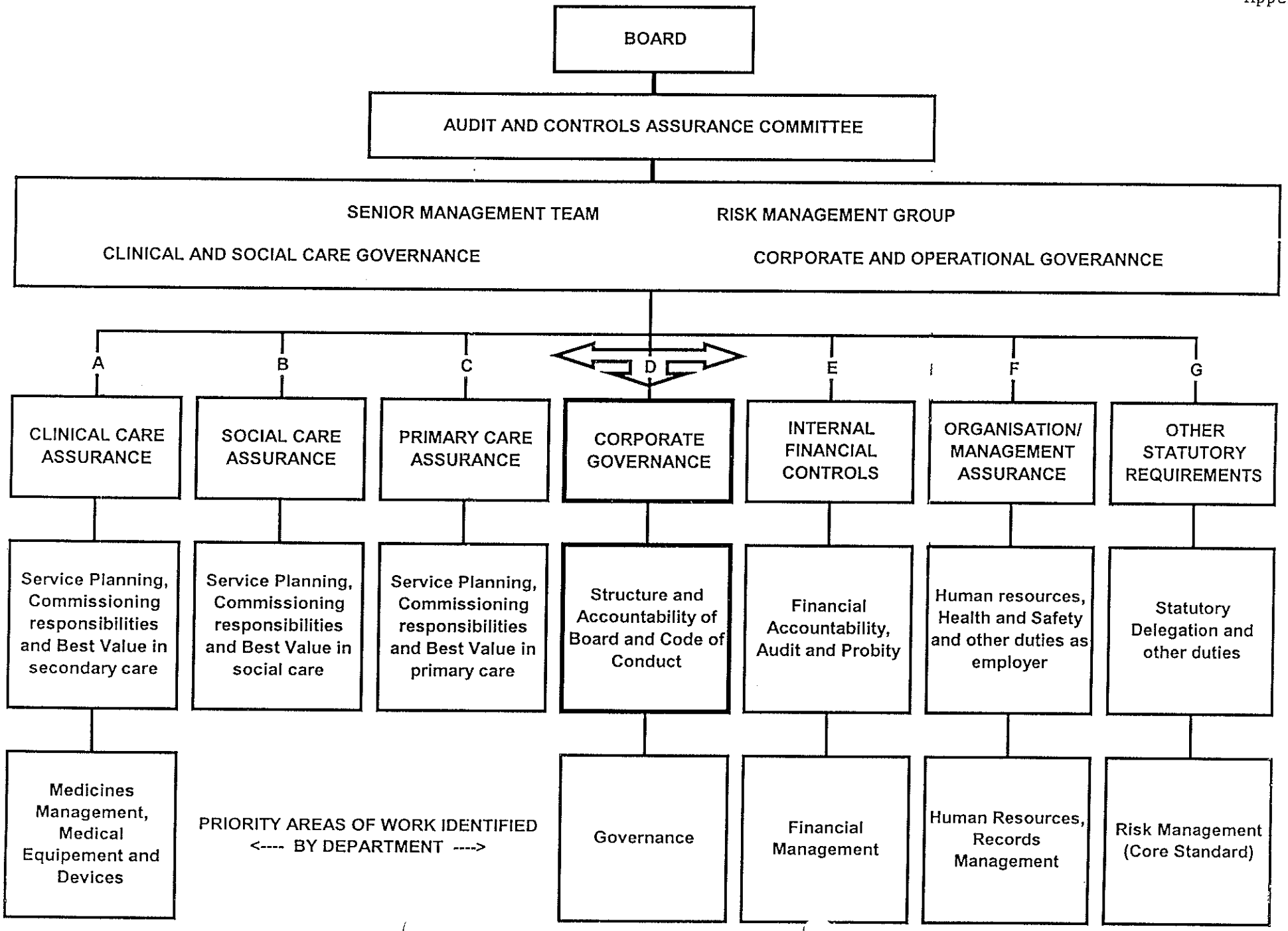

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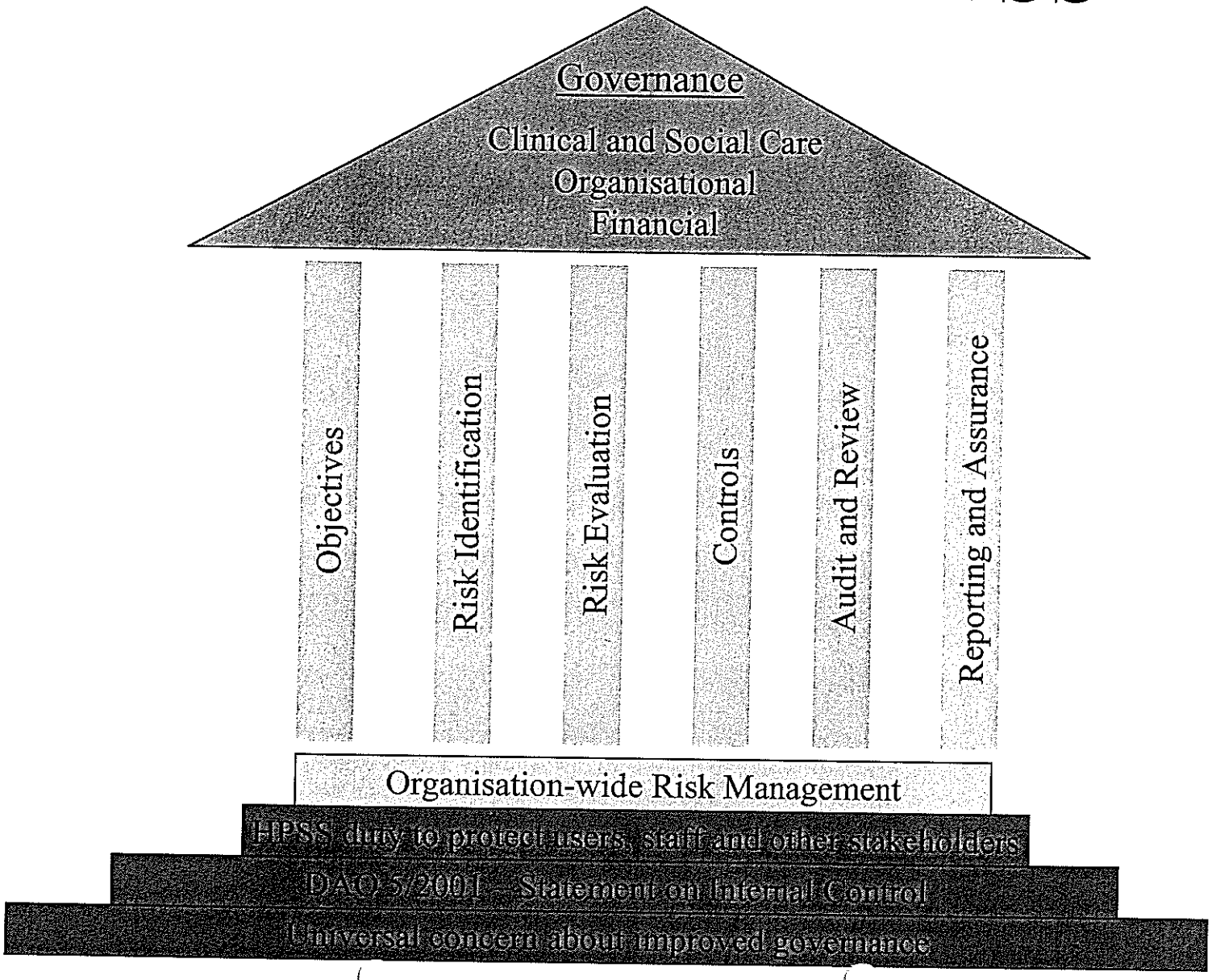
Governance in the HPSS



Governance & Risk Management Strategy and Framework Document

WORKING DRAFT

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Issue date:
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Version 1

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Contents

Governance & Risk Management Strategy
The Eastern Health and Social Services Board

1. Definition

The Eastern Health and Social Services Board (EHSSB), recognises governance as the systems and processes by which the Board will lead, direct and control its functions in order to achieve organisational objectives, and relate to its stakeholders.

To our staff we describe this as: -

'....the system by which on organisation directs and controls its functions and relate to its stakeholders'.

2. Background

Key Developments in recent years include: -

- 5 April 2001: Circular DAO (DFP) 5/2001 introduced the requirement for a wider Statement of Internal Control (SIC) in the accounts of the DHSSPS and of HPSS bodies. The circular referred to the Turnbull Report conclusion that a sound system of internal control must be based on a thorough and regular evaluation of the extent and nature of risks to which an organisation is exposed. The HRRI Review (1999) into risk management in the HPSS, concluded that, while good work was being done, the approach across the HPSS and within individual bodies tended to be fragmented and inconsistent.

- 26 July 2002: Circular HSS (PPM) 6/2002 announced that the DHSSPS, in recognition of the importance of a sound system of risk management, had entered into a license agreement with Standards Australia for the use of their internationally recognised risk management standard AS/NZS 4360:1999 (now updated to 2004 model). The application of this internationally recognised approach to risk management would be seen as an important piece of evidence in support of a Statement of Internal Control.

- 11 October 2002: The application of Controls Assurance standards within the HPSS, was announced in Circular HSS (PPM) 8/2002. This process would enable individual HPSS organisations to provide evidence that they are doing their reasonable best to protect users, staff, the public and other stakeholders against risk of all kinds. It is a means by which Chief Executives as Accountable Officers can discharge their responsibilities and provide assurances to the Department, the Assembly and the Public.

- 13 January 2003: The DHSS&PS issued guidance under Circular HSS (PPM) 10/2002, specific to clinical and social care governance. The guidance was to enable HPSS organisations to formally begin the process of developing and implementing clinical and social care governance arrangements within their respective organisations and set a framework for action which highlighted the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure delivery of high quality health and social care.

  The circular also stipulated the requirement that this new guidance should be read in the context of previous guidance already issued on the implementation of a common system of risk management and the development of controls assurance standards for financial and organisational aspects of governance.

- The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 was approved by Parliament and it places a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care have been issued by DHSSPS. They will be used by the new Regulation, Quality Improvement Authority (RQIA) to assess the quality of care provided by the HPSS. This requires all HPSS organisations to satisfy themselves that the quality of care it provides meets an acceptable standard.

- 24 January 2006: Guidance was issued on Establishing an Assurance Framework: a practical guide for management boards of HPSS organisations. This has been expressly written to help Boards provide assurances on the

effectiveness of their systems of internal control and the management of the principle risks to organisational objectives. (See Framework Section)

- 14 March 2006: The Quality Standards for Health & Social Care were formally issued. The document sets out the standards that people can expect from Health and Personal Social Services (HPSS) and are based around 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 Eastern Health and Social Services Board recognises that it is moving the Governance agenda forward in an environment of limited resources and that Governance issues which arise, will have to be tested and prioritised against other service pressures. Collaborative working across all HPSS organisations is particularly important so that duplication can be avoided and we can learn from each other's approaches.

3. Introduction

The core activity of the Eastern Health and Social Services Board (EHSSB) is the effective commissioning and provision of high quality health and social care within available resources, in order to improve the health and social well being of its population. This is a task that is central to the priorities of all staff regardless of profession or grade. The Eastern Board has a population of 665,000 covering the areas of Ards, Belfast, Castlereagh, Down, Lisburn, and North Down.

This Governance & Risk Management Strategy clarifies the scope of Corporate and Clinical and Social Care Governance; which are underpinned by sound systems of Risk Management. It brings together the various strands of governance activity within the Board into a coherent and corporate framework, ensuring that the health and social care the Board commissions and provides is safe, effective and monitored, to ensure that where possible there

is continuous improvement in service delivery by providers. The strategy has been developed in accordance with relevant guidance from the Department of Health and Social Services and Public Safety (DHSSPS), to ensure the Board discharges its functions in a way that risks are managed as effectively and efficiently as possible and to acceptable standards of quality.

4. Statement of Purpose

To improve the health and wellbeing of the population by working together with partners to influence determinants, shape policy and implement strategic change.

5. Core Values and Corporate Goals

Our statement of purpose is underpinned by 10 core values. (**See appendix XX – Corporate Plan**).

- Agent for Change
- Person-focused
- Equity
- Promoting Health & Social Wellbeing
- Quality
- Local Focus
- Partnerships
- Efficiency
- Openness & Accountability
- Valuing Staff

6. Strategic Purpose and Themes

In achieving this purpose and Corporate Goals the Board aims to continue to work to achieve improved health and social wellbeing for our population, tackle health and social inequalities and improve the quality and range of services within the resources available.

The purpose of this strategy is to provide a Governance Framework for the EHSSB through which it will not only meet its corporate objectives but also meet its statutory duty of quality to ensure that the service it commissions/provides strives to meet the highest possible standards for the population it serves. This will be accomplished by the Board's commitment to the application of the Quality Standards issued by DHSSPS (see section 2, Background). The standards consist of the following five quality themes:

Theme 1: Corporate Leadership and Accountability

Rationale / Aim: The EHSSB has a responsibility to assure the quality of the services it commissions/provides to both the public and its staff. Integral to this is the requirement to provide effective leadership and clear lines of professional and organizational accountability in order to make the most of its resources (people, skills, time and money), and to commission and deliver high quality services to the public in as safe an environment as is possible.

Theme 2: Safe and Effective Care

Rationale / Aim: The EHSSB has a responsibility to commission quality services that are safe, effective and sustainable. Services, which have been shown not to be of benefit, should not be provided or commissioned by the EHSSB.

This theme has been subdivided into three areas:

- Ensuring safe practice and the appropriate management of risk
- Preventing, detecting, communicating and learning from adverse events
- Promoting effective care

Theme 3: Accessible, Flexible and Responsive Services

Rationale / Aim: The EHSSB has a responsibility to ensure that services are sustainable, and are flexibly designed to best meet the needs of the local population and to ensure that 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. The Board strives to continuously improve on the services it provides and/or commissions.

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

Rationale / Aim: The EHSSB has a responsibility to work 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 geographical areas, socio-economic and

minority groups, taking account of equality and human rights legislation.

Theme 5: Effective Communication and Information

Rationale / Aim: The EHSSB has a responsibility to ensure that it 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.

7. Scope

This strategy encompasses all areas of activity under the direct control of the EHSSB. It also takes account of the planning and delivery of care by all Health & Social Care providers and organisations with whom we have entered into contract, or fostered partnerships, with on behalf of our population.

8. Relationship with other Strategies and Policies/Procedures

The development of this strategy is intended to complement other governance related documents therefore demonstrating a cohesive approach that ensures the structures, processes roles and responsibilities are in place to effectively deliver, monitor the function of the Board. Therefore, this strategy should be read in conjunction with the following documents, which the Board has placed in the public domain:

- Complaints Procedure
- FOI publication scheme

In addition the Board operates with a comprehensive suite of polices and procedures relating to Human Resources, Health & Safety, Information Communication Technology etc.

9. Governance Advice Leaflet

A governance advice leaflet has been produced by the Eastern Health & Social Services Board and has been made available on the staff handbook to all Board staff. This provides a simple explanation on the principles of governance within health and social services. (**See Appendix XX**)

10. Equality Screening

DRAFTING NOTE: This process will need to be undertaken

In accordance with S75 and Human Rights Legislation this strategy has been screened and it has been agreed that it does not discriminate against any of the groupings.

Ref	Description	Controls in place	Like-lihood	Impact	Risk level	Action Plan	Corp Plan Ref	No min ated Offi
EHB01	Health & Wellbeing Investment Plan - Challenges:- To effect the ongoing reform and modernisation agenda across the Eastern Area within a very challenging resource environment; to do this in a way that is open and accountable to the public and their representatives as well as Government with the risks that attach to expectations of all parties as to our performance and approach.	The Board & Strategic Programme Groups work closely with Trusts throughout the year to facilitate the implementation of plans agreed by DHSSPS. Monthly & quarterly progress reports are brought to the Board in respect of annual plans and, as necessary, in respect of specific major issues. We have consultation processes in relation to major service developments or changes of use, where we initiate the changes. The constrained time available for Health & wellbeing Investment Plans and the way in which priorities are set by central Government and the DHSSPS constrains significantly the involvement of the public in these processes. The Board has meetings with elected representatives to try to ensure open communication about the major agenda issues.	LIKELY	MED	MOD	The Board will work with 'Local Health & Care Economies' to implement the measures included in the Health & Wellbeing Investment Plan. This involvement is intended to improve the cross-Trust aspects of managing the system. We will expect Board, LHSCG's and Trusts to use every opportunity to communicate with stakeholders about the intentions to change and develop the service in a way which improves patient and client care and responsiveness to need. Pre-consultation processes will be used were possible to allow more people to be engaged in decision making where we have the flexibility to develop Eastern Area approaches.	F01 F02 F03	LYN CH
EHB02	Implications of Delegated Statutory Functions - for Vulnerable Adults, Mental Health/Learning Disability, Family and Child Care. Lack of clarity of the role of the Board in monitoring and measuring quality of Trust performance. Insufficient qualified staff in post to provide services to required standards. Specific areas of concerns include:- The care of children in residential homes The child protection/mental health interface C.A.M.H.S.	Annual Statutory Functions report from Trusts Six monthly Corporate Parenting reports	LIKELY	MED	MOD	A Board audit of Trust performance in implementing DHSSPS guidance of October 2004 on the discharge of people with a mental disorder who could present a risk. The Board have just completed their first homicide Inquiry Report and a second Inquiry is now underway. A comprehensive risk treatment plan has been drawn up regarding the availability of secure residential	F17 F18	CO NN

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Ref	Description	Controls in place	Like-	I Impact	Risk le	Action Plan		Corp Pl No
	Adult especially in Learning Disability Discharge of people with a mental disorder who could present a risk					accommodation for children. This issue is to be considered by the Children's Commissioning Team, liaising with Trusts concerned, with a view to enhancing semi-secure accommodation.		
EHB03	Financial Risks comprising:- Capitation position & gap Consultants contract Agenda for change implications Impact of non deliverability of Trust cash release targets in next 3 years Trust contingency arrangements Managing the Quality & Outcome framework Managing the variation in funding availability arising from the changing population in HCHPSS and GMS funding streams Managing GMS enhanced services/aligning budgeted activity to GP practice level Managing the impact of developments within available funds and other strategic change programmes Duty to remain in financial balance creates a risk on the maintenance of existing services and the provision of new services	Monthly reports on financial position and projections to SMT, EHSSB & DHSSPS Chief Executive/director of finance meet DHSSPS on financial implications for board of strategic change programmes, capitation etc. Strategic & Commissioning finance meeting held monthly with DHSSPS	LIKELY	HIGH	MAJOR	Review of in year changes in allocation Liaison/monitoring with providers Clear communications on a monthly basis of outturn and of projections with trust, Board and DHSSPS Involvement with Director colleagues agreeing service consequences of any Trust contingency or recovery plans.	F04 F05 F06 F07 F08 F09 F10 F11 F12 F13 F14 B08 B09 B10	PAI SLE
EHB04	Emergency Planning - Requirement to ensure there is a robust system in place to manage Outbreak/Environmental Health situation/Major incident. Work undertaken with other organisations e.g. 'Belfast Prepared'. Potential inability to effectively manage serious incidents such as major public health alerts.	A revised Board Emergency Plan has been drafted - work ongoing with other Boards, DHSSPS and other statutory organisations. Media training for and improved liaison with public health staff.	LIKELY	MED	MOD	Finalise Emergency Plan and assess impact of implementation. Review meeting with Trusts Input to DHSSPS initiatives Training of key Board staff	A08 F09	STE WA
EHB05	Provision of complaints handling - Capacity, timeliness, complexity. Quality standards, need for independent lay persons, training, governance issues, freedom of information.	Complaints Committee Trust Liaison Committee Monitoring of the nature and seriousness of complaints	LIKELY	MED	MOD	Review of internal procedures. Training of lay persons involved in complaints handling. Recruitment of additional lay persons.	F26	ADA MS
EHB06	Agenda for change implications - Partnership working, job matching and evaluation, knowledge skills framework.	Agenda for Change: work is to continue during 2006/07. Board group in place & co-ordinators in	LIKELY	MED	MOD	Process for evaluation and matching commenced April 2005. Board workshops with other 3 Boards	B14 C13 C14	ADA MS ALL

Ref	Description	Controls In place	Like-	I Impact	Risk le	Action Plan	Corp Fi	No
	Recruitment & retention of adequately trained/competent workforce within the Board and LHSCG's in light of RPA and financial factors. New GMS contract / Consultant contract.	post. Review Public Administration: SMT managing change, input to regional groups, Board RPA information bulletin board established. Vacancy control programme in place.				on implementation. Partnership with staff side is critical for this work. RPA groups and work now underway. 4 board work as well as EHSSB work ongoing. Monitor impact of vacancy control management.	G04	DIR
EHB07	Fire Safety Controls Assurance Standards	New Board Health & Safety Committee established. Ongoing buildings security review. Closer Management of outposted offices and staff. Fire policy has been reviewed and reissued in March 2006 Ongoing staff training.	UNLIKE	MED	MINOR	Systematic review of activities and revised guidance issued to Board staff and Champion House tenants	F19	ADA MS
EHB08	IT support to GMS contract Board fails to meet its obligations for IT support under the new GMS contract	Allocations for 2006/07 now confirmed	POSS	MED	MINOR	Currently being implemented. Negotiating enhanced support contracts with system suppliers.	B14	ADA MS ADA IR
EHB09	Potential inability to identify under performing doctors - Prevention, detection and management of underperforming GP's. Overseeing and implementation of GP appraisal.	LAIP committee is now functioning. Current system in place but needs to be revised in accordance with DHSSPS guidance.	POSS	MED	MINOR	Board will continue to press the DHSSPS for the power to suspend doctors who do not meet agreed performance standards	B14	ADA IR
EHB10	Data Protection, FOI & Confidentiality - Ensure Board maintain proper levels of data protection and confidentiality across all Board activity. Additional risk associated to obligations under FOI and records management implications	FOI issues being reviewed regularly. FOI workshop with Non Executive Directors Staff guidance leaflet on confidentiality issued.	POSS	MED	MINOR	Internal review of Board processes Training of staff and adopting of new Records Management System Close liaison with complaints processes.	F29	ADA MS
EHB11	Implications of Human Rights & Equality responsibilities	Ongoing awareness and specialist training Screening process in place Establishment of Quality Assurance Screening Group Regular reporting mechanisms in place	POSS	MED	MINOR	Clarification of the role of commissioner in respect of human rights and the processes for monitoring	E01 E03	LYN CH

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Ref	Description	Controls in place	Like-	I	Impact	Risk le	Action Plan	Corp Pl	No
EHB12	Difficulties in achieving full and productive engagement with other agencies, both statutory and voluntary, in Partnership Working. This may be more problematic as organisations and senior personnel during the Review Of Public Administration transition period.	All Departments continue to collaborate and maintain relationships in the interest of patients, clients and population.	UNLIKE	MED	MINOR			A01 A02 A03 A05 B02 B03 C01 C02 C03 C04 C05 C06 C07 C08 C09 C10 C11 C12 C13 C14 C15 C16	ALL DIR

Total number of records 12

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Appendix 3

EHSSB - First Cut Corporate Risk Register June 2004

	Insignificant	Minor	Moderate	Major	Catastrophic	Total
Corporate Services	8	29	8	4	0	49
Finance	2	32	8	0	0	42
Planning	5	9	2	1	0	17
Contracts	0	4	6	3	0	13
Pharmacy	0	6	4	3	0	13
GP Unit	3	4	7	7	0	21
PHN&M	1	4	4	5	0	14
PSSD	20	35	13	6	0	74
Dental	0	4	2	0	0	6
Probity	0	2	1	1	0	4
LHSCG	1	8 (+ 2)* =10	1	2	0	14
Total	**40**	**139**	**56**	**31**	**0**	**267**

* = Each LHSCG have identified 2 risk associated with the Environment (office/building).

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PSSD RISK REGISTER

Social Services Directorate

Objective	Risk Areas ie. Dept / Team	Description of Risk	Control Measures Already in Place	Likelihood	Impact	Risk Category	Risk Colour	Action Plan	Nominated Officer	Start Date	Complete Date	Review Date
Vulnerable Adults Policy	All Adult Programmes	Delegated Statutory Functions issue of not knowing the quality of Trust performance in respect:- Assessment, Supervision, Risk Management, Communication, Resources, Monitoring of Accidents, Poor practice.	Statutory Functions Report Quarterly Activity Report Quarterly Meeting of EHSSB Vulnerable Adult Group Untoward Incident Reports	3	4	Major		Improve statutory functions and untoward incident reporting, Meeting Trusts to specify standards and consistency of reporting Northern Ireland Review of Vulnerable Adults Policy and procedures expected to be completed by December 2004. Monitor Trust implementation of new Policy and Procedures - by June 2005 Review data set of quarterly activity report by December 2004	Joyce McKee	Apr-04	Dec-04	Sep-05
Mental Health (NI) Order 1986	Mental Health/Learning Disability	Delegated Statutory Functions issue of not knowing the quality of Trust performance in respect of:- Assessment, Supervision, Risk Management, Communication, Resources, Monitoring of Accidents, Poor practice.	Statutory Functions Report Untoward Incident Reports	3	4	Major		Meeting Trusts to specify standards and consistency of reporting Improve Statutory Functions Report to include report on Approved Social Work standards - by June 2004 Improve Untoward Incident reporting [Corporate Issue]. Programming inspections of Trust services [resource dependent]	Peter Gibson/ Aidan Murray	Apr-04	Dec-04	Sep-05
Safeguarding Children from Physical, Sexual and Emotional Abuse including:- Protection, Early Years, Family Support, Fostering, Residential, Adoption, After Care	Family & Child Care	Delegated Statutory Functions issue of not knowing the quality of Trust performance in respect of:- Assessment, Supervision, Risk Management, Communication, Resources, Monitoring of Accidents, Poor practice.	Corporate Parenting Reports every 6 months. Annual Discharge of Statutory Functions Report Quarterly Monitoring Reports ACPC Annual Reporting Article 20 Reviews Accountability Review Case Management Reviews Complaints monitoring Child Protection Policy & Procedures Monthly meetings with Trust Programme Managers Relevant Research Reports and Projects Registration and Inspection Reports	3	4	Major		Meeting Trusts to specify standards and consistency of reporting New Quarterly Monitoring System (including vacancies) Implement New Department Guidance on relationship with Trusts (Autumn 04) Audit Recommendations of Case Management Reviews Pilot of Social Work Practice Measurement Tool. New Guidance/Standards for Foster Care MES and PFA - April 2004. NISCC - October 2004 Improve reporting and review of Family & Child Care Complaints and Untoward Incidents. H&PSSR&IA 2005	Theresa Nixon	Apr-04	Dec-04	Sep-05
Protection - The Children [NI] Order 1995	Family & Child Care	Inadequate Provision of Servicee in terms of: - Quality Standards	Corporate Parenting Reports every 6 months Quarterly Monitoring Reports ACPC Annual Reporting Case Management Reviews Complaints monitoring Child Protection Policy & Procedures Relevant Research Reports and Projects Registration and Inspection Reports	3	4	Major		Audit Recommendations of Case Management Reviews Pilot of Social Work Practice Measurement Tool Regional Guidance on Management of Risk in Child Protection.	Laureen Walker	Apr-04	Dec-04	Sep-05

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Securing an appropriately qualified and competent workforce	Training - All Programmes	Insufficient qualified staff to provide services to required standards	Training Strategy determined Contracts and qualification targets established Monitoring arrangements in place	3	4	Major		Competence Framework being developed and standardised across Board's area Priority staff groups identified for investment. Verification providers established"	David Vance	Apr-04	Dec-04	Jun-05
Workforce Planning Assessment of current workforce requirements and skills mix.	Training - Al Programmes	Insufficient staff in post to provide service. Insufficient qualified staff to provide services to required standards.	Audit of priority staff groups in place i.e. Family and Child Care and Residential Child Care Workforce analysis of Statutory Functions Reports"	3	4	Major		Centralised information systems to be established Targeted groups to be defined and monitored Function analysis of job profits to be implemented	David Vance	Apr-04		
Vulnerable Adults Policy	All Adult Programmes	Trusts train insufficient staff to carry out investigations	Statutory Functions Report Regional Training Group for Joint Protocol training EHSSB Vulnerable Adult Group for other training	2	4	Moderate		Improve statutory functions reporting Include details of staff trained in new data set for quarterly activity report by December 2004	Joyce McKee	Apr-04	Dec-04	Sep-05
Disabled Persons (NI) Act 1989	Physical Disability	Poor co-operation with schools re. statements and transitions	Statutory Functions Report	4	3	Moderate		Specify detail to be included in Statutory Functions Report - by June 2004 Statutory Functions Report 2003-04 by Sept. 2004.	Peter Gibson/ Aidan Murray	Apr-04		
Insufficient Approved Social Workers trained to Discharge Duties under Mental Health (NI) Order 1986	Mental Health/Learning Disability	Trusts do not have capacity to respond to Mental Health emergencies within the Mental Health, Learning Disability Population	Statutory Functions Report	2	4	Moderate		Improve Statutory Functions Report to (1) include details on Approved Social Work standards and remedial action to address problems and (2) benchmark against Approved Social Work Standard on response times.	Peter Gibson/ Aidan Murray	Apr-04	Dec-04	Sep-05
Failure to monitor/ investigate Untoward Incidents	Mental Health/Learning Disability	People hurt/abused or absent from legal authority when subject to provision of Mental Health (NI) Order 1986	Untoward Incident Reports Statutory Functions Report	2	4	Moderate		Improve Untoward Incident Reports [Corporate issue] Programme of inspections [resource dependent]	Peter Gibson/ Aidan Murray	Apr-04	Dec-04	Sep-05
Protection - The Children (NI) Order 1995	Family & Child Care	Staffing	Corporate Parenting Reports every 6 months Annual Discharge of Statutory Functions Report Monthly meetings with Trust Programme Managers	2	4	Moderate		New Quarterly Monitoring System (including vacancies) Improve Workforce Monitoring (See training risk action plan)	Laureen Walker	Apr-04		
Early Years	Family & Child Care	Inspections	Quarterly Monitoring Reports Article 20 Reviews Provision of Additional Social Work staff Children Services Plan Reviews Relevant Research Reports and Projects	4	3	Moderate		New Quarterly Monitoring System (including vacancies) Check on updating of Web Databases. Improve reporting and review of Family & Child Care Complaints and Untoward incidents - H&PSS RIA 2005	Theresa Nixon	Apr-04	Dec-04	Sep-05
Family Support	Family & Child Care	Choice of Family Support e.g. Domiciliary	Quarterly Monitoring Reviews	4	3	Moderate		Improve Social Work and Provider ???	Theresa Nixon	Apr-04	Dec-04	Sep-05
Fostering	Family & Child Care	Quantity of Placements available	Corporate Parenting Reports every 6 months Annual Discharge of Statutory Functions Report Quarterly Monitoring Reports Relevant Research Reports and Projects	4	3	Moderate		New Quarterly Monitoring System (Including vacancies) Implement recommendations of Regional Strategy for Fostering Review of Expenditure and Bid in place for Implementation of 'Mumby'	Theresa Nixon	Apr-04	Dec-04	Sep-05

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Residential	Family & Child Care	Failure to maintain relevant registers of 'disqualified individuals' and to carry out staff checks	PECS system Registration and Inspection Reports	2	4	Moderate		Implementation of Children and Vulnerable Adults Legislation NISCC - 04	Michael Murray	Apr-04	Oct-04	Oct-05
Residential	Family & Child Care	Choice of appropriate placement	Corporate Parenting Reports every 6 months Annual Discharge of Statutory Functions Report Monthly meetings with Trust Programme Managers Registration and Inspection Reports	4	3	Moderate		Implementation of Children Matter, Including development of Intensive Support Units. Bail Fostering Scheme. Act on recommendations of Inspection Reports	Michael Murray	Apr-04	Dec-04	Sep-05
Residential	Family & Child Care	Numbers of Secure Places	Corporate Parenting Reports every 6 months.Annual Discharge of Statutory Functions Report Monthly meetings with Trust Programme Managers .Secure Accommodation Assessment Panel	5	3	Moderate		HPSSRIA 2005 Monitoring of Risk Assessment Tools	Michael Murray	Apr-04	Dec-04	Sep-05
Adoption - The adoption NI Order 1987	Family & Child Care	Supporting Children Post Adoption	Monthly meetings with Trust Programme Managers	4	3	Moderate		Monthly Strategy and Co-ordination Meeting. Additional Social Work/ psychology staff Conference and workshop on Adoption/Permanency. - Resources	Michael Murray	Apr-04	Oct-04	
Securing sufficient practice learning opportunities	Training - All Programmes	Failure to provide adequate Practice Learning Opportunities	Contracts in place with Trusts Trust co-ordinators established Board placement co-ordinated in post"	4	3	Moderate		Board planning team established to develop Practice Learning Strategy New placement opportunities being developed"	David Vance	Apr-04	Dec-04	Jun-05

Corporate Risk No 4			
Risk Area: ***CSD PA (NI) 1978***			
Description of Risk: ***Younger people are treated in Hospital with older people, this includes adult Mental Health Hospital.***			
Risk Linked to Following Corporate Objectives: ***1.3, 1.4, 1.6, 2.5, 3.3, 3.5, 4.3, 6.6***			
Grading	Likelihood	Severity	Risk Grade
	Possible	High	***Ma or***
Lead Officer: ***Director of Social Care***			

E isting Controls	*Internal and E ternal Assurances to the Board*	*Gaps in Controls and Assurances*	*Action Plan/Comments*	*Start Date for Action*	*Completion Date for Action*
Children's Disability Teams to advise Children's PCG Sub-group of exceptional cases No such placement should take place unless there has been prior consultation with the Board. ○ Matter raised with Trusts. ○ Proforma to track – Children with Disability (PCG). ○ Business Cases x 2 L/D respite and YP with challenging behaviours. Planning permission received for Board wide residential facility for children with disabilities and challenging behaviour and Team Manager appointed. Recruitment of staff will be progressed. ○ Monthly return from Trust re admissions of young people to adult facilities.	○ RQIA Reviews & Inspections ○ SAI Reports to DHSSPS & Board ○ SAI Regional Review Group.		There have been 3 admissions of young people to the Interim Assessment and Treatment Unit at Longstone since April 2007. While these admissions were for a relatively short period, one of these young people was re-admitted on 29.11.07 and is still in Longstone. There is currently one young person in Longstone and planning for discharge of one child from Muckamore is ongoing. Proforma expanded to include any child placed in psychiatric services. Two proposals are being considered to provide alternatives for children with learning disabilities and challenging behaviour who would previously have been taken to hospital. Planning for alternative accommodation for vulnerable children is being progressed. ○ Planning for alternative accommodation ongoing.	March 2007 September 07	

			○ Follow up of children admitted to adult wards in place re discharge plan and protection plan. ○ Admissions continue to be rare. ○ New build re facility for children and young people which challenging behaviour / learning disabilities planned – to be located within the Newry / Mourne area – complete 09/10. ○ Admissions to adult wards are monitored and confined to minimum numbers of young people ○ Resettlement of one identified young person from learning disability hospital imminent.	November 08	
○ Ongoing monitoring of admissions		○ Delay in resettlement of individual young person from learning disability hospital.	○ Trust has agreed date for completion of resettlement. ○ Number of young people admitted to adult wards maintained as a small number and only where clinical indications require an immediate admission.	February 09	March 09

CORPORATE RISK 17			
RISK AREA / CONTE T Ser ice Deli ery and Safety & Quality			
DESCRIPTION OF RISK There continues to be safeguarding concerns in Muckamore Abbey Hospital and the hospital is currently closed to admissions. ***Background*** *A number of serious adverse incident SAI reports raising concerns about the care and treatment of adult in patients with a learning disability led to a Level Independent Review.* *Adult Safeguarding investigations were also commenced and police investigation is ongoing. A number of staff have been suspended pending disciplinary and criminal proceedings. Referrals have been made to relevant professional / registering bodies.* *BHSCT has developed and commenced work on actions to ensure the safety and wellbeing of patients.* *HSC Trusts with patients in the hospital whose discharge is delayed are accelerating work to identify and develop suitable community placements to enable discharge / resettlement. HSCB has established and will chair a Directors forum to oversee this work.* *HSCB is leading on work to review and modernise services for people with a learning disability. Assessment and Treatment for people with a learning disability experiencing mental health difficulties currently treated in Learning Disability Hospitals has been identified as an accelerated work stream of the review.* *HSCB is supporting BHSCT and the other Trusts that have patients in MAH with contingency Planning* *HSCB has identified a lead officer with responsibility of leading and coordinating the system to deliver the ob ectives from DoH action plan deriving from the SAI review and the Permanent Secretary s commitments to the families of patients in MAH.* *A Leadership and Governance Review of Muckamore Abbey Hospital was commissioned by DOH through the HSCB and this is due to deliver its considerations and recommendations during August .*		
LINK TO CORPORATE OB ECTI ES Rele ant Themes 1 & 4		**Date Risk Added March 2019**	
LINK TO ASS RANCE FRAMEWORK Domain Safety & Quality			
GRADING	**LIKELIHOOD**	**SE ERITY**	**RISK GRADE**

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	LIKELY	HIGH	HIGH
RISK APPETITE	E PECTED SCORE	HIGH	TARGET SCORE	MEDI M
LEAD DIRECTOR Director of Social Care and Children			

E isting Controls	Internal and E ternal Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Re iew Date
Director of Social Care and Children's has constituted a Mental Health and Learning Disability Improvement Board to have oversight / drive improvements across the board. Membership at Director Level across HSC Trusts HSCB/PHA DoH and RQIA. Monthly meetings between Director of Social Care and Children's Directorate, Chief Social Services Officer, DoH and Director of Adult Services, BHSCT. BHSCT Director of Adult Services has been relieved of other duties to focus on addressing the issues arising at MAH. HSCB Director of Social Care and Children's is member of the DoH Muckamore Departmental Assurance Group. HSCB chairs a monthly Regional LD Operational Delivery Group with the	Director of Social Care Children's providing updates to SMT/AMT and HSCB Board.		BHSCT working to an operational improvement plan addressing the recommendations of the Independent Review Panel PSNI investigations ongoing HSCB/PHA coordinating regional and strategic action plan to address systemic issues identified in the Independent Review. HSC Trusts working on accelerated discharge for medically fit patients from MAH HSCB/PHA have commissioned an expert panel to review the delivery of assessment and treatment for people with LD experiencing serious mental illness including innovative, evidence based community delivery models. HSCB have commissioned HSC	March 2021

E isting Controls	Internal and E ternal Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Re iew Date
five HSC Trusts.			Trusts to commence development of alternative community based assessment and treatment services as an alternative to hospital admission HSCB have initiated negotiations with NIH and DfC to prioritise special needs housing developments for people with complex needs. Any action without a stipulated date is on-going and will be reviewed at next review i.e. ***March 2021***	

CORPORATE RISK 18			
RISK AREA / CONTE T Ser ice Deli ery and Safety & Quality			
DESCRIPTION OF RISK Muckamore Abbey Hospital - A number of serious adverse incident (SAI) reports raising concerns about the care and treatment of adult in-patients with a learning disability led to a Level 3 Independent Review. **Background** *Adult Safeguarding investigations were also commenced and police investigation is ongoing. A number of staff have been suspended pending disciplinary and criminal proceedings. Referrals have been made to relevant professional / registering bodies.* *BHSCT has developed and commenced work on actions to ensure the safety and wellbeing of patients.* *HSC Trusts with patients in the hospital whose discharge is delayed are accelerating work to identify and develop suitable community placements to enable discharge / resettlement. HSCB has established and will chair a Directors forum to oversee this work.* *HSCB is leading on work to review and modernise services for people with a learning disability. Assessment and Treatment for people with a learning disability experiencing mental health difficulties currently treated in Learning Disability Hospitals has been identified as an accelerated work stream of the review.* *HSCB is supporting BHSCT and the other Trusts that have patients in MAH with contingency Planning* *HSCB has identified a lead officer with responsibility of leading and coordinating the system to deliver the objectives from DoH action plan deriving from the SAI review; and the Permanent Secretary's commitments to the families of patients in MAH.*			
LINK TO CORPORATE OB ECTI ES Rele ant Themes 1 & 4		**Date Risk Added March 2019**	
LINK TO ASS RANCE FRAMEWORK Domain Safety & Quality			
GRADING	**LIKELIHOOD**	**SE ERITY**	**RISK GRADE**
	ALMOST CERTAIN	**MA OR**	**E TREME**
LEAD DIRECTOR Director of Social Care and Children			

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E isting Controls	Internal and E ternal Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Re iew Date
Director of Social Care and Children's has constituted a Mental Health and Learning Disability Improvement Board to have oversight / drive improvements across the board. Membership at Director Level across HSC Trusts HSCB/PHA DoH and RQIA. Monthly meetings between Director of Social Care & Children's Directorate, Chief Social Services Officer, DoH and Director of Adult Services, BHSCT. BHSCT Director of Adult Services has been relieved of other duties to focus on addressing the issues arising at MAH. HSCB Director of Social Care and Children's is member of the DoH Muckamore Departmental Assurance Group. HSCB chairs a monthly Regional LD Operational Delivery Group with the five HSC Trusts.	Director of Social Care Children's providing updates to SMT/AMT and HSCB Board.		BHSCT working to an operational improvement plan addressing the recommendations of the Independent Review Panel PSNI investigations ongoing HSCB/PHA coordinating regional and strategic action plan to address systemic issues identified in the Independent Review. HSC Trusts working on accelerated discharge for medically fit patients from MAH HSCB/PHA have commissioned an expert panel to review the delivery of assessment and treatment for people with LD experiencing serious mental illness including innovative, evidence based community delivery models. HSCB have commissioned HSC Trusts to commence development of alternative community based assessment and treatment services as an alternative to hospital admission	***December 2019***

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E isting Controls	Internal and E ternal Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Re iew Date
			HSCB have initiated negotiations with NIH and DfC to prioritise special needs housing developments for people with complex needs. Any action without a stipulated date is on-going and will be reviewed at next review i.e. ***December 2019***	

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Risk Ref	Description of risk	Existing Controls	Impact	Likelihood	Risk Rating	Treatment / Action Plan	Lead Officer	Review Date
SCSQ 18 **New risk added Dec 2018**	Independent Review of Serious Adverse Incidents at Muckamore Abbey Hospital and concurrent / ongoing investigation of Adult Safeguarding Investigations giving rise to a number of risks: • Safety and wellbeing of patients • Numbers of staff suspended • Closure of PICU • Pressures on system in effecting new admissions • Reputational damage	Joint Protocol investigations led by PSNI Adult Safeguarding procedures Staff suspensions	Major	Almost Certain	EXTREME	BHSCT • Appointed new management team • Action Plan arising from SAI report recommendations • Engaging agency staff to cover vacancies and ongoing recruitment • Ongoing systematic review of CCTV footage HSCB/PHA • DROs monitoring progress of SAI recommendations • Engage support of other LD hospitals and adult mental health system to support new admissions • Financial support to HSC Trusts to	Valerie McConnell, MH & LD Programme Manager	**March 2019**

Risk Ref	Description of risk	Existing Controls	Impact	Likelihood	Risk Rating	Treatment / Action Plan	Lead Officer	Review Date
						expedite delayed discharges • Ongoing liaison with DoH Permanent Sec • Regional review of acute care as an accelerated workstream for LD Service Model project Actions without stipulated dates are on-going and will be reviewed at next review i.e. **March 2019**		

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1	2	3	4				7		8	9
Identifier	Risk		SRO	Risk Appetite	Assessment Residual Risk (Current) Overall Rating 20 (High)		Assessment Treated Risk (Target) Overall Rating 1 (Medium)		Action Planned, Target Date & Owner	Actions completed, Completion Date & Owner
					Impact	Likelihood	Impact	Likelihood		
DS C05	Muckamore Hospital remains closed to admissions resulting in Adults with Learning Disability who require admission to hospital not being able to access the treatment they require.	To bring forward proposals for future Learning Disability Service provision in Tier 4	B Whittle	Open	4		4	4	Identify alternative service models to ensure individuals who require inpatient care receive it – ***Target Date une 2021*** nhance Community provision to prevent hospital admissions – ***Target Date September 2021*** xpedite discharge to free up capacity within Muckamore Hospital – ***Target Date April 2022*** Implement the recommendations of the Muckamore Hospital Action Plan – ***Target Date April 2022*** ***Owner of abo e actions L Conn***	Monthly meetings between the HSCB and BHSCT / S HSCT / NHSCT. Review the HSC Action Plan on a monthly basis with the DoH. Attend Community integration Meetings on a monthly basis. Chair the Regional Learning Disability Operational Delivery Group on a monthly basis.

Updated List of Abbreviations used in Brendan Whittle Witness Statement dated 10 February 2023 and this Addendum Statement

Ref	Full Name:
AHPs	Allied Healthcare Professionals
AIs	Adverse Incidents
ALBs	Arm's Length Bodies
BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
CDAO	Controlled Drugs Accountable Officer
CPD	Commissioning Plan Direction
DoH	Department of Health
DHSSPS	Department of Health, Social Services and Public Safety
DoJ	Department of Justice
DRO	Designated Review Officer
DSF	Delegated Statutory Functions
EHSSB	Eastern Health and Social Services Board
FHS	Family Health Services
FPS	Family Practitioner Services
GMGR	Good Management Good Records
GAIN	Guidelines Audit and Implementation Network
HPSS	Health and Personal Social Services
HSC	Health and Social Care
HSC Trusts	Health and Social Care Trusts
HSCB	Health and Social Care Board
HSSBs	Health and Social Services Boards
HSSTs	Health and Social Services Trusts
ICS	Integrated Care System
KPIs	Key Performance Indicators

Ref	Full Name:
LASPs	Local Adult Safeguarding Partnerships
LCGs	Local Commissioning Groups
LD	Learning Disability
LDSF	Learning Disability Service Framework
LDSM	Learning Disability Service Model
MAH	Muckamore Abbey Hospital
N&WBHSST	North and West Belfast Health and Social Services Trust
NHSSB	Northern Health and Social Services Board
NIAS	Northern Ireland Ambulance Service HSC Trust
NIO	Northern Ireland Office
NIPT	Non-Inpatient Psychological Therapy
NISAP	Northern Ireland Adult Safeguarding Partnership
PCC	Patient and Client Council
PHA	Public Health Agency
PMSID	Performance Management and Service Improvement Directorate
PSNI	Police Service of Northern Ireland
PSS	Personal Social Services
PSSID	Performance, Safety and Service Improvement Directorate
QSE	Quality Safety and Experience Group
RCA	Root Cause Analysis
RCSG	Regional Complaints Sub Group
RLDODG	Regional Learning Disability Operational Delivery Group
RPA	Review of Public Administration
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incident
SAIs	Serious Adverse Incidents
SBA	Service and Budget Agreement
SCCD	HSCB Social Care and Children's Directorate

Ref	Full Name:
SDU	Service Delivery Unit
SEA	Significant Event Audit
SHHSB	Southern Health and Social Services Board
SLA	Service Level Agreement
SMT	Senior Management Team
SPPG	Strategic Planning and Performance Group
SQA	Safety and Quality Alerts
SQAT	Safety and Quality Alert Team
TDPs	Trust Delivery Plans
WHSSB	Western Health and Social Services Board