Health and Social Care Board

HEALTH AND SOCIAL CARE BOARD

POLICY FOR THE MANAGEMENT OF COMPLAINTS

November 2020

1. Introduction

1.1 This policy sets out how staff working within the Health and Social Care Board (HSC Board) should deal with complaints raised by service users or former service users. It outlines a consistent procedure on complaints relating to the HSC Board, its actions and decisions are to be handled; and also how the monitoring of complaints processes and outcomes relating to the HSC Board, HSC Trusts and Family Practitioner Services is conducted. These procedures reflect the new arrangements for dealing with complaints which became effective from 1 April 2009 and should be read in conjunction with “Guidance in relation to the Health and Social Care Complaints Procedure” (April 2019).

1.2 The proper handling of complaints, suggestions or queries is a fundamental responsibility of the HSC Board. Complaints should therefore be dealt with promptly, sympathetically and constructively. It is important that every complainant should feel that his or her complaint has been dealt with appropriately.

What the Policy Covers

1.3 This policy deals with complaints about care or treatment, or about issues relating to the provision of health and social care. Complaints may, therefore, be raised about services provided by:

- The Health and Social Care Board (HSC Board)
    - Commissioning and purchasing decisions (for individuals);
- Family Practitioner Services (FPS).

What the Policy does not cover

1.4 This policy does **not** deal with complaints about:

- Private care and treatment or services including private dental care or privately supplied spectacles; or
- Services not provided or funded by the HSC, for example, provision of private medical reports.

1.5 Complaints may be raised within an organisation, which that organisation needs to address, but do not fall within the scope of the HSC Complaints Procedure. When this occurs, the HSC Organisation should ensure that there are other processes in place to deal with these concerns. For example:

- staff grievances;
- an investigation under the disciplinary procedure;
- an investigation by one of the professional regulatory bodies;
- services commissioned by the HSC Board;
- a request for information under Freedom of Information;
- access to records under the Data Protection Act 1998
- an independent inquiry;
- a criminal investigation;
- the Child Order Representations and Complaints Procedure;
- protection of vulnerable adults;
- child protection procedures;
- coroner's cases;
- legal action.

Confidentiality

1.6 The HSC Board must be cognisant of the legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the General Data Protection Regulations, (GDPR). Additional requirements are detailed in the Human Rights Act 1998 and the common law duty of confidence must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required if their personal information is to be disclosed. It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. However the service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter (paras 2.8 and 2.9).

2. Standards for Complaints Handling

2.1 The standards and guidelines for complaints handling reflect the changing culture across health and social care with an increasing emphasis on the promotion of safety and quality and the need to be open, to learn and take action in order to reduce the risk of recurrence. The standards for HSC Organisations in terms of complaints handling are: -

- Accountability
- Accessibility
- Receiving complaints
- Supporting complainants and staff
- Investigation of complaints
- Responding to complaints
- Monitoring
- Learning

These standards complement existing Controls Assurance Standards, the Quality Standards for Health and Social Care, the Nursing Homes and Residential Care Homes Standards and the Standards for Patient and Client Experience.

3. Standards and Guidelines for Resolution and Learning

3.1 These provide HSC Organisations with detailed, yet flexible, complaints handling arrangements designed to: -

- Provide effective local resolution
- Improve accessibility
- Clarify the options for pursuing a complaint

- Promote the use and availability of support services, including advocacy
- Provide a well-defined process of investigation
- Promote the use of a range of investigative techniques
- Promote the use of a range of options for successful resolution, such as the use of independent experts, laypersons and conciliation
- Resolve complaints more quickly
- Provide flexibility in relation to target response times
- Provide an appropriate and proportionate response
- Provide clear lines of responsibility and accountability
- Improve record keeping, reporting and monitoring
- Increase opportunities for shared learning
- Provide confidentiality to protect staff and those who complain
- Promote fairness with clear procedures and guidance
- Increase openness through clear communications
- Value diversity, equality and human rights.

3.2 Complaints should be dealt with patience and empathy but there will be times when nothing further can reasonably be done to assist the complainant, and parties should agree to come to a position of understanding. The Complaints Guidance includes an "Unacceptable Actions Policy" for handling unreasonable, vexatious or abusive complainants.

Where this is the case and further communications would place inappropriate demands on the HSC Board, staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

In determining arrangements for handling such complaints, staff need to ensure that the Complaints Procedure has been correctly implemented, appreciating that even habitual complainants may have grievances which contain some substance and identify the stage at which a complainant has become habitual.

The Unacceptable Actions Policy should only be used a last resort after all reasonable measures have been taken to resolve the complaint. The HSC Board will record all incidents of unacceptable actions by complainants.

4. Definitions

4.1 Complaint:

The HSC Complaints Procedure (Para 2.1) defines a complaint as:

> **"an expression of dissatisfaction that requires a response".**

A criticism of a service or the quality of care, whether written or oral, becomes a complaint when it requires a response. A single communication may include more than one complaint.

It should be noted that complainants may not always use the word 'complaint'. They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are really complaints and need to be handled as such.

4.2 Complainant:

Complainants will be existing or former users of the HSC Board's services and facilities, or someone acting on their behalf, providing they have obtained the consent of the service user.

Where a complaint concerns family health services, complainants will be either existing/former patients or family members raising concerns on a patient's behalf regarding a practitioner, who has arrangements with the HSC Board to provide family health services.

Complaints to the HSC Board may also be from existing/former users, or family members, of services provided by a family health services practitioner where the complainant has requested that the

HSC Board act as an “honest broker” or intermediary to assist in the local resolution of a complaint.

4.3 Consent

Explicit consent must be obtained from complainants, prior to their correspondence being shared with the Practice complained against. Any subsequent or follow up issues to those originally raised will be discussed on a case by case basis in order to determine how they should be appropriately handled. However, should a complaint raise issues of a clinical, professional or regulatory concern and/or issues regarding fraud, these will be shared with the Practice/HSC Organisation accordingly.

People may complain on behalf of existing or former patients/clients provided they have their consent. Complaints by a third party should be made with written consent of the individual concerned. There will be situations where it is not possible to obtain consent such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury, or serious communication problems);
- where the subject of the complaint is deceased.

4.4 Where a person is unable to act of him/herself, their consent shall not be required. However the Complaints Manager will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make a representation depends, in particular on the need to respect the confidentiality of the patient. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or senior person) must provide information in writing to the person outlining the reasons the decision has been taken.

5. Complaints concerning commissioning decisions by the HSC Board

5.1 The HSC Board has arrangements in place to deal with complaints about commissioning decisions it has made. It will also respond to complaints about its own actions and decisions.

5.2 Complaints about a commissioning decision of the HSC Board may be made by, or on behalf of, any individual personally affected by a commissioning decision taken by the HSC Board. The HSC Complaints Procedure may not deal with complaints about the merits of a decision where the HSC Board has acted properly and within its legal responsibilities.

5.3 The public or the Patient and Client Council may wish to raise general issues about commissioning decisions with the HSC Board and they should receive a full explanation of the HSC Board's policy. These are not, however, issues for the HSC Complaints Procedure.

6. Local resolution of complaints concerning commissioning decisions by the HSC Board

6.1 The HSC Board must have a local resolution process and designated complaints officers to deal with commissioning complaints and other complaints about the HSC Board's own actions and decisions.

The HSC Board’s complaints officers are based at 12-22 Linenhall Street, Belfast, BT2 8BS

Complaints Direct Line: 02895 363893 (Monday-Friday, 9am-4pm)
Text Relay: 18001 0289536 3893
Email: complaints.hscb@hscni.net

6.2 The primary objective of local resolution is to provide the fullest possible opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances. The emphasis is on complaints being dealt with quickly and, wherever possible, by those on the spot. The intention of local resolution is that it should be open, fair, flexible, and conciliatory. The complainant should be given the opportunity to understand all possible options for pursuing the complaint and the consequences of following any of these.

6.3 The process should encourage communication on all sides. The aim should be to resolve a complaint during this stage to the satisfaction of the complainant while being fair to staff. Rigid, bureaucratic, and legalistic approaches should be avoided at all stages of the procedure.

6.4 Complaints can be submitted, in writing via email, letter, in person or verbally. All complainants should receive a positive and full response, free of jargon. The aim should be to satisfy the complainant that their concerns have been heeded, and offer an apology and explanation as appropriate, referring to any remedial action that is to follow.

6.5 Under para 3.43 of the HSC Complaints Procedure the Chief Executive may delegate responsibility for responding to a complaint, where, in the interests of a prompt reply, a designated senior person may undertake the task. In addition, the discretion of the HSC Board Complaints Manager should be applied in determining which complaints regarding the HSC Board require the response to be signed off by the Chief Executive (or designated senior person in the absence of the Chief Executive) or those which can be delegated to a senior member of staff as appropriate (at least Assistant Director level). In such circumstances the clinical and social care governance arrangements must ensure that the Chief Executive maintains an overview of the issues.

In cases where the response is signed by a designated other, the Chief Executive will be provided with a copy. The HSC Board Complaints Office should at all times manage the complaints process.

7. HSC Board involvement in local resolution of complaints concerning Family Practitioner Services

7.1. Where requested, the HSC Board will act as ‘honest broker’ or intermediary in the resolution of a complaint or by assisting all parties in reaching a position of understanding. The objective for the HSC Board should be wherever possible to restore the trust between the patient and the practitioner/Practice staff. In addition, if requested by a complainant and/or a Family Practitioner Service (FPS), the HSC Board's Complaints Office with the agreement of both parties may arrange for a lay person or conciliator to be appointed to assist in resolution of the complaint. The advice of an independent expert will only be sought to provide clarification on clinical matters or were there is a risk to patient/client safety.

7.1.1 Once agreement has been received for the HSC Board to act as Honest Broker, the HSC Board Complaints staff (on behalf of FPS) will make necessary arrangements. The HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate lay person, conciliator or independent expert.

7.2 Lay Persons

The HSC Board has a number of Independent Lay Persons who will operate as a pool for all HSC Organisations. Lay Persons may be beneficial in providing an independent perspective of non-clinical or technical issues within the local resolution process.

They are not intended to act as advocates, conciliators or investigators and neither do they act on behalf of the Family Practitioner Service nor the complainant. The Lay Person’s involvement is to bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised.

Input from a Lay Person is valuable when testing issues such as communication, quality of written documents, attitudes and behaviours and access arrangements.

7.3 Conciliation

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to a better understanding of how the complaint has arisen. They will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations:

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the complainant and the practice/pharmacy/HSC Organisation and both parties feel it would assist in the resolution of the complaint;
- when there are misunderstandings with relatives during the treatment of the patient.

Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation, but both must agree to the process being used. The HSC Board has developed a select list of providers for HSC and the HSC Board's Complaints Office holds these details.

7.4 Independent Experts

The use of an independent expert in the resolution of a complaint may be requested by the complainant or FPS at any time, or suggested by the HSC Board. The HSC Board complaints office must seek an assurance from Integrated Care professionals that the use of an independent expert is appropriate. In deciding whether independent advice should be offered, consideration must be given, to the nature and complexity of the complaint and any attempts at earlier enhanced local resolution.

An independent expert may be considered beneficial where the complaint:

- cannot be resolved locally;
- indicates a risk to public or patient safety;
- could give rise to a serious breakdown in relationships;
- threaten public confidence in services or damage reputation;
- to give an independent perspective on clinical issues.

The HSC Organisation may decide to involve an independent expert in a complaint without the complainant's consent, outside the procedure, for the purposes of obtaining assurances regarding health and social care practice.

8. Receipt of Complaints

8.1 Complaints received orally should be dealt with by staff promptly, sympathetically and constructively. A statement should be taken and a record kept on file. Such complaints should be dealt with according to the principles of local resolution and should be resolved immediately or within two days of receipt.

8.2 Oral complaints which cannot be resolved to the complainant's satisfaction should be referred to the HSC Board's Complaints Office. Similarly a statement should be taken from the complainant and a record kept.

8.3 Complaints received through the Private Office of the Department of Health (NI) will be forwarded to the HSC Board's Complaints Office which will arrange for an acknowledgement and the preparation of a response. When the reply is ready it will be signed by the Chief Executive (or designated senior person).

8.4 Complaints addressed directly to the HSC Board Chairman or Chief Executive, such as those from Members of Parliament, Members of the Legislative Assembly, District Councillors etc, will be dealt with as in 8.3 above.

8.5 Complaints received from members of the public and others not specified above, will be forwarded to the HSC Board's Complaints Office who will arrange for an acknowledgement and the preparation of a response from the Chief Executive (or designated senior person).

8.6 Complaints concerning a HSC Board staff member will be investigated by the relevant Directorate who will take the appropriate action. The HSC Board's Complaints Office should, however, be made aware of the nature of the complaint and response.

FPS Complaints received by the Board

8.7 Complainants will receive an acknowledgement within 2 working days, their complaint will be investigated thoroughly, treated confidentially and responded to fully in writing within 20 working days. An expression of concern should be included within the acknowledgement.

8.8 If there is a delay in meeting the timescales set, the complainant will be advised of the situation and when a response is expected. Complainants will be also advised of what action they can take should they remain dissatisfied following consideration of the response.

Board Complaints received by the HSC Board

8.9 Complainants will receive an acknowledgement within 2 working days, their complaint will be investigated thoroughly, treated confidentially and responded to fully in writing within 20 working days. Similarly, an expression of concern should be included within the acknowledgement.

8.10 Written responses to complaints in which a patient has died, or those which are particularly complex, covering a number of HSC

Organisations or service areas, will be under the signature of the Chief Executive. Where the complaints response is not signed by the Chief Executive (paragraph 6.5 refers), a copy will be forwarded to the Chief Executive for information.

8.11 Complainants will be advised of what action they can take should they remain dissatisfied following consideration of the response, which will include recourse to the Northern Ireland Public Services Ombudsman (the Ombudsman). Complainants must bring their complaint to the Ombudsman within 6 months following completion of the HSC Board's internal complaints process.

Northern Ireland Public Services Ombudsman
33 Wellington Place
Belfast
BT1 6HN
Freephone: 0800 343424
Email: nipso@nipso.org.uk

8.12 Where a complaint is received by the HSC Board in error, the Complaints Office should ensure that it is passed immediately to the correct body with the consent of the complainant.

8.13 If timescales will not be adhered to, the complainant will be provided with an explanation for the delay and when a response should will be expected.

9. Northern Ireland Public Services Ombudsman

9.1 All papers relating to the local resolution stage will be made available to the Ombudsman where such a case has been referred by the complainant to the Ombudsman for investigation.

10. Complaints Monitoring

10.1 Under the HSC Complaints Procedure the complaints handling role and responsibilities of the HSC Board are to monitor complaints processes, outcomes and service improvement; and dissemination of learning. The use of this information will also inform commissioning processes and purchasing decisions.

10.2 The operation and effectiveness of the HSC Complaints Procedure will be monitored continuously. A Regional Complaints Sub-Group (HSC Board/Public Health Agency/Patient & Client Council) has been established and will meet on a quarterly basis to consider analysis of information pertaining to HSC Board complaints, Family Practitioner complaints and HSC Trust complaints. The Regional Complaints Sub-Group, will make recommendations to QSE via the HSCB Complaints Manager, in respect of potential regional learning.

10.3 This includes monitoring of the subject of complaints raised, the particular specialties they relate to and/or their locality, as well as ensuring that there are appropriate systems in place to manage complaints, that complaints are responded to comprehensively and in a timely manner and that in enhancing the local resolution stage, complaints can be resolved more quickly and as close to the source as possible.

10.4 If a complaint has escalated to an SAI, the SAI reference number will be shared with the HSCB Governance Team, who will relay any learning identified. This learning will be shared with the RSCG accordingly.

10.5 Monitoring information will be: -

(i) **Health and Social Care Board**

Regular statistical information must be made available in respect of complaints received from existing or former service users regarding commissioning decisions of the HSC Board, or from those being denied a service as a consequence of commissioning decisions of the HSC Board, and its actions and responses.

(ii) **Family Practitioner Services**

The HSC Complaints Procedure requires Family

Practitioners to forward to the HSC Board's Complaints Office an anonymised copy of each complaint and its subsequent response within 3 working days of issue of the response. Family Practitioners are also required to forward to the HSC Board's Complaints Office any other significant correspondence or report relating to the complaint and; copies of any correspondence received from the Ombudsman.

(Iii) Health and Social Care Trusts

HSC Trusts will supply monthly returns that provide a summary of all complaints received, their site location, classification of complaint (eg treatment and care, communication, staff attitude), response time and a summary of the outcome of the investigation and any actions taken or to be taken. These returns will also include details of complaints relating to out of hours services, independent sector providers (where the Trust has commissioned the care/service) and prison healthcare (South Eastern HSC Trust).

HSC Trusts will supply information relating to the investigation of any complaint(s) that the HSC Board considers necessary for monitoring and learning purposes.

In addition, Trusts will also advise the Board of the number of complaints received in a month, and the numbers reopened. In particular Trusts will highlight those which have progressed to the Ombudsman, or those from which learning has occurred.

11. Role of the Patient and Client Council

Advice should be made available at all stages of the HSC Complaints Procedure about the role of the Patient and Client Council in giving individuals advice and support on making complaints. Details of other advocacy or support organisations can also be identified.

12. Equality

12.1 The HSC Board takes account of duties under Section 75 Equality Legislation, other Equality Legislation and Human Rights Legislation in a way that promotes equality of opportunity, good relations and human rights. Where a particular need is identified we will consider the best way to respond to this is a way that values diversity.

12.2 The HSC Board will not treat a complainant less favourably because of their gender, age, disability, marital status, race, sexual orientation, religious or political opinion or if they have dependents.

12.3 This document can be made available on request and where reasonably practicable in an alternative format, Easy Read, Braille, audio formats (CD, mp3 or DAISY), large print or minority languages to meet the needs of those for whom English is not their first language.

This Policy will be reviewed in December 2021

HEALTH AND SOCIAL CARE BOARD

TERMS OF REFERENCE

REGIONAL COMPLAINTS SUB-GROUP

1.0 Introduction

The Health and Social Care Board (HSCB) is required to monitor how they or those providing care on their behalf, deal with and respond to complaints. The HSCB must maintain an oversight of all Family Practitioner Services (FPS) and Health and Social Care Trust complaints received.

The HSCB receives reports from HSC Trusts on a monthly basis which detail the complaint, actions taken, changes in practice and lessons learned. FPS Practitioners forward anonymised copies of each letter of complaint received along with the Practice response within 3 working days of the response being issued. Those which relate to clinical issues are shared with FPS Advisors who provide an assurance that the Practice has addressed the issues adequately.

The Quality Safety Experience Group, established in November 2013, has an over-arching responsibility to consider themes, patterns and areas of concern emerging from all existing sources and agree actions to be taken to address these, thus improving the safety and quality of services commissioned. The Regional Complaints Sub-Group therefore, will identify themes emerging from complaints and agree issues to be referred to the Quality, Safety and Experience Group (QSE).

2.0 Role and Remit of the Group

The role and remit of the Group shall be to;

2.1. Act as a sub-group of QSE, producing quarterly reports for its consideration and subsequently for SMT. This report will detail issues arising from the RCsG that require QSE consideration, any areas of concern/risk from Trust/FPS complaints, the themes/patterns or trends, or examples of good practice/suggested learning, and outlining key recommendations for action to include examples of complaints received. The report will also detail the number of complaints received across the HSC, on a quarterly basis and will provide an overview on open honest broker complaints and complaints regarding the HSCB.

2.2. Recommend key areas of learning to QSE for consideration and onward dissemination via appropriate routes on a regional basis; and follow up on agreed actions to be taken. Quarterly reports to QSE and SMT should include reference to decisions taken and highlight any delays regarding the provision of learning

2.3 Provide an assurance to the SMT of the HSCB in respect of compliance with the requirements of the Board as laid down in the Health and Social Care Complaints Procedure (April 2019).

2.4. To ensure that FPS fulfil their obligations in terms of information returns to the HSCB as laid down in the Health and Social Care Complaints Procedure (April 2019).

2.5. To ensure that HSC Trusts fulfil their obligations in terms of submitting information identified by the HSCB as required to enable the Board to fulfil its requirements as laid down in the Health and Social Care Complaints Procedure (April 2019).

2.6. Receive and consider the analysis of information received from HSC Trusts and complaints received by FPS, HSCB and PHA;

2.7 To work as a filter to inform other areas of work on-going in the HSCB/PHA relating to patient experience and patient/client safety;

2.8 To receive and consider reports on findings/recommendations made by the NI Public Services Ombudsman, and establish if any further action requires to be taken by appropriate HSCB/PHA Group;

2.9 To seek, where possible, to embed feedback from service users into HSCB/PHA processes;

2.10 To identify complaints for consideration at HSCB/PHA Complaints/SAI Learning Events

3.0. Working Arrangements between Existing Groups/Information Flow to QSE

3.1. The Regional Complaints Group will be a sub-group of QSE. It is a multidisciplinary Group which will meet on a quarterly basis, prior to QSE to consider in detail issues emerging from complaints; and agree issues which require to be referred to the QSE, together with recommendations for consideration.

3.2 QSE will be formally notified of issues relating to the effectiveness and efficiency of the RCsG and structures. A quarterly report will be submitted to highlight and escalate issues in relation to; operation of RCsG meetings; sharing of information; feedback from professionals; learning identified and agreed timeliness of publication.

3.3. HSCB/PHA professionals will receive complaints on a monthly basis from the HSC Trusts, and FPS Practitioners. These professionals will provide an update to the Complaints Sub-Group, detailing any concerns or issues that they require referral to the QSE.

4. Accountability of the Group

4.1. The Sub-Group will continue to report (via QSE) to the Senior Management Team and the Governance Committee of the HSCB on a biannual basis.

4.2. An annual report on complaints will be produced which will be considered by QSE, SMT and approved by the Governance Committee.

5. Membership of the Group

5.1 To ensure consistency and due to the nature of the complaints reviewed and considered, Core Members are asked to attend each meeting; however, if this is not possible, members should nominate a representative.

Core Members

Mrs Liz Fitzpatrick, Complaints/Litigation Manager, Corporate Services, HSCB (Chair)

Ms Anne-Marie Phillips, Patient Safety, Quality & Experience Nurse Lead PHA (Co-Chair)

Business Support Manager Representative, Integrated Care, HSCB

Commissioning Representative, HSCB

Social Care Commissioning Lead Representative, Social Services, HSCB

Public Health Consultant, PHA

Nurse Consultant, (Palliative Care) PHA

Allied Health Professionals Representative, PHA

Senior Midwife Consultant, Public Health, PHA

Complaints Manager, Patient and Client Council

Invited Members

GP Medical Representative(s), Integrated Care, HSCB

Dental Representative, Integrated Care, HSCB

Pharmacy Representative, Integrated Care, HSCB

Optometry Representative, Integrated Care, HSCB

Regional OOH Commissioning Manager, HSCB

Commissioning Representative, HSCB

Patient Safety, Quality and Experience Lead, (10,000 voices) PHA

In Attendance

Deputy Complaints Manager, Corporate Services, HSCB

Complaints Officers, HSCB

The Sub-Group will be chaired by the HSCB Complaints Manager, and co-chaired by the Patient Safety, Quality & Experience Nurse Lead (PHA). In the absence of the Complaints Manager, the Deputy Complaints Manager will deputise. The membership of this Sub-Group will be kept under review.

6. Quorum

6.1 There will be a quorum when four of the professionals within the Core Membership are present at the meeting.

7. Administrative Support to the Sub-Group

7.1. The agenda and papers will be developed and circulated by Complaints Staff. An Action Log will be taken by Complaints Staff and shared with the Group as soon as possible after the meeting.

8. Review of Terms of Reference

These Terms of Reference will be reviewed in March 2022

REGIONAL COMPLAINTS MONITORING AND DISCUSSION GROUP

TERMS OF REFERENCE

1.0 Introduction

The Strategic Planning and Performance Group (SPPG), on behalf of the Department of Health (DoH), is required to monitor how they or those providing care on their behalf, deal with and respond to complaints. This includes monitoring complaints processes, outcomes and service improvements and maintaining oversight of all HSC Trust complaints received.

The SPPG receives monitoring reports from HSC Trusts on a monthly basis which outline the complaint, actions taken, changes in practice and lessons learned. Those which relate to clinical issues are shared with SPPG/PHA professional advisors who review the correspondence and identify any clinical/professional/regulatory issues of concern.

In accordance with the “Guidance in relation to the Health and Social Care Complaints Procedure,” (April 2022) [HSC Complaints Procedure], all HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and make sure that lessons are learned to minimise the chance of mistakes recurring and to improve the safety and quality of services.

Learning is a critical aspect of the HSC Complaints Procedure and all HSC organisations must share intelligence gained through complaints. The Regional Complaints Monitoring and Discussion Group therefore, will provide a forum for structured discussion in relation to complaints arrangements.

2.0 Role and Remit of the Group

The role and remit of the Group shall be to;

- Review and discuss themes, trends and learning identified from the complaint monitoring returns, to include potential complaints which could be used for future Learning Events;

- Discuss complaints which have been reviewed by the NIPSO in which recommendations for action have been identified;

- Review any issues of concern identified by the HSC Trusts in respect of complaints monitoring/dissemination of learning;

- Continually review the complaints monitoring process ensuring that it is fit for purpose, that information is provided in a timely manner and is of sufficient detail;

3.0 Accountability of the Group

The Group will meet on a biannual basis and will report to the SPPG/PHA Regional Complaints SubGroup. This is a multidisciplinary Group which meets quarterly to consider any areas of concern/risk from Trust/FPS complaints, or examples of good practice/suggested learning, and outlining key recommendations for action.

4.0 Membership of the Group

To ensure consistency, members are asked to attend each meeting; however if this is not possible, a representative from the Trust should be nominated.

Complaints/Litigation Manager, Governance and Safety Directorate, SPPG (Chair)

Deputy Complaints Manager, Governance and Safety Directorate, SPPG (Deputy Chair)

Complaints Manager, Western Health and Social Care Trust

Governance Manager, Western Health and Social Care Trust

Complaints Manager, Belfast Health and Social Care Trust

Governance/Risk Director, Belfast Health and Social Care Trust

Complaints Manager, South Eastern Health and Social Care Trust

Complaints Manager, Northern Health and Social Care Trust

Governance/Risk Director, Northern Health and Social Care Trust

Complaints Manager, Southern Health and Social Care Trust

Governance Officer, Southern Health and Social Care Trust

Complaints Manager, Northern Ireland Ambulance Service

Risk/Governance Manager, Northern Ireland Ambulance Service

The Group will be chaired by the SPPG Complaints Manager and in her absence, the Deputy Complaints Manager will deputise. The membership of this Group will be kept under review.

5.0 Administrative Support

The agenda and papers will be developed and circulated by SPPG Complaints staff. An Action log will be taken and shared with the Group, by an SPPG Complaints Officer as soon as possible after the meeting.

6.0 Review of Terms of Reference

These Terms of Reference will be reviewed in June 2023.

BW/71

NORTH AND WEST BELFAST
HEALTH AND SOCIAL SERVICES TRUST

NOTIFICATION OF ACCIDENT / INCIDENT / UNAUTHORISED ABSENCES

NAME OF FACILITY: [redacted]

NAME OF WARD:

NAME OF PERSON:

DATE OF BIRTH:

HOME ADDRESS:

STATUS: Voluntary

The witness has exhibited a series of Serious Adverse Incident (SAI) Reports for illustrative purposes at pages 6442 to 6480. These Reports contain personal information relating to individual patients and are not to be disclosed. The reports relate to a multiplicity of issues, including sudden death, fracture, admission of child to adult ward and absconsion. The report at pages 6442-6443 is provided in redacted form for the purpose of demonstrating the format of such reports. The other reports are in the same format.

DATE OF OCCURRENCE: [redacted]

TIME OF OCCURRENCE:

NATURE OF OCCURRENCE:

Brief Description of occurrence:

[redacted]

IR00212

The following were informed:

[redacted]

Was the injured person referred for medical attention: [redacted]

Name(S) and address(es) of witness(es) if any: [redacted]

Have there been any previous occurrences in the past year involving this person? [redacted]

Name of person supplying above information:

[redacted]

[redacted]

IK00222

BW/72

[redacted]

[redacted]

IR00224

BW/73

[redacted]

[redacted]

IR00225

[redacted]

[redacted]

[redacted]

IR00234

[redacted]

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IR00315

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BW/91

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Noel McCann
Director of
Planning & Performance Management

Room D4.13, Castle Buildings
Stormont Estate
Belfast, BT4 3SQ

[redacted]

Date: 7 July 2004

For action:

Chief Executives of HSS Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies
General Medical, Community Pharmacy,
General Dental & Ophthalmic Practices

For information:

Chief Officers, HSS Councils
Directors of Public Health in HSS Boards
Directors of Social Services in HSS Boards and Trusts
Directors of Dentistry in HSS Boards and Trusts
Directors of Pharmacy in HSS Boards and Trusts
Directors of Nursing in HSS Boards and Trusts
Directors of Primary Care in HSS Boards
Medical Directors in HSS Trusts
Chairs, Local Health and Social Care Groups

Circular HSS (PPM) 06/04

Dear Colleague

REPORTING AND FOLLOW-UP ON SERIOUS ADVERSE INCIDENTS: INTERIM GUIDANCE

Introduction

1. The purpose of this guidance is to provide interim advice for HPSS organisations and Special Agencies on the reporting and management of serious adverse incidents and near misses, pending the issue of more comprehensive guidance on safety. This will be issued once the work currently being undertaken by the Department on the strategic review of the reporting, recording and investigation of adverse incidents and near misses has been concluded.

2. This interim guidance highlights, in particular, the need for the Department to be informed immediately about incidents which are regarded as serious enough for regional action to be taken to ensure improved care or safety for patients, clients or staff. It also draws attention to the need for the Department to be informed where a Trust, Board or Special Agency considers that an event is of such seriousness that it is likely to be of public concern. In addition, the guidance requires Trusts, Boards or Special Agencies to inform the Department where they consider that an incident requires independent review.

3. The guidance complements existing local and national reporting systems, both mandatory and voluntary, which have been established over the years. These provide for specific incidents relating, for example, to medical devices and equipment, medicines, mental illness, child protection, communicable disease and the safety of staff to be reported to various points in the Department. **These systems should continue to be used in addition to the action required by this interim guidance.** In the context of contractual arrangements for the independent family practitioner services, practices should report serious incidents, in the first instance, to the relevant HSS Board, which will communicate with the Department as appropriate.

Background

4. The consultation paper *Best Practice Best Care*, published by the Department in April 2001, recognised the need for more effective arrangements for monitoring adverse incidents. As a result, a Safety in Health and Social Care Steering Group was established by the Department, with a remit to develop a strategic approach to the reporting, recording and investigation of adverse incidents and near misses and the promotion of good practice to minimise risk.

5. As part of its work, the Steering Group is also undertaking an evaluation of the effectiveness of systems used to identify and manage adverse incidents and near misses, including the Northern Ireland Adverse Incident Centre (NIAIC). NIAIC operates a voluntary system for reporting and investigating adverse incidents in the HPSS and issues alerts and other material on the safety of devices and equipment.

6. It is hoped that the Steering Group will conclude its work later this year, following which comprehensive guidance on safety and the promotion of learning will be brought forward. This may include links, where appropriate, with the National Patient Safety Agency in the NHS.

Defining Serious Adverse Incidents

7. Preliminary feedback from the Steering Group's work highlights a lack of uniformity in incident reporting and management in the HPSS. This also applies to the definition of what constitutes a serious adverse incident.

8. In line with the action required by this Circular, the Department considers that a serious adverse incident should be defined as "*any event or circumstance arising during the course of the business of a HSS organisation/Special Agency or commissioned service that led, or could have led, to serious unintended or unexpected harm, loss or damage*". This may be because:

- it involves a large number of patients;
- there is a question of poor clinical or management judgement;
- a service or piece of equipment has failed;
- a patient has died under unusual circumstances; or
- there is the possibility or perception that any of these might have occurred.

9. Examples of serious adverse incidents include:

- any incident involving serious harm or potentially serious harm to a patient, service user or the public. This could include disease outbreaks, apparent clinical errors or lapses in care;
- any incident which has serious implications for patient or staff safety – involving potential or actual risk to patients or staff;
- any incident involving serious compromises or allegations of serious compromises in the proper delivery of health and social care services.

10. The above list is not exhaustive and Annex A provides a more comprehensive list.

Key Issues for HPSS Organisations

11. HPSS organisations and Special Agencies should be developing a culture of openness. Policies should be in place to raise awareness and to

actively encourage the reporting, assessment, management and learning from adverse incidents and near misses. If they have not already done so, all HPSS organisations and Special Agencies should nominate a senior manager at board level who will have overall responsibility for the reporting and management of adverse incidents within the organisation.

12. All HPSS organisations and Special Agencies should have developed, or be developing, centralised systems which facilitate the collection, analysis and reporting of adverse incidents and near misses relating to patients, clients, staff and others. These systems should be capable of supporting an analysis of the type, frequency and severity of the incident or near miss and, where appropriate, should record the action taken.

13. In those situations where a body considers that an independent review is appropriate, it is important that those who will be conducting it are seen to be completely independent. In addition, such reviews should normally be conducted by a multi-professional team, rather than by one individual. It is also important that the Department is made aware of the review at the outset.

Action

14. HPSS organisations and Special Agencies should continue to use established local or national reporting and investigation mechanisms to manage adverse incidents. This will include, where appropriate, notifying other agencies such as the Police Service, the Health and Safety Executive, professional regulatory bodies or the Coroner. Where there is any doubt as to which agencies should be notified, advice should be sought from the Department.

15. The Department will expect urgent local action to be taken to investigate and manage adverse incidents.

16. In addition, where a **serious** adverse incident occurs, it should be reported immediately to the senior manager with responsibility for the reporting and management of adverse incidents within the organisation. If the senior manager considers that the incident is likely to:

- **be serious enough to warrant regional action to improve safety or care within the broader HPSS;**
- **be of public concern; or**
- **require an independent review,**

he/she should provide the Department with a brief report, using the proforma attached at Annex B, within 72 hours of the incident being discovered. The report should be e-mailed to adverse.incidents@dhsspsni.gov.uk. In cases where e-mail cannot be used, the report should be faxed on (028) 9052 8126.

Action by the Department

17. The Department:

- will collate information on incidents reported to it through this mechanism and provide relevant analysis to the HPSS;
- may also, where appropriate, seek feedback from the relevant organisation on the outcome of the incident to determine whether regional guidance is needed;
- may, in independent reviews, provide guidance in relation to determining specialist input into such reviews.

Enquiries

18. Any enquiries about this Circular from the nominated senior manager should be made, in the first place, to Jonathan Bill, Planning & Performance Management Directorate, [redacted] or by e-mail at [redacted]

19. This guidance will be reviewed once the Safety in Health and Social Care Steering Group has concluded its work, at which point further, comprehensive, guidance will be issued. In the meantime, the Department will welcome feedback on the issues covered in this guidance. This should be addressed to Jonathan Bill on the e-mail address above, or to Room D2.3, Castle Buildings, Stormont, Belfast, BT4 3SQ.

Yours sincerely

NOEL McCANN
Director of Planning & Performance Management

ANNEX A

SERIOUS ADVERSE INCIDENTS - EXAMPLES

The following are examples of serious adverse incidents. It is not an exhaustive list and is intended as a guide only. Where there are any doubts about an incident it should be reported.

Major Incidents

- Any circumstance which necessitates the activation of an HSS Trust, HSS Board or wider community Emergency Plan

Clinical incidents

- Any clinical incident whose consequences would be regarded as severe
- Serious drug events which might require regional or national guidance, to prevent occurrence or reoccurrence within HPSS/NHS organisations, e.g. maladministration of a spinal medicine, major prescription error causing, or with the potential to cause, serious damage or death of a patient

Court Proceedings

- Any incident which might give rise to serious criminal charges
- Impending court hearing, including Coroners' Inquests, or out of court settlement in cases of large scale litigation
- Legal challenges to the HSS Trust or HSS Board

Incidents involving staff

- Serious complaints about a member of staff or primary care contractor
- Serious error or errors by a member of staff or primary care contractor
- Significant disciplinary matters (e.g. suspensions of staff)
- A serious breach of confidentiality
- Serious verbal and/or physical aggression towards staff

Mortality/morbidity incidents

- Clusters of unexpected or unexplained deaths
- The suicide of any person currently in receipt of health and personal social services on or off HPSS premises, or who has been discharged within the last twelve months.
- Death or injury where foul play is suspected
- Situations when a patient or patients require(s) additional intervention(s) as a result of serious failures in diagnostic processes

- The accidental death of, or serious injury to, a patient, a member of staff, or visitor to HPSS or primary care premises, or involving HPSS or primary care staff or equipment
- Significant harm to children where reported under child protection arrangements
- Vulnerable adult abuse

Premises/equipment incidents

- Serious damage which occurs on HPSS premises or premises on which primary care services are delivered, or to HPSS property or property on which primary care services are delivered, or any incident which results in serious injury to any individual or serious disruption to services (e.g. evacuation of patients due to fire)
- Failure of equipment so serious as to endanger life, whether or not injury results
- Suspicion of malicious activity e.g. tampering with equipment
- Circumstances that lead to the provider no longer being able to provide an element of service

Mental Health or Learning Disability incidents (including substance misuse services)

- The disappearance, absence without leave or absconding of a patient (whether or not detained under the Mental Health Order 1986) where there is serious cause for concern
- Escapes by patients (whether or not detained under the Mental Health Order 1986) from secure accommodation/area
- Homicide, or suspected homicide, by any patient who has received mental health services
- Unexpected death
- All deaths within secure settings
- All deaths of persons who are subject to the Mental Health Order or equivalent legal restriction who has or is receiving mental health service care and treatment
- Any serious criminal acts involving patients, or staff
- An incident that causes serious harm that places life in jeopardy
- Serious injury, resulting in the need for emergency medical treatment via an A&E department, sustained by patient, staff or visitor on HPSS property
- Where a member of staff is suspected of harming patients or serious fraud
- Hostage taking, mass / organised disturbance
- Any omissions/failings of security systems/procedures that jeopardise security
- All incidents reported to or involving the police

ANNEX B

SERIOUS ADVERSE INCIDENT REPORT
1. Organisation:
2. Brief summary (and date) of incident:
3. Why incident considered serious:
4. Action taken:
5. Is any regional action recommended? (if so, full details should be submitted) Y/N -
6. Is an Independent Review being considered? (if so, full details should be submitted) Y/N -
7. Other Organisations informed **PSNI** Y/N - **Coroner** Y/N - **NIHSE** Y/N - **HSS Board** Y/N - **Other** (please specify) Y/N -
8. Report submitted by (name and contact details of nominated senior manager or Chief Executive)

Completed proforma should be sent, by email, to:

adverse.incidents@dhsspsni.gov.uk

If e-mail cannot be used, fax to (028) 9052 8126

BW/92

Department of
Health, Social Services
and Public Safety

An Roinn
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agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Noel McCann
Director of Planning & Performance Management

Circular HSS (PPM) 05/05

Room D4.13, Castle Buildings
Stormont Estate
Belfast, BT4 3SQ

[redacted]

Your Ref:
Our Ref:

Date: 10 June 2005

For Action (with enclosures):

Chief Executives of HSS Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies

For information (without enclosure):

Chief Executive, HPSS Regulation & Improvement Authority
Chief Officers, HSS Councils
Directors of Public Health in HSS Boards
Directors of Social Services/Social Work in HSS Boards and Trusts
Directors of Dentistry in HSS Boards and Trusts
Directors of Pharmacy in HSS Boards and Trusts
Directors of Nursing in HSS Boards and Trusts
Directors of Primary Care in HSS Boards
Medical Directors in HSS Trusts
Chairs, Local Health and Social Care Groups
General Medical, Community Pharmacy,
General Dental & Ophthalmic Practices

Dear Colleague

REPORTING OF SERIOUS ADVERSE INCIDENTS WITHIN THE HPSS

Introduction

1. Circular PPM 06/04, issued in July 2004, provided interim advice for HPSS organisations and Special Agencies on the reporting and management of serious adverse incidents and near misses.

2. The purpose of this Circular is to provide an update on safety issues; to underline the need for HPSS organisations to report serious adverse incidents and near

misses to the Department in line with Circular PPM 06/04; and to request details of senior managers who have been assigned overall responsibility for the reporting and management of adverse incidents.

Update on Safety Issues

Safety Group

3. The Department established a Safety in Health and Social Care Steering Group initially to advise on the future role and function of the Northern Ireland Adverse Incident Centre (NIAIC), with particular emphasis on the establishment of NIAIC accountability boundaries. However, the Steering Group considered that there was a need for the Department to take a broader, more systematic approach to safety within the HPSS and to provide greater strategic direction on the recording, reporting and investigation of all adverse incidents and near misses.

4. As part of this work, the Steering Group commissioned Deloitte to carry out a scoping exercise on adverse incidents and near miss reporting in the HPSS and special agencies; and to evaluate the Northern Ireland Adverse Incident Centre.

Key Findings of Deloitte Report

5. The Deloitte report acknowledged that, within HPSS organisations, there is a consistent drive to improve the reporting and management of adverse incidents, based on a common belief and understanding of the benefits it can bring to patient and client safety and care. However, the report also noted inconsistencies in approach, including incident reporting systems, monitoring, collation, analysis and follow-up.

6. The report's key recommendations included the need for:

   - a consistent approach to the definition and coding of adverse incidents and near misses;
   - more Departmental guidance on risk assessment, reporting structures and links to other organisations;
   - the development of improved reporting systems to support the analysis and audit of incidents and the development of mechanisms to improve learning and knowledge;
   - links between local reporting arrangements and national, statutory, and confidential reporting mechanisms;
   - the development of guidance on local investigations and reviews; and
   - improved training and development of staff in the use of risk assessment tools, such as root cause analysis.

Further Work

7. In line with these proposals, a number of projects are now being taken forward by the Department. These include:

- work to standardise definitions and coding;
- the development of formal links with the National Patient Safety Agency; and
- the development of a safety framework for the HPSS.

8. Further information about progress with each of these projects will be issued at a later date.

Reporting Incidents

9. Circular HSS (PPM) 06/04 indicated that the Department, in collating information on serious adverse incidents and near misses, would feed back relevant analysis to the HPSS. In line with this undertaking, a small group has been established in the Department, which reviews all incidents that are notified. It is planned that regular feedback will be issued to the HPSS, including an annual report.

10. As the first step in this process, a briefing session has been arranged for safety managers on 15 June, when the Department will be providing feedback on the operation of the reporting and management arrangements established by Circular PPM 06/04.

11. In the meantime, it is important that notifications required under the interim guidance should continue to be provided to the Department. Safety managers should review the operation of local procedures on a regular basis to ensure that all serious adverse incidents are being reported to the Department.

12. All HPSS organisations are reminded that incidents which are regarded as falling in any of the categories below should be notified to the Department in accordance with the procedures outlined in the guidance:

- **incidents regarded as serious enough to warrant regional action to improve safety or care within the broader HPSS;**
- **incidents which are likely to be of public concern;**
- **incidents which are likely to require an independent review.**

13. All other existing systems should continue to be used. In particular, HPSS organisations should continue to report incidents involving medical devices and equipment to the NIAIC.

Management Arrangements

14. Circular PPM 06/04 indicated that HPSS organisations and Special Agencies should be developing a culture of openness. In that context, it requested all HPSS organisations and Special Agencies to nominate a senior manager at board level who would have overall responsibility for safety and the reporting and management of adverse incidents within the organisation. To assist with future communications on safety issues, the Department has decided to establish a central list of these safety managers.

Action

15. A copy of the Deloitte Report is enclosed for your information; also enclosed is a specific section relating to your Trust, Board or Special Agency as appropriate. Taken together, these should be used to inform the safety agenda within your organisation.

16. Chief Executives of Boards, Trusts and Special Agencies should ensure that copies of the Deloitte Report are available for distribution as appropriate.

17. In line with paragraph 14 above, I should be grateful if you would let Jonathan Bill ([redacted] name, position and contact details, **by 30 June 2005**.

Yours sincerely

NOEL McCANN

BW/93

Department of Health, Social Services and Public Safety
An Roinn Sálinte, Serbhísí Sóisialta augus Sábháilteacht Phiobslí

Subject:
Reporting and follow-up on serious adverse incidents

Circular Reference: HSS (PPM) 02/2006

Date of Issue: **20 March 2006**

For action by:

- Chief Executives of HSS Trusts
- Chief Executives of HSS Boards
- Chief Executives of Special Agencies
- Chief Executive of Central Services Agency
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Officers, HSS Councils
- Directors of Public Health in HSS Boards
- Directors of Social Services in HSS Boards and Trusts
- Directors of Dentistry in HSS Boards and Trusts
- Directors of Pharmacy in HSS Boards and Trusts
- Directors of Nursing in HSS Boards and Trusts
- Directors of Primary Care in HSS Boards
- Medical Directors in HSS Trusts
- Chairs, Local Health and Social Care Groups
- Chairs, Area Child Protection Committees
- Chief Executive, Regulation & Quality Improvement Authority
- Chief Executive, Mental Health Commission

Summary of Contents:

The purpose of this Circular is to notify a number of important points about the reporting and management of Serious Adverse Incidents (SAIs)

Enquiries:

Any enquiries about the content of this Circular should be addressed to:

Quality & Performance Improvement Unit
DHSSPS
Room D2.4
Castle Buildings
Stormont
BELFAST
BT4 3SQ

[redacted]

Related documents

HSS (PPM) 06/2004
HSS (PPM) 05/2005

Superseded documents

Circular HSS4 (OS) 1/73 - Notification of Untoward Events in Psychiatric and Special Care Hospitals

HSS (THRD) 1/97 - Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability

Annexes A and B to Circular HSS (PPM) 06/04

Status of Contents:

Action

Implementation:

Immediate

Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Noel McCann
Director of Planning & Performance Management

Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

[redacted]

For action:

Chief Executives of HSS Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies
Chief Executive of Central Services Agency
General Medical, Community Pharmacy
General Dental & Ophthalmic Practices

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Directors of Social Services in HSS Boards and Trusts
Directors of Dentistry in HSS Boards and Trusts
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Directors of Primary Care in HSS Boards
Medical Directors in HSS Trusts
Chairs, Local Health and Social Care Groups
Chairs, Area Child Protection Committees
Chief Executive, Regulation & Quality Improvement Authority
Chief Executive, Mental Health Commission

Circular HSS (PPM) 02/2006

20 March 2006

Dear Colleague

REPORTING AND FOLLOW-UP ON SERIOUS ADVERSE INCIDENTS

Introduction

1. Circular HSS (PPM) 06/2004, issued in July 2004, introduced new interim reporting procedures for serious adverse incidents (SAIs) and near misses for HSS Boards, Trusts, Agencies and Family Practitioner Services. Since then, the Department has been monitoring the operation of the system and the purpose of this circular is to notify a number of important points about the reporting and management of SAIs.

2. In particular, this guidance:

- draws your attention to certain aspects of the process which need to be managed more effectively;
- notifies important changes in the way that SAIs should be reported in future; and
- provides a revised report pro forma which should be used in all future reports.

3. This guidance also clarifies the processes that the Department has put in place to consider SAIs notified to it and outlines the feedback that will be made available to the HPSS.

Areas for improvement

4. On the basis of the review that the Department has undertaken, it is clear that a number of areas need to be improved:

Nominated Reporting Officers - for an HPSS organisation to comply with the current risk management controls assurance standard, the senior manager at board level with overall responsibility for the reporting and management of adverse incidents should consider the incident against the criteria set out in HSS(PPM) 6/2004. Having a nominated officer at board level provides assurance that incidents are being dealt with appropriately. However, the Department is concerned to note that incidents continue to be reported from a variety of sources within some organisations (in some cases, causing duplicate reporting). This potentially undermines the development of a coherent, co-ordinated and effective approach to incident management within organisations.

It is recognised that circumstances differ in the primary care environment. However, the principles of having a nominated lead to co-ordinate the reporting of incidents is just as relevant. As part of having effective governance arrangements, practices should report SAIs to their area HSS Board. Therefore it is important that both HSS Boards and practices have a nominated lead. It is recognised that different terms are used to mean the same thing in primary care, such as significant events, critical incidents or untoward events. Those events or incidents which occur at practice level and which can be classified as SAIs, should be communicated, within the specified timeframe, by the practice to the relevant HSS Board in the first instance. The HSS Board is responsible for the onward report to the Department of those events or incidents which meet the definition of an SAI. This will include specifying which criteria in HSS (PPM) 06/2004 is relevant in the context of the incident.

The arrangements in place within your organisation should be reviewed to ensure that incident management is co-ordinated and working effectively and that your designated senior manager is aware of those incidents reported to the Department as SAIs and that each meets the criteria set out below.

Appropriate reporting – whilst this circular relates to the reporting of SAIs to the Department, it should be noted that organisations should continue to follow existing reporting mechanisms in order to fulfil their statutory obligations (for example to RQIA or MHC(NI)) and national or local reporting commitments (such as National Confidential Enquiries or under *Co-operating to Safeguard Children*).

HSS (PPM) 06/2004 outlined the steps to be taken by the designated senior manager when alerted to an SAI. The manager has to consider whether the incident should be reported to the Department where it is likely to:

- be serious enough to warrant regional action to improve safety or care;
- be of public concern (such as serious media interest); or
- require an independent review.

A number of incidents reported do not fall into these categories. Although the Department continues to encourage organisations to use the SAI reporting system - and would advise organisations to report if in any doubt – there is a need to ensure that reports made to the Department are serious **and** fall within one or more of the categories set out above.

Children's Homes - in particular, the Department is receiving a substantial number of reports about children who go missing without permission from children's homes. A follow-up report usually arrives (within 24 hours) confirming that the child has been located. Schedule 5 to the Children's Homes Regulations sets out the statutory requirements for notification of such cases. **The Department should only be notified if the criteria set out above apply**. In particular, if an organisation intends to contact the media to assist it in locating a child or if a felony is suspected, the Department should be informed under the SAI reporting system, prior to notification being made to the media. In all other cases, unless they fulfil the SAI reporting criteria, incidents about children who go missing without permission should not normally be reported to the Department.

Confidentiality - incident reports sometimes include details about patients' or clients' names. This practice should be discontinued. All incident reports should be anonymised – generally the gender and age of the patient or client is sufficient detail. To aid any follow-up enquiries, however, you should provide the organisation's incident identifier number.

Delay in Reports - unless there is reasonable justification, a report to the Department should be submitted within 72 hours of the incident being discovered. Where an incident involves the death of a person every effort should be made to submit a report within 24 hours. There has been a number of incidents where the time delay in reporting has been considerable; in some cases, these have been accompanied by an explanation for the delay. Some, however, have failed to provide any explanation.

Electronic Reporting - some organisations have indicated concerns about reporting SAIs by e-mail, chiefly on the basis of uncertainty as to whether the information has been received by the Department. The SAI electronic system has a dedicated e-mail address which is regularly checked. However, in order to provide an additional assurance to the reporting organisation, a response acknowledging receipt of an incident report will in future be issued to the sender's e-mail address. If an organisation fails to receive such a response within 24 hours, it should contact the Department to ensure that the incident report has been received.

Revised Notification Arrangements

5. Previous guidance indicated that, until further notice, HPSS organisations should continue to use existing reporting systems alongside the SAI procedures introduced in 2004. In order to reduce duplication, however, it has been decided to discontinue the requirement to submit separate notifications to the Department in the case of untoward events in mental health, learning disability, nursing and residential homes and child care. When an SAI report is received on these issues, it will be forwarded to the relevant point within the Department. Existing guidance, contained in Circulars HSS4 (OS) 1/1973 (Notification of Untoward Events in Psychiatric and Special Care Hospitals) and HSS (THRD) 1/1997 (Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability) is now discontinued.

6. All other existing reporting systems should continue to be used.

Amendments to the SAI Report Proforma

7. The SAI Report proforma (formerly attached as Annex B to Circular HSS (PPM) 06/04) has been revised and is set out in the Annex to this letter. The additional elements are:

- Box 1 - provision for the organisation's own incident identifier number – this will facilitate easier tracing should the Department need to seek further information about the incident.
- Box 2 – in completing this section, reference should be made to any previous SAIs reported which are connected to this particular incident.
- Box 3 – now displays the SAI criteria for reporting to the Department and asks for an explanation as to why the incident meets the criteria.
- Box 4 – extended to include the incident classification as initially assessed by the organisation.
- Box 5 – extended to include the question "Are there any aspects of this incident which could contribute to learning on a regional basis?".
- Box 7 – inclusion of RQIA and facility to record the date on which other organisations are notified. ***Trusts and practices should note that all SAIs should be reported to their commissioning HSS Board as a matter of course***. These reports will help inform HSS Boards with regard to meeting their statutory duty of quality on the services they commission by providing an overview of the quality of service provision and, where appropriate, will facilitate regional learning. In the case of primary care practices, HSS Boards should report to the Department those 'significant events' which are SAIs and fall within the criteria of HSS (PPM) 6/2004.
- Box 8 – as outlined above, it is important that the Chief Executive and the designated senior manager is aware of the incident before the report is submitted to the Department.

Learning from Adverse Incidents

8. The Serious Adverse Incident process is not a performance management tool. However, a key objective in the process is to ensure, where possible, that lessons are learned from adverse incidents and that the quality of services is improved. The Department has, therefore, put in place arrangements to review incidents reported to it on a regular basis and to feed back relevant analysis to the HPSS. In this context, the Serious Adverse Incident Group in the Department meets on a monthly basis to consider reports submitted. It may seek clarification from organisations on the outcome of incidents to determine whether regional guidance is needed. In the case of independent reviews, the Department may also provide guidance as to specialist input into such reviews.

9. In June 2005, the Department provided a first regional briefing on SAIs, focusing on the key issues emerging from incidents reported until then. A further briefing event will take place later this year. Additionally, the Department intends to publish a report later this year which will summarise the key issues emerging and recurrent problems being encountered across the region. It is intended that this will assist organisations to review their clinical and social care governance processes, strengthen their incident reporting arrangements and improve the quality of services.

Action

10. All HPSS organisations are requested to:

- note the areas for improvement identified at paragraph 4 above and ensure that action is taken to address these;
- review the arrangements in place within organisations to ensure that incident management is co-ordinated and working effectively, that designated senior managers are aware of those incidents reported to the Department as SAIs and that such incidents meet the criteria set out in paragraph 16 of HSS (PPM) 06/2004;
- note that existing procedures (under 1973 and 1997 guidance) for the notification of untoward events in mental health services and learning disability are now discontinued;
- cancel Circulars HSS4 (OS) 1/73 (Notification of Untoward Events in Psychiatric and Special Care Hospitals) and HSS (THRD) 1/97 (Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability);
- note the amendments that have been made to the SAI Report Pro-forma; and
- ensure that the revised Pro-forma is brought into use immediately.

11. This Circular will be reviewed in 2007.

12. A copy of this Circular is being sent to designated senior managers responsible for incident reporting in HSS Boards, Trusts and Agencies.

Yours sincerely

NOEL McCANN

BW/93

ANNEX

SERIOUS ADVERSE INCIDENT REPORT

1. Organisation:

Incident Identifier No.

2. Date and brief summary of incident:

3. Why incident considered serious: (i) warrants regional action to improve safety or care within the broader HPSS; (ii) is of public concern; or (iii) requires an independent review.	**Briefly, explain why this SAI meets the criteria:**

4. Immediate action taken:

Classification of incident as initially assessed by organisation: Catastrophic / Major / Moderate / Minor / Insignificant

5. Is any regional action recommended? Y/N (if 'Yes', full details should be submitted):

Are there any aspects of this incident which could contribute to learning on a regional basis?

6. Is an Independent Review being considered? Y/N (if 'Yes', full details should be submitted):

7. Other Organisations informed:		**Date informed**	Other (please specify) Y/N **Date informed:**
HSS Board	Y/N		
HM Coroner	Y/N		
Mental Health Commission	Y/N		
NIHSE	Y/N		
PSNI	Y/N		
RQIA	Y/N		

8. I confirm that the designated senior manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Department. (*delete as appropriate*)
Report submitted by:
(name and contact details of reporting officer)

Date:

Completed proforma should be sent, by email, to:

adverse.incidents@dhsspsni.gov.uk
If e-mail cannot be used, fax to (028) 9052 8126

Jim Livingstone
Director of Safety, Quality and Standards

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

AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

POLICY CIRCULAR

Subject:

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

For action by:

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

For Information to:

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

Summary of Contents:

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

Enquiries:

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

Circular Reference: HSC (SQSD) 08/2010

Date of Issue: 30 April 2010

Related documents

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

Superseded documents

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

Status of Contents:

Action

Implementation:

From 1 May 2010

[redacted]

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

Dear Colleague

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

Introduction

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

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

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

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

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

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

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

Yours sincerely

Jim Livingstone

Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

Section 1: Reporting Serious Adverse Incidents

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

Changes to the reporting of Serious Adverse Incidents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health and Social Care Trusts

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

2.2 HSC Trusts are required to:

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

Family Practitioner Services

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

2.4 Family Practitioner Services are required to:

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

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

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

Health and Social Care Board

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

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

2.7 The HSC Board is required to:

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

Public Health Agency

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

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

2.10 The PHA is required to:

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

Regulation and Quality Improvement Authority

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

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

2.13 The RQIA will:

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

The Department

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

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

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

Timetable for Implementation of RAIL

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

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

Conclusion

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

Health and Social
Care Board

Procedure for the reporting and follow up of Serious Adverse Incidents

April 2010

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SECTION Page

1.0 BACKGROUND

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

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

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

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

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

Circular HSC (SQS) 19/2007 advised of refinements to the DHSSPS SAI system and of changes which would be put in place from April 2007, to promote learning from SAIs and reduce any unnecessary duplication of paperwork for organisations. It also clarified arrangements for the reporting of breaches of patients waiting in excess of 12 hours in emergency care departments.
http://www.dhsspsni.gov.uk/hss___sqsd___19-07.pdf

Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986, the Mental Health Commission has a duty to make inquiry into any case where it appears to the Commission that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to

reporting requirements under the above Order previously issued in April 2000 was reviewed, updated and re-issued in August 2007.
www.dhsspsni.gov.uk/utec_guidance_august_2007.pdf

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

Circular HSC (SQSD) Phase 2 – Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services April 2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of SAI reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA).

2.0 INTRODUCTION

The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Trusts, Family Practitioner Services (FPS) and Independent Service Providers (ISP) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of the business of an HSC organisation/Special Agency or commissioned service.

The requirement on HSC organisations to routinely report SAIs to the Department of Health, Social Services and Public Safety (DHSSPS) will cease from 1 May 2010. From this date, the arrangements for the reporting and follow up of SAIs, pending the full implementation of the Regional Adverse Incident Learning (RAIL) system, will transfer to the Health and Social Care Board (HSCB) working in close partnership with the Public Health Agency (PHA) and the Regulation Quality Improvement Authority (RQIA).

This new process aims to:

- Focus on service improvement for service users[1];

- Recognise the responsibilities of individual organisations and support them in ensuring compliance;

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

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

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

- Provide a mechanism to effectively share learning in a meaningful way across the HSC;

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

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[1] The term service user also refers to patients, clients, children and young people under 18 years and carers

3.0 APPLICATION OF PROCEDURE

3.1 Who does this procedure apply to?

This procedure applies to the reporting and follow up of SAIs arising during the course of the business of an HSC organisation / Special Agency or commissioned service specifically within:

HSC organisations including
HSC Trusts
HSCB, PHA and Business Services Organisation (BSO)
Special Agencies

Family Practitioner Services (FPS)
General Medical Services
Pharmacy
Dental
Ophthalmic

Independent Service Providers (ISPs)
Legal contract (for treatment and care) with HSCB or PHA
Legal contract (for treatment and care) with HSC Trust *(HSC Trust will be responsible for onward reporting to HSCB)*

3.2 Incidents no longer part of process

This procedure no longer requires the reporting of incidents relating to statutory functions required under The Children (Northern Ireland) Order 1995 such as:

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

Where any of the above incidents meet the SAI criteria as detailed in Section 4.2 these should **also** be notified in the manner set out in Section 5 of this procedure.

NOTE: FROM 1 MAY 2010 HSC TRUSTS MUST CONTINUE TO REPORT THE ABOVE STATUTORY FUNCTIONS NOTIFICATIONS DIRECTLY TO HSCB SOCIAL CARE AND CHILDREN (SCC) DIRECTORATE. THE MECHANISM FOR NOTIFICATION TO SCC WILL BE CONTAINED IN SEPARATE NEW GUIDANCE FROM SCC.

3.3 Other Reporting Arrangements

The reporting of Serious Adverse Incidents to the HSCB is without prejudice to reporting requirements to other statutory agencies and external bodies. It is not practical to list all relevant agencies/external bodies; however, examples include notifications to:

- Health and Safety Executive Northern Ireland (HSENI),
- Northern Ireland Adverse Incident Centre (NIAIC),
- Pharmaceutical Society of Northern Ireland (PSNI),
- Police Service of Northern Ireland (PSNI),
- DHSSPS Northern Ireland Head of Inspection and Enforcement (Pharmaceutical Branch).

All existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

This guidance does not provide for the DHSSPS Early Alert System which will be the subject of separate DHSSPS guidance.

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

‘Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation’.[2] arising during the course of the business of an HSC organisation / Special Agency or commissioned service.

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

4.2 SAI criteria

- serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self harm*) of :
  - a service user
  - a service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two [3] years)
  - a staff member in the course of their work
  - a member of the public whilst visiting an HSC facility.

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

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

- serious assault (*including homicide and sexual assaults*) by a service user
  - on other service users,
  - on staff or
  - on members of the public

  occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years).

- serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

IT SHOULD BE NOTED ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE NOTIFIED TO HSCB (*AND WHERE RELEVANT RQIA*) AS AN SAI.

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

[3] Mental Health Commission 2007 UTEC Committee Guidance

5.0 PROCESS

Reporting Serious Adverse Incidents

5.1 SAI occurs within an HSC organisation / Special Agency, an Independent Service Provider or Family Practitioner Service.

5.2 SAI to be reported within **72 hours** of the incident being discovered or in the case of an unexpected/unexplained death, (*where it is understood this poses a significant risk to service users, staff or the public*) where possible within **24 hours.** (*Existing out of hours arrangements to be used*). Reporting mechanisms will vary depending on organisation/practice:

- **HSC Trusts** – Complete the HSC SAI Report Form (Appendix 1) and forward to seriousincidents@hscni.net inserting the Unique Incident Reference/Number in the subject line. *(where relevant HSC Trusts to copy RQIA* mhld@rqia.org.uk *in line with notifications relevant to the functions, powers and duties of RQIA*[4])

- Where HSC Trusts have been informed of an SAI from an ISP with whom they directly commission services, the Trust will liaise with the ISP to complete the HSC SAI Report Form and the HSC Trust will forward to the HSCB at seriousincidents@hscni.net inserting the Unique Incident Reference/Number in the subject line.

- **HSCB / PHA / BSO** – The Senior officer[5] within the Directorate, where the SAI has occurred, will complete the HSC SAI Report Form and forward to seriousincidents@hscni.net inserting the Unique Incident Reference/Number in the subject line.

- **FPS** – Practices to continue to report SAIs to senior officers within the Integrated Care Directorate using adverse incident forms. The senior officer will determine (*in conjunction with PHA Nursing and Midwifery Officers, where relevant*) if the incident meets the criteria of an SAI and will complete the HSC SAI Report Form and forward to seriousincidents@hscni.net inserting the Unique Incident Reference/Number in the subject line.

- **ISPs** – (*for services directly commissioned by HSCB/PHA)* continue to report directly to Assistant

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[4] Notifications reported to both HSCB and RQIA - the management and follow up with HSC Trusts will be co-ordinated by the HSCB who will liaise with RQIA.

[5] Senior Officer is considered officer at Assistant Director Level or above

Director (AD) Contracting within the HSCB Commissioning Directorate using the adverse incident form. The AD Contracting will determine (*in conjunction with relevant officers from PHA*) if the incident meets the criteria of an SAI and will liaise with the ISP to complete the HSC SAI Report Form and forward to seriousincidents@hscni.net inserting the Unique Incident Reference/Number in the subject line.

NOTE: APPENDIX 2 PROVIDES GUIDANCE NOTES TO ASSIST IN THE COMPLETION OF THE HSC SAI REPORT FORM.

Management and follow up of Serious Adverse Incidents

5.3 Governance Lead[6] will record the SAI on the DATIX risk management system, assign to HSCB/PHA Designated Review Officer (DRO) and copy the SAI Report to:

- HSCB/PHA DRO for review and follow up
- Relevant Directors and AD's within the HSCB and PHA, for information
- Other relevant officers, for information.

5.4 The DRO will consider the SAI notification and ensure that immediate actions, if required, are put in place.

5.5 Governance Lead will electronically acknowledge receipt of the SAI report, issuing HSCB unique identification number, confirming the DRO and requesting the completion of an investigation report within **12 weeks** from the date the incident is reported. Where relevant RQIA will be copied into this receipt. (All investigation reports should be completed in line with the HSC Regional Template and Guidance for Incident Investigation/ Review Report - Appendix 3)

5.6 Governance Lead will complete Section 1 of the DRO Form (Appendix 4) and forward to DRO.

5.7 It is recognised that organisations/practices report SAIs based on limited information and the situation may change which could result in:

- the situation deteriorating or
- the incident reported no longer meeting the SAI criteria

in such instances an update should be provided by completing Section 14 of the initial SAI report and the revised/updated SAI report should be re-submitted to seriousincidents@hscni.net.

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[6] Governance Lead refers to Governance Lead within HSCB Local Offices

5.8 Where the reporting organisation/practice has determined that the incident reported no longer meets the criteria of an SAI a request to de-escalate the SAI must be submitted by completing Section 14 of the initial SAI report providing the rationale on why the incident does not warrant further investigation under the SAI process.

5.9 The DRO will review the de-escalation request and inform the reporting organisation of the decision within **10 working days.** The DRO may take the decision to close the SAI without a report rather than de-escalate it or may decide that the SAI should not be de-escalated and a full investigation report is required.

5.10 Investigation reports must be submitted within **12 weeks** from the date the incident is reported. If it is likely that the organisation /practice cannot complete the investigation within this timescale an update should be provided by completing Section 14 of the initial SAI report detailing the reason for the delay and the expected date for completion.

5.11 If an investigation report is not received within the 12 week timeframe and an explanation has not been provided the Governance Lead will ensure a reminder is issued to the relevant organisation/practice requesting the full report or where this is not possible a detailed progress report.

5.12 If the investigation report or progress report is still not received within **10 working days** or there has been no explanation for delay, the HSCB Chief Executive will write to the organisation/practice requesting an explanation for the delay in forwarding the report.

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

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

5.15 When the DRO is satisfied (*based on the information provided*) that the investigation has been robust and recommendations are appropriate, s/he will complete the DRO Form validating their reason for closure. The DRO (*in conjunction with relevant professionals/officers*) will agree that recommendations identified are appropriately addressed including development of any action

/implementation plan. The DRO will advise on any additional performance monitoring arrangements which need to be put in place.

5.16 The DRO will identify any learning arising from the SAI that should be brought forward by the HSCB/PHA SAI Review Group. The completed DRO Form will then be forwarded to the Governance Lead.

5.17 Governance Lead will forward a letter to the organisation/ practice advising the SAI has been closed by HSCB and, where relevant, any additional action to be taken. A copy of this will also be forwarded to RQIA (where relevant)

5.18 The HSCB/PHA SAI Review Group will meet on a bi-monthly basis to consider:

- number and breakdown of reports received, by programmes of care;
- specifics of any significant SAIs;
- identification of trends;
- any problematic issues relating to specific SAIs;
- any implications in respect of procedure;
- any learning identified by DRO;
- the correct mechanisms to share learning in a meaningful way and in a timely manner.

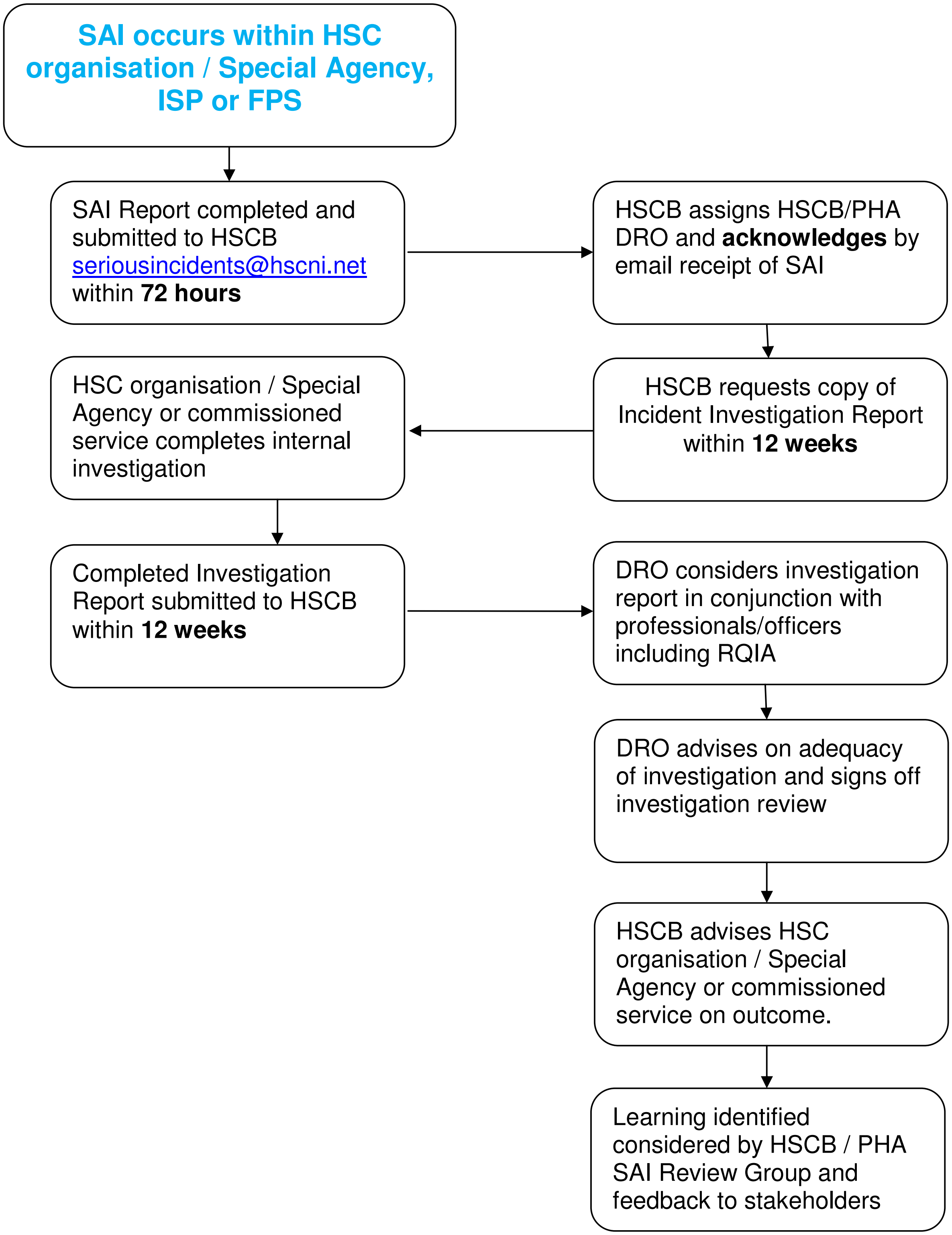
6.0 EQUALITY

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

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

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

7.0 PROCESS FLOW CHART – KEY STAGES



APPENDIX 1

HSC SERIOUS ADVERSE INCIDENT REPORT FORM

1. ORGANISATION:	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE**
3. DATE OF INCIDENT: DD / MMM / YYYY	**4. CONTACT PERSON:** *(Name of lead officer to contact for further details)*

6. DESCRIPTION OF INCIDENT:

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

7. IMMEDIATE ACTION TAKEN:

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

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

• serious injury to, or the unexpected/unexplained death, (*including suspected suicides or serious self harm*) of:	
– a service user;	
– a service user who has been known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two years);	
– a staff member in the course of their work;	
– a member of the public whilst visiting a Health and Social Care facility	
• unexpected serious risk to service user and / or staff member and / or member of the public	
• unexpected or significant threat to provide service and / or maintain business continuity.	
• serious assault (*including homicide and sexual assaults*) by a service user – on other service users, – on staff or – on members of the public occurring within a healthcare facility or in the community (where the service user is known to mental health services (*including CAMHS or LD*) within the last two years).	
• Serious incidents of public interest or concern involving theft, fraud, information breaches and data losses	

9. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED? *(please select)*	**YES**	**NO**

if 'YES' (*full details should be submitted*):

10. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HPC etc)* **if ‘YES’** (*full details should be submitted*):	**YES**	**NO**
if ‘YES’ (*full details should be submitted*):		

11. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	**DATE INFORMED:**	**OTHER:** **Please specify:** **Date informed:**
DHSS&PS EARLY ALERT		
SERVICE USER / FAMILY		
HM Coroner		
ICO		
NIAIC		
NIHSE		
PSNI		
RQIA		

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

Report submitted by: ______________________________ **Designation:** ______________________________

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

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

Additional information submitted by: _______________________ **Designation:** ____________________

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

Completed profroma should be sent to: seriousincidents@hscni.net
and (*where relevant*) mhld@rqia.org.uk

HSCB USE ONLY			**HSCB REF:**
GOVERNANCE LEAD		**GOVERNANCE OFFICE**	
DATE NOTIFIED	**DD / MMM /YYYY**	**DATE ACKNOWLEDGED**	**DD / MMM /YYYY**
DESIGNATED REVIEW OFFICER ASSIGNED		**DATE ASSIGNED**	**DD / MMM /YYYY**
INVESTIGATION REPORT DUE		**DD / MMM / YYYY**	

APPENDIX 2

Guidance Notes
HSC SERIOUS ADVERSE INCIDENT REPORT FORM

All Health and Social Care organisations, Family Practitioner Services and Independent Service Providers are required to report serious adverse incidents to the HSCB within 72 hours of the incident being discovered *(24 hours if the incident involves a death).* It is acknowledged that not all the relevant information may be available within that timescale; however, there is a balance to be made between minimal completion of the proforma and providing sufficient information to make an informed decision upon receipt by the HSCB/PHA.

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

2. ORGANISATION: *Include the details of the reporting organisation (Trust, FPS, ISP)*	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE** *Unique incident number / reference generated by the reporting organisation / practice*
3. DATE OF INCIDENT: DD / MMM / YYYY *Date incident occurred*	**4. CONTACT PERSON:** *(Name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident)*

5. DESCRIPTION OF INCIDENT:

Provide a brief factual description of what has happened and a summary of the events leading up to the incident, ensure sufficient information is provided so that the HSCB/ PHA are able to come to an opinion on the immediate actions, if any, that they must take. Where relevant include D.O.B, Gender, and Age. All reports should be anonymised – the names of any practitioners or staff involved must ***not*** *be included. Staff should only be referred to by job title.*

In addition include the following:

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

Children *– when reporting a child death indicate if the Regional Child Protection Committee have been advised*

Mental Health *- when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide or serious self harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last 2 years) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into the community arrangements; whether there was a history of DNAs, where applicable the details of how the death occurred, if known.*

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

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

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

6. IMMEDIATE ACTION TAKEN:

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

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

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

- serious injury to, or the unexpected/unexplained death, (*including suspected suicides or serious self harm*) of:
  - – a service user; ☐
  - – a service user who has been known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two years); ☐
  - – a staff member in the course of their work; ☐
  - – a member of the public whilst visiting a Health and Social Care facility ☐
- unexpected serious risk to service user and /or staff member and/or member of the public ☐
- unexpected or significant threat to provide service and / or maintain business continuity. ☐

- serious assault (*including homicide and sexual assaults*) by a service user
  - on other service users,
  - on staff or
  - on members of the public

  occurring within a healthcare facility or in the community (where the service user is known to mental health services (*including CAMHS or LD*) within the last two years).

- Serious incidents of public interest or concern involving theft, fraud, information breaches and data losses

8. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED? *(please select)*	**YES**	**NO**
if 'YES' (*full details should be submitted*):		
9. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(please select)* *(e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HPC etc) where there appears to be a breach of professional code of conduct*	**YES**	**NO**
if 'YES' (*full details should be submitted*):		

10. OTHER ORGANISATION/PERSONS INFORMED: *(insert date informed)*	**DATE INFORMED:**	**OTHER:**
DHSS&PS EARLY ALERT		
FAMILY/CARER		
HM Coroner		**Please specify:**
ICO		
NIAIC		
NIHSE		**Date informed:**
PSNI		
RQIA		

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

Additional information submitted by: ____________________ **Designation:** _________________

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

14. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION

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

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

The HSCB/PHA will review the de-escalation request and inform the reporting organisation of its decision within 10 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than deescalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full investigation report is required.

Use this section also to provide updates on progress with investigations – e.g. where the reporting organisation knows that the investigation report will not be submitted within the 12 week timeframe, this should be communicated to seriousincidents@hscni.net with the unique incident identification number/reference in the subject line and provide the rationale for the delay and revised timescale for completion .

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED INVESTIGATION REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA SAI REVIEW GROUP. THEY WILL BE MONITORED IN ACCORDANCE WITH THE 12 WEEK TIMESCALE. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREACHES ARE NOT REPORTED HSCB/PHA SAI REVIEW GROUP WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED.

Additional information submitted by: ____________________ **Designation:** _________________

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

Completed profroma should be sent to: **seriousincidents@hscni.net**
and (*where relevant*) **mhld@rqia.org.uk**

APPENDIX 3

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Health and Social Care Regional Template and Guidance for Incident Investigation/Review Reports

September 2007

Introduction

This work has been commissioned by the DHSSPS Safety in Health and Social Care Steering Group as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS*" (under 5.1.2 Agreeing Common systems for Data Collection, Analysis and Management of Adverse Events). The following work forms part of an on-going process to develop clarity and consistency in conducting investigations and reviews. This is an important aspect of the safety agenda.

This template and guidance notes should be used, in as far as possible, for drafting all HSC incident investigation/review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports. It should assist in ensuring the completeness and readability of such reports. The headings and report content should follow as far as possible the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

All investigations/reviews within the HSC should follow the principles contained within the National Patient Safety Agency (NPSA) Policy documents on "*Being Open – Communicating Patient Safety Incidents with Patients and their Carers*".
http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy111.pdf

It is also suggested that users of this template read the guidance document "*A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises*" – Regional Governance Network – February 2007.
http://www.dhsspsni.gov.uk/microsoft_word_-_hss__sqsd__18-07_patient_service_review_guidelines_-_final_feb07.pdf

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

The suggested template can be found in the following pages.

Template Title Page

Date of Incident/Event

Organisation's Unique Case Identifier (for tracking purposes)

Introduction

The introduction should outline the purpose of the report and include details of the commissioning Executive or Trust Committee.

Team Membership

List names and designation of the members of the Investigation team. Investigation teams should be multidisciplinary and should have an independent Chair. The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident. However, best practice would indicate that investigation / review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice. In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered. There may be specific guidance for certain categories of adverse incidents, such as, the Mental Health Commission guidance *http://www.dhsspsni.gov.uk/mhc_guidance_on_monitoring_untoward_events.pdf*

Terms of Reference of Investigation/Review Team

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

- To undertake an initial investigation/review of the incident
- To consider any other relevant factors raised by the incident
- To agree the remit of the investigation/review
- To review the outcome of the investigation/review, agreeing recommendations, actions and lessons learned.
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate

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

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

This list is not exhaustive

Summary of Incident/Case

Write a summary of the incident including consequences. The following can provide a useful focus but please note this section is not solely a chronology of events

- Brief factual description of the adverse incident
- People, equipment and circumstances involved
- Any intervention / immediate action taken to reduce consequences
- Chronology of events
- Relevant past history
- Outcome / consequences / action taken

This list is not exhaustive

Methodology for Investigation

This section should provide an outline of the methods used to gather information within the investigation process. The NPSA's "Seven Steps to Patient Safety" is a useful guide for deciding on methodology.

- Review of patient/ service user records (if relevant)

- Review of staff/witness statements (if available)

- Interviews with relevant staff concerned e.g.
    - Organisation-wide
    - Directorate Team
    - Ward/Team Managers and front line staff
    - Other staff involved
    - Other professionals (including Primary Care)

- Specific reports requested from and provided by staff

- Engagement with patients/service users / carers / family members

- Review of Trust and local departmental policies and procedures

- Review of documentation e.g. consent form(s), risk assessments, care plan(s), training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

Analysis

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care provided.

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

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

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

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

(ii) Contributory Factors

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

- Individual Factors
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors investigated and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful.
www.npsa.nhs.uk/health/resources/7steps

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

Conclusions

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

Involvement with Patients/Service Users/ Carers and Family Members

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

Recommendations

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

- Local recommendations
- Regional recommendations
- National recommendations

Learning

In this final section it is important that any learning is clearly identified. Reports should indicate to whom learning should be communicated and copied to the Committee with responsibility for governance.

APPENDIX 4

DESIGNATED SAI REVIEW OFFICER FORM

SECTION 1 TO BE COMPLETED BY HSCB GOVERNANCE LEAD

UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE	**HSCB IDENTIFICATION NUMBER**

SECTION 1: RECEIPT AND PROCESSING OF SAI			
DATE SAI NOTIFIED	DD / MMM /YYYY	**DATE ACKNOWLEDGED**	DD / MMM /YYYY
DESIGNATED REVIEW OFFICER ASSIGNED		**DATE ASSIGNED**	DD / MMM /YYYY
INVESTIGATION REPORT DUE:		DD / MMM / YYYY	

SECTIONS 2 to 6 TO BE COMPLETED BY DESIGNATED REVIEW OFFICER

SECTION 2: IMMEDIATE ACTION TAKEN BY DESIGNATED REVIEW OFFICER:

SECTION 3: RECEIPT OF INVESTIGATION REPORT		
INVESTIGATION REPORT RECEIVED WITHIN 12 WEEKS?	YES ***complete 4***	NO ***complete 3b***

SECTION 3b: INVESTIGATION REPORT OVERDUE (not submitted within 12 weeks)		
HAS AN EXPLAINATION/UPDATE BEEN PROVIDED?	YES	NO
DRO COMMENTS:		
DRO REMINDER SENT TO REPORTING ORGANISATION?	DD / MMM /YYYY	
CHIEF EXECUTIVE LETTER TO REPORTING ORGANISATION?	DD / MMM /YYYY	

SECTION 4: INVESTIGATION REPORT	
DATE INVESTIGATION REPORT RECEIVED	DD / MMM / YYYY
DATE INVESTIGATION REPORT FORWARDED TO RQIA *(where relevant)*	DD / MMM / YYYY
DRO COMMENTS ON ADEQUACY OF INVESTIGATION REPORT: *(in conjunction with other professionals and RQIA where relevant):*	

SECTION 5: CLOSURE OF SAI		
BASED ON INFORMATION PROVIDED IS DRO CONTENT TO CLOSE? *(confirm in conjunction with other professionals and RQIA where relevant):*	YES	NO *Continue to liaise with organisation/ practice*
DRO'S COMMENTS INCLUDING HOW IDENTIFIED RECOMMENDAITONS SHOULD BE MONITORED: *(in conjunction with other professionals and RQIA where relevant):*		
DRO CLOSURE LETTER SENT TO REPORTING ORGANISATION?	DD / MMM /YYYY	
SIGNATURE OF DRO:	**DATE:** DD / MMM /YYYY	
DESIGNATION:	**ORGANISAITON/DIRECTORATE:**	

SECTION 6 : LEARNING
LOCAL, REGIONAL, NATIONAL LEARNING IDENTIFIED: *(please specify)* *(learning identified will be submitted to HSCB/PHA SAI Review Group)*

Health and Social Care Board

HSC Board Headquarters
12-22 Linenhall Street
BELFAST
BT42 1QB

Tel : 028 90321313
Fax: 028 90553625

Web Site : www.hscboard.hscni.net

BY EMAIL

CXs HSC Trusts, BSO, NIBTS

22 April 2010

Dear Colleagues

HSCB Procedure for the reporting and follow up of Serious Adverse Incidents (SAIs)

You will be aware that the requirement on HSC organisations to routinely report SAIs to the Department will cease from 1 May 2010. From this date, the arrangements for the reporting and follow up of SAIs, pending the full implementation of the Regional Adverse Incident Learning (RAIL) system, will transfer to the HSCB.

The attached procedure reflects the responsibilities of all relevant organisations in respect to the reporting of SAIs and introduces a robust and streamlined system in relation to how they managed, working in close partnership with professionals from PHA and RQIA.

You will note that certain incidents relating to The Children (NI) Order 1995 have now been removed from the SAI process. The reporting of these incidents will now be made directly to the Social Care and Children Directorate, HSCB. Guidance in respect of these arrangements will be issued by the directorate prior to 1 May 2010.

I would like to take this opportunity to thank colleagues from the Department, PHA and RQIA, together with you and your staff for their involvement in the development of the procedure. This has included attendance at the workshop in February and the responses received from the consultation process; all of which has helped shape the procedure into one that is both coherent and comprehensive.

It is our intention to review the procedure during the course of the next year and would value your input at that time. This review will also take account of the DHSSPS Health and Social Care Regional Template and Guidance for Incident/Investigation/Review Report, which is currently part of this process.

If you have any queries in relation to the attached procedure, please contact:

[redacted]

Please note, a copy of the procedure can be accessed via the web link below:

http://www.hscboard.hscni.net/consult/Policies/HSCB Procedure for the reporting and followup of SAI - April 2010.pdf

Yours sincerely

John Compton
Chief Executive

cc: HSCB Directors
PHA Cx & Directors
RQIA Cx
PCC Cx
Director Safety, Quality and Standards DHSSPS
Medical Director, RQIA
HSC Trust Governance and Risk Management Leads
HSCB / PHA Regional SAI Review Group
Deputy Head, Safety, Quality & Standards Directorate, DHSSPS
Head of Programme MH & LD, RQIA

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Chief Executives, HSC Trusts
Chief Executive, Public Health Agency
Chief Executive, Business Services Organisation
Chief Executive, Northern Ireland Blood Transfusion Service
Chief Executive, Patient Client Council
Chief Executive, Northern Ireland Medical and Dental Training Agency
Chief Executive, Northern Ireland Practice and Education Council

20 September 2013

Dear Colleague

REVISED PROCEDURE FOR THE REPORTING AND FOLLOW UP OF SERIOUS ADVERSE INCIDENTS – OCTOBER 2013

On 1 May 2010 the responsibility for the management and follow up of Serious Adverse Incidents (SAIs) transferred from Department of Health, Social Services and Public Safety (DHSSPS) to the Health and Social Care Board (HSCB) working jointly with Public Health Agency (PHA) and collaboratively with Regulation Quality Improvement Authority (RQIA). In response, the HSCB issued the Procedure for the Reporting and Follow up of SAIs (the Procedure) to all HSC organisations and Special Agencies, which set out the process to be followed when a SAI occurred during the course of their normal business or commissioned service.

During 2012/13 the HSCB, working with the PHA, undertook a review of the procedure issued in 2010. This involved meetings with colleagues from across the HSC to identify ways in which the current procedure could be improved.

As a result of these discussions, a revised draft procedure was issued for consultation during August. Further amendments were made to reflect comments received during this exercise, and a copy of the final revised Procedure can be accessed via the web link below:

http://www.hscboard.hscni.net/publications/Policies/102%20Procedure_for_the_reporting_and_followup_of_Serious_Adverse_Incidents-Oct2013.pdf

I would particularly draw your attention to a number of changes to the Procedure as a result of the review:

- **SAI criteria** – an additional criterion has been included at paragraph 4.2.2 “*any death of a child in receipt of HSC Services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register”.*

  In addition, the timescale for reporting serious self-harm, serious assault *(including suspected suicides, homicides and sexual assaults)* SAIs, by a service user known to/referred to mental health services, has been revised from 24 months to 12 months prior to the incident.

- **Investigation levels** – the single investigation process for all SAIs has been replaced by three levels of investigation to reflect the complexity of the incident and to ensure the timely identification of learning.

- **Timescales** for conducting investigations have been revised in line with the level of investigation to be undertaken.

Implementation

In order to ensure a smooth transition from the current arrangements to the revised Procedure, implementation will be phased as follows:

- From **1 October 2013,** the revised SAI reporting criteria will be adopted along with the associated reporting documentation;

- The introduction of the revised investigation levels and associated timescales will be implemented by individual organisations over the next six months, to be fully operational from **1 April 2014**. This is to provide sufficient time for all organisations to provide training for staff and put in place local operational protocols to support the Procedure.

Conclusion

I would like to thank all of the staff from across the HSC who have contributed and provided input to the review of the SAI procedure. I believe that the revised procedure will strengthen governance arrangements at a local level within individual organisations and also enhance the arrangements regionally, to ensure learning from incidents is identified and disseminated in a timely manner to improve the safety and quality of services.

If you have any queries in relation to the Procedure, please contact: [redacted] the first instance.

Yours sincerely

JOHN COMPTON
CHIEF EXECUTIVE

Encs

cc Chief Medical Officer, DHSSPS
Chief Nursing Officer, DHSSPS
Acting Chief Pharmaceutical Officer, DHSSPS
Acting Director Safety, Quality and Standards DHSSPS
Deputy Head, Safety, Quality and Standards, DHSSPS
Dr Paddy Woods, DCMO, DHSSPS
RQIA Chief Executive - Glenn Houston
Medical Director, RQIA - Dr David Stewart
Director of Mental Health and Learning Disability and Social Work, RQIA -Theresa Nixon
Director of Regulation and Nursing, RQIA - Kathy Fodey
Head of Programme MH & LD, RQIA - Patrick Convery
HSC Trust Medical Directors
HSC Trust Directors of Nursing
HSC Trust Governance and Risk Management Leads
HSC Trust Directors of Mental Health and Learning Disability
HSCB SMT

HSCB / PHA Regional SAI Review Group
Medical Director/Director of Public Health, PHA
Director of Nursing & AHPs, PHA

Health and Social
Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

October 2013

CONTENTS

FOREWORD

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

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

The procedure seeks to provide a consistent approach to:

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

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

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

John Compton
Chief Executive

SECTION ONE

1.0 BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.0 INTRODUCTION

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

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

This process aims to:

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

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

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

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

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

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

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

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

SECTION TWO

3.0 APPLICATION OF PROCEDURE

3.1 Who does this procedure apply to?

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

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

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

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

3.2 Incidents reported by Family Practitioner Services (FPS)

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

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

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

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

or, if this cannot be determined;

- the HSC organisation who holds the contract with the IVCS

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

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

3.4 Reporting of HSC Interface Incidents

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

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

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the investigation. In these instances refer to Appendix 12 – Guidance on Joint Investigations.

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

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

3.5.1 Memorandum of Understanding (MOU)

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

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

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

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

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

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

The MOU is intended to help:

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

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

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

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

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

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

3.6 Reporting of SAIs to RQIA

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

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

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

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

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

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

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

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

4.2 SAI criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.0 SAI INVESTIGATIONS

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

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

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

5.1 Level 1 Investigation – Significant Event Audit (SEA)

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

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

The possible outcomes from the investigation may include:

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

(refer to Appendix 5 guidance on SEA investigations)

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

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

5.2 Level 2 – Root Cause Analysis (RCA)

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

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

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

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

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

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

- within 12 weeks from the date of the SEA.

5.3 Level 3 – Independent Investigation

Level 3 investigations will be considered for SAIs that:

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

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

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

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

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

5.4 Involvement of Service Users/Relatives/Carers in Investigations

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

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

6.0 TIMESCALES

6.1 Notification

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

6.2 Investigation Reports

LEVEL 1 – SEA

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

LEVEL 2 – RCA

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

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

LEVEL 3 – INDEPENDENT INVESTIGATIONS

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

6.3 Investigation Report Extensions

LEVEL 1 INVESTIGATIONS – SEA

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

LEVEL 2 INVESTIGATIONS - RCA

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

LEVEL 3 INVESTIGATIONS – INDEPENDENT

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

6.4 Responding to additional information requests

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

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

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

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

7.0 OTHER INVESTIGATIVE PROCESSES

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

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

7.1 Complaints in the HSC

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

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

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

7.2 HSCB Social Care Untoward Events Procedure

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

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

7.3 Child Protection and Adult Protection

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

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

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

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

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

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

7.4 Transferring SAIs to other Investigation Processes

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

This type of investigation includes:

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

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

7.5 De-escalating a SAI

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

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

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

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

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

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

8.0 LEARNING FROM SAIs

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

HSCB in conjunction with the PHA will:

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

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

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

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

9.0 REGIONAL ADVERSE INCIDENT LEARNING SYSTEM (RAIL)

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

10.0 TRAINING AND SUPPORT

10.1 Training

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

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

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

10.2 Support

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

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

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

11.0 INFORMATION GOVERNANCE

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

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

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

Further guidance is available from the HSCB Information Governance Team on: Tel 028 3741 4646

12.0 ROLE OF DESIGNATED REVIEW OFFICER (DRO)

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

- liaising with reporting organisations on any immediate action to be taken following notification of a SAI;
- agreeing the Terms of Reference for Level 2 and 3 investigations;
- reviewing completed SAI investigation reports and liaising with other professionals (where relevant);
- liaising with reporting organisations where there may be concerns regarding the robustness of the investigation or where there are any issues with proposed action plans;
- identification of regional learning, where relevant.

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

SECTION THREE

13.0 PROCESS

13.1 Reporting Serious Adverse Incidents

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

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

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

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

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

13.2 Reporting Interface Incidents

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

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

13.3 Acknowledging SAI Notification

On receipt of SAI notification HSCB Governance Team will record the SAI on the DATIX risk management system and electronically acknowledge receipt of SAI notification to reporting organisation; advising of the HSCB unique identification number, and requesting the completion of SEA Report within 4 week (6 weeks by exception) from the date the incident is reported. Where relevant, RQIA will be copied into this receipt (Refer to Appendix 14 – Administrative Protocol between HSCB and RQIA)

13.4 Designated Review Officer (DRO)

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

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

13.5 Investigation Reports

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

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

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

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

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

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

13.6 Closure of SAI

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

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

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

13.7 Regional Learning from SAIs

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

13.8 Communication

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

14.0 EQUALITY

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

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

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

SECTION FOUR APPENDICES

APPENDICES

APPENDIX 1

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

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

7. DESCRIPTION OF INCIDENT:

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

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: ***(refer to Guidance Notes)***	**DETAIL:** ***(refer to Guidance Notes)***	**ADVERSE EVENT:** ***(refer to Guidance Notes)***

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

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

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

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

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

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

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

13. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED: ***(please select)***	**YES**	**NO**

if 'YES' (*full details should be submitted*):

14. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? ***(refer to guidance notes*** *e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.)* ***please specify where relevant***	**YES**	**NO**

if 'YES' (*full details should be submitted including the date notified*):

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

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

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

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

Report submitted by: ____________________________ **Designation:** ___________________________

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

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

Additional information submitted by: ______________________ **Designation:** ___________________

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

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 2

Guidance Notes

HSC SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

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

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

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

7. DESCRIPTION OF INCIDENT:

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

In addition include the following:

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

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

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

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

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

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

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

8. IMMEDIATE ACTION TAKEN TO PREVENT RECURRANCE:

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

9. CURRENT CONDITION OF SERVICE USER:

__Where relevant__ please provide details on the current condition of the service user the incident relates to.

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

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

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

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

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

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

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

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

Report submitted by: ______________________________ **Designation:** ______________________________

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

18. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION

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

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

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

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

Additional information submitted by: ________________________ **Designation:** ____________________

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

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 3

HSC INTERFACE INCIDENTS NOTIFICATION FORM

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

5. DESCRIPTION OF INCIDENT:

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

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

7. PROVIDE SUFFICIENT DETAILS TO ALLOW FOLLW UP:

8. IMMEDIATE ACTION TAKEN BY REPORTING ORGANISATION:

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

10. OTHER COMMENTS:

REPORT SUBMITTED BY: ______________________________ **DESIGNATION:** ______________________________

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

Completed proforma should be sent to: seriousincidents@hscni.net

APPENDIX 4

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT

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

WHAT HAPPENED?

WHY DID IT HAPPEN?

WHAT HAS BEEN LEARNED?

WHAT HAS BEEN CHANGED?

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

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

THE INVESTIGATION TEAM :

INVESTIGATION TERMS OF REFERENCE:

APPENDIX 5

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT GUIDANCE

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

WHAT HAPPENED?

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

WHY DID IT HAPPEN?

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

WHAT HAS BEEN LEARNED?

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

WHAT HAS BEEN CHANGED?

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

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

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

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

APPENDIX 6

Insert organisation Logo

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

Organisation’s Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

Date submitted to HSCB:

1.0 EXECUTIVE SUMMARY

2.0 THE INVESTIGATION TEAM

3.0 INVESTIGATION TERMS OF REFERENCE

4.0 INVESTIGATION METHODOLOGY

5.0 DESCRIPTION OF INCIDENT/CASE

6.0 FINDINGS

7.0 CONCLUSIONS

8.0 LESSONS LEARNED

9.0 RECOMMENDATIONS AND ACTION PLANNING

10.0 DISTRIBUTION LIST

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APPENDIX 7

Health and Social Care Regional Guidance

for

Level 2 & 3 RCA Incident Investigation/Review Reports

INTRODUCTION

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

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

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

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

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

Insert organisation Logo

Report on the investigation of a Serious Adverse Incident

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

Date submitted to HSCB:

1.0 EXECUTIVE SUMMARY

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

2.0 THE INVESTIGATION TEAM

Refer to GUIDANCE ON INVESTIGATION TEAM MEMBERSHIP

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

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

3.0 INVESTIGATION TERMS OF REFERENCE

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

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

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

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

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

3.0 INVESTIGATION TERMS OF REFERENCE

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

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

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

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

This list is not exhaustive

4.0 INVESTIGATION METHODOLOGY

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

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

This list is not exhaustive

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

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

5.0 DESCRIPTION OF INCIDENT/CASE

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

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

This list is not exhaustive

6.0 FINDINGS

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

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

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

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

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

(ii) Contributory Factors

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

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

6.0 FINDINGS

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

This list is not exhaustive

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

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

7.0 CONCLUSIONS

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

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

8.0 LESSONS LEARNED

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

9.0 RECOMMENDATIONS AND ACTION PLANNING

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

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

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

10.0 DISTRIBUTION LIST

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

APPENDIX 8

MINIMUM STANDARDS FOR ACTION PLANS

The action plan must define:

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

The action plan **MUST** contain the following

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

APPENDIX 9

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

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

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

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

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

APPENDIX 10

LEVEL TWO INVESTIGATION - GUIDANCE ON INVESTIGATION TEAM MEMBERSHIP

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

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

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

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

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

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

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

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

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

APPENDIX 11

LEVEL THREE INVESTIGATION - GUIDANCE ON INVESTIGATION TEAM MEMBERSHIP

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

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

APPENDIX 12

GUIDANCE ON JOINT INVESTIGATIONS

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

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

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

Points to consider:

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

This guidance should be read in conjunction with:

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

APPENDIX 13

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

1. INTRODUCTION AND PURPOSE

1.1. INTRODUCTION

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

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

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

1.2. PURPOSE

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

2. THE PROCESS

2.1. REPORTING SERIOUS ADVERSE INCIDENTS

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

2.2. MULTI-DISCIPLINARY REVIEW

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

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

2.3. ESTABLISHING AN INDEPENDENT REVIEW TEAM

2.3.1 CHAIR

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

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

2.3.2 MEMBERSHIP

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

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

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

3. TERMS OF REFERENCE

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

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

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

4. TIME SCALES

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

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

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

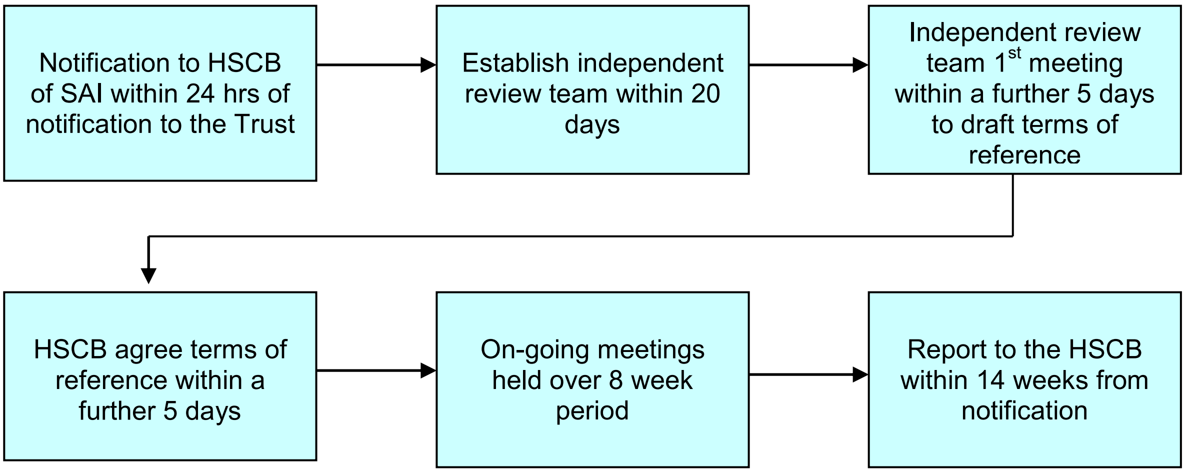
The team should meet to draft the terms of reference within a further five working days (i.e. twenty five days from notification of the incident to the Trust).

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

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

FLOWCHART OF PROCESS WITH TIMESCALES

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



5. THE HEALTH AND SOCIAL CARE BOARD RESPONSIBILITY

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

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

APPENDIX 14

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

ADMINISTRATIVE PROTOCOL

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

1. HSCB acknowledgement email to Trust advising on timescale for investigation report will also be copied to RQIA.
2. On receipt of the investigation report from Trust, the HSCB Governance Team will forward to the HSCB/PHA Designated Review Officer (DRO).
3. At the same time, the HSCB Governance Team will also forward the investigation report to RQIA, together with an email advising of a **3 week** timescale from receipt of investigation report, for RQIA to forward comments for consideration by the DRO.
4. The DRO will continue with his/her review liaising (where s/he feels relevant) with Trust, RQIA and other HSCB/PHA professionals until s/he is satisfied SAI can be closed.
5. If no comments are received from RQIA within the 3 week timescale, the DRO will assume RQIA have no comments.
6. When the SAI is closed by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

All communications to be sent or copied via:

HSCB Governance Team:* *seriousincidents@hscni.net
and RQIA: seriousincidents@rqia.org.uk

APPENDIX 15BW/98

HSC Regional Impact Table – with effect from April 2013

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

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

Risk Likelihood Scoring Table

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

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

Health and Social Care Board

Public Health Agency

Chief Executives of Arm's Length Bodies

HSC Board and PHA Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: 0300 555 0115

17 November 2016

Dear Colleagues

Revised Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAI) – November 2016

Over recent months a number of issues have arisen that impact on the current SAI process. The HSCB and PHA have therefore recently completed a review of the procedure, and as a result a number of amendments have been made to the procedure.

The main changes to the procedure are as follows:

- **Quality Assurance of Level 1 SEA Review Reports (page 14 of attached procedure refers)**
    - ✓ The revised process requires reporting organisations to quality assure the robustness of level 1 SEA Reviews prior to submission to the HSCB. The changes to the process have been discussed with Designated Review Officers (DROs), Trust professional Directors and Trust Governance Leads.
    - ✓ Level 2 and 3 SAI Reviews will continue to be managed as per the current SAI process.
    - ✓ Additional guidance on the use of an 'incident debrief' for each level of SAI review has been developed in order to provide organisations with a mechanism to support staff and to identify any immediate service actions.
    - ✓ The role of HSCB/PHA DROs has been updated to reflect the above amendments (page 24 refers)
- **Never Events (page 25 of procedure refers)**
    - ✓ In line with DoH circular HSC(SQSD) 56/16 (Never Events), the current SAI notification form has been revised to enable reporting organisations to identify relevant SAIs as a Never Event and confirm that Service Users/Family/Carers have been informed.
    - ✓ A new field has also been set up on the HSCB DATIX reporting system which will allow all Never Events to be recorded in line with the current categories listed in the NHS England Never Event list.

- **Engagement/Communication with Service Users/Family/Carers following a Serious Adverse Incident**

  ✓ *Service User/Family/Carer Engagement Checklist (appendices 4 - 7 refers)*

  The above checklist which forms part of all levels of review reports, has been updated to reflect where relevant, the service user/family carer has been advised:

  ○ the SAI is a never event;
  ○ if a case has been referred to the Coroner, where the reporting organisation had a statutory duty to do so.

  ✓ *A guide for Health and Social Care Staff (Addendum 1 of procedure refers)*

  The above guidance has been revised to reflect:

  ○ the term 'SAI Review' (this has also been reflected throughout the revised procedure);
  ○ a service user/family's right to contact the Northern Ireland Public Services Ombudsman (NIPSO) where they are dissatisfied with the HSC organisation's attempts to resolve their concerns following a SAI review;
  ○ the engagement leaflet has been updated to reflect the organisation's responsibility to advise the service user/family/carer of a Never Event.

▪ **Reporting of Falls (page 20 of procedure refers)**

The Report on Falls Resulting in Moderate to Service Harm was issued in March 2016. As a result, a new process has been developed, with phased implementation, which enables Trusts to undertake a timely local post falls review, and report the learning from these incidents to the Regional Falls Group, rather than being reported routinely as SAIs.

In addition to the above, all other changes to the process, previously communicated to ALBs since October 2013, are incorporated within this review.

Implementation

- In relation to level 1 SAIs, the learning summary template should be fully implemented from 1 January 2017.

- All other aspects of the procedure are to be implemented with immediate effect.

I would therefore request you circulate this letter together with the attached procedure to all relevant staff within your organisation. The procedure can also be accessed via the following link:

http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf.

Templates contained within the procedure will be issued separately, in word format, to your Governance Lead or relevant point of contact.

A further review of the procedure may be required following the completion of the two RQIA/GAIN strategic projects and subsequent publication of those reports. In the meantime, if you have any queries in relation to the attached, please contact [redacted] in the first instance.

Yours sincerely

Valerie Watts

Valerie Watts
Chief Executive

Encs

cc Chief Medical Officer, DoH
Chief Nursing Officer, DoH
Chief Pharmaceutical Officer, DoH
Dr Paddy Woods, DCMO, DoH
Mr Brian Godfrey, Head of Safety Strategy Unit, DoH
Mr Fergal Bradley, Safety, Quality and Standards, DoH
Medical Director, RQIA
Mrs Theresa Nixon, Director of Mental Health and Learning Disability and Social Work, RQIA
Kathy Fodey, Director of Regulation and Nursing, RQIA
HSC Trust Medical Directors
HSC Trust Directors of Nursing
HSC Trust Governance and Risk Management Leads
HSC Trust Directors of Mental Health and Learning Disability
HSCB SMT
Mrs Anne Kane, Governance Manager, HSCB
Ms Lynne Charlton, Head of Nursing, Quality, Safety & Patient Experience

Health and Social
Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

November 2016
Version 1.1

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FOREWORD

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

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

The procedure seeks to provide a consistent approach to:

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

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

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

This procedure will remain under continuous review.

Valerie Watts
Chief Executive

SECTION ONE - PROCEDURE

1.0 BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986, the Regulation & Quality Improvement Authority (RQIA) has a duty to make inquiry into any case where it appears to the Authority that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to reporting requirements under the above Order previously issued in April 2000 was reviewed, updated and re-issued in August 2007. (Note: Functions of the previous Mental Health Commission transferred to RQIA on 1 April 2009).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.0 INTRODUCTION

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

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

This process aims to:

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

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

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

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

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

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

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

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

3.0 APPLICATION OF PROCEDURE

3.1 Who does this procedure apply to?

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

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

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

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

3.2 Incidents reported by Family Practitioner Services (FPS)

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

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

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

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

or, if this cannot be determined;

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

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

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

3.4 Reporting of HSC Interface Incidents

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

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

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

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

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

3.5.1 Memorandum of Understanding (MOU)

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

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

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

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

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

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

The MOU is intended to help:

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

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

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

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

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

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

3.6 Reporting of SAIs to RQIA

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

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

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

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

- The HSCB/PHA Designated Review Officer (DRO) will lead and co-ordinate the SAI management, and follow up, with the reporting organisation; however for these SAIs this will be carried out in conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 15.

3.7 Reporting of SAIs to the Safeguarding Board for Northern Ireland

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

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

AND

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

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

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

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

4.2 SAI criteria

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

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

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

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

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

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

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

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

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

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

4.2.7 serious incidents of public interest or concern relating to:

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

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

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

5.0 SAI REVIEWS

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

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

The HSC Regional Risk Matrix (refer to Appendix 16) may assist organisations in determining the level of 'seriousness' and subsequently the level of review to be undertaken. SAIs which meet the criteria in 4.2 above will be reviewed by the reporting organisation using one or more of the following:

5.1 Level 1 Review – Significant Event Audit (SEA)

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

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

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

The possible outcomes from the review may include:

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

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

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

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

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

5.2 Level 2 – Root Cause Analysis (RCA)

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

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

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

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

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

5.3 Level 3 – Independent Reviews

Level 3 reviews will be considered for SAIs that:

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

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

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

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

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

5.4 Involvement of Service Users/Family/Carers in Reviews

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

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

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

6.0 TIMESCALES

6.1 Notification

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

6.2 Review Reports

LEVEL 1 – SEA

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

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

LEVEL 2 – RCA

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

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

LEVEL 3 – INDEPENDENT REVIEWS

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

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

6.3 Exceptions to Timescales

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

6.4 Responding to additional information requests

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

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

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

7.0 OTHER INVESTIGATIVE/REVIEW PROCESSES

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

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

7.1 Complaints in the HSC

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

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

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

7.2 HSCB Social Care Untoward Events Procedure

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

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

7.3 Child and Adult Safeguarding

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

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

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

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

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

7.4 Reporting of Falls

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

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

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

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

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

7.5 Transferring SAIs to other Investigatory Processes

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

This type of investigation includes:

- Case Management Reviews
- Serious Case Reviews

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

7.6 De-escalating a SAI

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

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

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

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

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

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

8.0 LEARNING FROM SAIs

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

HSCB in conjunction with the PHA will:

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

- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;
- review and consider learning from external/independent reports relating to quality/safety.

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

9.0 TRAINING AND SUPPORT

9.1 Training

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

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

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

9.2 Support

9.2.1 Laypersons

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

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

9.2.2 Clinical/Professional Advice

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

10.0 INFORMATION GOVERNANCE

The SAI process deals with a considerable amount of sensitive personal information. Appropriate measures must be put in place to ensure the safe and secure transfer of this information. All reporting organisations should adhere to their own Information Governance Policies and Procedures. However, as a minimum the HSCB would recommend the following measures be adopted when transferring patient/client identifiable information via e-mail or by standard hard copy mail:

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

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

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

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

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

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

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

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

11.0 ROLE OF DESIGNATED REVIEW OFFICER (DRO)

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

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

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

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

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

- identification of regional learning, where relevant;

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

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

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

12.0 PROCESS

12.1 Reporting Serious Adverse Incidents

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

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

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

Reporting managers must comply with the principles of confidentiality when reporting SAIs and must not refer to service users or staff by name or by any other identifiable information. A unique Incident Reference/Number should be utilised on all forms/reports and associated correspondence submitted to the HSCB and this should NOT be the patients H &C Number or their initials. (See section 10 – Information Governance)

12.2 Never Events

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

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

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

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

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

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

12.3 Reporting Interface Incidents

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

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

12.4 Acknowledging SAI Notification

On receipt of the SAI notification the HSCB Governance Team will record the SAI on the DATIX risk management system and electronically acknowledge receipt of SAI notification to reporting organisation; advising of the HSCB/PHA DRO, HSCB unique identification number, and requesting the completion of:

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

Where relevant, RQIA will be copied into this receipt.

12.5 Designated Review Officer (DRO)

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

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

12.6 Review/Learning Summary Reports

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

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

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

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

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

12.7 Closure of SAI

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

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

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

12.8 Regional Learning from SAIs

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

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

12.9 Communication

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

13 EQUALITY

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

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

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

SECTION TWO APPENDICES

APPENDICES

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

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

8. DESCRIPTION OF INCIDENT:

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

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

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

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

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

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

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

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

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

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

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

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO
if 'YES' (*full details should be submitted*):		

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: DD/MM/YY
	NO	*specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO
if 'YES' (*full details should be submitted including the date notified*):		

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

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

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

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

Report submitted by: ______________________________ Designation: ______________________________

Email: Telephone: Date: DD / MM / YYYY

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

Additional information submitted by: _______________________ Designation: ____________________

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 2

Revised November 2016 (Version 1.1)

Guidance Notes

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

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

1. ORGANISATION: *Insert the details of the reporting organisation (HSC Organisation /Trust or Family Practitioner Service)*	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE *Insert the unique incident number / reference generated by the reporting organisation.*
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred) Insert the details of the hospital/facility/specialty/department/ directorate/place where the incident occurred* **5.** DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	**4.** DATE OF INCIDENT: DD / MM / YYYY *Insert the date incident occurred*
6. CONTACT PERSON: *Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident*	**7.** PROGRAMME OF CARE: *Insert the Programme of Care from the following: Acute Services/ Maternity and Child Health / Family and Childcare / Elderly Services / Mental Health / Learning Disability / Physical Disability and Sensory Impairment / Primary Health and Adult Community (includes GP's) / Corporate Business(Other)*

8. DESCRIPTION OF INCIDENT:

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

In addition include the following:

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

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

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

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

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

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

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

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: *(refer to Guidance Notes)* *Insert CCS Stage of Care Code description*	DETAIL: *(refer to Guidance Notes)* *Insert CCS Detail Code description*	ADVERSE EVENT: *(refer to Guidance Notes)* *Insert CCS Adverse Event Code description*

10. <u>IMMEDIATE</u> ACTION TAKEN TO PREVENT RECURRENCE:

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

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

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

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

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

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

15. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO

if 'YES' *(full details should be submitted):*

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? *(please select)*	YES	DATE INFORMED: DD/MM/YY *Insert the date informed*
	NO	*Specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO

if 'YES' (*full details should be submitted including the date notified*):

GENERAL MEDICAL COUNCIL **(GMC)**
GENERAL DENTAL COUNCIL **(GDC)**
PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)**
NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)**
LOCAL MEDICAL COMMITTEE **(LMC)**
NURSING AND MIDWIFERY COUNCIL **(NMC**)
HEALTH CARE PROFESSIONAL COUNCIL **(HCPC)**
REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)**
SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)**

OTHER – PLEASE SPECIFY BELOW

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

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

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

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

Report submitted by: ______________________________ Designation: ______________________________

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION:

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

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

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

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

Additional information submitted by: ________________________ Designation: ____________________

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 3

Revised November 2016 (Version 1.1)

HSC INTERFACE INCIDENT NOTIFICATION FORM

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

5. DESCRIPTION OF INCIDENT:

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

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

7. PROVIDE DETAIL ON ISSUES/AREAS OF CONCERN:

8. IMMEDIATE ACTION TAKEN BY REPORTING ORGANISATION:

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

10. OTHER COMMENTS:

REPORT SUBMITTED BY: ______________________ **DESIGNATION:** ______________________

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

Completed proforma should be sent to: seriousincidents@hscni.net

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION:	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY	
8. SUMMARY OF EVENT:	

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
11. SERVICE USER DETAILS: ***Complete where applicable***	
12. WHAT HAPPENED?	
13. WHY DID IT HAPPEN?	

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED:

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

16. RECOMMENDATIONS (please state by whom and timescale)

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

18. FURTHER REVIEW REQUIRED? YES / NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	20. PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

22. TERMS OF REFERENCE *(If known or submit asap)*:

SECTION 5

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME:	24. DATE APPROVED:

25. DESIGANTION:

SECTION 6

26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate** (✓))				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*

1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			

3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

---

[1] *Service User or their nominated representative*

APPENDIX 5

Revised November 2016 (Version 1.1)

GUIDANCE NOTES
LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1 (To be submitted to the HSCB)

1. ORGANISATION: *Insert unique identifier number*	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: *Self- explanatory*
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: *Self- explanatory*	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY *Self- explanatory*
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS: *Self- explanatory*

7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY *Self- explanatory*

8. SUMMARY OF EVENT:

As per notification form. (If the notification form does not fully reflect the incident please provide further detail.)

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER: *Refer to guidance on Level 1 review team membership for significant event analysis – Appendix 10*	10. TEAM MEMBERS PRESENT: *NAMES AND DESIGNATIONS*
11. SERVICE USER DETAILS: ***Complete where applicable*** *DOB / GENDER / AGE*	
12. WHAT HAPPENED? *(Describe in detailed chronological order what actually happened. Consider, for instance, how it happened, where it happened, who was involved and what the impact was on the patient/service user[1], the team, organisation and/or others).*	
13. WHY DID IT HAPPEN? *(Describe the main and underlying reasons contributing to why the event happened. Consider for instance, the professionalism of the team, the lack of a system or failing in a system, the lack of knowledge or the complexity and uncertainty associated with the event)*	

[1] *ensure sensitivity to the needs of the patient/ service user/ carer/ family member is in line with Regional Guidance on Engagement with Service Users, Families and Carers issued February 2015 (Revised November 2016)*

All sections below be submitted to the HSCB

SECTION 3 - LEARNING SUMMARY

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

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

NOTE: Action plans should also be developed and set out how learning will be implemented, with named leads responsible for each action point (Refer to Appendix 7 Minimum Standards for Action Plans).

Action plans for this level of review will be retained by the reporting organisation.

16. RECOMMENDATIONS (please state by whom and timescale) *It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.*

It is the responsibility of the reporting organisation to communicate to service users, families and carer's that learning identified relevant to other organisations (arising from the review of a SAI) and submitted to the HSCB/PHA, to consider and review, may not on every occasion result in regional learning.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

Self- explanatory

18. FURTHER REVIEW REQUIRED? YES / NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	20. PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP(If known or submit ASAP):

Refer to section 2 of appendix 7.

22. TERMS OF REFERENCE(If known or submit ASAP):

Refer to section 3 of appendix 7.

SECTION 5 - (COMPLETE THIS SECTION FOR ALL LEVELS OF REVIEW)

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME: *Self- explanatory*	24. DATE APPROVED: *Self- explanatory*

25. DESIGANTION: *Self- explanatory*

SECTION 6

26. DISTRIBUTION LIST:

List of the individuals, groups or organisations the final report has been shared with.

APPENDIX 5

To be submitted to the HSCB

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: **_*If multiple service users are involved please indicate the number involved_**			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not ‘patient/service user’ related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

	a) Draft review report has been shared and further engagement planned to share final report	
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONERS OFFICE
(under section 7 of the Coroners Act (Northern Ireland) 1959)

(complete this section for all death related SAIs)

1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			

3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

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[1] *Service User or their nominated representative*

APPENDIX 6

Revised November 2016 (Version 1.1)

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

2.0 THE REVIEW TEAM

3.0 SAI REVIEW TERMS OF REFERENCE

4.0 REVIEW METHODOLOGY

5.0 DESCRIPTION OF INCIDENT/CASE

6.0 FINDINGS

7.0 CONCLUSIONS

8.0 LESSONS LEARNED

9.0 RECOMMENDATIONS AND ACTION PLANNING

10.0 DISTRIBUTION LIST

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select <u>**only one**</u> rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓**))				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select <u>**only one**</u> rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			
	c) Report not shared but contents discussed ***(if you select this option please also complete 'I' below)***			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓**)				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONERS OFFICE
(under section 7 of the Coroners Act (Northern Ireland) 1959)

(complete this section for all death related SAIs)

1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓**)	**YES**		**NO**					
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓**)	**YES**		**NO**					
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓**)	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

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[1] *Service User or their nominated representative*

APPENDIX 7

Revised November 2016 (Version 1.1)

Health and Social Care Regional Guidance

for

Level 2 and 3 RCA Incident Review Reports

INTRODUCTION

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

The purpose of this template and guide is to provide practical help and support to those writing review reports and should be used, in as far as possible, for drafting all **HSC Level 2 and Level 3** incident review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports.

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

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

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

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including
Service User/Family/Carer Engagement Checklist

Organisation’s Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

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

2.0 THE REVIEW TEAM

Refer to Guidance on Review Team Membership

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

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

3.0 SAI REVIEW TERMS OF REFERENCE

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

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

- To undertake a review of the incident to identify specific problems or issues to be addressed;
- To consider any other relevant factors raised by the incident;
- To identify and engage appropriately with all relevant services or other agencies associated with the care of those involved in the incident;
- To determine actual or potential involvement of the Police, Health and Safety Executive, Regulation and Quality Improvement Authority and Coroners Service for Northern Ireland[2] [3]
- To agree the remit of the review - the scope and boundaries beyond which the review should not go (e.g. disciplinary process) – state how far back the review will go (what point does the review start and stop e.g. episode of care) and the level of review;
- To consider the outcome of the review, agreeing recommendations, actions to be taken and lessons learned for the improvement of future services;
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate. The level of involvement clearly depends on the nature of the incident and the service user's or family's wishes or carer's wishes to be involved and must be in line with Regional Guidance on Engagement with Service Users, Families and Carers issued November 2016;

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

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

3.0 SAI REVIEW TERMS OF REFERENCE

- To agree the timescales for completing and submitting the review report, including the SAI engagement checklist, distribution of the report and timescales for reviewing actions on the action plan;

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

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

This list is not exhaustive

4.0 REVIEW METHODOLOGY

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

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

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

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

- Concise factual description of the serious adverse incident include the incident date and

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

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

5.0 DESCRIPTION OF INCIDENT/CASE

type, the healthcare specialty involved and the actual effect of the incident on the service user and/or service and others;

- People, equipment and circumstances involved;
- Any intervention / immediate action taken to reduce consequences;
- Chronology of events leading up to the incident;
- Relevant past history – a brief description of the care and/or treatment/service provided;
- Outcome / consequences / action taken;
- Relevance of local, regional or national policy / guidance / alerts including professional codes of conduct in place at the time of the incident

This list is not exhaustive

6.0 FINDINGS

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

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

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

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

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

(ii) Contributory Factors

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

- Individual Factors (include employment status i.e. substantive, agency, locum voluntary etc.)
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

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

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

7.0 CONCLUSIONS

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

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

8.0 LESSONS LEARNED

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

9.0 RECOMMENDATIONS AND ACTION PLANNING

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

- Recommendations for the reviewing organisation
- Suggested /proposed learning that is relevant to other organisations

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

It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.

It is the responsibility of the reporting organisation to communicate to service users/families/carers that regional learning identified and submitted to the HSCB/PHA for consideration may not on every occasion result in regional learning.

10.0 DISTRIBUTION LIST

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

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			

2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			

3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)

(complete this section for all death related SAIs)

1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			

3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

---

[1] *Service User or their nominated representative*

APPENDIX 8

GUIDANCE ON MINIMUM STANDARDS FOR ACTION PLANS

The action plan must define:

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

The action plan **MUST** contain the following

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

APPENDIX 9

GUIDANCE ON INCIDENT DEBRIEF

- ### Level 1 - SEA Reviews

For level 1 reviews, the incident debrief can serve the purpose of the SEA review, (these can also be known as 'hot debriefs').

The review should:

- Collect and collate as much factual information on the event as possible, including all relevant records. Also gather the accounts of those directly and indirectly involved, including, where relevant, service user/relatives/carers or other health professionals.

- The incident debrief/significant event meeting should be held with all staff involved to provide an opportunity to:

    - support the staff involved[6]
    - assess what has happened;
    - assess why did it happened;
        - what went wrong and what went well;
    - assess what has been changed or agree what will change;
    - identify local and regional learning.

- The meeting/s should be conducted in an open, fair, honest, non-judgemental and supportive atmosphere and should be undertaken as soon as practical following the incident.

- Write it up – keep a written report of the analysis undertaken using the SEA Report template (see Appendix 4)

- Sharing SEA Report – SEA reports should be shared with all relevant staff, particularly those who have been involved in the incident.

- ### Level 2 and 3 RCA Reviews

An incident debrief can also be undertaken for level 2 and 3 reviews. This would be separate from the RCA review and should occur quickly after the incident to provide support to staff and to identify any immediate service actions.

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[6] *Note: link to ongoing work in relation to Quality 2020 - Task 2 - Supporting Staff involved in SAIs and other Incidents*

APPENDIX 10

LEVEL 1 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

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

Membership of the team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved. Ultimately, for a Level 1 review, it is for each team to decide who is invited, there has to be a balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited.

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

- Co-ordinate the information gathering process
- Arrange the review meeting
- Explain the aims and process of the review
- Chair the review meeting
- Co-ordinate the production of the Significant Event Audit report
- Ensure learning is shared in line with the Learning Summary Report

APPENDIX 11

LEVEL 2 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

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

The core review team should comprise a minimum of three people of appropriate seniority and objectivity. Review teams should be multidisciplinary, (or involve experts/expert opinion/independent advice or specialist reviewers). The team shall have no conflicts of interest in the incident concerned and should have an Independent Chair. (*In the event of a suspected homicide HSC Trusts should follow the HSCB Protocol for responding to SAIs in the event of a Homicide – revised 2013*)

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

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

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

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

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

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

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

APPENDIX 12

LEVEL 3 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review shall be proportionate to the significance of the incident. The same principles shall apply, as for Level 2 reviews. The degree of independence of the review team will be dependent on the scale, complexity and type of the incident.

Team membership for Level 3 reviews will be agreed between the reporting organisation and the HSCB/PHA DRO prior to the Level 3 review commencing.

APPENDIX 13

GUIDANCE ON JOINT REVIEWS/INVESTIGATIONS

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

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

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

Points to consider:

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

This guidance should be read in conjunction with:

- Guidance on Incident Debrief (Refer to Appendix 9)
- Guidance on Review Team Membership (Refer to Appendix 11 & 12)
- Guidance on completing HSC Review Report Level 2 and 3 (Refer to Appendix 7)

APPENDIX 14

PROTOCOL FOR RESPONDING TO SERIOUS ADVERSE INCIDENTS IN THE EVENT OF A HOMICIDE – 2013 (updated November 2016 in line with the HSCB Procedure for the Reporting and Follow up of SAIs)

1. INTRODUCTION AND PURPOSE

1.1. INTRODUCTION

The Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs) was issued in April 2010 and revised November 2016. This procedure provides guidance to Health and Social Care (HSC) Trusts and HSCB Integrated Care staff in relation to the reporting and follow up of SAIs arising during the course of business of a HSC organisation, Special Agency or commissioned service.

This paper is a revised protocol, developed from the above procedure, for the specific SAIs which involves an alleged homicide perpetrated by a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident.

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

1.2. PURPOSE

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

2. THE PROCESS

2.1. REPORTING SERIOUS ADVERSE INCIDENTS

Refer to the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents revised in 2016.

2.2. MULTI-DISCIPLINARY REVIEW

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

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

2.3. ESTABLISHING AN INDEPENDENT REVIEW TEAM

2.3.1 CHAIR

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

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

2.3.2 MEMBERSHIP

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

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

Members of the review team should be trained in the Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016.

3. TERMS OF REFERENCE

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

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

- establish the facts of the incident;
- analyse the antecedents to the incident;
- consider any other relevant factors raised by the incident;
- establish whether there are failings in the process and systems;
- establish whether there are failings in the performance of individuals;
- identify lessons to be learned from the incident; and

- identify clearly what those lessons are, how they will be acted upon, what is expected to change as a result, and specify timescales and responsibility for implementation.

4. TIMESCALES

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

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

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

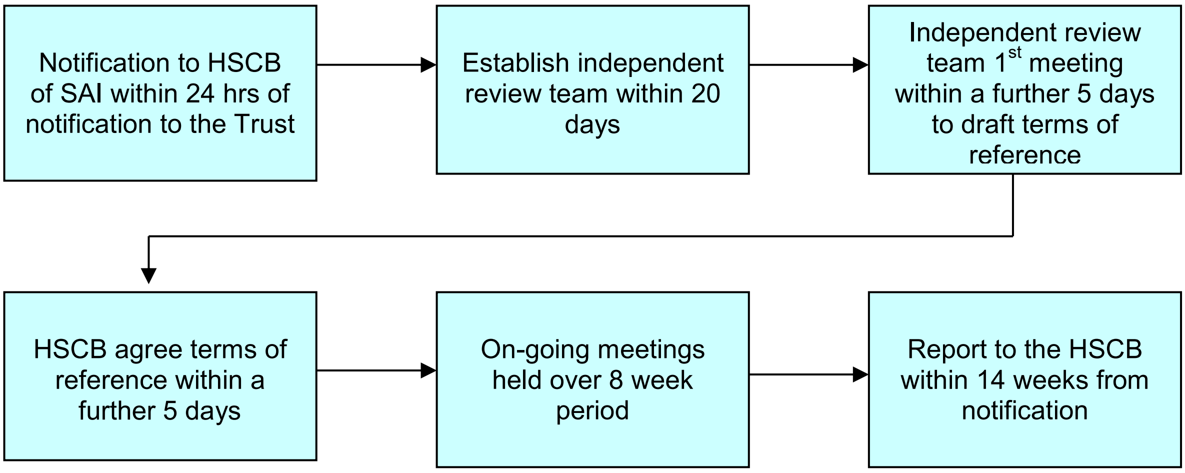
The team should meet to draft the terms of reference within a further five working days (i.e. twenty five days from notification of the incident to the Trust).

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

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

FLOWCHART OF PROCESS WITH TIMESCALES

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



5. THE HEALTH AND SOCIAL CARE BOARD RESPONSIBILITY

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

The HSCB must advise the Department of Health, (DoH) as to whether or not an Independent Inquiry is required in this particular SAI.

APPENDIX 15

ADMINISTRATIVE PROTOCOL

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

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

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

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

3. At the same time, the HSCB Governance Team will also forward the review report/learning summary report[1] to RQIA, together with an email advising of a **3 week** timescale from receipt of review report/learning summary report, for RQIA to forward comments for consideration by the DRO.

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

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

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

All communications to be sent or copied via:

HSCB Governance Team: seriousincidents@hscni.net
and RQIA: seriousincidents@rqia.org.uk

[1] For Level 1 SAIs the HSCB only routinely receive the Learning Summary Report. If RQIA also wish to consider the full SEA Report this should be requested directly by RQIA from the relevant Reporting Organisation.

APPENDIX 16

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

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

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

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

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

APPENDIX 17

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES

The Procedure for the Reporting and Follow up of Serious Adverse Incidents (Revised November 2016) provides guidance to Health and Social Care organisations in relation to the reporting and follow up of Serious Adverse Incidents arising during the course of their business or commissioned service.

The guidance notes that the SAI review should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

The guidance notes that there are three possible levels of review of an SAI and specifies the expected timescale for reporting on a review report as follows:

Level 1 Review – Significant Event Audit (SEA). To be completed and a Learning Summary Report sent to the HSCB within 8 weeks of the SAI being reported.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review timescales for completion of the RCA will be determined following submission of the Learning Summary Report to the HSCB.

Level 2 Review – Root Cause Analysis (RCA). The final report to be submitted to the HSCB within 12 weeks from the date the incident was notified.

Level 3 Review – Independent Review. Timescales for completion to be agreed by the DRO.

It should be noted that not every referral to child or adult safeguarding processes will proceed to the completion of an SAI report. Within Children’s Services, the most complex cases and those that involve death or serious injury to a child, where concerns about how services worked together exist, will be notified to the HSCB as an SAI and may be assessed as meeting the criteria for a Case Management Review (CMR) in which case they will be managed out of the SAI system. The CMR report will highlight the learning from the case.

However, the timescales for the completion of SAI reviews at Level 2 and 3 have proved to be challenging for the cases that do not reach the threshold for a CMR or which result from allegations of abuse of an adult. These are more likely to be some of the more complex cases, and generally involve inter- and multi- agency partnership working.

In responding to allegations of the abuse, neglect or exploitation of a child or vulnerable adult where it is suspected that criminal offence may have been committed, the Health and Social Care Trusts operate under the principles for joint working with the PSNI and other agencies as set out in

- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009);

- Sharing to Safeguard (DoH Revised HSCC 3/96 and currently being revised by DoH);
- Co-operating to Safeguard Children (DoH 2003); and
- Protocol for joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013)

The Memorandum of Understanding: Investigating patient or client safety incidents (2013) states that in cases where more than one organisation may/should have an involvement in investigating any particular incident, then:

"The HSC Organisation should continue to ensure patient or client safety, but not undertake any activity that might compromise any subsequent statutory investigations."

In addition "Achieving Best Evidence: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy" (revised in 2012), sets out clear protocols for interviewing vulnerable witnesses or victims, whether they are children or adults. This guidance ensures that interviews with vulnerable witnesses and victims are led by specially trained staff, conducted at the victims pace and take place in an environment that is conducive to the needs of the victim.

Clearly, there is an inter-dependency between PSNI and HSC investigations/reviews in complex cases involving multi-agency approaches and protocols. The identification and analysis of learning from these events is likely to be incomplete until both the PSNI and HSC have completed their separate and joint investigations/reviews using the protocols outlined above, and it is unlikely that this can be achieved within the timescales set out for both Level 1 and Level 2 reviews under the SAI procedure.

In such circumstances, the following process should be used:

- Trust report SAI to HSCB using the SAI Notification Form;
- The SAI Notification Form or section 22 of the notification form i.e. 'additional information following initial notification, should indicate the following:
  - The SAI is also a Safeguarding incident
  - PSNI are conducting an investigation of the circumstances surrounding the SAI
  - SAI evaluation will commence at the conclusion of the initial PSNI investigation;
  - Set out the arrangements for keeping the DRO informed of the progress of the PSNI initial investigation;
- If satisfied, the DRO will advise the Trust via the SAI Mailbox that he/she is in agreement with the proposal to delay the SAI review until the conclusion of the initial PSNI investigation;
- The reporting HSC Trust will inform the DRO as soon as the initial PSNI investigation has concluded, along with any outcomes and advise the SAI evaluation has commenced;
- The SAI will continue to be monitored by HSCB Governance team in line with timescales within the Procedure for the Reporting and Follow up of SAIs;
- If the DRO is **not** in agreement with the proposal to delay the SAI review, the reasons for this will be clearly conveyed to the Trust via the SAI Mailbox. Possible reasons for this may include, for example, situations where a criminal incident has occurred on HSC Trust premises but does not involve HSC Trust staff, or an incident involving a service user in their own home and a member of the public is reported to the PSNI by HSC Trust staff.

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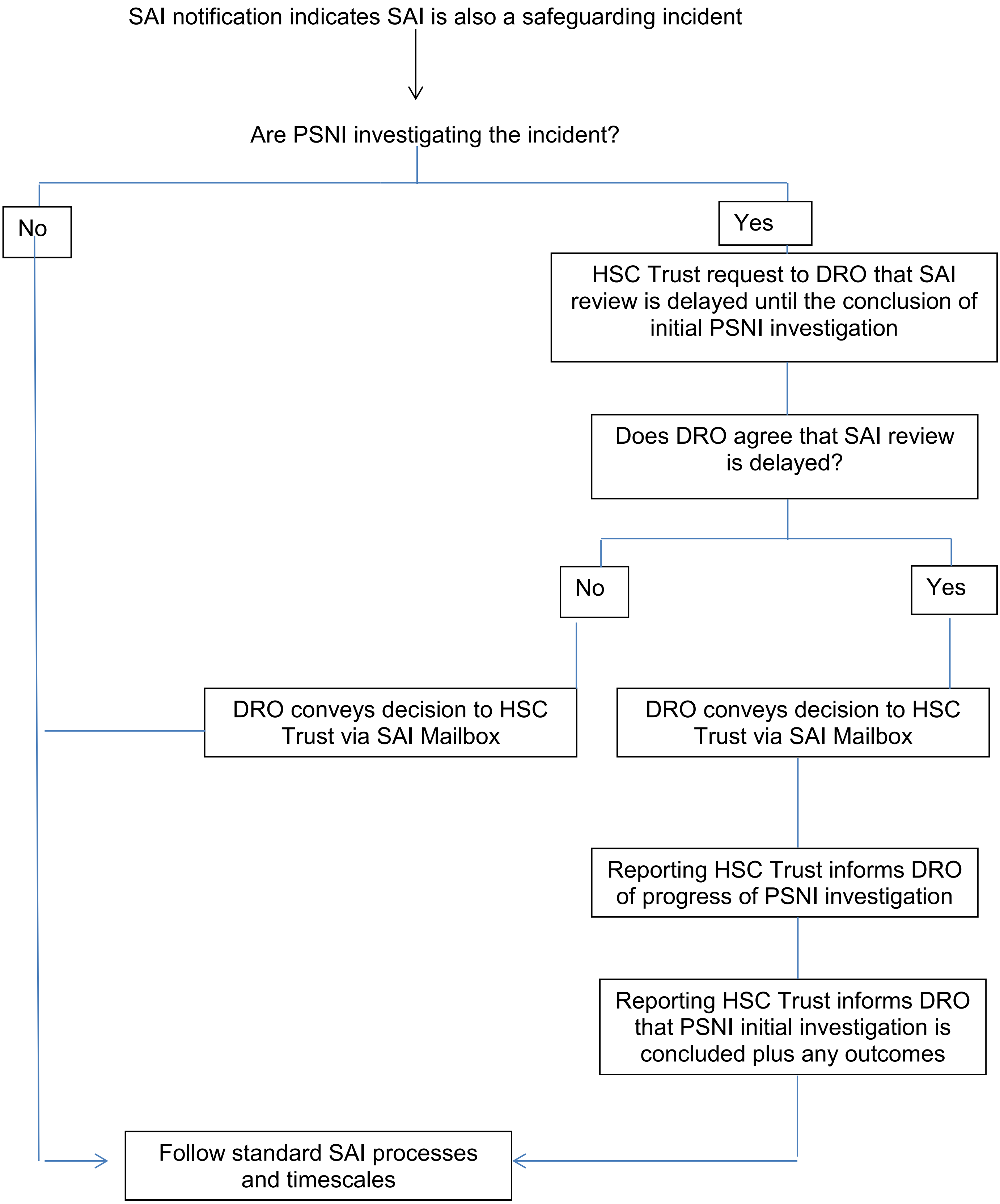
CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES



SECTION THREE ADDENDUM

ADDENDUM

ADDENDUM 1

A Guide for Health and Social Care Staff

Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

November 2016
Version 1.1

Contents

Notes on the Development of this Guidance

This guidance has been compiled by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) working in collaboration with the Regulation and Quality Improvement Authority (RQIA), the Patient Client Council (PCC) and Health and Social Care (HSC) Trusts.

This guidance has been informed by:

- National Patient Safety Agency (NPSA) Being Open Framework (2009)
- Health Service Executive (HSE) – Open Disclosure National Guidelines (2013)

Please note the following points:

- *The term 'service user' as used throughout this guidance includes patients and clients availing of Health and Social Care Services from HSC organisations and Family Practitioner Services (FPS) and/or services commissioned from the Independent Sector by HSC organisations.*

- *The phrase 'the service user / family' is used throughout this document in order to take account of all types of engagement scenarios, and also includes a carer(s) or the legal guardian of the service user, where appropriate. However, when the service user has capacity, communication should always (in the first instance) be with them (see appendix 1 for further guidance).*

A review / re-evaluation of this guidance will be undertaken one year following implementation.

1.0 Introduction

When an adverse outcome occurs for a service user it is important that the service user / family (as appropriate) receive timely information and are fully aware of the processes followed to review the incident.

The purpose of a Serious Adverse Incident (SAI) review is to understand what occurred and where possible improve care by learning from incidents. Being open about what happened and discussing the SAI promptly, fully and compassionately can help the service user / family cope better with the after-effects and reduce the likelihood of them pursuing other routes such as the complaints process or litigation to get answers to their questions.

It is therefore essential that there is:

- full disclosure of a SAI to the service user / family,
- an acknowledgement of responsibility,
- an understanding of what happened and a discussion of what is being done to prevent recurrence.

Communicating effectively with the service user / family is a vital part of the SAI process. If done well, it promotes person-centred care and a fair and open culture, ultimately leading to continuous improvement in the delivery of HSC services. It is human to make mistakes, but rather than blame individuals, the aim is for all of us to identify and address the factors that contributed to the incident. The service user / family can add valuable information to help identify the contributing factors, and should be integral to the review process, unless they wish otherwise.

2.0 Purpose

This is a guide for HSC staff to ensure effective communication with the service user / family, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner.

It is important this guidance is read in conjunction with the regional Procedure for Reporting and Follow up of SAIs (November 2016) and any subsequent revisions relating to the SAI process that have or may be issued in the future. This will ensure the engagement process is closely aligned to the required timescales, documentation, review levels etc. *To view the SAI Procedure please follow the link below* http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf.

The HSCB Process works in conjunction with all other review processes, statutory agencies and external bodies. Consequently, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI. It is therefore important that all existing processes continue to operate in tandem with the SAI procedure and should not be an obstacle to the engagement of the service user / family; nor should an interaction through another process replace engagement through the SAI process.

In that regard, whilst this guidance is specific to 'being open' when engaging with the service user / family following a SAI, it is important HSC organisations are also mindful of communicating effectively with the service user / family when investigating adverse incidents. In these circumstances, organisations should refer to the NPSABeingOpenFramework www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726 which will provide assistance for organisations to determine the level of service user / family engagement when investigating those adverse incidents that do not meet SAI criteria.

The Being Open Framework may also assist organisations with other investigative processes e.g. complaints, litigation, lookback exercises, and any other relevant human resource and/or risk management related policies and procedures.

3.0 Principles of Being Open with the Service User / Family

Being open and honest with the service user / family involves:

- Acknowledging, apologising and explaining that the organisation wishes to review the care and treatment of the service user;
- Explaining that the incident has been categorised as a SAI, and describing the review process to them, including timescales;
- Advising them how they can contribute to the review process, seeking their views on how they wish to be involved and providing them with a leaflet explaining the SAI process (see appendix 2);
- Conducting the correct level of SAI review into the incident and reassuring the service user / family that lessons learned should help prevent the incident recurring;
- Providing / facilitating support for those involved, including staff, acknowledging that there may be physical and psychological consequences of what happened;

- Ensuring the service user / family have details for a single point of contact within the organisation.

It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

The following principles underpin being open with the service user / family following a SAI.

3.1 Acknowledgement

All SAIs should be acknowledged and reported as soon as they are identified. In cases where the service user / family inform HSC staff / family practitioner when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all professionals.

In certain circumstances e.g. cases of criminality, child protection, or SAIs involving theft, fraud, information breaches or data losses that do not directly affect service users; it may not be appropriate to communicate with the service user / family. When a lead professional / review team make a decision, based on a situation as outlined above, or based on a professional's opinion, not to disclose to the service user / family that a SAI has occurred, the rationale for this decision must be clearly documented in the SAI notification form / SAI review checklist that is submitted to the HSCB.

It is expected, the service user / family will be informed that a SAI has occurred, as soon as possible following the incident, for all levels of SAI reviews. In very exceptional circumstances, where a decision is made not to inform the service user / family, this decision must be reviewed and agreed by the review team, approved by an appropriate Director or relevant committee / group, and the decision kept under review as the review progresses. In these instances the HSCB must also be informed:

- **Level 1 reviews - on submission of Review Report and Checklist Proforma**
- **Level 2 and 3 reviews - on submission of the Terms of Reference and Membership of the review team.**

3.2 Truthfulness, timeliness and clarity of communication

Information about a SAI must be given to the service user / family in a truthful and open manner by an appropriately nominated person (see 4.2.2). The service user / family should be provided with an explanation of what happened in a way that considers their individual circumstances, and is delivered openly. Communication should also be timely, ensuring the service user / family is provided with information about what happened as soon as practicable without causing added distress. Note, where a number of service users are involved in one incident, they should all be informed at the same time where possible.

It is also essential that any information given is based solely on the facts known at the time. Staff should explain that new information may emerge as an incident review is undertaken, and that the service user / family will be kept informed, as the review progresses. The service user / family should receive clear information with a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of jargon, should be avoided.

3.3 Apology / Expression of Regret

When it is clear, that the organisation / family practitioner is responsible for the harm / distress to the service user, it is imperative that there is an acknowledgement of the incident and an apology provided as soon as possible. Delays are likely to increase the service user / family sense of anxiety, anger or frustration. Relevant to the context of a SAI, the service user / family should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm / distress that has occurred as a result of the SAI.

3.4 Recognising the expectations of the Service User / Family

The service user / family may reasonably expect to be fully informed of the facts, consequences and learning in relation to the SAI and to be treated with empathy and respect.

They should also be provided with support in a manner appropriate to their needs. Specific types of service users / families may require additional support (see appendix 1).

In circumstances where the service user / family request the presence of their legal advisor this request should be facilitated. However, HSC staff should ensure that the legal advisor is aware that the purpose of the report / meeting is not to apportion liability or blame but to learn from the SAI. Further clarification in relation to this issue should be sought from Legal Services.

3.5 Professional Support

HSC organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report SAIs. Staff should feel supported throughout the incident review process because they too may have been traumatised by being involved. There should be a culture of support and openness with a focus on learning rather than blame.

HSC organisations should encourage staff to seek support where required form relevant professional bodies such as the General Medical Council (GMC), Royal Colleges, the Medical Defence Union (MDU), the Medical Protection Society (MPS), the Nursing and Midwifery Council, the Northern Ireland Association for Social Work (NIASW) and the Northern Ireland Social Care Council (NISCC).

3.6 Confidentiality

Details of a SAI should at all times be considered confidential. It is good practice to inform the service user / family about those involved in the review and who the review report will be shared with.

3.7 Continuity of Care

In exceptional circumstances, the service user / family may request transfer of their care to another facility; this should be facilitated if possible to do so. A member of staff should be identified to act as a contact person for the service user / family to keep them informed of their on-going treatment and care.

4.0 Process

Being open with the service user / family is a process rather than a one-off event. There are 5 stages in the engagement process:

- Stage 1 – Recognition
- Stage 2 - Communication
- Stage 3 – Initial Meeting
- Stage 4 – Follow up Discussions

- Stage 5 – Process Completion

The duration of this process depends on the level of SAI review being undertaken and the associated timescales as set out in the Procedure for the Reporting and Follow up of SAIs (2013).

4.1 Stage 1 - Recognition

As soon as the SAI is identified, the priority is to prevent further harm / distress. The service user / family should be notified that the incident is being reviewed as a SAI.

4.1.1 Preliminary Discussion with the Service User / Family

On many occasions it will be at this stage when the lead professional / family practitioner responsible for the care of the service user will have a discussion with the service user / family, advising of the need to review the care and treatment. This preliminary discussion (which could be a telephone call) will be in addition to the formal initial meeting with the service user / family (see 4.3).

A Level 1 review may not require the same level of engagement as Levels 2 and 3 therefore the preliminary discussion may be the only engagement with service user / family prior to communicating findings of the review, provided they are content they have been provided with all information.

There may be occasions when the service user / family indicate they do not wish to engage in the process. In these instances the rationale for not engaging further must be clearly documented.

4.2 Stage 2 – Communication

4.2.1 Timing of Initial Communication with the Service User / Family

The initial discussion with the service user / family should occur as soon as possible after recognition of the SAI. Factors to consider when timing this discussion include:

- service user's health and wellbeing;
- service user / family circumstances, preference (in terms of when and where the meeting takes place) and availability of key staff *(appendix 1 provides guidance on how to manage different categories of service user / family circumstances);*

4.2.2 Choosing the individual to communicate

The person[7] nominated to lead any communications should:

- Be a senior member of staff with a comprehensive understanding of the facts relevant to the incident;
- Have the necessary experience and expertise in relation to the type of incident;
- Have excellent interpersonal skills, including being able to effectively engage in an honest, open and transparent manner, avoiding excessive use of jargon;
- Be willing and able to offer a meaningful apology / expression of regret, reassurance and feedback.

If required, the lead person communicating information about the SAI should also be able to nominate a colleague who may assist them with the meeting and should be someone with experience or training in communicating with the service user / family.

The person/s nominated to engage could also be a member/s of the review team (if already set up).

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[7] *FPS SAIs involving FPS this will involve senior professionals/staff from the HSCB Integrated Care Directorate.*

4.3 Stage 3 - Initial Meeting with the Service User / Family

The initial discussion is the first part of an on-going communication process. Many of the points raised here should be expanded on in subsequent meetings with the service user / family.

4.3.1 Preparation Prior to the Initial Meeting

- The service user / family should be given the leaflet - What I Need to Know About a SAI (see appendix 2);
- Share with the service user / family what is going to be discussed at the meeting and who will be in attendance.

4.3.2 During the Initial Meeting

The content of the initial meeting with the service user / family should cover the following:

- Welcome and introductions to all present;
- An expression of genuine sympathy or a meaningful apology for the event that has occurred;
- The facts that are known to the multidisciplinary team;
- Where a service user has died, advising the family that the coroner has been informed (where there is a requirement to do so) and any other relevant organisation/body;
- The service user / family are informed that a SAI review is being carried out;
- Listening to the service user's / families understanding of what happened;
- Consideration and formal noting of the service user's / family's views and concerns;
- An explanation about what will happen next in terms of the SAI review, findings, recommendations and learning and timescales;
- An offer of practical and emotional support for the service user / family. This may involve getting help from third parties such as charities and voluntary organisations, providing details of support from other organisations, as well as offering more direct assistance;
- Advising who will be involved in the review before it takes place and who the review report will be shared with;
- Advising that all SAI information will be treated as confidential.

If for any reason it becomes clear during the initial discussion that the service user / family would prefer to speak to a different health / social care professional, these wishes should be respected, and the appropriate actions taken.

It is important during the initial meeting to try to avoid any of the following:

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different health and social care individuals.

It should be recognised that the service user / family may be anxious, angry and frustrated, even when the meeting is conducted appropriately. It may therefore be difficult for organisations to ascertain if the service user / family have understood fully everything that has been discussed at the meeting. It is essential however that, at the very least, organisations are assured that the service user / family leave the meeting fully aware that the incident is being reviewed as a SAI, and knowing the organisation will continue to engage with them as the review progresses, so long as the service user / family wish to engage.

Appendix 3 provides examples of words / language which can be used during the initial discussion with the service user / family.

4.4 Stage 4 – Follow-up Discussions

Follow-up discussions are dependent on the needs and wishes of the service user / family.

The following guidelines will assist in making the communication effective:

- The service user / family should be updated if there are any delays and the reasons for the delays explained;
- Advise the service user / family if the incident has been referred to any other relevant organisation / body;
- Consideration is given to the timing of the meetings, based on both the service users / families health, personal circumstances and preference on the location of the meeting, e.g. the service users / families home;
- Feedback on progress to date, including informing the service user / family of the Terms of Reference of the review and membership of the review panel (for level 2 and 3 SAI reviews);
- There should be no speculation or attribution of blame. Similarly, the health or social care professional / senior manager communicating the SAI must not criticise or comment on matters outside their own experience;
- A written record of the discussion is kept and shared with the service user / family;
- All queries are responded to appropriately and in a timely way.

4.5 Stage 5 – Process Completion

4.5.1 Communicating findings of review / sharing review report

Feedback should take the form most acceptable to the service user / family. Communication should include:

- a repeated apology / expression of regret for the harm / distress suffered;
- the chronology of clinical and other relevant factors that contributed to the incident;
- details of the service users / families concerns;
- information on learning and outcomes from the review
- Service user / family should be assured that lines of communication will be kept open should further questions arise at a later stage and a single point of contact is identified.

It is expected that in most cases there will be a complete discussion of the findings of the review and that the final review report will be shared with the service user / family. In some cases however, information may be withheld or restricted, for example:

- Where communicating information will adversely affect the health of the service user / family;
- Where specific legal/coroner requirements preclude disclosure for specific purposes;
- If the deceased service users health record includes a note at their request that he/she did not wish access to be given to his/her family.

Clarification on the above issues should be sought form Legal Services.

There may also be instances where the service user / family does not agree with the information provided, in these instances Appendix 1 (section 1.8) will provide additional assistance.

In order to respond to the timescales as set out in the Procedure for the Reporting and Follow up of SAIs (November 2016) organisations may not have completed stage 5 of the engagement process prior to submission of the review report to HSCB. In these instances, organisations must indicate on the SAI review checklist, submitted with the final review report to the HSCB, the scheduled date to meet with the service user / family to communicate findings of review / share review report.

4.5.2 Communicating Changes to Staff

It is important that outcomes / learning is communicated to all staff involved and to the wider organisation as appropriate.

4.6 Documentation

Throughout the above stages it is important that discussions with the service user / family are documented and should be shared with the individuals involved.

Documenting the process is essential to ensure continuity and consistency in relation to the information that has been relayed to the service user / family.

Documentation which has been produced in response to a SAI may have to be disclosed later in legal proceedings or in response to a freedom of information application. It is important that care is taken in all communications and documents stating fact only.

Appendix 4 provides a checklist which organisations may find useful as an aide memoire to ensure a professional and standardised approach.

5.0 Supporting Information and Tools

In addition to this guidance, supporting tools have been developed to assist HSC organisations with implementing the actions of the NPSA's Being Open Patient Safety Alert.

Training on being open is freely available through an e-learning tool for all HSC organisations.

Information on all these supporting tools can be found at: www.**npsa**.nhs.uk/**beingopen** and www.nrls.**npsa**.nhs.uk/**beingopen**/.

Guidance on sudden death and the role of bereavement co-ordinators in Trusts can be found at:
http://webarchive.proni.gov.uk/20120830110704/http://www.dhsspsni.gov.uk/sudden-death-guidance.pdf

List of Acronyms and Abbreviations

FPS - Family Practitioner Services
GMC - General Medical Council
HSC - Health and Social Care
HSCB - Health and Social Care Board
HSE - Health Service Executive
MDU - Medical Defence Union
MPS - Medical Protection Society
NIASW - Northern Ireland Association for Social Work
NISCC - Northern Ireland Social Care Council
NMC - Nursing and Midwifery Council
NPSA - National Patient Safety Agency
PCC - Patient Client Council
PHA - Public Health Agency
RC - Royal colleges
RCA - Root Cause Analysis
RQIA - Regulation and Quality Improvement Authority
SAI - Serious Adverse Incident
SEA - Significant Event Audit

Appendix 1

Particular Service user Circumstances

The approach to how an organisation communicates with a service user / family may need to be modified according to the service user's personal circumstances.

The following gives guidance on how to manage different categories of service user circumstances.

1.1 When a service user dies

When a SAI has resulted in a service users death, the communication should be sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened.

1.2 Children

The legal age of maturity for giving consent to treatment is 16 years old. However, it is still considered good practice to encourage young people of this age to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the communication process after a SAI.

The opportunity for parents / guardians to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents / guardians alone or in the presence of the child. In these instances the parents' / guardians' views on the issue should be sought.

1.3 Service users with mental health issues

Communication with service users with mental health issues should follow normal procedures unless the service user also has cognitive impairment (see1.4 Service users with cognitive impairments).

The only circumstances in which it is appropriate to withhold SAI information from a service user with mental health issues is when advised to do so by a senior clinician who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion may be required to justify withholding information from the service user.

In most circumstances, it is not appropriate to discuss SAI information with a carer or relative without the permission of the service user, unless in the public interest and / or for the protection of third parties.

1.4 Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them.

In these cases communication would be conducted with the carer / family as appropriate. Where there is no such person, the clinicians may act in the service users best interest in deciding who the appropriate person is to discuss the SAI with.

1.5 Service users with learning disabilities

Where a service user / family has difficulties in expressing their opinion verbally, every effort should be made to ensure they can use or be facilitated to use a communication method of their choice. An advocate / supporter, agreed on in consultation with the service user, should also be identified. Appropriate advocates / supporters may include carer/s, family or friends of the service user or a representative from the Patient Client Council (PCC).

1.6 Service users with different language or cultural considerations

The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss SAI information. Avoid using ‘unofficial translators’ and / or the service users family or friends as they may distort information by editing what is communicated.

1.7 Service users with different communication needs

Service users who have communication needs such as hearing impaired, reduced vision may need additional support.

1.8 Service users who do not agree with the information provided

Sometimes, despite the best efforts the service user/family/carer may remain dissatisfied with the information provided. In these circumstances, the following strategies may assist:

- Facilitate discussion as soon as possible;
- Write a comprehensive list of the points that the service user / family disagree with and where appropriate reassure them you will follow up these issues.
- Ensure the service user / family has access to support services;
- Offer the service user / family another contact person with whom they may feel more comfortable.
- Use an acceptable service user advocate e.g. PCC or HSC layperson to help identify the issues between the HSC organisation and the service user / family and to achieve a mutually agreeable solution;

There may be occasions despite the above efforts the service user/family/carer remain dissatisfied with the HSC organisation’s attempts to resolve their concerns. In these exceptional circumstances, the service user/family/carer through the agreed contact person, should be advised of their right to approach the Northern Ireland Public Services Ombudsman (NIPSO). In doing so, the service user/family requires to be advised by the HSC organisation that the internal procedure has concluded (within two weeks of this process having been concluded), and that the service user/family should approach the NIPSO within six months of this notification.

The contact details for the NIPSO are: Freephone 0800 34 34 34 or Progressive House, 33 Wellington Place, Belfast, BT1 6HN.

1.9 Service Users who do not wish to participate in the engagement process

It should be documented if the service user does not wish to participate in the engagement process.

Appendix 2

Health and Social Care Board

Public Health Agency

What I need to know about a Serious Adverse Incident

Information for Service Users, Family Members and Carers

Insert Name of Organisation

This leaflet is written for people who use Health and Social Care (HSC) services and their families.

**The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

Introduction

Events which are reported as Serious Adverse Incidents (SAIs) help identify learning even when it is not clear something went wrong with treatment or care provided.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Health and Social Care Board (HSCB) by the organisation where the SAI has occurred. It may be:

- an incident resulting in serious harm;
- an unexpected or unexplained death;
- a suspected suicide of a service user who has a mental illness or disorder;
- an unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

A SAI may affect services users, members of the public or staff.

Never events are serious patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers. A small number of SAIs may be categorised as never events based on the Department of Health Never Events list.

SAIs, including never events, occurring within the HSC system are reported to the HSCB. You, as a service user / family member / carer, will be informed where a SAI and/or never event has occurred relating to treatment and care provided to you by the HSC.

Can a complaint become a SAI?

Yes, if during the follow up of a complaint the **(insert name of organisation)** identifies that a SAI has occurred it will be reported to the HSCB. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

How is a SAI reviewed?

Depending on the circumstance of the SAI a review will be undertaken. This will take between 8 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The (**insert name of organisation**) will discuss with you how the SAI will be reviewed and who will be involved. The (**insert name of organisation**) will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

How is the service user or their family/carer involved in the review?

An individual will be identified to act as your link person throughout the review process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the review;
- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;

- Are offered advice in the event that the media make contact.

What happens once the review is complete?

The findings of the review will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by **(insert name of organisation)** staff that is acceptable to you.

How will learning be used to improve safety?

By reviewing a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

We believe that this process will help to restore the confidence of those affected by a SAI.

For each completed review:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system. Therefore as part of our process to improve quality and share learning, we may share the anonymised content of the SAI report with other HSC organisations'

Do families get a copy of the report?

Yes, a copy of the review report will be shared with service users and/or families with the service user's consent.

If the service user has died, families/carers will be provided with a copy of the report and invited to meet with senior staff.

Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to review some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA work in conjunction with the HSCB / PHA with regard to the review of certain categories of SAI including the following:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.
- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the **(insert name of organisation)** to ensure that the recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the (**insert name of organisation**).

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the review will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

Further Information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below:

Your link person is ……………………………………………………..………

Your link person's job title is…………………………………………….…….

Contact number ……………………………………………………………….

Hours of work……………………………………………………………..……

Prior to any meetings or telephone call you may wish to consider the following:

Think about what questions and fears/concerns you have in relation to:

(a) What has happened?
(b) Your condition / family member condition
(c) On-going care

You could also:

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

Contact details:
Free phone number: 0800 917 0222

Appendix 3

Examples of communication which enhances the effectiveness of being open	
Stage of Process	**Sample Phrases**
Acknowledgement	“We are here to discuss the harm that you have experienced/the complications with your surgery/treatment” “I realise that this has caused you great pain/distress/anxiety/worry” “I can only imagine how upset you must be” “I appreciate that you are anxious and upset about what happened during your surgery – this must have come as a big shock for you” “I understand that you are angry/disappointed about what has happened” “I think I would feel the same way too”
Sorry	“I am so sorry this has happened to you” “I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital an extra few days for observation” “I truly regret that you have suffered xxx which is a recognised complication associated with the x procedure/treatment.” “I am so sorry about the anxiety this has caused you” “A review of your case has indicated that an error occurred – we are truly sorry about this”
Story	**Their Story** “Tell me about your understanding of your condition” “Can you tell me what has been happening to you” “What is your understanding of what has been happening to you” **Your understanding of their Story: (Summarising)** “I understand from what you said that” xxx “and you are very upset and angry about this”

	Is this correct? (i.e. summarise their story and acknowledge any emotions/concerns demonstrated.) "Am I right in saying that you……………………………..." **Your Story** "Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned? "Do you mind if I tell you what we have been able to establish at this stage?" "We have been able/unable to determine at this stage that……….." "We are not sure at this stage about exactly what happened but we have established that ……………………. We will remain in contact with you as information unfolds" "You may at a later stage experience xx if this happens you should …………………."
Inquire	"Do you have any questions about what we just discussed?" "How do you feel about this?" "Is there anything we talked about that is not clear to you?"
Solutions	"What do you think should happen now?" "Do you mind if I tell you what I think we should do?" "I have reviewed your case and this is what I think we need to do next" "What do you think about that?" "These are your options now in relation to managing your condition, do you want to have a think about it and I will come back and see you later?" "I have discussed your condition with my colleague Dr x we both think that you would benefit from xx. What do you think about that?"
Progress	"Our service takes this very seriously and we have already started a review into the incident to see if we can find out what caused it to happen" "We will be taking steps to learn from this event so that we can

	try to prevent it happening again in the future” “I will be with you every step of the way as we get through this and this is what I think we need to do now” “We will keep you up to date in relation to our progress with the review and you will receive a report in relation to the findings and recommendations of the review team” “Would you like us to contact you to set up another meeting to discuss our progress with the review?” “I will be seeing you regularly and will see you next in….days/weeks. “You will see me at each appointment” “Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by……………..” “If you think of any questions write them down and bring them with you to your next appointment.” “Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services”

Appendix 4

Organisations may find this checklist useful an aide memoire to ensure a professional and standardised approach

Before, During and After Communication / Engagement Documentation Checklist

BEFORE	***Note taking***
Service users full name	
Healthcare record number	
Date of birth	
Date of admission	
Diagnosis	
Key HSC professional(s) involved in service user's care	
Date of discharge (if applicable)	
Date of SAI	
Description of SAI	
Outcome of SAI	
Agreed plan for management of SAI	
Agreed professional to act as contact person with the service user / family	

Service user / family informed incident is being reviewed as a SAI: • Date • By Whom • By what means (telephone call / letter / in person)	
Date of first meeting with the service user / family	
Location of first meeting (other details such as room booking, arrangements to ensure confidentiality if shared ward etc)	
Person to be responsible for note taking identified	
Person Nominated to lead communications identified	
Colleague/s to assist nominated lead	
Other staff identified to attend the disclosure meeting	
Anticipated service user / family concerns queries	
Meeting agenda agreed and circulated	
Additional support required by the service user / family, if any?	
The service user / family has been advised to bring a support person to the meeting?	
The service user consented to the sharing of information with others such as designated family members / support person?	

It has been established that the service user / family requires an interpreter? If yes, provide details of language and arrangements that have been or to be made.	

Signature: ____

***Date*:** ____

DURING	***Note taking***
There has been an acknowledgment of the SAI in relation to the service user / family experience.	
An apology / expression of regret provided	
The service user / family was provided with factual information regarding the adverse event	
The service user / family understanding of the SAI was established	
The service user / family was provided with the opportunity to: - Tell their story - Voice their concerns and - Ask questions	
The next steps in relation to the service user's on-going care were agreed and the service user was involved in the decisions made.	
The service user / family was provided with information in relation to the supports available to them.	
Reassurance was provided to the service user / family in relation to the on-going communication of facts when the information has been established and available – continuity provided.	
Next meeting date and location agreed	

Signature: ______________________________________

Date: ______________________________________

AFTER

Circulate minutes of the meeting to all relevant parties for timely verification.
Follow through on action points agreed.
Continue with the incident review.
Keep the service user included and informed on any progress made – organise further meetings.
Draft report to be provided to the service user in advance of the final report (if agreed within review Terms of Reference that the draft report is to be shared with the service user prior to submission to HSCB/PHA).
Offer a meeting with the service user to discuss the review report and allow for amendments if required.
Follow through on any recommendations made by the incident review team.
Closure of the process is mutually agreed.
When closure / reconciliation was not reached the service user was advised of the alternative courses of action which are open to them i.e the complaints process.

Signature: ____

***Date*:** ____

From the Deputy Chief Medical Officer
Dr Paddy Woods

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

Reference: HSC (SQSD) 56/16 **Date of Issue: 21st October 2016**

NEVER EVENTS

For Action:

Chief Executives of HSC Trusts
Chief Executives HSCB and PHA
Chief Executive NIMDTA

For Information:
Distribution as listed at the end of this PSA.

Related documents
N/A

Superseded documents
N/A

Implementation
Immediate

DoH Safety and Quality Circulars including Patient Safety Alerts can be accessed on: https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Dear Colleagues

NEVER EVENTS

SUMMARY

The purpose of this circular is to advise you of the intention to introduce a Never Events process based on the NHS England list of Never Events and that information relating to these events will be captured as part of the Serious Adverse Incident (SAI) process.

ACTION

Chief Executives of HSC Trusts should:

- Disseminate this alert to all relevant Trust staff for information.

- Ensure that any Never Events are reported to the HSCB/PHA in line with the SAI guidance.

Chief Executives, HSCB and PHA should:

- Disseminate this alert to all relevant HSCB/PHA staff, and through the Directorate of Integrated Care to all GPs, Community Pharmacists, Dentists and Optometrists
- Consider it through the normal HSCB/PHA processes for assuring implementation of safety and quality alerts
- Monitor the reporting of Never Events via the SAI process
- Include information on Never Events in the six-monthly SAI Learning Reports published in the HSCB/PHA internet site (including numbers while adhering to data protection requirements).

Chief Executive, NIMDTA should:

- Disseminate this alert to doctors and dentists in training in all relevant specialities.

BACKGROUND

Sir Liam Donaldson in his report “The Right Time, the Right Place” made a number of recommendations aimed at improving the safety, quality and effectiveness of the delivery of health and social care services in Northern Ireland. Recommendation 6 of the Donaldson report states that the system for Serious Adverse Incident and Adverse Incident reporting should be retained but modified by the creation of a limited list of Never Events.

In his statement to the Assembly on 27 January 2015, the former Health Minister Jim Wells, advised Assembly members that “a Never Events list would be developed for Northern Ireland and, as an interim measure, urgent consideration would be given to the list of Never Events for England to determine its applicability to Northern Ireland”.

NHS England define Never Events as serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all healthcare providers.

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

Social Care Events

As the NHS England Never Events list does not include any events relating to social care, the HSCB were asked to examine the current SAI data on social care incidents to identify if there were any areas which would be suitable for inclusion in the HSC Never Events list. The HSCB worked with Trusts to seek views on potential areas for inclusion and concluded that the NHS England Never Events list already includes three areas which also refer to social care settings and no further social care specific incidents were identified as suitable for inclusion in the proposed list of HSC Never Events.

It has been decided, therefore, that the Never Events process will be based on the adoption of NHS England Never Event list. A copy of this and details of guidance that has already been issued for each of the Never Events is attached for information (**Annexe 1**).

Modifications to the SAI process

The HSCB and PHA have been asked to take forward modifications to the SAI process to include notification of Never Events as part of that process. A revised version of the SAI Procedure for the Reporting and Follow up of Serious Adverse incidents will be issued by HSCB shortly. A new field has also been set up on the DATIX reporting system which will allow all Never Events to be recorded in line with the current categories listed in the NHS England Never Event list.

Engagement with Service Users, Families, Carers as part of the SAI process.

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

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Safety Policy Branch
Department of Health
Room D2.4
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: 028 9052 2239
qualityandsafety@health-ni.gov.uk

Dr Paddy Woods
Deputy Chief Medical Officer

Distributed for Information to:

CMO
CNO
CPO
Chief Executive, RQIA
Chief Executive, NIAS
Safety & Quality Alerts Team, HSC Board
Medical Director, PHA
Director of Nursing, PHA
Director of Social Care, HSCB
Director of Integrated Care, HSCB
Director of Performance Management & Service Improvement, HSCB
Prof. Sam Porter, Head of Nursing & Midwifery, QUB

Prof. Pascal McKeown, Head of Medical School, QUB
Prof. Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Owen Barr, Head of School of Nursing, UU
Prof. Paul McCarron, Head of Pharmacy School, UU
Post Graduate Dean, NIMDTA
Staff Tutor of Nursing, Open University
Director, Safety Forum
Clinical Education Centre
NI Royal College of Nursing

NEVER EVENT LIST FOR THE HSC IN NORTHERN IRELAND (Issued October 2016) **Annexe 1**

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
1. Wrong site surgery	A surgical intervention performed on the wrong patient or wrong site (for example wrong knee, wrong eye, wrong limb, wrong tooth or wrong organ); the incident is detected at any time after the start of the procedure. • Includes wrong level spinal surgery and interventions that are considered surgical but may be done outside of a surgical environment e.g. wrong site block (unless being undertaken as a pain control procedure), biopsy, interventional radiology procedures, cardiology procedures, drain insertion and line insertion e.g. PICC/ Hickman lines. • Excludes interventions where the wrong site is selected because of unknown/unexpected abnormalities in the patient's anatomy. This should be documented in the patient's notes. • Excludes incidents where the wrong site surgery is due to	Safer Practice Notice – Standardising Wristbands improves patient safety, 2007, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824 Patient Safety Alert – WHO Surgical Safety Checklist, 2009, available at http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/ How to Guide to the five steps to safer surgery', 2010, available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901 -Standards for providing a 24 hour interventional radiology service, 2008, The Royal College of Radiologists. Available at http://www.rcr.ac.uk/docs/radiology/pdf/Stand_24hr_IR_provision.pdf	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2016-08.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20SQSD%20Learning%20Communication%2005-09_0.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-18-2009.pdf

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
	incorrect laboratory reports/ results or incorrect referral letters **Setting:** All patients receiving NHS funded care.		
2. Wrong implant/prosthesis	Surgical placement of the wrong implant or prosthesis where the implant/prosthesis placed in the patient is other than that specified in the operating plan either prior to or during the procedure. The incident is detected at any time after the implant/prosthesis is placed in the patient and the patient requires further surgery to replace the incorrect implant/prosthesis and/or suffers complications following the surgery. • Excludes where the implant/prosthesis placed in the patient is intentionally different from the operating plan, where this is based on clinical judgment at the time of the operation. • Excludes where the implant/prosthesis placed in the patient is intentionally planned and placed but later found to be suboptimal.	Safer Practice Notice – Standardising Wristbands improves patient safety, 2007, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824 Patient Safety Alert – WHO Surgical Safety Checklist, 2009, available at http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/ Safer Surgery Checklist for Cataract Surgery, 2010, available at http://www.rcophth.ac.uk/page.asp?section=365&sectionTitle=Information+ How to Guide to the five steps to safer surgery', 2010, available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2016-08.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20SQSD%20Learning%20Communication%2005-09_0.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-18-2009.pdf

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
	Setting: All healthcare premises.		
3. Retained foreign object post-procedure	Retention of a foreign object in a patient after a surgical/invasive procedure. 'Surgical/invasive procedure' includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside of the surgical environment e.g. central line placement in ward areas 'Foreign object' includes any items that should be subject to a formal counting /checking process at the commencement of the procedure and a counting /checking process before the procedure is completed (such as swabs, needles, instruments and guide wires) **except where:** • Items are inserted any time before the procedure that are not subject to the formal counting/checking process, with the intention of removing them during the procedure • Items are inserted during the procedure that are subject to the	Standards and recommendations for safe perioperative practice, 2011, available at http://www.afpp.org.uk/books-journals/books/book-123 Accountable items, swab, instrument and needle counts 2012, available at http://www.afpp.org.uk/careers/Standards-Guidance Patient Safety Alert – WHO Surgical Safety Checklist, 2009, available at http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/?entryid45=59860&p=3 Reducing the risk of retained swabs after vaginal birth and perineal suturing, 2010 available at http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=74113 Reducing the risk of retained throat packs after surgery, 2009, available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59853	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2009-10.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20SQSD%20Learning%20Communication%2006-09.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-18-2009.pdf NICE CG190: Intrapartum care http://www.nice.org.uk/guidance/cg190

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
	counting/ checking process, but are intentionally retained after completion of the procedure, with removal planned for a later time or date and clearly recorded in the patients notes • Items are known to be missing prior to the completion of the procedure and may be within the patient (e.g. screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or be more damaging than retention		
4. Mis – selection of a strong potassium containing solution	Mis - selection refers to: • When a patient intravenously receives a strong potassium solution rather than an intended different medication **Setting:** All patients receiving NHS funded care.	Patient safety alert – Potassium chloride concentrate solutions, 2002 (updated 2003), available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59882	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2034-14.pdf NICE CG174: Intravenous Fluid Therapy in Adults in Hospital (**NOTE NI Caveats**)http://www.nice.org.uk/guidance/cg174 NICE Quality Standard 66: IV Fluid Therapy in Adults

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
			http://www.nice.org.uk/guidance/qs66 NICE CG130: Hyperglycaemia in acute coronary syndromes https://www.nice.org.uk/guidance/cg130 NICE CG84: Diarrhoea and vomiting in children http://www.nice.org.uk/guidance/cg84 NICE CG99: Constipation in children and young people http://www.nice.org.uk/guidance/cg99 NICE CG32: Nutritional support in adults http://www.nice.org.uk/guidance/cg32
5. Wrong route administration of medication	The patient receives one of the following: • Intravenous chemotherapy administered via the intrathecal route • Oral/enteral medication or feed/flush administered by any parenteral route	HSC2008/001: Updated national guidance on the safe administration of intrathecal chemotherapy, 2008, available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_086870	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2061-08.pdf

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
	• Intravenous administration of a medicine intended to be administered via the epidural route **Setting**: All patients receiving NHS funded care.	Rapid Response Report NPSA/2008/RRR004 using vinca alkaloid minibags (adult/adolescent units), 2008, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59890 Minimising Risks of Mismatching Spinal, Epidural and Regional Devices with Incompatible Connectors, 2011, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=132897 Patient safety alert on non-Luer spinal (intrathecal) devices for chemotherapy 2014. available at http://www.england.nhs.uk/2014/02/20/psa-spinal-chemo/ Patient Safety Alert NPSA/2007/19 - Promoting safer measurement and administration of liquid medicines via oral and other enteral routes, 2007, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59808 Patient Safety Alert NPSA/2007/21, Safer practice with epidural injections and infusions, 2007, available at	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2085-09.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2085-09%20Addendum.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2006-11.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2050-08_0.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2028-07.pdf

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
		http://www.nrls.npsa.nhs.uk/resources/?entryid45=59807	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2085-09.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2085-09%20Addendum.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2006-11.pdf NICE CG55: Intrapartum Care https://www.nice.org.uk/guidance/cg55 NICE Interventional Procedure 249: Ultrasound-guided catheterisation of the epidural space http://www.nice.org.uk/guidance/ipg249

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
6. Overdose of Insulin due to abbreviations or incorrect device	Overdose refers to: • When a patient receives a tenfold or greater overdose of insulin because a prescriber abbreviates the words 'unit' or 'international units' , despite the care setting having an electronic prescribing system in place • When a health care professional fails to use a specific insulin administration device i.e. does not use an insulin syringe or insulin pen to measure insulin **Setting:** All patients receiving NHS funded care.	Rapid response report – Safer administration of insulin, 2010, available at http://www.nrls.npsa.nhs.uk/alerts/?entryid45=74287Diabetes: insulin, use it safely Patient information booklet 03 January 2011 - NHS Diabetes and Kidney Care Available at http://www.nhsiq.nhs.uk/resource-search/publications/nhs-dakc-insulin-use-it-safely.aspx Insulin use safety: Patient Safety Resource Centre The Health Foundation Available at http://patientsafety.health.org.uk/area-of-care/diabetes/insulin-use-safety	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2012-10.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2003-11.pdf
7. Overdose of methotrexate for non-cancer treatment	Overdose refers to • When a patient receives methotrexate ,via any route, for non-cancer treatment which results in more than the intended weekly dose being taken, despite the care setting having an electronic prescribing and administration system , or in primary care an electronic prescribing and dispensing system, in place	Patient safety alert - Improving compliance with oral methotrexate guidelines, 2006, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59800	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-08.pdf

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
	Setting: All patients receiving NHS funded care.		
8. Mis-selection of high strength of midazolam during conscious sedation	Mis - selection refers to • When a patient receives an overdose due to the selection of a high strength midazolam preparation (5mg/ml or 2mg/ml) rather than the 1mg/ml preparation, in a clinical area performing conscious sedation. • Excludes clinical areas where the use of high strength midazolam is appropriate. These are generally only in general anaesthesia, intensive care, palliative care, or where its use has been formally risk assessed within an organisation. Setting: All healthcare premises.	Rapid Response Report - Reducing risk of overdose with midazolam injection in adults, 2008, available at http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/medication-safety/?entryid45=59896&p=2 Safe sedation, analgesia and anaesthesia with the radiology department, 2003, available at http://www.rcr.ac.uk/publications.aspx?PageID=310&PublicationID=186 Over sedation for emergency procedures in isolated locations, 2011, available at http://www.nrls.npsa.nhs.uk/resources/type/signals/?entryid45=94848	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/rrr-11-midazolam.pdf
9. Failure to install functional collapsible shower or curtain rails	Involves either; • failure of collapsible curtain or shower rails to collapse when an inpatient suicide is attempted/ successful. • failure to install collapsible rails and an inpatient suicide is attempted/successful using these non-collapsible rails	Safety Notice- archived document NHSE SN (2002) 01: Cubicle rail suspension system with load release support systems, 2002, http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Estatesalerts/DH_4122863?PageOperation=email Safety Notice – archived document	**Due to the content of the information and the potential for security breaches the following NIAIC information is not published on the public facing website. For details of thse alerts please contact the NIAIC at** **niaic@health-ni.gov.uk**

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
	Setting: All mental health inpatient premises.	NHSE (2004) 10: Bed cubicle rails, shower curtain rails and curtain rails in psychiatric in-patients settings, 2004, www.dh.gov.uk/en/publicationsandstatistics/lettersandcirculars/estatesalerts/dh_4119476	EFA/2010/009 - Flush fitting anti-ligature curtain rails: ensuring correct installation. EFA/2010/003 - Anti-ligature curtain rails (including shower curtains): risks from incorrect installation or modification MDEA(NI)2007/61 - Cubical curtain track rails (anti ligature): Installation issues with anti ligature cubical curtain track rails
10. Falls from poorly restricted windows	A patient falling from a poorly restricted window. • Applies to windows “within reach” of patients. This means windows (including the window sill) that are within reach of someone standing at floor level and that can be exited/fallen from without needing to move furniture or use tools to assist in climbing out of the window.	*Health Building Note (HBN) 00-10 Part D: Windows and associated hardware*, available via https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273867/20131223_HBN_00-10_PartD_FINAL_published_version.pdf *DH(2014)/003 – Window restrictors of cable and socket design, 2014, available at https://www.cas.dh.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=102246*	**The following safety alert information has been issued by NIAIC and is available from niaic@health-ni.gov.uk** EFA/2014/003 - Window Restrictors of Cable and Socket Design EFA-2013-002 - Window Restrictors

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
	• Includes windows located in facilities/areas where healthcare is provided and where patients can and do access. • Includes where patients deliberately or accidentally fall from a window where a restrictor has been fitted but previously damaged or disabled, but does not include events where a patient deliberately disables a restrictor or breaks the window immediately before the fall. • Includes where patients are able to deliberately overcome a window restrictor by hand or using commonly available flat bladed instruments as well as the 'key' provided. **Setting:** All patients receiving NHS funded care.	*Risk of falling from windows*, available at http://www.hse.gov.uk/healthservices/falls-windows.htm	EFA/2012/001 - Integral side-stay mechanism window restrictors Health Building Note 00-10Part D: Windows and associated hardware- **Other Information** NICE PH29 – Strategies to prevent unintended injuries among the under-15s http://www.nice.org.uk/guidance/ph29
11. Chest or neck entrapment in bedrails	Entrapment of a patient's chest or neck within bedrails, or between bedrails, bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress	*Safer practice notice – Using bedrails safely and effectively,* 2007, available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59815	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2022-07.pdf

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
	dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance **Setting:** All settings providing NHS funded healthcare, including NHS funded patients in care home settings, and equipment provided by the NHS for use in patients' own homes.	*DB 2006(06) v 2.1 Safe use of bed rails,* Dec 2013, available at http://www.mhra.gov.uk/home/groups/dts-bs/documents/publication/con2025397.pdf *Local Authority Circular - Bed Rail Risk Management,* 2003, available at http://www.hse.gov.uk/lau/lacs/79-8.htm *Safe use of bedrails*, available at http://www.hse.gov.uk/healthservices/bed-rails.htm	
12. Transfusion or transplantation of ABO-incompatible blood components or organs	Unintentional transfusion of ABO-incompatible blood components. • Excludes where ABO-incompatible blood components are deliberately transfused with appropriate management. Unintentional ABO mismatched solid organ transplantation. • Excluded are scenarios in which clinically appropriate ABO incompatible solid organs are transplanted deliberately • • In this context, 'incompatible' antibodies must be clinically significant. If the recipient has donor	Safer Practice Notice – Right Patient, Right Blood, 2006, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59805 SHOT Lessons for clinical staff, 2007, available at http://www.shotuk.org/wp-content/uploads/2010/03/SHOT-lessons-for-clinical-staff-website.pdf SHOT Lessons for Clinical Staff 2009, available at http://www.shotuk.org/wp-	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2030-07.pdf QIPP – Electronic Blood Transfusion – Improving safety & efficiency of transfusion systems https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3a%2f%2farms.evidence.nhs.uk%2fresources%2fQIPP%2f29453%2fattachment%3fniceorg%3dtrue

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
	specific anti-ABO antibodies and is therefore, likely to have an immune reaction to a specific ABO compatible organ then it would be a never event to transplant that organ inadvertently and without appropriate management. **Setting:** All patients receiving NHS funded care. **Guidance:** -		NICE TA156: Routine antenatal anti-D prophylaxis is recommended as a treatment option for all pregnant women who are RhD negative https://www.nice.org.uk/guidance/ta156
13. Misplaced naso - or oro-gastric tubes	Misplacement and use of a naso- or oro-gastric tube in the pleura or respiratory tract where the misplacement of the tube is not detected prior to commencement of feeding, flush or medication administration. **Setting:** All patients receiving NHS funded care.	*Patient safety alert – Reducing harm caused by misplaced nasogastric feeding tubes,* 2005, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59794 *Patient safety alert – Reducing harm caused by misplaced naso and orogastric feeding tubes in babies under the care of neonatal units*, 2005, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59798&q=0%c2%acnasogastric%c2%ac *Reducing the harm caused by misplaced naso-gastric feeding tubes in adults, children and infants*, 2011, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=129640&p=2	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%20Learning%20Communication%2002-11.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2002-12.pdf https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20SQSD%20

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
		Harm from flushing of naso-gastric tubes before confirmation of placement, 2012. available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=133441 *Patient safety alert on placement devices for nasogastric tube insertion* - http://www.england.nhs.uk/2013/12/05/psa-ng-tube/	Learning%20Communication%2002-09.pdf
14. Scalding of patients	Patient being scalded by water used for washing/bathing • Excludes scalds from water being used for purposes other than washing/bathing (e.g. from kettles) **Settings:** All patients receiving NHS funded care.	- Health Technical Memorandum 04-01 - The control of Legionella, hygiene, "safe" hot water, cold water and drinking water systems, 2006, available via http://www.whtlimited.com/doc/lib/98/htm-04-01-part-b-20061009113435.pdf - Hospital Technical Memorandum HTM64 (Sanitary assemblies), 2006, available from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/DH_4118956(login required) - Scalding risks from hot water in health and social care LAC: 79/5, 2007, available at http://www.hse.gov.uk/lau/lacs/79-5.htm	Health Technical Memorandum 04-01 - The control of Legionella, hygiene, "safe" hot water, cold water and drinking water systems, 2006, applicable to NI HBN 00-10 part C Sanitary Assemblies

NEVER EVENT (15/16)	RELATED INFORMATION	RELATED NHS/NRLS GUIDANCE	RELATED SAFETY, NICE & NIAIC GUIDANCE
		- Scalding and burning, available at http://www.hse.gov.uk/healthservices/scalding-burning.htm	

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

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

8. DESCRIPTION OF INCIDENT:

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

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

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: *(refer to Guidance Notes)*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

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

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

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

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

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

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

15. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO

if 'YES' (*full details should be submitted*):

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: DD/MM/YY
	NO	*specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO

if 'YES' (*full details should be submitted including the date notified*):

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

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

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

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

Report submitted by: ______________________________ Designation: ______________________________

Email: Telephone: Date: DD / MM / YYYY

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

Additional information submitted by: ______________________ Designation: ___________________

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

Health and Social Care Board

Public Health Agency

What I need to know about a Serious Adverse Incident

Information for Service Users, Family Members and Carers

Insert Name of Organisation

Revised November 2016 – Version 1.1

This leaflet is written for people who use Health and Social Care (HSC) services and their families.

**The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

Introduction

Events which are reported as Serious Adverse Incidents (SAIs) help identify learning even when it is not clear something went wrong with treatment or care provided.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Health and Social Care Board (HSCB) by the organisation where the SAI has occurred. It may be:

- an incident resulting in serious harm;
- an unexpected or unexplained death;
- a suspected suicide of a service user who has a mental illness or disorder;
- an unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

A SAI may affect services users, members of the public or staff.

Never events are serious patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers. A small number of SAIs may be categorised as never events based on the Department of Health Never Events list.

SAIs, including never events, occurring within the HSC system are reported to the HSCB. You, as a service user / family member / carer, will be informed where a SAI and/or never event has occurred relating to treatment and care provided to you by the HSC.

Can a complaint become a SAI?

Yes, if during the follow up of a complaint the **(insert name of organisation)** identifies that a SAI has occurred it will be reported to the HSCB. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

How is a SAI reviewed?

Depending on the circumstance of the SAI a review will be undertaken. This will take between 8 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The (**insert name of organisation**) will discuss with you how the SAI will be reviewed and who will be involved. The (**insert name of organisation**) will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

How is the service user or their family/carer involved in the review?

An individual will be identified to act as your link person throughout the review process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the review;
- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;

- Are offered advice in the event that the media make contact.

What happens once the review is complete?

The findings of the review will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by **(insert name of organisation)** staff that is acceptable to you.

How will learning be used to improve safety?

By reviewing a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

We believe that this process will help to restore the confidence of those affected by a SAI.

For each completed review:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system. Therefore as part of our process to improve quality and share learning, we may share the anonymised content of the SAI report with other HSC organisations'

Do families get a copy of the report?

Yes, a copy of the review report will be shared with service users and/or families with the service user's consent.

If the service user has died, families/carers will be provided with a copy of the report and invited to meet with senior staff.

Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to review some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA work in conjunction with the HSCB / PHA with regard to the review of certain categories of SAI including the following:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.
- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the (**insert name of organisation)** to ensure that the recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the (**insert name of organisation**).

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the review will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

Further Information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below:

Your link person is ……………………………………………………...………

Your link person's job title is…………………………………………….…..…..

Contact number ………………………………………………………………….

Hours of work……………………………………………………………..……..

Prior to any meetings or telephone call you may wish to consider the following:

Think about what questions and fears/concerns you have in relation to:

(a) What has happened?
(b) Your condition / family member condition
(c) On-going care

You could also:

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

Contact details:
Free phone number: 0800 917 0222

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **<u>only one</u>** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **<u>only one</u>** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed **(*if you select this option please also complete ‘l’ below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete ‘l’ below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate** (✓))				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*

1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate** (✓)	**YES**		**NO**					
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected ‘YES’ to question 1, has the review report been shared with the Coroner? **Please select as appropriate** (✓)	**YES**		**NO**					
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) ‘If you have selected ‘YES’ to question 1, has the Family / Carer been informed? **Please select as appropriate** (✓)	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

---

[1] *Service User or their nominated representative*

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

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

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

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

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

Jim Livingstone
Director of Safety, Quality and Standards

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

AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

POLICY CIRCULAR

Subject:

Early Alert system

For action by:

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

For Information to:

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

Summary of Contents:

The Circular provides guidance on the operation of an Early Alert System, designed to ensure that the Department is made aware in a timely fashion of significant events occurring within HSC organisations.

Enquiries:
Any enquiries about the content of this Circular should be addressed initially to:
Safety & Quality Unit
DHSSPS
Room D1
Castle Buildings
Stormont
BELFAST
BT4 3SQ
[redacted]

Circular Reference: HSC (SQSD) 10/2010

Date of Issue: 28 May 2010

Related documents

HSC (SQSD) 22/2009: Phase 1 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

HSC (SQSD) 08/2010: Phase 2 – Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

Superseded documents

Status of Contents:

Action

Implementation:

From 1 June 2010

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

Dear Colleague

ESTABLISHMENT OF AN EARLY ALERT SYSTEM

In March 2009, I wrote to you about the initial steps being taken to phase out the reporting of Serious Adverse Incidents (SAIs) to the Department, and the implementation of the Regional Adverse Incident and Learning (RAIL) system (Circular HSC (SQSD) 22/2009).

Circular HSC (SQSD) 08/2010, which issued on 30 April 2010, advised of the transfer of responsibility for managing SAIs from the Department to the HSC Board and Public Health Agency with effect from 1st May 2010, and the revised reporting arrangements which will be in place until the new RAIL system is fully implemented.

The purpose of this circular is to provide specific guidance on the arrangements which should be followed with effect from 1st June to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

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

Yours sincerely

Jim Livingstone

Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

Introduction of an Early Alert System

Purpose of the Early Alert System

1.1 The Early Alert System will provide a channel which will enable Chief Executives and their senior staff (Director level or higher) in Health and Social Care (HSC) organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

It is important to note that this reporting system is intended to complement, not replace, existing channels of communication, both formal and informal.

1.2 While it is likely that some of the notifications reported as Early Alerts will also require to be managed as adverse incidents by HSC organisations**, many adverse incidents will NOT need to be reported through this channel.**

Criteria for using the Early Alert System

1.3 The established communications protocol between the Department and HSC organisations emphasises the principles of ‘no surprises’, and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. ***Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;***

2. ***The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;***

3. ***The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;***

4. ***The media have inquired about the event;***

5. ***The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless;***
    i. ***there has been an event which has caused harm to a patient or client and which has given rise to a Coroner’s investigation; or***
    ii. ***evidence comes to light during the Coroner’s investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received, or***
    iii. ***the Coroner’s inquest is likely to attract media interest.***

6. ***The following should always be notified:***
    i. ***the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;***
    ii. ***the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;***
    iii. ***allegations that a child accommodated in a children's home has committed a serious offence; and***
    iv. ***any serious complaint about a children's home or persons working there.***

7. ***There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.***

1.4 Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

1.5 It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

1.6 It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice speaks in person to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

1.7 The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within 24 hours of notification of the event, to the Department at earlyalert@dhsspsni.gov.uk and the HSC Board at earlyalert@hscni.net

ANNEX A

☒ **Initial call made to** **(DHSSPS) on** **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name

Organisation

Position

Telephone

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - please confirm report has been forwarded to Chair of Regional CPC.***

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact

Contact details: Telephone (work or home) ……………………………………………

Mobile (work or home) ……………………………………………..

Email address (work or home) ……………………………………………

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: ………………………………….. Office: ……………………………..

Forwarded for consideration and appropriate action to: …………………………… Date: …..............................

Detail of follow-up action (if applicable) ………………………………………………………………………….

From the Chief Medical Officer
Dr Michael McBride

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

Castle Buildings
Stormont
BELFAST
BT4 3SQ
[redacted]

BY EMAIL

Chief Executives, HSC Trusts
Chief Executive, HSC Board
Chief Executive, Public Health Agency
Chief Executive, NIBTS
Chief Executive, Business Services Organisation

Your Ref:
Our Ref: DH1/12/83057
Date: 6 October 2014

Dear Colleagues

HSC (SQSD) 7/2014 – PROPER USE OF THE EARLY ALERT SYSTEM - REMINDER

Recent events have highlighted the importance of ensuring proper adherence to the requirements of the Early Alert System. The system is designed to ensure that the Department receives prompt and timely details of events which fulfil criteria which are set out in TAB A by way of reminder. Some of these events (but not all) may become serious adverse incidents and may be notified separately to the HSCB. This does not negate the need for them to be reports as Early Alerts.

Trusts were originally advised of the system on 28 May 2010, when Circular HSC (SQSD) 10/2010] was issued. It can be accessed at: http://www.dhsspsni.gov.uk/hsc_sqsd_10-10.PDF. However, there would seem to be a number of issues around the proper use of the system and speed of reporting. On some occasions events have not been reported at all or not reported immediately and, on a number of occasions, HSC bodies have not followed up their initial telephone notification of an Early Alert to the Department by forwarding a completed pro-forma (attached at Annex A of the 2010 circular) providing further details of the incident to **earlyalert@dhsspsni.gov.uk** within 24 hours of the initial telephone notification.

You are reminded that it is not sufficient to share details via a telephone conversation with a senior official. If an event fulfils the Early Alert criteria, you must notify the Department formally using the proforma as part of the Early Alert system within 24 hours.

The Early Alert System preserves the governance arrangements which are associated with reporting incidents. It ensures that consideration is given as to who should have sight of the detail of event/issues thus providing Department staff and their colleagues with the opportunity to brief Minister or to contribute to that briefing where they are not the lead official.

The importance of the Early Alert System was also emphasised in November 2013 at the public hearings of the Inquiry into Hyponatraemia-Related Deaths. Several witnesses gave evidence of the time when the system was not in place and those arrangements have already been heavily criticised. The Early Alert System was designed to improve upon that situation.

I remind you that it is the responsibility of the reporting HSC organisation to ensure that someone of Director level or higher level reports to a senior member of staff in the Department (Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) and that in ALL cases the initial contact is followed up in the written pro forma within 24 hours.

You are asked to:

- Note the purpose, criteria and operational arrangements outlined within the Early Alert System

- Communicate this letter and the originating circular [HSC (SQSD 10/2010] to all relevant staff within your organisation.

- Ensure full compliance with the guidance.

Thank you for your assistance in this matter.

Yours sincerely

Michael McBride

DR MICHAEL MCBRIDE

cc Catherine Daly
Sean Holland
Julie Thompson
Charlotte McArdle
Mark Timoney
Simon Reid
Ronan Henry
Hazel Whinning
Brian Godfrey
Fergal Bradley
Conrad Kirkwood

ANNEX A

☒ **Initial call made to** ☐ **(DHSSPS) on** ☐ **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name ☐ Organisation ☐

Position ☐ Telephone ☐

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - please confirm report has been forwarded to Chair of Regional CPC.***

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Appropriate contact within the organisation should further detail be required:

Name of appropriate contact ☐

Contact details: Telephone (work or home) ………………………………………………

Mobile (work or home) ……………………………………………………..

Email address (work or home) …………………………………………

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: …………………………………….. Office: ………………………………..

Forwarded for consideration and appropriate action to: ……………………………… Date: …............................

Detail of follow-up action (if applicable) …………………………………………………………………………

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

Reference: HSC (SQSD) 64/16

Date of Issue: 28 November 2016

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive PHA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

HSC (SQSD) 07/14: Proper use of the Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-14.pdf

Superseded documents: N/A

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

For Information:
Distribution as listed at the end of this Circular.

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue the guidance and Early Alert notification to advise staff of the procedures to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

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

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principles of ‘no surprises’, and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

- *i. there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
- *ii. evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
- *iii. the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

- *i. the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
- *ii. the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
- *iii. allegations that a child accommodated in a children's home has committed a serious offence; and*
- *iv. any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
[redacted]
qualityandsafety@health-ni.gov.uk

Yours sincerely

Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Dir of Performance Management & Service Improvement, HSCB
Dir of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts

Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Prof. Sam Porter, Head of Nursing & Midwifery, QUB
Prof. Pascal McKeown, Head of Medical School, QUB
Prof. Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Owen Barr, Head of School of Nursing, UU
Prof. Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

BW/108
ANNEX A

☒ **Initial call made to** ☐ **(DoH) on** ☐ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name		Organisation	
Position		Telephone	

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

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……………………………………………………………………………………………

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact:

Contact details:

Email address (work or home) ……………………………………………………………………

Mobile (work or home) ………………………………. Telephone (work or home) ……………………………

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DoH:

Early Alert Communication received by: ……………………………………… Office: ………………………………

Forwarded for consideration and appropriate action to: ……………………………… Date: ………………………

Detail of follow-up action (if applicable) ……………………………………………………………………

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

Reference: HSC (SQSD) 5/19

Date of Issue: 27th February 2019

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB and PHA for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System

HSC (SQSD) 07/14: Proper use of the Early Alert System

Superseded documents**:**

HSC (SQSD) 64/16: Early Alert System

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

For Information:
Distribution as listed at the end of this Circular.

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue revised guidance for the procedure to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

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

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principle of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
    ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
    iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

    i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
    ii. *the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
    iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
    iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, Assistant Secretary or professional equivalents) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

To assist HSC organisations in making contact with Departmental staff, **Annex A** attached provides the contact details of a range of senior Departmental staff together with an indication of their respective areas of responsibility. **The senior officers are not listed in order of contact. Should a senior officer with responsibility for an area associated with an event not be available, please proceed to contact any senior officer on the list.**

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at **Annex B**, and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net.

It is the responsibility of the reporting HSC organisation to comply with any other possible requirements to report or investigate the event they are reporting in line with any other relevant applicable guidance or protocols (e.g. Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), Professional Regulatory Bodies, the Coroner etc.) **including compliance with GDPR requirements for information contained in the Early Alert pro forma and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches. The information contained in the pro forma should relate only to the key issue and it should not contain any personal data.**

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: [redacted]
qualityandsafety@health-ni.gov.uk

Yours sincerely

Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Director of Performance Management & Service Improvement, HSCB
Director of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts
Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Professor Donna Fitzimmons, Head of Nursing & Midwifery, QUB
Professor Pascal McKeown, Head of Medical School, QUB
Professor Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Neil Kennedy, Acting Director of Centre for Medical Education, QUB
Professor Sonja McIlfatrick, Head of School of Nursing, UU
Professor Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

ANNEX A
EARLY ALERT SYSTEM: DEPARTMENTAL OFFICER CONTACT LIST
FEBRUARY 2019

HEALTHCARE POLICY GROUP

[redacted]

RESOURCES AND PERFORMANCE MANAGEMENT GROUP

[redacted]

SOCIAL SERVICES POLICY GROUP

[redacted]

CHIEF MEDICAL OFFICER GROUP

[redacted]

BW/109
ANNEX B

☒ **Initial call made to** ☐ **(DoH) on** ☐ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name ☐ Organisation ☐

Position ☐ Telephone ☐

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

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Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: ☐

Contact details:

Email address (work or home) ………………………………………………………………………

Mobile (work or home) ……………………………. Telephone (work or home) ………………………………

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DoH:

Early Alert Communication received by: ……………………………………………… Office: ………………………………………

Forwarded for consideration and appropriate action to: ……………………………………… Date: ……………………………………

Detail of follow-up action (if applicable) ………………………………………………………………………………………

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

Reference: **HSC (SQSD) 5/19**

Date of Issue: 12 November 2020

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive, PHA
Chief Executive NIAS
Chief Executive RQIA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

For Information:
Distribution as listed at the end of this Circular.

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

HSC (SQSD) 07/14: Proper use of the Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-14.pdf

Superseded documents**:**

HSC (SQSD) 64/16: Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-64-16.pdf

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Issue

This updated circular advises on the use of the Early Alert System with respect to COVID 19 incidents/outbreaks and also serves as a reminder to the operation of the Early Alert system. COVID 19 incidents/outbreaks that are being managed as part of a normal operational response (usual business) should not be routinely reported through the Early Alert system. Such outbreaks/incidents should continue to be reported to Health Protection Team in the PHA as notifiable disease and HSC organisations should continue to provide regular updates to HSCB through established SITREP arrangements.

Action

Chief Executives of HSCB and PHA should:

- Disseminate this circular to all relevant HSCB and PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant staff and all relevant independent sector providers.

Chief Executive of NIMDTA should:

- Disseminate this circular to all relevant staff and doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The Early Alert protocol is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events, which may require the attention of the Minister, Chief Professional Officers and/or policy leads. The purpose of this circular is to clarify arrangements with respect to COVID 19 incidents/outbreaks and re-issue updated guidance for the procedure to be followed if an Early Alert is appropriate.

This updated circular will also serve as a reminder to HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department. The protocol, criteria and operational arrangements for the Early Alert system are provided at **Annex A**, an updated summary of departmental contact numbers is provided at **Annex B**, amendments to these guidance documents, last issued 27 February 2019, are highlighted in yellow for your attention.

During this current surge of COVID-19 incidents/outbreaks have become more prevalent across all HSC organisations, and the handling and management of many of these has become embedded in usual operational business arrangements across HSC organisations. Healthcare outbreaks that are being actively managed as part of an organisation’s normal operational response should not be routinely reported through the Early Alert System. These incidents/outbreaks in health and social care settings should instead continue to be reported to the Health Protection Team within the PHA through established processes for notifiable diseases. Such incidents/outbreaks will subsequently be notified to the Department via daily SITREPs collated by HSCB and via daily update reports shared by PHA's Health Protection service with the Chief Medical Officer's office.

It is important to note that certain COVID-19 incidents/outbreaks, including where there is a serious impact on service delivery, that are not being handled through normal operational response may fall within some of the criteria listed below in **Annex A** and therefore they may warrant an Early Alert. HSC organisations should assess events as they occur/emerge and should they determine that one or more of the criteria listed in Annexe A is met they should report through the Early Alert system as appropriate.

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

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Mr David Wilson
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ

qualityandsafety@health-ni.gov.uk

Yours sincerely

Lourda Geoghegan

Dr Lourda Geoghegan
Deputy Chief Medical Officer

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Director of Performance Management & Service Improvement, HSCB
Director of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts
Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Professor Donna Fitzimmons, Head of Nursing & Midwifery, QUB
Professor Pascal McKeown, Head of Medical School, QUB
Professor Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Neil Kennedy, Acting Director of Centre for Medical Education, QUB
Professor Sonja McIlfatrick, Head of School of Nursing, UU
Professor Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

ANNEX A

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads and/or require urgent action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principle of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
    ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
    iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

- i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
- ii. *the death of, or significant harm to, a Looked After Child, a child on the Child Protection Register or a young person in receipt of leaving and after care services*
- iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
- iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, Assistant Secretary or professional equivalents) regarding the event, and also an equivalent senior executive in the HSC Board and the Public Health Agency, as appropriate, and any other relevant bodies.

To assist HSC organisations in making contact with Departmental staff, **Annex B** attached provides the contact details of a range of senior Departmental staff together with an indication of their respective areas of responsibility. **The senior officers are not listed in order of contact. Should a senior officer with responsibility for an area associated with an event not be available, please proceed to contact any senior officer on the list.**

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the updated pro forma attached at **Annex C** and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net.

It is important that, when completing the proforma, the information about the person making the notification to the Department, the person who received the information within the Department and the date on which the information is exchanged, is accurate (for recording purposes).

It is the responsibility of the reporting HSC organisation to comply with any other possible requirements to report or investigate the event they are reporting in line with any other relevant applicable guidance or protocols (e.g. Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), the Safeguarding Board for Northern Ireland, Professional Regulatory Bodies, the Coroner etc.) **including compliance with GDPR requirements for information contained in the Early Alert proforma and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches. The information contained in the proforma should relate only to the key issue and it should not contain any personal data.**

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial/personnel changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

ANNEX B

EARLY ALERT SYSTEM: DEPARTMENTAL OFFICER CONTACT LIST NOVEMBER 2020

HEALTHCARE POLICY GROUP

[redacted]

RESOURCES AND PERFORMANCE MANAGEMENT GROUP

[redacted]

SOCIAL SERVICES POLICY GROUP

[redacted]

[redacted]

CHIEF MEDICAL OFFICER GROUP

[redacted]

CHIEF NURSING OFFICER

[redacted]

BW/110
ANNEX C

☎ **Initial call made to** ______ **(DoH) on** ______ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name ______ Organisation ______

Position ______ Telephone ______

Criteria under which event is being notified (mark as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children/young people in care or receiving after care support***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: *If this relates to a child please specify DOB, legal status, placement detail*

** If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of the Safeguarding Board for Northern Ireland (SBNI).*

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: ______

Contact details:

Email address (work or home) ……………………………………………………………

Mobile (work or home) ……………………………… Telephone (work or home) ……………………………

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DoH:

Early Alert Communication received by: ……………………………………… Office: ……………………………………

Forwarded for consideration and appropriate action to: ……………………………………… Date: ……………………………

Detail of follow-up action (if applicable) ………………………………………………………………………

Health and Social Care Board

Public Health Agency

HSCB/PHA Procedure for the Management of Early Alerts

1.0 Background

Circular HSC (SQSD) 10/2010 issued by DHSSPS provided guidance on the introduction of an Early Alert System. The system provides a channel which enables Chief Executives and senior staff in HSC organisations to notify the Department, HSCB and PHA in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads and/or require urgent action by the Department.

2.0 Purpose

The purpose of this procedure is to provide guidance to staff working within the HSCB and PHA on internal processes for the effective management of Early Alerts in conjunction with the procedure for the Reporting and Follow up of Serious Adverse Incidents.

3.0 Notifying Early Alerts

3.1 How to Report

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation communicates verbally (within 48 hours of the event in question) with a senior member of staff in the Department regarding the event, and with a senior officer in the HSC Board, and the PHA, as appropriate, and any other relevant body.

In the case of Family Practitioner Services (FPS) , it is the responsibility of the reporting FPS practice to ensure that a senior person from the practice speaks in person to the Director of Integrated Care (or deputy) in the HSC Board regarding the event, who will in turn communicate with the Department and report the early alert.

Following the above verbal communication, the reporting organisation must arrange for the content of the initial contact to be recorded on the relevant pro forma (appendix 1) and forwarded within 24 hours of notification of the event, to the Department at earlyalert@dhsspsni.gov.uk and the HSC Board at earlyalert@hscni.net

3.2 Criteria for reporting Early Alerts

Appendix 2 lists the criteria for reporting early alerts.

4.0 Process

The process within the HSCB and PHA for managing early alerts will be carried out in conjunction with the Procedure for the Management and Follow up of SAIs. For that reason, there are two possible approaches to be taken:

i. Outside of the SAI process – when a SAI for the same incident has **not** been received

ii. When a SAI for the same incident has been received

4.1 Process when SAI is not received

4.1.1 Early alert is verbally communicated to HSCB and PHA senior staff. Member of staff receiving call will inform (where relevant) other senior staff and professionals within the HSCB/PHA.

4.1.2 Early alert proforma received into mailbox earlyalert@hscni.net and logged onto Datix system by Governance Dept.

4.1.3 Governance Dept will identify a lead officer based on the same basis for allocating SAIs, and issue to the lead officer, copied to Directors and other relevant HSCB/PHA staff (as per appendix 3).

4.1.4 Lead officer will liaise with other relevant professionals within the HSCB/PHA and contact the reporting organisation if appropriate, to determine whether further action is required or if early alert can be closed. This may include:

- establish more details of the incident
- check if DHSSPS has been advised
- consider if organisation has taken reasonable steps based on information available
- consider whether regional action is required
- consider if relevant regulatory body has been informed

This may also include advising the reporting organisation via the Governance Dept that a SAI notification is necessary and liaison will continue until SAI notification is received (see point 4.2.2)

If early alert can be closed go to point 4.1.6

4.1.5 If further action is required, the Lead officer will liaise with reporting organisation and continue to liaise with all other relevant HSCB/PHA professionals.

4.1.6 When a lead officer is content that appropriate action has been taken in response to the early alert he/she will contact Governance Dept to advise rational for closure.

4.1.7 Governance Dept will close early alert on Datix.

4.2 Process when SAI is received

4.2.1 See points 4.1.1 & 4.1.2

4.2.2 If a SAI has already been received, the Governance Dept will circulate the early alert to lead officers, directors and other relevant HSCB/PHA staff (as per appendix 3) advising a SAI has been received and the early alert is being circulated for information purposes only. The early alert will be closed on Datix at this stage – noting that it is being actioned through the SAI process.

4.2.3 If a SAI is received following receipt of a early alert the SAI procedure will be implemented and the early alert will be automatically closed on Datix by the Governance Dept.

Appendix 4 highlights the above steps by way of a flowchart

5.0 Early Alert Reporting

The Governance Dept will prepare and submit to SMT, regular reports detailing the action taken in response to each early alert received.

Initial call made to: ☐ **(DHSSPS) on** ☐
(DATE)

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name ☐ Organisation ☐

Position ☐ Telephone ☐

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify BOD, legal status, placement address if in RRC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child – Looked After or on CPR – please confirm report has been forwarded to Chair of Regional CPC.***

☐

Name of appropriate contact ☐

Contact details: Telephone (work or home)

Mobile (work or home) ....

Email address (work or home)

Forward proforma to the Department at:earlyalert@dhsspsni.gov.uk and the HSCB Board at: earlyalert@hscni.net

FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: .... Office: ....

Forwarded for consideration and appropriate action to: ....Date: ....

Detail of follow-up action (if applicable) ....

Appendix 2

Criteria for Reporting Early Alerts

1. Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;

2. The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;

3. The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;

4. The media have inquired about the event;

5. The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless;
    i. there has been an event which has caused harm to a patient or client and which has given rise to a Coroner's investigation; or
    ii. evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received, or
    iii. the Coroner's inquest is likely to attract media interest.

6. The following should always be notified:
    i. the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;
    ii. the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;
    iii. allegations that a child accommodated in a children's home has committed a serious offence; and
    iv. any serious complaint about a children's home or persons working there.

7. There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.

NAMES OF LEAD OFFICERS

NAMES OF RELEVANT DIRECTOR AND SENIOR STAFF TO RECEIVE COPY OF EARLY ALERT

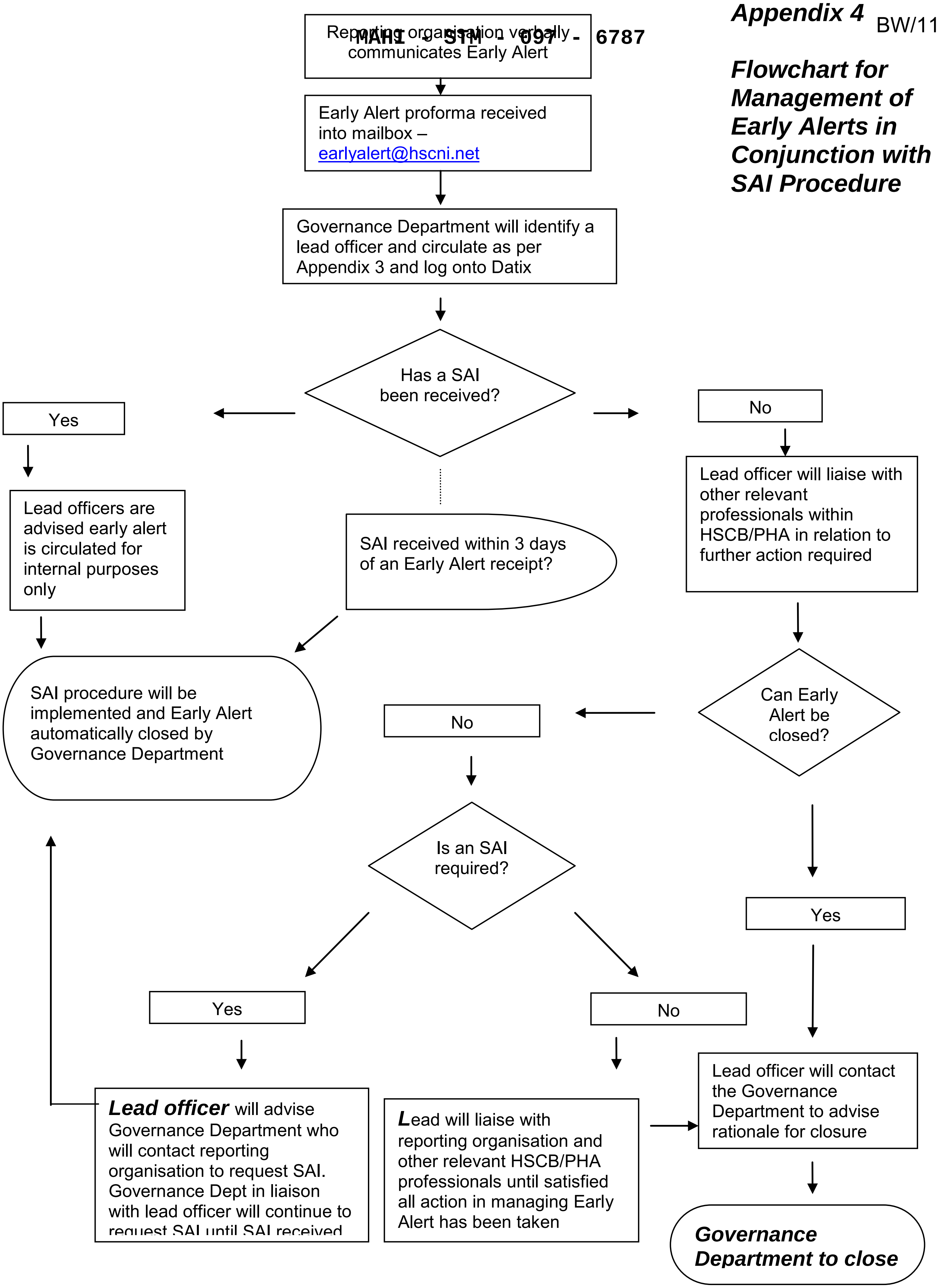
PROGRAMME OF CARE	LEADS	COPIED TO
Acute Services & **Specialist Areas**	**Lead Officer North** Dr Heather Reid **Lead Officer South** Dr Diane Corrigan **Lead Officer East** Dr Paul Darragh **Lead Officer West** Dr Caroline Mason	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Family & Childcare **(Child Protection)**	**Regional Lead HSCB** Mr Tony Rodgers **Regional Lead Nurse PHA** Ms Deidre Webb	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Mental Health / Learning Disability	**Regional Lead SW HSCB** Mr Aiden Murray **Regional Lead Dr PHA** Dr Gerry Waldron **Regional Lead Nurse** Mrs Molly Kane	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Maternity/Child Health/Acute Paediatrics	**Regional Lead Dr PHA** Dr Fiona Kennedy **Regional Lead Nurse** Ms Denise Boulter **Regional Lead SW HSCB** Mr Tony Rodgers	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff

Elderly	**Regional Lead SW HSCB** Mr Kevin Keenan **Regional Lead Dr PHA** Dr Paul Darragh **Regional Lead Nurse PHA** Ms Siobhan McIntyre	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Physical and Sensory Disability	**Regional Lead SW HSCB** Mr Kevin Keenan **Regional Lead Dr PHA** Mr Paul Darragh **Regional Lead Nurse PHA** Mrs Molly Kane	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Independent Service Providers (Acute)	**Regional Lead Dr PHA** Dr Paul Darragh **Regional Lead Nurse PHA** Ms Rose McHugh	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Prison Health	**Regional Lead SW HSCB** Mr Aiden Murray **Regional Lead PHA** Dr Paul Darragh **Regional Lead Nurse PHA** Mrs Molly Kane	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Corporate Business	Mr Michael Bloomfield Mrs Mary Hinds	Cx & Directors HSCB Cx & Directors PHA Head of Communications Senior Governance Staff

INTEGRATED CARE		
PROGRAMME OF CARE	**LEADS**	**COPIED TO**
GMS	Dr Katherine MacLurg	Cx & Directors HSCB Cx & Directors PHA Head of Communications Senior Governance Staff
Pharmacy	Ms Brenda Bradley	Cx & Directors HSCB Cx & Directors PHA Head of Communications Senior Governance Staff
Optometry	Ms Margaret McMullan	Cx & Directors HSCB Cx & Directors PHA Head of Communications Senior Governance Staff
Dentistry	Ms Judi McGaffin	Cx & Directors HSCB Cx & Directors PHA Head of Communications Senior Governance Staff

Appendix 4

Flowchart for Management of Early Alerts in Conjunction with SAI Procedure



Health and Social Care Board

Public Health Agency

HSCB/PHA Protocol for the reporting and follow up of the DoH Early Alert System

February 2017

Contents

Appendices

1.0 Background

In June 2010, the process for Early Alerts was introduced by the Department of Health (DoH). Circular HSC (SQSD) 64/16 issued 28 November 2016 (Addendum 1), provided updated guidance on the operation of the Early Alert System. This system is designed to ensure that the Department (and thus the Minister) receive prompt and timely details of events (*these may include potential serious adverse incidents*) which may require urgent attention or possible action by the Department.

The Early Alert System provides a channel which enables Chief Executives and their senior staff (*Director level or higher*) in HSC organisations to notify the Department, in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by the Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the DoH.

Organisations are also required to alert the HSCB of all Early Alert notifications to DoH.

2.0 Purpose

The purpose of this protocol is to provide guidance to staff working within the HSCB and PHA on the internal processes for the effective management of Early Alerts where:

.

a) The Early Alert has occurred in HSCB or PHA and is required to be reported to DoH (refer to 3.0);

and/or

b) The HSCB has received a copy of the Early Alert from a reporting organisation in line with the above circular and it will be managed in conjunction with the Procedure for the Reporting and Follow up of Serious Adverse Incidents (refer to 4.0).

3.0 Notifying DoH of Early Alerts that occur within HSCB/PHA

3.1 When an event has occurred within the HSCB/PHA that meets the criteria for reporting an Early Alert to the DoH (see Appendix 2), it is the responsibility of a senior person from the organisation (*at Director level or higher*) to communicate verbally (<u>within 48 hours of the event in question</u>) with a senior member of staff in the DoH[1], all other appropriate senior executives in the HSCB/PHA, and any other relevant bodies regarding the event.

[1] *For example: the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary.*

3.2 In the case of Family Practitioner Services (FPS), it is the responsibility of the reporting FPS practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSCB regarding the event, who will in turn communicate with the DoH and report the Early Alert as per 3.1.1.

3.3 Following the above verbal communication, and in **all** cases, the HSCB/PHA must arrange for the content of the initial contact to be recorded on the relevant pro-forma (Appendix 1) and forwarded within **24 hours** of notification of the event, to the DoH at earlyalert@health-ni.gov.uk. This pro-forma will also be forwarded to the HSCB at earlyalert@hscni.net.

4.0 Process for Follow Up of Early Alerts that have been Notified to HSCB

As detailed above, all Early Alerts notified to DoH are also forwarded to the HSCB. The following steps therefore outline the HSCB/PHA internal process for the management of these, which is in conjunction with the Procedure for the Management and Follow up of SAIs.

4.1 Early Alert proforma received into mailbox earlyalert@hscni.net and logged onto Datix system by Governance Department.

4.2 Governance Department will identify a Lead Officer based on the process for allocating SAIs, and issue to the Lead Officer via email to review as outlined in 4.3 below. Directors and other relevant HSCB/PHA staff are copied into the email (*Refer to SAI DRO Allocation Listing held by HSCB Governance Department*).

Note: If a SAI has already been received, the Governance Department will circulate the Early Alert as per above for information purposes only and close the Early Alert on Datix noting that it is being actioned through the SAI process.

4.3 Lead Officer will review the Early Alert and liaise with other relevant professionals within the HSCB/PHA to determine:

a) If further/immediate action is required (refer to 4.3.1);
b) If, in their professional opinion, a SAI should be submitted (refer to 4.3.2); or
c) If no further action is required by HSCB/PHA and the Early Alert can be closed on Datix (refer to 4.3.3).

The Lead Officer in reviewing the Early Alert may wish to contact the reporting organisation if appropriate to:

- Establish more details of the incident;
- Check if DoH has been advised;
- Consider if organisation has taken reasonable steps based on information available;

- Consider whether regional action is required;
- Consider if relevant regulatory body has been informed.

Note: All communication between HSCB/PHA and reporting organisation must be conveyed between the HSCB Governance Department and Governance Departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the Early Alert, is recorded on the HSCB DATIX risk management system.

4.3.1 Where further/immediate action is required the Lead officer will liaise with the reporting organisation via the Governance Department to request further information or immediate actions.

4.3.2 If the Lead Officer in their professional opinion decides a SAI should be submitted, the HSCB Governance Department will notify the reporting organisation that a SAI notification is necessary. Liaison between the HSCB and Reporting Organisation Governance Departments will continue until SAI notification is received and the Early Alert can be closed (see point 4.3.4)

4.3.3 Where the Lead Officer determines that appropriate action has been taken, or no further action is required i.e. no SAI notification to be submitted the Lead Officer will contact the Governance Department to advise rational for closure.

4.3.4 Governance Department will close Early Alert on Datix.

Note: There may be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert, which has already been reported. The Governance Department will forward any updates received to the identified Lead Officer.

A flowchart in Appendix 3 outlines the key stages within the above process.

5.0 Early Alert Reporting

The Governance Department will prepare and submit to SMT, regular reports detailing the action taken in response to each Early Alert received.

APPENDIX 1 – EARLY ALERT PROFORMA

Initial call made to: (DOH) on (DATE)

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name		Organisation	
Position		Telephone	

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify BOD, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child – Looked After or on CPR – please confirm report has been forwarded to Chair of Regional CPC.***

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact

Contact details:

Email address (work or home)………………………………………………………………..

Mobile (work or home) …………………Telephone (work or home) ………………………..

Forward proforma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

---

FOR COMPLETION BY DoH:

Early Alert Communication received by: .... Office: ....

Forwarded for consideration and appropriate action to: .... Date: ....

Detail of follow-up action (if applicable)……...

Working for a Healthier People

INVESTORS IN PEOPLE

Criteria for Reporting Early Alerts

1. Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;

2. The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;

3. The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;

4. The event may attract media attention;

5. The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless;

   i. *there has been an event which has caused harm to a patient or client and which has given rise to a Coroner's investigation; or*
   ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received, or*
   iii. *the Coroner's inquest is likely to attract media interest.*

6. The following should always be notified:

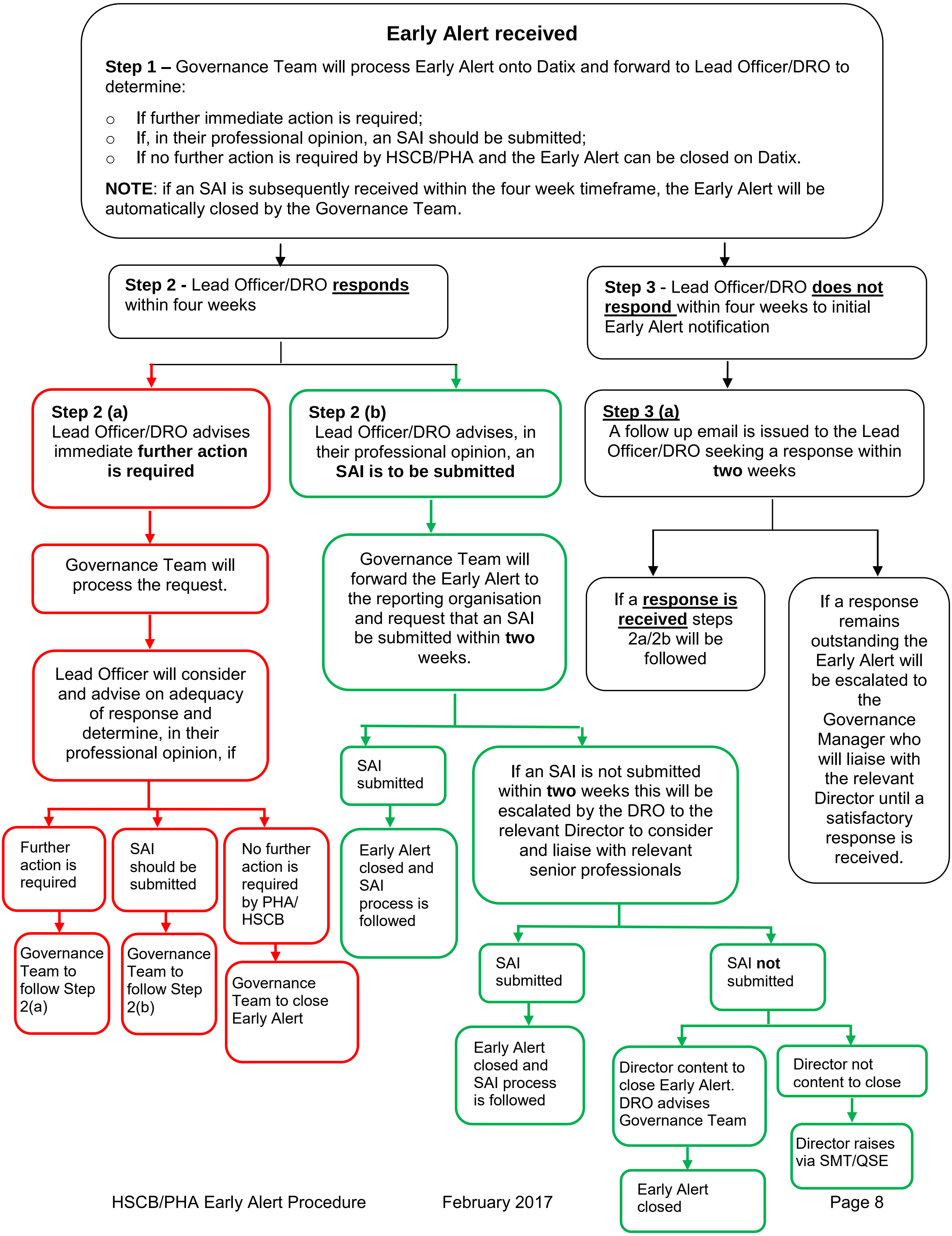
   i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
   ii. *the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
   iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
   iv. *any serious complaint about a children's home or persons working there.*

7. There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.

Family Practitioner Services should notify the HSCB about events within the services they provide that meet one or more of these criteria. The HSCB will notify the DoH.

APPENDIX 3

HSCB/PHA Early Alerts PROCESS FLOWCHART – KEY STAGES



Early Alert received

Step 1 – Governance Team will process Early Alert onto Datix and forward to Lead Officer/DRO to determine:

- If further immediate action is required;
- If, in their professional opinion, an SAI should be submitted;
- If no further action is required by HSCB/PHA and the Early Alert can be closed on Datix.

NOTE: if an SAI is subsequently received within the four week timeframe, the Early Alert will be automatically closed by the Governance Team.

Step 2 - Lead Officer/DRO **responds** within four weeks

Step 2 (a) Lead Officer/DRO advises immediate **further action is required**

Governance Team will process the request.

Lead Officer will consider and advise on adequacy of response and determine, in their professional opinion, if

Further action is required

Governance Team to follow Step 2(a)

SAI should be submitted

Governance Team to follow Step 2(b)

No further action is required by PHA/ HSCB

Governance Team to close Early Alert

Step 2 (b) Lead Officer/DRO advises, in their professional opinion, an **SAI is to be submitted**

Governance Team will forward the Early Alert to the reporting organisation and request that an SAI be submitted within **two** weeks.

SAI submitted

Early Alert closed and SAI process is followed

If an SAI is not submitted within **two** weeks this will be escalated by the DRO to the relevant Director to consider and liaise with relevant senior professionals

SAI submitted

Early Alert closed and SAI process is followed

SAI **not** submitted

Director content to close Early Alert. DRO advises Governance Team

Early Alert closed

Director not content to close

Director raises via SMT/QSE

Step 3 - Lead Officer/DRO **does not respond** within four weeks to initial Early Alert notification

Step 3 (a) A follow up email is issued to the Lead Officer/DRO seeking a response within **two** weeks

If a **response is received** steps 2a/2b will be followed

If a response remains outstanding the Early Alert will be escalated to the Governance Manager who will liaise with the relevant Director until a satisfactory response is received.

BW/112

ADDENDUM 1

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

Reference: HSC (SQSD) 64/16

Date of Issue: 28 November 2016

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB for cascade to:
- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive PHA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

For Information:
Distribution as listed at the end of this Circular.

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

HSC (SQSD) 07/14: Proper use of the Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-14.pdf

Superseded documents: N/A

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue the guidance and Early Alert notification to advise staff of the procedures to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

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

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principles of ‘no surprises’, and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does <u>not</u> include any deaths routinely referred to the Coroner, <u>unless:</u>*

   i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
   ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
   iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

   i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
   ii. *the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
   iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
   iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: [redacted]
qualityandsafety@health-ni.gov.uk

Yours sincerely

Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Dir of Performance Management & Service Improvement, HSCB
Dir of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts
Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Prof. Sam Porter, Head of Nursing & Midwifery, QUB
Prof. Pascal McKeown, Head of Medical School, QUB
Prof. Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Owen Barr, Head of School of Nursing, UU
Prof. Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

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ANNEX A

☒ **Initial call made to** ☐ **(DoH) on** ☐ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name		Organisation	
Position		Telephone	

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact:

Contact details:

Email address (work or home) ……………………………………………………………………

Mobile (work or home) …………………………… Telephone (work or home) ………………………

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DoH:

Early Alert Communication received by: ……………………………………… Office: ……………………………

Forwarded for consideration and appropriate action to: ……………………………… Date: ……………………

Detail of follow-up action (if applicable) ……………………………………………………………………………

Health and Social Care Board

Public Health Agency

Health and Social Care Board / Public Health Agency

Regional Procedure for Safety and Quality Alerts

Reference	**Responsible Officer/s**	**Review Frequency**
SQAT-09.07.18	• Head of Corporate Services, HSCB • Director of Nursing, Midwifery and Allied Health Professionals, PHA	Annual
Approved by **HSCB SMT**	**Approval Date:** 10 July 2018	**Next review due** June 2019

Superseded documents (if applicable)

HSCB/PHA Protocol for Implementation of SQAs (April 2012)
HSCB/PHA Protocol for Implementation of SQAs (August 2013)
HSCB/PHA Protocol for Implementation of SQAs (May 2015)
HSCB/PHA Protocol for Implementation of SQAs (July 2016)
HSCB/PHA Protocol for Implementation of SQAs (March 2017)

Version 1.0

INDEX

HSCB/PHA Regional Procedure for Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: June 2018

1.0 Introduction

The Department of Health (DoH), Health and Social Care Board (HSCB), Public Health Agency (PHA) and other organisations issue a variety of correspondence collectively referred to as Safety and Quality Alerts (SQAs).

SQAs focus on the dissemination of regional learning for the health and social care system within Northern Ireland and are issued to service providers to support improvement in practice.

The learning identified in SQAs may arise from information provided from a variety of sources for example, Serious Adverse Incidents (SAIs), Adverse Incidents (AIs), Complaints, reviews by the Regulation and Quality Improvement Authority (RQIA), legislative changes, medicines regulators, equipment or device failures, national safety systems, independent reviews and Learning Notifications.

There are already procedures in place for the management, reporting and identification of learning from a range of sources including:

- SAIs
- Complaints
- Post Fall Reviews, and
- Early Alerts.

Appendix 1 provides an overview of these established processes and links to the relevant procedures.

This revised procedure enables any HSC organisation who may have identified learning from another source, other than those identified above, and wish it to be considered for a Safety Quality Alert.

The learning may originate from one of the following sources and which the referring organisation consider significant and would benefit other Providers.

- Improved practice;
- Learning from:
    - An Adverse Incident or incident trends;
    - Mortality and Morbidly Review;
    - Patient, Client Experience;
    - Coroner's Inquests;
    - Audit or other reviews;
- Any other concern.

This new addition to the Safety Quality Alerts process is referred to as a **'Learning Notification'**.

2.0 What are Safety Quality Alerts?

Safety and Quality Alerts are the regional process which the Health and Social Care Board (HSCB) and Public Health Agency (PHA) oversee the identification, co-ordination, dissemination and implementation of learning.

Safety Quality Alerts (SQAs) are subdivided into a number of categories detailed below:

Category 1 SQAs include:

- Department of Health (DoH) Safety Quality & Standards (SQS) guidance and letters/circulars and Patient Safety Alerts (PSAs);

- Learning Letters (including other professional related letters) or Reminder of Good Practice Letters arising from established processes as outlined in Appendix 1;
- 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;
- Learning notifications.

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:

- NICE guidance.
- Drug alerts and recalls;
- Professional In-Confidence alerts regarding individual practitioners.

However in conjunction with the NICE co-ordinating process and where there are specific safety concerns in relation to commissioning issues, these will be considered by the SQA Team and referred where relevant to QSE. (***Refer to appendix 1** – **Overview of processes that link into the arrangements for the issuing of HSCB/PHA SQAs***)

3.0 Application of Procedure

3.1 Who does this procedure apply to?

The procedure applies to the following HSC organisations:

HSC organisations (HSC)

- Health and Social Care Board *(including the Directorate of Integrated Care on behalf of Primary Care providers i.e. GPs, Community Pharmacists, Dentists and Opticians)*
- Public Health Agency

- Business Services Organisation
- Belfast Health and Social Care Trust
- Northern Health and Social Care Trust
- Southern Health and Social Care Trust
- South Eastern Health and Social Care Trust
- Western Health and Social Care Trust
- Northern Ireland Ambulance Service
- Regulation & Quality Improvement Authority
- Other ALBs/Special Agencies (SA)
    - Northern Ireland Blood Transfusion Service
    - Patient Client Council
    - Northern Ireland Medical and Dental Training Agency
    - Northern Ireland Practice and Education Council
    - Northern Ireland Guardian Ad Litem Agency (NIGALA)
    - Northern Ireland Social Care Council (NISCC)

4.0 Management Arrangements for SQAs

To ensure that learning is shared in a prompt, targeted and effective way, the HSCB and PHA have two key groups:

- The Quality, Safety and Experience Group;
- The Safety and Quality Alerts (SQA) Team.

4.1 Role of HSCB/PHA Quality, Safety and Experience Group

The QSE group co-ordinates and supports the activities related to safety, effectiveness and patient client focus within the HSCB and PHA. Membership and Terms of Reference are detailed at Appendix 2.

A key function of this group is to promote and share learning a component of which is the identification of learning and approval of SQAs.

The group meet monthly and is chaired by the PHA Executive Director of Nursing, Midwifery and Allied Health Professionals or nominated deputy.

An Assistant Governance manager will oversee the process, maintain an up-to-date log, prepare for and support QSE Team meetings.

4.2 Role of HSCB/PHA Safety Quality Alerts Team

The Safety Quality Alerts Team (SQAT) is responsible for the dissemination, implementation and assurance of all Category 1 SQAs and some Category 2 SQAs (as required)

The SQA Team Terms of reference and membership are detailed at Appendix 3 with membership including HSCB and PHA representatives from professional groups, and Corporate Services.

The SQA Team is chaired, by the Medical Director/Director of Public Health (DPH) or nominated deputy.

To ensure timely co-ordination and implementation of regional safety and quality alerts, the Team will meet every 2 weeks. HSCB/PHA has arrangements in place to ensure that any immediate issues that need to be addressed are processed immediately.

An Assistant Governance manager will oversee the process, maintain an up-to-date log, prepare for and support SQA Team meetings.

4.3 Role of the HSCB Alerts Office

All SQAs will be logged by the Alerts office which is managed by the Governance Team within HSCB Corporate Services.

All correspondence in relation to alerts will be channelled through the HSCB Alerts mailbox at Alerts.HSCB@hscni.net. The Alerts Office will maintain a system to track progress on implementation.

4.4 Learning Notifications – The Process

Trusts and ALBs can advise the HSCB/PHA of potential regional learning via established processes as detailed in Appendix 1 or through the completion and submission of a Learning Notification (Appendix 4 – Learning Notification Template).

In completing the Learning Notification Template organisations should consider the Trigger Tool at Appendix 5.

It is important to note that it's the responsibility of Trusts / ALBs / Special Agencies as individual organisations to undertake their own risk assessments of the issue and to take steps to mitigate the risk within their own organisation and in advance of any further regional advice, guidance or solution i.e. do not delay acting to assess and mitigate risk until a regionally agreed solution is in place.

Completed templates should be forwarded to Alerts.HSCB@hscni.net.

The Notifications will be added to the SQAT database as a category 1 alert, circulated to SQAT members and automatically listed for the next SQAT fortnightly meeting.

SQAT will also consider the following in conjunction with the trigger tool referred to in appendix 6:

- regional learning and the timeliness of this learning
- the most effective method of regional learning
- are assurances required
- is it already being considered as part of another process e.g. SAI, Complaint etc.

Where an organisation has indicated a Learning Notification requires immediate action, the Alerts office will seek confirmation from the Chair of SQAT or their nominated deputy if an immediate SQA is to be issued. If a decision is made not to issue an immediate SQA, feedback will be provided to the referring organisation.

If the Learning Notification has been determined as requiring an immediate SQA, the Chair of SQAT will assign a lead officer to develop the SQA for issue, in liaison with the Assistant Governance Manager and Chair of QSE or their nominated deputy.

The target for issuing an immediate SQA is 3 working days.

Each Trust / ALB / Special Agency is required to identify a first point of contact for queries regarding SQAs (Appendix 7 – Trust Contact points).

Appendix 8 illustrates the process used to submit learning to the HSCB/PHA

4.5 Alerts Relating to Independent Sector Providers and Primary Care Providers

Independent / primary care providers are required to respond to many types of Alerts covered by this procedure. The DoH or HSCB/PHA will send Alerts that they issue to RQIA for dissemination to relevant independent providers and to the HSCB Directorate of Integrated Care for dissemination to relevant primary care providers.

RQIA can also alert the HSCB/PHA of any regional learning they may identify in the discharge of their functions which would support improvement in the health and social care service, via a Learning Notification.

The HSCB Directorate of Integrated Care will alert the HSCB/PHA of any regional learning via the internal safety and quality structures within the HSCB/PHA.

4.6 Interface with other Safety/Quality-related organisations (not ALBs)

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 9), as required.

4.7 Process for Sharing Regional Learning from Northern Ireland with England, Wales, Scotland and Ireland

A process for sharing regional learning from Northern Ireland has been put in place whereby points of contact (named individuals) have been identified for England, Wales, Scotland and Ireland in the event of learning needing shared more widely. Arrangements have been established with NHS Improvement to allow participation in an observatory capacity on the monthly National Patient Safety Response Advisory Panel.

5.0 Process

5.1 Process prior to dissemination of SQAs

The Department of Health (DoH) issues a variety of correspondence collectively referred to as Safety Alerts. These are issued to service providers to identify those actions which providers should undertake to assure patient and client safety and best practice. The following describes the process prior to finalisation and dissemination of SQAs.

The DoH, HSCB and PHA share certain SQAs between their respective organisations for comment prior to dissemination to the HSC. These include:

- All Patient Safety Alerts (PSAs) issued by DoH;
- Learning Letters issued by PHA/HSCB.

For SQAs developed by the DoH these will be sent to the HSCB Alerts mailbox at Alerts.HSCB@hscni.net for issue to relevant health and social care professionals within HSCB and PHA, to seek comment prior to issue by the DoH to the HSC.

For SQAs developed by the PHA / HSCB these will be sent to the DoH Safety, Quality and Standards mailbox at qualityandsafety@health-ni.gov.uk for issue to relevant Policy Leads for review to ensure compatibility with DoH policy prior to issue by the HSCB/PHA.

At this stage the level of assurance may be also considered as outlined in section 5.3.

This approach is intended to ensure that the actions required of organisations are clear through a single communication.

5.2 Dissemination of SQAs

5.2.1 Dissemination of SQAs issued by DoH

SQAs from the DoH will be issued to the Chief Executive's office of relevant organisations, and copied to the HSCB/PHA Alerts mailbox at Alerts.HSCB@hscni.net, the first point of contact in Trusts for alerts, Governance Leads in Trusts and other relevant Directors of Trusts / ALBs / SAs.

5.2.2 Dissemination of Learning Letters/Reminder of Good Practice Letters issued by PHA/HSCB

When regional learning is identified a learning letter / reminder of good practice letter may be issued to the appropriate organisations for wider circulation, application of learning and where identified assurance that learning has been embedded.

These SQAs will be disseminated via the HSCB Alerts Office to the Chief Executive's office of relevant organisations, the first point of contact in Trusts for alerts, Governance Leads in Trusts and other and other relevant Directors of Trusts / ALBs / SAs using the standard distribution list. (see Appendix 10)

5.3 Process for Determining Assurances

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

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

If regional action is required, the proposed actions may be discussed where necessary with Trusts and/other relevant organisations to agree the precise task.

It is important to note that any regional actions do not in any way negate the responsibilities of Trusts or other organisations to take necessary actions to implement the Alert locally; immediate necessary action should not be delayed. However, it is recognised that some aspects of implementation may be more efficient, and may ensure a better outcome for patients, clients, staff and the public if they are developed in a standard way across the region.

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

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

Appendix 11 provides an overview of the HSCB/PHA Process for the Management of Safety and Quality Alerts.

5.3.1 Criteria for Identifying Regional Action and Assurance Levels

The PHA/HSCB SQA Team will determine the detail of the method of assuring implementation of an Alert. This will be proportionate to the assessed level of risk associated with the issue covered by the Alert. It will work on the principle of using existing systems of assurance as much as possible. Options for assurance methods include:

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

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

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

In making its decisions, the HSCB/PHA SQA Team will take account of:

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

5.3.2 Informing of Regional Action/Assurances Required

On completion of the processes outlined above, if regional action or assurance is required, the Chair of the Safety Quality Alerts Team will inform Trusts, primary care, and other relevant providers or stakeholders of the next steps or requirements. Communication will be to the Trust Chief Executive’s office, copied to the nominated Trust Governance Lead.

5.3.3 Reviewing Compliance of SQAs

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

In addition bi-annual progress reports to Governance Committee will be prepared by the SQA Team for the following:

- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports and equivalent robust other national enquiries/audits;

These reports will detail the progress on implementation of report recommendations and provide the necessary appropriate assurance mechanism that all HSCB/PHA actions contained within reports are implemented.

6.0 Annual Reporting of SQAs

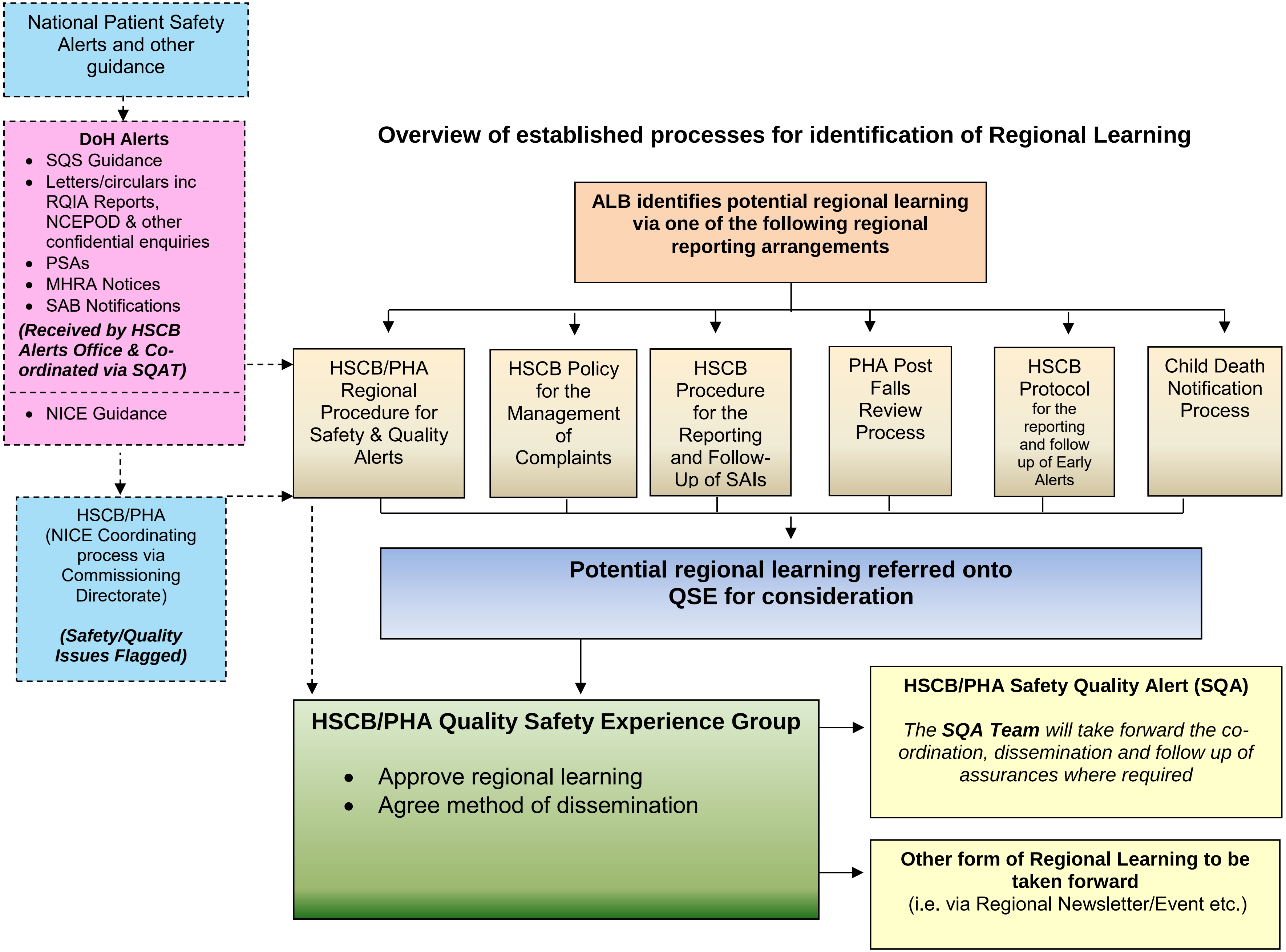
An annual report will also be prepared for the HSCB/PHA SQA Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board, DoH, Trusts and others as required.

7.0 Review of this procedure

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

Appendix 1

Overview of established processes for identification of Regional Learning



National Patient Safety Alerts and other guidance

DoH Alerts

- SQS Guidance
- Letters/circulars inc RQIA Reports, NCEPOD & other confidential enquiries
- PSAs
- MHRA Notices
- SAB Notifications

(Received by HSCB Alerts Office & Co-ordinated via SQAT)

- NICE Guidance

HSCB/PHA (NICE Coordinating process via Commissioning Directorate)

(Safety/Quality Issues Flagged)

ALB identifies potential regional learning via one of the following regional reporting arrangements

HSCB/PHA Regional Procedure for Safety & Quality Alerts

HSCB Policy for the Management of Complaints

HSCB Procedure for the Reporting and Follow-Up of SAIs

PHA Post Falls Review Process

HSCB Protocol for the reporting and follow up of Early Alerts

Child Death Notification Process

Potential regional learning referred onto QSE for consideration

HSCB/PHA Quality Safety Experience Group

- Approve regional learning
- Agree method of dissemination

HSCB/PHA Safety Quality Alert (SQA)

*The **SQA Team** will take forward the co-ordination, dissemination and follow up of assurances where required*

Other form of Regional Learning to be taken forward
(i.e. via Regional Newsletter/Event etc.)

Links to relevant procedures that link into the HSCB/PHA Regional Procedure for SQAs

Please click on the links below to access other relevant procedures/policies:

Procedure For the reporting and Follow Up of SAIs 2016

HSCB-PHA Protocol for the reporting and follow up of Early Alerts 2017

Falls Shared Learning Template

HSCB Policy for the Management of Complaints

Complaints in HSC - Standards and Guidelines for Resolution and Learning

DoH circular HSS(MD) 01 2016 - Process for Reporting Child Deaths

DoH circular - HSS(MD) 04 2017 - Process for Reporting Child Deaths

Appendix 2

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY
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.

The purpose of the Quality, Safety and Experience Group is 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. A diagrammatic overview of the Quality, Safety Experience Internal co-ordination arrangements for the PHA/HSCB is attached in annex 1.

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

Joint Chairs: **Director of Nursing, Midwifery and Allied Health Professionals;**

Director of Public Health/Medical Director;

Director of Performance and Corporate Services;

Director of Social Care;

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

Representative for General Medical Services/Safety and Quality;

Head of Pharmacy and Medicines Management;

Assistant Director of Public Health Medicine (Safety and Quality)

Clinical Director, Safety Forum;

Governance Manager;

Head of Nursing, Quality and Patient Safety;

Safety, Quality and Patient Experience Nurse, PHA;

Pharmacy Lead – Medicines Governance and Public Health;

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

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.

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Appendix 3

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY

TERMS OF REFERENCE

SAFETY AND QUALITY ALERTS TEAM (SQAT)

1.0 Introduction

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

The Safety and Quality Alerts Team (SQAT) was formed in April 2012 to co-ordinate the implementation of regional safety and quality alerts, letters and guidance. A subsequent procedure which outlines the management of the process was established and endorsed by the DoH in July 2013 and is reviewed on an annual basis.

4.0 Accountability of the Group

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

5.0 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.

6.0 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:

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services
- 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
- 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

7.0 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.

8.0 Administration

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

7.0 Relationship/Links with Other Groups

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

- HSCB / PHA Regional SAI Review Sub Group
- HSCB / PHA Regional Complaints Sub Group
- Patient and Client Experience Steering Group
- Promoting Good Nutrition Implementation Steering Group
- Regional Falls Prevention for Acute Services Group
- Regional Pressure Ulcer Prevention Advisory Group
- Regional Project Steering Group Evidencing Care through key nursing performance indicators
- Medicines Governance Advisors Groups
- Regional Child Protection Committee (RCPC)
- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board
- Medicines Safety Sub-Group (MSSG)

- PHA/HSCB SAI Professional Groups

8.0 Frequency of Meetings

Meetings of the Team will be fortnightly.

9.0 Review of Terms of Reference

The SQA Team will review its Terms of Reference on a biennial basis or earlier as required.

Appendix 4

LEARNING NOTIFICATION TEMPLATE

Subject / Learning	*Self- explanatory*			
Organisation / Trust	*Self- explanatory*			
Organisation / Trust ref no.	*Self- explanatory*			
Service Area / Speciality	*Self- explanatory*			
Contact Person	*Self- explanatory*			
Please indicate if the propsoed Regional Learning is considerded Immediate ***select as appropriate (✓)***	Yes		No	

SUMMARY OF EVENT

Guidance Notes:

Provide a ***brief factual description*** *of what has happened and a summary of the facts leading up to the event.*

Where relevant include D.O.B, Gender and Age. ***All should be anonymised*** *– the names of any practitioners or staff involved must* ***not*** *be included. Staff should only be referred to by job title.*

LOCAL ACTION TAKEN BY REPORTING ORGANISATION

Guidance Notes:

Based on the understanding of why the event happened and the identification of learning, outline the action(s), agreed and implemented locally within your organisation. This should include immediate and ongoing action.

REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA

Guidance Notes:
Please list learning points you feel should be considered by the HSCB/PHA to share regionally indicating the programmes of care where the learning is applicable.

Please refer to appendix 5 - 'Trigger tool for submission of a Learning Notification Template' to determine if regional learning should be issued i.e. is one or more of the following criteria met:

No.	**Criteria** ***select as appropriate (✓)***	**Yes**	**No**
1	New or under-recognised Risk identified.		
2	Action is outside the remit of the reporting organisation		
3	Likelihood of this happening again and the potential for harm has been identified;		
4	There is a requirement for more robust barriers to be developed for regional implementation;		
5	Relevant to a specialist service		

LEARNING SOURCE

Please identify the source of this proposed regional learning and any other relevant information as appropriate (✓)

Example of good practice		Audit or other review	
Adverse Incident (AI)		Coroner's inquest	
Mortality and Morbidity (M&MR)		Litigation Claim	
Patient Client Experience (PCE)		Incident trends	
Other (please specify below)			

Additional Information:

SUGGESTED METHOD OF REGIONAL LEARNING

If your organsiation has a suggested method for dissemination of the propsoed regional learning please select as appropriate and include narrative (✓)

Rapid / Immediate Alert		Learning Letter ***(new learning where there is no existing guidance or policy)***	
Reminder of Best Practice Guidance Letter ***(where there already is regional guidance or policy in place)***		Professional Letter	
Regional Newsletter Article i.e. Learning Matters / GMS / Med Safe Newsletter etc.		Existing Work stream or Network	
Propose Thematic Review		Establish a task and finish group	
Refer to other regulatory body		Training Event/ Workshop / Seminar	
ECHO videoconference session		Other	

Additional Information:

Approved by:	*This must be approved by the designated point of contact within your organisation for quality and safety communication.*
Designation:	*Self- explanatory*
Date approved:	*Self- explanatory*

Please note it remains the responsibility of your organisation to have undertaken your own risk assessment of the issue and steps to mitigate the risk in advance of any further regional advice.

On completion please submit to Alerts.HSCB@hscni.net

Appendix 5

TRIGGER TOOL FOR SUBMISSION OF A LEARNING NOTIFICATION TEMPLATE

This is an aide to Provider organisations when considering the submission of a Learning Notification.

The action we take as a result of what we learn from incidents/events is vital in protecting patients/clients across the HSC from harm and ensures we continue to improve the health and social care service.

To identify if a Learning Notification Template should be submitted to the HSCB/PHA for consideration of regional action the following criteria should be considered.

1. **New or under-recognised Risk** - Talk to experts, patients and their families, and frontline staff to confirm the risk is **new or under-recognised**; these groups may have different perspectives.

2. **Outside the remit of the reporting organisation** - Check whose **remit** an issue falls under, as some aspects of patient safety are handled by other organisations and can be passed to them for action.

3. **Likelihood of this happening again and the potential for harm** - Look for up-to-date detail about the issue, research studies and other published material, and seek advice from specialists and frontline staff to help identify the **likelihood of this happening again and the potential for harm**.

4. **Requirement for more robust processes to be developed for regional implementation**- Explore whether organisations can do something more **constructive** than simply raising awareness and warning people to be vigilant against error, and the options for these actions (including interim actions while more robust barriers to error are developed).

5. **Relevant to a specialist service** - If your Trust is responsible for a s**pecialist service**, it is still important to report any safety concerns in order to identify potential regional learning across the system.

Note: The above trigger list has been based on the NHS Improvement Patient Safety Review and Response Report (April to September 2017) which has been adopted for the purposes of this procedure.

Submission of a Learning Notification

Each notification must be submitted by the agreed point of contact within each organisation (see appendix 4) and sent to Alerts.HSCB@hscni.net

Appendix 6

TRIGGER TOOL FOR THE ISSUE OF A HSCB/PHA REGIONAL SAFETY AND QUALITY ALERT

This aid is used by the HSCB/PHA in the decision making process for issuing a Safety Quality Alert (SQA). A SQA is typically issued to make providers organisations aware of and share any substantial new regional learning that will help to improve patient/client safety or to share or remind of best practice guidance.

The HSCB/PHA consider the following questions before planning or issuing a SQA:

By issuing a SQA will it…		**Why is this important?**
	Address an issue that causes, or has potential to cause, severe harm or death or significantly improve care?	This helps providers implement improvement or target resources where they are most needed.
	Detail new learning, or will it include some new or under-recognised content?	SQAs have their greatest impact if they are part of an overall plan to support uptake and implementation of improvement.
	Reinforce information published by one or more national bodies, professional or patient organisations or networks, bearing their logo and hosted on their website?	This ensures the SQAs are developed with the necessary specialist expertise to give them credibility, and ensures they remain updated.

↗	Be substantial, in relation to a patient/client safety issue or area of good practice?	This question relates to whether the SQA addresses a substantial part of a patient/client safety or improvement issue.
🔧	Practical and helpful?	SQAs must support Provider organisations to improve their services.
⚠	Focused on patient/client safety or a key aspect of improvement?	Public health messages and other aspects of quality (such as clinical effectiveness guidelines from the National Institute for Health and Care Excellence (NICE), have their own communication routes.
🛡	Relevant to most health and social care providers	If SQAs apply only to a specialist service provided by the minority of providers in a sector, their communication can be directly targeted instead.

Note: If a decision is reached not to issue a SQA, learning can also be shared through the other identified routes:

- Newsletter article
- Learning Event
- Thematic Review/Audit
- Shared with an existing network/forum
- Establish a Task and Finish Group

Once it has been determined to issue a SQA it is important to ensure the actions are specific and defined. Therefore the HSCB/PHA should consider the following:

Are the actions:		**Why is this important?**
	Developed and tested to the point we can be confident are the sole or best current approach to improving safety, are practical and do not introduce new risks?	In complex health and social care systems, even with the best possible proactive risk assessment, a change that is expected to make an improvement can have unintended effects.
	Provides an effective barrier to error **or** requires standardisation to a single consistent approach across the HSC?	Where no strong or moderately strong barrier has been identified to avoid error addressing less serious issues can be shared through other routes.
	Acceptable without wider public consultation?	For actions where the HSCB/PHA is concerned about adverse impacts or costs, or has conflicting views on which of two or more current approaches to adopt as standard, a wider public consultation may be needed.
	Relevant to most health and social care providers?	If the actions apply only to a specialist service provided by the minority of providers in a sector, their communication can be directly targeted instead.
	Is the cost proportionate to the reduction in harm the actions can be expected to achieve?	Calculating the scale and cost of current harm and the impact of the intervention is not straightforward for most patient safety issues, but we work within the principles of cost per year of quality-adjusted life used by NICE, so that finite NHS resources are directed at the patient safety issues where they have the greatest impact. For some issues, potential to reduce costs of litigation may also need to be factored in.

Note: The above trigger list has been based on the NHS Improvement Patient Safety Review and Response Report (April to September 2017) which has been adopted for the purposes of this procedure.

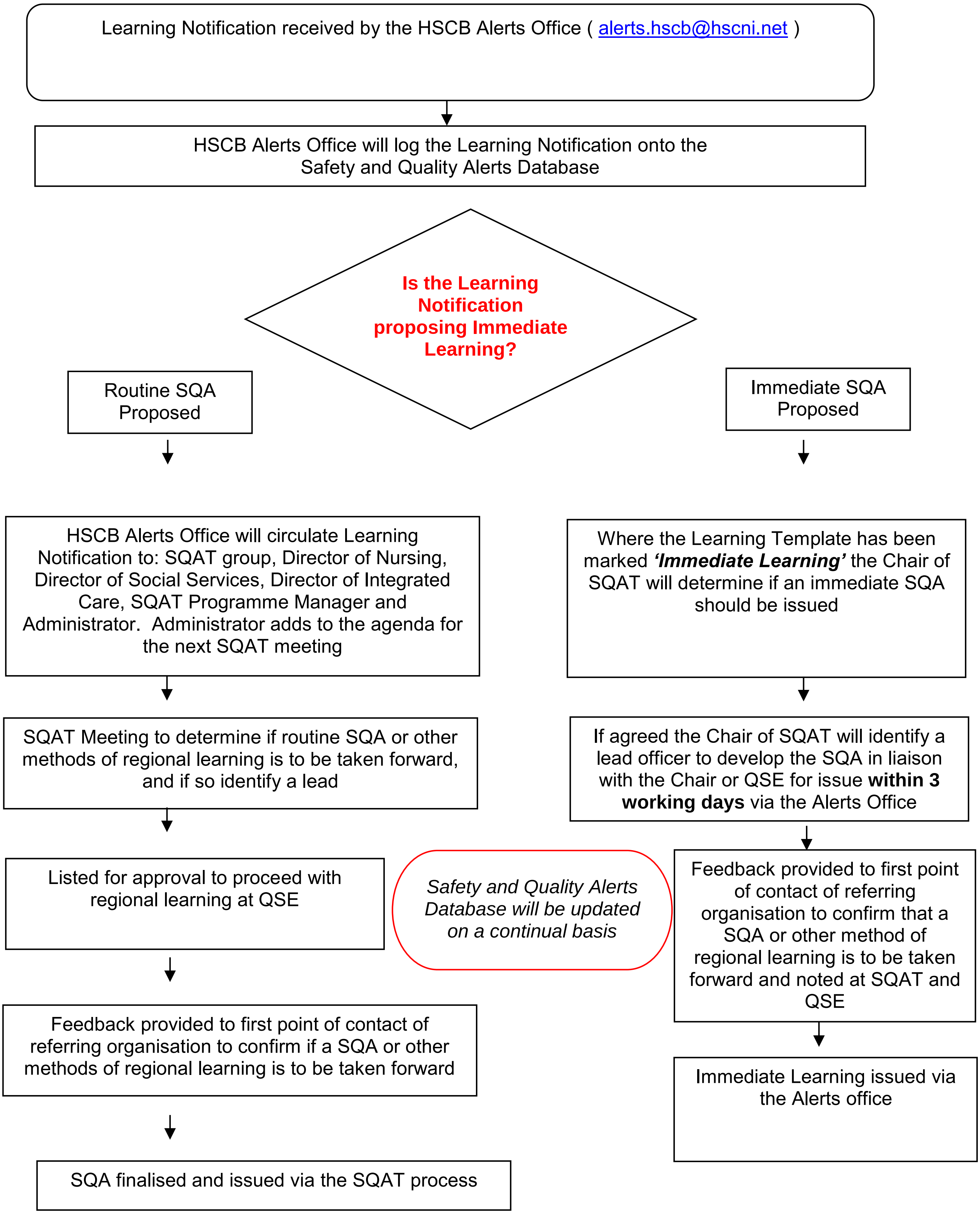
Appendix 7

HSC Trust Contacts

HSC Trust	Medical Director	Governance Lead	SQA First Point of Contact	Contact point for responses to assurances
BHSCT	Dr Cathy Jack	Claire Cairns	trusthq@belfasttrust.hscni.net	Jill Shaw O'Doherty **Copy:** • Martine McNally • trusthq@belfasttrust.hscni.net
NHSCT	Mr Seamus O'Reilly	Sinead O'Kane	Ruth McDonald **Copy:** quality.safety@northerntrust.hscni.net	Ruth McDonald **Copy:**quality.safety@northerntrust.hscni.net
SEHSCT	Dr Charlie Martyn	Irene Low	Liz Campbell **Copy:** Irene Low Linda Kelly	Liz Campbell **Copy:** Irene Low Linda Kelly
SHSCT	Dr Ahmed Khan	Margaret Marshall	Nicole O'Neill **Copy:** • StandardsAndGuidelines@southerntrust.hscni.net • Caroline Beattie	Nicole O'Neill **Copy:** • StandardsAndGuidelines@southerntrust.hscni.net • Caroline Beattie
WHSCT	Dr Dermot Hughes	Therese Brown	Therese Brown	Teresa Murray
NIAS	Dr Nigel Ruddell	Katrina Keating	Katrina Keating **Copy:** • Dr Nigel Ruddell	Katrina Keating **Copy:** • Dr Nigel Ruddell

Appendix 8

HSCB/PHA Internal Process for Managing Learning Notifications from HSC Trusts & other ALBs



Learning Notification received by the HSCB Alerts Office (alerts.hscb@hscni.net)

HSCB Alerts Office will log the Learning Notification onto the Safety and Quality Alerts Database

Is the Learning Notification proposing Immediate Learning?

Routine SQA Proposed

HSCB Alerts Office will circulate Learning Notification to: SQAT group, Director of Nursing, Director of Social Services, Director of Integrated Care, SQAT Programme Manager and Administrator. Administrator adds to the agenda for the next SQAT meeting

SQAT Meeting to determine if routine SQA or other methods of regional learning is to be taken forward, and if so identify a lead

Listed for approval to proceed with regional learning at QSE

Feedback provided to first point of contact of referring organisation to confirm if a SQA or other methods of regional learning is to be taken forward

SQA finalised and issued via the SQAT process

Safety and Quality Alerts Database will be updated on a continual basis

Immediate SQA Proposed

Where the Learning Template has been marked ***'Immediate Learning'*** the Chair of SQAT will determine if an immediate SQA should be issued

If agreed the Chair of SQAT will identify a lead officer to develop the SQA in liaison with the Chair or QSE for issue **within 3 working days** via the Alerts Office

Feedback provided to first point of contact of referring organisation to confirm that a SQA or other method of regional learning is to be taken forward and noted at SQAT and QSE

Immediate Learning issued via the Alerts office

Note: This appendix should be read in conjunction with the flow chart in appendix 11

Appendix 9

Safety Quality Alerts Team Membership and Links with other Safety/Quality-related organisations

HSCB/PHA Safety Quality Alerts Team Membership

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services, HSCB
- Assistant Director Nursing, Safety & Quality & Patient Experience, PHA
- Safety, Quality and Patient Experience Nurse, PHA
- Assistant Director Service Development & Screening, PHA
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care (Head of GMS) HSCB - when required
- Social Care and AHP input for Alerts relevant to those professions
- Assistant Governance Manager, Safety and Quality, HSCB

SQA Team Roles

- Chair – Dr Carolyn Harper
- Lead Performance – Lisa McWilliams
- Lead Nurse – Mary McElroy / Christine Armstrong
- Lead Service Development & Screening – Dr Brid Farrell
- Lead Pharmacist – Matthew Dolan
- Lead Public Health Doctor / Safety Forum – Dr Jackie McCall
- Lead AHP – through Michelle Tennyson
- Lead GP – Dr Margaret O’Brien
- Lead Social Worker – through Cecil Worthington
- Assistant Governance Manager / Programme Manager – Margaret McNally
- Admin Support – Christine Thompson / Elaine Hyde

Link as required with the following **Safety/Quality-related organisations**

- NI Social Care Council
- Safeguarding Board NI
- NI Adult Safeguarding Partnership
- Trust Leads for professional education
- Under and postgraduate training bodies
- NIAC, DoH
- NHS Improvement
- Healthcare Improvement Scotland
- NHS Wales
- Health Service Executive, RoI

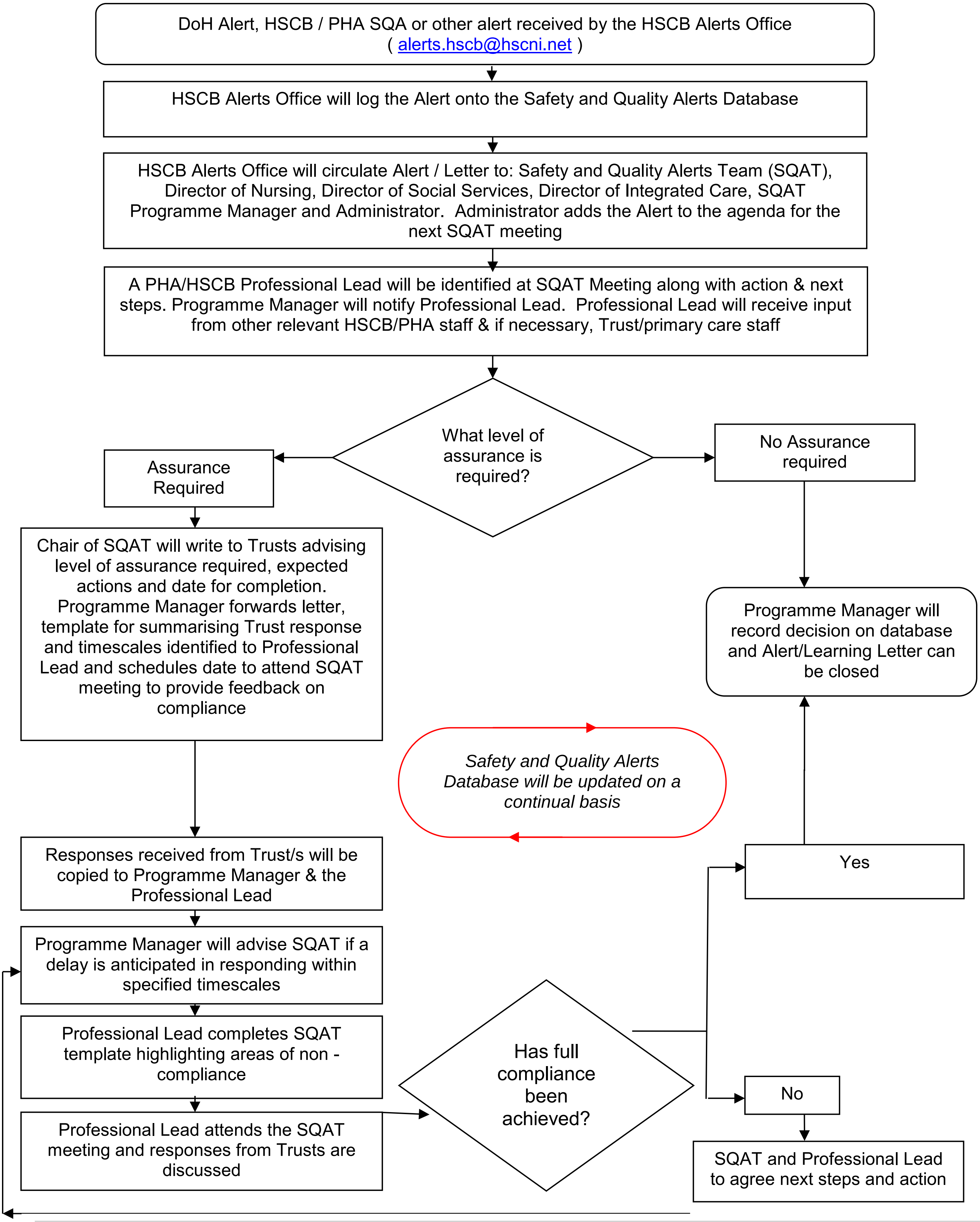
Template Distribution List

Appendix 10

	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		
Directors of Human Resources			Clinical Director Safety Forum		
NIAS			**HSCB**		
CEX			CEX		
Medical Director			Director of Integrated Care		
RQIA			Director of Social Services		
CEX			Director of Commissioning		
Director of Quality Improvement			Alerts Office		
Director of Quality Assurance			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			**BSO**		
Head of Social Work School			Director of Human Resources		
Head of Pharmacy School			**Open University**		
Head of Dentistry School			Head of Nursing Branch		
UU			**DoH**		
Head of Nursing School			CMO office		
Head of Social Work School			CNO office		
Head of Pharmacy School			CPO office		
Head of School of Health Sciences (AHP Lead)			CSSO office		
Clinical Education Centre			CDO office		
NIPEC			Safety, Quality & Standards Office		
NICPLD			**NI Social Care Council**		
NI Medicines Governance Team Leader for Secondary Care			**Safeguarding Board NI**		
Coroners Service for Northern Ireland			**NICE Implementation Facilitator**		

Appendix 11 BW/113

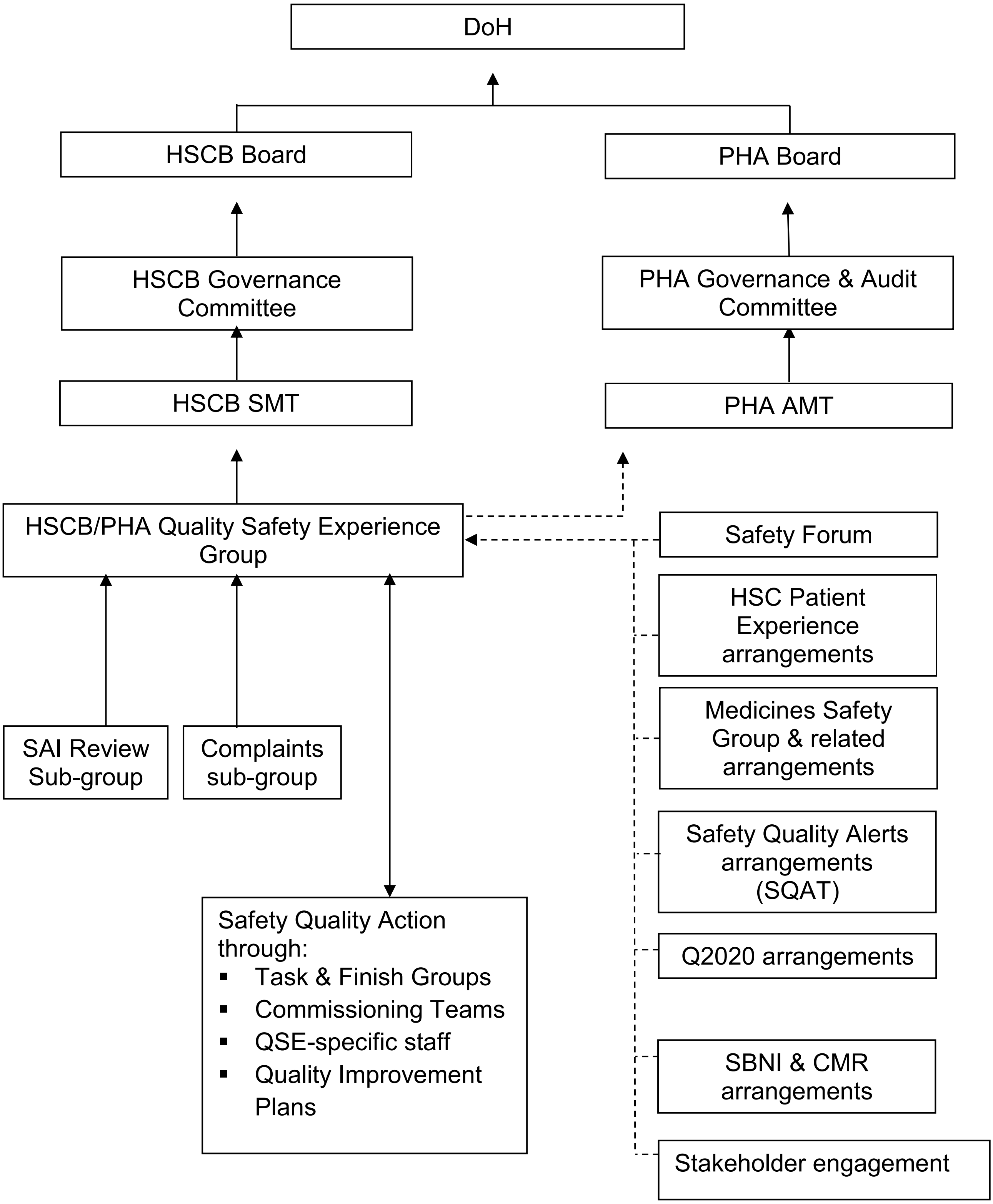
HSCB/PHA Internal Process for the Management of Safety and Quality Alerts



Note: Category 2 Alerts are not automatically listed for SQAT meetings. These are received and logged by the Alert Office. The Lead Public Health Doctor/Safety Forum reviews these on receipt and escalates to SQAT as required.

Annex 1

Diagrammatic Overview of Quality Safety Experience Internal Coordination Arrangements – HSCB/PHA



HSCB/PHA Protocol for Implementation of Safety Alerts

27 June 2012

Introduction

1. This protocol describes the process which the Health and Social Care Board (HSCB) and Public Health Agency (PHA) will use with Health and Social Care (HSC) Trusts, and primary care providers to implement Safety Alerts and equivalent correspondence issued by the Department of Health Social Services and Public Safety (DHSSPS). It will apply to relevant correspondence issued since 1 April 2012. It is summarised in Appendix 1.

Context

2. Safety Alerts come from a variety of sources to the HSCB, PHA, Trusts and primary care providers. The volume of alerts is challenging for providers and commissioners to manage; some alerts relate to substantive safety issues that require a high level of assurance, while others relate to risk which can be managed within existing risk management and clinical governance arrangements; staff resource capacity and clinical quality measurement systems in providers and commissioners are limited; and for some actions, it is more efficient to have one regional process, rather than each provider taking action individually.

3. This protocol was designed in that context.

Scope

4. This protocol covers Safety Alerts and equivalent correspondence as outlined below.

Category 1

5. Category 1 Safety Alerts include
   - Safety Quality & Standards (SQS) guidance and letters
   - SQS Learning Letters, SAI learning letters
   - NPSA alerts, or equivalent; these may come through SABS
   - Safety or quality-related professional letters from DHSSPS.

Category 2

6. Category 2 Safety Alerts include
   - MHRA notices
   - SABS (Safety Alert Broadcast System) notifications
   - Drug alerts and recalls
   - Medical staff alerts
   - Nursing staff alerts.

Dissemination of Alerts

7. DHSSPS issues Safety Alerts and equivalent correspondence to HSC organisations; some of these require an assurance template to be completed and returned to the HSCB.

HSCB Central Coordinating Office

8. From 1 April 2012, Safety Alerts and equivalent correspondence will be logged by a central coordinating office (CCO) managed by HSCB Corporate Services under the Head of Corporate Services. The Medical Director/DPH will send relevant correspondence to the CCO for logging. The central coordinating office (CCO) will maintain a system to track receipt, follow-up arrangements, progress on implementation and other key information. The CCO will also provide regular summary reports for the HSCB/PHA Safety Quality Alerts Team, SMT, LCG Chairs, HSCB Governance Committee, Board and others as required.

9. A Programme Manager will oversee the process and amongst other duties, will maintain an up-to-date log, prepare for and support team meetings, and prepare an annual summary. They will be supported by a Database Officer who will enter information in the database and produce reports. A lead public health doctor and nurse will act as the first points of contact for the Programme Manager on professional and other issues relevant to the overall process. The CCO will liaise closely with the Administrative support to the Safety and Quality Alerts Team.

HSCB/PHA Safety Quality Alerts Team

10. HSCB and PHA will manage arrangements for the implementation and assurance of Category 1 Safety Alerts through the Safety Quality Alerts Team (SQAT).

11. The Team will include HSCB & PHA representatives from professional groups, and Corporate Services (Appendix 2). 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.

Regional Alerts Group

12. To ensure input from Trusts and other key groups with a role in safety and quality the Team will work closely with named professional and governance points of contact in each Trust. Trust points of contact will be at Associate Medical Director or Medical Director level. Trust points of contact, the chair of the Trust Collaborative Group, and the HSCB/PHA Safety Alerts Team, will form a Regional Alerts Group (RAG).

13. The Regional Group will provide a forum to
    a. Obtain clinical input to determine the nature and timescale of any regional action
    b. Agree which organisation should lead on a task for the region, with input from relevant others

14. The Regional Group may meet in person and/or work virtually. The Regional Group will be in place for as long as Trusts support it and take an active role in taking forward actions for the region.

Interface with other Safety/Quality-related organisations

15. The HSCB/PHA Team and/or the Regional Safety Quality Alerts Group will seek input from training bodies, GAIN, Business Support Organisation, Health Estates, RQIA and others as required to ensure coordinated action.

Process for Determining Appropriate Arrangements

16. Category 1 Alerts will be reviewed by the professional leads on the Safety Quality Alerts Team to make an initial determination on
    a. Whether or not regional action is required to assist Trusts or primary care, and
    b. The nature of the assurance required regarding implementation.

17. 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.

18. If regional action is required, the proposed actions will be discussed with the Regional Safety Quality Alerts Group and/other relevant organisations to agree the precise action(s) required. 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 and 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 if they are developed in a standard way across the region. Training modules, audit tools, 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.

19. To take forward work for the region, the principle of using existing systems as much as possible, will apply. However, if necessary, the Regional Group may set up a Task and Finish Group. Work done for the region would be led by one organisation and then agreed by all relevant parties; this will assist all Trusts in meeting their responsibilities while making efficient use of staff time.

20. Category 2 Alerts will be implemented primarily through existing systems. If, on occasions, explicit assurance or other action is required, it will be identified by the Safety Quality Team and described to Trusts and primary care providers as outlined for Category 1 Alerts.

Criteria for Regional Action and Assurance Levels

21. 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, including those with a requirement by DHSSPS for completion of an assurance template. 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
    a. Level 1 – material risks which cannot be managed within normal Trust governance and safety arrangements e.g. SAI systems
    b. 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
    c. Level 3 – completion of an audit specified by HSCB/PHA.

22. 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
    a. The risk to an individual patient is high (impact)
    b. The number of patients who may be exposed to the risk is high (likelihood)
    c. Aspects of implementation are complex and outwith the control of Trusts or relevant organisations (complexity)
    d. A regional approach is achievable (deliverability & stakeholder agreement)
    e. Regional action will not introduce undue delay (timeliness)

f. The Alert relates to an issue with a high public/political profile (public confidence)
g. Other reasons (professional judgment).

23. In making its decisions, the Team will take account of
    - Other Alerts relating to the clinical area in question
    - Common themes within a range of Alerts
    - Learning from SAIs
    - Existing safety quality initiatives for example, through the Safety Forum, the Trusts' Collaborative Group, and the Medicines Safety Subgroup
    - Other relevant initiatives, for example, by GAIN, RQIA, NIMDTA, NIPEC, undergraduate training bodies for health and social care staff.

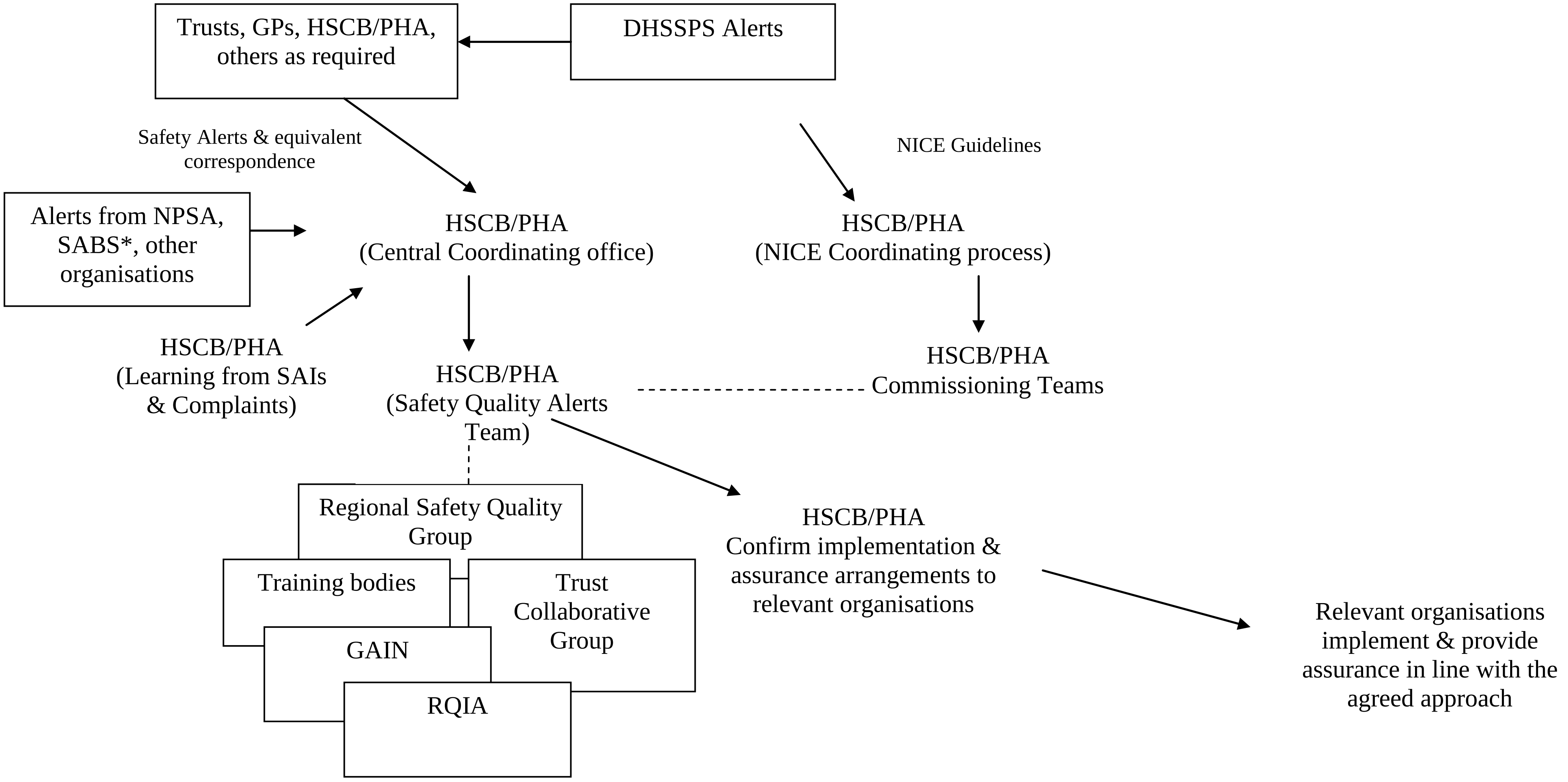
Informing Trust and Primary Care of the Outcome

24. On completion of the processes outlined above, the HSCB will inform Trusts, primary care and other relevant providers or stakeholders of the next steps or requirements. Communication with Trusts will typically be from the HSCB/PHA Medical Director to the Trust Chief Executive's office, copied to the Trust Medical Director.

25. This protocol will be tested and refined in light of experience.

HSC System for Managing Safety and Quality Alerts – Structural Overview

Appendix 1



** All SABs notifications will be reviewed by a PHA Consultant and those requiring action will be discussed at the Safety and Quality Alerts Team*

Membership **Appendix 2**

HSCB/PHA Safety Quality Alerts Team

- Medical Director/DPH, PHA (Chair)
- Assistant Director Nursing, Safety & Quality & Patient Experience
- Assistant Director Service Development & Screening
- General Practice, HSCB
- Pharmacy, HSCB
- Commissioning, HSCB
- Public Health, PHA
- Nursing, PHA
- Central Coordinating Office, HSCB
- Safety Forum, PHA
- As necessary, social care and AHP input

SAQ Team Roles

- Lead Public Health Doctor – Jackie McCall
- Lead Nurse – Mary McElory
- Lead Pharmacist – Brenda Bradley
- Lead GP – Zara Mayne
- Programme Manager – Elaine Hamilton
- Admin Support – Christine Thompson

Regional Alerts Group

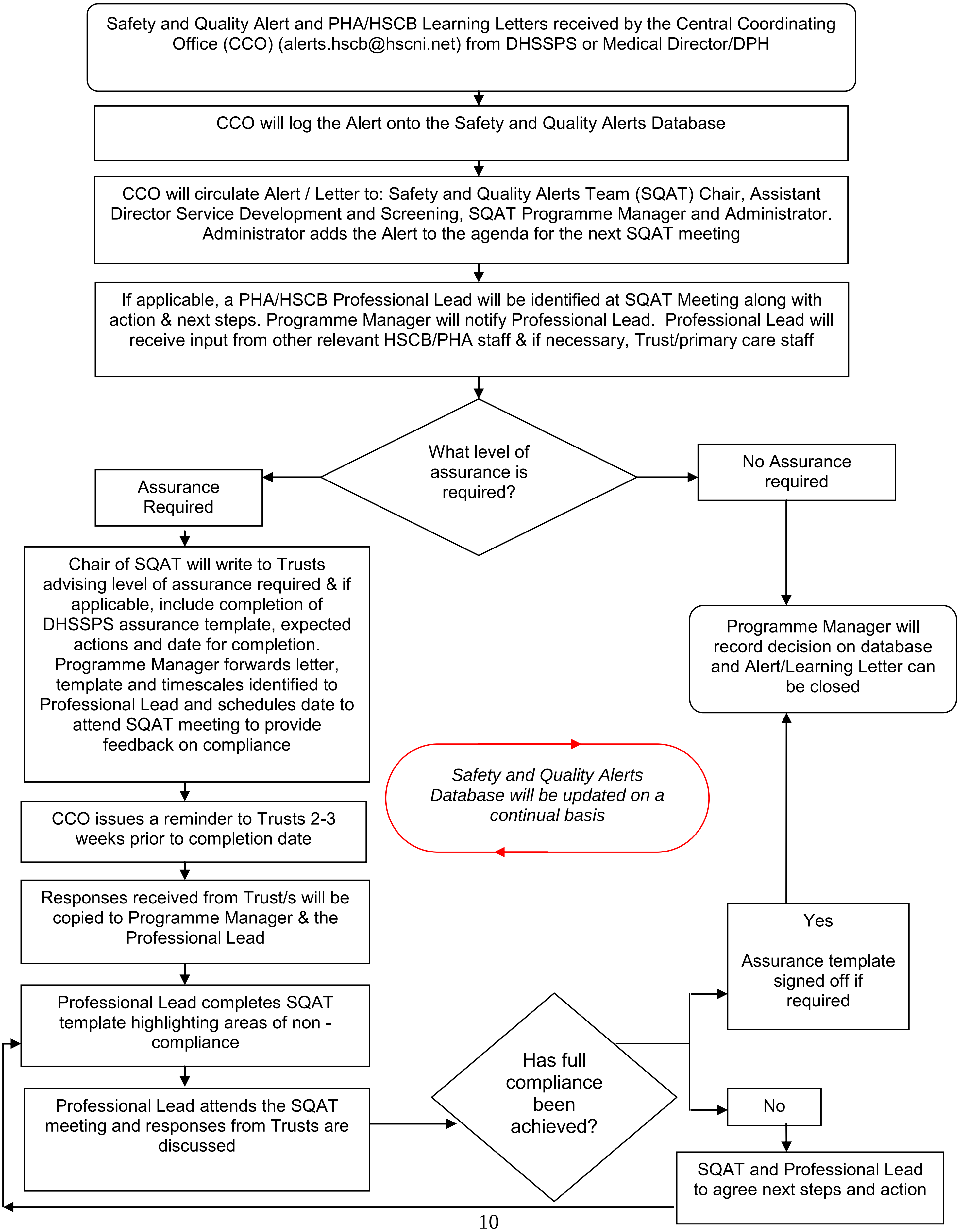
- HSCB/PHA Safety Quality Alerts Team
- Named leads in each of the HSC Trusts & NIAS
- Chair of the Trust Collaborative Group
- Trust points of contact
    - Belfast – Dr. Julian Johnston and June Champion
    - South East – Dr. David Hill and Linda Kelly
    - Southern – Dr. John Simpson and Debbie Burns/Caroline Beattie
    - Northern – Dr Jim Carson and Hazel Baird
    - Western – TBC

Link as required with

- Named PCP Clinical lead in each of the LCG areas
- Trust Leads for medical education
- NIMDTA
- NIPEC
- Undergraduate training bodies
- GAIN
- RQIA
- BSO Procurement
- Health Estates, DHSSPS

Appendix 3

HSCB/PHA Process for the Management of Safety and Quality Alerts



Safety and Quality Alert and PHA/HSCB Learning Letters received by the Central Coordinating Office (CCO) (alerts.hscb@hscni.net) from DHSSPS or Medical Director/DPH

CCO will log the Alert onto the Safety and Quality Alerts Database

CCO will circulate Alert / Letter to: Safety and Quality Alerts Team (SQAT) Chair, Assistant Director Service Development and Screening, SQAT Programme Manager and Administrator. Administrator adds the Alert to the agenda for the next SQAT meeting

If applicable, a PHA/HSCB Professional Lead will be identified at SQAT Meeting along with action & next steps. Programme Manager will notify Professional Lead. Professional Lead will receive input from other relevant HSCB/PHA staff & if necessary, Trust/primary care staff

What level of assurance is required?

Assurance Required

No Assurance required

Chair of SQAT will write to Trusts advising level of assurance required & if applicable, include completion of DHSSPS assurance template, expected actions and date for completion. Programme Manager forwards letter, template and timescales identified to Professional Lead and schedules date to attend SQAT meeting to provide feedback on compliance

Programme Manager will record decision on database and Alert/Learning Letter can be closed

Safety and Quality Alerts Database will be updated on a continual basis

CCO issues a reminder to Trusts 2-3 weeks prior to completion date

Responses received from Trust/s will be copied to Programme Manager & the Professional Lead

Professional Lead completes SQAT template highlighting areas of non - compliance

Professional Lead attends the SQAT meeting and responses from Trusts are discussed

Has full compliance been achieved?

Yes

Assurance template signed off if required

No

SQAT and Professional Lead to agree next steps and action

HSCB/PHA Protocol for Implementation of Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: 23 August 2013

Introduction

1. 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.

Context

2. 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.

3. This protocol was designed in that context.

Scope of Safety Quality Alerts (SQAs)

4. 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. A separate process is in place for NICE guidance. Appendix 1 gives a

schematic overview of the interfaces between this process and the process for NICE guidance.

Category 1

5. Category 1 SQAs include
   - DHSSPS Safety Quality & Standards (SQS) guidance and letters
   - Learning Letters arising from serious adverse incidents (SAIs)
   - National Patient Safety Agency (NPSA) alerts, or equivalent
   - Safety or quality-related professional letters from DHSSPS
   - RQIA Reports and other independent reviews.

Category 2

6. Category 2 Safety Alerts include
   - Medicines and Healthcare products Regulatory Agency (MHRA) notices
   - Safety Alert Broadcast System (SABS) notifications
   - Drug alerts and recalls
   - Professional alerts regarding individual practitioners.

Dissemination of Safety Quality Alerts (SQAs) issued by DHSSPS

7. 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.

8. DHSSPS will issue SQAs that do not have an assurance loop directly to relevant organisations.

9. 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.

HSCB Central Coordinating Office

10. SQAs where Trusts or the independent sector have a primary role in implementation will be logged by a central coordinating office (CCO) managed by HSCB Corporate Services. The central coordinating office (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.

11. A Programme Manager will oversee the process, maintain an up-to-date log, prepare for and support team meetings, and prepare an annual report. They will be supported by a Database Officer, Administrative Officer, and members of the Safety Quality Alerts Team.

HSCB/PHA Safety Quality Alerts Team

12. 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 lead Directors (Director of Nursing and Allied Health Professionals, and the Director of Social Services, respectively).

13. 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.

Trust Input

14. 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).

Interface with other Safety/Quality-related organisations

15. 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.

Process for Determining Appropriate Arrangements

16. Category 1 Alerts will be reviewed by the Safety Quality Alerts Team to make an initial determination on
    a. Whether or not regional action is required to assist Trusts or primary care with implementation, and
    b. The nature of the assurance required regarding implementation.

17. 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.

18. If regional action is required, the proposed actions will be discussed 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.

19. 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.

20. 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.

Criteria for Regional Action and Assurance Levels

21. 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
    a. Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements
    b. 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
    c. Level 3 – completion of an audit specified by HSCB/PHA.

22. 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
    a. The risk to an individual patient, client, staff member or member of the public, is high (impact)

b. The number of patients, clients, staff or public who may be exposed to the risk is high (likelihood)
c. Aspects of implementation are complex and outwith the control of Trusts or relevant organisations (complexity)
d. A regional approach is achievable (deliverability & stakeholder agreement)
e. Regional action will not introduce undue delay (timeliness)
f. The Alert relates to an issue with a high public/political profile (public confidence)
g. Other reasons (professional judgment).

23. 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.

Informing Trusts and Primary Care of the Outcome

24. 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.

Alerts Relating Solely to Primary Care Providers

25. Some Alerts relate solely to primary care providers. The Directorate of Integrated Care has arrangements in place to disseminate, monitor and assure implementation of those Alerts. Those arrangements will continue, and the Director of Integrated Care will report separately on those Alerts to the HSCB Senior Management Team, Governance Committee and Board.

Alerts Relating to Independent Sector Providers

26. Independent providers are already required to respond to many of the types of Alerts covered by this protocol. In addition, DHSSPS or

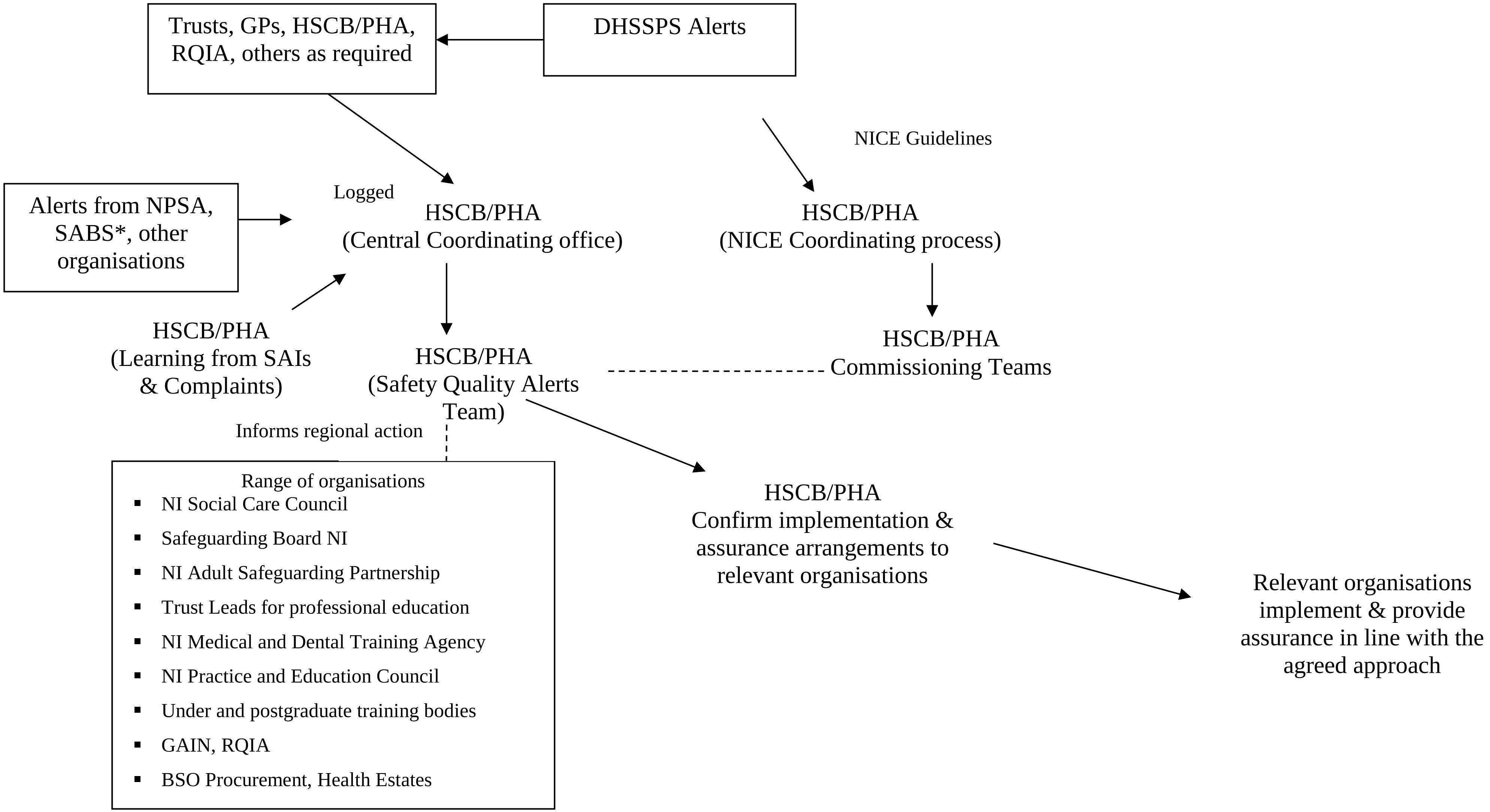
HSCB/PHA will send Alerts that they issue to RQIA for dissemination to relevant independent providers. DHSSPS also agree the annual work programme of RQIA which may include reviews of governance systems in independent providers, and/or assurance on implementation of specific SQAs.

Review of this protocol

27. This protocol will be refined on an ongoing basis and not less than annually.

HSC System for Managing Safety and Quality Alerts – Structural Overview

Appendix 1



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		
NIAS			AD Nursing		
CEX			AD Allied Health Professionals		
Medical Director			Clinical Director Safety Forum		
RQIA			**HSCB**		
CEX			CEX		
Medical Director			Director of Integrated Care		
Director of Nursing			Director of Social Services		
Director for Social Care			Director of Commissioning		
NIMDTA			Alerts Office		
CEX / PG Dean			Dir PMSI & Corporate Services		
QUB			**Primary Care (through Integrated Care)**		
Dean of Medical School			GPs		
Head of Nursing School			Community Pharmacists		
Head of Social Work School			Dentists		
Head of Pharmacy School			**Open University**		
Head of Dentistry School			Head of Nursing Branch		
UU			**DHSSPS**		
Head of Nursing School			CMO office		
Head of Social Work School			CNO office		
Clinical Education Centre			CPO office		
NI Social Care Council			CSSO office		
Safeguarding Board NI			**NIPEC**		
			Chief Executive		

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
- General Practice, HSCB
- Pharmacy, HSCB
- Public Health, PHA
- Nursing, PHA
- Central Coordinating Office, HSCB
- Safety Forum, PHA
- Social care and AHP input for Alerts relevant to those professions

SAQ 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 – Zara Mayne
- Programme Manager – Elaine Hamilton
- Admin Support – Christine Thompson

Trust Governance Lead Contacts

- Belfast – Dr Julian Johnston and June Champion
- South East – Dr David Hill and Linda Kelly
- Southern – Dr John Simpson and Debbie Burns/Caroline Beattie
- Northern – Dr Jim Carson and Suzanne Pullins
- Western – Dr Alan McKinney

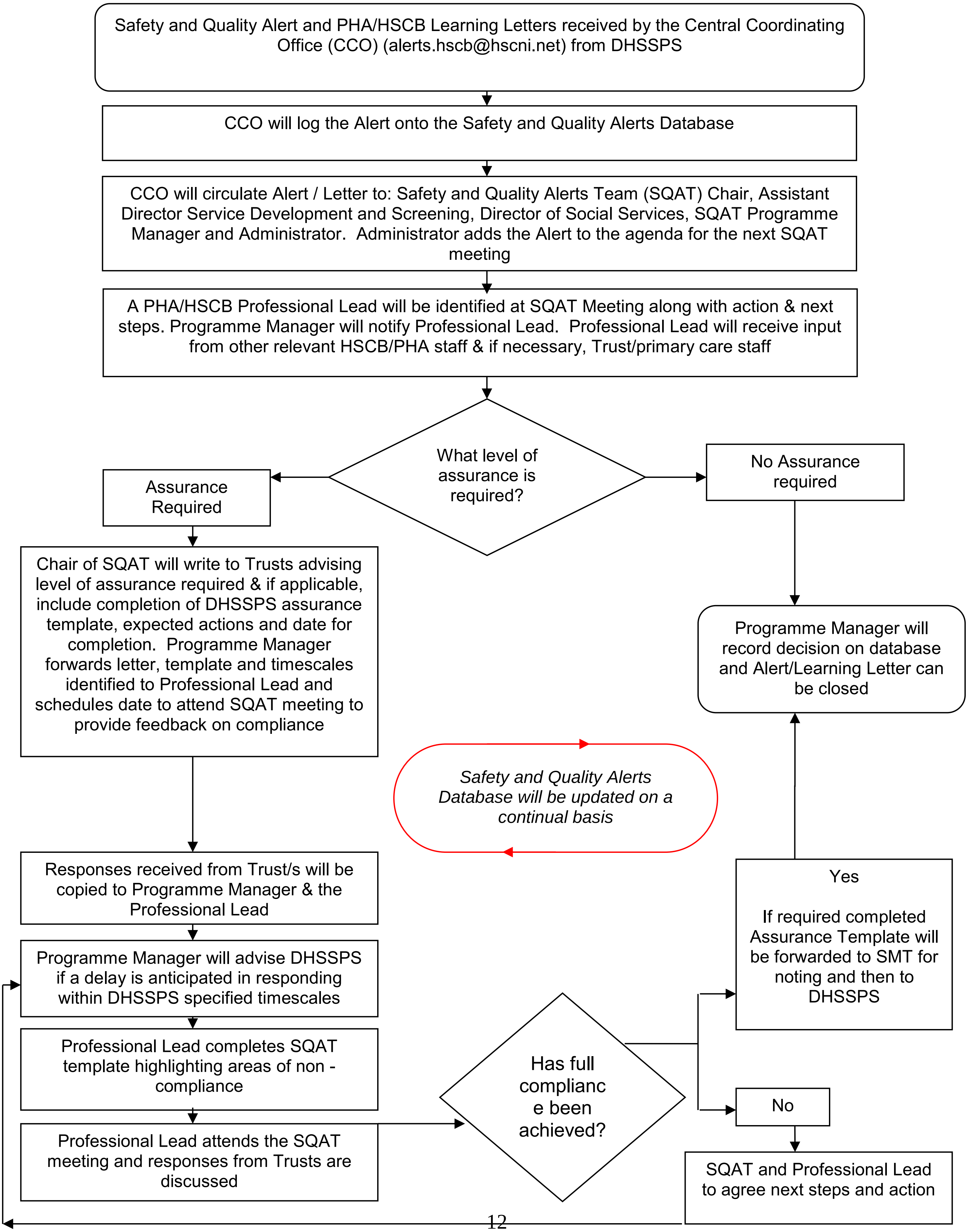
Link as required with

- 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



Safety and Quality Alert and PHA/HSCB Learning Letters received by the Central Coordinating Office (CCO) (alerts.hscb@hscni.net) from DHSSPS

CCO will log the Alert onto the Safety and Quality Alerts Database

CCO will circulate Alert / Letter to: Safety and Quality Alerts Team (SQAT) Chair, Assistant Director Service Development and Screening, Director of Social Services, SQAT Programme Manager and Administrator. Administrator adds the Alert to the agenda for the next SQAT meeting

A PHA/HSCB Professional Lead will be identified at SQAT Meeting along with action & next steps. Programme Manager will notify Professional Lead. Professional Lead will receive input from other relevant HSCB/PHA staff & if necessary, Trust/primary care staff

What level of assurance is required?

Assurance Required

Chair of SQAT will write to Trusts advising level of assurance required & if applicable, include completion of DHSSPS assurance template, expected actions and date for completion. Programme Manager forwards letter, template and timescales identified to Professional Lead and schedules date to attend SQAT meeting to provide feedback on compliance

Responses received from Trust/s will be copied to Programme Manager & the Professional Lead

Programme Manager will advise DHSSPS if a delay is anticipated in responding within DHSSPS specified timescales

Professional Lead completes SQAT template highlighting areas of non - compliance

Professional Lead attends the SQAT meeting and responses from Trusts are discussed

Has full compliance been achieved?

Yes

If required completed Assurance Template will be forwarded to SMT for noting and then to DHSSPS

No

SQAT and Professional Lead to agree next steps and action

No Assurance required

Programme Manager will record decision on database and Alert/Learning Letter can be closed

Safety and Quality Alerts Database will be updated on a continual basis

HSCB/PHA Protocol for Implementation of Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: 28 May 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.

For learning letters prior to issue the Central Co-ordinating Office (CCO) (see section 6.0) will forward the draft Learning Letter 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

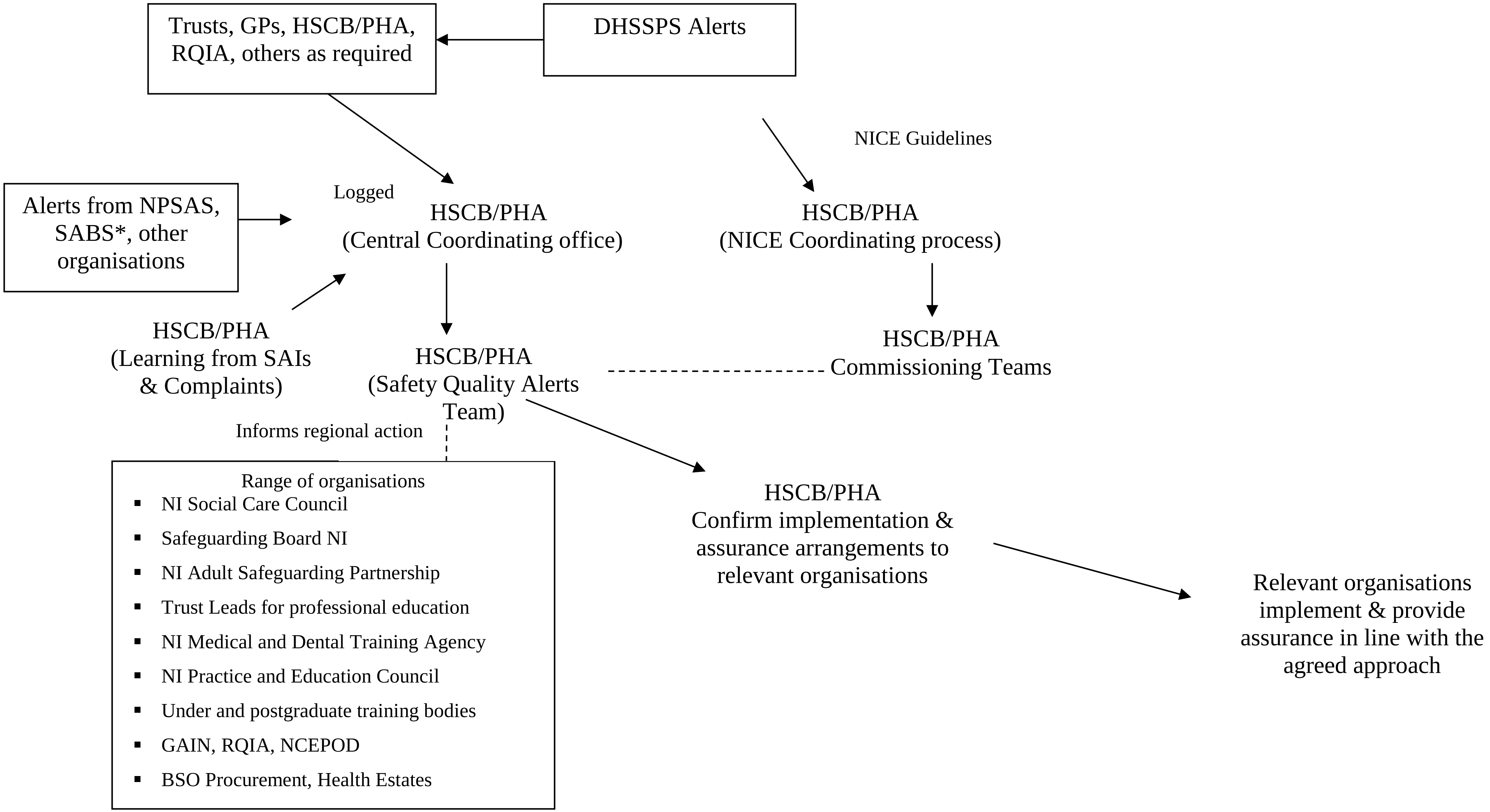
Independent providers are already required to respond to many of the types of Alerts covered by this protocol. In addition, DHSSPS or HSCB/PHA will send Alerts that they issue to RQIA for dissemination to relevant independent providers. DHSSPS also agree the annual work programme of RQIA which may include 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



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

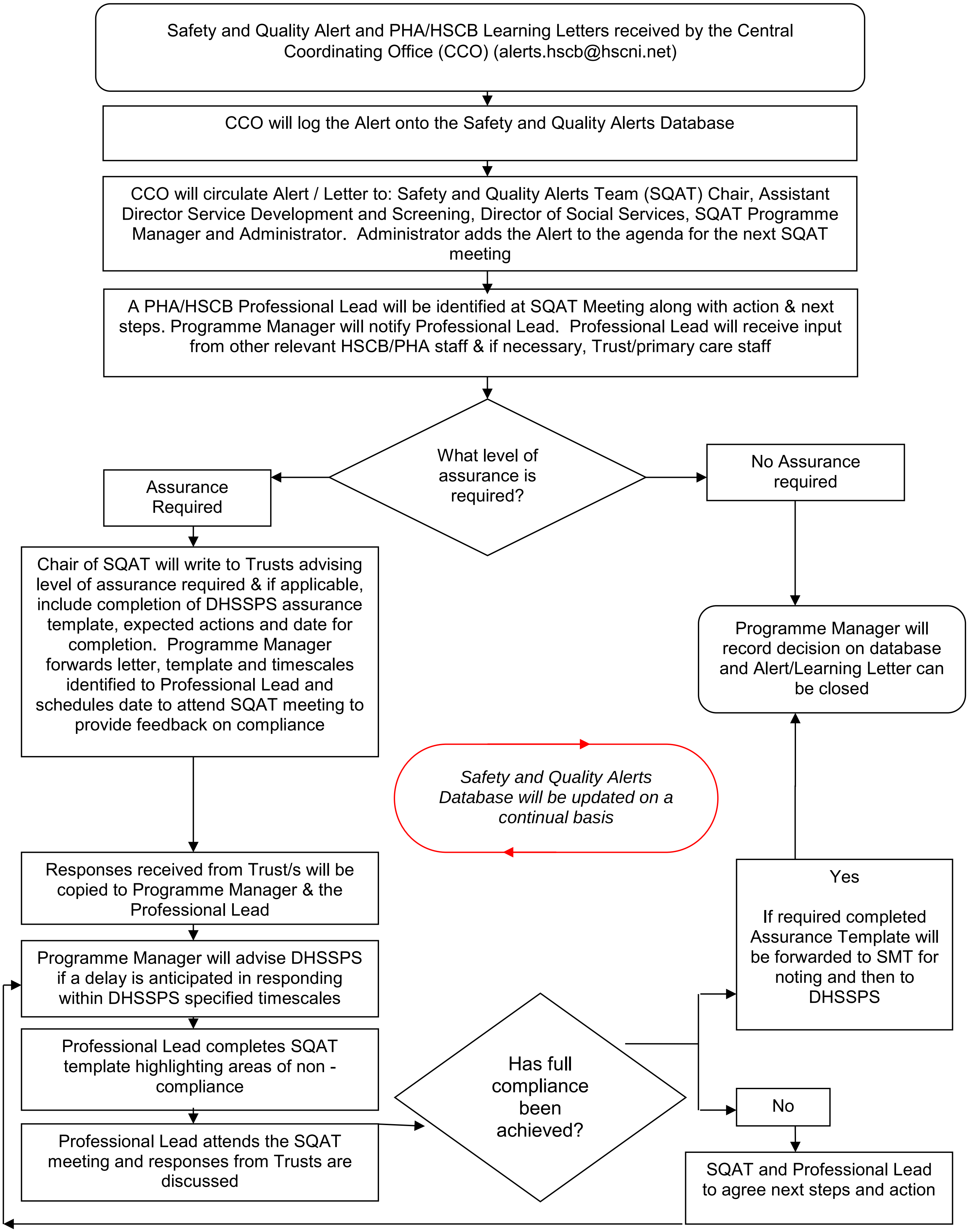
- Belfast – Dr Cathy Jack and Claire Cairns/Christine Murphy
- South East – Dr Charlie Martyn and Irene Low/Liz Campbell
- Southern – Dr John Simpson and Margaret Marshall/Dawn Mackin
- Northern – Dr Ken Lowry and Suzanne Pullins/Ruth McDonald
- Western – Dr Alan McKinney and Therese Brown/Teresa Murray

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



Safety and Quality Alert and PHA/HSCB Learning Letters received by the Central Coordinating Office (CCO) (alerts.hscb@hscni.net)

CCO will log the Alert onto the Safety and Quality Alerts Database

CCO will circulate Alert / Letter to: Safety and Quality Alerts Team (SQAT) Chair, Assistant Director Service Development and Screening, Director of Social Services, SQAT Programme Manager and Administrator. Administrator adds the Alert to the agenda for the next SQAT meeting

A PHA/HSCB Professional Lead will be identified at SQAT Meeting along with action & next steps. Programme Manager will notify Professional Lead. Professional Lead will receive input from other relevant HSCB/PHA staff & if necessary, Trust/primary care staff

What level of assurance is required?

Assurance Required

No Assurance required

Chair of SQAT will write to Trusts advising level of assurance required & if applicable, include completion of DHSSPS assurance template, expected actions and date for completion. Programme Manager forwards letter, template and timescales identified to Professional Lead and schedules date to attend SQAT meeting to provide feedback on compliance

Programme Manager will record decision on database and Alert/Learning Letter can be closed

Safety and Quality Alerts Database will be updated on a continual basis

Responses received from Trust/s will be copied to Programme Manager & the Professional Lead

Programme Manager will advise DHSSPS if a delay is anticipated in responding within DHSSPS specified timescales

Professional Lead completes SQAT template highlighting areas of non - compliance

Professional Lead attends the SQAT meeting and responses from Trusts are discussed

Has full compliance been achieved?

Yes

If required completed Assurance Template will be forwarded to SMT for noting and then to DHSSPS

No

SQAT and Professional Lead to agree next steps and action

HSC Health and Social Care Board

HSC Public Health Agency

Health and Social Care Board / Public Health Agency

Protocol for Implementation of Safety and Quality Alerts

Reference SQAT-01.08.16	**Responsible Officer** Director of Corporate Services	**Review Frequency** Annual
Approved by SQAT	**Approval Date:** 1 August 2016	**Next review due** July 2017
Superseded documents (if applicable) HSCB/PHA Protocol for Implementation of SQAs (April 2012) HSCB/PHA Protocol for Implementation of SQAs (August 2013) HSCB/PHA Protocol for Implementation of SQAs (May 2015)		

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Appendices

Appendix 1 - HSC System for Managing Safety and Quality Alerts – Structural Overview

Appendix 2 - Standard distribution list for SQAs

Appendix 3 - HSCB/PHA SQA Team – Membership / Trust Governance Lead Contacts / Organisations and bodies that contribute to safety and quality of H&SC

Appendix 4 - HSCB/PHA Process for the Management of Safety and Quality Alerts

HSCB/PHA Protocol for Implementation of Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: July 2016

1.0 Introduction

Safety and Quality Alerts (SQAs) may arise from a variety of sources, including Serious Adverse Incidents (SAIs), reviews by the Regulation and Quality Improvement Authority (RQIA), safeguarding reports, legislative changes, medicines regulators, equipment or device failures, national safety systems, and independent reviews.

This protocol describes the process which the Health and Social Care Board (HSCB) and Public Health Agency (PHA) will use to oversee implementation of Safety and Quality Alerts (SQAs) by Health and Social Care (HSC) Trusts, including actions relevant to primary care providers. It applies to SQAs issued since 1 April 2012.

2.0 What are Safety Quality Alerts (SQAs)

This protocol covers SQAs and equivalent correspondence as outlined below. It applies to health and social care-related SQAs though the vast majority relate to health care. Specific arrangements for the independent sector and for SQAs that relate mainly to primary care are described later.

Category 1 SQAs include:

- Department of Health (DoH) Safety Quality & Standards (SQS) guidance and letters/circulars and Patient Safety Alerts (PSAs);
- Learning Letters or Reminder of Good Practice Letters arising from serious adverse incidents (SAIs) / Complaints;
- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports and equivalent robust other national enquiries/audits;
- Guidelines and Audit Implementation Network (GAIN) Reports.

Category 2 SQAs include:

- Medicines and Healthcare products Regulatory Agency (MHRA) notices;
- Safety Alert Broadcast System (SABS) notifications.

A separate process is in place for the following:

- NICE guidance. Appendix 1 gives a schematic overview of the interfaces between this process and the process for NICE guidance;
- Drug alerts and recalls;
- Professional In-Confidence alerts regarding individual practitioners.

3.0 Application of Protocol

3.1 Who does this procedure apply to?

This protocol applies to the process for ensuring that care is safe and that adverse events and harm are minimised, involves identifying risks, managing those risks by responding appropriately, disseminating information effectively, and applying the learning from safety or quality related adverse events. The protocol applies to the following HSC organisations:

HSC organisations (HSC)

- Health and Social Care Board
- Public Health Agency
- Business Services Organisation
- Belfast Health and Social Care Trust
- Northern Health and Social Care Trust
- Southern Health and Social Care Trust
- South Eastern Health and Social Care Trust
- Western Health and Social Care Trust
- Northern Ireland Ambulance Service
- Regulation & Quality Improvement Authority

4.0 Management Arrangements for SQAs

4.1 Role of HSCB/PHA Safety Quality Alerts Team

The HSCB and PHA will manage arrangements for the implementation and assurance of all Category 1 SQAs and some Category 2 SQAs (as required) through the Safety Quality Alerts Team (SQAT). Serious Adverse Incidents and Complaints are managed through their respective teams and reports to the Quality, Safety and Experience Group (QSE).

The SQA Team will include HSCB and PHA representatives from professional groups, and Corporate Services (Appendix 3). It will be sponsored, and chaired as necessary, by the Medical Director/Director of Public Health (DPH).

It will report through the Senior Management Team of HSCB to the HSCB Governance Committee and Board at the frequency outlined in the HSCB safety quality reporting framework.

To ensure timely co-ordination and implementation of regional safety and quality alerts, the Team will meet every 2 weeks. HSCB/PHA will put arrangements in place to ensure that any immediate issues that need to be addressed are processed immediately.

A Programme Manager will oversee the process, maintain an up-to-date log, prepare for and support SQA Team meetings. Appendix 4 gives a schematic overview of the HSCB/PHA Process for the Management of Safety and Quality Alerts.

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SQAs where Trusts or the independent sector have a primary role in implementation will be logged by the Alerts office managed by the Governance Team within HSCB Corporate Services.

All correspondence in relation to alerts will be channelled through the HSCB Alerts mailbox at Alerts.HSCB@hscni.net. The Alerts Office will maintain a system to track progress on implementation.

4.3 Trust Input

To ensure input from Trusts, the SQA Team will seek advice from relevant Trust professionals. Each Trust has identified a first point of contact for queries regarding SQAs (Appendix 3).

4.4 Interface with other Safety/Quality-related organisations

To ensure coordinated action across the wider system, the HSCB/PHA SQA Team will also seek input from the range of organisations and bodies that contribute to safety and quality of health and social care (Appendix 3), as required.

4.5 Alerts Relating to Independent Sector Providers

Independent providers are already required to respond to many of the types of Alerts covered by this protocol. In addition, the DoH or HSCB/PHA will send Alerts that they issue to RQIA for dissemination to relevant independent providers. The DoH also agree the annual work programme of RQIA which may include reviews of governance systems in independent providers, and/or assurance on implementation of specific SQAs.

4.6 Process for Sharing Regional Learning from NI with ROI and GB

A process for sharing regional learning from Northern Ireland with the Republic of Ireland and Great Britain is currently being considered. This protocol will be updated to detail the process once agreed.

5.0 Process

5.1 Process prior to dissemination of SQAs

The Department of Health (DoH) issues a variety of correspondence collectively referred to as Safety Alerts. These are issued to service providers to identify those actions which providers should undertake to assure patient and client safety and best practice. The following describes the process prior to finalisation and dissemination of SQAs.

The DoH, HSCB and PHA share certain SQAs between organisations for comment prior to dissemination to the HSC. These include:

- All Patient Safety Alerts (PSAs);
- Safety and Quality Alerts where assurance is required;
- Learning Letters.

For SQAs developed by the DoH these will be sent to the HSCB Alerts mailbox at Alerts.HSCB@hscni.net for issue to relevant health and social care professionals within HSCB and PHA, to seek comment prior to issue by the DoH to the HSC.

For SQAs developed by the PHA / HSCB these will be sent to the DoH Safety, Quality and Standards mailbox at qualityandsafety@health-ni.gov.uk for issue to relevant Policy Leads for review to ensure compatibility with DoH policy prior to issue by the HSCB/PHA.

At this stage the level of assurance may be also considered as outlined in section 5.3.

This approach is intended to ensure that the actions required of organisations are clear through a single communication.

5.2 Dissemination of SQAs

5.2.1 Dissemination of SQAs issued by DoH

SQAs from the DoH will be issued to the Chief Executive's office of relevant organisations, and copied to the HSCB/PHA Alerts Office, the Governance Leads in Trusts and other relevant Directors. A standard distribution list is given in Appendix 2.

5.2.2 Dissemination of Learning Letters/Reminder of Good Practice Letters issued by PHA/HSCB

When regional learning is identified following the review of an SAI, complaint or other incident a learning letter/ reminder of good practice letter may be issued to the appropriate HSC organisations for wider circulation, application of learning and assurance that learning has been embedded.

A Learning letter/reminder of good Practice Letter will then be issued via the HSCB Alerts Office to the Chief Executive's office of relevant organisations, Governance Leads in Trusts and other relevant using the standard distribution list. (see Appendix 2)

5.3 Process Following Dissemination of SQAs

5.3.1 Process for Determining Assurances

Category 1 Alerts will be reviewed by the Safety Quality Alerts Team to make an initial determination on:

- Whether or not regional action is required to assist Trusts or primary care with implementation, and
- The nature of the assurance required regarding implementation.

If regional action is required, the proposed actions may be discussed where necessary with Trusts and/other relevant organisations to agree the precise task.

It is important to note that any regional actions do not in any way negate the responsibilities of Trusts or other organisations to take necessary actions to implement the Alert locally; immediate necessary action should not be delayed. However, it is recognised that some aspects of implementation may be more efficient, and may ensure a better outcome for patients, clients, staff and the public if they are developed in a standard way across the region.

To take forward work for the region, the principle of using existing systems as much as possible, will apply. However, if necessary, a Task and Finish Group may be established, including all relevant professionals and managers from relevant providers, and as appropriate, service users and/or the public.

Category 2 Alerts will be implemented primarily through existing systems. If on occasion explicit assurance or other action is required, it will be identified by the Safety Quality Alerts Team and described to Trusts and primary care providers as outlined for Category 1 Alerts.

5.3.2 Criteria for Identifying Regional Action and Assurance Levels

The PHA/HSCB SQA Team will determine the detail of the method of assuring implementation of an Alert. This will be proportionate to the assessed level of risk associated with the issue covered by the Alert. It will work on the principle of using existing systems of assurance as much as possible. Options for assurance methods include:

- Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements;

- Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA;
- Level 3 – completion of an audit specified by HSCB/PHA.

The following criteria will be used to assess whether or not regional action is required to assist implementation, and to determine the level of assurance required:

- The risk to an individual patient, client, staff member or member of the public, is high (impact);
- The number of patients, clients, staff or public who may be exposed to the risk is high (likelihood);
- Aspects of implementation are complex and outwith the control of Trusts or relevant organisations (complexity);
- A regional approach is achievable (deliverability & stakeholder agreement);
- Regional action will not introduce undue delay (timeliness);
- The Alert relates to an issue with a high public/political profile (public confidence);
- Other reasons (professional judgment).

In making its decisions, the HSCB/PHA SQA Team will take account of:

- Other Alerts relating to the service area in question;
- Common themes within a range of Alerts;
- Learning from Serious Adverse Incidents and Complaints;
- Existing safety and quality initiatives in health and social care.

5.3.3 Informing of Regional Action/Assurances Required

On completion of the processes outlined above, if regional action or assurance is required, the Chair of the Safety Quality Alerts Team will inform Trusts, primary care, and other relevant providers or stakeholders of the next steps or requirements. Communication will be to the Trust Chief Executive's office, copied to the Trust Governance Lead.

5.3.4 Reviewing Compliance of SQAs

The Safety and Quality Alert Team will consider responses to SQAs and 'close' the Alert when it is assured that actions have been implemented, or there is an existing robust system in place to ensure implementation.

In addition bi-annual progress reports to Governance Committee will be prepared by the SQA Team for the following:

- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports and equivalent robust other national enquiries/audits;

These reports will detail the progress on implementation of report recommendations and provide the necessary appropriate assurance mechanism that all HSCB/PHA actions contained within reports are implemented.

6.0 Reporting of SQAs

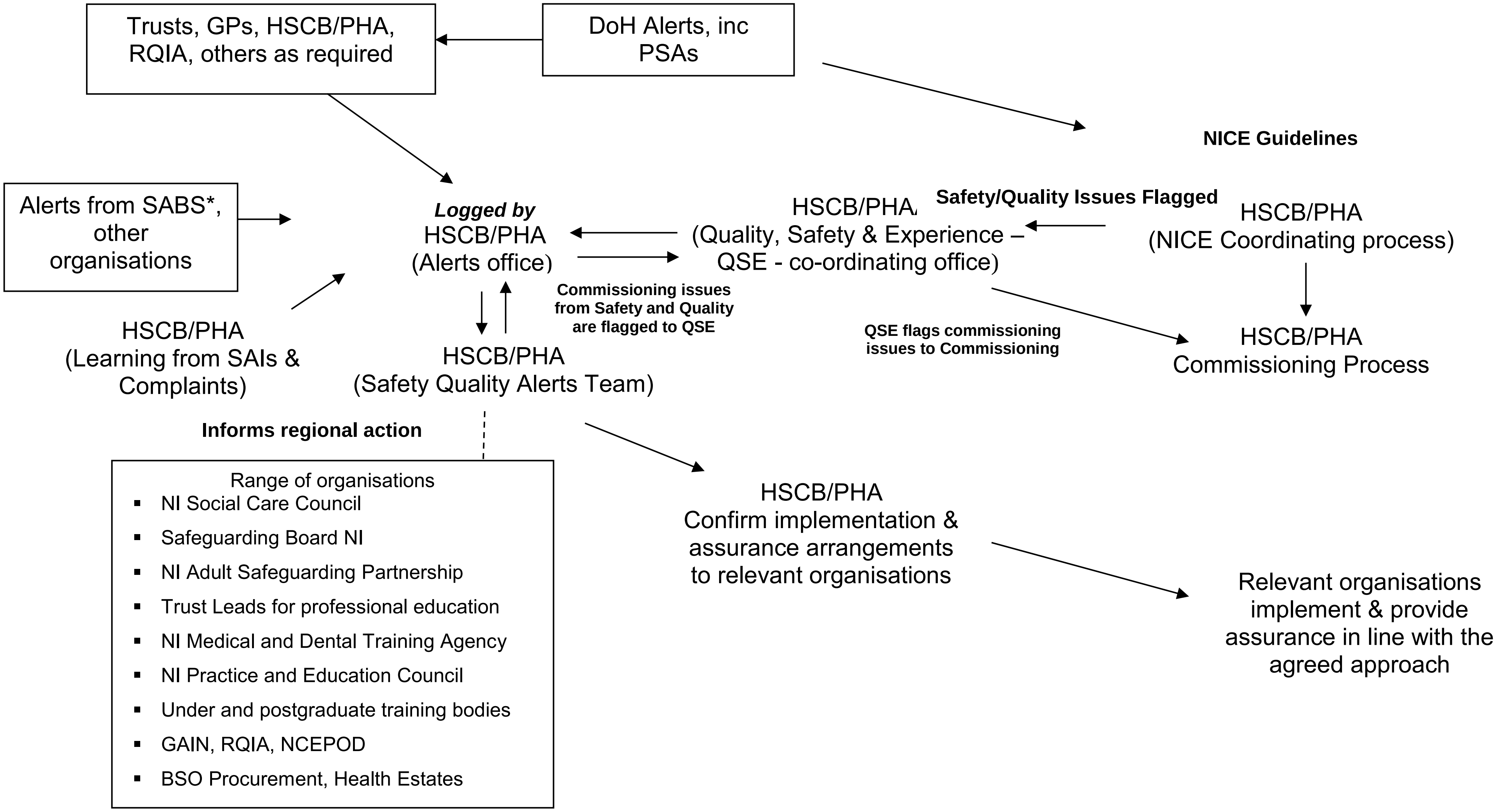
An annual report will also be prepared for the HSCB/PHA SQA Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board, DoH, Trusts and others as required.

7.0 Review of this protocol

This protocol will be refined on an on-going basis and not less than annually.

HSC System for Managing Safety and Quality Alerts – Structural Overview

Appendix 1



Trusts, GPs, HSCB/PHA, RQIA, others as required

DoH Alerts, inc PSAs

NICE Guidelines

Alerts from SABS*, other organisations

Logged by
HSCB/PHA
(Alerts office)

HSCB/PHA
(Quality, Safety & Experience – QSE - co-ordinating office)

Safety/Quality Issues Flagged

HSCB/PHA
(NICE Coordinating process)

Commissioning issues from Safety and Quality are flagged to QSE

QSE flags commissioning issues to Commissioning

HSCB/PHA
(Learning from SAIs & Complaints)

HSCB/PHA
(Safety Quality Alerts Team)

HSCB/PHA
Commissioning Process

Informs regional action

Range of organisations

- 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, NCEPOD
- BSO Procurement, Health Estates

HSCB/PHA
Confirm implementation & assurance arrangements to relevant organisations

Relevant organisations implement & provide assurance in line with the agreed approach

Template Distribution List

Appendix 2

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs			CEX		
Medical Director			Medical Director/Director of Public Health		
Directors of Nursing			Director of Nursing/AHPs		
Directors of Social Services			PHA Duty Room		
Governance Leads			AD Health Protection		
Directors of Acute Services			AD Service Development/Screening		
Directors of Community/Elderly Services			AD Health Improvement		
Heads of Pharmacy			AD Nursing		
Allied Health Professional Leads			AD Allied Health Professionals		
NIAS			Clinical Director Safety Forum		
CEX			**HSCB**		
Medical Director			CEX		
RQIA			Director of Integrated Care		
CEX			Director of Social Services		
Medical Director			Director of Commissioning		
Director of Nursing			Alerts Office		
Director for Social Care			Dir PMSI & Corporate Services		
NIMDTA			**Primary Care (through Integrated Care)**		
CEX / PG Dean			GPs		
QUB			Community Pharmacists		
Dean of Medical School			Dentists		
Head of Nursing School			**Open University**		
Head of Social Work School			Head of Nursing Branch		
Head of Pharmacy School			**DoH**		
Head of Dentistry School			CMO office		
UU			CNO office		
Head of Nursing School			CPO office		
Head of Social Work School			CSSO office		
Head of Pharmacy School			CDO office		
Head of School of Health Sciences (AHP Lead)			Safety, Quality & Standards Office		
Clinical Education Centre			**NI Social Care Council**		
NIPEC			**Safeguarding Board NI**		
GAIN Office			**NICE Implementation Facilitator**		
NICPLD			**Coroners Service for Northern Ireland**		

Membership **Appendix 3**

HSCB/PHA Safety Quality Alerts Team

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services, HSCB
- Assistant Director Nursing, Safety & Quality & Patient Experience, PHA
- Safety, Quality and Patient Experience Nurse, PHA
- Assistant Director Service Development & Screening, PHA
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care (Head of GMS) HSCB - when required
- Social Care and AHP input for Alerts relevant to those professions
- Assistant Governance Manager, Safety and Quality, HSCB

SQA Team Roles

- Chair – Dr Carolyn Harper
- Lead Performance & Corporate Services – Michael Bloomfield
- Lead Nurse – Lynne Charlton / Mary McElroy
- Lead Service Development & Screening – Dr Brid Farrell
- Lead Pharmacist – Matthew Dolan
- Lead Public Health Doctor – Dr Jackie McCall
- Lead Safety Forum – Dr Gavin Lavery
- Lead AHP – through Michelle Tennyson
- Lead GP – Dr Margaret O'Brien
- Lead Social Worker – through Fionnuala McAndrew
- Programme Manager – Margaret McNally
- Admin Support – Christine Thompson / Mareth Campbell

Trust Governance Lead Contacts

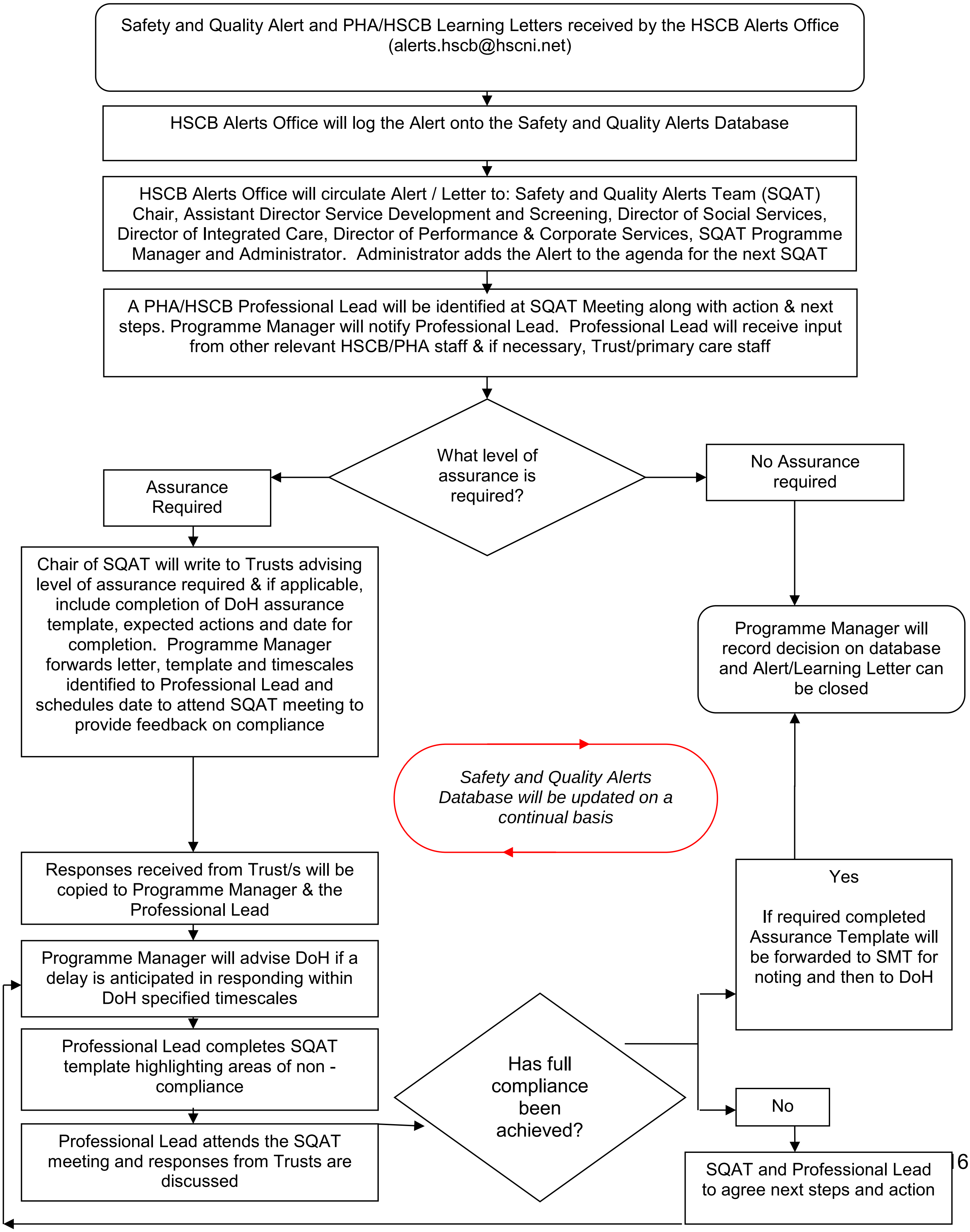
- Belfast – Dr Cathy Jack and Claire Cairns/Christine Murphy
- South East – Dr Charlie Martyn and Irene Low/Liz Campbell
- Southern – Dr Richard Wright and Margaret Marshall/Anne Quinn
- Northern – Dr Ken Lowry and VACANT/Ruth McDonald
- Western – Dr Dermot Hughes and Therese Brown/Teresa Murray

Link as required with

- NI Social Care Council
- Safeguarding Board NI
- NI Adult Safeguarding Partnership
- Trust Leads for professional education
- NI Medical and Dental Training Agency
- NI Practice and Education Council
- Under and postgraduate training bodies
- GAIN
- RQIA
- BSO Procurement
- Health Estates, DOH

Appendix 4

HSCB/PHA Process for the Management of Safety and Quality Alerts



HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY

TERMS OF REFERENCE

SAFETY AND QUALITY ALERTS TEAM (SQAT)

1.0 Introduction

The Health and Social Care Board (HSCB) and Public Health Agency (PHA) are responsible for the co-ordination and implementation of regional safety and quality alerts (SQAs), letters and guidance issued by the Department of Health (DoH), HSCB, PHA, Regulation and Quality Improvement Authority (RQIA) and other organisations.

The Safety and Quality Alerts Team (SQAT) was formed in April 2012 to co-ordinate the implementation of regional safety and quality alerts, letters and guidance. A subsequent protocol which outlines the management of the process was established and endorsed by the DoH in July 2013 and is reviewed on an annual basis. (See annex 1)

2.0 Accountability of the Group

The SQA Team shall report to the HSCB/PHA Quality and Safety Experience Group (QSE).

3.0 Objectives of the SQA Team

The SQA Team provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation. The Team ‘closes’ an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

4.0 Membership of the Group

Core membership of the SQA Team will consist of the following officers, or their nominated representative, from the HSCB and the PHA: (see annex 2 which details the current membership as at March 2017)

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services
- Assistant Director Nursing, Safety & Quality & Patient Experience
- Assistant Director Service Development & Screening
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Safety, Quality and Patient Experience Nurse, PHA

- Assistant Governance Manager, Safety and Quality, HSCB
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care, Head of GMS, HSCB when required
- Social Care and AHP input for Alerts relevant to those professions

5.0 Quorum

The SQA Team shall be quorate by the attendance of three members of the group; usually including representation of two professional areas. Where meetings proceed without relevant professionals present this can be endorsed at the next meeting.

6.0 Administration

- The Action log shall be taken by the Chair of the group (or nominated deputy)
- The agenda and papers will be developed by the Assistant Governance Manager and circulated by the PA to the Chair.
- The Assistant Governance Manager will oversee the process, maintain an up-to-date log, prepare for and support team meetings, and prepare an annual report. They will be supported by the Governance Support Manager and a Governance Support Officer.

7.0 Relationship/Links with Other Groups

There are a range of other quality and safety groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SQA Team will work in conjunction with various groups which include the following list of groups which is not definitive:

- HSCB / PHA Regional SAI Review Sub Group
- HSCB / PHA Regional Complaints Sub Group
- Patient and Client Experience Steering Group
- Promoting Good Nutrition Implementation Steering Group
- Regional Falls Prevention for Acute Services Group
- Regional Pressure Ulcer Prevention Advisory Group
- Regional Project Steering Group Evidencing Care through key nursing performance indicators
- Medicines Governance Advisors Groups
- Regional Child Protection Committee (RCPC)

- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board
- Medicines Safety Sub-Group (MSSG)
- PHA/HSCB SAI Professional Groups

8.0 Frequency of Meetings

Meetings of the Team will be fortnightly.

9.0 Review of Terms of Reference

The SQA Team will review its Terms of Reference on a biennial basis or earlier as required.

Annex 1

HSC Health and Social Care Board

HSC Public Health Agency

Health and Social Care Board / Public Health Agency

Protocol for Implementation of Safety and Quality Alerts

Reference SQAT-06.03.17	**Responsible Officer** Director of Corporate Services	**Review Frequency** Annual
Approved by SQAT	**Approval Date:** 6 March 2017	**Next review due** March 2018
Superseded documents (if applicable) HSCB/PHA Protocol for Implementation of SQAs (April 2012) HSCB/PHA Protocol for Implementation of SQAs (August 2013) HSCB/PHA Protocol for Implementation of SQAs (May 2015) HSCB/PHA Protocol for Implementation of SQAs (July 2016)		

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Date commenced: 1 April 2012

Last updated: March 2017

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When regional learning is identified following the review of an SAI, complaint or other incident a learning letter / reminder of good practice letter may be issued to the appropriate HSC organisations for wider circulation, application of learning and assurance that learning has been embedded.

A Learning letter/reminder of good Practice Letter will then be issued via the HSCB Alerts Office to the Chief Executive's office of relevant organisations, Governance Leads in Trusts and other relevant using the standard distribution list. (see Appendix 2)

5.3 Process Following Dissemination of SQAs

5.3.1 Process for Determining Assurances

Category 1 Alerts will be reviewed by the Safety Quality Alerts Team to make an initial determination on:

- Whether or not regional action is required to assist Trusts or primary care with implementation, and
- The nature of the assurance required regarding implementation.

If regional action is required, the proposed actions may be discussed where necessary with Trusts and/other relevant organisations to agree the precise task.

It is important to note that any regional actions do not in any way negate the responsibilities of Trusts or other organisations to take necessary actions to implement the Alert locally; immediate necessary action should not be delayed. However, it is recognised that some aspects of implementation may be more efficient, and may ensure a better outcome for patients, clients, staff and the public if they are developed in a standard way across the region.

To take forward work for the region, the principle of using existing systems as much as possible, will apply. However, if necessary, a Task and Finish Group may be established, including all relevant professionals and managers from relevant providers, and as appropriate, service users and/or the public.

Category 2 Alerts will be implemented primarily through existing systems. If on occasion explicit assurance or other action is required, it will be identified by the Safety Quality Alerts Team and described to Trusts and primary care providers as outlined for Category 1 Alerts.

5.3.2 Criteria for Identifying Regional Action and Assurance Levels

The PHA/HSCB SQA Team will determine the detail of the method of assuring implementation of an Alert. This will be proportionate to the assessed level of risk associated with the issue covered by the Alert. It will work on the principle of using existing systems of assurance as much as possible. Options for assurance methods include:

- Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements;

- Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA;
- Level 3 – completion of an audit specified by HSCB/PHA.

The following criteria will be used to assess whether or not regional action is required to assist implementation, and to determine the level of assurance required:

- The risk to an individual patient, client, staff member or member of the public, is high (impact);
- The number of patients, clients, staff or public who may be exposed to the risk is high (likelihood);
- Aspects of implementation are complex and outwith the control of Trusts or relevant organisations (complexity);
- A regional approach is achievable (deliverability & stakeholder agreement);
- Regional action will not introduce undue delay (timeliness);
- The Alert relates to an issue with a high public/political profile (public confidence);
- Other reasons (professional judgment).

In making its decisions, the HSCB/PHA SQA Team will take account of:

- Other Alerts relating to the service area in question;
- Common themes within a range of Alerts;
- Learning from Serious Adverse Incidents and Complaints;
- Existing safety and quality initiatives in health and social care.

5.3.3 Informing of Regional Action/Assurances Required

On completion of the processes outlined above, if regional action or assurance is required, the Chair of the Safety Quality Alerts Team will inform Trusts, primary care, and other relevant providers or stakeholders of the next steps or requirements. Communication will be to the Trust Chief Executive's office, copied to the Trust Governance Lead.

5.3.4 Reviewing Compliance of SQAs

The Safety and Quality Alert Team will consider responses to SQAs and 'close' the Alert when it is assured that actions have been implemented, or there is an existing robust system in place to ensure implementation.

In addition bi-annual progress reports to Governance Committee will be prepared by the SQA Team for the following:

- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports and equivalent robust other national enquiries/audits;

These reports will detail the progress on implementation of report recommendations and provide the necessary appropriate assurance mechanism that all HSCB/PHA actions contained within reports are implemented.

6.0 Reporting of SQAs

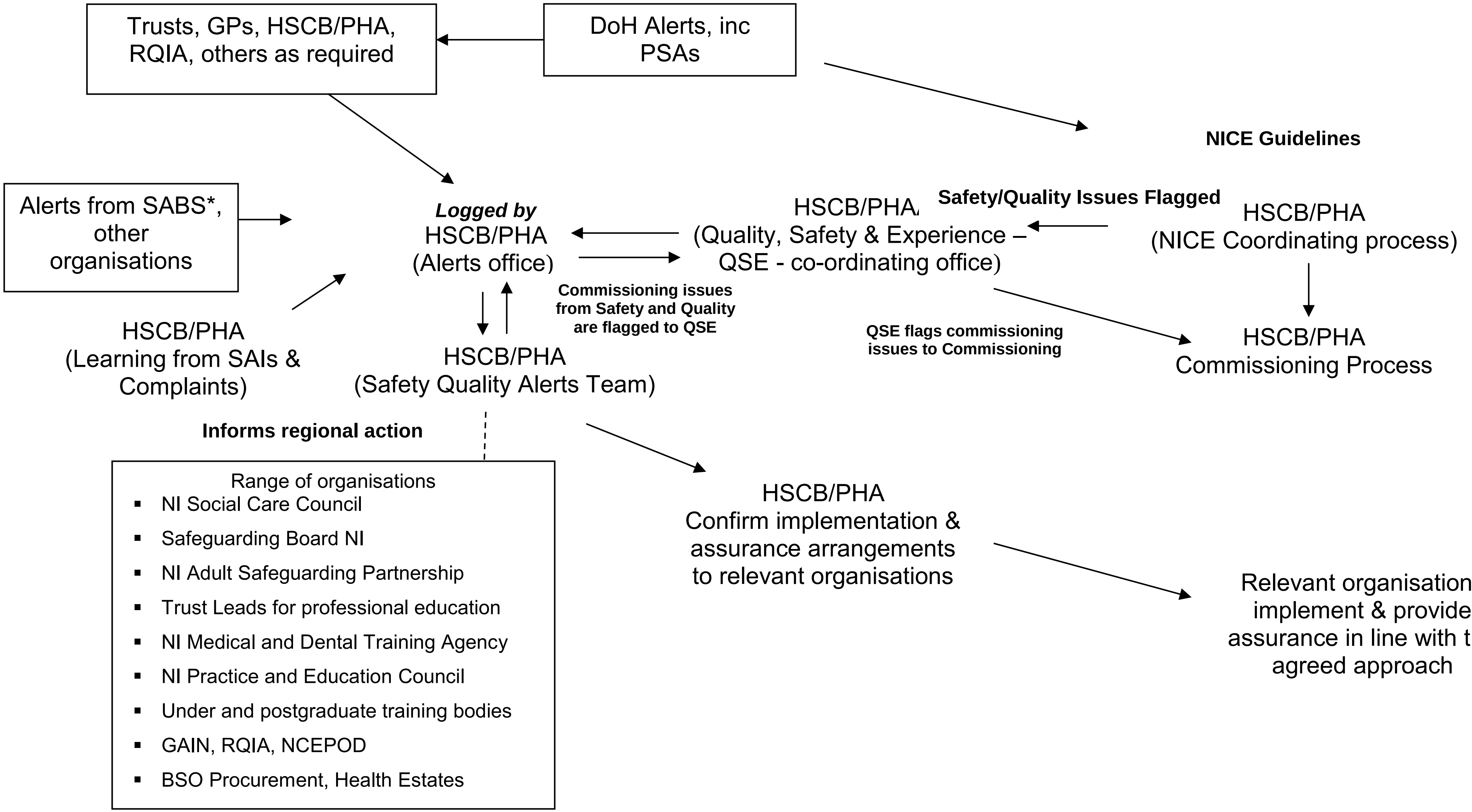
An annual report will also be prepared for the HSCB/PHA SQA Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board, DoH, Trusts and others as required.

7.0 Review of this protocol

This protocol will be refined on an on-going basis and not less than annually.

HSC System for Managing Safety and Quality Alerts – Structural Overview

Appendix 1



Trusts, GPs, HSCB/PHA, RQIA, others as required

DoH Alerts, inc PSAs

NICE Guidelines

Alerts from SABS*, other organisations

Logged by HSCB/PHA (Alerts office)

HSCB/PHA (Quality, Safety & Experience – QSE - co-ordinating office)

Safety/Quality Issues Flagged

HSCB/PHA (NICE Coordinating process)

Commissioning issues from Safety and Quality are flagged to QSE

QSE flags commissioning issues to Commissioning

HSCB/PHA (Learning from SAIs & Complaints)

HSCB/PHA (Safety Quality Alerts Team)

HSCB/PHA Commissioning Process

Informs regional action

Range of organisations

- 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, NCEPOD
- BSO Procurement, Health Estates

HSCB/PHA Confirm implementation & assurance arrangements to relevant organisations

Relevant organisations implement & provide assurance in line with the agreed approach

Template Distribution List Appendix 2

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs			CEX		
Medical Director			Medical Director/Director of Public Health		
Directors of Nursing			Director of Nursing/AHPs		
Directors of Social Services			PHA Duty Room		
Governance Leads			AD Health Protection		
Directors of Acute Services			AD Service Development/Screening		
Directors of Community/Elderly Services			AD Health Improvement		
Heads of Pharmacy			AD Nursing		
Allied Health Professional Leads			AD Allied Health Professionals		
NIAS			Clinical Director Safety Forum		
CEX			**HSCB**		
Medical Director			CEX		
RQIA			Director of Integrated Care		
CEX			Director of Social Services		
Medical Director			Director of Commissioning		
Director of Nursing			Alerts Office		
Director for Social Care			Dir PMSI & Corporate Services		
NIMDTA			**Primary Care (through Integrated Care)**		
CEX / PG Dean			GPs		
QUB			Community Pharmacists		
Dean of Medical School			Dentists		
Head of Nursing School			**Open University**		
Head of Social Work School			Head of Nursing Branch		
Head of Pharmacy School			**DoH**		
Head of Dentistry School			CMO office		
UU			CNO office		
Head of Nursing School			CPO office		
Head of Social Work School			CSSO office		
Head of Pharmacy School			CDO office		
Head of School of Health Sciences (AHP Lead)			Safety, Quality & Standards Office		
Clinical Education Centre			**NI Social Care Council**		
NIPEC			**Safeguarding Board NI**		
GAIN Office			**NICE Implementation Facilitator**		
NICPLD			**Coroners Service for Northern Ireland**		
NI Medicines Governance Team Leader for Secondary Care					

Membership **Appendix 3**

HSCB/PHA Safety Quality Alerts Team

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services, HSCB
- Assistant Director Nursing, Safety & Quality & Patient Experience, PHA
- Safety, Quality and Patient Experience Nurse, PHA
- Assistant Director Service Development & Screening, PHA
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care (Head of GMS) HSCB - when required
- Social Care and AHP input for Alerts relevant to those professions
- Assistant Governance Manager, Safety and Quality, HSCB

SQA Team Roles

- Chair – Dr Carolyn Harper
- Lead Performance & Corporate Services – Michael Bloomfield
- Lead Nurse – Lynne Charlton / Mary McElroy
- Lead Service Development & Screening – Dr Brid Farrell
- Lead Pharmacist – Matthew Dolan
- Lead Public Health Doctor – Dr Jackie McCall
- Lead Safety Forum – Dr Gavin Lavery
- Lead AHP – through Michelle Tennyson
- Lead GP – Dr Margaret O’Brien
- Lead Social Worker – through Fionnuala McAndrew
- Programme Manager – Margaret McNally
- Admin Support – Christine Thompson / Elaine Hyde

Trust Governance Lead Contacts

- Belfast – Dr Cathy Jack and Claire Cairns/Christine Murphy
- South East – Dr Charlie Martyn and Irene Low/Liz Campbell
- Southern – Dr Richard Wright and Margaret Marshall/ /Caroline Beattie Nicole Evans
- Northern – Mr Seamus O’Reilly and Sinead O’Kane /Ruth McDonald

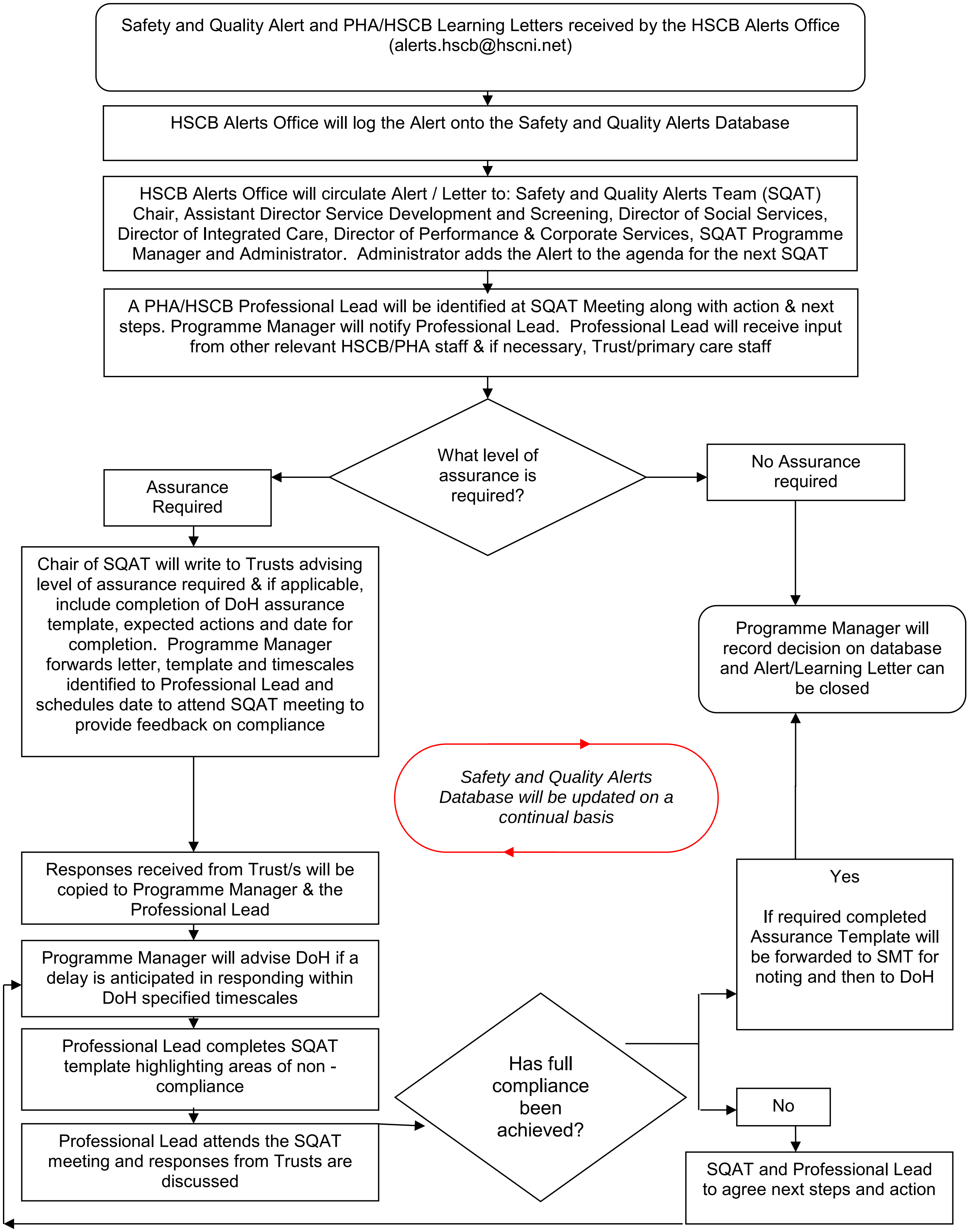
- Western – Dr Dermot Hughes and Therese Brown/Teresa Murray

Link as required with

- NI Social Care Council
- Safeguarding Board NI
- NI Adult Safeguarding Partnership
- Trust Leads for professional education
- NI Medical and Dental Training Agency
- NI Practice and Education Council
- Under and postgraduate training bodies
- GAIN
- RQIA
- BSO Procurement
- Health Estates, DoH

Appendix 4

HSCB/PHA Process for the Management of Safety and Quality Alerts



J McCann

BW/119

PEOPLE FIRST

1990s

DHSS

COMMUNITY CARE IN NORTHERN IRELAND FOR THE 1990s

PEOPLE FIRST: COMMUNITY CARE IN NORTHERN IRELAND IN THE 1990s

FOREWORD

It has been said that the best measure of a civilised society is how well it cares for those of its members who for whatever reason cannot live totally independently. Most of this care is given outside hospital: in people's own homes, in various residential settings, whether in the public or independent sector, and in nursing homes. The Government's vision of care needed in the community at large has three central principles: first, to help such people to lead, as far as possible, full and independent lives; second, to respond flexibly and sensitively to the needs and wishes of individual people and the relatives and friends who care for them; and third to concentrate professional skills and public resources on those who need them the most.

The proposals in this paper open up new opportunities for everyone whose business it is to care for and support people living in the community. The new arrangements for financing and managing community care will equip the Health and Social Services Boards - and the many other agencies which have a contribution to make - to meet the substantial challenges of the next decade. They will give the users of the caring and supportive services a wider choice. They will also ensure that individuals' needs are properly assessed and that appropriate services are provided to meet them.

A great deal of excellent work is already being done to turn the Government's vision of community care into a reality. The Regional Strategy for the Health and Personal Social Services for 1987-1992 has already focused attention on the need to develop humane and high quality caring services - services which enable people who are vulnerable through age, physical disability, mental illness, mental handicap or other causes to live as full and independent lives as possible in whatever setting best suits their needs.

As in all modern industrial societies, the health and social services in Northern Ireland are having to satisfy increasing demands and meet rising public expectations out of budgets which are necessarily limited. We are fortunate in that we already have an integrated structure for these services, an advantage not enjoyed by other parts of the United Kingdom. The progress that has been made since 1987, in particular, is a tribute to the energy and enthusiasm of the many different professional and other groups working in the field, and to the efforts of numerous dedicated individuals working in the statutory health and social services and in other public, private and voluntary agencies. I know that my colleague Roger Skelmersdale is committed to building on the excellent foundations which they have laid to enhance further the quality of life of everyone in Northern Ireland who needs care in the community.

The proposals in this paper, coming as they do on top of the substantial programme of reforms heralded in the White Papers "Working for Patients" and "Promoting Better Health", present a major challenge to the staff of the community health and personal social services. I do not underestimate the size of the task. But I am confident that, if everyone works together towards the common objectives set out in the first chapter of the paper, we shall greatly strengthen our collective capacity to help many of the most needy and vulnerable people in our society.

Peter Brooke

PETER BROOKE
Secretary of State for Northern Ireland

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CHAPTER ONE: BETTER CARE IN THE COMMUNITY

Introduction

1.1 Community care matters to everyone, and it is in everyone's interest to consider it objectively and to move forward together to realise fully its potential. Community care matters especially to the many people who are or will become vulnerable through ageing, mental illness, mental handicap or physical disability, and to those looking after them. Community care, which consists of both health and social care, has as its overriding objective to enable people to live as full a life as possible, in whatever setting best suits their needs.

1.2 This paper complements the White Papers "Working for Patients" and "Promoting Better Health", which set out the Government's plans for the future management of the hospital and general practitioner services. The purpose underlying those plans was to improve the quality of the services by extending people's freedom of choice, by delegating responsibility to those who actually deliver services and by ensuring value for money.

The Griffiths Report

1.3 The proposals in this paper originated in Sir Roy Griffiths' report "Community Care: Agenda for Action", published in March 1988. He identified as one central aim "to provide structure and resources to support the initiatives, the innovation and the commitment at local level and to allow them to flourish; to encourage the success stories in one area to become the commonplace of achievement everywhere else". A second central aim was "to spell out responsibilities, insist on performance and accountability and to evidence that action is being taken". This paper subscribes to these aims.

1.4 In making his recommendations, Sir Roy noted that they would "increase the ability of managers in all community care services to ensure that:

- the right services are provided in good time, to the people who need them most;
- the people receiving help will have a greater say in what is done to help them, and a wider choice;
- people are helped to stay in their own homes for as long as possible, or in as near a domestic environment as possible, so that residential, nursing home and hospital care is reserved for those whose needs cannot be met in any other way."

1.5 Although the Griffiths Report did not extend to Northern Ireland, its broad thrust is very much in keeping with the Regional Strategy for the Northern Ireland Health and Personal Social Services 1987-1992. The Regional Strategy places great emphasis on the successful and humane implementation of the community care policy. It calls for close targeting on the main priorities; gives high priority to support for families caring for dependent relatives; and notes the importance of clear arrangements for co-ordination and joint planning between Health and Social Services Boards and other agencies, including voluntary organisations. It also seeks to secure a more appropriate balance of care between hospital and community services.

"Caring for People"

1.6 In November 1989, the Government published the White Paper "Caring for People", which set out in detail its proposals for improving community care in Great Britain. This paper explains how the national policy objectives in the White Paper are to be pursued in the context of Northern Ireland's unique integrated health and social services, and in the context of the new role which Boards will assume in line with "Working for Patients".

Recent developments

1.7 The successful implementation of the community care policy depends on the availability of adequate, appropriate and accessible services. The past decade has been one of substantial growth in community care services, made possible by a significant increase in public expenditure.

1.8 Chapter 2 indicates how different forms of care in the community have been developing in Northern Ireland. The following figures illustrate this development in general terms:

* by 1988/89, expenditure on community health and personal social services stood at £177m, up from £69m in 1979/80 - an increase of 36% in real terms;

* the number of people in independent residential care and nursing homes receiving social security support rose from under 300 in 1979 to some 3500 in 1989;

* over the same period, the number of places in statutory and registered residential care homes rose by 24%, from 4964 to 6163; and the number of places in registered nursing homes by 698%, from 307 to 2450.

The need for change

1.9 Although the past decade has been one of substantial growth and achievement and despite the advantage of our integrated structure, progress has been slower and more uneven than the Department would like. The arrangements for public funding have contained a built-in bias towards residential and nursing home care, rather than services for people at home. In some places, there have been great strides in the development of community services, but in others they are less well advanced. The Department's aim is that in future all contributors to community care should strive to achieve a more consistent performance in line with people's needs.

1.10 For most people, effective community care offers a better quality of life and a wider range of choice than they would have expected in the past. The Department recognises that community care is not an easy policy to implement successfully and may in some cases make intensive demands on resources and manpower. It is not a narrow task but a broad programme designed to enrich the lives of those it helps. It requires inputs from and co-operation amongst various agencies: the Department of Health and Social Services, Health and Social Services Boards, Social Security Offices, the Department of the Environment, the Housing Executive, the Department of Economic Development, the Employment and Training Agency, the Department of Education, Education and Library Boards, and independent sector service providers. The Department's aim is to ensure that better working relationships and partnerships are formed; that inter- agency planning and negotiation takes place; and that there is a common understanding of community care policy objectives.

1.11 The focus of this paper is on clarifying the roles and responsibilities of Health and Social Services Boards. However, the achievement of this aim will require these various agencies to re-examine their roles and responsibilities. They all have a contribution to make in enabling people to live independent lives in their own homes or in homely surroundings; to help them to realise their full potential and contribute to the community in which they live; and to allow them a full say in how they live their lives and in the services they need.

Principles

1.12 The great bulk of community care is provided by family, friends and neighbours. The decision to take on a caring role is often difficult. However, many people make that choice, and it is right that society should support them in looking after those close to them.

1.13 The principles underpinning the Government's approach to community care are that:

- services should respond flexibly and sensitively to the needs of individuals and the relatives and friends who care for them;
- services should wherever practicable offer users a range of options;
- services should intervene no more than is necessary to foster independence;
- services should concentrate on those with the greatest needs.

Central objectives

1.14 "Caring for People" sets out six central objectives, which apply as much to Northern Ireland as to Great Britain:

- to promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever possible;
- to ensure that service providers make practical support for carers a high priority;
- to make proper assessment of need and good case management the cornerstone of high quality care;
- to promote the development of a flourishing independent sector alongside good quality public services;
- to clarify the responsibilities of agencies and so make it easier to hold them to account for their performance;
- to secure better value for taxpayers' money by introducing a new funding structure for community care.

Main changes

1.15 In order to achieve these objectives, the Department proposes to make seven main changes in the way in which community care is delivered and funded in Northern Ireland:

first, the role of Health and Social Services Boards as co-ordinators, purchasers and quality controllers will be strengthened relative to their present primary role as service providers;

second, Boards will be expected to target resources more effectively by assessing individuals' needs more systematically, tailoring care packages more precisely to meet these needs within available resources;

third, Boards will be expected to make full use of the independent sector.

fourth, there will be a new funding structure for those seeking public support for residential and nursing home care from April 1991;

fifth, from April 1991 applicants with few or no resources of their own will be eligible for Income Support and Housing Benefit on much the same basis, whether they are living in their own homes or in independent sector residential care or nursing homes;

sixth, Boards will be expected to establish registration and inspection units, at arm's length from the management of their own services, which will be responsible for monitoring standards in Boards' homes as well as independent sector residential care and nursing homes;

seventh, planning procedures will be improved to focus more clearly on the development, monitoring and evaluation of community care services.

Services for children

1.16 The Government is preparing new children's legislation to replace the Children and Young Persons Act (NI) 1968, and intends to publish a proposal for a Draft Order in Council later in the year. This will include provision for disabled children. The child care and community care programmes are consistent and complementary and, taken together with the health service reforms, set a fresh agenda and new challenges for the Boards for the new decade.

CHAPTER TWO: COMMUNITY CARE IN PRACTICE

A spectrum of care

2.1 Community care is not a new concept. The term, however, means different things to different people. This paper uses the term to mean care outside hospital.

2.2 In providing such care, the aim has been and will continue to be to ensure as far as practicable that a full spectrum of services and facilities is available. Ideally, this spectrum ranges from support offered to people at home, with access to respite and day care as necessary; through family placements, sheltered housing, group homes and hostels where increasing levels of care are available; to residential care and nursing homes for those for whom other forms of care are either inappropriate or no longer enough. An essential characteristic of community care is that it helps people to live as independently as possible in their own homes or in homely settings in the community.

2.3 While this paper focuses largely on the role of statutory agencies working in partnership with the independent sector, most care is given by relatives, friends and neighbours - the so-called "informal carers". Most informal carers take on their extra responsibilities willingly, but many need help. Their lives can be made much easier if the right support is there at the right time, and it is one of the Health and Social Services Boards' main responsibilities to do all they can to see that it is.

2.4 Although families, and usually women, continue to be the principal source of care for dependent people, informal care can no longer be taken for granted. Higher participation rates by women in the work force, increased geographical mobility, a rising divorce rate and the trend towards smaller families (which changes the ratio of informal carers to those who need care) are all tending to reduce the availability of informal carers. Nevertheless the family will continue to be the major supplier of social and personal care, and the obligations of kin and affection will remain powerful motivators. It is in society's interest to sustain that motivation and to see that appropriate packages of support are assembled for people who are able and willing to care for others.

2.5 The personal social services have an important contribution to make not only in supporting carers but also, directly, in providing or securing care and practical help for people who need it. The essential services which they offer include information, advice and counselling; help with personal and domestic tasks such as cleaning, washing and preparing meals; help with disablement equipment and home adaptations; and help with transport, budgeting and many aspects of daily living.

2.6 Health care in the community is also important. The primary care team has a vital part to play. The general practitioner is commonly the individual's first point of contact with the health and social services, and often the first to identify new problems or needs.

2.7 The private and voluntary sectors have been making their own distinctive contributions to the development of particular community care services. Individual people and organisations in those sectors have been to the fore in translating the policy into practice in imaginative and innovative ways.

The Regional Strategy

2.8 The central themes of "Caring for People" are already covered in or are complementary to the Department of Health and Social Services' most recent statement of strategic aims and policy objectives - the Regional Strategy for the Northern Ireland Health and Personal Social Services 1987-1992 - to which the Department remains committed.

2.9 The Regional Strategy emphasises that elderly people and people with a mental illness, mental handicap or physical disability should be enabled to live in the community, in their own homes whenever possible, and to participate as fully as possible in regular work, social and educational activities. It also calls on the Health and Social Services Boards to make a substantial shift in resources from hospital to community care.

2.10 Good headway has already been made towards the attainment of these objectives. The remainder of this chapter will look at some recent developments in community care which point the way forward towards improving provision for each of the four groups which make the greatest demands on community care services.

Elderly people

2.11 There were 192,300 people over 65 years of age in NorthernIreland in 1988, roughly 1 in 8 of the population. Most elderly people live in the community and are active, energetic and independent citizens. However, illness and disability, often age-related, result in some elderly people having significant needs for help and support. At present, about half of public expenditure on the personal social services in Northern Ireland is devoted to the care of the elderly.

2.12 The pattern of care for elderly people in Northern Ireland owes much to a major review of health and personal social services provision for the elderly, which took place in the early 1980s. The resulting report "Past 65 - Who Cares?" pointed to the importance of domiciliary, day and respite services in maintaining vulnerable elderly people in their own homes; advocated a multi-disciplinary approach to targeting services at those in greatest need; highlighted the need to develop a range of services for elderly people suffering from dementia; stressed the importance of co-operation amongst professions and agencies caring for the elderly; and underlined the importance of taking full account of service users' wishes.

2.13 The Regional Strategy in turn drew heavily on the major themes of this report. It highlighted the importance of targeting domiciliary care on those in greatest need; of supporting carers; of improving the quality of life of elderly people; and of improving co-operation amongst agencies and between the statutory, voluntary and private sectors.

2.14 The voluntary sector, in particular, has played an important part in pursuing these objectives. A good illustration of how innovative packages of care can be put together for dependent elderly people in their own homes is provided by the North and West Belfast Dementia project. This scheme stems from a partnership between Extra Care and the Eastern Board. As well as providing relief on a regular basis for those caring for elderly confused people at home, the project offers intensive short-term support for carers at times of crisis.

People with a physical disability

2.15 Some 40,000 people are recorded by Health and Social Services Boards as suffering from some form of physical disability. This is roughly 1 in 40 of the population. There is a high correlation between disability and age. More than 60% of those physically disabled people known to the Boards were over 65.

2.16 In Great Britain, recent OPCS surveys have shown that over 6,000,000 adults have some degree of physical, mental or sensory disability. More than 66% of these people were aged over 65. The OPCS surveys do not cover Northern Ireland. However, a parallel survey is now being conducted here, which will provide comparable information on all aspects of disability.

2.17 Most physically disabled people live in their own homes, and services are geared to enabling them to stay there. A small number need continuing care in residential care or nursing homes or in hospital.

2.18 The Regional Strategy recognised a considerable overlap between programmes of care for people with a physical disability and those for elderly people and people with a mental handicap, who may also have a physical disability. It noted that services for people with a physical disability required substantial improvement and that there was an urgent need to improve services for those with impaired sight or hearing. It proposed that Boards should enhance their paramedical and other services to reduce disparities across their areas; that artificial limb and appliance services should be further developed; that Boards should strengthen their links with voluntary and other agencies at local level, specifically in the housing field; and that there was a need to improve day care facilities. It also asked Boards to reduce the numbers of young people with a physical disability in residential units for elderly people.

2.19 In the wake of the Regional Strategy, services have grown and developed in a number of directions. There has been a significant increase in the number of staff employed in the therapeutic professions allied to medicine; new contract arrangements have been introduced for the supply of artificial limbs and appliances which should improve these services; and the number of housing adaptations has continued to increase. There have also been several worthwhile initiatives for people with sensory disabilities.

2.20 An example of a project which promotes both independent living and integration with the rest of the community is run by the Northern Ireland Council for Orthopaedic Development (NICOD) in partnership with the Habinteg Housing Association. It is organised around a housing scheme at Duke Street in East Belfast for six people, including three who use wheelchairs. The housing scheme is supported by NICOD staff, who help residents to cope with the activities of daily living. A community assistant employed by Habinteg provides 24 hour emergency cover. This development is integrated with a larger Habinteg scheme accommodating families, single people and other people with physical disabilities. The whole scheme is located near shops and other facilities.

People with a mental illness

2.21 Each year around 8,000 people are admitted to psychiatric hospitals, including 3,000 new patients. Most of them stay in hospital for less than a year, and of these people the average stay is six weeks. At any one time there are about 2,200 patients in psychiatric hospitals who have been there for a year or more. However, most people with a mental health problem are now able to live at home, and to receive the medical treatment they need from their general practitioners or from specialists through outpatient clinics. This treatment is backed up in the community by services ranging from an occasional visit by a nurse or social worker for those with minor transient conditions to a full package of nursing and social care for those who suffer from permanently disabling disorders.

2.22 The Regional Strategy emphasises the development of comprehensive community based services with a corresponding reduction in dependence on inpatient places. It sets a specific target of a 20% reduction over the five years to 1992 in the numbers of patients in psychiatric hospitals. At the same time, the Regional Strategy emphasises that this target is merely a guideline and that alternative and better forms of care in the community must be developed **before** patients are discharged from hospital; and that some patients will always need sanctuary for periods. It requires Boards to develop effective rehabilitation and resettlement programmes in all continuing care units. Finally, it calls for the monitoring and evaluation of changes in the pattern of care.

2.23 Services for people with a mental illness have traditionally been concentrated in and around the six major psychiatric hospitals and in psychiatric units in general hospitals. Since the publication of the Regional Strategy, however, there has been significant progress in the development of community based services and rehabilitation programmes. This development has opened up opportunities for a better quality of life for the patients concerned. All four Boards have created or are planning for more day care and day hospital places and special housing arrangements, and all six psychiatric hospitals now have rehabilitation and resettlement programmes at various stages of development.

2.24 The progress which has already been made is a credit to the energy and enthusiasm of many committed individuals, including dedicated people working to develop community services from within the hospitals.

2.25 The Audit Commission has commended the use of bridging finance in England and Wales as a means to enable service providers to develop new community services while reducing hospital bed numbers. In Northern Ireland such money has already proved highly effective as a force for change since 1987 towards meeting the Regional Strategy targets for the mental health and mental handicap programmes.

2.26 Bridging finance was first made available in 1987, and £18m had been committed by January 1989 for the period to 1992. These resources are allocated to Boards against specific schemes which meet certain criteria - primarily that the project will enable people with a mental illness or mental handicap who have spent a long period in hospital to move into the community with sufficient care and support. They have been used to free staff to co-ordinate special initiatives; to appoint more community psychiatric and mental handicap nurses, social workers and psychologists; to support rehabilitation teams and discharge projects; to train staff; and to provide more places in day hospitals, day centres, special housing projects and work therapy schemes.

2.27 A second significant factor in the recent development of community services for people with a mental illness has been the successful partnerships forged in many places between the statutory and voluntary sectors: Boards have allocated a substantial proportion of their bridging finance to voluntary sector projects.

2.28 The Regional Strategy emphasised the importance of close collaboration between hospital and community services. The development of integrated mental health services in the Coleraine, Magherafelt, Cookstown and Dungannon districts has been hampered by the fact that, since psychiatric hospital catchments originally related to county boundaries, they have looked to the Western Board for psychiatric hospital services and to the Northern or Southern Boards for community services. To rectify this historical anomaly, the Northern and Southern Boards are now in the process of assuming responsibility for the full range of mental health services for these districts in accordance with a phased programme which is to be completed by March 1991. The Department will be providing an additional £1.76 million to the two Boards on a recurrent basis for this purpose. The consequential savings to the Western Board will be available for the further development of community mental health services in its area.

2.29 In September 1989, as part of its undertaking in the Regional Strategy to evaluate the policy of care in the community, the Department commissioned an independent study which will trace all people with a mental illness or mental handicap discharged from hospital over a three year period after a stay of at least one year. Costing £300,000, the study will be the most comprehensive ever in the United Kingdom of the effects of the policy on the dependency and quality of life of individual service users and on the use of resources for their care. It is being conducted by a consortium led by the Health and Health Care Research Unit of the Queen's University of Belfast, and including Research and Development for Psychiatry and the Personal Social Services Research Unit of the University of Kent. As far as possible, the study will be integrated with the local monitoring systems which some hospitals have already put in place.

2.30 The way in which health and social care for people with a mental illness can be integrated, while taking into account the characteristics of a particular geographical area, is exemplified by the proposed Fermanagh psychiatric day care programme. This programme provides for a rural area with a scattered population and no established infrastructure for tackling mental illness. Its aim is to bring individually tailored packages of service to people's homes rather than requiring them to travel long distances to a single centre. Two community mental health teams will bring support to people in their own homes, including support normally associated with day hospitals and day centres. One team will deal with people over 65, the other with younger people. Each team includes both health and social service professionals. They will operate from a common base, but otherwise the Board is not investing in bricks and mortar. The scheme incorporates multi-disciplinary assessment, using a case management approach, and quality control procedures. The case management function is discharged by key workers who are professional members of the team, supported by assistant community workers. The programme will include the voluntary sector. The Industrial Therapy Organisation is to organise employment training and work therapy on a decentralised basis. The Northern Ireland Association for Mental Health is supporting a number of patients who have been discharged from hospital and who are living in housing provided by the Habinteg Housing Association.

People with a mental handicap

2.31 There are over 7,300 people with a mental handicap in Northern Ireland, some 70% of whom live at home. The core of the Department's policy, which will continue to be the basis for service development in the coming decade, is to help them lead their lives as normally as possible and to keep to a minimum the need for care in a hospital or other institutional settings.

2.32 From 1979 to 1987, the number of patients in hospitals for people with a mental handicap fell from 1,476 to 1,238 - a modest reduction. The number of people under 16 in these hospitals fell from 113 to 31.

2.33 The Regional Strategy gave a sharper focus to this policy. It set a target reduction of at least 20% in the numbers of people in mental handicap hospitals and said that within this general target the Department placed a particular emphasis on reducing the number of children with a mental handicap in hospital. The Regional Strategy also called for effective rehabilitation programmes in all continuing care units; improved respite care services for families caring for relatives with a mental handicap; and the development of the genetic counselling service.

2.34 Since 1987 the pace of change has quickened, assisted to a large extent by the use of bridging funds, and a number of significant new developments have occurred. The three mental handicap hospitals in Northern Ireland have developed rehabilitation and resettlement programmes. Boards have continued to develop respite care schemes in hospitals, residential care homes and family homes. More potential parents have used the genetic counselling service. The number of children with a mental handicap in hospital dropped from 31 in 1987 to 13 in 1988.

2.35 The general thrust of the community care strategy was advanced in 1987 by transferring responsibility for educating children with a mental handicap to the education authorities. The transfer involved over 1,200 children, and at the same time the Government provided £850,000 to improve paramedical services in special schools. These funds enabled Health and Social Services Boards to appoint 25 speech therapists, 19 occupational therapists, and 15 physiotherapists.

2.36 The development of community services is evidenced to some extent by the expansion in the number of places available in Adult Training Centres and in multi-client day centres. These provide valuable respite for informal carers as well as social training and occupation activity aimed at assisting people with a mental handicap to achieve their full potential. However, it is widely recognised that ATCs, which provide mainly centre-based activities, do not satisfactorily meet the needs of all people with a mental handicap. Other forms of daily activity making use of leisure centres, colleges of further education and work training places, together with other forms of support for carers, have recently begun to be developed to complement them.

2.37 Community mental handicap teams are now operating successfully in many places and have responsibility for co-ordinating the shift in the balance of care from hospital to community. Families have been identified who are willing to foster people with a mental handicap on a permanent basis. New and expanding forms of special housing include core and cluster schemes, residential homes run by voluntary organisations and housing associations, and residential care and nursing homes run by the private sector.

2.38 Success in the provision of community care services for people with a mental handicap in future will depend upon innovation, co-operation, mutual understanding and diversity. Some general elements of this approach have already been indicated. A specific illustration is provided by the Bridge Association Training Unit at Antrim, which opened in January 1988. The Unit provides places for 36 people with a mental handicap from 16 to 50 years of age. It aims to equip the more able for work on the open market or under the Department of Economic Development's Sheltered Placement Scheme. The Unit is an example of a successful partnership between a locally based voluntary body and the Northern Board. It has been supported with bridging finance and has received funding from the European Social Fund. The Bridge Association also plans to run a 15-place residential scheme being provided by the Nih Housing Association with support from the Department of the Environment. The scheme is designed to dovetail with the Training Unit and to help people with a mental handicap to move from hospital into the community.

The way forward

2.39 Although there have been many promising developments in services for these four client groups over the past two years, and significant progress towards meeting the main Regional Strategy objectives, provision remains uneven and there are still substantial gaps in the spectrum of care in many places. As a consequence, people are still being inappropriately admitted to hospitals, residential care homes and nursing homes; people who have successfully completed rehabilitation and resettlement programmes are having to stay in hospital; domiciliary care services are uneven and sometimes poorly targeted; and packages of care are not being tailored appropriately to meet individuals' needs. This policy paper identifies ways of addressing these deficiencies and of improving the quality of community care.

CHAPTER THREE: CARING IN THE 1990s

Rising to the challenge: elderly and physically disabled people

3.1 Over the next 10 years, the number of people over 65 in Northern Ireland is expected to increase by 4,000, or 2%, and of those over 85 by 6,000, or 40%. The number of frail elderly people, often exhibiting interacting physical, social and mental problems, will increase significantly. This change in the age profile will have major implications for health and social services in the community.

3.2 As indicated in Chapter 2, many elderly people suffer from a physical disability. The number of people with a physical disability will undoubtedly rise as the population ages. Trends in the incidence of disability amongst younger people are less easy to discern. Preventive measures may reduce disability, but any decline will be offset by medical advances which have increased the life expectancy of those born disabled. While it is not clear how these trends will affect the number of the young disabled, it is likely that the nature of their disabilities will change over time.

3.3 The needs of people with a mental illness are diverse. Many have relatively simple medical needs, which will be met by the straightforward use of the community health services. More complex needs demand special measures of intervention and support. The Regional Strategy emphasises the importance of providing properly for patients being discharged back into the community from hospital after a lengthy period of care. This emphasis will continue, but there are other groups who will pose the main challenges for the community mental health programme in the 1990s. They include the growing number of elderly people with a mental infirmity and younger people with substantial and continuing disability, particularly resulting from schizophrenia. For this latter group, refined programmes of rehabilitation and resettlement and special packages of community support will need to be developed.

3.4 As many people with a mental handicap are living longer, their carers are themselves ageing and finding it progressively more difficult to look after them. As an increasing proportion of babies with a mental handicap survives, the demand rises for services for such children.

Rising to the challenge: elderly and physically disabled people

3.5 The Department remains committed to the policies set out in the Regional Strategy. In services for elderly and physically disabled people, it places particular emphasis on the following priorities which are reflected in all four Boards' current operational plans:-

* reducing the need for inpatient and residential care by promoting healthy lifestyles and developing effective health surveillance and screening programmes;

* continuing to provide for those who require it a full spectrum of care, including acute inpatient services, specialist geriatric and psychogeriatric services, rehabilitation services and a range of therapeutic and social services;

- ensuring that decisions on the provision of services are based on careful assessment of individuals' needs, and that adequate domiciliary care and day care services are available;
- involving users of services in their development; and
- improving access to information about services, including respite care.

3.6 Carers are often the cornerstone of support for an elderly or physically disabled person in the community. The presence of a caring relative or friend does not, however, mean that the person being cared for has no need of support from the health and personal social services. Indeed to preserve this caring relationship Boards must ensure that a range of services is available to assure the carer that at times of crisis expert or professional help will be provided immediately and to assist the elderly or disabled person and the carer to live as normal a life as possible.

3.7 Caring 24 hours a day inevitably places a great deal of pressure on the carer. For this reason Boards should actively plan for the provision of respite care to allow for periodic breaks for carers. Respite care may take various forms. For example, it may be the relief provided by day care, or the type of support offered in the home by voluntary organisations such as Crossroads. While the availability of support at times of crisis provides a major reassurance to carers, it is important that support is also available as a preventive measure to prevent crises from occurring.

3.8 If elderly and physically disabled people are to be supported in the community, they must have ready access to treatment and rehabilitation. Otherwise increasing handicap may make long-term hospital care unavoidable. Boards should ensure that effective rehabilitation and resettlement programmes are available for elderly people and people with a physical disability. They need to have access to such programmes not only in hospital, but also, following their discharge, in the community, if they are to be able to resume their normal lives successfully.

3.9 Deaf and blind people in the community have additional problems related both to isolation and communication. The need to improve services for these client groups, spelt out in the Regional Strategy, has still to be met, especially outside the Belfast area.

Rising to the challenge: people with a mental illness or mental handicap

3.10 In taking forward the Regional Strategy the Department recognises that the need for respite care services is particularly pressing for parents who are looking after profoundly mentally handicapped children. It intends over the next year to review the level of demand for and adequacy of these services. It also attaches particular importance to achieving by 1992 the objective that no child should grow up in a mental handicap hospital. In other words, no child with a mental handicap should by then be the subject of continuing care in hospital.

3.11 The Department is taking several steps to improve the care of people suffering from a mental illness or handicap. First, in view of the success of bridging finance in supporting the move of patients from hospitals into the community, it will be committing a further £6m for this purpose over the 3 year period from 1990 to 1993. This brings the total so far committed to bridging up to £24m.

3.12 Second, the Department will be setting aside a development fund of £150,000 for pilot schemes in the voluntary sector which pioneer forms of community care, new to Northern Ireland, for people with a mental handicap or mental illness. Priority will be given to projects which offer or complement home or respite care; offer additional support for carers; or involve users in the planning, development and operation of services.

3.13 Third, the Department is preparing a Code of Practice dealing with the guardianship or admission to hospital and medical treatment of the small proportion of people with a mental illness or mental handicap who present such a substantial threat to themselves or to other people while they remain in the community that special powers under the Mental Health (Northern Ireland) Order 1986 have to be exercised in caring for them.

CHAPTER FOUR: MEETING INDIVIDUALS' NEEDS

4.1 The Department recognises that in responding to the challenges of the 1990s highlighted in Chapter 3, Boards will need to ensure that services are better targeted towards the specific requirements of those individuals who need them most. This will require well co-ordinated and flexible systems for assessing individuals' needs and planning and delivering packages of care to meet them. Responsibility for these functions will have to be clearly assigned.

4.2 Combined with the changes set out elsewhere in this paper, the Department expects that an improved capacity to respond flexibly to individuals' needs will result in a shift of emphasis towards domiciliary care services. A range of such services is already available to enable people to continue to live in the community. However, their provision is uneven and in some places poorly co-ordinated. There is a tendency to fit clients to services, rather than adapting services to clients' needs. A report published by the Social Services Inspectorate in February 1990 has revealed considerable variations in the level of resources allocated to domiciliary care, and in how these resources are targeted. There is clearly scope for improvement.

Assessment

4.3 Sir Roy Griffiths saw as an essential basis for community care the requirement, within the resources available, to "identify and assess individuals' needs, taking full account of personal preferences (and those of informal carers), and design packages of care best suited to enabling the consumer to live as normal a life as possible". A primary purpose of these assessments is to ensure that services are tailored to individuals' particular needs. The Government has accepted this recommendation.

4.4 It is not the Government's intention that everyone needing care and support in the community should be referred for a comprehensive multi-disciplinary assessment. For example, people with exclusively health care needs which can be met in the community - including nursing care - will continue as at present to have direct access to and receive service directly from the community and primary care services. People who need straightforward social services support, including practical help, advice and information, will continue to look directly to the personal social services. In many cases such as these, the need will be identified by the client's general practitioner, who will be able, as at present, quickly and informally to make arrangements directly with the provider of the service his or her patient needs.

4.5 Boards will be expected to reach their own views about when a more comprehensive assessment or reassessment involving two or more professional disciplines should be triggered. In so doing, they will have to take into account the complexity of the case and the level of resources involved, and to acknowledge that in any individual case the decision on what services to provide will be ultimately a matter for professional judgment. In most cases, it should be possible to build on existing arrangements, making present roles explicit and ensuring that all the available information relevant to a client's needs and circumstances is brought together. This information will include not only the contributions of health and social services professionals, but also the views of the client, his or her informal carers, and material from other agencies.

4.6 The comprehensive assessment process should always be activated when the decision to be taken is whether the client should move on a permanent basis into a residential care home, nursing home or continuing care hospital unit, or back from one of these into the community. The decision to move into a home or hospital is a critical one in the life of any person. Once he or she has moved out of his or her own home into any form of institutional care, it may become difficult to go back to independent living. The purpose of requiring a full assessment at this important juncture is to establish whether a co-ordinated package of domiciliary care - perhaps including personal care, emotional support and help with mobility, domestic tasks, financial affairs, accommodation, leisure and employment - would enable the person to go on living at home. Equally, no vulnerable person should be discharged from hospital without a complete assessment involving all appropriate disciplines.

4.7 Assessments should take account of the wishes of the individual and his or her carers, and of carers' ability to continue to provide care. Where possible, they should include clients' and their carers' active participation. An effort should be made to offer a range of options which enables individuals and carers to make choices.

4.8 The objective of a comprehensive assessment is to decide on the best means available to help individuals and their carers. It should focus positively on what the individual can and cannot do, and can be expected to achieve, taking account of his or her personal and social relationships. It should not focus only on the person's suitability for a particular existing service. The aim should be to review the possibility of enabling the person to continue to live at home, even if this means arranging a move to different accommodation within the local community; and, if that possibility does not exist, to consider whether residential, nursing home or continuing care in hospital would be appropriate.

4.9 All agencies and professions involved with the individual and his or her problems should be brought into the assessment procedure as appropriate. These may include social workers; general practitioners; community nurses; hospital staff working in geriatric medicine, psychiatry and rehabilitation; physiotherapists; occupational therapists; speech therapists; psychologists; pharmacists; dietitians; dentists; chiropodists; continence advisers; community psychiatric nurses; staff dealing with vision and hearing impairment; housing officers; social security officials; Department of Economic Development resettlement and rehabilitation officers; home helps; home care assistants; and voluntary workers.

4.10 Decisions on admission to continuing care beds in hospital are a medical responsibility. They should be based on full assessment including social as well as medical factors, just as when a move to residential care or nursing home is being contemplated. Multi-disciplinary assessment is already common practice for non-urgent admissions to hospital geriatric units. Where admission is required so urgently that the scope for prior assessment is limited, more comprehensive assessment should be undertaken after the patient goes into hospital. While the decision to admit is the responsibility of the consultant, general practitioners should contribute by providing information on relevant medical and other factors, and should consider invoking the community care assessment process before requesting hospital admission. There should be close collaboration between hospital teams and those responsible for assessment in the community, particularly in considering possible alternatives to prolonged hospital stay. Such collaboration is equally essential when decisions have to be made by hospital doctors about the discharge of vulnerable patients.

The organisation of assessments

4.11 In Great Britain, local authority social services departments will have a specific responsibility for the organisation of comprehensive assessments. This is in keeping with the Griffiths principle that responsibilities should be clearly assigned. In Northern Ireland, Boards' Area General Managers will be expected to ensure that efficient and effective assessment procedures are in place throughout their areas. In line with the approach adopted in Great Britain, the Department expects that social services will usually have the lead responsibility at Unit level for the co-ordination of assessments. In some circumstances, another profession might be given lead responsibility: this might be appropriate, for example, in a psychiatric Unit of Management. Whichever profession is assigned lead responsibility will co-ordinate all assessments, regardless of the placement or services under consideration.

4.12 Within that profession, a single worker should be given responsibility for ensuring that each assessment is conducted in accordance with the established procedures. He or she will receive requests for assessment; co-ordinate any contributions by other professions and interested parties; ensure that comprehensive assessments are properly conducted whenever they are appropriate; and see that the resulting recommendations are taken forward.

4.13 There are a number of ways in which an individual may seek help and may therefore need an individual assessment. For example, he or she may apply for a package of home care services or a place in a Board residential care home. In addition, as will be explained in Chapter 6, it will from April 1991 be possible for people to ask for Board funding towards the cost of a place in an independent sector residential care or nursing home. Boards should aim to develop common procedures for all these situations, and to ensure that people are offered the help they need irrespective of the basis on which their first contact with the Board is made.

4.14 Boards' assessment procedures will need to take account of local circumstances. They should be straightforward and efficient, and responsibility for their operation should be clearly assigned. Assessments should be carried out without undue delay. Contributions should be sought quickly and informally. It is not always necessary for all contributors to attend meetings. Costly and time-consuming case conferences should be avoided, as should duplication of effort, for example between hospital and community based professionals.

4.15 In allocating responsibility for assessment and subsequent action, Boards should take account of the important part played by general practitioners and the fact that their practice areas are not co-terminous with Units of Management. The allocation of responsibility for assessment should therefore be as straightforward as possible, and Boards should tell all general practitioners who is the responsible officer in each Unit which overlaps with their practice areas.

Further guidance

4.16 The new assessment arrangements outlined above will involve significant changes in the way professional workers operate. The Department proposes two measures to facilitate this:-

- it will circulate guidance on the workings of the new system, to be prepared following consultation with professional and representative bodies;

- each Board will be expected to publish a local guide to the principles and workings of its own assessment system. These guides should be made available to all those involved in assessments, to local agencies and voluntary groups, and to members of the public. They should explain the means of referral to and criteria of eligibility for assessment and reassessment, and should include details of contact points.

Action following an assessment

4.17 Once a comprehensive individual assessment has been completed, and a decision has been taken that publicly funded care can and should be arranged, it will be the responsibility of the Board at Unit level to design appropriate care arrangements, in consultation with the client, his or her informal carers, and all care professionals involved. These arrangements should take account of the local availability of services and support, and should, where necessary, include help and respite for informal carers.

4.18 Assessments will have to be made in the context of the Department's strategic guidance and the Board's operational priorities. Although the ideal is to meet all the person's health and social care needs in full, decisions on service provision will inevitably have to take account of what is available and affordable, and priority will have to be given to those whose needs are greatest.

4.19 Each Board should monitor the outcomes of its assessment process, and the implications of these outcomes for the future development and procurement of services.

Case management

4.20 People's care needs may change over time and must be monitored. Where an individual's needs are complex or significant levels of resources are involved, the Department sees considerable merit in Sir Roy Griffiths' recommendation that a single professional worker should be assigned as that individual's personal contact, to ensure that each individual's needs are regularly reviewed and that resources are managed effectively.

4.21 The idea of a 'key worker' emerged during the 1970s as a single contact point for an individual client faced with an array of agencies offering different services. In the 1980s, the concept evolved into that of the 'case manager'. A case manager is the principal contact for the client. He or she takes responsibility for designing and assembling a package of services tailored to the client's needs; and for ensuring that these services are effectively co-ordinated, delivered and monitored.

4.22 The case management model is increasingly being used within existing multi-disciplinary approaches. A particular member of the team is given responsibility for a number of clients. As case manager he or she acts as a broker between the various agencies concerned with each client; monitors the client's progress; plans social and occupational programmes; and, above all, maintains a supportive caring relationship with the client.

4.23 Many agents may contribute to a person's care in the community. They include social services, housing agencies, general practitioners, hospital and community health staff, Department of Economic Development resettlement and employment personnel, Education and Library Boards, social security offices, private and voluntary organisations and others. Without proper co-ordination, they may not know which other services a client is receiving and whether the total package is sufficient. The case manager will be aware of all the client's needs, the extent to which they are being met and by whom. He or she should keep the different parties informed of what is being done and bring to their notice any apparent unmet need.

4.24 The case manager may or may not be the designated person responsible for the original assessment of the client's needs and design of the package of care. He or she should be the person best fitted to help the client with those problems which are predominant at the time, regardless of his or her particular professional or career background.

4.25 Case management provides an effective method of targeting resources and planning services to meet the specific needs of individual people. The approach has already been used successfully in a number of projects in Northern Ireland. The Department believes that the wider introduction of the key principles of case management would confer considerable benefit, particularly for clients with complex needs, and it will seek to encourage their application more widely.

4.26 The Department also sees advantage in linking case management with delegated responsibility for budgetary management. This need not be pursued down to the level of the individual client, but, used flexibly, is an effective way of enabling those closest to the identification of client needs to make the best possible use of the resources available.

CHAPTER FIVE: ROLES AND RELATIONSHIPS

"Working for Patients"

5.1 The White Paper "Working for Patients" set out the Government's plans for improving the quality and efficiency of the National Health Service. Together with the proposals in "Caring for People", those plans are being taken forward in the National Health Service and Community Care Bill, which was published in November 1989. Corresponding legislation is being prepared for Northern Ireland.

5.2 The principles underlying the health service reforms apply as much to care in the community as to hospital care, and to the personal social services as much as community health services. Central features of the reforms include:

* delegating as much power and responsibility as possible to the local level;
* strengthening management at local level through the appointment of Unit General Managers throughout the health and personal social services;
* Units increasingly assuming responsibility for delivering contracted services within quantity and quality specifications to a number of clients which may include the 'parent' Board;
* developing a simpler system for resource allocation which will fund Boards for their resident population, weighted to take account of demographic factors, rather than for the services they provide;
* developing Boards' role at Area level as the purchasers of services and quality controllers;
* reconstituting Boards as management bodies, linked to the development of new advisory and consultative arrangements.

5.3 The remainder of this chapter will look at Boards' evolving role and responsibilities for the design, delivery and monitoring of community care services in the context of the "Working for Patients" reforms. It will also look at Boards' relationships with the private and voluntary sectors and with housing agencies in the exercise of those responsibilities. There are in addition many statutory agencies such as social security and employment and training, with which Boards must work in partnership.

Boards' role and responsibilities

5.4 Boards already have a wide range of statutory powers and duties to help vulnerable people in the community. They are responsible for meeting community care needs in their areas by arranging the provision of residential and nursing home care, day care, community nursing and domiciliary care services and respite care.

5.5 The development of the community care initiative in the context created by the "Working for Patients" reforms will require Boards to work towards the following goals:

- to assess the community care needs of their areas, set local priorities and service objectives, and develop plans for addressing these needs, in consultation with the Housing Executive and other statutory agencies, housing associations, voluntary and private sector service providers;
- to make arrangements for clearly assigning responsibility for co-ordinating the assessment of individuals' needs for health and social care;
- to arrange for the design of packages of care which are tailored to meet the assessed needs of individuals and their carers;
- to secure the delivery of community care services not simply by acting as direct providers, but also by developing their purchasing and contracting roles; to ensure that information is readily available to the public about community care services, where and how to seek them;
- to establish procedures for receiving comments and complaints from service users;
- to monitor the quality and cost-effectiveness of services;
- to establish arrangements for assessing clients' ability to contribute to the cost of residential and nursing home care.

5.6 Other chapters consider some of these responsibilities in greater detail. In strengthening their systems for planning, accountability, financial control, purchasing and quality control to implement the proposals in "Working for Patients", Boards will have to bear in mind the effective and efficient discharge of their community care responsibilities, and to recognise that special arrangements may be needed for the community care services.

Integrated health and social care [illegible]

5.7 A central theme in "Caring for People" is the need for stronger links between health authorities and local authority social services departments in Great Britain, and improved co-ordination between the professional groups which they employ. Northern Ireland already enjoys the advantage of an integrated organisational structure embracing both health and social care. It is not therefore necessary to introduce formal arrangements such as those set out in "Caring for People" for joint working and planning between health authorities and social services authorities. Nor would it be appropriate for the Department to assign responsibilities to specific professional groups. It is nevertheless essential that responsibilities for the co-ordination of assessment, identification of priorities, planning, monitoring and service specification and delivery should be clearly assigned to individuals, both at Area and Unit level, and related to responsibilities for programmes of care for all client groups.

5.8 General Managers at Area and Unit level will be expected to ensure that the caring professions work closely together at all operational levels, with each recognising and respecting the others' contributions and responsibilities, cross-referring cases when appropriate, and seeking advice and information when relevant. Acute hospital care, continuing hospital care and community care should be complementary and should be planned to provide a well co-ordinated range of services. There is no room in community care for a narrow view of individuals' needs nor of ways of meeting them. It is also essential that the caring services recognise the need to work in partnership with other agencies.

Developing a mixed economy of care

5.9 The Government's aspiration is to see a range of different service providers, with the statutory, private and voluntary sectors working together. It is intended that such a range should establish a framework within which Boards as purchasers can offer a choice to their clients of good care at a realistic cost to the public purse. The Department will expect Boards, in discharging their new and expanded responsibilities, to use services provided by the independent sector whenever it is appropriate and cost effective to do so. Boards will continue to play an important role in the provision of services, but where they are still the main or sole providers, they will be expected to take all reasonable steps to promote diversity of provision.

5.10 The Department believes that stimulating the development of independent sector service providers will result in a range of benefits for the consumer, in particular:

- a wider range of choice;
- services which meet individual needs in a more flexible and innovative way;
- competition between providers, resulting in better value for money.

5.11 At present, independent sector activity in Northern Ireland is largely concentrated in the residential care and nursing home field. Independent sector domiciliary care, day care and respite care is less well-developed. The Department hopes that the proposals in this paper will result in greater diversification by independent sector service providers.

5.12 Boards will be expected to develop sound working relationships not just with the voluntary sector but also the private sector. The objectives of this partnership approach will be to communicate clearly to independent sector providers the care needs which Boards have identified, the localities where they most urgently require them to be met and the categories and levels of dependency of clients for whom they are seeking to purchase care. The Department believes that the independent sector should be encouraged to provide care for people with various degrees of dependency, including profound and severe handicap and frailty.

5.13 Boards should promote a mixed economy of care in a number of ways, which might include:

- determining clear specifications of their service requirements;
- establishing clear procedures for tendering and contracting and making sure that they are widely known and well understood by potential providers;
- taking steps to stimulate the setting up of "not for profit" agencies;
- identifying areas of their own work which are sufficiently self-contained to be suitable for floating off as self-managing units;
- stimulating the development of new voluntary sector activity.

5.14 The Department believes that the wider use of service specification and tendering is likely to be one of the most effective ways of stimulating new activity in the independent sector. It has decided against extending compulsory competitive tendering to community care services, and favours giving Boards an opportunity to make greater use of service specifications, agency agreements and contracts in an evolutionary way. This will require Boards to define clearly the outcomes they want; to be more specific about the nature of the service they are seeking to provide to achieve those outcomes; and to identify the necessary inputs.

5.15 At the same time as seeking to increase the contribution of the independent sector, Boards will need to consider carefully the advantages and safeguards attaching to the direct provision of care by themselves for different groups of clients and different levels of dependency. In doing so, they should bear in mind the value to them of maintaining in-house care management experience and expertise and of having a base of comparison for the proper level of charging that should be made for different types of care. The Department will expect Boards to retain the ability to act as direct service providers if other forms of provision are unavailable or unsuitable, or break down; and Boards' direct services should not be confined to people who are difficult to place elsewhere.

The partnership with the [illegible]

5.16 The value of grants paid by the Department and Boards to voluntary bodies has increased in real terms over the past decade by 255%, well in excess of the overall increase in spending on services.

5.17 Sir Roy Griffiths identified the need for a stronger basis for funding the voluntary sector. He recommended that there should be a clear contractual relationship between a public agency and a voluntary body. This is in line with the Government's overall strategy for working with the voluntary sector, and Boards will be expected to develop an increasingly contractual relationship with each of the voluntary bodies which they fund. This will help to clarify the role to be played by voluntary organisations and Boards' expectations of them; give voluntary bodies more certainty in planning for the future; and stimulate innovation and flexibility.

5.18 Some voluntary organisations may need to make major changes in their approach to service planning and delivery if they are to make the most of the opportunities now on offer, and there is likely to be advantage for both sides of the partnership if they are involved at an early stage in the negotiation of a contract. Contracts should be related to clear specifications and fully understood by both partners.

5.19 The Department recognises that some important voluntary sector activities are not suitable for a contractual funding approach. Furthermore, it will be important to allow scope for the emergence of new, small-scale groups and to avoid the over predominance of large, well established voluntary bodies. For both these purposes, Boards will continue to make grants towards the local administrative expenses of voluntary organisations. The Department itself will continue to offer grants towards the regional administrative expenses of voluntary organisations and towards innovative local pilot projects.

The partnership with housing agencies

5.20 Housing is often the key to independent living. If dependent people are to be helped to continue living in the community, their homes must be places where they can go on caring for themselves and where it is possible for others to provide the support they need. It is essential that there should be a close working relationship between Health and Social Services Boards, the Housing Executive and the voluntary housing movement. In assessing their clients' needs and trying to assemble packages of care to meet those needs, Boards will recognise that the housing dimension is crucial.

5.21 It is important that owner-occupiers receive advice and help at the right time to enable them to go on living in their own homes for as long as possible. Voluntary bodies run local care and repair schemes through which they offer advice to elderly people on how to keep their homes in good repair and on finance for repairs and adaptations. With increasing disability, people may only be able to stay in their own homes if these are suitably adapted. Adaptations may include the provision of hand rails, chairlifts and alarm systems; or they may be more substantial. People who are more severely disabled might be helped by a move into some form of specialised accommodation, such as purpose designed housing for people in wheelchairs, or core and cluster developments for people with a mental handicap. There are various forms of sheltered housing for elderly disabled people.

5.22 The Housing Executive and the voluntary housing movement have been working closely and with increasing success for over a decade on the provision of high quality accommodation for people with special housing needs. The Housing Executive, the single comprehensive housing authority for Northern Ireland, has a total stock of over 170,000 dwellings. Applicants with special care needs are given priority status under its Housing Selection Scheme. The voluntary housing movement, which has grown rapidly since 1976, now includes 46 independent registered associations, funded by the Department of the Environment, which have a total stock for rent of about 9,000 dwellings.

5.23 The present policy of the Housing Executive and for housing associations is that all new homes for general needs should include some features which contribute to better mobility. All new bungalows and ground floor flats are designed to be convenient to all walking disabled tenants, including those who use wheelchairs but are not chairbound. In 1988/89 some 33% of new dwellings built by the Executive were built to full mobility standards. Such standards are also applied to most sheltered accommodation provided by housing associations for elderly and disabled people.

5.24 Adaptations to existing stock represent an important contribution to community care. In 1988/89 the Executive carried out over 6,500 adaptations to meet special needs and paid more than 650 grants towards the carrying out of similar work in the private sector. Public and private sector adaptations in 1988/89 represented a total investment of over £2m.

5.25 At 1 April 1989 special provision accounted for about 9% of the Executive's total stock, as follows:-

- old people's dwellings	7,098
- homes built to mobility standards	5,643
- sheltered dwellings	1,962
- wheelchair accessible homes	102
- adapted stock	1,495

5.26 The Executive also makes available dwellings to be let on a shared basis to patients leaving institutional care. Recently the Executive has been working with voluntary organisations on the development of dispersed intensively supported housing (DISH) schemes. The Executive provides housing to a voluntary group which sublets to people in need and provides a package of care and support.

5.27 Housing associations are playing an increasing role in housing and caring for special needs groups. Since the current funding arrangements were introduced in 1976, they have provided some 4300 sheltered and other specially designed units for the elderly, some 140 units for people with a mental handicap, 50 for people with a mental illness and 160 for people with a physical disability.

5.28 At regional level, the Departments of Health and Social Services and the Environment have agreed that priority in the allocation of funds for special needs housing schemes during the period from 1990 to 1993 should be given to projects for people with a mental illness or mental handicap and heavily dependent elderly people. The Department of the Environment has asked the Housing Executive to identify the extent and distribution of future special housing needs, in consultation with Health and Social Services Boards and the Northern Ireland Federation of Housing Associations.

5.29 At present there is a measure of consultation at local level amongst Boards, the Housing Executive and individual housing associations over specific schemes. It is in Boards' interest to develop this process of communication. The aim should be for these three parties to agree local priorities and plans, on the basis of which they can contribute to an overall strategy to meet the accommodation needs of client groups throughout Northern Ireland.

5.30 To achieve the best possible results from the partnership between Boards and housing agencies, the two Departments will explore the possibility of harmonising the planning cycles of Boards, the Housing Executive, and housing associations.

CHAPTER SIX: RESIDENTIAL CARE AND NURSING HOMES

Role

6.1 One of the Government's main objectives is to promote the development of domiciliary, day and respite care services to enable people to live in their own homes wherever feasible and practical. Nevertheless residential care homes and nursing homes will continue to play an important part in meeting people's care needs. Some people will always need more support than can reasonably be provided in their own homes or in sheltered housing. Much depends not only on their physical needs but also on their emotional needs and their personal and social circumstances. The Government's proposals for reforming the funding of residential and nursing home care are intended to ensure that people enter homes with public funding when - and only when - a proper assessment of their needs and all their circumstances has established that this is the right form of care for them.

Recent growth

6.2 Provision for those people in Northern Ireland requiring residential or nursing home care is made in a range of homes in the statutory, private and voluntary sectors. Although these homes cater increasingly for people with a physical disability, mental illness, mental handicap or terminal illness, most residents are elderly. The table below shows the growth in the number of places provided from 1979 to 1989.

	Residential Care		Nursing Homes		Total	
Sector	1979	1989	1979	1898	1979	1989
Statutory	3597	4034	0	0	3597	4034
Independent	1367	2129	307	2450	1674	4579
Total	4964	6163	307	2450	5271	8613

6.3 There was a substantial increase from 1979 to 1989 in the number of places provided by the independent sector: a 56% increase in residential care homes and 698% in nursing homes.

The effects of social security payments

6.4 This increase can be attributed to the ready availability of social security funds. Special arrangements for social security benefits, principally Income Support, apply at present to most residents of independent sector homes. The arrangements embrace all registered homes and a few others, such as those run by the Abbeyfield Society or by organisations established by Royal Charter or Act of Parliament.

6.5 Income Support is available to people on low incomes, provided they do not have capital of over £6000, to help with the home's fees and the cost of any meals not included in the charge. A separate personal expenses allowance is provided. Housing Benefit is generally not available. The amount which can be paid towards fees is subject to an overall limit. Limits vary according to the type of home and the nature of the care provided. Because Income Support provides help with accommodation and care as well as living costs, a claimant in a home obtains substantially higher benefit than someone outside a home claiming the normal Income Support personal allowances and premiums.

6.6 These arrangements have undoubtedly been of real value to many vulnerable people and their families and have been the channel through which significant public resources have been invested in the provision of community care. However, their unintended consequence has been that priority in the development of community care services has not been given to services which enable people to stay in their own homes. Sir Roy Griffiths noted that" ... the ready availability of social security makes it easy to provide residential accommodation for an individual regardless of whether it is in his best interest .. if overall resources are limited residential accommodation may take an undue proportion of available money to the exclusion of more satisfactory alternatives of keeping people in their own homes."

6.7 The social security system does not readily permit any assessment of whether its individual payments represent good value for money. Social Security Adjudication Officers have neither the duty nor the expertise to determine whether the charges met from Income Support are reasonable for the level and quality of care provided. There is a considerable variation in the cost of appropriate care across different client groups and levels of dependency.

New funding arrangements

6.8 Sir Roy recommended that public finance for people who require residential home care or nursing home care should be provided only following an assessment of their need for care. The Government has accepted this recommendation, and now proposes that the costs of community care should be drawn from the same budget, whether the care is provided in a person's own home or in an independent residential care or nursing home. This budget will include the care element currently contained in social security payments to people in these homes. In Northern Ireland, the budget will be managed by Health and Social Services Boards. They will be given responsibility for making the best use of the funds available in the light of their assessments of individuals' needs and of their overall priorities.

6.9 Consequential changes will be needed in the way in which Income Support is paid to people in independent sector homes. People who enter these homes under the new funding structure and who need public financial support will no longer have their care costs met by the social security system. In place of the special limits, help will be available from the normal Income Support system of personal allowances and premiums and from Housing Benefit. Clients will receive assistance on much the same basis as when in their own homes. The financial incentive towards residential and nursing home care under current Income Support rules will therefore be eliminated. Other than any necessary adjustments to the Housing Benefit entitlement, the sources of income from the benefit system will remain the same when a person enters or leaves an independent sector home.

6.10 Under the new arrangements the Housing Executive, which administers the rent rebate and allowance schemes in Northern Ireland, will be responsible for determining what constitutes the "eligible rent" on which Housing Benefit can be paid. The Government will bring forward proposals on the method to be used.

6.11 The Government intends to introduce these changes from 1April 1991. In order to secure a smooth transition, the new arrangements for social security benefit will apply only to people who become resident in the homes concerned on or after that date. Chapter 7 sets out the arrangements for people who are already resident in homes on that date.

Securing places

6.12 If, after carrying out an assessment of a person's needs, a Board decides that a residential care or nursing home place represents the right choice for the person involved, it will arrange a place in one of its own homes or an independent sector home. A place in a nursing home will be arranged only if the assessment establishes a need for nursing care as the whole or main component of the care required.

6.13 Each Board will have to estimate the number of places it will need and then arrange, subject to the constraint of available resources, to meet the projected demand. There will be no nationally set limits to the level of fees which it may meet: Boards will exercise their purchasing power to achieve best value and quality of care for their clients.

6.14 There are several ways to achieve this: a Board could, for example negotiate fees with an individual proprietor for an agreed number of places or set limits on the level of fees it is prepared to pay. In any event, it is important that all purchasing arrangements should be firmly based on a clear contractual foundation.

6.15 As with all other services, contracts will have to be drawn up carefully and will need to specify precisely the level and quality of service required. Specifications might usefully require proprietors to set up and operate systems for evaluating their own performance. The Board's own procedures for monitoring and evaluating performance should be clearly stated from the outset.

6.16 The Department believes that the introduction of contractual arrangements and possibily also of competitive tendering in relation to the purchase of residential and nursing home care will enhance Boards' ability to obtain value for money. They will be well placed to use their new purchasing power to give priority to those with the most pressing needs and highest levels of dependency; to ensure high quality care; and to determine what range of care is provided, and where.

6.17 Once a charge has been negotiated and agreed with an independent sector home, the Board will itself meet that charge. It will then assess the ability of its clients to contribute towards the cost from any benefits or other income. In most cases a financial assessment will already have been carried out for social security purposes.

6.18 The Department recognises that the need to assess each applicant's financial means will result in extra work for Boards. However, the new system builds on existing arrangements for the residents of Boards' homes.

Consumer choice

6.19 For many people, entering a residential care or nursing home will mean moving permanently from their own home and neighbourhood where they may have lived for a long time. This can be a difficult step, which requires sensitivity in helping the individual reach a decision. Subject to the availability of resources, people should be able to exercise the maximum possible choice about the home they enter and its location, which need not be in the area of the Board making the arrangements. The preferences of relatives and other carers should also be taken into account. If individuals, their relatives or friends wish and are able to make a contribution towards the cost of care, they may decide to look for a place in a more expensive home. Boards' arrangements should be sufficiently flexible to permit this.

6.20 Some people will wish to enter a home in an area other than that in which they normally live, for example to move nearer to family or friends. Subject to the availability of resources, people will continue to be able to do this under the new funding arrangements. Their needs will be assessed by the Board in the area in which they are living. If they are assessed as needing residential or nursing home care, that Board will indicate how much it is prepared to pay towards the cost, either allowing the clients to find places for themselves, or making arrangements directly with the Board into whose area the clients wish to move.

People with a terminal illness

6.21 Most terminally ill people wish to spend their remaining days in familiar surroundings, and services are available to support the individual and their family by providing skilled home care. Hospice facilities are available to support those who require more concentrated care in a centre specially designed and organised and with staff skilled in pain relief and symptom control. Increasingly they also provide day care and support to those wishing to live at home as much as possible. Responsibility for planning and co-ordinating the provision of terminal care rests with Health and Social Services Boards whether they use their own facilities or those provided by independent sector organisations.

Boards' homes

6.22 There will be no change in the arrangements for paying social security benefits to residents of Boards' homes. Boards will continue to meet the full cost, including the costs of accommodation and food. In these circumstances, they may wish to review the extent to which they should maintain homes of their own. In so doing, Boards are asked to bear in mind the benefits outlined in Chapter 5 of retaining some level of capacity, skill and experience in this area.

CHAPTER SEVEN: HELP FROM SOCIAL SECURITY

7.1 The Government will continue to provide financial support for those who need care and for their carers. The social security system does this in a number of ways: through Invalid Care Allowance, Disability Benefits, Income Support, Housing Benefit and the Social Fund. Social Fund Community Care Grants will continue to complement the Boards' funding of community care.

7.2 Chapter 6 has outlined the main changes proposed to the way in which social security benefits will be paid to people in independent residential care and nursing homes when the new funding structure is in place. This chapter sets out the Government's proposals for paying Income Support to people who are already in homes when the new arrangements come into effect and describes the effects of the new structure on residents' entitlement to social security benefits other than Income Support.

Preserved rights for existing residents

7.3 The Government intends to preserve the present scheme of special Income Support limits for existing claimants who are in residential care and nursing homes when the new funding structure is introduced on 1 April 1991. The right to claim Income Support under the preserved scheme will also be safeguarded for residents who are not claimants at that date but who subsequently claim.

7.4 Access to the preserved scheme will be given if, on 31 March 1991, a resident or claimant is, or would normally be, living in a residential care or nursing home where the Income Support limits apply. Income Support will continue for claimants, including existing residents who subsequently become claimants, whose entitlement in a home is not interrupted. Entitlement will not be affected by a claimant or resident moving to another home or, in most circumstances, leaving a home for long periods - for example to go into hospital.

7.5 These rules will apply to the residents of all registered homes and to the residents of those homes which are not registerable but are specially catered for in the present Income Support scheme, such as homes run by the Abbeyfield Society.

Respite care away from home

7.6 Elderly or disabled people, normally cared for at home by relatives, may be placed temporarily in alternative accommodation, to give their usual carers a break. Such temporary placements are provided by the Boards in their own accommodation and in independent sector residential care and nursing homes, but Boards and voluntary organisations also support a range of schemes in less formal environments. The funding of such respite care is affected by the new arrangements only insofar as it is currently provided through Income Support. In future, the funding of respite care away from home will reflect Boards' primary responsibility for arranging and purchasing it. The existing rules which preclude the payment of Housing Benefit to meet the accommodation costs of admission to respite care will be retained. However, the transfer of resources to be made to Boards after April 1991 will take into account their responsibility for this developing area.

[illegible]

7.7 Attendance Allowance is a non-means-tested benefit paid to severely disabled people who need a great deal of support. It is paid at two rates, one for people who have attendance needs by day or by night, and a higher amount for people with attendance needs by day and night. Together with the Invalid Care Allowance, it is an important part of the social security support for community care.

7.8 The proposed changes in the funding of community care will not alter the present arrangements for paying Attendance Allowance to people in private households or to people who go into independent sector residential care or nursing homes without any assistance from public funds other than state benefits. The transfer to Boards of responsibility for assisting with the care costs of residents in independent sector homes will however require a change in the current rules intended to prevent double funding.

7.9 At present, Attendance Allowance is offset against any Income Support paid to residents in independent sector homes and is not paid at all to residents in Board and other publicly funded accommodation. For people in independent sector homes with preserved rights to Income Support, the position on or after 1 April 1991 will be the same as it is now.

7.10 However, Attendance Allowance will not be paid to residents in independent sector homes who from 1 April 1991 will be assisted by a Board. This new rule will make no difference to the residents concerned, nor will it remove any continuing, underlying entitlement to Attendance Allowance. It will, however, put such Board assisted independent sector care on the same footing as other publicly funded accommodation. Any underlying entitlement to Attendance Allowance established before or during any period of Board assisted residence and still in force when that period stops can be activated once that period stops, and Attendance Allowance then paid immediately in the normal way.

[illegible]

7.11 The Independent Living Fund is a charitable trust whose purpose is to help very severely disabled people with the cost of employing domestic help or personal care which they need to enable them to live independently in the community. There would clearly be an overlap between the Fund and the intended responsibilities of Boards, and this will be reviewed.

CHAPTER EIGHT: QUALITY CONTROE

8.1 The Department attaches great importance to ensuring that publicly funded community care services are of the highest quality possible within the resources available. Chapter 1 outlined the main attributes of a high quality community care system: flexibility, responsiveness to individuals' particular needs, consumer choice, and promoting users' independence. These attributes will be the touchstone against which quality can be assessed. This chapter will outline some of the means through which this is be done.

Quality of life

8.2 The term "quality control" refers to a whole array of different procedures for monitoring and evaluating quality, from the analysis of crude activity indicators to in-depth research programmes. Action is already in hand, at both Board and Department level, to improve arrangements for the collection and analysis of statistical indicators of performance. As quality control procedures are developed, they will increasingly be slanted towards and used to measure the quality of life for users and their carers. Quality control procedures will pay more attention to factors such as the appropriateness of services to individuals' needs, homeliness in residential settings, the opportunities afforded to users for maintaining and developing personal relationships and respect for users as individuals.

8.3 The purposes of the quality control system include providing management and staff at all levels with regular feedback on the success of their activities; helping managers to plan and review policies and procedures; helping professional staff review and improve their practice; ensuring that minimum standards are being met; and promoting efficiency in the use of resources. Issues to be addressed include the quality of users' physical and social environment; the appropriateness and effectiveness of care, treatment and rehabilitation programmes; impacts on carers; and user satisfaction.

8.4 Quality control is not an isolated activity to be undertaken exclusively by researchers or inspectors coming into a facility or service from outside. The most immediately effective form of quality control is that undertaken by staff as part of their day to day activity, and staff should always be alert to feedback from service users. Quality control is a fully integrated component of good professional and management practice. At operational level, for example, case conferences, peer review procedures, quality assurance groups and patient follow-up studies all contribute to the quality control system as a matter of routine.

8.5 The introduction of a contractual relationship between purchasers and providers will give quality control a sharper focus at all organisational levels. Performance measures will have to be clearly specified, and systems put in place to ensure that agreed standards are secured and sustained. Contracts will have to include provision for monitoring and break-clauses in the event of specifications not being met.

8.6 Where these do not already exist, the Department will expect Boards to establish and publicise straightforward procedures for receiving comments and complaints from service users. Such procedures are an essential safeguard for consumers and an important monitoring and managing instrument for both purchasers and providers.

8.7 Arrangements for external monitoring and evaluation will also be needed, primarily to ensure that internal quality control systems are working properly and that comparable standards are being applied throughout Northern Ireland and in both the public and independent sectors.

Inspection [illegible]

8.8 Arrangements are already in place under existing legislation to safeguard people in independent residential care and nursing homes. The Department is currently reviewing this legislation in light of the experience gained in England and Wales through the operation of the Registered Homes Act 1984. The Department issued a consultative paper in 1988 as a first step in the process of promoting a Registered Homes Order for Northern Ireland, which would consolidate and update the existing legislation, and intends to publish a legislative proposal later his year. Independent sector homes are subject to registration and inspection by Boards. This has given rise to concern about the standards required by Boards, by comparison with the standards achieved in statutory homes. Of those who addressed the issue in responding to the Department's consultative paper, the overwhelming majority called for greater independence of the inspectorate.

8.9 The Department believes that common standards should apply across all sectors. To assist this, it proposes that Boards should set up arm's length inspection units, charged with inspecting and reporting on both statutory and registerable residential care and nursing homes. The Department proposes to transfer the responsibility for the registration and inspection of voluntary children's homes to Boards. The new units could ultimately be responsible for inspecting these homes together with statutory children's homes.

8.10 The arm's length units would be independent of the day to day management of statutory homes at Unit level and would be accountable directly to the Area General Manager. They would apply the same quality assurance criteria to all homes. They would include inspectors recruited from outside their Board's employment: for example former owners or managers in the independent sector or former Board staff experienced in residential or nursing care.

8.11 Boards may also wish to call upon the new units to inspect residential and non-residential services delivered by other agencies under contract. They should be willing and able to advise those whose responsibilities include preparing service specifications, tender documents and the terms and conditions of contracts.

8.12 There will be consultations with Boards, professional and independent sector interests on the detail of this proposal. These will cover such matters as the organisation and management of the new inspection units, arrangements for the submission and scrutiny of reports, the follow-up of reports, recruitment of staff from outside the Boards, reports to Area Health and Social Services Councils, and the role of the units in monitoring compliance with contracts and in investigating users' complaints.

8.13 The Department proposes to issue further guidance for registration and inspection staff on the conditions to be expected in a good home, after consultation with Boards, professional and independent sector interests. This guidance will complement the advice in the code of practice for residential care, "Home Life" and in the handbook "Registration and Inspection of Nursing Homes". It will give special emphasis to assessing the quality of care provided and residents' quality of life, as well as physical conditions.

Regional bodies

8.14 As Chapter 9 will outline, the Department will be using the operational planning and accountability review system to monitor more systematically the management, co-ordination and delivery of community care services and the use of resources. In addition, from time to time it will commission one-off, in-depth independent studies of particular aspects of service provision.

8.15 The Department will participate in or keep in close touch with national development initiatives, including the three year development programme now under way in Great Britain, which aims to test and promote new ways of improving the quality of life of people in residential care. The programme is based on recommendations in the report of the committee chaired by Lady Wagner, "Residential Care: A Positive Choice". This programme aims at better training for staff in homes, better information for users; effective, readily accessible arrangements for making suggestions and complaints, a closer relationship between homes and their local communities; and better management.

8.16 The Department's social services and nursing advisers will retain their current responsibilities for monitoring the quality of services. They will also play an important role in advising Boards on the introduction of new quality control arrangements, including the establishment and operation of the arm's length registration and inspection units. They will report to the Minister and the Department on the effectiveness of local quality control arrangements and the methods and standards to be applied when measuring quality.

8.17 The Northern Ireland Hospital Advisory Service will continue to monitor standards in continuing care hospital units; advise on good practice; and report to the Department. In due course, the Department will review the Service's role in the light of experience following implementation of the proposals in this paper and in "Working for Patients".

8.18 The Mental Health Commission will continue to make an important contribution to quality control, with its specific emphasis on the rights and welfare of individual patients.

CHAPTER NINE: PLANNING AND RESOURCES

The planning system

9.1 The integration of health and personal social services in Northern Ireland under the total management responsibility of the four Health and Social Services Boards provides an opportunity unique in the United Kingdom, to plan a coherent and comprehensive range of community care services. The arrangements for securing the achievement in Northern Ireland of the main objectives set out in Chapter 1 must make the most of this integrated structure. This chapter sets out the Department's proposals for doing so in relation to the planning and monitoring of community care services and the allocation of funds. It also explains how these proposals will be taken forward in conjunction with the proposals set out in "Working for Patients".

9.2 Good progress has been made in recent years in developing the planning system for the health and personal social services. Under this system, the Department sets guidelines for, and Boards prepare, five-year strategic plans and annual operational plans. Both sets of plans are based on a programme of care approach. Boards are expected to plan a comprehensive service for each client group, ranging from home care to hospital services. The key programmes of care in the context of this paper are those for people with a mental handicap, a mental illness or a physical disability and elderly people.

9.3 Recent developments have resulted in a more quantitative approach at the strategic planning level with a clear emphasis on shifting the balance of care towards helping people to live full and independent lives in the community. Specific targets have been set for reductions in the in-patient populations of psychiatric and mental handicap hospitals. As indicated in Chapter 2, significant progress has already been made towards meeting these targets. The operational planning system has also developed, with Boards on an annual basis identifying how to progress towards achieving the Regional Strategy objectives within the resources available to them.

Developing the planning system

9.4 As a result of the changes proposed in "Working for Patients", strategic planning will in future take a different form at all levels of the health and personal social services. Changes in the pattern of provision will be effected, largely through changes in the rolling three year contracts that Boards, at Area level, will enter into with Units of Management. Strategic planning at Area level will provide a framework for those changes and will be the means whereby an assessment of the health and social care needs of the population is translated into a statement about the type and volume of services that are required to meet those needs. Each Board's strategic plan will identify specific objectives for changes in the balance of care for particular services and client groups. It will also include clear statements on how these objectives are to be met.

9.5 At present, the Regional Strategy for 1987-92 constitutes the only comprehensive statement of the Department's policies and objectives for the future planning and provision of integrated health and personal social services across the spectrum of care.

Since its publication in 1987, a number of important policy initiatives have been taken by the Government, including those set out in "Working for Patients" and in this paper. The implementation task facing the Department and the Boards is a considerable one, not least when set against the overriding importance of maintaining high quality services during a period of considerable organisational change.

9.6 The progressive implementation of these initiatives requires a planned approach. To this end the Department's Management Executive will be developing in consultation with Area General Managers a three-year rolling management plan for the health and personal social services. This plan will reflect available resources of finance and staff and will set out key objectives, identify priorities and determine performance targets over the three-year period, particularly in the year ahead. The plan will constitute a strategic management framework to secure the efficient and effective delivery of high quality services, within the Department's overall policies for the delivery of services, including those set out in the Regional Strategy.

9.7 The preparation of the management plan will provide an annual opportunity to review the workload facing the Department and Boards and to co-ordinate action. It will also provide a framework for the preparation of Boards' own operational plans, including statements on individual programmes of care. In these plans, Boards will be expected, in their new purchaser role, to set out for the programme of care for each client group:

- their assessment of the need for the programme;
- the extent to which this need can be met during, and their priorities for, the year ahead;
- the resources which will be made available and the level of service to be provided;
- how these services will be provided through contracts, whether with directly managed units, self-governing units or the independent sector;
- the quality of services expected from providers;
- the extent of co-ordination with other agencies, including housing agencies and the independent sector.

9.8 Boards' operational plans are already public documents intended to communicate Boards' policies and priorities to a wide audience. In future Boards will be asked to ensure that the community care sections in their plans are produced in such a way as to give a good overview of the main programmes of care and the direction in which they are moving and to be as informative as possible to interested parties outside the Boards. The first plans under the new arrangements will concentrate on the management and delivery of the main changes set out in this paper and in "Working for Patients". In particular, Boards will be expected to explain:

- how they intend to identify and meet their needs for the information on which to base future planning;

- the arrangements at Unit level for assessing individual applicants for care;
- how the new purchasing tasks are to be organised and managed;
- how services for people at home, including their carers, are to be improved;
- how they are co-ordinating plans and activities with those of housing and other agencies;
- what preparations they are making for the introduction of case management, including training;
- what information is to be provided to service users and their carers about services;
- what training is to be provided for relevant staff groups;
- how the contribution of the independent sector is to be stimulated, particularly in fields other than residential and nursing home care;
- what progress has been made on the establishment of arm's length registration and inspection units;
- what quality assurance systems are to be established, including complaints and contract compliance procedures.

[redacted]

9.9 The Department will have to assure itself that the Boards' plans are in line with its strategic guidance and that action is being taken to put the above elements in place without undue delay in the light of available resources. Boards' performance is monitored through the annual accountability reviews led by the Minister. These reviews will be reshaped to take account of the structural changes introduced in the Department and the creation in January 1990 of the post of Chief Executive. The objective will be to develop stronger accountability and monitoring arrangements reflecting the greater delegation to Boards and their Units of Management of responsibility for determining the pattern and quality of services.

[redacted]

9.10 It is a matter for each Board, within the strategic framework set out by the Department, to determine the pattern of services appropriate to its local needs and priorities. The current Regional Strategy has identified that too great a share of the overall funding is devoted to the hospital sector, and Boards are required to plan to remedy this. The Strategy envisages that by 1991/92 the proportion of funds going to community services will rise from 26% to around 30%.

9.11 In line with "Working for Patients", the arrangements for allocating funds to Boards will change from 1992/93, reflecting their new roles as purchasers of care for their resident populations. The distribution of funds provided through the Public Expenditure Survey process will be determined by a formula which will take account of the age and sex of each Board's population and relative levels of need. With the resources provided each Board will be expected to purchase a comprehensive range of services including community care for its local population.

9.12 The whole thrust of development in management and accountability in the health and personal social services in recent years has been to devolve responsibility for managing and developing services to the operational level, as re-affirmed in "Working for Patients". Boards will have maximum operational flexibility (subject to strategic guidance from the Department) to make their own decisions in the light of their knowledge of local needs and circumstances. The Department will expect Boards to devote an increasing proportion of their expenditure to community services in line with the Regional Strategy.

9.13 The Department recognises that Boards will need adequate resources to enable them to discharge their expanded responsibilities for assessment, case management and service delivery. In keeping with the Government's proposals for reforming the funding of residential and nursing home care, as set out in Chapter 6, the Department will provide additional resources to the Boards to finance the care of people in independent sector residential care and nursing homes.

9.14 The quantum of additional resources will take account of the following factors:

- the Income Support that would have been payable under the present scheme;
- the normal Income Support and Housing Benefit that will be payable to new residents;
- the continuing commitment to those residents with preserved rights to the current scheme, as described in Chapter 7;
- the rate at which Boards will assume responsibility for the care of new clients. Account will be taken both of natural turnover and growth in demand due to demographic and other factors.

Account will also be taken of the changes in the payment of Attendance Allowance described in Chapter 7. Decisions on resource issues will be taken following the 1990 Public Expenditure Survey.

9.15 The additional provision will be phased to reflect the declining proportion of residents in independent sector homes previously eligible for Income Support who continue to be supported entirely by social security. This phasing will ensure a smooth transition to the new structure and enable Boards to build up their activity as the numbers of people requiring financial support from them increase.

9.16 In due course, the additional provision for community care will be distributed through the capitation formula. There will, however, be a transition period linked to the phasing in of capitation funding. Since the changes in funding for residential and nursing home care will be introduced from April 1991, the additional funds will be distributed for an initial year in line with the existing allocation arrangements.

Information needs

9.17 The availability and effective use of relevant, timely and accurate information is crucial to the successful implementation of the proposals in this paper. Information provision in community care is particularly complex in that

- several programmes of care are involved;
- different staff groups are included in each programme;
- there are many connections between programmes;
- there are many connections amongst various parts of the health and personal social services;
- there are many connections to other statutory and voluntary agencies providing complementary programmes.

9.18 Information for assessing the needs of individuals and of the community as a whole, and for delivering the appropriate services, will need to be brought together from various programmes and bodies. Careful planning will be essential to ensure that everyone in the chain has a common understanding of the information presented. There will be great variation in need, ranging from the detailed, instant data required to support day to day case management through to the more comprehensive, aggregated information needed to support functions such as inspection, monitoring, contracting and planning.

9.19 Existing information systems will have to be examined to assess their relevance, to identify gaps within and between organisations and to confirm that the frequency at which they provide information is compatible with the uses to which the information is put. Systems will have to be established to ensure that data are captured from the appropriate source, processed and delivered in the correct format and in time. This will require close co-operation across a range of professions and bodies. Important issues such as common access to and confidentiality of data will have to be resolved. Many of the information needs identified are likely to overlap with those arising from "Working for Patients", and Boards will have to address the requirements of the two sets of reforms together. In this context, the Department will be working with the Boards to develop, before the end of 1990, a comprehensive information strategy for the health and personal social services.

The workforce

9.20 The provision of community care services is a labour intensive activity. In taking on their new responsibilities, health and social services staff will be building on existing skills and competencies, but their training will need to reflect their new roles.

9.21 The community workforce is diverse, with staff operating at vocational, professional and managerial levels. Boards will have to ensure that their workforces are properly trained and appropriately deployed to discharge their expanded responsibilities.

9.22 The proposals in this paper have implications for the roles of all staff involved in community care, including management and planning staff, staff with assessment and case management responsibilities and staff directly involved with the delivery of care and support. There will also be implications for staff working in the independent sector.

[illegible]

9.23 The Department's Working Paper "Education and Training in Northern Ireland", published in February 1990, deals with the education and training implications of "Working for Patients". The management development needs arising from this policy paper are similar, and Boards will be expected to address them together. In designing skills training for managers in areas such as service specification and contract management, Boards should take the community care dimension fully into account. It cannot be assumed that training in contracting for hospital services will be sufficient to equip management for contracting in the community care field.

9.24 Professional staff working not only in the social services but also in nursing are increasingly being trained to work in both community and hospital settings. Pre-registration training for nurses will include preparation for caring in both hospital and community settings.

9.25 Professional staff working in the community have traditionally been trained separately. Further work will need to be done to promote multi-disciplinary training for professional groups at both qualifying and post-qualifying levels. New programmes of in-service training on assessment and case management should as far as possible be conducted on a multi-disciplinary basis.

9.26 In association with the Department of Health, training authorities and professional and representative bodies, the Department will be taking further action to identify and prioritise the training implications for professional staff of the proposals in this paper, including the proposals for assessment and case management.

9.27 The Social Services Inspectorate will participate in the national development projects on assessment and case management and purchasing and budgeting, and will be available to offer advice and guidance on these and on training issues.

9.28 Vocational staff, such as care assistants and home helps, will become increasingly important as the number of dependent people to be cared for in the community grows and as greater emphasis is placed on supporting them in their own homes. These staff will have to be properly trained and adequately prepared for their extended responsibilities.

9.29 In the past the training needs of vocational staff have not generally been well met. In order to address these shortcomings, the Government set up the National Council for Vocational Qualifications in 1986. A consortium of interests (the Care Sector Consortium) representing employers and staff from the statutory and independent sectors is working to secure a recognised national pattern of vocational qualifications and training for all those working in the care sector. Their further work on the NVQ will take account of the Government's proposals for community care. Northern Ireland's interests are represented by a Shadow Care Consortium which will keep local agencies in touch with developments in this area.

9.30 Boards need to plan for their workforces as a whole and ensure a suitable mix of skills. Shortages of professionally qualified staff may have a limiting effect on what can be achieved, but Boards have to ensure that they are making the most effective use of the skills of their professional staff. They should aim to complement and support the efforts of their professional staff through the appropriate deployment of suitably trained vocational staff.

9.31 The independent sector will equally need to consider the implications of the proposals in this policy paper for the skill mix and training of its workforce. This is essential if private and voluntary sector employers are to meet effectively the needs of clients assessed by Boards as requiring particular forms and levels of care. Staff in the independent sector should have the same access to training opportunities as those in the public sector. In some instances, joint training may be appropriate. Whether or not training is provided jointly, independent sector employers will have to invest in induction and in-service training for their staff.

CHAPTER TEN: WHAT IS TO BE DONE

10.1 Community care is being practised, with varying degrees of energy, financial input and success, in every area of Northern Ireland. The proposals in this paper are intended to create a clearer framework and better opportunities for its successful practice.

10.2 Good progress has already been made in shifting the balance of care from hospital to the community and in enabling clients to stay in the community. Much more remains still to be achieved. The Department expects further work to be done in the spirit of this policy paper and in line with the central objectives set out in Chapter1.

10.3 Although this paper calls for changes in the way in which community care is planned and delivered, the overall direction of these changes is not new. Because the paper presents a vision for the decade, in its totality it offers a great many challenges. However not all the changes which it foreshadows have to be introduced immediately, and some will have to be made gradually, over a period of years. The availability of resources overall will naturally influence the pace at which the new policy is implemented.

10.4 New social security arrangements will take effect in April 1991. They will require Boards to have in place by then procedures for assessing individuals' care needs, for securing care, including residential and nursing home care for those who need it, and for working out how much people should pay for residential and nursing home care. Those receiving care in Board homes will from the same date be subject to a new system of financial assessment aligned to the systems used to assess eligibility for Income Support and Housing Benefit. Boards will have to reassess their present residents' financial contributions.

10.5 There are associated changes which Ministers also want to see implemented by April 1991. By that date, arm's length inspection units should be established and accessible and effective complaints procedures should be in place.

10.6 Boards' operational plans for 1991/92 will have to state the arrangements which they have made to give effect to the changes required by April 1991 and the arrangements which they plan to make to implement the other changes proposed in this paper.

10.7 The evolutionary nature of some of these changes means that Boards will plan systematically for their introduction over a longer period, building on existing good practice and piloting innovative services. These longer term changes include developing the case management approach, promoting a mixed economy of care and introducing new purchasing and contracting arrangements. This developmental work should all be driven by the central aim of identifying and meeting clients' individual needs. In taking this work forward, Boards will have to take the initiative in creating a partnership with the independent sector which allows for frank and open discussion of the needs which Boards identify and of the provision which they wish to purchase. A partnership of mutual trust and understanding should enable the independent sector to assess market opportunities more accurately and should permit Boards to identify the most appropriate contribution to be made by that sector to their clients' care.

10.8 The Department intends to support Boards in the implementation of the changes in this paper by issuing guidance; by linking into implementation work under way at national level; and by participating in and disseminating the outcomes of national professional development projects.

THE REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY
(NORTHERN IRELAND)

A Strategic Framework for Adult Mental Health Services

June 2005

CONTENTS

FOREWORD

In the summer of 2002, I was invited to chair this independent Review, commencing in October that year. Shortly after this Professor Roy McClelland was appointed Deputy Chair. It took about 6 months to clarify our terms of reference, guiding principles, high-level objectives, strategic framework and even our title, which became “The Review of Mental Health and Learning Disability (Northern Ireland)”. By March 2003 it was clear that the work consisted of several interlinked reviews under one overarching title, and encompassing policy, services and legislation.

The Review Steering Committee presides over the work of 10 major Expert Working Committees. Four Committees commenced their work by April 2003, and a further 6 by November 2003. In consultation with Government, we agreed to produce our reports separately in a phased manner. All of our Committees have adopted an evidence-based approach, drawing upon existing relevant information and research, and where necessary commissioning research. Exemplars of best practice local, national and international, have informed our Reports.

We have maintained a clear vision for mental health and learning disability services in Northern Ireland. Widespread consultations with stakeholders have endorsed our vision and the strategic direction of the Review. A feature of the Review process is the contribution of Users and Carers across both Mental Health and Learning Disability. Their insights, advice and guidance continue to be invaluable. The recommendations for service reform have been underpinned by a sound economic appraisal carried out by our Needs and Resources Committee. As recent research by the Northern Ireland Association for Mental Health has shown, the cost of mental health needs of the people of Northern Ireland are considerable and extend well beyond the direct cost of health and social care.

This first report from the Review set out a vision for adult mental health services for the next 15 to 20 years. The sucess of this depends on the contribution of stakeholders, but most of all, Government, who must give a lead in implementing the process of change. We fully recognise the resource implications and urge Government, in particular the Department of Health, Social Services and Public Safety, to begin the necessary process of reform and modernisation of these services as quickly as possible.

I thank all involved in this Review for their efforts. An immense amount of work is in progress.

DAVID R BAMFORD (PROFESSOR)
CHAIRMAN
June 2005

INTRODUCTION

BACKGROUND

1. A Review of the policy, practice and legislation relating to mental health and learning disability was commissioned by the Department of Health, Social Services and Public Safety (DHSSPS) in October 2002. The main factors influencing the decision to establish the Review were:

- recent reviews of mental health legislation in neighbouring jurisdictions;
- the need to ensure that law, policy and practice is in keeping with human rights and equality law; and
- the need to reflect current evidence of best practice.

HUMAN RIGHTS AND EQUALITY PRINCIPLES

2. Everyone has human rights and must be valued for his/her self-worth. Moreover, States and international organisations have a duty to uphold and protect these rights.

3. However, since people live in social settings, the human rights of any individual have to be considered in the context of relevant and often competing rights and interests, for example, the right not to have one's liberty restrained carries with it a potentially opposing right of another individual not to be endangered.

4. Human rights, including the rights of people with disabilities or mental disorder, should not be arbitrarily diminished. There are circumstances when it may be appropriate to curtail a person's human rights, but this should be limited to the minimum extent necessary, and a person whose rights have been curtailed should be entitled to appropriate care and treatment.

5. Those who deliver health and social care must uphold these human rights and equality duties in performing their functions. Ultimately, law and decision-makers, including members of this Review, have to strike the appropriate balance in relation to the relevant rights and interests.

6. Rights are useless unless people enjoy the protection offered by human rights in their daily lives. It is crucial that people know about their rights and, where these appear to have been breached, are able to enforce their rights.

7. To enable people with a mental health problem or a learning disability to exercise the same rights as others, additional support, information and training

may be required to maximise understanding and participation. Ensuring equality of opportunity can also mean making structural changes, tackling discrimination and addressing the assumptions and attitudes of others about learning disability or mental health.

8. Putting human rights and equality principles at the centre of the law, policy and delivery of these services under review is a legislative imperative because of international and domestic law. These principles also need to be taken into account in professional codes of conduct and practice.

9. The principles on which the Mental Health (Northern Ireland) Order 1986 should be interpreted are contained in the relevant Code of Practice 1992. These include reference to:

- dignity;
- individual background;
- resources;
- least degree of control and segregation commensurate with individual safety and the safety of others;
- lease restrictive alternative; and
- treatment and care that promotes self-determination and responsibility.

10. While the clearest outworking of this Review's deliberations on human rights and equality issues will be seen in future reports from the Social Justice and Citizenship and Legal Issues Committees, human rights and equality considerations are reflected in all of the Review's work, including this report.

STRUCTURE OF REVIEW

Steering Committee

11. To oversee the Review, a Steering Committee was established under the chairmanship of Professor David Bamford. The Committee has representation from a wide range of professional interests, the voluntary sector and from service users and their carers. Three members come from neighbouring jurisdictions.

12. Details on the Committee membership are at Annex 1. The Terms of Reference agreed by the Committee are at Annex 2.

Expert Working Committees

13. Work on specific aspects of the Review has been delegated to 10 Expert Working Committees, which were established in two phases during 2003. Brief details on these are at Annex 3.

14. Conscious that the workforce is a key resource, the Steering Committee has been collaborating with DHSSPS on a workforce planning group on mental health and learning disability services under the chairmanship of Mr David Bingham, Director of Human Resources in that Department. The Steering Committee is anxious to see not just an increase in the numbers of staff working in the mental health and learning disability fields, but also that these staff are equipped with the appropriate skills for the models of service delivery envisaged in the future.

15. The Steering Committee decided that reports would be made to Govemment in stages, as the work of the Committees was completed. This report represents the first major report from the Review, and deals with adult mental health services across primary, community and hospital sectors. Other reports will follow over the next 12 months.

VALUES AND PRINCIPLES

16. One of the Steering Committee's first tasks was to agree a set of values and principles to underpin its work. Key among these are:

- Involvement and Open Access;
- Inclusivity;
- Quality;
- Existing Excellence; and
- Research and Information.

The Views of Stakeholders

17. At the outset of the Review, Professor Bamford wrote to over 200 stakeholder organisations in the statutory and voluntary sector, seeking their views on priority areas which the Review should examine. A series of meetings with stakeholders was held and a policy of open access to the Review and its work has been maintained. The comments received from both written responses and the stakeholders meetings have informed the work of the Committees.

18. Working Committees are also engaging with stakeholders as their work progresses. The Review operates an open access policy, in that any individual or organisation can present their views to the Steering Committee or any of the Working Committees.

19. A website has been established to keep stakeholders and the general public informed on progress and with the work of the Review (www .rmhldni.gov.uk).

Service Users and Carers

20. The views of service users, carers and families are central to the Review . The Steering Committee and Working Committees have user and carer representation within their membership.

21. User and carer reference groups have been established in respect of both mental health and learning disability services. Each of these groups has a membership of about 15-20 people. With their help, consultation events have been held in various locations to allow a wide range of people to voice their opinions and tell their experiences. A freephone message line (0800 3284260) was also established to enable service users and carers to make their views known, in an anonymous way, if they wished.

The Evidence Base

22. One of the principles informing the Review is that it should be grounded on the best available evidence base. As part of defining the quality and appropriateness of evidence, due consideration has been given to relevance, applicability, reliability and validity. While noting these various dimensions, for the Review as a whole the following classification has been adopted:

    (A) An expert user group or carer group opinion;

    (D) Descriptive surveys of client groups; Evaluation of client needs and services; Systematic user surveys;

    (N) Interventions studies – non – randomised trials;

    (R) At least one randomised controlled trial; and

    (S) Systematic reviews including at least one randomised controlled trial.

23. It should be noted that the optimal evidence for particular issues may be quite different, for example, descriptive analysis for community mental health morbidity. The various dimensions of evidence need to be considered with the emphasis on fitness for purpose. That said, the adequacy of the evidence base

in a number of areas is still relatively weak and the Review emphasises the importance of strengthening this with new research and service evaluation initiatives.

The Adult Mental Health Expert Working Committee

24. This Committee first met in February 2003. Details on its membership are at Annex 4. While this portion of the Review focuses on adult mental health, several areas of adult services are the subject of separate reviews – Forensic Services, Alcohol and Substance Misuse, Dementia and Mental Health Issues of Older Adults.

Structure of the Strategic Framework for Adult Mental Health

25. The report recognises and follows the natural division of our Health and Social Services into Community and Primary Care (Chapter 3) and Secondary Care (Chapters 4, 5 and 6). It also considers the requirement for regional level services because of the expertise required for people with particular mental health needs (eg people with eating disorders) (Chapter 6). While general consideration of the nature and size of mental health problems is considered in Chapter 2, the particular epidemiology of the disorders considered in Chapter 6 and Annex 6 are, for convenience, considered alongside the service considerations and recommendations for each of these groups.

Interface Issues

26. The Strategic Framework for Adult Mental Health is part of a review of the whole system of provision for people with mental health problems and people with learning disability embracing services, policy and legislation. The Strategic Framework, therefore, must be seen in the context of the entire Review. The success of any reform of adult mental health services is dependent upon the successful reform of the system as a whole. There are many interfaces between adult mental health services and other services. This Strategic Framework reflects these interfaces and, where appropriate, gives detailed consideration to them. That said, because of the phasing of the work of the Review, there may be issues in the interface areas which are identified subsequent to the drafting of the Strategic Framework and may need to be incorporated. Services in several areas outwith adult mental health have historically been less well developed, notably child and adolescent services, forensic services and specialist services within adult mental health.

27. While the emphasis of the Strategic Framework is the service needs of people with mental health problems, a holistic approach to the issues of mental ill-health also requires a robust strategy for prevention and mental health promotion. Issues surrounding secondary prevention and the needs of families and carers have been considered core to the service reform proposals within this Strategic Framework. The broader requirements of a strategy for mental health promotion are the subject of a separate report.

28. The Review includes reform of legislation driven by principles and priorities underpinning policy and service reform. This we believe is the right way round. Nevertheless, the review of mental health legislation is likely to have an impact on service development and provision. Again, as with other interface issues, the Strategic Framework for Adult Mental Health will need to consider the impact of legislative reform on service requirements.

USER REFERENCE GROUP STATEMENT

As Experts by Experience we are key to the Review. We claim our right to be valued for our diversity and dignity and to shape the community and practice of mental health care. Everyone has mental health needs and anyone might have need of services. In an imperfect world people become emotionally stressed, depressed and unwell and can benefit from help and healing. Mental health services need to be delivered in terms of needs and rights.

For the New Vision to be achievable the values and principles must be upheld and implemented. Legislation must follow these values and principles.

Each of us in the Experts by Experience Group has our story of the negative effect of the conditions and provisions of care. One element must be changed and that is the attitudes of the professionals and all those who engage with us. Essential to empowerment and recovery is a person centred approach. Understanding the person on their own terms and placing them at the centre of the process.

When the cause of the 'crisis' is commonly social and emotional, clinical responses are often inappropriate and ineffective. What is needed are respect, understanding, and the provision of a safe and welcoming environment. Hospitals do not often provide these responses. Home or respite service responses should be the norm.

As Experts by Experience we recommend crisis responses from a variety of sources that include service user and carer initiatives and participation. The person in crisis must have a choice of care.

Responses to people with mental health problems have been driven by an ethos of doing to rather than being with, resulting in service users become objects to control, maintain and rehabilitate. We are deeply concerned that treatments which are controversial, invasive and which can be fatal are still in use. Within this environment, individual recovery can never be fully realised.

Empowerment and recovery must replace older notions of rehabilitation. Mental health workers will encourage and support persons on their own journey of recovery. The role of the mental health worker should be augmented by the advocate, in particular the peer-advocate, to aid communication, create an equal and positive relationship between the mental health worker(s) and the person.

The community has a critical responsibility towards the recovery of the person, providing sanctuary in times of crisis and alternatives to acute hospital care. The community must support networks for the person, allowing them to affect their recovery with support from peers, their families and friends.

Service users must be involved with real consideration of the positive contribution they can make to the mental health services. We are invaluable in the planning, development, delivery and monitoring of services.

Our experience of services gives us a unique insight into:

- Self: only you can know yourself
- Others: an appreciation of others in distress
- Service provision: what works and what does not work
- Other statutory and voluntary agencies and how problematic they can be for the individual.

Service user-led initiatives provide a safe, confidential and supportive environment and must be resourced and supported.

The expertise of people who have experienced mental health problems must be recognised equally with research based evidence or practice evidence. Evidence-based research needs to include social, psychological and environmental investigations. They must be valued and promoted equally with pharmaceutically funded research.

Mental health service users' skills must be incorporated within professional training and education.

Service users must be involved in the recruitment of mental health personnel and in continued assessment of all professional development.

A STATEMENT PREPARED BY THE CARERS' REFERENCE GROUP

We in the Carers' Reference Group all have family members or close friends who have had experience of the mental health services and therefore have a deep and personal interest in, and a significant contribution to make to the development of services relevant to mental health and learning disability. We fully endorse the statement submitted by the Service User Reference Group.

We welcome the current Review and the opportunity to be involved in its work. As carers we wish to assert, and with enthusiasm and commitment implement, our right to active participation in the Review and in subsequent planning, monitoring and development of public services which intimately affect our lives and the lives of those for whom we care. As is the case with service users, carers need to be involved at all levels, from individual assessments and care planning to reviews of government policy in community care.

Consultation with, and involvement of service users and carers in policy making which affects their lives is a legal requisite, especially under Section 75 of the Northern Ireland Act 1998. Good practice is assessed in terms of how well such consultation and involvement is carried out, and the relationships and improvements in policy making and implementation that develop from it.

We endorse government policy concerning the need for partnership between civil society and statutory authorities as the basis of effective change and express our willingness as carers to become actively involved in partnerships across and within sectors.

We support a human rights, equality, and needs-based approach to the development of policies and delivery of services, and a commitment to providing the necessary resources for the implementation of the Review's recommendations.

A model of recovery and empowerment, rather than traditional paternalistic notions of rehabilitation, is strongly endorsed by the Carers' Group as the way forward in the maintenance of good mental health. The nature of support should be person-centred and holistic, recognising and utilising the fact of social existence as the essence of humanity and well-being.

We acknowledge complex and sensitive relationship issues that can arise with mental health service users and their families, including that of confidentiality: that they can be successfully dealt with. Carers have an enormous, often unacknowledged, contribution to make in being part of a community of support for those they love and care for.

In the development of care plans carers have a, frequently untapped, wealth of experience and information that can enable the formation of an appropriate support package.

In terms of community care, carers seek acknowledgement and support for their involvement as part of the series of community based networks – circles of friends – that will contribute to the recovery of their family member or friend.

We wish to be part of the creation of a process that makes a real difference to lives. One that is self-reflective and responsive to need, and in which the expertise and experience of the services users and carers is central.

CHAPTER 1

VISION, PRINCIPLES AND POLICY

A NEW VISION FOR ADULT MENTAL HEALTH

1.1 The vision underpinning this Strategic Framework is common to the Review as a whole:

- valuing those of us with mental health needs, including rights to full citizenship, equality of opportunity and self-determination;
- addressing the challenges facing people with mental health needs; and
- a process of reform, renewal and modernisation of services that will make a real and meaningful difference to the lives of people with mental health problems, to their carers and families.

1.2 The vision has been greatly informed by core values derived from the consultations, the submissions to the Review and the direct involvement of users and carers throughout our work. People with mental health needs and their carers should receive services which:

- respect them as individuals – through openness in the providing of information, respect and courtesy in individual interactions with service users, true partnership and empowerment in service planning and provision – with Government, providers and the wider society each accepting their respective responsibilities;
- demonstrate justice and fairness – resources for services should be allocated and managed according to criteria which are transparent and which demonstrate equity.

1.3 These values are underpinned by our obligations as a community under Equality and Human Rights legislation.

PRINCIPLES

1.4 The principles for the Strategic Framework draw on the vision and values of the Review and are as follows:

- partnership with users and carers in the planning, development, evaluation and monitoring of services;
- partnership with users in the individual assessment process and all therapeutic interventions of care and support;

- delivery of high quality, effective therapeutic interventions, care and support;
- equity of access and provision of services, including the needs of people from minority cultures, people with disabilities, people subject to the criminal justice system;
- provision of services which are readily accessible;
- delivery of continuity of care and support for as long as is needed;
- provision of a comprehensive and co-ordinated range of services and accommodation based on individual needs;
- taking account of the needs and views of carers, where appropriate, in relation to assessment, therapeutic interventions, care and support;
- provision of comprehensive and equitable professional and peer advocacy, where required or requested;
- promotion of independence, self-esteem, social interaction and social inclusion through choice of services, facilitation of self management, opportunities for employment and social activities;
- promotion of safety for service users, carers, providers and members of the public;
- provision to staff of the necessary education, training and support; and
- services subject to quality control, informed by the evidence.

1.5 Informed by these values and principles, the Review has provided a unique opportunity to address the full spectrum of issues relating to adult mental ill-health. The Strategic Framework provides the blueprint – a blueprint that is as dependent on a cultural change as much as investment of new resources. This incorporates a new sense of partnership and equality of esteem for service users, a valuing of carers as equal partners in service provision, effective team working and collaboration with and between provider groups including user provided services.

POLICY

Where we have come from

1.6 Over the past 30 years successive local and national strategies and a growing body of research evidence have advocated refocusing of service provision away from hospital settings towards community based provision. This shift reflects the preference of service users for home life over institutional care, for local services over distant ones, for services sensitive to community needs and the pursuit of normalisation and integration. It has led to a strong emphasis on the provision of more and better care in the community, embracing support for primary care services and the development of a spectrum of community facilities and services; the participation of service users and carers as partners in service planning, development, delivery and monitoring.

Where we are

1.7 In its consultation with Boards and Trusts, the Review has been greatly encouraged by the efforts currently being taken to address the present shortcomings in service provision. Planning initiatives have been well-informed by new research evidence and exemplars of service development elsewhere. The voice of users and carers is becoming better organised and they are gradually becoming more involved in the planning and development of services. We are fortunate in having a very committed and professional workforce.

1.8 Within Northern Ireland, considerable development in the provision of community mental health services and care has taken place. Nevertheless, recent reviews by Boards, professional organisations and voluntary organisations,[1] while noting the strengths of present provision, have highlighted deficiencies. For example:

- while Northern Ireland policy has focussed on the development of community mental health service provision, the pace of development has lagged significantly behind developments in England;
- identified deficiencies point to the following service needs:
    - a person-centred approach;
    - more inclusive and integrated services, including better working between primary and secondary care;
    - better community alternatives, particularly in the area of assessments and crisis;
    - better services promoting recovery including greater participation of service users and, where appropriate, their carers;
    - greater availability of psychological therapies;
    - better out-of-hours service provision;
    - a more collaborative and inclusive approach to care planning; and
    - more accessible advocacy, with user and carer involvement.

Where we need to get to

1.9 The goals of this Framework are to:

(i) provide better health outcomes and better outcomes for personal and social functioning for all people with mental health needs;

(ii) ensure effective, accessible and safe services;

(iii) guarantee service users and their carers significantly improved experience of and satisfaction with services; and

(iv) give staff real and meaningful opportunities for professional development and job satisfaction.

1.10 The aim is to ensure that each person with mental health needs receives appropriate services, where and when he/she requires them. The emphasis is on fitness for purpose.

How to get there

1.11 To ensure a balanced and inclusive Strategic Framework, the following high level objectives have been set:

- specific reforms and modernisation of services for people with mental health needs;
- specific models of care and standards of provision in relation to the quality, comprehensiveness, effectiveness, accessibility and acceptability of provision;
- detailed consideration of primary and secondary care services, the interface between services, the linkages and interfaces between health and social care, education, culture, arts and leisure, employment and housing, the complementary roles of statutory and independent services and the issues surrounding multi-disciplinary and multi-agency working.

1.12 Fundamental to the creation of improved services for people with mental health needs are:

Workforce development:

- with an increased supply of health and social care professionals;
- with improvements in the skills and competencies of professional staff;
- with greater development of user and carer led services; and
- with the flexibility to change and to contribute to change.

Information on:

- services, for users and carers;
- the prevalence of mental health morbidity and needs for services; and
- how successfully services meet the needs of people for therapeutic interventions and care.

Sustained interdepartmental support and investment to:

- provide for a substantial increase in a wide range of community services, supports, options and opportunities; and
- improve the quality and accessibility of inpatient provision.

1.13 The Strategic Framework envisages a broad and detailed reform and modernisation of services. Given the complexity of this process, clear signposts to mark out the highway of reform are essential. This is provided by 10 Framework Standards which, in turn, are underpinned by a detailed roadmap for change (Chapters 3, 4, 5 and 6).

1.14 Given the anticipated long-haul nature of the reforms, requiring many years to achieve the Strategic Framework goals, it will be essential that the implementation process is performance-managed. The Standards and their underpinning recommendations, therefore, have been mapped directly onto a set of Performance Indicators (Chapter 8).

THE STANDARDS

1.15 Ten Standards are proposed to give clear direction to the Strategic Framework.

Standard 1. Services to be Person-Centred

1.16
- A person-centered approach to planning and provision, with recovery central to the vision
- A whole systems approach to strategic reform and modernisation
- A planned approach to the whole system of mental health services organisation and development
- Independent providers fully engaged
- User and carer involvement in planning, development, delivery and monitoring
- Good managerial cohesion, information management and team working
- A comprehensive workforce strategy.

(Recommendations 19 – 23)

Standard 2: Effective Community and Primary Care Services

1.17 – Community groups including employers and educational providers promoting the mental well-being of those for whom they have responsibility

- Person-centred planning and a quality assured range of provision at primary care level
- Service user and carer involvement in service development, delivery, monitoring and evaluation of Primary Care Services
- A range of advocacy provision in Primary Care
- Targeted investment in primary care teams
- Seamless arrangements between primary and secondary care settings
- Access to a named mental health professional
- Accessible out of hours services
- Effective arrangements for continued professional development.

(Recommendations 1- 18)

Standard 3. Effective Community Mental Health Services

1.18 – Comprehensive coverage by CMHTs

- CMHTs adequately staffed to a minimum of 50/100,000
- Ready access to a range of community resources including independent and user led provision
- For people with complex and enduring needs:
- User participation in preparation of care plans
- Yearly multi-disciplinary review
- Mental health liaison services for all general hospitals
- Accessible and effective range of evidence-based and up-to-date therapeutic interventions
- Tier 2 services for people with psychological trauma, eating disorder, personality disorder, disorders of gender or sexuality, women with perinatal mental health problems, deaf people with mental health problems.

(Recommendations 24 – 28, 54 – 63)

Standard 4. Effective Crisis Services

1.19 – Comprehensive provision of 24/7 appropriately resourced Home Treatment Services

- A single system of acute and crisis provision including Home Treatment, Day Hospital, Step-up, Step-down and Inpatient services
- All services of high quality providing a range of therapeutic interventions, sensitive to gender and cultural needs
- A lead clinician or manager with overall responsibility for inpatient services.

(Recommendations 29 - 35)

Standard 5. Promoting Recovery

1.20 – Those with greatest need given highest priority

- A comprehensive range of community services available to facilitate recovery of those with complex needs, including appropriately resourced CMHTs, Home Treatment and Assertive Community Treatment Teams
- Separate services for younger people with a first episode of psychosis
- Appropriate provision for people with mild learning disability, service users growing older, people with challenging behaviours, people with mental health problems along with alcohol or substance misuse
- Tier 2 services for adults with acquired brain injury or progressive brain disease, Asperger's Syndrome or high functioning autism.

(Recommendations 36 – 53, 64+65)

Standard 6. Sustaining Meaningful Lives

1.21 – Service users with complex and enduring needs enabled to live fulfilling personal, family and social lives

- Opportunities for education, occupation and leisure
- Choice of a range of accommodation and support
- A readily accessible Social Security system
- Easy access to Advocacy services
- Services sensitive to cultural, religious and spiritual needs.

(Recommendations 66 – 80, 85+86)

Standard 7. Providing for People with Special Needs

1.22 – Specialist regional services in addition to primary and secondary care services for people with eating disorders, acquired brain injury or progressive brain disease, psychological trauma, personality disorder, people with Asperger's Syndrome or high functioning autism, disorders of gender and sexuality, women experiencing mental health problems during the perinatal period and deaf people with mental health needs.

(Recommendations 100 – 136)

Standard 8. Meeting the Information and Support Needs of Service Users, Carers and Families

1.23 – Full implementation of existing policy and legislative obligations relating to users and carers

- Easy access to comprehensive information on services
- Service users and carers provided with appropriate support, education and information
- Family interventions should be an integral part of mental health practice
- Service users who are parents supported in their parenting role
- Where children may require protection, agreed protocols established between young people's services and mental health services.

(Recommendations 81– 84, 87 – 99)

Standard 9. Ensuring Sound Information for Mental Health

1.24 – Information systems to support professional staff, service providers and to enable the Department of Health, Social Services and Public Safety to monitor effectively the roll-out of its new Strategic Framework

- A Research and Development Strategy to inform and update the Strategic Framework.

Standard 10. Delivering an Effective, Competent and Confident Workforce

1.25 – A comprehensive regional, flexible workforce strategy to underpin the Strategic Framework, embracing multi-disciplinary workforce training, recruitment, retention;

- Provider workforce strategies which include recruitment, retention, training, support, career opportunities.

1.26 These 10 Standards underpin the detailed recommendations emerging from this Review (Chapters 3, 4, 5 and 6) and map directly onto the Performance Indicators which signpost the delivery of the Strategic Framework (Chapter 8).

A BLUEPRINT FOR CHANGE

1.27 The Strategic Framework provides a blueprint for reform and modernisation of services based on the agreed principles and values. It adopts a strong user and carer perspective and specifies evidence-based service models aimed at addressing the current problems and barriers to good practice (Chapters 3, 4, 5 and 6). It is underpinned by programme recommendations for funding, human resources, information management, research, service evaluation and performance management (Chapters 7 and 8).

CHAPTER 2

THE PRESENT STATE OF MENTAL HEALTH NEEDS AND PROVISION OF SERVICES

INTRODUCTION

2.1 Consistent informal advice and information from service users, carers and service providers emphasise the existence of significant gaps and deficiencies in service provision for people with mental health needs. Strategic planning, to be effective however, must be grounded on detailed population based information on mental health needs. This should include knowledge of:

- the prevalence of people with mental disorder*;
- the nature and prevalence of problems experienced by those suffering from mental disorder; and
- the extent to which current services meet the needs of these people.

Each of these issues is considered in the following sections for mental health problems in general. The prevalence of those disorders for which regional provision are proposed are described along with specific service requirement (Chapter 6).

THE PREVALENCE OF MENTAL ILL-HEALTH

2.2 From a global perspective, the scale of the challenge posed by mental illness has become increasingly clear in recent years. One in ten adults worldwide are affected by mental health problems at any one time, accounting for over 12% of the global burden of disease[1]. Mental health problems account for over 30% of all years lived with disability, and in the developed world account for over 40% of the total burden of disability.

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* Mental disorder is best understood as deriving from an interplay of biological, psychological and social factors. The term mental disorder is used throughout this Review to refer to a range of specific mental illnesses such as schizophrenia, bipolar disorder, depressive disorder. It includes other disorders such as mental health problems arising from neurological disorders for example epilepsy, Parkinson's Disease, brain injury secondary to trauma or substance misuse. These are defined in the International Classification of Disease (version 10).

The term mental health problem is also used in recognition of the fact that, particularly for people with more complex and enduring mental health needs, problems may extend beyond the disorder itself; indeed the primary disorder may be in remission. These problems include difficulties with thinking and decision making, problems with esteem or self confidence, difficulties with social tasks and functions. These are defined within the International Classification of Disabilities and Handicaps.

2.3 Within the United Kingdom (UK) there are significant variations in the level of mental health morbidity. Socio-economic deprivation has a significant impact on prevalence, reflected in, for example, the level of unemployment and the quality of the social environment. The social deprivation experienced by the Northern Ireland community is among the worst in Western Europe.[2] In the period 1997 – 2002, average gross weekly household income in Northern Ireland was only 78% of the UK average. Northern Ireland's unemployment rate has been consistently higher than that of Great Britain, and in 2001 was 6.2%, almost 30% higher than the UK average. In addition, the community has experienced 30 years of civil conflict.

2.4 While social and economic factors contribute significantly to mental well-being the opposite is also true. Around half of the disabled population in the UK are economically inactive compared with only 15% of the non-disabled population. Moreover, people with mental health difficulties have the lowest employment rate of all disabled people (18% compared to 48%).[3] In Northern Ireland more than a third of Incapacity Benefit claimants have a mental or behavioural disorder.[4] In 2002, over 37,000 people were on Incapacity Benefit as a result of mental and behavioural disorders, and just under one in five people receiving Disability Living Allowance (DLA) gave mental health reasons as the main disabling condition.

2.5 Using the General Health Questionnaire, the Northern Ireland Health and Social Well Being Survey (2001) found a prevalence of mental health problems of 24% among women and 17% among men. Such rates are over 20% higher than the rates in England or Scotland.[5]

2.6 While at the present time we do not have an in-depth profile for Northern Ireland as a whole, a detailed prevalence study has been completed for the District of Derry.[6] The 1-year prevalence of psychiatric disorder was over 12%, consisting mostly of depressive and anxiety disorders. The overall prevalence was again greater than the UK average and similar to a deprived inner city area of London.[7] The prevalence of psychotic illness was 0.46%, similar to findings from UK national surveys.

2.7 While this study does not allow one to generalise to the rest of Northern Ireland, it provides important pointers to the expected general prevalence of disorder elsewhere. In particular, it confirmed clear and strong associations between the level of psychiatric morbidity and poverty.[8]

2.8 Within Northern Ireland there is a significant variation in the level of social deprivation.[9] Among the most deprived are homeless people. A recent study of homelessness in Belfast found that 37% had mental health problems, rising to 41% among single residents in accommodation for homeless people, half of whom had moderate or severe levels of mental health impairment, as well as high levels of unmet need for most services.[10]

2.9 The impact of 30 years of civil conflict on community mental health has been assessed in several community based studies. In a random sample of 1000 adults, Cairns and Mallett[11] found 16% to be "direct" victims and 30% "indirect" victims of civil conflict. Perception of being a victim was consistently associated with poorer psychological well-being.

2.10 Again O'Reilly and Stevenson[12] in a separate household survey found a positive association between the extent to which people and areas were affected by the conflict and significant mental health problems. A variety of evidence, including the findings of these prevalence studies,[8, 11, 12] is revealing that the ceasefires have not been associated with any improvement in mental well-being. The civil conflict has, therefore, cast a long shadow on the mental health of the community in Northern Ireland.

2.11 Suicidal behaviour is one of the major health challenges in Ireland, north and south: a challenge for mental health policy, services and the wider community. A particular problem is the substantial increase in suicide over the past 20 years among younger people. It is now the number one cause of death among 18-24 year olds in Ireland.

2.12 While suicide is a major health challenge, it is the tip of an iceberg. Recent research in Ireland and the UK have found rates among those who would consider committing suicide to be around 20% among young people, with 7% carrying out acts of deliberate self-harm. While the challenge is particularly in the area of primary prevention, the service needs of young people in psychological crises needs to be considered particularly at community and primary care levels.

NEEDS FOR CARE

2.13 Needs can be considered as problems which may benefit from care or treatment. Prevalence of mental ill-health is only an approximate guide to needs, as these are not just determined by symptoms, but from associated features such as impaired social functioning. Many aspects of a person's life may be disrupted as a consequence of a mental disorder. This may include suffering caused by symptoms, loss of independence, lower quality of life and difficulties with social interaction.

2.14 Assessment of population needs is an essential step in the planning of services. A systematic and comprehensive evaluation of mental health needs for care and treatment has not been carried out for Northern Ireland as a whole. However, in the District of Derry study, needs for care were found to be met in less than 30% of care episodes. In a large proportion, needs were not met because people had either not presented or not continued with treatment. This reluctance to engage with services, which has been confirmed in national studies,[13] highlights a need for better public education and information and for services that are more accessible and user-friendly.

2.15 The generally agreed priorities for mental health services highlight the needs of the severely mentally ill. The District of Derry study included recording the number of people with psychotic disorder known to primary, secondary and non-statutory services. This gave a prevalence of 0.46%, consistent with the most recent UK prevalence estimates.[14] Schizophrenia was the most single common diagnosis, present in over half.

2.16 The Medical Research Council Needs Assessment Interview was used to assess psychological and social need. While the most frequent problem areas related directly to illness, (eg psychotic symptoms, the effects of medication), other symptoms (eg anxiety, depression) were relatively common. In addition, a wide range of problems were found in social functioning. The presence of these additional problems must be considered in service provision.

2.17 The wide profile of problems affecting this group of people highlights the need for a holistic approach to service development and delivery. Of equal importance for service planning is the extent to which current services are meeting the needs of this group. While in the above study the most common problem area, psychotic symptoms, was for the most part being dealt with satisfactorily, medication side-effects were being addressed in just over half.

2.18 A substantial amount of unmet need was also identified in the areas of psychological and social functioning, including under-activity, difficulties with day to day activities, where between one third and one quater of all needs were unmet. The issue of unmet need in relation to neurotic symptoms may be important, not only for quality of life, but also in relation to the well-recognised high suicide risk among this group of people. Unmet need was greatest among males and people with longer duration of illness.

2.19 A new Northern Ireland Strategic Framework for mental health must include better information on mental health and better information on service needs.

SERVICE PROVISION

2.20 A third element in the information requirements concerns services, both current and planned, and a matching of these to local population needs. As part of this Review, baseline information is currently being obtained on existing services provided by each Trust throughout the Board areas.

2.21 Mental health inpatient provision in Northern Ireland, as in the rest of Ireland, is and has been significantly greater than in England. Historically this may have reflected greater commitment from local administration in providing for the most vulnerable in our society. However, the present relatively high level of provision reflects a lack of alternative provision, the result of deficiencies in the current and previous strategies, lack of investment and resources. Baseline information recently obtained from service providers for the Review indicates current acute inpatient provision for adults under 65 years to be approximately 50/100,000 adult (<65) population and continuing care inpatient provision for all adults to be 28/100,000 adult population. There is significant variability across Northern Ireland.

2.22 Local evidence points to high levels of need among people with the most severe forms of mental disorder and to significant service gaps, particularly in relation to co-morbid emotional needs and social provision. Services for the severely mentally ill in particular require better community provision and better resourcing of day care and community based interventions, including adequate numbers of appropriately trained staff.

THE ECONOMIC AND SOCIAL COSTS OF MENTAL ILL-HEALTH

2.23 The Health and Personal Social Services expenditure on adult mental health in the year 2002/03 was £110 million, 6.1% of the total expenditureon health and social care. Over half (57%) of the mental health expenditure was on hospital services.

2.24 However the total economic costs of mental illness is much greater than the direct health services costs. For example, the estimated economic effect of depression on employment, and hence on national productivity in cost terms, is over twenty times greater than the costs falling to the health services[15]. In a recent study the Northern Ireland Association for Mental Health, in collaboration with the Sainsbury Centre for Mental Health, London, has estimated that the total financial cost arising from mental ill health in Northern Ireland in 2004 to be £2,852,000,000[16]. This includes the cost of care, loss of output and the human cost. It has been estimated that overall about 70% of the costs of mental illness is borne by the individuals who experience it and their families[17].

2.25 Currently the Northern Ireland expenditure on mental health services is less than the comparator expenditure in England. From the Needs and Effectiveness Evaluation Report the per capita expenditure for 1999/2000 in Northern Ireland was at a similar level to that in England. This, however, takes no account of the characteristics of the populations of the different countries with different levels of need.

2.26 Two significant indicators used in resource allocation formulae are dependence on income support and standardised mortality ratios. Research evidence shows a strong correlation between deprivation and need for adult mental health and social care services. In Northern Ireland the proportion of 16-64 year olds dependent on Income Support is 60% higher than in England. The standardised mortality ratio, a measure of early death and a proxy for morbidity, for 65-74 year olds is 6% higher than in England. The Needs and Effectiveness Report estimated that Northern Ireland's need for mental health services was around 25% higher than in England.

2.27 Since 1999 and with implementation of the National Service Framework for Adult Mental Health in England and Wales there has been a significant investment in mental health services. Expenditure on mental health in 2002/03 accounted for 11.8% of public spending on health and social services compared with 8.4% in Northern Ireland for the same period[17].

CONCLUSIONS

2.28 Present information on mental ill-health needs for treatment, care and service provision, together with economic evaluation, point to the requirement for greater investment in mental health services throughout Northern Ireland.

2.29 A new Northern Ireland Strategic Framework for mental health must include better information on mental illness and better information on service needs.

The evidence base for local practice must be underpinned by greater investment in epidemiological and mental health services research.

2.30 A holistic and comprehensive approach to service provision and mental health practice is necessary to address the high prevalence and the wide spectrum of health, psychological and social needs of people with mental health problems throughout our community.

CHAPTER 3

COMMUNITY AND PRIMARY CARE SERVICES

INTRODUCTION

3.1 A fundamental principle of this Review is that mental health and social care should be provided in the community unless there is good reason for not doing so. Mental health care in the community embraces the spectrum of mental health promotion, pre-primary (community) care through social networks, ill-health prevention, generic care, specific interventions by primary healthcare teams and specialist secondary services. The following key themes provide a rationale and foundation for the development of community (pre-primary) care and primary mental health care:

- The principle of equity must underpin future community and primary care services;
- Much psychological and emotional distress can be resolved by the imaginative use of generic services, the voluntary sector and by community development approaches which provide support to people at times of need;
- Most people with mental health problems who receive health and social care services do so entirely in a primary care setting;
- Service users and their carers prefer primary care based services, which are accessible, responsive, and work in partnership, thus respecting the insight of service users and carers;
- Investment in primary care produces better healthcare outcomes in respect of activity in both primary and secondary care[1];
- Each individual with mental health problems should be given the opportunity to have their mental health needs understood and addressed promptly within primary care settings, taking into account biological, psychological and social dimensions;
- Commissioners of mental health services must carry out comprehensive needs assessments at population and community level; and
- Community and primary mental health care requires systematic efforts being directed towards mental health improvement. This is being examined by a separate Expert Working Committee.

ILL HEALTH PREVENTION

3.2 Mental health service providers can assist other organisations such as employers, educational establishments and community groups to develop specific strategies in time to prevent mental ill-health. Such strategies should be directed towards people who show no overt signs of mental disorder, but who are in high risk groups such as young adult males in socially disadvantaged localities. Much can be done using dedicated support systems and services for vulnerable individuals who show evidence of psychological distress.[2]
Good Practice Example (Annex 5.3.1).

3.3 Early detection of signs of distress may lead to the speedy resolution of the problem. Where the problem is more persistent, then it is essential that people have access to services offering early assessment and early treatment. At these early stages psychological distress does not often fit easily into conventional classifications and should be addressed in a manner and setting which is acceptable and accessible to those suffering. These early interventions have much in common with the public health model described by Albee.[3]
Good Practice Examples (Annex 5.3.2).

3.4 Early prevention and assessment strategies can minimize any stigma associated with traditional mental health models. It is clear that there will always be those who, in spite of the very best system of prevention, will develop more severe or enduring problems.

3.5 Employers have a duty to ensure the mental well-being of their employees. The use of employee assistance and counselling programmes is commended by the Review and should be made more widely available.
Good Practice Example (Annex 5.3.3)

Recommendation

1. Employers, educational establishments and community groups must promote and ensure the mental well-being of those for whom they have responsibility.

3.6 Voluntary agencies play an important role in providing services to people with mental health problems. However, they are often unable to rely on consistent and planned levels of funding from statutory bodies. There are clear opportunities to expand the role of voluntary agencies at primary care level.

Voluntary agencies often have the flexibility to respond innovatively to the changing demands of mental health care.
Good Practice Example (Annex 5.3.4)

3.7 The Review believes that those responsible for assessing mental health needs at community and primary care level must have available a quality assured range of adequately funded, supervised and monitored voluntary services to whom they might refer. In particular ready access should be ensured to self-help and guided self-help through a variety of media including video, audio, written word and electronic storage.

Recommendation

2. Commissioners of mental health services must seek to develop and expand the range of independent services in order to provide a planned and quality-assured profile of care available to service users at primary care level.

USERS AND CARERS INVOLVEMENT

3.8 In spite of much recent progress involving services users and their carers in the planning and delivery of mental health services, there is much left to do.[4] All services providing care for mental health problems should foster a culture where users and carers are actively involved in the planning and delivery of services as well as being fundamental to the monitoring, developing and refinement of services.[5] Service users and their carers have much to offer to programmes of education and initiatives designed to reduce stigma and increase acceptability of mental health services. Carers may have their own mental health needs requiring support and specific interventions.[6]

Recommendation

3. All community and primary care mental health services provided by and commissioned by statutory services must have service users, their carers and families involved in the development, delivery, monitoring and evaluation of services.

ADVOCACY

3.9 At present the use of advocacy in community and primary care is not well-developed. The Review recognises that primary care professionals advocate for service users in secondary services and welcome both formal and informal advocacy within the primary care setting. Advocacy occurs at individual, family, group and service level. Particular problems associated with mental illness might require specific advocacy skills. Advocacy services described in Chapter 5 should be linked to services within primary care.

Recommendation

4. Community and primary care organisations must ensure that advocacy arrangements are developed within primary care settings.

PERSON-CENTRED PLANNING

3.10 People should be encouraged to take as much control as possible over their own care. A Person-centred Plan could be developed, led by the service user, supported by his or her carers and advocates, in partnership with professionals. This would enable care to be planned in the context of the individual's aspirations and life as a whole. It would also enable service users to make more effective use of direct payments.

Recommendation

5. Community and primary care organisations should facilitate person-centred planning.

PRIMARY CARE TEAMS

Team Structure

3.11 At present primary care teams in Northern Ireland face many difficulties. They vary in composition and size, and in the skills available within them. A full range of professionals is often not clearly identified, deployed or networked as a team, and there are a number of different management arrangements within teams. These include independent contractors such as General Medical Practitioners, Community Pharmacists; practice employed staff such as Nurses and Receptionists; Trust staff, such as District Nurses, Health Visitors, Community Midwives, Social Workers and aligned staff such as specialist mental health professionals or Allied Health Professionals.

3.12 Quality patient care is dependent on the effective functioning of primary care teams. It is vital that the teams comprise the full complement of professionals and that the varying contractual arrangements and managerial structures do not impede effective team working. A strategy for the development of primary care in Northern Ireland must recognise the obstacles to effective team working. Each practitioner should have a clear knowledge of the roles and responsibilities and when onward referral is appropriate.

Recommendations

6. Membership of the primary care team should be clearly defined and each team should have the full complement of professionals. Organisational barriers should not impede effective multi-disciplinary working.

7. There should be targeted investment in the development of primary care teams to promote better recognition of common mental health problems and clear working arrangements for managing such problems.

WORKING ARRANGEMENTS

3.13 Contractual arrangements for delivery of general medical services offer opportunities to improve mental health care at primary care level. Work is be required to determine how mental health services can best be arranged within the framework of core, additional, extended and enhanced services.

3.14 Local Health and Social Care Groups play a key role in the development of primary care mental health services. Where they become commissioners of services, it will be necessary to ensure that conflicts of interest do not occur within organisations responsible for both commissioning and provision of similar services.

3.15 Contractual arrangements for groups such as Community Pharmacists offer opportunities to reflect the substantial contribution to be made by people throughout the primary care setting.

3.16 Efficient working at primary care level can be dependent on efficiency of working at secondary care level. Mental health care working in Northern Ireland shows that seamless delivery by single management structures provides better services than when several Trusts are involved in delivering care. It is in service users best interest that management boundaries are broken down where possible.

Recommendations

8. Statutory mental health services must have seamless management arrangements between secondary and primary settings in order to maximise the efficiency and effectiveness of service delivery.

9. New working arrangements in primary care should seek to maximise treatment of mental health problems in primary care.

ASSESSMENT

3.17 The fundamental role for primary care is to ensure that individual needs are met in a timely, appropriate and accessible manner. In many cases this can be achieved by members of the primary care team such as Social Workers, offering social care and intervention, Health Visitors and Community Midwives giving advice about the emotional effects of pregnancy and childbirth, Practice Nurses giving lifestyle advice, Community Pharmacists managing concordance and the General Practitioner prescribing for significant depressive illnesses.

3.18 For assessment of more complex needs appropriate expertise must be available at primary care level and appropriate referral to other agencies arranged where necessary. A minority of practices presently have directly attached mental health workers (link workers). Such arrangements have advantages for patients and for the primary care team. It is important however that such workers retain the ethos of team working with colleagues from a mental health background and that adequate professional supervision, clinical guidance and personal support are offered, as well as opportunities for continuing professional development. It is equally important that mental health workers feel part of the primary care team in order to integrate care within primary care services. Identified primary care mental health professionals (link workers) should offer support, advice and guidance within the primary care team. The assessment process should be auditable and should contribute to the continuing education of all involved. Lessons may be learnt from the experience of innovative projects such as in Limavady and Mid Ulster. It will also be appropriate for primary care teams directly to employ mental health workers to provide specific psychological, social or pharmacological interventions. It is envisaged that such workers will be few in number at first (2/100,000 population) but will increase as workforce competencies and funding permit.

Good Practice Examples (Annex 5.3.5)

Recommendations

10. All primary care teams must have access to a named mental health professional (a Link Worker) in order to provide timely, appropriate and accessible assessment and management of people with mental health problems.

11. Mental health services must be accessible in order to provide timely and appropriate assessment and treatment in a manner valued by service users, their carers and by practitioners.

IDENTIFICATION AND ACCESSIBILITY

3.19 Most people with mental illness should be and are treated in the primary care setting. There is a problem of under-recognition of mental health problems by General Practitioners and other members of the primary care team. Present evidence suggests that educational initiatives, whose effectiveness has been measured, have a limited effect, which might only be of short duration. There are many contributory causes to under-recognition of illness including time constraints, characteristics of the practitioner, setting of the consultation and characteristics of the patient.

3.20 It is recognised that issues of stigma can prevent people accessing appropriate mental health care.[7] It is important the primary care teams recognise the internal[8] and external causes of stigma[9] in order to devise working arrangements to facilitate access. Teams should formulate policies of good practice for health promotion, disease prevention, early diagnosis, illness management and referral within and outside the team. Difficulties regarding confidentiality and consent should be addressed specifically.

3.21 One of the key skills of a General Practitioner is to interpret the complex and different range of problems often presented by their patients, to come to an agreed understanding regarding the nature of these problems and then negotiate an appropriate course of action for each problem. General Practitioners have crucial roles to play in managing inter-relationship between physical and mental health problems and ensuring the delivery of holistic healthcare to people.

3.22 Similarly, one of the key skills for Social Workers, working with client groups such as families, people with disabilities and vulnerable adults is to identify psychological and emotional stress and refer on appropriately.

3.23 The uptake of specialist community mental health services is likely to be better where such services are developed locally, are not perceived to be institutional and provide specific interventions as well as offering supportive aspects of care.

3.24 It is known that major psychiatric illnesses such as schizophrenia and affective disorders, carry a significantly increased burden of mortality and morbidity from physical causes. It is essential that primary care structures offer opportunities for assertive recognition and management of risk factors and early management of physical health problems in those with mental illness.

OUT OF HOURS SERVICES – THE NEED FOR MENTAL HEALTH SERVICES NOT CONFINED TO OFFICE HOURS

3.25 Service users and carers value the opportunity to get advice about their problems and about treatment. Crisis assessment and intervention services (see Chapter 4) should be provided for those for whom hospital admission would be the only other alternative. Mental health providers should also however, offer locally-based dedicated telephone advice from qualified staff. Such services might also offer support, advice and arrange appointment for people with services that might be offered during the next or subsequent working days.

3.26 All providers should seek to offer extended hours facilities and services at times convenient for users, rather than those based on office hours that avoid holidays and weekends. Examples include statutory services provided by Trusts and Voluntary sector services.
Good Practice Example (Annex 5.3.6)

3.27 Access to mental health services in an emergency can be through a number of means. Primary care out-of-hours services may overlap with hospital based accident and emergency departments and with dedicated mental health services. The targeting of Crisis Intervention Services to those who would previously have been admitted to hospital leaves a significant number of people who are experiencing significant personal difficulty for example overwhelming social distress, have self-harmed or are acutely intoxicated. It should be clear to service users, carers and to practitioners how best to access appropriate services. Local agreements will be required to define the working relationships between hospital liaison teams, primary care teams and community mental health services.

Recommendation

12. The means of access to out-of-hours mental health services should be stratified according to clinical need and to comprise face-to-face contact, telephone advice and arrangements for organisation of services during subsequent working days.

SCREENING TOOLS

3.28 There is evidence that the use of screening tools in healthcare increases the detection of mental health problems. Commonly used research tools are recognised to run the risk of identifying disorders where none are present. This can cause significant worry to those being screened and divert attention from those with greater needs. There is not evidence to advocate the widespread use of screening tools. The Review encourages their use to support trained practitioners in the assessment of targeted populations at risk or suffering severe mental health problems, such as those admitted to hospital following deliberate self-harm, or those thought to be at risk of developing perinatal psychiatric illness.

3.29 Many practitioners value checklists for common disorders, such as those contained in the World Health Organisation Guide to Mental Health in Primary Care.[10]

Recommendation

13. Formal screening tools should be used to support trained practitioners in a holistic assessment of at risk populations.

PSYCHOSOCIAL CARE, COUNSELLING AND SPECIFIC PSYCHOLOGICAL THERAPIES IN COMMUNITY AND PRIMARY CARE

3.30 There is patchy and inadequate provision of psychological therapies in community and primary care. There is clear evidence that psychological therapies should be routinely considered as an option when considering mental health problems, with particularly strong evidence for patients suffering from addictions, depression, psychosis, anxiety disorder, eating disorders and post traumatic stress symptoms. Specific psychological therapies do not preclude the simultaneous use of medication or social interventions. Indeed such combinations may have a complementary effect for treatment of some presentations.[11]

3.31 It is recommended that a tiered approach to assessment and treatment is utilised (see Chapter 6.4).

3.32 All primary care workers offer a degree of psychological support. In addition some will have specific competencies to provide tier 1 or tier 2 interventions. Mental Health Link Workers should aid other practitioners to secure access to psychological therapies and to more specialised services.

3.33 The evidence for counselling is variable in quality and outcome. The best evidence for efficacy is for structured specific interventions rather than generic counselling[15]. Counselling is not recommended as the main intervention for severe and complex mental health problems or personality disorders. Much support and counselling can be provided by voluntary agencies providing that guaranteed standards are assured.
Good Practice Examples (Annex 5.3.7)

3.34 Much can be achieved by people availing of self-help. This may be through access to written or electronic media, guided self help or by participating in self help groups.

SKILLS AND COMPETENCIES

3.35 All professional staff in the mental health field have a role in providing psychological interventions. This may include psychosocial interventions which are an integral component of routine mental health care and/or specific psychological interventions. The qualifications, training and skills of each practitioner will differ. More complex problems require greater skills. [14] It is essential that anyone delivering psychological treatments has received the minimum level of training that would enable them to carry out therapies safely and effectively. It is also essential that adequate clinical supervision is provided for the work to ensure that it is done safely and effectively. Continuing development of a therapist's skills and supervision is also important if therapy is to be delivered to an acceptable standard. [12]

3.36 Key considerations with regard to psychological therapies are:

- education, training and workforce development for all primary care staff to develop cultures of excellence;
- the use of partnerships between statutory and voluntary sectors, particularly to allow creative use of community resources for those with less severe mental health problems;

- the provision of health promotion and illness prevention programmes targeted at those in at risk groups;
- the need for the service to develop with regard to evidence-based guidelines to practice in order to allow joint decisions between practitioner and service user about care packages; and
- a focus of adequate resources in primary care.

Recommendations

14. People receiving care at primary care level must have access to a high standard of psychosocial care and to a range of psychological therapies delivered by people working in managed clinical teams.

15. All practitioners offering psychological therapies must have assured levels of qualification, experience, supervision and monitoring.

USE OF MEDICATION

3.37 There is clear evidence for the use of antidepressants in moderate or severe depression, for the use of antipsychotic drugs in psychosis, for prescribing mood stabilising agents in bi-polar affective disorder and for the short-term use of anxiolytic agents.

3.38 Perceived problems in Northern Ireland include long term use of benzodiazepines, polypharmacy, failure to offer appropriate treatment to those who need such treatment and use of treatment in those unlikely to benefit from treatment.

3.39 There are opportunities to develop closer working arrangements between prescribers and pharmacists. All people with mental illness, living in the community, who require medication will obtain this through a community pharmacy. The role of the community pharmacist is developing. The DHSSPS strategy[13] or pharmacy in the community envisages pharmacies as an open door to the health service providing up-to-date quality focused care. Opportunities exist to extend the existing Medication Management Service to psychiatric medications prescribed within the community.

3.40 Guidelines are available outlining the evidence-base for the use of drugs in the major mental health categories. It is known that guidelines seldom work unless practitioners have been involved in the production and ownership of such guidelines. The Review commends evidence-based guidelines such as those prepared by the British Association of Psychopharmacology[14] and the National Institute of Clinical Excellence.[15]

3.41 Involvement of users and carers in the development of locally-agreed practice guidelines is important. Pharmacists can provide a valuable role in developing treatment protocols. They can also facilitate educational initiatives with primary care staff as well as offering opportunities to patients to have their medication regimens monitored and tailored according to safety, tolerability and efficacy considerations.

3.42 Factors of particular note include:

- antidepressants are a first line treatment for major depression irrespective of environmental factors. Antidepressants are not indicated for initial presentation of acute mild depression. Education, support and problem-solving are indicated. People with minor depression are at risk of developing major depression:
- it is essential that tolerability, safety and efficacy of the prescribed drugs are reviewed regularly:
- particular care should be given in preparing patients for discontinuation of medication:
- the choice of drug treatment should be made jointly by the individual and the clinician responsible for treatment based on an informed discussion of the relative benefits of drugs and their side-effect profile:
- whatever treatments are offered it is essential to engage the service user in a collaborative, trusting and caring relationship at the earliest opportunity:[18]

Recommendation

16. Those responsible for prescribing physical treatments in mental illness must be encouraged, within a multidisciplinary framework, to develop protocols for the prescribing, monitoring and review of treatment regimens according to evidence-based guidelines.

RESEARCH, EDUCATION, DEVELOPMENT AND CLINCIAL AND SOCIAL CARE GOVERNANCE

3.43 There is currently no clear structure in Northern Ireland for the recognition and dissemination of good practice in mental health care.

3.44 There is a clear need to stimulate innovation by directing funding towards research into service delivery and treatment choice in primary care settings.

3.45 The challenge of delivering continuous targeted education is great.[16] There is a constant need for professionals to maintain high levels of knowledge and skills, while fostering developing and sharing examples of best practice.

3.46 The implementation mechanism following this Review must ensure that provider agencies are facilitated in delivering high quality, evidence based, accountable service models.

3.47 There is much that services in Northern Ireland can learn from other local services and by practitioners sharing information within their own services. There are also clear opportunities for fostering teaching and research links both locally and nationally.

Recommendations

17. The Department of Health, Social Services and Public Safety must ensure that there are mechanisms to identify examples of good practice and to encourage widespread implementation of these.

18. Local statutory mental health providers must be funded for, and take responsibility for, the continued professional development of primary and secondary care staff by ensuring targeted and audited learning. The Review commends the use of multidisciplinary models of learning.

CHAPTER 4

SECONDARY MENTAL HEALTH SERVICES – PART I

A PERSON-CENTRED APPROACH

4.1 The Strategic Framework provides a service blueprint for adults with more severe mental health problems and needs* requiring the specialist skills and facilities of mental health services. This includes:

- enhanced support for primary care services;
- a range of services for people with acute needs;
- support and interventions to promote recovery and address the residual effects of mental disorder which can significantly impact on the personal, domestic and occupational aspects of daily life;
- the psychological, educational and training needs and aspirations of service users;
- the management and prevention of relapse; and
- the need for psychoeducational support for family members and carers.

4.2 A person-centred approach to service planning and provision is fundamental. The focus for strategic development is the individual service user and his/her family, person-centered and family-orientated services enabling and empowering the person with mental health needs and their family. Mental health services must reflect the multi-dimensional nature of service user and carer need, embracing:

Health Needs	Education/Training
Occupation	Income
Accommodation	Personal Life, Family Life and Culture
Carer and Family Needs	Advocacy

Recovery must be core to the vision for strategic development of services.

4.3 The Framework envisages a major shift in the centre of gravity of secondary mental health services being achieved over the next 10-15 years. With appropriate development of the full range of community based services it is anticipated that the need for admission to hospital will be much reduced and the duration of admissions much shorter.

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* More severe health problems and needs arise from such mental disorders as schizophrenia, bipolar affective disorders, severe depression

The Whole System of Care

4.4 **Service Planning and Development**. While the sections which follow review each of these issues and associated service requirements, beginning with health needs, consideration must also be given to the whole system of service organisation and delivery. Central to effectiveness of a person-centred holistic approach is the integration of services – the relationships between different service elements and functions require careful planning, including sequencing, appropriate for local arrangements. The optimal shape of local community mental health services should therefore be the subject of careful planning and consultation including the involvement of representative service users and carers. Independent providers must be fully engaged as appropriate, in planning, development and service delivery. Person-centred services must be needs-driven considering both service users and their carers.

4.5 Service configuration should be considered for mental health as a whole (see 4.118). The principles that must inform configuration are that:

- delivery of services are focused on the community and not dealt with separately from other community health and social services;
- service delivery bodies cover a population of sufficient size to allow for delivery of an appropriate range of services;
- resources are equitably allocated according to need;
- transparent accountability for resources exists within each programme of care;
- commissioning of services is based on population groups co-terminous with one or more providers;
- a regional mechanism is used for commissioning and delivering highly specialised services;
- a regional body has responsibility for strategic planning and for monitoring of strategy implementation, service development and delivery;
- administrative boundaries for HPSS Services are aligned with other public services (for example, education, housing);
- the role of the independent sector in the planning and delivery of services is fully recognised;
- partnership arrangements which integrate the independent and statutory sectors are supported.

4.6 A smaller number of delivery bodies than currently exist, covering larger populations, would give each of them more leverage in terms of budget and a better capacity to deliver smaller sub-specialities. Based on consultations, provider units based on an adult population size of 200,000-300,000 is recommended, informed by the Review of Public Administration. A regional mechanism is required for a small number of highly specialist services.

4.7 Inpatient services are an important element in the whole system of care and must be considered in that context, not in isolation. While Northern Ireland still has its six large psychiatric hospital sites, the direction of change throughout the UK, Western Europe and beyond is away from this form of provision. This change has been achieved through development of community care and alternatives to hospital for both acute and longer term care.

4.8 The Review's vision for service development includes a significant acceleration of this process for the people of Northern Ireland. Acute inpatient services should be located within the community they serve and closely integrated with the other service elements, particularly crisis services (see 4.23). For people requiring longer term residential care, this should, as far as possible, be community based. Some service users with persistent and severely challenging behaviour may require prolonged periods of hospital provision (see 4.34, 4.63). The present balance of resource spend is approximately 60% on hospital services and 40% on community services. The recommended developments in community services should be reflected in a reversal of this balance of expenditure within 10 years of implementation of the Strategic Framework.

4.9 For each of the groups with special needs (see Chapter 6) there is a small requirement for highly supported provision, including independent sector provision where appropriate. The needs of adults requiring treatment in conditions of security are considered in the report by the Forensic Services Committee.

4.10 Configuration of services is considered further at paragraph 4.118 following review of the various elements of service provision.

4.11 **The process of change**. The sequencing of planned changes will be most important. In general, investment and development in community based services will be an essential first step to service development, including any restructuring of inpatient services. It is essential that the needs of those within the current model of provision, service users, carers and staff, are addressed as part of the change process. Particular attention must be given to the small number of people still resident in mental hospital settings, many now elderly and frail.

4.12 Adult Mental Health Services cannot be considered in isolation. There are many interfaces between adult services and other services. A key interface is between primary and secondary care (see Chapter 3). Consideration must be given to the transitional needs of younger people, older adults and those with less severe learning disability , in consultation respectively with child and adolescent services, services for older adults and learning disability services. There are also important interfaces with substance misuse and forensic services. The needs of people requiring specialist services (see Chapter 6) must be reviewed by each local service provider in consultation with the Department. While all Trusts should assume responsibility for tier 2 services (see Chapter 6) some must assume responsibility for tier 3 and 4 services.

4.13 The service reforms and developments envisaged for Mental Health Services are considerable. The changes and the process of change will present formidable challenges for professional staff, administrative staff and management at all levels. These challenges must be adequately prepared for. Robust service organisation, information management, team working and communication will all be pivotal in realising and maintaining these reforms.[1] (see 7.7) These must be complemented with a comprehensive workforce strategy embracing recruitment, retention, training, supervision and also the participation of service users.

Recommendations

19. A person-centred approach to service planning and provision must be adopted with recovery core to the vision of strategic development.

20. Strategic reform and modernisation, including service configuration, must be considered for each local system of provision as a whole, based on whole populations of 200-300,000.

21. Each provider should adopt a planned approach, including sequencing, to the whole system of mental health service organisation and service development in their area:
    - all statutory and independent providers must be fully engaged and involved

- representative service users and carers must be involved in service planning, development, delivery and monitoring
- service vision, plans and strategy should be needs driven, based on local assessment
- the needs of specific service users must be considered:
  - younger people and older adults
  - adults with mild learning disability
  - current long stay residents in mental hospital settings
  - the mental health needs of people in general hospital settings
  - people requiring specialist services (Chapter 6)
- the interface with Forensic, Alcohol and Substance Misuse Services, Services for Younger People and Older People must be included within service plans for Adult Mental Health.

22. Services must be underpinned by good managerial cohesion, information management, team working and communication.

23. Provider units must have a comprehensive workforce strategy embracing recruitment, retention, training, support and supervision tailored to the specific needs of staff and work requirements. This must address specific training needs of specialist services and primary care mental health training. Training should be multidisciplinary and include teamworking and leadership skills, as well as therapeutic skills.

MENTAL HEALTH NEEDS

4.14 From a user perspective the various elements of services required to meet individual mental health needs must be available and accessible. In the planning and delivery of services a user perspective on the pathways into, through and out of services is essential. Such a perspective emphasises the importance of the connectedness of services, patient and carer information appropriate to their situation, and the maintenance of hope for recovery and restitution through the provision of appropriate services and supports.

4.15 A modern mental health service consists of a complex set of activities and functions designed to meet the needs of individual service users. From a person-centered and needs perspective, the complement of mental health services can be considered in three domains:

- living in the community;
- times of crisis, including acute episodes of mental disorder and social difficulty; and
- promoting recovery of health, personal functioning and fulfilment.

Each of these is considered in detail below, followed by a review of the needs of people with specific service requirements, therapeutic interventions and physical health needs.

Living in the Community

4.16 For people whose mental health needs cannot be met within primary care, ready access to mental health services is essential. The Community Mental Health Team (CMHT) with its close links to primary care forms the cornerstone of person-centred secondary services.

4.17 **Community Mental Health Teams.** Throughout most of Great Britain generic CMHTs have become the basic building block of community mental health services.[2] CMHTs are central to supporting service users and their families within community settings and for supporting the mental health work of Primary Care Teams.[3, 4, 5] Within this Strategic Framework, CMHTs are considered central to the care of the majority of people with mental health problems in the community requiring secondary services, including tier 2 services for people requiring specialist services (Chapter 6).

4.18 **Person-centred services.** A central advantage of generic CMHTs is their ability to provide a wide range of services and continuity and flexibility of care. Service users may, at times, require intensive contact, for example during a relapse, and at other times require relatively low levels of support. People with complex and enduring mental health needs arising from their mental disorder should be provided with a yearly multi-disciplinary review including review of care plans, physical health and risk assessment.[6]

4.19 In many places CMHTs are undergoing a process of change, but their core functions remain. The wide spectrum of service user needs has led to a differentiation of functions within or between established CMHTs with a focus on either primary care liaison or services promoting recovery. These services are considered in detail in subsequent sections.

4.20 The effectiveness of CMHTs is dependent on a number of factors:

- Resources. Teams must be adequately staffed by a range of health and social care professionals, including social work, nursing, occupational therapy, support workers, clinical psychology and medicine. There should also be ready access to specialist psychological therapy services. One advantage of larger catchment-based services (50,000) is a corresponding enlargement of CMHTs to provide a greater range of skills, competencies and increasing patient choice. Based on the service mapping data in England in 2004, the median provision of community staffing was 78 staff/100,000 adult population.[7] For Northern Ireland this is equivalent to 50 staff/100,000 whole population.
- Skills. Staff must be appropriately skilled and competent to respond to the range of health and social needs of service users embracing a wide spectrum of treatments, support, care, health promotion and relapse prevention. There should be a facility for continuing professional development and mechanisms for supporting staff.
- Information. CMHTs must have access to a detailed knowledge of the number and needs of individuals with severe mental health illness in their area.
- Effective Team Working. Staff require effective team working skills. There must also be effective team leadership and team management. The integrity of the team – issues such as professional accountability, agreed policies on confidentiality and information sharing - need to be agreed.
- Access. The boundaries for teams need to be agreed with local stakeholders. Access arrangements need to be clear and transparent to service users and carers. Primary care's relationship with its local CMHT is fundamental to effective working. The team's relationship with the local A&E department, the Liaison Mental Health Service (LMHS) and the Home Treatment (HT) service should be clear (see 4.91).

4.21 Although a key building block, CMHTs cannot work in isolation. They must develop appropriate relationships with other mental health services. Access to a range of day-time facilities and accommodation is essential. Effective working relationships with primary care, day care, day hospital and inpatient services are fundamental. Within a given service sector Primary Care Teams must have ready access to a CMHT (See Chapter 3). This may be achieved by a CMHT being based in a primary care setting or a mental health professional working in primary care supported by or part of a CMHT (see Chapter 3). Where appropriate, effective access arrangements should be assured for the student health and counselling services within further and higher education. Primary care provision for people with more complex mental health needs must be determined locally and requires the development of shared care protocols.[8]

4.22 Access to a range of non-healthcare services, including employment agencies (see 5.8) and housing agencies (see 5.16), voluntary and user-led facilities are essential. Co-locating services to the workbase of CMHT can provide a One Stop Shop for services and improve access and efficiency.

Recommendations

24. Community Mental Health Teams should be established so as to provide comprehensive coverage of each provider unit's population as an essential element of future mental health service provision. They must have or be provided with detailed information on the numbers and needs of individuals in their area, particularly those with more complex and enduring needs.

25. CMHTs must be adequately staffed with a range of health and social care professionals. A minimum provision of 50 care staff/100,000 whole population, including community rehabilitation is recommended.

26. Where CMHTs are providing input to primary care, then the seamlessness of provision must be addressed, including the identification of a named individual on the CMHT for primary care staff. In addition to service support, such input has an important educational role (see Chapter 3). The relationship with primary care, A&E and HT services should be clearly defined and agreed by both provider and referring services.

27. CMHTs must have access to and good interface arrangements with a range of community facilities and services, including day hospitals, day activities, special accommodation including respite facilities, vocational and leisure services, independent and user-led facilities. Where other community teams, for example, HT teams, are separate from CMHTs, then good interface arrangements are essential.

28. People with more complex and enduring mental health needs should be provided with a yearly multidisciplinary review, including review of care plans, physical health and risk assessment. The participation of service users and, where appropriate, their key carer in the preparation and review of care plans is essential for person-centred care.

In Times of Crisis

4.23 People with more complex and enduring mental disorder often experience acute difficulty or need which may arise through relapse of their mental disorder or through problems in coping with the demands of their social and personal situation. At present the most common service response to people in such situations is admission to hospital.

4.24 Present evidence suggests that conventional community services, including CMHTs working within normal working day arrangements are unable to respond adequately to the needs of people with severe mental health problems at times of urgent need. Research also suggests that up to one third of inpatients could have been provided with therapeutic interventions and care in more appropriate settings.[9, 10, 11, 12]

4.25 **Home Treatment/Crisis Resolution.** Home Treatment/Crisis Resolution has been introduced in a number of western countries as a community alternative to inpatient hospital care. The purpose of modern HT services is to provide flexible assessment and home-based treatment, care and support, as an alternative to inpatient care on a 24 hours a day 7 days a week basis. The introduction of HT is greatly appreciated by service users and families and can make a significant impact on the requirements for inpatient admission.[11,13,14] HT teams typically have a time-limited role (weeks) but nevertheless assume responsibility for the period of acute need. Referrals are accepted from General Practitioners, A&E departments, social services departments. Arrangements may also be made for HT teams to respond to the needs of mentally disordered people in police stations.

4.26 A second function of HT is to provide a gatekeeper function for hospital admission which can make an impact on the requirement for admission.[11,13,14,15] Teams can also facilitate the early discharge to home of patients admitted to hospital.[16] Together these impact on inpatient service requirements. HT services may be a stand alone team or a sub-function within a CMHT (see Configuration of Services 4.118).

4.27 More research is required on the various elements that may optimise the functioning of HT and on their relationship with CMHTs. Nevertheless key elements found to be central to effectiveness include:

- Policy. Services must be targeted – specifically the needs of those who would otherwise require admission to hospital. Typically people with acute psychosis, people with relapsing chronic mental disorder, severe depression or acute reaction to severe stress.

- Philosophy. HT is premised on the view that the management of a person's problems can be achieved within a community setting.
- Assessment – a comprehensive initial assessment is fundamental with access to multiple sources of information. This should embrace clinical, social and risk assessment.
- Planning. Flexible plans prepared in collaboration with the service user and, where appropriate, their key carer is essential. All participants in the situation must understand the plan.
- Management. Action plans must address practical problems, for example accommodation, financial issues. Treatment must be at the point of need. Follow-up frequency must be appropriate to the needs of the situation. HT team members must aim to build a trusting relationship with the user and carers. The HT team remains involved until the crisis is settled. For people with enduring mental health needs involvement of the key worker from the CMHT facilitates continuity of care.
- Gatekeeping. HT teams must interface efficiently with primary care and A&E services on the one hand and be given a clear gatekeeping function for hospital admission on the other. HT teams must be closely integrated with all elements of crisis services – acute inpatient, acute day hospital and crisis arising in the work of CMHTs.
- Skills. Staff require appropriate skills to deal with a range of healthcare and social situations.
- Resources. HT teams must be appropriately resourced and supported including the availability of crises houses.

4.28 The Review strongly recommends early consideration of HT services. Adequately resourced HT teams with clear gatekeeping functions can significantly reduce the pressures on inpatient services and CMHTs while providing users with increased choice of provision at times of crisis. Over time, as HT becomes a dominant characteristic of recovery services, HT teams should become part of Recovery CMHTs (see 4.121).
Good Practice Examples (Annex 5.4.1)

4.29 If a person cannot be maintained in their own home an effective alternative to hospital is community step-up residential care.[17,18]
Good Practice Example (Annex 5.4.2)

4.30 **Day Hospital Services**. Acute day hospitals should be considered as a cost-effective option for the provision of acute care both as an alternative to acute admission to hospital and to facilitate early discharge from inpatient care.[19] A recent systematic review identifying 9 randomised controlled trials found that day hospital treatment was a feasible alternative to inpatient admission in between 23% and 38% of instances. There is also evidence of greater satisfaction among patients and no evidence of increased burden on carers. The cost-effectiveness of this model of provision over home treatment is an important consideration.[20] Within a modern community focused service Day Hospitals are an important element in Crisis Services, provide a valuable step-down function and a base for Community Teams.

4.31 Day hospitals can also provide an import base for Recovery Services (see 4.38) and for specialist services, for example, Eating Disorder and Personality Disorder services (Chapter 6).
Good Practice Example (Annex 5.4.3)

4.32 **Inpatient Provision**. Acute inpatient care is an integral part of mental health services. In the context of well-developed community services, inpatient admission should only be required for people with most severe episodes of mental disorder, typically psychosis and severe depression. Improving the quality of inpatient care and its integration with the other key elements of the whole system of service provision form an essential part of this Framework.

4.33 Several reports, including reports from service users and from the Northern Ireland Association for Mental Health on inpatient services, have highlighted significant shortcomings and dissatisfaction with current provision.[11,21-24] From a service user perspective, if a period of inpatient care is necessary, this must be of high quality and provide an appropriate range of therapeutic interventions and services including, where necessary, intensive care. (see 4.65).

4.34 A small number of people with severe and enduring mental health problems will require the safety and security of hospital provision for lengthy periods of time, for example people recovering from severe brain injury, people suffering from psychosis with ongoing high risks to themselves or others (see 4.63). While there is a need for a better evidence base on inpatient services, several reviews and surveys provide strategic pointers for addressing present shortcomings.[11, 22, 23, 25]

4.35 **System of Care.** A single system of co-ordinated acute and crisis care is fundamental for service effectiveness. In particular, there must be joint working between inpatient and HT services. Inpatient services work best when they are close to the service user's local community, maximising their connections and integration with community mental health services, including CMHTs and supports.[15, 26] Such connectedness can be facilitated by the formation of Acute Care Fora involving representative users and carers along with service providers, with clear accountable links to Trust management.[21] While the Royal College of Psychiatrists recommends inpatient units are best located on district general hospital sites, [23] Boards and Trusts should explore the full range of choices for providing care.

4.36 **Milieu and Environment.** Service user-centred provision is a fundamental principle which should underpin inpatient services. Service users require individual care plans specific for their needs. A range of therapeutic resources must be available appropriate for need. The hospital environment must be designed to deliver a relaxed, secure and non-stigmatising atmosphere. Provision must be appropriate for gender and cultural needs.

4.37 **Leadership and Staffing.** Clinical and professional leadership is essential for ensuring co-ordination across the Acute Care system. Staff must also be provided with support and supervision. Staff levels and skill mix must be appropriate for service user needs and staff must be provided with opportunities for education, training and professional development.

Recommendations

Home Treatment Services

29. HT services must be available and accessible to each provider's catchment area, on a 24 hour basis subject to demand, accessible to general practitioners, A&E departments, CMHTs, social services and police.

30. There should be a single system of co-ordinated acute care, including step-up community residential care and inpatient provision. HT services must become the gatekeeper for hospital admissions.

31. HT teams must be appropriately resourced and skilled to deal with the range of healthcare and social situations for people in mental health crisis, their carers and families, including risk management.

Day Hospitals

32. Within each Trust consideration should be given to providing day hospital provision as an alternative to acute admission and complementing HT teams.

Inpatient Services

33. Acute inpatient services should be based in well-designed facilities and close to the community they serve such as general hospital sites.

34. The quality of inpatient services should be the subject of both regional and local review. Services must be of high quality and provide an appropriate range of assessments, therapeutic interventions and services including intensive nursing services. They must deliver a therapeutic and safe atmosphere and be sensitive to gender and cultural needs.

35. Each provider must designate a lead clinician or manager to take overall responsibility for inpatient services.

Promoting Recovery

4.38 Central to recovery from a mental disorder is regaining control of one's life. Individuals who have experienced recovery highlight the importance of hope, self esteem, empowerment and social connectedness.

> "A person with mental illness can recover even though the illness is not "cured" ...Recovery is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in ones life and as one grows beyond the catastrophic effects of mental illness. (Dr W A Anthony, 1993)"[27]

4.39 For people with more complex and enduring mental health needs, a diverse range of services is required to promote recovery, tailored to individual needs and circumstances. They have, by definition, greatest need and should be afforded the highest priority. Services are also required to give carers the information, skills and support necessary to assist them in their caring role and to minimise the stress associated with that role.[28] In this section, detailed consideration is given to the needs of people with more complex and enduring needs and the services necessary to meet these, including Rehabilitation Services and Assertive Outreach Services. Some people have special needs including needs arising from challenging behaviour, co-morbid substance misuse, growing older. They may also have secondary problems related to income (see 5.32) and accommodation (see 5.16). These issues are dealt with in subsequent sections.

4.40 Research, including local research, has shown deficiencies in services particularly in the areas of psychological and social provision[29,30] including provision for educational needs, work-related activity, domestic functioning and socialisation and also emotional needs (see Chapter 5).[29]

4.41 The needs of this group of people often cannot be met fully by current generic CMHTs and require specialist community services, for example, by sub-specialisation of or within CMHTs.[31] People with complex needs require service responses which guarantee continuity, flexibility and accessibility.[32] This can be facilitated by Care Plans and consideration of their individual Care Pathways, based on a multi-disciplinary approach and the involvement of users and, where appropriate, carers in the planning arrangements.[33]

4.42 When people with complex and enduring needs no longer require the intensive provision of acute services they may still, for a time, require a range of supportive services within an appropriate residential environment. Such "step-down" facilities need not be within a hospital setting and may often be more appropriately provided in the community and nearer to home. Nevertheless their functional integration with acute services is essential.[34,35] The continuum of provision includes services led by service users.

4.43 Given the aim of full community integration, every effort should be made to destigmatise and normalise aids to recovery, making maximum appropriate use of mainstream facilities and resources.

4.44 Essential professional skills to promote social integration for service users include:[31]

- prescription and supervision of complex medication regimens;
- evidence-based psychosocial interventions;
- training/support for independent living skills;
- training for vocational skills;
- evidence-based psychological treatments, including family work;

- social skills training; and
- financial management.

4.45 In the context of community based recovery and longer term support the role of carers is often pivotal. In addition to their own health needs they require and can greatly benefit from formal education, training and support for their caring role (see 5.62).
Good Practice Examples (Annex 5.4.4)

4.46 **Assertive Outreach.** A small number of people with complex mental health needs have difficulty maintaining involvement with the services they require. As a result, they are at high risk of relapse which would require readmission to hospital. Present evidence suggests that Assertive Community Treatment (ACT) is a successful alternative to inpatient hospital treatment, enabling service users with the highest levels of disability and greatest vulnerability to be maintained more successfully in community settings.[34-41] Effectiveness depends on small caseload and on staff having the necessary skills.[42, 43]

4.47 ACT sits best within the spectrum of services promoting recovery, enabling the most vulnerable and severely mentally ill to move more easily from inpatient settings to community settings and reducing the need for lengthy inpatient stays.[44,45] Present evidence[46,47,48] demonstrates that Assertive Outreach* can:

- improve engagement;
- reduce hospital admissions;
- reduce length of stay when hospitalisation is required;
- increase stability in the lives of service users and their carers/family;
- improve social functioning; and
- be cost-effective.

4.48 The goal of Assertive Outreach is to increase stability within the lives of service users, to facilitate personal growth and provide opportunities for personal fulfilment. Fundamental to the effectiveness is the establishment of meaningful engagement with service users. The aim is to provide a service that is sensitive and responsive to users' needs and supportive to service users and their families over sustained periods of time. This must include effective risk assessment and risk management. ACT services must also ensure effective

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*The term Assertive Outreach is used in this context to refer to the availability of an Assertive Community Team.

liaison with community forensic services. While treatment support and care for this group of people will usually be required on a long term basis, this need not necessarily be provided by ACT.

4.49 Assertive Outreach cannot work effectively in isolation. The generic needs of this group of users are similar to all people with mental illness. These include the need for adequate income, accommodation, meaningful day time activity, support with daily living, in addition to both primary care and specialist mental health interventions.[49] This, in turn, depends on a readily available range of services, including suitable supported accommodation, a range of daytime activities including employment opportunities, clear arrangements for accessing safe 24 hour care.

4.50 While more research is required on the specific elements of Assertive Outreach which contribute to service effectiveness, present evidence suggests two key features. First, staff must be appropriately skilled [39, 49, 50] in:

(i) assessment – embracing mental state, general functioning, needs and risks;

(ii) planning – including care planning and management;

(iii) interventions with service user and families including medicine management and concordance, problem solving and goal setting, issues surrounding dual diagnosis, information and education, family interventions;

(iv) social support with housing, education, work and welfare benefits; and

(v) multi-disciplinary team working.

Second, ACT must be adequately resourced. The Royal College of Psychiatrists recommends an optimal team size of between 8-10 FTEs with social work, nursing, occupational therapy, clinical psychology and medicine as essential disciplines.[31] An optimal caseload for individual care co-ordinators is about 12.[39, 5] The relationships among services promoting recovery, CMHTs and ACT teams need to be carefully planned, appropriate for local needs. *Good Practice Example (Annex 5.4.5).*

Recommendations

36. The service requirements of people with complex and enduring mental health needs should be given the highest priority and clearly defined for each Trust's catchment area.

37. Identifiable services promoting recovery should be established within each Trust for people with complex needs and providing comprehensive coverage of the Trust area. Care plans embracing risk assessment should be provided based on a multidisciplinary and when required a multi-programme approach. Risk assessment should include accommodation needs. Users and, where appropriate, carers must be involved in care planning.

38. A comprehensive range of community services must be available to facilitate recovery for people with complex needs. The introduction of step-down facilities should be considered to facilitate discharge from acute inpatient care.

39. Every effort must be made to destigmatise and normalise, making maximum appropriate use of mainstream facilities and resources.

40. ACT should be provided for service users with highest levels of disability and greatest vulnerability, particularly those who have difficulty maintaining links with existing services.

41. ACT teams must be adequately resourced – an optimal individual caseload for delivering care is 10-12.

People with Specific Service Needs

(i) Younger People

4.51 The Review envisages a substantial development in young people's services. Nevertheless, there is a need for flexibility and, where appropriate, joint working appropriate for the needs of individuals. It is essential that there are seamless transitional arrangements for people whose mental health problems arise in childhood and extend into adult life. These should include specific plans for:

- younger people with psychotic illness that may require lifelong care;
- adults with developmental disorders such as autistic spectrum disorders, learning disability and attention deficit hyperactivity disorder; and
- adults with mental health problems arising from adverse childhood experiences including people who are survivors of abusive experiences.

4.52 While a comprehensive adolescent service must include appropriate inpatient facilities, the reality at the present time is a deficiency of such places. It is wholly unsatisfactory that older adolescents are admitted to adult inpatient units. Nevertheless, until additional adolescent inpatient facilities are established, it is essential that there are agreed flexible arrangements at local level to allow, where necessary, young people to be admitted to adult inpatient facilities.

4.53 Further consideration on the interface between Child and Adult Services is given in the Review of Child and Adolescent Mental Health Services which is the subject of a separate report.

4.54 **People with a first episode of psychosis.** There have been growing concerns regarding the shortcomings of service provision for younger people, both adolescents and young adults, with severe mental disorder. These arise from the evidence that delays in first treatment may lead to poor outcomes both the short term and long term.[51, 52] Surveys of services by Rethink have highlighted delays on average of twelve months between onset of psychotic symptoms and initiation of treatment. They also report services to be insensitive to the needs of younger people including their training and employment needs.

4.55 Emerging evidence suggests that early intervention, embracing assessment, medical and psychological treatment and appropriate assistance with training and educational needs, can improve recovery and social functioning.[53-56] General Practitioners are key pathway players. Based on current evidence the NSF Implementation Guidelines[5] suggest the following principles for service provision:

- separate, age-appropriate facilities for younger people;
- emphasis on service users' needs including support, education and employment;
- family-orientated services;
- age, gender and culture sensitivity;
- treatment provided in the least restrictive and stigmatising setting; and
- emphasis on managing symptoms rather than diagnosis.

4.56 The aims of early intervention are:

- to encourage liaison between primary/secondary care in the early detection and management of the first psychotic episode to reduce duration of untreated psychosis;
- early effective interventions to accelerate remission and prevent relapse, including pharmacotherapy and adjunctive psychosocial interventions;
- normalising experiences and reducing adverse consequences of trauma, depression and suicide; and
- maximising social, educational and work functioning.[57]
  Good Practice Examples (Annex 5.4.6)

Recommendation

42. Separate age-appropriate services for younger people with a first episode of psychosis should be established. Services should be gender and culture sensitive.

(ii) Adults with Mild Learning Disability

4.57 The majority of people who have a mild learning disability live in society without formal additional support and may be well-integrated into their communities. While not necessarily disabled in their daily functioning, by their intellectual impairment they are at increased risk of mental disorder[58]. Mental disorder in addition to pre-existing intellectual impairment may be disabling. Adults with mild learning disability and their carers wish to access health services as other adults including, where appropriate, Adult Mental Health Services.

4.58 The Royal College of Psychiatrists[59] endorsed informal examples of good practice in Northern Ireland where adult mental health services and learning disability services co-operate to provide treatment and care for people with various degrees of learning disability. Community based models of treatment in both programmes are broadly similar although differ in resources and skills.

4.59 Services should be based on individual context and a comprehensive assessment of need. Continuity of care is of great importance for people with a learning disability.

4.60 Fuller consideration of the mental health needs of people with learning disabilities is given in the Equal Lives Review.

Recommendations

43. Adults with mild learning disability should be facilitated in accessing adult mental health services as a first preference. The preferences of people already within either adult mental health services or learning disability services should be respected.

44. Adult mental health services should be resourced to include people with mild learning disabilities. Additional time and expertise are required for assessment and for consultation between professionals within and across programmes of care. Co-operative working, sharing of facilities and expertise between adult mental health services and learning disability services must be established in each Trust area.

(iii) People Becoming Older with Enduring or Relapsing Mental Illness

4.61 With increased life expectations generally more people with major mental disorders such as schizophrenia, bipolar affective disorder, organic brain disease, severe depression, are living into later life. Given the separate development of health and social service services for older people it is essential that there are locally agreed arrangements for service provision for people within adult mental health services who reach 65 years of age. As noted by the Royal College of Psychiatrists,[60] graduation from one age group to the next offers an important opportunity to review treatment and care needs including any comorbid physical illness. Such a review by the lead service providers should include social needs including accommodation, support, and the needs of carers.

4.62 Further consideration on the interface between Adult Services and Services for Older People is given in the Review of Mental Health Issues of Older People which is the subject of a separate report.

Recommendations

45. Local arrangements for meeting the needs of people who enter old age with enduring or relapsing mental disorder must be agreed. Where individuals graduate from adult mental health services to services for older adults, therapeutic and care needs should be the subject of review.

46. Local population needs of people entering older age and their carers should be assessed.

(iv) People with Challenging Behaviour

4.63 Within adult mental health, the term ‘challenging behaviour’ refers to people who are suffering from a serious mental illness, for example schizophrenia or sequelae of head injury and who, in addition to severe and often persistent symptomatology, show a range of behavioural problems, such as aggression, violence, repeated self-harm, extreme self-neglect, fire-setting or inappropriate sexual behaviour.[61-63]

4.64 The majority is young males, most of whom have schizophrenia, whose disorder is poorly controlled and have co-morbid drug and/or alcohol misuse.[61] Second, is an older group, often with treatment resistant bipolar disorder, which is likely to account for a further 20%. Third, is a group with significant cognitive impairment due to acquired brain damage, alcohol misuse, pre-senile dementia or psychosis associated with severe cognitive decline. Estimating the numbers in each category is difficult. Wing [65] suggests that, for specialist residential care for this group, between 10 and 30 places per 100,000 might be needed.

4.65 **Therapeutic Options.** Specialist Supported Living. Residential provision for this group of service users attempts to combine the best features of hospital care (high staffing levels, intensive professional input, individualised programmes of care) with a setting that is both homely and domestic in scale and operation. A range of residential provision is essential including the use of the “ward in a house” and the “hospital hostel”. [66] The emphasis must be on improving and maintaining functioning rather than simply symptomatic improvement.

4.66 Intensive community support. Present evidence favours the use of Assertive Outreach for people with psychotic disorders who relapse frequently, requiring hospital admission and with low engagement with services and concordance with treatment. [67] People targeted for Assertive Outreach services have complex needs, including challenging behaviour.

4.67 Hospital treatment and care. The following definitions were developed by a multidisciplinary practice development network as part of their work in developing national minimum standards for Psychiatric Intensive Care Units (PICU) and low secure units, and published by the Department of Health.[68]

4.68 ‘Psychiatric intensive care (PICU) is for patients compulsorily detained usually in secure conditions who are in an acutely disturbed phase of a serious mental disorder. PICUs must be part of acute inpatient services. They should provide a comprehensive range of activities and therapies, underpinned by a core philosophy of risk assessment, risk management and intensive engagement.'

4.69 'Low secure units deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff for patients who demonstrate disturbed behaviour in the context of a serious mental disorder who require the provision of security…. Patients will be detained under the Mental Health Act …. needing rehabilitation for a period of up to 2 years'.

4.70 Secure locally-based NHS facilities are also part of a seamless forensic service. The Reed Report[69] into services for mentally disordered offenders and others requiring similar services, proposed that, in addition to medium secure facilities, access to local intensive care facilities should be available more widely and that 'secure provision should include provision… for those who require long-term treatment and/or care'.

4.71 The Cavan/Monaghan project[70] recommends that patients who have enduring disturbed and challenging behaviour in the context of mental illness require care in a specialist unit, possibly provided on a regional basis in view of the very small numbers of people requiring such facilities. A policy statement from Rethink[71] stated that sufficient secure facilities should be available for those who need them, that they should be locally based and used for the shortest possible time.

4.72 Further consideration on the interface with Forensic Services is given in the Review of Forensic Services which is the subject of a separate report.

Recommendations

47. Service providers must plan for the needs of people with challenging behaviour:
    - community mental health services with the capacity to provide intensive support
    - specialist accommodation with appropriately skilled staff (see recommendations).
    - local intensive care
    - low secure inpatient services with a recovery ethos and with links to Community Recovery and Assertive Outreach services.

48. Low secure units can function as 'step-down' services from the Regional Secure Unit.

49. Longer term high quality hospital provision is likely to prove necessary for a small group of people whose behavioural problems are often chronic and severe.

(v) People with Mental Health Needs Subject to the Criminal Justice System

4.73 People with mental disorder may, like other members of society, become subject to the criminal justice system. Thus, people with mental disorder may be found in police stations, on bail, attending court, on probation, in prison or recently released from prison. Not all of the people require designated forensic services to meet their mental health needs. Adult mental health services must co-ordinate effectively with forensic services to address the needs of each individual, including those who are transferred from forensic services. There is a need for co-ordination in the development of services and for a training strategy to support adult mental health services. This is likely to involve the work of CMHTs including, where appropriate, inreach services to prisons (see 4.17). Further consideration on the interface with Forensic Services will be given in the report on the Review of Forensic Services.

Recommendation

50. Service providers must ensure co-ordinated development of adult mental health and forensic services.

(vi) People with Co-existing Substance Misuse and Mental Health Problems (Dual Diagnosis)

4.74 While the term "dual diagnosis" is unsatisfactory as personality disorders and serious medical problems are also frequently present in those with a history of substance misuse and mental health problems, it is retained here as other alternatives are less succinct. Providing high quality care to those with a dual diagnosis of concurrent mental health problems and substance misuse problems- alcohol and/or drugs – has been identified as a major challenge for mental health services.

4.75 Concerns have been raised that people with a dual diagnosis have fallen between the mental health and addictions services.[72] The Safer Services report[73] recommended that people with concurrent severe mental health problems and substance misuse should be managed within mainstream mental health services. The commonest co-morbid disorders are anxiety states, affective disorders and personality disorders.[74]

4.76 Drug use in inpatient units is an increasing cause of concern in the UK. Some service users with dual diagnosis may continue to use alcohol or drugs in acute inpatient units.[75] There is also evidence that the routine assessment of alcohol or drug use at the time of admission to acute units markedly underestimates substance misuse problems.[76]

4.77 **Substance misuse, suicide and homicide**. Substance misuse is an important risk factor of suicide and homicide. In Northern Ireland, the estimated risk of suicide in the presence of current alcohol misuse or dependence was found to be 8 times greater than in the absence of current alcohol misuse or dependence.[77] The National Suicide Prevention Strategy for England (2002) identified the need for mental health services to implement local strategies for dual diagnosis covering training on the management of substance misuse, and joint working with substance misuse services.[78]

4.78 **Substance misuse and co-existing physical disorders**. The health problems associated with alcohol and drug misuse are widespread. People with a history of injecting drug misuse are particularly at risk from overdose, infections and blood borne viruses such as hepatitis C and to a lesser extent hepatitis B and HIV. The highest risks of premature death from natural and unnatural death for common mental disorders are for substance misuse and eating disorders. Opioid dependence and abuse had a mortality risk for suicide of 10 times that expected, for violent deaths 13 times that expected and for natural deaths 4 times that expected.[79]

4.79 **Management and Services Models**. Guidance on good practice in relation to people with a mental disorder and also alcohol or substance misuse reflect the complex interactions between substance misuse and mental health problems.[80-85] Three main models of service delivery have been proposed for people with dual diagnosis; serial, parallel and integrated.

4.80 The serial treatment model proposes mental health and substance misuse disorders are treated consecutively For example, patients presenting to mental health services with a substance-induced mood disorder which subsequently quickly resolves following a brief period of abstinence would then be appropriately referred on to addictions services. In the parallel treatment model concurrent input is proposed by substance misuse services and mental health services. However this may create tensions in treatment delivery between the two services. In the integrated treatment model treatments for both psychiatric and substance misuse are provided within one clinical team. Specialist integrated services have been established in both the USA and UK for people with dual diagnosis.

4.81 While there is a lack of sound evidence on the relative effectiveness of these models[86] current UK guidance strongly supports an integrated treatment model delivered within mainstream services by mental health staff who are appropriately trained in substance misuse. The National Treatment Agency for substance misuse have been developing modules of care for the treatment of drug misusers, including care pathways, which will incorporate issues pertinent to dual diagnosis workers.[87]

4.82 Further consideration on Dual Diagnosis services is given in the Review of Alcohol and Substance Misuse Services which is the subject of a separate report.

Recommendations

51. Trusts should make provision for people with mental health problems and co-existing alcohol or drug misuse. Local prevalence and needs of people with dual diagnosis should be assessed.

52. People with co-existing substance misuse and mental health problems should be treated using an integrated treatment model within a single service.
    - The needs of those with complex, enduring and relapsing mental disorders can best be met by adult mental health services.
    - The needs of those with less severe mental health problems, whose main difficulties are directly related to substance misuse, can best be met by substance misuse services.
    - Agreed arrangements need to be established between any specialist services for people with personality disorder and substance misuse services.
    - There should be systems of liaison between substance misuse and other mental health services to ensure that people with a dual diagnosis have access to the full range of the most appropriate treatment services.

- Physical health problems associated with substance misuse need to be identified and addressed.

53. The needs of people with co-existing substance misuse and mental health problems in contact with the criminal justice system should be identified and addressed.

(vii) People in General Hospital Settings

4.83 Mental health services are required to address the needs of people with mental health problems presenting in general hospital settings. There is increasing recognition of the high prevalence of mental health problems in general hospital settings, both inpatient and outpatient. The following are the most common.

4.84 **Deliberate Self-Harm**. The frequency of deliberate self-harm (DSH) has risen steadily since the 1960s and currently there are 140,000 such presentations per year at general hospitals in England and Wales with this behaviour.[88] The individual intent in DSH varies. Underlying the act of self-harm there are a variety of situational, addictive and mental health disorders that require accurate assessments. Between 5-20% of people who present with an act of deliberate self-harm require urgent psychiatric admission for their own safety.[89] In the year following an attempt of self-harm about 1% commit suicide. There is a significantly higher rate of suicide after self-harm in those who are not adequately assessed.[90]

4.85 **Alcohol and Drug Misuse**. Alcohol misuse contributes to 20-25% of all general hospital admissions.[91, 92] Alcohol misuse is a risk factor for many serious health problems including cancers, heart disease, stroke, accidents and suicide. Screening for alcohol misuse in a general hospital setting is simple and effective. There is also clear evidence of the efficacy of brief interventions to reduce alcohol misuse in those identified and appropriately counselled.[93]

4.86 **Organic Brain Syndromes**. Dementia is common in general hospital populations reflecting the age profile of patients today. Prevalence rates as high as 35% have been reported, increasing with age. Delirium is also common with prevalence rates in general hospital patients of up to 60%. This is particularly common after cardiac and hip fracture surgery and again with increasing age. Both dementia and delirium are important indicators of physical illness and are associated with increased mortality and increased length of stay in hospital.

4.87 **Medically Unexplained Symptoms.** Some people present with physical symptoms for which there is no obvious underlying physical cause, or where symptoms are disproportionate to any underlying medical disorder. In many but not all, the presentation is associated with underlying mental health problems. While such conditions are known by a variety of different terms, "medically unexplained symptoms" is to be preferred, as this does not imply any specific cause. Medically unexplained symptoms account for 40-50% of service users in hospital outpatient clinics. The more physical symptoms that people report, the greater the likelihood of associated mental illness regardless of the nature of their symptoms. Appropriate psychological intervention can reduce such functional somatic symptoms, generally best tried initially by the treating physician with mental health specialists involved where problems are more intractable. [93]

4.88 **Behaviours and Emotional Reactions Impacting on/or associated with Medical Care.** Lifestyle issues account for a significant proportion of physical illness. Smoking for example, despite education regarding its negative consequences, risk taking behaviours, which negatively affect physical morbidity or mortality, may be helped by specific psychological interventions. The emotional needs of people with physical health problems may require specific psychological interventions in addition to general support.

4.89 **People with Physical and Mental Ill-Health.** Given that mental health problems are common, many people admitted to general hospitals may have unconnected mental disorders, which may require advice or adjustment of treatment because of the associated physical difficulties.

4.90 It is important that medical specialists should have access to Liaison Mental Health services to allow input where necessary[91] particularly to the above groups of people.

4.91 A multidisciplinary Liaison Mental Health Service (LMHS) provides the best means of ensuring effective methods of dealing with the mental health needs of service users in a general hospital setting.

4.92 Liaison Teams are also suitably placed to provide education and to improve the knowledge and skills required to treat people with mental health problems and learning difficulties in general hospital settings, regardless of whether or not they need to be referred to specialist services.

4.93 **Identification and Assessment of Needs.** It is generally acknowledged that the identification of mental health problems in general hospital settings is poor. Identification is based on clinical assessment, history taking and mental state assessments, supplemented by other sources of information. Whilst it may sometimes be difficult, staff should endeavour to identify admitted patients who have a mental health problem, learning disability or dementia and any special needs they may have arising from this. Where appropriate and with the person's consent additional information should be sought from key informants. Appropriate information and education should be provided to general hospital staff to enable them to undertake psychosocial assessments. Ward staff should liaise with professionals in the community.

4.94 **Stigma.** People with mental health problems, learning disability or dementia have the same fundamental rights as any other person, including rights to the same standards of health and social care. General hospital staff should be trained in mental health awareness to prevent medical patients with mental health problems feeling stigmatised or prejudiced. They should also have access to an advocate, should they wish to avail of this.

4.95 **Care Environment.** General hospital staff should consider the immediate environment of patients in terms of physical needs, safety and where appropriate potential risk of deliberate self-harm. Staff undertaking such duties should have adequate training in the care of patients with mental health needs. It may be advisable that specific staff or units are allocated such patients because of familiarity and experience in dealing with the above difficulties.

4.96 **Referral to Liaison Services.** On occasion referral to a mental health specialist is appropriate for assessment, advice and management of a service users' mental health problem. Referral should be to a LMHS, a multi-disciplinary team that may typically consist of a liaison nurse, social worker, clinical psychologist, psychiatric trainee and consultant psychiatrist. The LMHS should provide prompt and, ideally, same day assessment to assess risk, identify mental illness, and advise on physical and appropriate psychological treatments and follow-up. The LMHS team can also give specialist advice regarding the use of the Mental Health (Northern Ireland) Order 1986 and offer training and education to hospital staff for identification and management of mental health problems in the general hospital setting.

4.97 Because of potential dangers in certain presentations, it is important that the LMHS team can respond quickly (usually within one hour) if requested. There is a need for clear referral protocols from the general hospital ward. It is also important that the LMHS team have effective patterns of communications with General Practitioners and other mental health professions, allowing clear aftercare plans to be made prior to the service user leaving the general hospital.

4.98 In view of the sensitivity of many of the issues surrounding mental health in the general hospital setting, it is important that consultation arrangements ensure comfort, privacy and security for service users and for the mental health professionals involved. In view of the unpredictability of crises, it is important that appropriate services are available 24 hours per day, 7 days per week.

4.99 **Accident and Emergency (A&E) Services**. The range of presentations noted above can present to A&E departments and often in a more acute state than on a general hospital ward.[94] It is important therefore that departments have appropriate access to Mental Health services 24 hours per day, 7 days per week. The speed of response is imperative because of the potential dangers of severe untreated mental health emergencies but also to alleviate distress to waiting service users and their carers. Agreement will be required between LMHS teams, HT teams and CMHTs regarding nature and configuration of services (see 4.17).

4.100 Deliberate self-harm is a very common reason for presentation to departments and as noted above there is a wide range of mental health problems associated with this presentation. It is important that as many users are offered psychosocial assessment and where necessary support. Misuse of alcohol and drugs is common within the deliberate self-harm group and while brief counselling can be undertaken in an A&E setting, it is important that there is ready access to addiction services.

4.101 It is again important that comfortable, confidential and safe accommodation is provided for interviewing in the A&E environment. In view of the potential for aggression there should be clear policies including support procedures by security staff.

4.102 Young people attending A&E with mental health problems should be seen by those with appropriate expertise. Clear protocols authorising responsibility (based on relevant expertise) should be in place between Liaison Teams and CAMHS teams.

4.103 **Commissioning and Audit of Service.** The above services should be developed in all general hospitals throughout Northern Ireland, the extent depending upon the size of the hospital and particular patient mix. Specialist hospitals may require emergency liaison mental health assessments and local arrangements should be established for each hospital. This should be part of the commissioning process although LMHS teams may not be required at these hospitals.

Recommendations

54. Appropriate education should be provided to general hospital staff:
    - to prevent people with mental health needs feeling stigmatised
    - to provide basic psychosocial assessments and support.

55. Acute hospitals should ensure that appropriate liaison services are established:
    - clear referral protocols should be in place
    - general ward staff should, where necessary, have access to appropriately trained and experienced mental health professionals on a 24 hour basis
    - Liaison Services should provide prompt same day assessment and advice on therapeutic interventions, risk management and follow-up.
    - confidential, comfortable and safe accommodation must be provided to interview service users in A&E environments and general hospital settings. Policies outlining the support procedures from security staff should be established.

56. Liaison Services must be able to access addiction services promptly for service users willing to avail of them.

57. Liaison Services to A&E departments should be appropriate for user needs:
    - all people with deliberate self-harm should be offered psychosocial assessment and appropriate after care plans
    - people with problems relating to addiction attending A&E should be able to avail of prompt access to community addiction services
    - young people attending A&E with mental health problems should be seen by those with appropriate expertise. Clear protocols should be in place between Liaison Teams and CAMHs teams.

Therapeutic Interventions

(i) General

4.104 From a health perspective services, their configuration and organisation, are but vehicles to promote recovery and underpin optimal delivery of specific therapeutic interventions, care and support. Service users with more complex and severe mental disorders often have enduring or intermittent problems including residual symptoms, functional impairments and disabilities affecting their role and functions within their family, work and wider social situation.

4.105 The variety of needs require a range of skills, including self help skills, and understanding grounded in evidence-based health and social care, including evidence based processes of care provision.[95] This in turn assumes the availability of an appropriately trained and adequately staffed workforce (see Chapter 7). Service user participation in service delivery can make a significant contribution to both the values base and the effectiveness of services.

4.106 Evidence, including strong and consistent user consultant responses to the Review, directs attention to the importance of the service user/professional relationship. This is a key element in the recovery process and for all therapeutic work. Optimal holistic therapeutic interventions and care depend fundamentally on collaborative working between persons with mental health needs, their families, carers and the professionals and organisations involved. In addition to specific intervention skills, health and social care professionals require a range of general skills including interpersonal skills, team-working and communication skills.

4.107 **Psychological Therapies**. One of the consistent observations received by the Review is the relatively poor development of psychological therapies in Northern Ireland, resulting in limited access and unacceptability long waiting lists for assessment and treatment.[96] There must be improved access to psychological therapies, from appropriately trained, qualified and supervised staff.[97]

4.108 A number of service examples for the delivery of psychological therapy are in operation within the NHS, for example the Northumberland Tiered Approach.[98] Their aim is to increase access to a broad spectrum of psychological therapies for a range of problem severity and complexity. Services place emphasis on training and supervision as well as the provision of intensive and dedicated therapy services. These can probably be best provided through a Trust-wide multi-professional department.
Good Practice Example (Annex 5.4.7)

(ii) Treatments and Interventions

4.109 The complexities of mental illness and their sequalae often require a variety of approaches – medication, psychological therapy, psychosocial interventions and specific social and occupational programmes such as vocational training. Recent developments in models of service delivery, psychological and social interventions suggest that the range of therapeutic options is likely to expand significantly.

a. Use of Medication

4.110 Medication is an important aspect of therapeutic interventions for specific mental health disorders. The most up to date evidence based guidelines such as those of the British Association of Psychopharmacology and the National Institute for Clinical Excellence (NICE) should be employed and the medication should be within the recommended dose ranges stated in the British National Formulary. Medication can be an important part of a comprehensive care package which addresses an individual's clinical, emotional and social needs.[99-103, 105-117] The choice of treatment intervention should be made jointly by the individual, the clinician responsible for treatment, and where appropriate the individual's [101] carer or advocate. [104]

b. Psychological Interventions

4.111 Major advances in psychological treatments have taken place in the last few decades, both in terms of their sophistication and proliferation. In parallel, a more rigorous approach to researching clinical effectiveness has resulted in a number of reports advising which psychological therapies may be helpful for particular conditions. [118,119,120] The evidence is now strong in relation to the effectiveness of specific psychological therapies for anxiety disorders with marked symptomatic anxiety (panic disorder, social phobia, obsessional compulsive disorder and generalised anxiety disorder). [120] Likewise, rigorous protocols have been developed for post traumatic stress disorder and moderate levels of depression.[120] A report from NICE clarifies the state of the evidence in relation to psychological approaches to the treatment of eating disorders.

4.112 Evidence about the efficacy of psychological approaches with people who have severe and enduring mental illness is relatively recent and it may suffer from a bias that affects all research on such treatments. [122-144] Certain treatments, because they can be protocol driven (such as cognitive behaviour therapy (CBT)) lend themselves to investigation through randomised controlled trials, whilst others such as the psychodynamic therapies do not. This may result in some treatments being assigned an artificially low grade of evidence.

4.113 Increased knowledge about the interaction of biological, psychological and social factors involved in psychosis, the "stress-vulnerability" model [121] has led to a multi-factorial understanding of risk and relapse in psychosis. This model suggests that each of us has a different level of vulnerability to the development of psychotic experience. The vulnerability may be the result of biological factors (e.g. genetic, or birth trauma) or psychosocial ones (e.g. resilience to stress or history of childhood abuse or neglect). This model underpins and provides a rationale for psychological and social interventions. For example, it hypothesises that if an individual is provided with increased resources for coping with stress, or reduce the stress in the environment, significant advances in outcome could be made.

4.114 Access to Psychological Interventions. Accessibility to psychological interventions remains extremely poor within Northern Ireland. Increasing accessibility to evidence-based interventions for psychosis is a major challenge involving a number of elements. This includes staff training.

4.115 **Staff Training**. There is a requirement for training across all mental health professional groups in developing skills of therapeutic relationship building and the use of evidenced-based psychosocial therapies. [124]
Good Practice Examples (Annex 5.4.8)

Recommendations

58. The choice of therapeutic interventions should be made jointly by the individual and the clinician responsible for treatment.

59. Medication, psychological and social interventions must be integrated within a complete package of treatment, care and support.

60. Therapeutic interventions must be provided within a multidisciplinary framework, according to evidence-based guidelines.

61. Psychological therapy services must be organised in ways that promote the use of psychological interventions in routine practice.

62. A workforce strategy developing psychological therapy services must be addressed as a matter of urgency.

63. A Northern Ireland-wide training strategy to improve access to psychological therapies and psychosocial interventions must be developed as a matter of priority.

PHYSICAL HEALTH

4.116 People with mental health problems are at increased risk of having physical health problems. Many of the excess deaths of people with more complex and enduring mental disorder are potentially preventable by better medical treatment and attention to lifestyle, including diet and smoking. Smoking as substance use is part of the specific Review of Alcohol and Substance Misuse. Assessment, therefore, should cover physical health needs. One approach to identifying and targeting people with more severe and enduring mental health needs is the establishment of case registers at primary care level.[145] Primary and secondary care services, in conjunction with the service user, should jointly identify which service will take responsibility for monitoring physical health.

4.117 General Practitioners should consider the health promotion of people with severe mental health problems within their practice and regularly monitor their physical health. The NICE Guidelines for Schizophrenia recommend paying particular attention to endocrine disorders such as diabetes and hyperprolactanaemia, cardiovascular risk factors, side-effects of medication and lifestyle factors such as smoking.[19]

Recommendations

64. The assessment of people with more complex mental health needs must include assessment of physical health needs. Local providers of services should agree which service (primary or secondary) will take responsibility for monitoring physical health.

65. Registers should be established of people with severe mental health needs at primary care level.

Configuration of Person-Centred Services

4.118 The goal of the whole system of care is to provide person-centred services for a wide range of needs. All provider units should aim to have the main elements of service provision (above) in place and operational by 2010. Organisational structures play a key role in effective and efficient delivery of services. While the details of service configuration must be informed by the local context the following is presented as a model of good practice. The following key elements must be supported by the full range of service elements with optimal functioning interfaces with other services eg forensic services, child and adolescent services.

4.119 **A Model Service Configuration**. As noted earlier, the Review recommends provider units serving populations of between 200,000 and 300,000. Provider unit service configuration is here considered for a community of 250,000 people. The short-term community staffing goal for this population is 150 (see 4.20) with appropriate training including staff required for Home Treatment and Assertive Community Treatment. As service providers advance towards their goals of a comprehensive person-centred service the following configuration of the key building blocks of provision are recommended, based on present evidence and on the principles informing the Strategic Framework.

4.120 **CMHTs Supporting Primary Care**. Present evidence suggests that the optimal model of CMHT configuration is 5 teams, each of approximately 11 staff, supporting primary care services, each servicing a population of approximately 50,000 (see Figure). Teams will require access to a comprehensive range of community resources, both statutory and independent sector. Such teams should provide Tier 2 level services for deaf people with mental health problems and women with perinatal mental health needs. Where a provider unit has a general hospital within its catchment then one of the local CMHTs should have close links with the Liaison Mental Health Services. Teams must have a multidisciplinary ethos (nursing, social work, psychology, medical) in order to provide a broad range of skills and therapeutic interventions. Teams should have user membership, engaged through appropriate employment arrangements.

4.121 **Recovery Service CMHTs**. Sectorised services are required for people with enduring and recurring mental disorder. Three CMHTs are recommended, one each underpinning Recovery Services for approximately 85,000 people (see Figure). As a short-term goal, the staff complement for each team should be approximately 23 with a multidisciplinary composition appropriate for the needs of recovery services including nursing, social work, occupational therapy, speech therapy, physiotherapy, medical and user participation. These CMHTs will be required to provide Tier 2 level services for the mental health needs of people with brain disease and injury, ASD, also services for people with challenging behaviour, dual diagnosis, first episode of psychosis and mild learning disability. HT and Assertive Community Treatment teams should be closely associated with each Recovery CMHT.

4.122 **Home Treatment Teams**. In order that HT teams can provide 24/7 services, it is recommended that the complement for a provider for 250,000 should be 24 staff, configured as three teams of 8 staff, each team linked with a Recovery

CMHT. Close association between each HT team and CMHT is essential to enable HT teams fulfil their gatekeeping function and ensure continuity of care between Recovery CMHTs and inpatient services. In order to ensure out of hours services, HT teams will need to co-operate across the Provider Unit. Five staff working in Assertive Community Treatment should be linked to each Recovery CMHT. A home-based approach to community service provision is recommended as the long-term goal of Recovery services. This is dependent on adequate staffing and can be linked to a convergence of the roles of HT teams, ACTs and Recovery CMHTs.

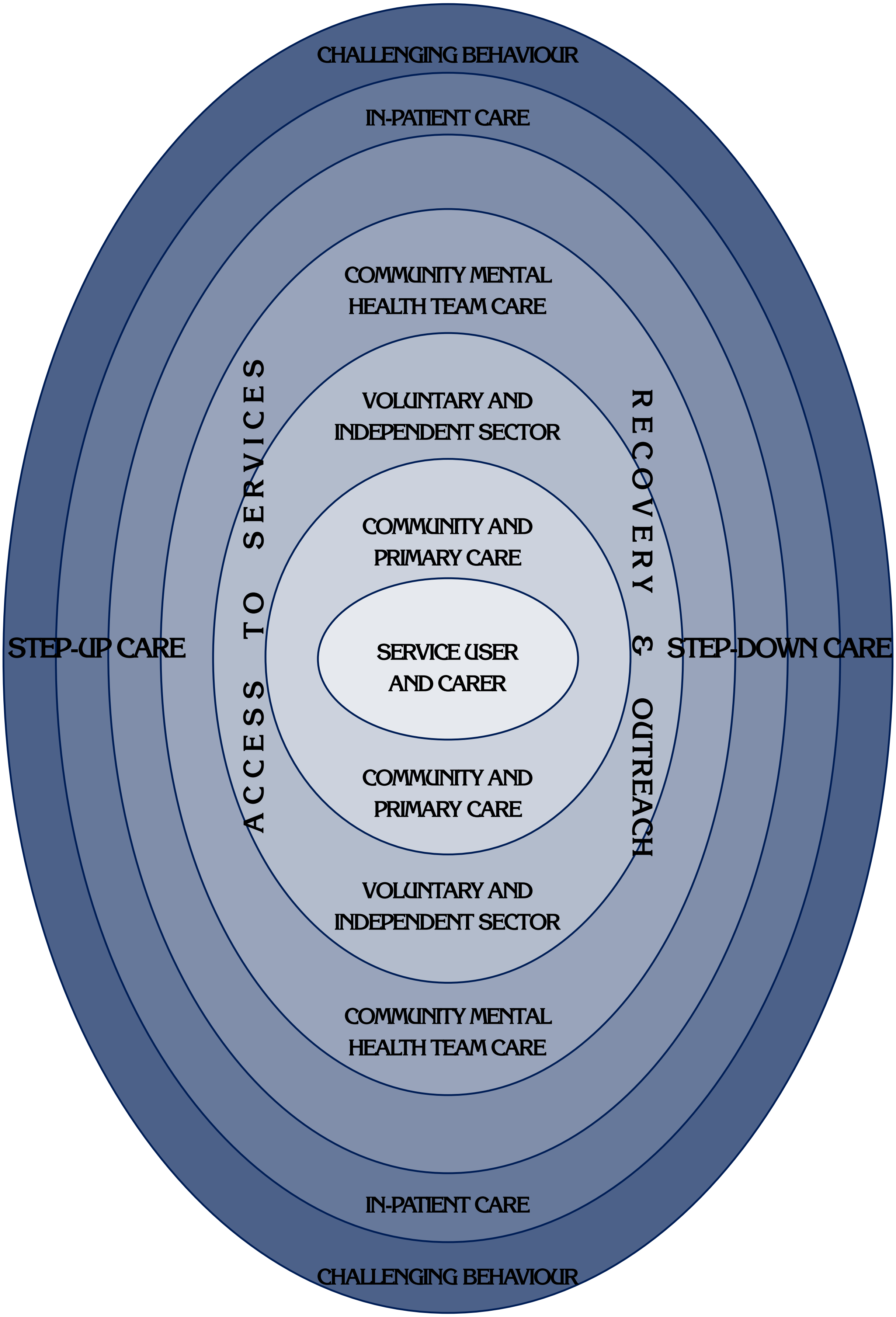
4.123 **Psychological Therapy Services**. Psychological therapy services should be consolidated into a single unit from which support, supervision and training can be provided for all CMHT staff. They should be responsible for specialist services for people with psychological trauma, people with eating disorders and people with personality disorders.

4.124 **Inpatient Provision**. Acute inpatient services should be provided as part of an integrated model of crisis services with locally accessible units, utilising where possible, the facilities of general hospitals. Acute inpatient services can be complemented by step-up and step-down houses in close collaboration with HT teams (see Figure). As the goals of the Strategic Framework are achieved, then the requirement for acute inpatient provision should reduce to approximately 20 places per 100,000, their location recognising the advantages of general hospital settings.

4.125 In addition, inpatient facilities for people with challenging behaviour with approximately 25 places for a population of 250,000 people will be required. The requirements for inpatient provision will turn critically on the adequacy and comprehensiveness of alternative community provision, including residential facilities.

4.126 The model is predicated on all of the services elements specified above for secondary services, including the skill levels of staff, being successfully implemented to high fidelity with the recommendations. Monitoring and evaluation of this implementation will, therefore, be essential.

The Whole System of Care



CHAPTER 5

SECONDARY MENTAL HEALTH SERVICES - PART II

INTRODUCTION

5.1 A person-centred approach is core to the vision of the Strategic Framework and, as noted in Chapter 4, services must reflect the multi-dimensional nature of user and carer needs. While the primary focus of the last chapter was on health and social care services reform, we must now consider a range of other issues – education; training; occupation; accommodation; income; advocacy; personal life; family life and culture; and carer and family needs.

EDUCATION, TRAINING, OCCUPATION

5.2 Occupation, defined as all purposeful human activity, encompasses personal activities of daily living, leisure activities and work activity. Education and training relates to activities compatible with both vocational outcomes and personal development. Occupation is a basic human need, which is directly related to the meaning and quality of ones life[1] and important for both physical and mental well-being. Everyday occupations play a significant part in maintaining structure, meaning and social inclusion.

5.3 Serious mental illness often results in a disruption of occupational balance, with lack of meaningful occupation limiting social connections and increasing stress and isolation.[2] In quality of life studies, service users report lack of a job, loneliness, health problems, looking after self and lack of leisure activities as priority areas in relation to quality of life.[3, 4, 5] The Labour Force Survey of 2002 Great Britain found that only 21% of adults with mental illness were in employment.[6] Three issues are important for the Strategic Framework - assessment, barriers to employment and employment models.

Assessment

5.4 Recent clinical guidelines emphasise the importance of holistic assessment including social functioning, occupational status and potential, with interventions beginning at the earliest opportunity. The importance of assistance to access employment, education and training opportunities has been acknowledged.[7] Supported employment programmes are but one aspect of work activity which should be made available. Interventions aimed at maintaining and improving social networks through appropriate day care programmes should be available to all service users.[8]

5.5 The Mental Health Policy Implementation Guidance advises that the availability of specialised employment, education and occupation services should be a priority for all those with severe mental health needs. Trained professionals with the skills to assess these areas should be available to all community mental health teams. With respect to early intervention for psychosis the guidance is that all users should have a vocational assessment within three months of referral to the service.[9]

Barriers to Return to Work

5.6 Many people with enduring mental health problems are financially better off if they remain unemployed and in receipt of social security benefits. Current rules and financial incentives to move from benefit to work are complex, fragmented and assume a move from no work to full-time work. For those on Incapacity Benefit, work is allowed in specific circumstances. Even with the support of Disablement Employment Advisors and professional staff the process can be complicated and daunting.[10]

5.7 The Department for Work and Pensions has recognised these difficulties and produced new proposals to address some of the issues. The proposals emphasise rehabilitation and job retention. Specialist help will only be effective provided there are closer working relationships between DHSSPS, Department of Enterprise, Trade and Investment (DETI), Department of Employment and Learning (DEL), Department of Education (DE), Department of Social Development (DSD), healthcare providers, the voluntary sector and employers.[11]

Employment Models

5.8 The following are models of employment, which encompass the range of provision from social support through to health care and to those concerned with productivity.[12] With the exception of Clubhouse, all of these options exist in Northern Ireland.

Vocational rehabilitation (Prevocational skills training)
Sheltered employment
Clubhouse
Voluntary work
PACT (Placement, Assessment and Counselling Team)
Transitional employment
Supported employment
Social firms/ businesses

5.9 The paucity of quality research in this area could lead to a narrow view of those services which represent ‘best practice’. While a Cochrane review concluded that "supported employment is more effective than prevocational training in helping severely mentally ill people to obtain employment."[13], it must be noted that there is a tendency to select more able individuals for supported work placements. Most of the studies reviewed were conducted in America, where the social security systems are less extensive than in the UK.

5.10 Two features of employment programmes that have most empirical support are: integration of mental health and vocational services within a single service team; and the avoidance of pre-placement training. [14] People with complex mental health problems should be offered choice in terms of occupational, education and training opportunities, facilitating service users to experience a meaningful day and consequently improving quality of life. Emphasis should be placed on user-focused initiatives that allow a progression towards paid employment where this is the most appropriate option for the client. A range of occupational services should be provided within each Trust area to allow professionals and service users to match the level of need with the service provided. The continuum should include:

services with a predominantly treatment function

leisure and creative activities

good quality vocational guidance

specialist day care

high quality sheltered workshops

links to learning and training opportunities and voluntary work

social enterprises

access to supported placements in competitive employment.

5.11 The use of mainstream community services, facilities and activities should promote social inclusion and help reduce the stigma that mental health service users face. Effective links to voluntary work and organisations such as Further Education Colleges, Educational Guidance Service for Adults and the various job brokers and training organisations will expand the opportunities for people with complex mental health needs.

5.12 Some service users require considerable support in order to access mainstream services. Supported education initiatives for employment or leisure services have been shown to be effective in relation to health gains for people with more enduring mental health needs. [15] The key worker should retain a co-ordinating role for the client[16]. Service providers, particularly those with a mental health remit, should be exemplary in providing and promoting employment opportunities for service users. Sensitive, needs-led, flexible support must be maintained to reduce anxiety and alleviate barriers to engagement.[17]

5.13 Significant benefits of volunteering have been observed for those with mental health problems.[18] For those service users with complex and enduring mental health needs adequate support and tailoring of opportunities must be provided in order to maximise the benefit from volunteering.

5.14 Leisure as an occupation contributes to social identity and is fundamental to physical, social and psychological well-being. For many service users successful engagement in leisure activities can be a catalyst towards employment. For others it can be the predominant occupation that defines their identity and maintains social inclusion. At all levels, leisure occupation should be valued and facilitated by mental health workers.
Good Practice Examples (Annex 5.5.1)

5.15 Assessment of an individual's occupational performance, exploration of vocational goals and networking with local service providers is currently being performed by many CMHTs within Northern Ireland. However, many teams do not have access to Occupational Therapist (OT) expertise or, when present in teams, they are engaged in generic work due to high caseload numbers amongst multidisciplinary team members. The 'Avon' model (Annex 5.5.1) could be replicated in Northern Ireland. The interventions required are core skills of OTs and partnership working is already established in many Trusts.

Recommendations

66. People with severe mental health needs should be offered an early opportunity to participate in a full occupational assessment. This should be reviewed on an annual basis as part of the service user's review. Assessment should be conducted by an OT with the emphasis on quality of life, time management and occupational issues.

67. More straightforward and flexible social security benefits should be introduced to facilitate the transition from benefits to work.

68. A comprehensive range of occupational services must be provided within each Trust area and should include access to voluntary work, educational and leisure opportunities.

69. Day care services should provide a comprehensive range of activities and opportunities to support the different needs of service users.

70. Vocational specialists with mental health expertise and the flexibility to work on an interagency basis should be commissioned to enhance the rehabilitative function of CMHTs.

ACCOMMODATION

5.16 Having a home is a basic human right. The impact of poor housing on mental health has been well documented, as has the association between type of housing and prevalence of mental health problems. The Audit Commission 1994 found that:

- poor housing is particularly common among people with mental health problems;
- mental disorder is a frequent cause of tenancy problems and tenancy breakdowns; and
- poor housing and inappropriate accommodation can lead to the development or exacerbation of mental health problems.

5.17 Suitable accommodation is a fundamental element of effective services to support people with mental health problems. A number of principles need to be considered in order to ensure an appropriate range of accommodation and support. These principles draw mainly on the recommendations of the Newby Inquiry:[19]

- as far as possible, people with mental health problems should have a choice of the type of accommodation in which they wish to live. This has to be balanced in relation to the degree of risk posed to themselves or others;
- assessment of accommodation needs should be a component of an overall assessment;
- support for people receiving mental health services should be available to people with mental health problems regardless of where they are accommodated; and

- providers of accommodation should receive training and should be supported regardless of whether the accommodation is statutory, voluntary or private.

5.18 Supporting individuals in suitable housing in ordinary settings will help them gain access to a wide range of mainstream services and resources. The challenge is to provide accommodation with support for the range of needs experienced by those with mental health problems without recreating institutions.

5.19 Homeless and rough sleepers present particular challenges. A recent study in Belfast identified mental health problems among 86% of single homeless people.[20]

5.20 The Northern Ireland Housing Executive, through joint planning arrangements with the Health and Personal Social Services, seeks to extend the supported housing option for various client groups in response to discharge from hospital and wider community needs. Each year 20% of the new build programme is targeted to meet supported housing needs.[21]

Accommodation Needs

5.21 People with mental health needs have a range of accommodation requirements. The foundations of good provision include quality of care and management. Accommodation needs range from independent tenancies in mainstream housing to 24 hour intensively supported accommodation. A key objective of People First: Community Care in Northern Ireland for the 1990's was to promote the development of domiciliary day and respite services to enable people to live in their own homes, whenever possible.

Types of Supported Housing

5.22 Supported housing involves providing integrated housing and support. The type of housing available covers a wide range including:

- temporary or homeless hostels: shared housing where board or access to cooking facilities are provided;
- rehabilitative supported housing: shared housing in group homes or hostels providing a rehabilitation service;
- shared supported housing accommodation in shared housing or flats providing a permanent home;

- self contained supported houses: housing provided in flats or houses, which is not shared with others but has targeted integrated support; and
- residential care homes: usually shared accommodation, which are registered under the Registered Homes (Northern Ireland) Order 1992 (since April 2003 many of the registered care homes in Northern Ireland managed by the voluntary sector and the statutory sector with special provision for people with mental health needs have de-registered and now operate under Supporting People).

5.23 People who require support to stay in their own or rented accommodation may require essential support at a practical level to ensure the maintenance of the tenancy, e.g. floating support, home help, mental health support workers. Those who need respite on a short stay basis to prevent acute admission may require emergency or non-emergency respite. Non-emergency respite may be required to accommodate people whose mental health is deteriorating and who require input from experienced staff over a period. Examples of this provision is available mainly in statutory/non hospital facilities in Northern Ireland.
Good Practice Example (Annex 5.5.2)

5.24 Crisis diversion/non-hospital accommodation may be provided as part of Crisis Response to prevent inappropriate admission to hospital.
Good Practice Example (Annex 5.5.3)

5.25 People who are returning to independent living as part of their rehabilitation require specialist accommodation with support. They should, as far as possible, have choice of location. Moving out of an institutional setting to independence can be daunting. Many will require phased independence combining suitable accommodation and daytime occupation. Staff in supported housing can provide valuable help to those who lack social skills. This can be enhanced by access to daytime occupation and leisure facilities. Confidence building is important and input is required from trained and experienced staff.
Good Practice Example (Annex 5.5.4)

5.26 People with challenging behaviour require specialist facilities with high staffing levels (see 4.63). This accommodation may be provided by the Housing Executive or Housing Associations in conjunction with Trusts or voluntary sector. It may also be provided through therapeutic type communities. It is important that the layout of the accommodation provides adequate personal space and access to daytime occupations and intensive staff support. Staff

require specialist training in relation to dealing with challenging behaviour and potential violence. Risk assessment should be carried out to identify patterns of behaviour, which may lead to harm either to the resident or others. Thorough risk assessment and risk management are essential to allow an acceptable level of freedom and independence for personal development within a context of safety for both service users and staff.
Good Practice Example (Annex 5.5.5)

5.27 People with mental health problems without accommodation pose a particular challenge. Homelessness may have been caused or exacerbated by their mental health problems. Some may have become displaced because of their mental health problems or rejected from accommodation as a result of their health problems or the degree of challenge posed to staff. Many have dual diagnosis. (See 4.74)

5.28 It is essential that homeless people with mental health problems have access to mainstream services at primary and secondary care level. Accident and Emergency Services provide an important access point to care. Good communication between generic and mental health services is essential.
Good Practice Examples (Annex 5.5.6)

5.29 Access to housing alone is not sufficient and must be complemented by the provision of appropriate therapeutic interventions and support, for example using Assertive Community Treatment [22] (see 4.46).
Good Practice Example (Annex 5.5.7)

5.30 The Homeless Strategy and Service Review Northern Ireland Housing Executive 2001 aims to reduce the levels of homelessness by the provision of a tenancy support service and by developing move on accommodation as part of their supported housing programme.

5.31 Discharge protocols in mental health services in Northern Ireland require further refinement to ensure that people leaving mental health facilities have appropriate accommodation on discharge. Close co-operation is required between housing, mental health services and the independent sector.

Recommendations

71. Providers should ensure that a complete range of accommodation is available to meet the needs of people with mental health problems. Supporting People partnership between Trusts, Boards, Northern Ireland Housing Executive and the independent sector should be sufficiently flexible to make timely responses to the accommodation needs of people with mental health problems.

72. Service users should have choice of accommodation appropriate to their needs and given maximum independence through appropriate levels of support. Care environments and practices should be designed to maximise personal autonomy and reduce the risks of institutionalisation. Service principles must underpin the development of standards and must focus on the needs and rights of individuals.

73. Discharge protocols should ensure that people leaving mental health facilities have appropriate accommodation.

74. Staff working in residential settings should have adequate support and training including, where appropriate, training in the management of people with challenging behaviour.

75. Statutory services should provide support to residents and staff to optimise community living, prevent unnecessary hospital admission and to reduce the risk of homelessness in people with mental health needs.

76. Monitoring and evaluation of services should be a continuous process and involve users and carers.

SOCIAL SECURITY BENEFITS AND SUPPORT

5.32 In the non-disabled population in the UK, 15% of people are economically inactive compared to around half of the disabled population. The figure for people with mental health difficulties is around 80%.[23] In Northern Ireland, more than a third of Incapacity Benefit claimants have a mental or behavioural disorder. In November 2002, over 37,000 people were in receipt of Incapacity Benefit as a result of mental and behavioural disorders and just under one in five people receiving Disability Living Allowance cited mental health problems as their main disabling condition.[24]

5.33 The key issues facing people with mental health problems are:

- inadequate levels of benefit, for example, personal expenses payments for people in residential/institutional care, help with the cost of prescriptions, problems with the Social Fund;
- assessment – the prevalence of medical examinations that are often seen as intimidating; many of those conducting assessments have limited experience of mental illness;
- easing the transition to work; there is much of a gap between incapacity and getting back to work. The current rules and financial incentives to move from benefit to work are complex and fragmented and there is a need for simpler, more flexible and improved financial incentives to allow people to return to work without the fear of penalties if unsuccessful; and
- delivery – there is a need to take greater account of mental health issues in the administration of social security benefits. Awareness training, increased user involvement in training and planning, improved claim forms and tailored independent advice and advocacy services are all needed.

Levels of Benefit

5.34 While considerable effort has been made to improve the level of financial assistance available to families (both in and out of work) and older people, Incapacity Benefit for a single person unable to work because of ill-health or disability is worth barely one sixth of average earnings. The weekly rate of Income Support based Jobseeker's Allowance for a single person is presently (2004) £55 if aged 25 or over and £44 if under 25.

5.35 Young single people's difficulties are compounded by private rented sector housing benefit rules which apply a 'single room rent' rule to entitlement. Many young single people with mental health problems fall foul of this rule and get into difficulties paying rent. Young people, therefore, find themselves pushed towards less self-contained, cheaper accommodation which may not be appropriate. An exemption to the single room rent should be made for people with mental health difficulties.

5.36 Social Fund rules make it difficult for single people to qualify for grants for essential items such as furniture or household equipment. Often, the only option is a loan which compounds financial difficulties. The Social Fund should be reviewed so that loans do not continue to be the main form of discretionary support.

5.37 Income Support for people in residential care or other institutional settings currently (2004) entails paying a personal allowance of £17.50 a week to meet living expenses. This can lead to difficulties in managing the transition to independence.

5.38 Prescription charges can be a major cost to people with ongoing health problems. Often, people with long-term mental health problems on incapacity benefit alone do not qualify for help with prescriptions. Pre-payment certificates allowing multiple and long-term prescriptions to be paid in advance are helpful but are often beyond the means of people on low incomes. People with severe mental health problems should be exempt from such charges.

Assessment

5.39 The current strategy for Social Security is 'work for those who can, security for those who cannot'. As a result, a considerable effort has been put into encouraging the long term sick and disabled back into work.* However, there is a need to recognise that not everyone is capable of open employment (going beyond those granted an automatic exemption from these arrangements). It is important that all frontline employment advisers receive mental health awareness training, part of which should involve interaction with people directly affected by mental ill health.

5.40 The current strategy also contains an element of compulsion. People on Incapacity Benefit who fail to attend interviews can be penalised by loss of benefit or incapacity status. This fails to acknowledge the pressure having to attend such interviews can cause for someone with a severe mental illness.

5.41 Medical assessment is a regular feature of establishing and retaining entitlement to key disability benefits (notably Incapacity Benefit and Disability Living Allowance) and the quality of such assessments has been subject to significant scrutiny.[25] Rushed assessments, lack of knowledge of mental ill-health, disbelief of claimants, a disregard of specialist evidence and cultural insensitivity are not uncommon experiences. A report on the Social Security Agency's Medical Referee Service by the Advice Services Alliance in 2002 was also critical of the quality of assessment and sensitivity of some doctors.[26] The Social Security Agency (Northern Ireland) has recently announced a review of the Medical Referee Service. This could usefully lead to greater use of occupational nurses and mental health specialists (medical and non-medical).

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* For example, the introduction of Jobcentre Plus, compulsory work centred interviews for new and recent incapacity benefit claimants, the New Deal for Disabled People initiative and tax credit and benefit reforms aimed at easing transition back to work.

Easing the Transition to Work

5.42 People with mental health problems who have been on benefit for long periods often need intensive support to get back to work. The current Social Security system does not allow for a continuum that would enable a person to move gradually through voluntary work to part time work and full time work or to stay at one level for a prolonged period if appropriate. The Government has improved flexibility within the social security system to encourage a return to work, but the current arrangements are complex, fragmented and not easily understood by claimants. An understanding of the arrangements requires extensive knowledge of social security and concerns have been raised that a move into training or work triggers a review on the assumption that a person's condition has improved. This is a disincentive to rehabilitation through work or training.

5.43 Improvements have been made to claim forms in recent years, but there is a considerable way to go. The claim form for Disability Living Allowance remains complex and significantly oriented towards physical impairments. The claim form for incapacity benefit has an open question about mental health with no guidance as to the information required.

5.44 The Social Security Agency is moving towards providing greater support to assist with claims for disability benefits. It has also worked with the voluntary sector to look at ways of enhancing its customer service to particular groups (for example, physically disabled people and ethnic minorities). A similar exercise working with voluntary sector and other interested parties to examine customer service issues for people with mental health problems would be a welcome development.

5.45 There is a need to ensure that all those involved in frontline benefit administration and decision-making receive mental health awareness training that incorporates interaction with people with mental health problems. This also applies to the Medical Referee Service personnel, as well as chairpersons and panel members hearing social security appeals. People with mental health problems should have access to an independent dedicated advice and advocacy service to deal with social security problems.

5.46 The social security system should support and enable people with mental health problems to live independently with dignity and a good quality of life, both in and out of work.

Recommendations

77. The Social Fund should be reviewed with a view to ending loans as the main form of discretionary financial support. An exemption to the single room rent should be made for people with mental health difficulties. People with severe mental health problems should be exempt from prescription charges.

78. Trusts must ensure that people with mental health problems have access to independent dedicated advice and advocacy services to provide assistance in dealing with social security problems.

79. Returning to work: people with mental health problems wishing to work and who have been on benefit for long periods should be provided, as necessary, with intensive support. Rules encouraging a return to work should be made more flexible and easier to understand.

80. Staff Training and Development. All frontline benefit advisers, social security decision-makers, medical referee service staff and appeal tribunal members should receive mental health awareness training, part of which should involve interaction with people directly affected by mental ill-health. Medical assessors must have appropriate skills in assessing the mental health needs of applicants. Consideration should be given to greater use of mental health specialists (medical and non-medical).

PERSONAL LIFE, FAMILY LIFE AND CULTURE

5.47 Mental well-being has been defined as the emotional and spiritual resilience which enables us to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own and other dignity and worth.[27]

Social Self

5.48 A person's social connectedness – activities, relationships, interests, networks – has a significant impact on mental well-being and self-esteem. The reactions of others are often influenced in our social life, our activities, interactions, our social self. Becoming mentally unwell can profoundly affect both our own social interactions and the reactions of others. It is in such situations that the experience of ignorance, fear and stigma can bring a new dimension of distress to the sufferer.

5.49 Mental ill-health and the accompanying distress can affect all aspects of one's social life and relationships - within the family, with friends, with work colleagues. The sense of feeling isolated and stigmatised is a very real experience of many sufferers. There is also a sense of disempowerment and the distress arising from this – "my life will never be the same again". Acknowledgement of these issues and concerns can be of particular importance in promotion of recovery and needs to be recognised by professionals.

Relationship between Service User and Professionals

5.50 The relationship between service providers and service users is of considerable importance in building and maintaining self-esteem, hope and self-worth for individuals with severe episodes of mental illness, experiencing loss of insight, loss of control, in addition to the painful experience of the symptoms of mental illness. This relationship can also provide a role model for family members who themselves may be bewildered and distressed through the experience of an illness episode. The engagement and empowerment of family members can greatly assist in the recovery and re-engagement of the service user in their social life and relationships.

Sharing of Information

5.51 From a service user perspective, knowing that the professional to whom you are relating is trustworthy, will listen in a non-judgemental way and respects user views and requests, is essential to a partnership of trust, respect and empowerment. Confidentiality is an important part of this relationship. However, if a service user asks a family member or friend to request information on his/her behalf, this request should be respected by professional staff. Once a delegated person has been named and the request confirmed by the user of the service requested, information should be given to the nominated person. This need not include personal information.

5.52 Access to information has generally been experienced as a problem for service users in mental health services. It is often difficult to get clear information and this lack of clarity is a problem for users, family and friends. The failure to convey relevant information clearly and in simple terms can cause distress to the user and their families. Information is required about services, choice of services, specific interventions including, for example, medication side-effects and crisis arrangements.

5.53 In the situation of involuntary admission, clarity takes on even greater importance. The sufferer in such situations often experiences a significant intrusion into their personal and family privacy. Involuntary admission procedures should be clearly explained and all involved should identify themselves to the sufferer, family and friends. Difficulties for the user in understanding information at such times requires professionals to pay even greater attention to communication and information sharing.

Spirituality

5.54 Within a multi-cultural society, the service user's specific cultural, spiritual and religious needs need to be recognised and acknowledged. With the emphasis on community based care and treatment, the religious and spiritual dimension of an individual's life should be considered as part of holistic assessment.

5.55 From a user perspective, spirituality can be an important part of one's personal life and in times of crisis a major source of sustenance. This can be of particular importance in situations where admission to hospital is required with the inevitable separation from family, friends and one's local community. It is a common user experience when in hospital, that religious and spiritual needs are not adequately met. Service providers need to be sensitive to the spiritual needs of service users at such times.

Culture

5.56 Culture shapes many aspects of mental health and people from ethnic minority communities have needs and concerns related to their cultural uniqueness, their minority position and often issues related to recent immigrant status. Culture shapes both perception and expression of mental distress and disorder. It also influences attitudes and coping mechanisms for the person, the family and for the specific cultural group. Ethnic minorities are especially vulnerable to stigmatisation, discrimination, racial stereotyping and social isolation. Many of these issues have been highlighted in the recent user survey of ethnic minorities in Northern Ireland.[28]

5.57 Mental health services must be sensitive to these issues and to the particular needs of ethnic minorities. The Department of Health report "Inside Outside"[29] emphasises three key objectives:

- to reduce and eliminate ethnic inequalities in mental health service experience and outcome;
- to develop cultural capability of mental health services; and

- to engage the community and build capacity through community development workers.

5.58 Important factors are personal attitude, professional skills and competencies, and awareness and appraisal of specific cultural norms. These point to important aspects of professional development among mental health professionals. Priority must also be given to the provision of better information and better communication including the appropriate use of interpreters and translators.

Recommendations

81. Information. Service users and, where appropriate, carers, family and friends should be provided with relevant information in clear and simple terms. The information and communication needs of service users in situations of non-voluntary admission require special attention. Priority must be given to improved methods of communication and information for people from ethnic minorities, including the use of interpreters and translators.

82. Services must be sensitive to the cultural needs of people from ethnic minority communities. Within a multi-cultural society, the service user's specific communication, cultural, spiritual and religious needs must be recognised and acknowledged.

83. Advocacy services should be sensitive and appropriate for the needs of people from ethnic minority communities.

84. Staff training and awareness. The distress accompanying mental illness and its impact on an individual's personal life, including a sense of stigma, need to be recognised and acknowledged by mental health professionals. The importance of the relationship between service providers and service users in the maintenance of self-esteem, hope and self-worth needs to be recognised and valued by providers.

ADVOCACY

5.59 In 1996 Building Bridges[30] identified service user involvement as a fundamental principle in mental health care and user advocacy as an important support of this process. The Mental Health Patient's Charter[31] states that service users should be informed of and have access to local advocacy services. The purpose of advocacy is to ensure maximum preservation of each service user's personal autonomy and self determination.[32] Advocacy assists service users in expressing their views and taking an active part in decision making affecting their situation. The United Kingdom Advocacy Network (UKAN) stresses that a key objective of advocacy is to enable people to advocate for themselves. Nevertheless, there are occasions when people are unable to represent their own views and interests.

5.60 Peer advocacy is particularly valued by service users. It challenges the discrimination and stigma attached to mental illness. It is a process for empowerment by which to build or rebuild well-being for people whose mental health condition has damaged self-esteem and confidence.[33]

5.61 The Review considers advocacy as an essential part of mental health services and expects the issue to be taken forward by the Legal Issues Expert Working Group.
Good Practice Example (Annex 5.5.8)

Recommendations

85. Independent Advocacy services ensuring maximum preservation of each service users personal autonomy and self determination must be established in all Trusts providing mental health services.

86. Advocates should be involved in service planning and development, be given access to appropriate service information and receive support, as necessary, from Trust staff.

CARER AND FAMILY NEEDS

5.62 The UK Government's National Strategy report 'Caring about Carers'[34] states that

- Northern Ireland has 250,000 carers, 7% (17,500) of whom are caring for a person with mental health needs and a further 15% (37,500) for someone with both a mental and physical disability;
- carers need support and information, especially when caring for someone with a mental health problem;
- nearly 60% of carers receive no regular support from service providers;
- stress related health problems are most acute among carers of people with a chronic mental health condition such as schizophrenia; and
- helping carers is one way of helping those they care for.

5.63 In the past, mental health systems around the world tended to focus on the individual without considering the system in which they lived, often overlooking their roles within families and communities.[35] Yet the family usually has primary responsibility for care, with approximately 50% of those with severe mental illness living with family or friends, and many who do not, still receiving substantial support from them.[36] The cost of this care in Northern Ireland, if provided by the state, is estimated by the Sainsbury Centre for Mental Health to be £122 million.

5.64 The inter-relationships between service user, carer and other family members are important for each person's well-being. The carer who is a spouse may have to assume new roles and responsibilities. The carer who is a mother may concentrate on the ill family member to the neglect of others. A child whose parent is unwell may become a 'young carer' and may suffer adverse consequences.

5.65 Mental disorder can be demanding and stressful for a family. It can be intermittent, adding uncertainty to family life and an inability to plan in the short and long term. Children may experience difficulties at home but not speak about them at school because of stigma. Carers and families commonly experience fear of the unknown arising from lack of knowledge of the illness and its consequences, and grieving for the loss of future potential in their own lives and that of their family member.

5.66 Individuals within a family whose lives are affected by these circumstances must be identified and offered support in their own right in order to avoid adverse consequences to their health and well-being.

Carers

5.67 **Current Policy and Legislation.** Service providers have traditionally shown a reluctance to comprehensively address the needs of carers. However, the needs of those caring for others with severe and enduring mental illness are especially high and cannot be ignored. Valuing Carers[37] (2002), Northern Ireland's carers' strategy, recognises that carers' health needs must be met, that they must be provided with adequate information and be involved in the planning and provision of services.

5.68 Its key elements relating to carers of those with serious mental illness are:

Recognition

- all organisations must begin to recognise carers and be prepared and able to direct them to sources of support;
- older carers should be sought out and supported; and
- young carers should be identified and supported in their education and development.

Assessment

- carers should be informed of their right to a separate assessment, separately recorded.
- Information and Support
- clinicians should seek their patient's consent to provide relevant information to the carer;
- carers should be fully involved in the timing of hospital discharge and given the information they require for the aftercare of the patient. The carer's name should be included in the discharge letter to the GP;
- the training needs of carers must be assessed and training provided;
- handbooks of local services are required, as is information on the Internet; and
- locality-based and disability-specific self-help groups should be encouraged.

Services for Carers

- carer services should be reviewed with carers;
- reviews must be made of respite opportunities. Carers and service users must be involved in the reviews;
- a carer liaison or co-ordinator position should be created in each Health and Social Services Trust;
- carer advocates should be developed and trained; and
- front line staff should deal sympathetically with complaints.

5.69 The recent Carers and Direct Payments Order (Northern Ireland) 2003 entitles those who provide regular and substantial care to an assessment of their own needs and enables Trusts to provide services directly to carers after assessment. Assessments should be undertaken annually and a written care plan produced and implemented in consultation with the carer. In looking at the circumstances of both service user and carer consideration must be given to the degree of support a carer can, or is willing to provide, so that there are no adverse effects on her/his own health and well-being.

5.70 **Identifying the Carer.** Mental health professionals should know who is providing care and support. General Practitioners, other clinicians and mental health professionals should actively seek the consent of service users to provide their key carer with relevant information. This should be done on the basis of clear protocols for the identification of key carers.

5.71 Service users should be encouraged to nominate a key carer, who may not be a family member. This information should be reviewed regularly, as many carers would not identify with the term 'carer' or describe themselves as such, seeing their role simply as a family responsibility. The Review recommends the concept of a User-Key Carer partnership

5.72 **Partnership with the Carer.** Agencies and care providers should recognise and value carers and accord them equal status with other providers of care.[37] Working with service users and carers in partnership is conducive to the creation of holistic support networks, which are important in bringing relief from isolation and loneliness. A culture of creating and encouraging support systems for the whole family should be developed.

5.73 With the consent of the service user the key-carer should be involved in the drawing up of care plans, consulted about hospital discharge and periods of leave from hospital. Hospital admission and discharge are particularly difficult as they are often unplanned, with little or no involvement of patient or carer.[38]

5.74 **Information for the Carer.** Carers and families need a wide range of information to manage their day-to-day circumstances and alleviate the helplessness many experience. This would include information on social security benefits, the law, their own rights and entitlements and those of the service user. Social security benefits can create urgent problems around the times of hospital admission and discharge. Carers are generally not familiar with mental health legislation and the associated processes and structures. Carers need information about the structure of health and social services so that they can effectively deal with them.

5.75 On occasion the needs of carers and families for information may conflict with the wishes of the service user. While the fundamental right to confidentiality for the service user must be respected, a way forward should be negotiated to ensure that the needs of the carer and family are also met. A person-centred approach to the delivery of care will both highlight and moderate these conflicting rights, with measures which can be put into effect at times when the service user may not well enough to make informed decisions, such as advance directives, identifying and working in partnership with the carer, providing carers and families with information about the illness.

5.76 With the consent of the service user key-carers should be provided with information about the mental disorder affecting their loved-ones, including medication and its side-effects, what choices are available regarding therapeutic interventions, prognosis, how to get help, what to do in a crisis, how to deal with certain situations and symptoms.[39] Carers must be provided with names and telephone numbers of who to contact in a crisis. Carers need to be listened to when they report that a crisis is pending.

5.77 **Support for the Carer**. Stigma, guilt and shame can bring about a breakdown in natural, supportive social networks causing carers and families to experience a deep sense of isolation. Self-help groups provide an effective counteracting measure where people can speak about their circumstances, receive and give support and make sense of their experiences. A variety of flexible and responsive support mechanisms should be on offer to assist families in dealing with the many issues they face including helplines available during and after business hours, dedicated carer and family workers and opportunities for respite breaks. Carers of people with mental health problems find family worker support of value. It should be sensitive to ethnic diversity. A range of opportunities for breaks is required for users and carers. Partnerships involving the independent sector are often an effective way of providing this service. Support services for carers provided by the independent sector, and involving carers have particular advantages.[36]
Good Practice Examples (Annex 5.5.9)

5.78 **Empowerment of the Carer through Training**. Training programmes have been established to empower carers to respond to the challenges arising from mental health problems, increase their knowledge, develop coping skills and deal with grief and isolation. These should be made widely available. The anticipated developments in Home Treatment and Crisis Resolution make it imperative that carers receive appropriate training to carry out the tasks required of them.

They need to know about risk management and be advised about vulnerable periods such as the period following hospital discharge.
Good Practice Examples (Annex 5.5.10)

5.79 Family interventions can have considerable benefits for relatives' psychological distress, family functioning and the carer's relationship with the service user.[40,41] Despite its effectiveness, few carers and families currently have access to this form of support.
Good Practice Example (Annex 5.5.11)

Children and Young People

5.80 It is estimated that 30% of adults with mental health needs have dependent children. Rates of psychiatric diagnosis in these children range from 30% to 50% compared to 20% in the general population.[42] The presence of alcohol or drug misuse among parents can add significantly to the mental health difficulties of children. Service users may also be reluctant to seek help because of fear that children may be taken into care.

5.81 In the UK, it has been shown that children who become involved in the child protection system often have significant experience of parental mental illness, parental substance misuse and/or domestic violence.[47] A survey conducted in 2000 in the Northern Health and Social Services Board area found that 72% of the 467 children placed on the child protection register had a history of parental mental illness or substance misuse while, 79% of the 703 children who received services under the Children (N.I.) Order 1995 had a history of parental mental illness or substance misuse.[44]

5.81 The potential effects of mental health problems of parents and siblings on the health and well-being of children in the same household has been recognised for some time. These children are more likely to experience financial hardship, marital discord and social isolation than children in a household without a parent with mental health problems.[45] They may experience anxiety, extended periods of separation, disruption in schooling and, in a relatively small number of cases, neglect and/or abuse.[46] Other risks include:

- between 25% and 50% of children of parents affected by severe mental illness will experience psychological disturbance during childhood or adolescence with up to 14% of such children developing a psychotic disorder in adult life;
- risk may double for children where both principal caregivers are affected;

- risks to children increase during the acute phase of an illness and are exacerbated by marital breakdown, social isolation and stigma; and
- some children may become involved in parental symptomatology.[47]

5.83 The mode of delivery of services can sometimes reveal tensions in a system that has been primarily created to help adults, sometimes at the expense of their children. For example:

- patient confidentiality can sometimes be an obstacle to the sharing of crucial information;
- understanding of roles and responsibilities in multi-disciplinary teams can be highly variable; and
- inpatient facilities are often not best suited to the needs of parents, babies, small children and/or adolescents.

5.84 Routine good practice among child protection workers is to consider the special needs of children in these circumstances. However, there is no certainty that these needs are routinely taken into account during the course of assessments carried out by mental health workers. Although there is a wider recognition of child protection issues among all professions, the recognition of these issues by hospital based multidisciplinary teams varies. It is essential that the assessment process for parents with a diagnosis of severe mental illness includes an assessment of the needs of children within the household. Written child protection protocols and policies, agreed between child care and mental health services, are an essential element of good practice and it will be vital to ensure that such protocols remain in place and are reviewed as organisational structures change and evolve.

5.85 Support for the family must become an integral component of a comprehensive service which encourages a 'family wrap-around' approach.[43] Appropriate support must be provided for the children of those with mental illness so that they benefit from the same life chances as other children.[36] Their needs must be identified in the course of drawing up a care plan for the service user and they should be fully included and addressed in any subsequent care planning process.

5.86 Very young children may put additional pressure on the coping capacity of both service users and carers requiring measures to be taken to prevent extra stress within the home. These issues should be recognised as early as possible in the assessment process. In the longer term, children will need advice and help to 'navigate' their way through their education and transition to adulthood.

5.87 Children and parents value a range of supportive measures including:

- a contingency plan drawn up for times of crisis;
- maximum continuity and minimum disruption for children when their parent is admitted to hospital;
- an age-appropriate explanation for children of events surrounding an admission;
- the availability of a confidante for children during a crisis;
- facilitated access to other children in similar circumstances;
- continuity of family support workers;
- suitable visiting arrangements in hospital; and
- parental support groups.[48]

5.88 An agreed, formal protocol between children's and mental health services should be established for those responsible for delivering health and social care to families where children may require protection. This would govern the sharing of information, the management of cases and the identification of lead agency and key worker status and roles.

5.89 **Young Carers.** Some children may be undertaking levels of care that are considered inappropriate for their age. As a result 'Young Carers' have been highlighted as a priority group by government policy in recent years. These children and young people assume levels of responsibility for caring which impacts on their health, education and development.

5.90 Valuing Carers[37] makes specific reference to young carers and recommends that they are identified and that services are put in place to ensure that their development and education do not suffer as a result of their caring duties. The Internet should be considered as a means of making information available to them.

5.91 The key messages in guidance from the Department of Health, Social Services and Public Safety are that joint assessment of parent and children is necessary and that services should be comprehensive, flexible and timely.[34] Assessments can be seen as a means of supporting the family and of considering both their

strengths and the areas in which they need support. Service users should be supported in their parenting and caring roles.
Good Practice Examples (Annex 5.5.12)

Resources

5.92 While much of the support that carers need to continue in their caring role is relatively inexpensive, additional resources are necessary. In England and Wales, the Government made available £140 million over two years, to facilitate the creation of a wider range of services to allow carers to take a break from their caring responsibilities. In resourcing changes to the mental health services in Northern Ireland, funding must be similarly earmarked and ring-fenced for carer and family support. The voluntary sector should continue to play a significant role in the provision of this support.

Recommendations

87. Boards and service providers must fully implement existing policy and legislative obligations relating to carers.

88. The needs of carers, children and other relevant family members, should be identified at assessment.

89. Key carers should be provided with appropriate support, education and information to carry out their role, as partners with the service user.

90. Agencies should accord carers equal status with other providers of care.

91. Key carers should be offered an annual assessment and a written care plan.

92. Family interventions should become an integral part of mental health practice.

93. Training programmes for dealing with mental health problems should be made available to all carers.

94. Service providers should ensure that a range of support services, in the form of helplines, self-help groups, directories of services, help with social security benefits and respite opportunities, is provided for carers and families. Providers should make available dedicated carer and family workers. The services of appropriately trained professionals should be made available for key carers.

95. Service users who are parents should be supported in their parenting role.

96. Children of people with mental health problems should be provided with appropriate support in their day-to-day lives and measures taken to support them in times of crisis, including the availability of a confidante.

97. Hospitals must ensure there are suitable visiting arrangements for families.

98. Agreed protocols must be established between child and adolescent services and mental health services where children may require protection.

99. Staff training must include engagement with carers and the assessment and management of their needs as carers.

CHAPTER 6

SERVICES FOR PEOPLE WITH SPECIAL NEEDS

6.1 Most people with mental health problems receive services exclusively at the primary care level. For people with more complex and more enduring mental health needs mental health services are required. There are, however, a number of specific mental health problems which cannot be fully addressed at either the primary or secondary care levels, usually because interventions are necessary which require specialist skills and specialist services. In this section of the Strategic Framework, the needs of people requiring such specialist services are addressed. We have identified eight specific areas:

- People with eating disorders;
- People with acquired brain injury or progressive brain disease;
- Deaf people with mental health needs;
- People with mental health needs arising from psychological trauma;
- People with personality disorders;
- People with Asperger's Syndrome or High Functioning Autism;
- People with disorders of gender and sexuality; and
- Women with perinatal mental health problems

6.2 While forensic services and services for people with substance misuse or alcohol related health problems are also specialist services, these are already established services and are therefore the subject of specific independent reviews, to be reported on separately. The interface between community and primary care and secondary care services with these services is dealt with in Chapters 3, 4 and 5.

6.3 Some of the services being considered, for example eating disorder services, are currently the subject of DHSSPS initiatives. In others, for example services for people with acquired brain injury or progressive brain disease, aspects of service development are already in progress. Nevertheless, the needs of people with more severe and often protracted mental health problems still require to be addressed.

6.4 A common aspect to the service requirements of people with special needs is a tiered approach to provision. That is, there are needs that can be met at a local level, whether community or primary care (Tier 1). Other needs can be met within local community mental health services (Tier 2). However for some individuals, some or all of their needs can only be met through highly specialised services (Tier 3 and 4).

SERVICES FOR PEOPLE WITH EATING DISORDERS (for background see Annex 6.1)

6.5 Services for people with eating disorders must be able to respond to the multidimensional nature of the problems presented, the different levels of severity and complexity and be able to cater for the needs of service users across the age range. There are now several evidence-based guidelines that give guidance regarding specific treatments.[1, 2, 3]

6.6 There is a relative lack of research-supported interventions in anorexia nervosa. The management of medical complications and nutritional rehabilitation is a priority. Structured psychological therapy by a competent therapist over a steady period of time is a central part of treatment. Family therapy is particularly helpful with younger sufferers. Medication may be required for co-existing psychiatric conditions but needs to be used with particular caution. Chronic, severe anorexia nervosa where the service user may not be fully engaged in treatment poses many challenges.

6.7 There is more research evidence for treatment interventions in bulimia nervosa. As before, physical stabilisation may be the immediate concern, particularly in view of potential electrolyte disturbance. A specific form of cognitive behavioural therapy (CBT) appears to be the clear treatment choice and this can be delivered in a variety of ways. Thereis some evidence that interpersonal therapy (IPT) can be as effective as CBT, but may take longer to work. Antidepressant drugs, in particular higher-dose fluoxetine, can rapidly reduce the frequency of binge-eating and vomiting but the longer-term effects are unknown.

6.8 The current guidance on atypical eating disorders is that they should be treated according to which of the above conditions they most closely resemble. The treatment of binge-eating disorder seems to be developing along the lines of treatments for bulimia nervosa with CBT based approaches and specific antidepressants being used to some effect.

6.9 Following extensive stakeholder consultation, consideration of good practice examples elsewhere and much strategic discussion, the DHSSPS has developed a Four -Tier Model of Service Provision that will aim to provide a comprehensive service for sufferers of eating disorders within Northern Ireland.

6.10 Tier 1 involves primary care services, voluntary organisations, self-help groups and families/carers. The development need in this area is in regard to health promotion, early detection, basic psychosocial intervention and effective physical monitoring. Tier 1 will require access to a comprehensive range of services at Tier 2-4.

6.11 Tier 2 involves assessment and intervention by existing community adult and child and adolescent mental health services and general hospital services, where necessary. These services offer more in-depth mental and physical health assessments and include short-term psychological treatments and longer-term support. This Tier will be important in the management of co-existing physical and psychiatric conditions.

6.12 Tier 3 is envisaged as the main provider of locally based specialist services within each HPSS Board area. Each Board has been tasked to establish a multidisciplinary specialist Tier 3 team in its area to provide an effective local response for people suffering from an eating disorder across the age range. In addition, teams will also provide training and supervision of practitioners within Tiers 1 and 2, shared care arrangements with primary care services, generic mental health services, obesity clinics and general hospital services as well as overseeing research, monitoring and evaluation of eating disorders services.

6.13 It is expected that the Tier 3 teams will come together as a regional network in order to share expertise and resources. These are likely to include the assessment and treatment of more complex cases, ‘gatekeeping’ for extra-contractual referrals and ongoing clinical supervision, training and professional development.

6.14 Tier 4 refers to specialist day patient and inpatient provision. Given the limited level of resources available and, in addition, that most people with an eating disorder can be successfully managed as an outpatient, the initial priority is to develop Tiers 1-3. However, once the regional network is established, it would be appropriate to examine both interim arrangements for inpatient provision elsewhere and to formally examine the need for inpatient beds within Northern Ireland over the longer term.

6.15 The Regional Eating Disorders Working Group is sensitive to the issues and difficulties that may arise in the formation of new specialist services, such as ensuring equitable provision and the recruitment, training and retention of adequate numbers of staff. The principles of good communication, interagency coordination and collaborative planning are viewed as being essential to the service development process.

Recommendations

100. The Regional Eating Disorders Working Group needs to continue its work of overseeing the strategic planning and practical implementation of eating disorders service development.

101 DHSSPS and service providers should establish Tier 3 teams.

- Tier 3 teams should define local operational policies and form a regional network enabling expertise and resources to be shared across the Province.
- Tier 3 teams should support Tiers 1 and 2 through training, supervision and shared care arrangements.

102. Strategic planning should continue for longer term needs such as Tier 4 services and the further development of specialist child and adolescent mental health services.

SERVICES FOR PEOPLE WITH ACQUIRED BRAIN INJURY OR PROGRESSIVE BRAIN DISEASE

(for background see Annex 6.2)

6.16 A four tier model as described by the Health Advisory Service[4] should be adopted to plan comprehensive service provision to meet the mental health needs of people with acquired brain injury (e.g., arising from trauma, haemorrhage, anoxia, infections, toxins including alcohol, nutritional deficiency, epilepsy) and progressive brain disease (e.g. Multiple Sclerosis, Parkinson's Disease, Huntington's Disease, early onset dementia).

6.17 **Tier 1: Primary Care Services**

Primary care services working with non-statutory organisations, families and carers are essential in addressing mental health needs, through medical treatments, education and psychosocial interventions. They should be supported through a range of services at Tier 2-4 levels.

6.18 **Tier 2: Secondary Care Services**

Mental health services play an important role in addressing the needs of people with acquired brain injury or progressive brain disease. Linkages between adolescent, adult and older adult mental health services are important to ensure smooth transitions across these services. Close collaborative working relationships between mental health and physical disability services are essential. Specialist expertise needs to be integrated within both mental health and physical health and disability services to ensure that they have the capacity to address needs.

6.19 **Tier 3: Dedicated Community Based Services**

Services dedicated to the needs of those with acquired brain injury or progressive brain disease are required at local provider levels. Such services should include the expertise to address mental health needs. Community Brain Injury Teams already provide services promoting recovery and community reintegration for those with acquired brain injury and have demonstrated their effectiveness within this area [5]. They work directly with the service users and their families and in collaboration with local statutory and independent services. Dedicated multidisciplinary services for adults with progressive brain disease should be developed to optimise service user functioning across the physical, cognitive, emotional and social aspects of their lives.

6.20 Specialist residential and supported living facilities are required to address the needs of those with acquired brain injury or progressive brain disease, who also have emotional, social behavioural or other mental health problems. *Good Practice Examples (see Annex 5.6. 1-3).* A range of individual facilities are required to meet the differing needs of those with acquired brain injury or progressive brain disease. Flexibility regarding access is required, with a focus on individual needs rather than on diagnostic category.

6.21 **Tier 4: Regional/Sub-regional Specialist Services**

Specialist services to promote mental health and well-being and neurobehavioural recovery are required. A specialist multidisciplinary mental health team with core inputs from neuropsychiatry and clinical neuropsychology/clinical psychology is required. This team would offer expertise in the assessment, diagnosis, therapeutic interventions and management of mental health needs of people with acquired brain injury and those with progressive brain disease. It should provide direct care to people with complex mental health problems, together with a consultation/liaison role to a range of medical specialities (e.g. neurology, rehabilitation medicine, general medicine, geriatrics, psychiatry and older adult psychiatry). It should also provide a consultation role to dedicated community services for people with acquired brain injury or progressive brain disease (Tier 3) and sessional input to the Regional Brain Injury Rehabilitation Unit.

6.22 A specialist inpatient facility is required for people whose behavioural difficulties are so severe that they cannot be managed within other services. This facility would offer multidisciplinary mental health assessment and treatment, aimed at reducing the behavioural problems that impede community placement. Teams generally comprise clinical neuropsychology, neuropsychiatry, specialist occupational therapy, physiotherapy, speech and language therapy, social work and RMN trained nursing staff.
Good Practice Examples (see Annex 5.6.4).

Recommendations

103. Planning and Development. Services should be developed to address the psychological and mental health needs of people with acquired brain injury or progressive brain disease, their carers and families. Partnerships are required across statutory and independent sectors. Service planning must involve clinical leaders, users and carers. Local information on needs must inform planning and development of services:

- Local primary care and secondary care physical disability and mental health services should be strengthened.
- Priority should be given to the ongoing development of community brain injury teams throughout Northern Ireland.
- Service planning for those with progressive brain disease must address the cognitive, emotional, social, behavioural and mental health needs of this group. An emphasis should be placed on multidisciplinary team working within community based services for people with progressive brain disease.
- Development of day care, respite, residential and supported living options are required for those who present with cognitive, emotional, social, behavioural and other mental health problems associated with acquired brain injury and progressive brain disease.

- A specialist regional mental health team is required to offer expertise in the assessment, diagnosis, treatment and management of mental health problems in acquired brain injury and progressive brain disease.
- Maine Neurobehavioural Unit should be enabled to develop fully as a regional specialist service. This might provide services on an all-Ireland basis.
- The development of care pathways is required to develop links and networks between different services and service components for both brain injury and brain disease.

104. Partnerships. Partnership between statutory and independent sectors and within statutory sector organisations (health, housing, education, employment and training) should be pursued, to ensure a comprehensive range of service provision.

105. Workforce. A workforce strategy is required to ensure that there are sufficient numbers of appropriately qualified staff, across the range of disciplines, required to enable service developments to address the mental health needs of both acquired brain injury and progressive brain disease.
    - Attention to skill mix and the development of new job roles in required.
    - Attention to the training and ongoing development needs of specialist staff is required.
    - Specialist services should provide training and support to local community services and to care staff working in acute hospital, residential and day care settings.

SERVICES FOR DEAF PEOPLE WITH MENTAL HEALTH NEEDS (for background see Annex 6.3)

Specialist Mental Health Services for Deaf People

6.23 With the introduction of the Disability Discrimination Act (1995) and the modernisation of mental health services, particularly the development in community based provision, there is an opportunity to address issues of equality of access, and the needs of minority and excluded groups. The Department of Health consultation document “Sign of the Times”[6] outlines proposals for future developments for deaf mental health services. There should be a tiered approach to the provision of mental health services for deaf people[7].

6.24 Outreach Clinics in Northern Ireland from the Birmingham and Solihull specialist service have provided assessment and treatment, and patients have been admitted to their beds. Teaching, liaison and joint working have established a basis for further local service development. The recent appointment of a part time specialist consultant psychiatrist in Northern Ireland and a full time community psychiatric nurse, and the planned appointments of other team members, create an opportunity to offer locally based clinics and community services. The planning of future services will include consultation and involvement of service users and carers.

6.25 **Primary Care Services.**

Patient access to primary care should be improved to comply with the implementation of the Disability Discrimination Act. Deaf awareness training, technology such as loops and text phones, and access to interpreters should facilitate assessment and referral by GPs. At present social workers for deaf people initiate many psychiatric referrals. These need to be channelled through GPs, as for hearing people, but with joint working, as required.
Good Practice Example (see Annex 5.6.5)

6.26 **Hospital Inpatient Facilities.**

Hospital inpatient facilities are required for a small number of clients with more acute mental health problems[8]. Consideration should be given to developing such a facility on an all-Ireland basis[9].

6.27 **Deafened and Partially Hearing People.**

Specialist deaf services should have a low threshold for assessments, including for deafened or partially hearing people, in any circumstance where a mental health problem is suspected, and the person's deafness is significant to him or her. Mental health input to rehabilitation programmes for deafened people is essential to address the additional stresses due to anxiety and depression which frequently occur.
Good Practice Examples (see Annex 5.6.6)

6.28 **Training.**

There is clearly a need for training of mental health workers in the psychological, sociological and psychiatric aspects of deafness[10] and the training of staff as mental health professionals.
Good Practice Examples (see Annex 5.6.7)

Recommendations

106. There should be a tiered approach to the provision of mental health services for deaf people. A regional plan for services should be developed with service user and carer involvement and should include audit, research, teaching and health promotion. There should be effective interfaces and liaison between primary care, social services, voluntary organisations and the deaf community. Protocols for effective joint working between local Community Mental Health Teams and services and the specialist mental health service for deaf people should be developed.

107. Long-term plans should be developed for the local establishment of inpatient facilities, possibly on an all-island basis.

108. The deaf service user must be given full information about his or her rights and referred as soon as possible to specialist services, if they are required.

109. For deaf people being assessed for inpatient admission, protocols must be developed for the use of interpreters and other relevant professionals, such as Social Workers with deaf people, in addition to the Approved Social Worker. During an admission period, appropriate and accessible communication support must be provided within a maximum of 24 hours. All service users should be enabled to give fully informed consent for their treatment, or to appeal against it.

110. Primary care teams should be provided with appropriate information about mental health & deafness services to enable them to refer service users for specialist assessment.

111. Deaf Awareness training, appropriate technology and access to communication support, especially interpreters, are essential for those working with the Deaf Community.

112. Staff in Community Mental Health Teams and services must be provided with knowledge and skills to enable them to work, if necessary through interpreters, with deaf people, including staff in day services and out-of-hours services.

113. Specialist mental health services for deaf people must:

- develop a multidisciplinary team which should include deaf professionals;
- provide assessment and treatment for service users at clinics in all the Health and Social Services Boards and in the community;
- work jointly with primary care, local mental health teams and other specialist mental health services, including with learning disability, older adult forensic and psychological therapy services;
- carry out preventative work including provision for deaf children, adolescents and their families, rehabilitation programmes for people with acquired deafness.

114. Specialist mental health services for deaf people should work with other agencies including education, social services, the independent sector, deaf community organisations, employment and housing.

SERVICES FOR PEOPLE WITH PSYCHOLOGICAL TRAUMA (for background see Annex 6.4)

6.29 **Policy and Philosophy**. Northern Ireland (CREST) guidance on the management of Post Traumatic Stress Disorder (PTSD) in adults was issued in 2003.[11] This followed the guidance issued by the International Society for Traumatic Stress Studies[12] (2000) and the Department of Health,[13] which, on the basis of available research evidence, pointed to the treatments of choice for (inter alia) PTSD. In 2004, The National Institute for Clinical Excellence (NICE – England & Wales) issued draft guidance on the treatment of PTSD in both adults and children (with a final version of this guidance expected in 2005). The CREST guidance is a key element in the development of an evidence-based approach to the understanding, recognition, treatment of PTSD and related conditions. It forms a key building block in the development of a response to this area of need and should form the basis for the development of policy, services and training.

6.30 Key to the recognition, assessment and treatment of people suffering from PTSD, and related conditions, is the level of awareness amongst professionals and organisations that represent first points of contact. Beyond detection of psychological trauma lies the important task of evidence-based assessments, which examine in detail the specific impact on each individual who is referred, including associated needs, risks and complicating factors.

6.31 The development to date of services has been piecemeal and patchy, and lacks both a managerial and professional coherence. The development of the CREST guidance represents a significant building block in addressing these shortcomings. The establishment of a managed service network, identifying the contributions of all providers of services would enable significant progress to be made. Service pathways and menus should include the contributions of clinicians who have been treating trauma, mainstream mental health services, voluntary and community organisations supporting those affected by trauma-related disorders, Trauma Advisory Panels and specialist trauma services.

6.32 Given the developing understanding of needs arising from exposure to traumatic experiences and the implications for functioning and health, the developing knowledge and skills base in recognition, assessment and treatment, and the emergence of clear guidance on treatment etc. there is a strategic opportunity for progress in this area.

6.33 **Identification, Referral and Treatment.** Whilst research demonstrates that those who have mental ill-health are at higher risk of developing post trauma-related conditions, other considerations are important in terms of identifying and providing treatment for trauma-related needs. Clinical experience demonstrates that many people who have had no significant mental health ill-health prior to the trauma have acquired a post trauma condition. Further, it is well established that avoidance of any reminders of the traumatic experience (including the prospect of seeking treatment) is a key component of trauma-related conditions. These features (and the additional sensitivities required by the context of the Troubles) point to the need for specific response to needs and potential needs. Particular groups of those affected by violence, whose ability to access services is adversely affected by the context of the Troubles and who have multiple psychological, mental health and social needs, would benefit from a multi-agency and multi-professional approach.

6.34 **Training.** Treatment services should employ appropriately trained staff, preferably drawn from a range of professional backgrounds to provide added value and perspective to the assessment and treatment of people with trauma. Further, staffing levels, experience and skill mix must be geared to the provision of effective care at each level in the service tiers. Clarity about what a service can (and cannot) offer should inform recruitment and training strategies. Appropriate training in evidence-based practice (appropriate to each level) is required for staff involved in identifying, assessing, treating and supporting people with trauma-related needs.

6.35 Viewed from a potential service user perspective, the response of the health and social care services (statutory and independent) should reflect the following characteristics:

- clear and non-bureaucratic points of access to information and services;
- proactive awareness of and sensitivity to potential trauma-related needs by key first-point-of-contact professionals and organisations;
- effective first line responses offering reassurance, clear information, initial care, and onward referral;
- active response and follow up to reduce the potential for drop-out associated with avoidance;
- individualised care to reflect the highly individualistic presentations of trauma-related needs, and the personal associated circumstances (e.g. other illnesses, financial hardships, disability etc.) and any co-morbid mental ill-health needs;
- access to a range of evidence-based therapeutic resources;
- services should place a clear emphasis on creating a safe and confidential treatment environment; and
- services should have in place key links and arrangements to respond to urgent and other needs that cannot be met within the specific service.

Recommendations

115. The development and expansion of evidence-based services, including CREST guidelines, to address psychological trauma and including adult survivors of childhood trauma should be taken forward as a priority. The expertise developed in the non-statutory sector should inform the development of the overall trauma network.

116. To facilitate progress, a coherent tiered strategy should be developed, based on a managed service network:

– service planning must involve clinical leaders, users and carers and clinical managers;

– an audit of what is currently available (i.e. resources and skills), tested against the CREST guidance (2003), should be undertaken;

- future service configurations should build upon the experience and expertise that has been developed in both the statutory and non-statutory sectors;
- standards should be developed to support the development of and access to services.

117. Primary care staff (and other front line services), in line with CREST guidance, should be provided with the necessary guidance, training and support in the detection, preliminary intervention and appropriate referral of people with trauma-related needs.

118. A workforce plan, which addresses staff levels and qualifications, training and re-training, should be developed.
    - Training. Pre-professional training for health and social care professions should include appropriate content on the conceptualisation, recognition and treatment (including referral) of psychological trauma.
    - Advanced training for the treatment of PTSD (and related conditions) should follow current evidence-based guidance on the management and treatment of psychological trauma.

119. Health promotion programmes to address the specific needs of those affected by traumatic events should be developed in line with evidence-based practices and principles.

120. Organisations which employ people who, in the course of their work, may be exposed from time to time to traumatic experiences should put in place measures relevant to the nature of the work and risks.

SERVICES FOR PEOPLE WITH PERSONALITY DISORDERS (for background see Annex 6.5)

6.36 In line with guidance in other parts of the UK, people with a personality disorder who experience significant distress or mental illness as part of their disorder and the mentally ill who suffer from co morbid personality disorders are part of the business of mental health services.[13] The needs of Personality Disordered Offenders within the criminal justice system are considered separately by the Forensic Services Expert Working Committee. Services for people with

Personality Disorders should be accessible and bring discrete components of care together including psychotherapy, medication, housing, social care.

The National Institute for Mental Health in England has proposed a generic service model.[14] The model is a 'hub and spoke' specialist service supported by local initiatives it is a tiered structure, as in the prototype being developed in the Thames Valley Personality Disorder Initiative.

6.37 **Tier 1.** At community and primary care early detection is important. Interventions include psychoeducation, guided self-help and basic psychological interventions. The voluntary agencies have an important role in providing information, support, advocacy and an avenue through which families and carers can contribute. User-experts should be supported in the provision of support and education, eg to housing officials, schools, those involved in social care provision.

6.38 **Tier 2.** Mental Health Services may be necessary if other significant mental disorders co-exist and when needs cannot be met at Tier 1. A number of service models have been developed ranging from the sole-practitioner model, through divided function model to liaison-consultation. Essentially, the service user is supported through a CMHT either by a dedicated practitioner, with the support of other team members or within the team, supported by an expert in this field. A fully integrated service would provide therapeutic interventions at all levels, with one point of entry for expert assessment, clear referral criteria and explicit indicators for treatment in different components of the service.

6.39 **Tiers 3 & 4.** A Specialist Team to provide Community/Outpatient/Day Hospital and Therapeutic Community Services. Clinical outcome and economic studies support this development. The main roles of this service include assessment and therapeutic interventions for people with more severe and complex needs. Interventions include structured specialised therapies, medication, social and housing management. Specialist services must also provide teaching, training and supervision for Tier 1 & 2 services, lead in audit and research, and oversee the function and development of the overall service.

Recommendations

121. Specialist services for people with personality disorder must be established to augment secondary care services. Service planning must involve clinical and service leaders, users and carers and the independent sector.

   - Service requirements should be the subject of needs assessment.
   - Residential and day treatment services for people with personality disorders should be established in Northern Ireland.
   - Specialist multidisciplinary teams should be established to provide assessment, education and support to other services who may come into contact with people with personality disorders.

122. Specialist services for people with personality disorder should co-ordinate with other mental health services such as forensic services, substance misuse and with learning disability services.

123. Training. Specialist services must provide education and support for staff in the diagnosis and management of people with personality disorders. In primary and secondary care, awareness training of the needs of those with personality disorders should be provided for such services as primary care, A&E, perinatal services, medical and surgical staff.

124. User and Carer initiatives to support service users and carers of those with personality disorders should be facilitated.

SERVICES FOR PEOPLE WITH ASPERGER'S SYNDROME OR HIGH FUNCTIONING AUTISM (AS/HFA)

(for background see Annex 6.6)

6.40 The following requirements have been identified consistently in research audits for people with Asperger's Syndrome or High Functioning Autism (AS/HFA):

- training and awareness programme to increase professional understanding across a wide range of community services including social, housing, school, continued education, health and employment services;

- clear support pathway so families know who they can contact to request assessment regarding possible diagnosis;
- an improvement in employment opportunities, support and training;
- interventions to reduce social isolation and clinical mental health difficulties;
- interventions to develop independent living skills, relationships and personal development;
- better post-diagnostic emotional support, information and advice for people with AS/HFA and their families;
- a range of appropriate supported and independent housing options;
- better social and academic support and learning opportunities within secondary schools during transition and continued education;
- carers' needs to be assessed and met, including education/information, advice, counselling (including genetic counselling, if appropriate) and 'respite' type services, such as befriending for their sons and daughters;
- more appropriate service provision. Many adults are placed in services that are not suitable for AS/HFA, due to poor provision or misdiagnosis;
- access to advocacy services, for families and people with AS/HFA;
- sensitive crisis intervention (not necessarily mental health inpatient);
- forensic services (to support the minority of people who display behaviour likely to put themselves or others at risk of harm).

6.41 A tiered service including the service needs of people with AS/HFA is recommended. The initial priority is the formation of a core team (Tier 3) in each Board area, with the necessary expertise to provide training and support for local providers. Based on current evidence, such a team should include professional input from clinical psychology, occupational therapy, psychiatry, family support co-ordinators and intervention therapists to assess and support housing and employment. Services for people with AS/HFA must be identified at local provider level (Tiers 1 and 2) in response to local assessment of need and with the support of Tier 3 services. Adequate information systems must be developed to assess need and inform service planning.

6.42 **Assessment and Diagnosis.** In considering the needs of people with AS/HFA, the following points are highlighted:

- complex cases require highly specialist diagnostic assessment. Professional background is largely irrelevant, whereas expertise in autism and knowledge of current diagnostic classification systems is of paramount importance;

- co-morbidity of AS/HFA with mental illness, indicates strongly a need to have the combined knowledge of professionals experienced in each (few possess expertise in both mental illness and autism at the present time);
- co-working between programmes of care within Health & Social Services will be necessary for the foreseeable future, until mental health professionals acquire the requisite additional skills in diagnostic evaluation.

Therapeutic Interventions.

6.43 A range of interventions are required:

- Management of psychological problems will require consideration of the social environment ie support needed to access employment opportunities and housing options, interventions to reduce social isolation, develop independent living skills and relationships, and to foster personal development;
- Drug treatment may be indicated if there is a clearly identified co-morbid mental disorder, but is never an effective long-term solution for behavioural problems;[15]
- Autism and Autistic Spectrum Disorders (ASD) are accepted as being neuro-developmental in origin. The resultant impairments of people with AS/HFA mean that psychodynamic therapy and reflective counselling are not appropriate. Use of these approaches in the past has been reported to cause unnecessary confusion and distress for the individuals and their families.[16,17,18] Any therapy that attempts to 'treat' the core symptoms of AS/HFA as an emotional issue will be counter-productive, as will therapists and counsellors who do not understand the psychological theories of autism;[26]
- Cognitive Behavioural, Behavioural, and Personal Construct Therapy by a skilled practitioner who can adjust intervention to the deficits of ASD, are regarded now as the most beneficial; [19,20]
- Research on the inner experience of people with autism and AS/HFA also supports the use of visual strategies as appropriate and effective adaptations to such therapies for these individuals; [21,22]
- In addition, it is beneficial to help adults with AS/HFA understand the expectations and perceptions of others, to develop social skills, to understand personal needs and develop concrete strategies for meeting those needs, and to manage their anxiety.[22]

6.44 It is essential to provide support for the individual and their family in understanding the disability and adjusting to confirmation of a diagnosis – usually after many years of uncertainty and self-blame. Many cases have reached crisis point for both the referred person and those who are struggling in their efforts to live with, and help them.

6.45 Local research indicates high levels of psychological distress and mental ill-health amongst the parents of AS/HFA adolescents and adults. It revealed that 25% of carers have a diagnosed mental health problem, with an additional 28% reporting significant symptoms of stress and anxiety. These were attributed directly, by parents, to the difficulties associated in caring for their son or daughter.[23]

6.46 Research carried out by the NAS[17] reported that 70% of carers felt that finding appropriate care facilities was the major barrier to them accessing work. This research also highlighted the responsibility of social services to urgently prioritise support for carers. Bernard et al[24] noted that parents are often the sole carers for their son or daughter with ASD, providing regular and substantial amounts of care.

6.47 It must be noted too that adults who are in long-term relationships are being identified increasingly. In such cases, their spouse or partner requires equal support to parents of those with AS/HFSA. Carers of individuals with ASD can be supported in their caring roles. Yet, when this does not happen, costs to the individual and their family are considerable.

6.48 Some people with AS/HFA will not require any statutory services. However, most diagnosed adults need understanding and support from specialist services, but currently cannot access existing health and social care because they do not 'fit' the perceived remit of mental health or learning disability services.

6.49 Without appropriate provision many adults with AS/HFA will become socially isolated, drop out of school or college, will be unable to work, will suffer mental health problems and psychological breakdown. The suicide risk for people with this condition must also be recognised.

6.50 Lack of support services for people who are experiencing difficulties can lead to police involvement, prison sentences, admission to psychiatric units and trial-and-error drug treatments.[25] These consequences could be avoided for many, or reduced greatly, by a relatively low level of ongoing support, saving severe distress and the costs of inappropriate agencies becoming involved.

6.51 The range of needs experienced by adults with AS/HFA demands a person-centred approach from agencies to provide them with the required services and support. Many will need significant and ongoing assistance to achieve maximum independence. 'There is need in some cases for specialist services, but there is a wide need for existing services to develop specialist approaches'.[26]

6.52 Housing. Only 54% of adults with ASD reported that they were satisfied with their living arrangements and only 3% with AS/HFA live fully independently.[25] More adults with a disability live in the family home than in any other setting. Many individuals with AS/HFA are vulnerable to abuse and exploitation and have a range of housing needs, from independent living to supported housing. Even independent living often requires an element of support to help people with ASD cope with day-to-day demands and unexpected situations.

6.53 Appropriate 'respite' care provision is required, from befriending to short-term breaks that would allow adults with AS/HFA, and their families, the necessary time apart to prevent the crises that can lead to ultimate breakdown.

6.54 **Employment.** National Autistic Society research [27] reported that many more people with ASD could and would be able to work if better support were available. Despite having a strong desire for employment, only 12% of adults with AS/HFA are in a paid position. A UK economic study in 2000 estimated the average additional lifetime cost of a person with AS/HFA at almost £800,00.[28] With appropriate intervention, adults with AS/HFA can be supported in employment and achieve their full potential as citizens. [29]

Recommendations

125. A needs assessment of people with AS/HFA and their families should be completed as a priority

126. The mental health programme of care should assume overall responsibility for ensuring the development of services across health and social services for all people with ASD including Asperger's Syndrome/High Functioning Autism. Service planning must involve users and carers, clinicians, relevant statutory and voluntary organisations.

127. Assessment. Multidisciplinary teams should be established for each provider area for specialist assessment services (Tier 3) with clear pathways to service access.

128. Appropriate, timely person-centered interventions should be provided based on best available evidence
   - clear referral pathways to mainstream services (Tiers 1 and 2);
   - specialist interventions by appropriately trained specialists (Tier 3)

129. Individual and family support. Emotional and practical support and resources must follow assessment in a timely fashion and is especially required at times of transition (eg leaving school). Appropriate respite services must be developed. Access to leisure and meaningful activity should be assured. Social inclusion including opportunities for further and higher education and employment should be supported. A range of supported accommodation should be developed.

130. Training. Provider units should ensure the provision of training for parents and staff. Staff training specific for the service needs for people with ASD should be assured within the workforce training strategy at regional and provider levels (Recommendations 23 & 62), including awareness training and specialist training.

131. A senior manager in each provider unit should have overall responsibility for the development and delivery of services for people with ASD.

SERVICES FOR PEOPLE WITH DISORDERS OF GENDER AND SEXUALITY

(for background see Annex 6.7).

6.55 In the past year, a strategy group has been established by the DHSSPS, with representatives from the four Board areas to examine the provision of psychosexual services and, in particular, those for transpeople. There is a general view that, as individuals with sexual dysfunctions often have comparatively less complex problems and usually require shorter periods of intervention often with simpler interventions, their needs usually should be addressed locally. This would mean that individuals with more complex cases (in particular disorders of gender and sexual preference) would be referred to the more specialist services in Belfast (and where appropriate Omagh). This would also facilitate more of a focus in the Belfast service on the needs of transpeople and individuals with disorders of sexual preference.

6.56 From a recent survey on services available for transpeople in Great Britain[30] services were often so distant from patients' homes that there was real difficulty in supervising key areas of the patients' assessment and treatment due to unfamiliarity of service staff with the local circumstances of patients.
Good Practice Example (see Annex 5.6.8)

6.57 With the introduction into the psychosexual service in the Belfast City Hospital of psychoanalytically based treatments, there is now an opportunity in Northern Ireland for the management and treatment of patients with disorders of sexual preference who would previously have been referred to very specialist centres such as the Portman Clinic in London. This element of treatment could also provide a beneficial service to patients in the new Regional Secure Unit, as there is an acknowledged higher level of disorder of sexual preference in this group and an acknowledged link between violence and perverse behaviour. However, development of this element of service (as with gender services) will depend on whether more locally based services for sexual dysfunction can be progressed.

6.58 The planning and strategic process will need to address:

- the means of establishing a more locally available treatment for sexual dysfunction and the relationship of this to central specialist services;
- the refocus of specialist services on the more complex conditions;
- a specific focus on Gender Identity Disorders, giving consideration to replicating in Northern Ireland the Scottish Needs Assessment (SNAP) Survey (2001), in order to identify fully the needs of transpeople and also inform a more co-ordinated system of services.

Recommendations

132. People with disorders of gender and sexuality in Northern Ireland should be offered the full range of services which have been shown to produce positive therapeutic outcomes. Service planning must involve clinical leaders, users and carers and clinical managers.
    - As contact with services is often long-term, the majority of provision should be local and community based, with appropriate access to regional specialist services when this is required.
    - Services should be community based and person-centred.
    - Regional services should be targeted at individuals with the most complex needs.

133. There is a need to evaluate the workforce requirements for service changes and for training.

SERVICES FOR WOMEN WITH PERINATAL HEALTH PROBLEMS

6.59 For women, childbirth is the time of greatest vulnerability for becoming severely mentally ill. About 10% of all recently delivered women have a major depressive illness. The incidence of admission to hospital for puerperal psychosis is 2 per 1000 women delivered and about 2 per 1000 women delivered in the UK are admitted to hospital suffering from non-psychotic conditions.[31,32]

6.60 The antenatal period and the contact it brings with obstetricians and other antenatal staff offers a unique opportunity to identify and screen women at risk. The risk of relapse or recurrence of psychotic mental disorder is well established and factors that increase the risk of non-psychotic postpartum mental disorder can also be identified. Close liaison between mental health professionals and members of the obstetric team is essential for addressing mental health needs of women during pregnancy and the puerperium.

6.61 Perinatal mental health problems need to be addressed with a clear regional strategy focused on the different levels of services required and ensuring that all staff involved receive adequate training and support.

6.62 Puerperal mood disorders occur across a spectrum of severity ranging from mild depressive disorders through to puerperal psychosis. The conditions in general are very responsive to treatment and, if treated early and effectively, have reasonably good prognoses. At one end of the spectrum all that may be required is simple reassurance, whereas at the other, hospital admission and specialist treatment are needed to prevent adverse outcomes. The vast majority of puerperal mood disorders can be dealt with and managed at primary care level. Staff require training and support from secondary services.

6.63 An essential part of the tiered service provision for women with perinatal mental health needs is a specialist perinatal mental health service. This service has a number of functions including assessing and managing those suffering from puerperal psychosis and other severe postnatal mental disorders. It would provide a range of facilities including community based alternatives to hospital.

6.64 In addition, specialist services can advise on and, where necessary, provide services for people with continuing mental health problems who become pregnant whilst under the care of adult mental health services. It would provide an obstetric liaison service, assessing mental health problems associated with pregnancy or the postpartum period and respond to emergencies. It would liaise with primary healthcare professionals to assist in the management of less serious mental health problems. It would provide prenatal counselling and high risk management for women at risk of developing postpartum mental disorder. It may undertake the assessment of women with complex and enduring mental health problems. It would also take a lead role in the development of services at all levels of healthcare provision, contribute to the education and training of other healthcare professionals and engage in research and innovative practice.

Recommendations

134. A regional specialist mental health service should be established for women with mental health problems occurring in the perinatal period. The requirement for inpatient mother and baby facilities should be the subject of a regional needs assessment.

135. Protocols for the management of women who are at risk of a relapse or recurrence of a serious mental disorder during the perinatal period must be in place in every provider unit with maternity services:

    – comprehensive assessment of maternal health must include mental health.

136. Women who have a past history of serious non-postpartum mental disorder, should be offered assessment by a psychiatrist in the antenatal period and a management plan instituted regarding the high risk of recurrence following delivery:

    – substance misuse services should be accessible throughout antenatal care.

CHAPTER 7

SUPPORTING CHANGE

INTRODUCTION

7.1 The Framework outlined in Chapters 3 to 6 provides a road map for major reform of mental health services for adults. It will take 10-15 years to achieve and depends on a number of underpinning elements and processes. Four key elements are considered in this section of the Review:

- Workforce requirements, including its magnitude and the necessary skills;
- Financial resource based on a sound economic appraisal;
- Information to support management of services, the Review process and to monitor change;
- Research and development.

DEVELOPING THE WORKFORCE

Introduction

7.2 The vision and principles underpinning the Strategic Framework recognise the fundamental importance of the workforce in delivering the aims and goals of the Strategic Framework. The Strategic Framework is premised on a significant increase in the workforce. The capacity to deliver the vision turns on having an adequate workforce, appropriately trained and working effectively together and in partnership with service users and their carers to achieve meaningful change in the quality and standards of care delivery throughout Northern Ireland. The demands of the workforce to see through the changes and to deliver the Strategic Framework require attention to workforce health needs including the need for support and supervision.

7.3 Northern Ireland is fortunate in having a motivated, stable and skilled workforce in most of the disciplines involved in mental health care. Our educational establishments provide quality training and education at further education, undergraduate and postgraduate levels in a wide range of the areas necessary for skilling the workforce.

7.4 Nevertheless, there are a number of challenges in the workforce situation that will need to be addressed as a matter of priority if the Strategic Framework is to achieve its objectives. These challenges include:

- difficulties in recruiting suitably qualified staff;

- the need to recruit unqualified staff and train them;
- pressures on staff to leave for better pay and conditions offered elsewhere;
- the need to develop effective strategies to retain existing staff; and
- reduction in the number of people available to volunteer.

Current Work

7.5 The anticipated need for substantial development in the workforce triggered a joint planning initiative between the Review and the Department. The work of this Group forms an essential pre-requisite to an effective workforce strategy for Adult Mental Health and includes analysis of the current workforce, mapping the skills and competencies, defining the changes required in educational arrangements to address both the demand profiles of the workforce and their skills requirements, including the training needs of non-qualified staff. The emerging findings include evidence of shortage of staff in all areas, problems in relation to career progression, considerable variability in training opportunities, the need for incentives for the retention of staff.

Proposals

7.6 The Review recommends the establishment of a Workforce Strategy for mental health adopting the recommendations emerging from the Workforce Planning Group including:

- the establishment of a Workforce Development Group;
- the establishment of a central Information and Advisory service about careers;
- collaboration with training providers and regulatory bodies to develop “Fit for Purpose” training;
- agreeing with service providers targets for recruitment and retention across Northern Ireland, across the statutory and voluntary sector; and including the participation of service users;
- addressing skill mix issues, for example the training of nurses to prescribe, using more support workers to complement the role of trained staff;
- ensuring that appraisal systems based on agreed National Occupational Standards are in place to identify staff development and training requirements;
- joint working between the health and social care sector and training sector to ensure appropriate training opportunities to required standards are available accessible;

- the development of a qualifications framework which includes a range of qualifications and an assessment strategy to encourage career progression and flexibility between professional groups; and
- joint working between DHSSPS and service providers on the improvement of organisational culture, including stress reduction and management programmes, increased flexible working and improved work/life balance.

INFORMATION

The Role of Information in Mental Health Care

7.7 Good information is at the heart of high quality mental health care and decision making. It comes in many forms:

- individual data held in personal records (eg a patient file);
- consumer and professional surveys (eg a satisfaction survey of carers);
- service performance reviews from inspection and inquiry reports (eg Mental Health Commission reports);
- governance and risk management reports (eg an estates report on environmental problems within an acute ward);
- needs assessments (eg a research study of the prevalence of psychiatric illness within a city);
- financial information (eg a monthly budget report to managers);
- aggregated activity data (eg how many admissions occurred within a specified period of time);
- service directories (eg a directory of counselling services); and
- human resource records and reports (a strategic workforce planning report).

7.8 Without these sources, clinicians, practitioners, managers, planners and commissioners would be unable to deliver the sort of care and service expected by the general public. With the advances in information technology and a growing expectation that better information will lead to better services, there is an increasing drive in modern mental health services for:

- fully integrated service user records;
- routine, anonymised data analysis at population level;
- widely accessible consumer information on problems and services;
- speedy dissemination of the evidence base; and
- continuous service improvement through improving information analysis.

7.9 Information gathering will become increasingly important for the evaluation of outcomes, performance management and for population needs, based on aggregated individual assessments. These objectives are likely to represent the future agenda for information management.

Current Issues

7.10 Increasingly, professional staff have access to a database that provides clinical or management support and it is possible, within limits, to gather and analyse information about diagnostic related groups, service activity and unmet need at population level. In addition, the use of geo-mapping (linking postcodes to service activity) is enabling more sophisticated needs assessment analyses. However, there are deficits within the current mental health services within Northern Ireland:

- information systems, particularly in secondary care, vary considerably in design and application and are under-developed in some locations;
- information collection and analysis is not clinically driven and may reflect a HPSS market culture;
- staff skills in using currently available information are under-developed;
- record integration and communication within health and social care across boundaries and beyond is highly variable; and
- information currently gathered at a regional level may no longer be fit for purpose.

7.11 These problems are having an adverse impact on the quality of care. No rationalisation of information demands has occurred for more than 20 years and staff feel increasingly disenfranchised in relation to the ownership of information. They perceive a potential disconnection between data analysis and policy and practice. Some information returns are simply not utilised but continue to be collected. There is a growing desire among professional staff delivering care for a greater focus on information gathering that:

- reflects the complexity of health and social care tasks they are engaged in rather than the volume;
- supports staff in the provision of care;
- forms needs assessment and research; and
- informs the evidence base for improvements in care.

Towards a Vision for Information

7.12 Professional staff and service managers require a vision for information and information management that enables them to see the relevance of data gathering and that will support them in their daily work.

7.13 It is proposed that this vision is developed through the production of a comprehensive Regional Information Strategy for Mental Health, with an implementation plan. This strategy must address the following issues:

- outdated data items and methods of collection and terminating their use;
- a minimum data information set, its relevance to clinicians and practitioners and the new framework for data collection;
- the use of the Person Centred Information System (PCIS) to provide the optimum clinical and management information;
- a programme of training that maximises the use of information; and
- information for service users and carers.

7.14 Such a strategy would provide the link between outcome measurement and data collection. It would also give a focus to performance management by clearly identifying critical targets, the timescales for their achievement and the information required to enable decision making on achievement.

7.15 As a first step, it is proposed that the DHSSPS develops a comprehensive understanding of the profile of adult mental health services in Northern Ireland by mapping service provision. This would enable future investment to be targeted towards gaps in the provision of those services identified as critical to achieving the vision of a modernised and properly resourced service. To enable this to happen, service providers must identify a local information provider (LIP) to work with DHSSPS in establishing an accurate and up-to-date information base.

RESEARCH AND DEVELOPMENT

Background

7.16 While the work of the Review has been founded on the best current research evidence on clinical and service effectiveness, there are many gaps in our knowledge base at the present time. High quality research and information is needed on mental health, and mental ill-health and their determinants, effectiveness of interventions and on closing the gap between research information and service implementation of new research evidence.

Local Research and Development

7.17 Within Northern Ireland there have been several recent research investigations into aspects of mental health. However, in the absence of any clear centrally-led strategy for mental health and learning disability there has been no clear vision of research and development needs and no co-ordination of existing research effort. There are notable deficiencies in the range, quality and reliability of information on mental ill-health and service needs for Northern Ireland as a whole. The lack of detailed prevalence information on mental health and learning disability is a particular problem at the beginning of a new strategy for service reform.

7.18 Nevertheless, the time is right for the establishment of a coherent research and development strategy for mental health in Northern Ireland. The Review as a whole covering policy, services, legislation; and including the entire range of service users and carers, provides a strong signal for a Research & Development Strategy to underpin the work of the Review and its implementation. In addition, there have been recent initiatives within Ireland and the UK which provide new opportunities for collaboration and networking for research and development work and for the sharing of new information and new knowledge.

7.19 The National Disability Authority in Ireland has established a Research Advisory Committee to advise on matters pertaining to disability research. It has recently recommended a National Strategy for Mental Health Research to ensure that research in this area is prioritised, commissioned and managed in a collaborative, strategic manner with the participation of the complete range of stakeholders, including service users.

7.20 A Mental Health Research Network has recently been established for England and Wales with a commitment to collaboration across the UK. The development of effective research networks across the UK and Ireland provides timely opportunities not only for research collaboration, support and information sharing but also for the development and delivery of large scale trials and studies necessary to address many of the questions relating to clinical service effectiveness in mental health and learning disability.

A NORTHERN IRELAND RESEARCH AND DEVELOPMENT (R&D) STRATEGY

7.21 The Review recommends the establishment of a broad based R&D Strategy to underpin the Review as a whole and its implementation. The aims of the Strategy are threefold:

- To deliver high quality research and provide quality research information on mental health and learning disability, prioritising areas of greatest need and areas of highest information deficiency. Research information is required on a range of issues including mental health morbidity, the needs of users and carers, effectiveness of current and emerging interventions at both the individual and service levels;
- Closing the gap between research knowledge and service uptake. Research and development initiatives are required to close the existing gap between established research knowledge and service uptake of such knowledge. New initiatives are required to translate research knowledge into health and social care practice at both the individual and service levels and so to contribute to the quality and effectiveness of services and better outcomes for individuals, for carers and families;
- The establishment and contribution to UK and Ireland research networks in mental health and learning disability. This is essential to strengthen the research base, share knowledge, and provide support for the health and social care research community in mental health and learning disability.

7.22 One of the first steps in the development of an R&D Strategy is the establishment of a small Strategy Group with input from both the service side, including user and carer representation, and the academic community. An early requirement of this Group will be to set priorities for research and development. The principal initial funding support for health and social care research is the DHSSPS R&D Office. A first step is the submission of an outline R&D Strategy. This should be followed by a detailed strategy with prioritised project proposals including commissioned research to support new mental health policies and investigator led research. An important aspect of a new Research Strategy will be enhancement of the research capacity in mental health through education and training for young researchers.

7.23 Within Adult Mental Health a number of research priorities are likely to include:

- Specific interventions:
  - detailed information on mental health morbidity and need;

  - outcomes research, including the effectiveness and cost effectiveness under usual service conditions of psychological therapies and psychosocial interventions;
  - service user satisfaction with specific services, including service interventions; and
  - the development of agreed outcome measures.
- Service delivery and organisation:
  - variations in the use of individual services and their impact on service user outcomes including satisfaction;
  - evaluation of organisational changes;
  - investigations into staff morale, retention and performance and their impact on service effectiveness; and
  - assessing the barriers to the implementation of research evidence.
- Service user involvement
  - evaluating service users' views on services and how services can best meet their needs.

7.24 The development aspect of R&D should focus on the barriers to implementation of research knowledge. New roles are likely to be required to support the implementation of research conclusions as part of service improvement at local level.

RESOURCING THE CHANGES

7.25 The programme of change that is required for adult mental health services in Northern Ireland represents major challenges at both regional and local levels. The proposals have major implications for future Health and Personal Social Services Mental Health revenue and capital investment programmes and for future estate requirements. With anticipated reorganisation and reconfiguration local providers must ensure that resources follow service users.

7.26 These changes cannot occur without protected investment from Government to drive local service development. The need for additional investment is justified on a number of well recognised factors:

- socio-economic deprivation in Northern Ireland is significantly higher than in Great Britain;
- the rurality of our population distribution is contributing to higher costs;

- the health of our population is generally poorer compared to Great Britain;
- the link between deprivation and health and social care need is particularly strong in the mental health programme of care;
- the aftermath of the troubles is still being experienced, for example, in terms of mental health problems and needs and this is likely to continue for many years;
- investment levels in mental health services has not kept pace with other areas of the UK and there are significant gaps in service provision; and
- as a result of a general failure to replace or redevelop aging estate and to address a growing backlog across Northern Ireland, a significant capital investment in mental health services is required.

7.27 This situation has arisen in the context of relatively low HPSS management and administrative costs compared with Great Britain. Although hospital productivity has doubled over the last ten years, the model of care in Northern Ireland is accepted to be too reliant on inpatient care. New funding needs to be matched by rigorous performance management at all levels to ensure the introduction of the essential new services and to secure a modern service, fit for the needs of our population in the early part of the 21st century.

7.28 The Review recommends the establishment of a Mental Health Modernisation Programme, essentially a financial plan that brings together the service recommendations of the Strategic Framework and matches them with both the necessary funding streams and the performance milestones that will guide local investment (See Chapter 8).

7.29 The service elements that will require investment include:

- User and Carer involvement and support;
- Advocacy services;
- Independent sector services;
- Mental health promotion;
- Primary care mental health services including Early Intervention;
- Community mental health services including CMHTs, HTTs, ACTs, Crisis Response teams;
- General Hospital Psychiatric Liaison services including A&E services; Perinatal services;
- Crisis services including day hospital care;

- Services promoting recovery including the needs of service users with Challenging Behaviour;
- Dual Diagnosis services;
- Community accommodation;
- Homelessness support;
- Day care including prevocational training and employment;
- Prescribed drugs;
- Psychological Therapy services;
- Specialist services including services for people with eating disorders, people with acquired brain injury or progressive brain disease, personality disorders, psychological trauma, disorders of gender and sexuality, women with perinatal mental health problems, people with AS/HFA and deaf people with mental health needs; and
- Workforce training needs.

7.30 Detailed comparitor work has been undertaken with regional and local adult mental health services in England. Comprehensive and detailed costings have been prepared to advise the DHSSPS of the resource costs necessary to achieve the Strategic Framework.

CHAPTER 8

IMPLEMENTING THE STRATEGIC FRAMEWORK

INTRODUCTION

8.1 This Strategic Framework, incorporating the 10 Standards for service development outlined in Chapter 1, together with the detailed evidence-based recommendations in Chapters 3-6 provides a comprehensive blueprint for realising the new vision for Adult Mental Health Services. In Chapter 7 consideration has been given to the infrastructure requirements of the Service Framework. Consideration must also be given to the processes by which the new Strategic Framework for Adult Mental Health can be realised. Three processes are considered fundamental to successful implementation:

- regional support for change;
- local implementation; and
- performance assessment.

Regional Support for Local Implementation

8.2 The Department of Health, Social Services and Public Safety (the Department) has been generative in establishing the independent Review, responsible for the crafting of this Strategic Framework for Adult Mental Health. The Department has also worked in close partnership with the Review to define and clarify the infrastructure issues on which the Service Framework depends, including workforce, information and costings.

8.3 The Department will play a key role in:

- delivering workforce and information strategies. These strategies are fundamental to the success of the Strategic Framework (see Chapter 7);
- overseeing the roll-out of the Strategic Framework to agreed standards and timescales
- securing funding for resources.

8.4 Implementation should be directed by an Implementation Team which should include user and carer input. Within Health and Personal Social Services organisations, the new Duty of Quality will drive the quality agenda, underpinned by Health & Social Care Governance. The Department must ensure engagement of other Government Departments so that those elements of the Strategic Framework outwith health and social care are delivered both successfully and on time.

8.5 The success of the Strategic Framework depends on many stakeholder groups, the support of Government and the wider public. The Implementation Team with the support of the Department have an important role in facilitating the processes necessary for engagement and communication with all stakeholder groups and for the broad agenda of change management.

Local Providers

8.6 Local providers will ultimately be responsible for ensuring the implementation of the Strategic Framework and must translate it into local delivery plans. This, in turn, requires local partnerships with all relevant statutory and independent providers and a shared vision. Successfully harnessing the energies and resources of the independent sector and of users and carers will be pivotal in realising the vision.

8.7 The Strategic Framework brings a new opportunity for change, with a clear statement of what has to be done and firm performance management. It provides a sound evidence base for action together with examples of good practice.

8.8 Translating the Strategic Framework into effective local implementation arrangements will present significant challenges for professional staff, management and local service leaders. It envisages a broad-based and complex reform of mental health services. It is also occurring in the context of anticipated substantial reorganisation and re-configuration of health and social services and local administration. A major challenge is the change in culture necessary to deliver this Strategic Framework, a culture of partnership, collaboration and empowerment.

8.9 Keeping the perceptions and needs of service users and carers at the centre of our vision will be most important throughout the change process. The involvement of service users and carers can greatly assist the realisation of a new vision and a new culture at local level. Barriers to change must be recognised, identified and overcome. The current interest, commitment and skill of professional staff, service managers and service leaders provide a sound foundation on which to build the local implementation of the Strategic Framework. There is much to be gained by collaborative learning and working across provider groups, sharing examples of good practice, exploring

opportunities for complementary contributions to, in particular, more specialist services, and working opportunities for joint initiatives in staff training.
Good Practice Example (Annex 5.8.1)

8.10 The Strategic Framework provides a unique opportunity to consider the use of learning networks, "communities of practice", self assessment and peer review as models of organisational change and development. Self-assessment combined with external validation by peer teams provide valuable learning opportunities and facilitate multidisciplinary professional development.[182]

ENSURING PROGRESS – PERFORMANCE ASSESSMENT

8.11 The Strategic Framework represents an ambitious agenda for change within adult mental health services, aimed at driving up quality across all aspects of services. In Chapter 1, 10 Standards for service development were identified. Each Standard provides a central pillar of the Strategy around which succinct areas of service development and improvement must be built (see Recommendations). To ensure progress in each of the 10 areas a set of 54 Performance Indicators have been specified and against which progress on implementation can be measured. Performance Indicators can measure:

- inputs to the Strategic Framework, such as the allocation of specific resources;
- processes, such as the establishment of new service elements for improvements within existing services; and
- outcomes, including users' and carers' experience of service, health outcomes, improvements in social functioning.

8.12 Outcomes, including user and carer experience of services, are the ultimate test of service effectiveness. An important objective of the Strategic Framework is the development and implementation of suitable outcome measures of known provenance. Nevertheless, specific service processes, which have an evidence based relationship with outcomes, provide important measures of service quality and effectiveness. Performance indicators, based on process measures, eg the establishment of Crisis Response services, provide a basis for monitoring and evaluating progress on implementation of the Strategic Framework. A set of performance indicators for each Standard are presented in the following Table. The strategic vision, standards and framework within this review of adult mental health, underpinned by a clear implementation plan, together provide a coherent basis for the necessary reform and modernisation of services.

Standard 1. Services to be Person-Centred

Performance Indicators	Targets	Milestones	Lead Responsibility	Information and Sources
Providers adopt a planned approach to the whole system of service provision	Whole system strategic plans	Year 1	Local Mental Health Service provider (MHS)	Submission of strategic plans by providers to Commissioners and Department
Service users and carers must be involved in mental health service planning, development and delivery Deliver monitoring	Representative user and carer involvement in planning and development y, Monitoring and Evaluation Comprehensive infrastructure to support users & carers	Year 1 Year 2 Year 2	Local MHS provider	Local Information Provider (LIP) confirmation
Service vision, plans and strategy must be needs-driven.	Local assessment of need	Year 1	Local MHS provider	LIP confirmation

Standard 2. Effective Community and Primary Care Services

Performance Indicators	Targets	Milestones	Lead Responsibility	Information and Sources
Primary care mental health services must have service users and carers involved in development, delivery and monitoring of services	Service user and carer participation on Local Primary Care Groups	Year 2	Local Primary Care Group (LPCG)	LPCG confirmation
Primary care team access to a named mental health professional	Named mental health professional	Year 1	Local MHS provider	LPCG confirmation
Screening Perinatal arrangements for perinatal mental health	screening	Year 2	LPCG	LPCG confirmation
Multidisciplinary protocols for medication for management for depression	Agreed protocols depression	Year 2	LPCG	LPCG confirmation
Access to high standards of psychological support and therapies	Therapists have assured levels of qualification and supervision Agreed access to psychological therapies. – 50% – 100%	Year 5 Year 7 Year 12	LPCG LPCG and local MHS provider	LPCG confirmation LPCG confirmation

Standard 3. Effective Community Mental Health Services

Performance Indicators	Targets	Milestones	Lead Responsibility	Information and Sources
CMHTs must be adequately staffed with a range of health and social care professionals	30 care staff per 100,000 adult population	Year 3	Local Mental Health Service providers	LIP confirmation
	50 care staff per 100,000 adult population	Year 7		
People with complex and enduring mental illness offered yearly assessment by CMHT	Annual assessment completed for 80% of service users	Year 3	Local MHS provider	LIP confirmation
	Annual assessment completed in 90% of service users	Year 5		LIP confirmation
Provision of services for people with dual diagnosis	Needs assessment completed	Year 3	Local MHS provider	LIP confirmation
	Strategy for people with dual diagnosis	Year 5		
Mental health services for people in acute hospital settings including A&E	Liaison service needs defined by each acute hospital	Year 2	Acute services providers	LIP confirmation
	Agreed services established	Year 5	Acute service providers	
Meeting the physical health needs of people with complex and enduring needs	Locally agreed protocols	Year 2	Local MHS provider and LPCG	LIP confirmation

Standard 3. *Continued*

Performance Indicators	**Targets**	**Milestones**	**Lead Responsibility**	**Information and Sources**
Effective Tier 2 services for people with eating disorders, acquired brain injury or progressive brain disease, deaf people with mental health needs, mental health needs arising from psychological trauma, personality disorders, people with Asperger's Syndrome or high functioning autism, disorders of gender and sexuality, for women at risk of mental disorder including relapse or recurrence of serious mental disorder in the perinatal period	Locally agreed protocols	Year 5	Local MHS provider	LIP confirmation

Standard 4. Effective Crisis Services

Performance Indicators	Targets	Milestones	Lead Responsibility	Information and Sources
Evidence-based Home Treatment Services 50% established for each Provider's catchment area	HT services established for of catchment area	Year 1	Local MHS provider	LIP confirmation
	HT services established for 100% of catchment area	Year 3		
Day hospital, step-up and step-down ser residential established services established within each provider area	Day hospital or step-up vices	Year 3	Local MHS provider	LIP confirmation
	Day hospital and step-up services established	Year 8		
Inpatient Services	Review of Inpatient provider Services	Year 1	Local MHS and DHSSPS	LIP confirmation
	Business Case for Acute Inpatient and for Challenging Behaviour Services prepared	Year 2	Local MHS provider	
	Agreed inpatient provider facilities established	Year 10	Local MHS	LIP confirmation

Standard 5. Promoting Recovery

Performance Indicators	**Targets**	**Milestones**	**Lead Responsibility**	**Information and Sources**
The needs of those with complex and enduring mental health needs should be clearly defined for each Provider catchment area	Needs assessment completed for SMI	Year 1	Local MHS provider	LIP confirmation
Community services for promoting recovery established by each MH service provider	Community recovery services	Year 3	Local MHS provider	LIP confirmation
Assertive Community Treatment teams established for service users with highest level of disability and vulnerability	ACTs established – coverage 50% – coverage 100%	Year 3 Year 4	Local MHS provider	LIP confirmation
In addition to meeting the equality obligations under Section 75 of the Northern Ireland Act 1998, service users' specific communication, cultural, spiritual and religious needs recognised and acknowledged	Culture sensitive information and communication provision Information accessible to people with a learning disability	Year 2 Year 2	Local MHS provider	LIP confirmation
Comprehensive advocacy services	Accessible independent advocacy services	Year 2	Local MHS provider	LIP confirmation

Standard 5. *Continued*

Performance Indicators	**Targets**	**Milestones**	**Lead Responsibility**	**Information and Sources**
Separate age - appropriate services for younger people with a first episode of psychosis	First episode services – coverage 50% – coverage 100%	Year 3 Year 5	Local MHS provider	LIP confirmation
Services for people with mild learning disability	Local assessment of need Local service agreement in place	Year 1 Year 2	Local MHS provider	LIP confirmation
Local arrangements for people growing older with enduring or relapsing mental illness	Local needs assessment Local service agreements in place	Year 1 Year 2	Local MHS provider	LIP confirmation
Services for people with challenging behaviour	Needs assessment completed Low secure provision strategy agreed In-patient and community provision in place	Year 2 Year 3 Year 5	Local MHS provider	LIP confirmation
Tier 2 services for people with acquired brain injury or progressive brain disease; people with Asperger's Syndrome or high functioning autism	Locally agreed protocols	Year 3		

Standard 6. Sustaining Meaningful Lives

Performance Indicators	Targets	Milestones	Lead Responsibility	Information and Sources
People with complex and enduring needs should be provided with appropriate provider opportunities for education, training and occupation	Occupational assessment including yearly review – 50%	Year 1	Local MHS	LIP confirmation
	– 80%	Year 3	Local MHS provider	LIP confirmation
	A comprehensive range of occupational services	Year 5	Local MHS provider	LIP confirmation
	Vocational specialists provider appointed	Year 5	Local MHS	LIP confirmation
	A comprehensive range of day care services	Year 5		
A comprehensive range of accommodation for people with severe and enduring mental health needs	Discharge protocols for accommodation needs		Local MHS provider	LIP confirmation
	– 50%	Year 1		
	– 80%	Year 2		
	– 100%	Year 3		
	Choice of accommodation appropriate for need		DSD	LIP confirmation
	– 50%	Year 5		
	– 90%	Year 10		
Exemption to the single room rent for people with complex and enduring needs	Exemption provision	Year 2	DSD	DHSS&PS

Standard 6. *Continued*

Performance Indicators	**Targets**	**Milestones**	**Lead Responsibility**	**Information and Sources**
Exemption from prescription charges for people with complex and enduring needs	Prescription exemption	Year 2	DHSSPS	DHSS&PS
Provision of intensive support for those wishing to get back to work	Intensive support – 50% – 70% – 90%	 Year 3 Year 5 Year 10	Local MHS provider and DEL	LIP confirmation

Standard 7. Providing for People with Special Needs

Performance Indicators	Targets	Milestones	Lead Responsibility	Information and Sources
A tiered strategy for people with eating disorder	Needs assessment Regional Y strategy	Year 1 ear 2	DHSSPS	DHSSPS
A tiered strategy for people with acquired brain injury or progressive brain disease	Needs assessment Regional strategy	Year 2 Year 3	DHSSPS	DHSSPS
A tiered strategy for deaf people with mental health problems	Needs assessment Regional Y strategy	Year 2 ear 3	DHSSPS	DHSSPS
A tiered strategy for people with Asperger's Syndrome or high functioning autism	Needs assessment Regional strategy	Year 2 Year 3		
A tiered strategy for psychological services including services for people with psychological trauma and psychosexual disorders	Needs assessment Regional strategy	Year 2 Year 3	DHSSPS	DHSSPS
A tiered strategy for people with personality disorder	Needs assessment Regional strategy	Year 2 Year 3	DHSSPS	DHSSPS
A tiered strategy for women with mental health problems in the perinatal period	Needs assessment Regional strategy	Year 2 Year 3	DHSSPS	DHSSPS

Standard 8. Meeting the Information and Support Needs of Service Users, Carers and Families

Performance Indicators	Targets	Milestones	Lead Responsibility	Information and Sources
Existing policy and legislation relating to users and carers	Implementation of existing policy and legislation mostly implemented fully implemented	Year 2 Year 5	Local MHS provider	LIP confirmation
Information and education for users and carers	Basic information education and support Comprehensive information, education and support	Year 1 Year 3	Local MHS provider	LIP confirmation
Carers should be offered an annual assessment and a written care plan	Annual assessments and written care plans partly implemented fully implemented	Year 3 Year 5	Local MHS provider	LIP confirmation
Providers should make available support for appointed carers including dedicated carer and family workers	Carer and family workers partly implemented fully implemented	Year 3 Year 5	Local MHS provider	LIP confirmation
Suitable hospital visiting ar arrangements for families including children	Visiting rangements for families partly implemented fully implemented	Year 3 Year 5	Local MHS provider	LIP confirmation

Standard 8. *Continued*

Performance Indicators	**Targets**	**Milestones**	**Lead Responsibility**	**Information and Sources**
Agreed protocols between children's and mental health services for children requiring protection	Protocols agreed	Year 2	Local MHS provider	LIP confirmation
	Protocols partially implemented	Year 3		
	Protocols Y implemented fully	ear 5		

Standard 9. Ensuring Sound Information for Mental Health

Performance Indicators	**Targets**	**Milestones**	**Lead Responsibility**	**Information and Sources**
Baseline information on current services	Baseline information	Year 1	Local MHS provider	LIP confirmation
Mental health information strategy (MHIS)	Agreed MHIS	Year 1	DHSSPS	DHSSPS
Agreed Indicators for roll out of MHIS	To be agreed	To be agreed	DHSSPS	DHSSPS
Development and implementation of agreed mental health outcome measures including A measures appropriate for people with special needs	Agreed outcome measures for use in secondary care services greed outcome measures for use in specialist services Incorporation Y of clinical outcome measures into PCIS and supported in routine clinical practice	Year 2 Year 3 ear 5	DHSSPS DHSSPS DHSSPS	DHSSPS DHSSPS DHSSPS
User and carer evaluation of services	Baseline user and carer evaluation completed User and carer evaluation of services implemented at local provider level User and carer re-evaluation of services	Year 1 Year 2 Year 3, Year 7, Year 10		
A Northern Ireland R&D Strategy for adult mental health services	Agreed first phase of R&D Strategy (Years 1-5)	Year 1	DHSSPS	DHSSPS

Standard 10. Delivering an Effective, Competent and Confident Workforce

Performance Indicators	Targets	Milestones	Lead Responsibility	Information and Sources
A comprehensive workforce strategy for adult mental health	Agreed strategy	Year 1	DHSSPS	DHSSPS
A strategy for workforce recruitment	Strategy implementation targets to be agreed	To be agreed	DHSSPS	DHSSPS
A strategy for multidisciplinary training appropriate for CMHTs, rehabilitation, other community teams and hospital based staff	Agreed strategy for workforce skilling	Year 1	DHSSPS	DHSSPS
	Implementation targets to be agreed	To be agreed	DHSSPS	DHSSPS
Agreed strategy for psychological therapies training including the requirements for psychological trauma, eating disorder and psychosexual disorder	Agreed strategy for psychological therapies	Year 1	DHSSPS	DHSSPS
	Implementation targets to be established	To be agreed	DHSSPS	DHSSPS

ANNEX 1

STEERING COMMITTEE MEMBERSHIP

Chair – Professor David Bamford, University of Ulster

Deputy Chair - Professor Roy McClelland, Queen’s University, Belfast

Mrs Martha McClelland, Mind Yourself

Mr Martin Daly, LAMP

Mrs Marie Crossin, CAUSE

Mr Winston McCartney, Northern Ireland Association for Mental Health (NIAMH)

Reverend Trevor Williams

Dr Raman Kapur, Threshold

Dr Paschal McKeown, MENCAP

Dr Fred Browne, Chair, NI Division, Royal College of Psychiatrists

Dr Oliver Shanks

Ms Eileen Sherrard, Down Lisburn HSS Trust

Mr Nevin Ringland, PRAXIS

Mrs Maureen Ferris, EHSS Board

Mrs Mary O’Boyle, Holywell Hospital

Mr Patrick Convery, Gransha Hospital

Mr Leslie Frew, DHSSPS

Professor Tony McGleenan, University of Ulster

Mr Brendan Mullen, Ulster Community and Hospitals HSS Trust

Professor Alan Ferguson, Northern Ireland Association for Mental Health, (NIAMH)

Mr Brian Dornan, Causeway HSS Trust (and latterly SHSS Board)

Mr Mark Timoney, DHSSPS (and latterly SHSS Board)

Dr John Owens, Cavan/Monaghan Community Mental Health Project

Professor Geoff Shepherd, Cambridgeshire & Peterborough Mental Health Partnership NHS Trust

Mr Colin Beck, City of Edinburgh Council

Miss Joanne McDonald, Buzz Advocacy Group

Dr John Hunter, Department of Education

Master Brian Hall, Master of Care and Protection

Mrs Siobhan Bogues, ARC (NI)

Detective Superintendent Andrew Bailey, PSNI

Ms Moira Davren, Royal College of Nursing

Dr Diana Patterson, Shaftesbury Square Hospital, Belfast

Mrs Marian Nicholas, Carer Representative

Dr Walter Boyd, GP, Clogher (until September 2003)

Professor James Scott Brown, University of Ulster (Replacing Dr Walter Boyd from December 2003)

Mr Bill Halliday, Equality Commission (NI)

ANNEX 2

TERMS OF REFERENCE

1. To carry out an independent review of the effectiveness of current policy and service provision relating to mental health and learning disability, and of the Mental Health (Northern Ireland) Order 1986.

2. To take into account:
    - the need to recognise, preserve, promote and enhance the personal dignity of people with mental health needs or a leaning disability and their carers;
    - the need to promote positive mental health in society;
    - relevant legislative and other requirements, particularly relating to human rights, discrimination and equality of opportunity;
    - evidence - based best practice developments in assessment, treatment and care regionally, nationally and internationally;
    - the need for collaborative working among all relevant stakeholders both within and outside the health and personal social services sector;
    - the need for comprehensive assessment, treatment and care for people with a mental health need or a learning disability who have offended or are at risk of offending; and
    - issues relating to incapacity.

3. To make recommendations regarding future policy , strategy, service priorities and legislation, to reflect the needs of users and carers.

ANNEX 3

EXPERT WORKING COMMITTEES

FIRST WAVE

- ### Social Justice and Citizenship:
  Convenor: Bill Halliday, Equality Commission for Northern Ireland
  To consider relevant legislative and other requirements, particularly relating to human rights, discrimination and equality of opportunity; and how best to promote the social inclusion of people with a mental health problem or leaning disability and their carers, taking account of employment, housing, education, social security, personal finance and other social issues.

- ### Legal Issues:
  Convenor: Master Brian Hall, Office of Care and Protection
  To include a review of the Mental Health (Northern Ireland) Order 1986; the Mental Health Commission; the Mental Health Review Tribunal; the procedures for the transfer of patients to and from Northern Ireland; issues relating to people who are not able to look after their own property and affairs as a result of a mental health problem or learning disability; and issues relating to people with a mental health problem or a learning disability who are in contact with the criminal justice system.

- ### Learning Disability:
  Convenor: Siobhan Bogues, Manager, ARC (NI)
  To review policy and services for children and adults with learning disability.

- ### Adult Mental Health:
  Convenor: Professor Roy McClelland, Deputy Chair of the Review
  To include consideration of primary care provision, acute services, rehabilitation and community care for adults with a mental health problem.

SECOND WAVE

- **Mental Health Promotion:**

  Convenor: Professor Alan Ferguson, Chief Executive, Northern Ireland Association for Mental Health

  To include consideration of how best to promote positive mental health in society, with particular reference to the impact of the recently-published Mental Health Promotion Strategy, and how best to meet the needs of people at risk of suicide.

- **Child and Adolescent Mental Health:**

  Convenor: Moira Davren, Royal College of Nursing

  To include consideration of primary care provision, acute services, rehabilitation and community care for children and adolescents.

- **Dementia and Mental Health Issues of Older People:**

  Convenor: Nevin Ringland, Chief Executive, PRAXIS Care Group

  To include consideration of primary care provision, acute services, rehabilitation and community care for older people with dementia or a mental health problem.

- **Alcohol and Substance Misuse:**

  Convenor: Dr Diana Patterson, Shaftesbury Square Hospital

  To include consideration of the links between mental health and alcohol and substance misuse, and the provision of the most appropriate assessment, treatment and care for those involved.

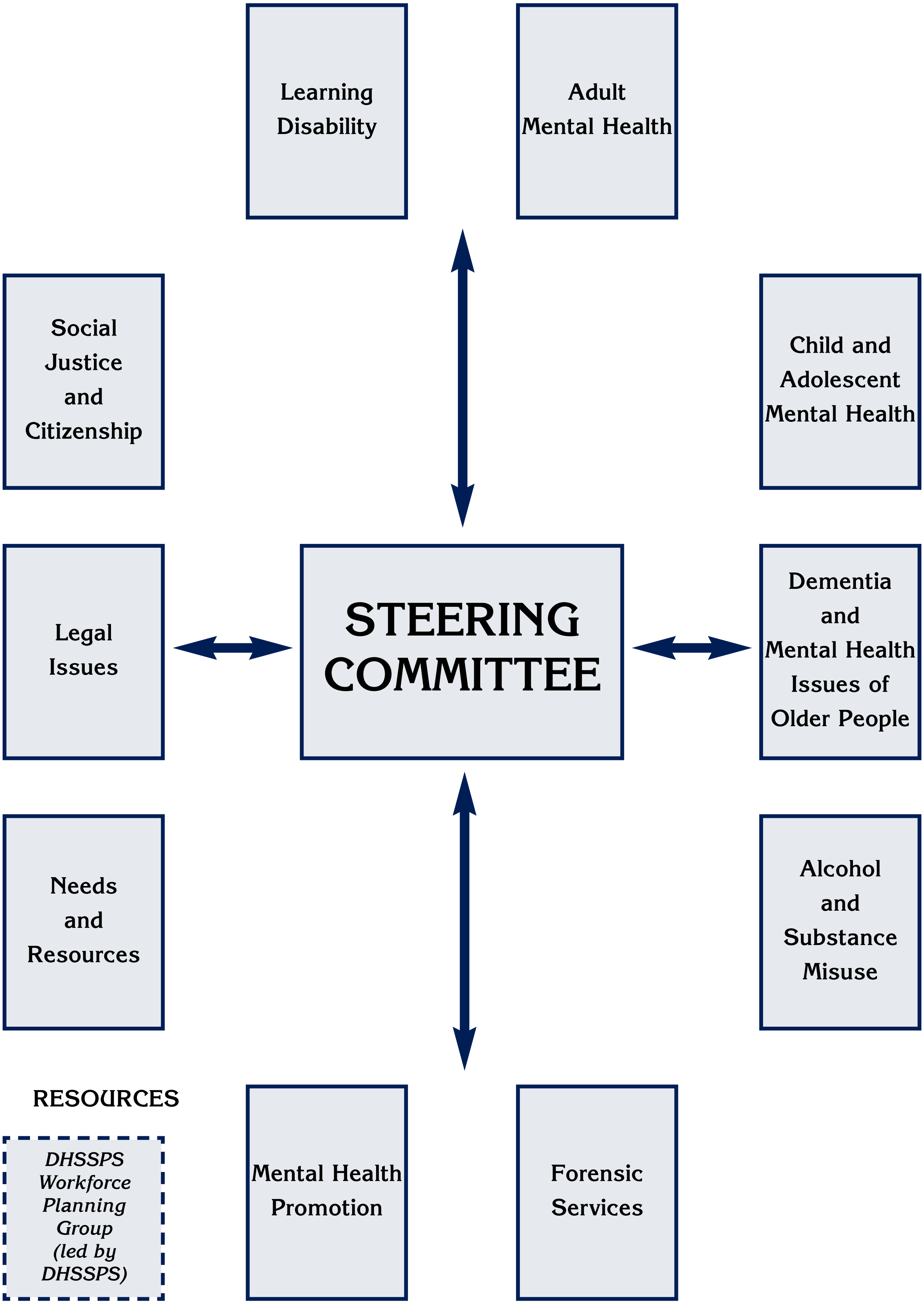
- **Forensic Services:**

  Convenor: Dr Fred Browne, Chair, Northern Ireland Division, Royal College of Psychiatrists

  To consider the assessment, care and treatment of people with a categorical mental illness, severe personality disorder or who engage in dangerous or persistently challenging, aggressive behaviour, and who may be in contact with the criminal justice system.

BW/120

EXPERT WORKING COMMITTEE STRUCTURE



ANNEX 4

ADULT MENTAL HEALTH WORKING COMMITTEE

Brendan Armstrong
David Bamford
Desi Bannon
Walter Boyd
Diana Cody
Peter Colvin
Liz Cuddy
Maxine Cresswell
Marie Crossin
Martin Daly
Jayita Deodhar
Brian Dornan
Alan Ferguson
Victoria Greenwood
Stephen Guy
Bill Halliday
Molly Kane
Michael Kelly
Seamus Logan
Carolyn Maxwell
Roy McClelland (Convenor)
Arthur McClean
Brian McCrum
Graeme McDonald
Ian McMaster
Maria McManus
Maureen McParland
Mary O'Boyle
John Owens
Diana Patterson

In addition, the following assisted the work of the Review , providing papers on specific themes:

Clare Adams
David Bolton
Marie Goss
Billy Gregg
Richard Ingram
Chris Kelly
Gerry Lynch
Janine Lynch
Maria O'Kane
Oliver Shanks
Eileen Sherrard
Brian Symington
Janice Thompson
Ken Yeow

ANNEX 5

GOOD PRACTICE EXAMPLES

CHAPTER 3

5.3.1 **Rural Support.** A local example of good practice is in the farming community, where use of a telephone helpline and a rural Health Action Zone has been of benefit to many. (Contact: 0845 6067607)

5.3.2 **Creggan estate, Londonderry, partnership approach to Health promotion.** This project demonstrates that statutory/community partnerships, accompanied by proper planning and long term commitment, work effectively, even in areas of high social disadvantage. Professional boundaries can be reduced, and a more open and flexible approach to health and social needs adopted. (Contact: 028 71373870)

Croydon Social Prescribing Scheme. Social prescribing schemes are increasingly recognized as effective in dealing with early signs of stress and psycho-social difficulties. In this Scheme, GPs have established a partnership with the voluntary and community sector, and employed a community worker based at a health centre. Practice staff refer patients to this worker, who has extensive knowledge of local community and voluntary services.
(Contact: www.mindincroydon.org.uk)

5.3.3 **Both the University of Ulster and Queen's University** have recently invested in the appointment of full time staff dedicated to supporting the mental health well-being of staff.
(Contact: QUB 028 90245133 and UU 028 90366336).

5.3.4 **City of Toronto Mental Health Services.** This is an example of explicit funding arrangements combining statutory and voluntary sectors. A mixed economy of care is practiced, with clear definitions of responsibility and accountability in allowing planned and timely delivery of targeted care. All mental health service providers, including the local hospital, have entered into formal legal agreements to create a highly accessible system for the consumer, based on the strengths of each of the partner organisation.
(Contact: www.toronto.cmha.ca).

5.3.5 **Limavady Pilot Project.** The pilot review of referral pathways and the use of a senior skill professional based in primary care has led to reductions in log jamming of referrals, improvement of morale and development of timely, accessible assessment services. Audits of satisfaction have shown enthusiasm for continuing the service from service users, primary care staff and secondary care staff. (Contact: 028 77722123).

The Mid Ulster Primary Care Mental Health Project. This began in June 2002. The aim of the project is to provide a primary care based mental health service offering brief therapies to patients of 45 General Practitioners within 16 surgeries. Early evaluations showed high levels of acceptability to service users and practitioners with a significant demand for extension of the service. (Contact: 028 86747250).

5.3.6 **The Northern Ireland Association for Mental Health** offers contract based 24 hour counselling services to staff groups both within the health and social services sector and other employers. The Carecall Counselling Service (Contact: 028 90245821).

5.3.7 **Lenadoon Counselling Service, West Belfast.** This service is under the guidance of a management panel of local community representatives, a Clinical Psychologist, a Consultant Psychiatrist and a General Medical Practitioner. A number of trained counsellors provide focused counselling interventions to a population that has experienced a substantial burden of civil disturbance and socio-economic deprivation. This service is highly valued by the local community, by local statutory providers and by General Medical Practitioners. (Contact: 028 90585544).

The Primary Care Counselling Service, Armagh. This counselling service, established in 2000, provides for people with: mild to moderate depression with a first time diagnosis, delayed or unresolved post-natal depression, acute bereavement, Post Traumatic Stress Disorder, anxiety disorders, panic disorders, health anxiety, low self-esteem, stress, interpersonal difficulties. The Service has been a very effective and successful initiative, not only in clinical efficacy, but in reduced referral figures to the Community Mental Health Teams and in admission rates. It has also prevented a number of mental health problems developing into more serious disorders. The successful outcomes led to a request to expand the service to the Dungannon area, and in conjunction with the local Health and Social Care Group the service is being extended to this area. (Contact: 028 37522037).

CHAPTER 4

5.4.1 **Homefirst Crisis Response (CR) Service.** This Trust-wide service was established in April 2003 for people experiencing a mental health crisis that could have the potential to result in an admission to hospital. The CR team comprises nursing, social work, medical professionals and support workers. The CR team offers a multi-disciplinary approach to care and a single point of access for referral agents.

The objectives are to:

- Offer a rapid, 24 hour response and assessment service for patients referred with mental health difficulties who present to the service in crisis
- Provide a flexible, accessible service which will work alongside existing to enhance the care and treatment of people with a mental health crisis
- Support carers and families of those with mental illness in crisis
- Work alongside primary and secondary care to provide a more seamless service for users
- Support general hospital facilities in providing assessment and advice for those who present with mental health problems.

In its first year, the team accepted 2903 appropriate referrals. The team was able to maintain approximately 90% of those who presented in the community, and achieved a reduction in hospital admissions of 39% compared with the year before the service was introduced. (Contact: 028 9040 2038)

Newcastle Crisis and Treatment (CAT) Service is based on a Crisis Response and Home Treatment model with high fidelity to five key components:

- Provision of 24/7 access – in this team, the night shift is only two people but they are on-site, not on-call (demand for home treatment beyond 6.00 pm is described as very low).
- Involvement until resolution of the crisis – this can range from a few days to several weeks.
- Multidisciplinary care – the key components are seen as medicine, nursing, social work and occupational therapy.
- Team mobility – they must be able to assess in a variety of locations at any time and usually within two hours or sooner
- Gatekeeping of admission to places in psychiatric acute hospital – to ensure achievement of the overall goal, the home treatment of psychiatric crises.

A crucial part of the operation of the team is a triage arrangement with all referral agents. Once someone is identified as being in need of an urgent assessment (at risk of significant harm to self or others or at risk of hospital admission), they are seen by a team member, assessed and a decision made on the management of their care and treatment. The aim is to offer home based treatment if at all possible, based on a partnership with carers and the imaginative use of whatever resources can be brought to bear on the situation. The CAT team currently consists of 34 staff serving a catchment population of 460,000. Operating now for three years they have had a significant impact on inpatient requirements with a fall from 30 adult places/60,000 to a planned requirement next year of 20/60,000. (Contact 0191 370 7760)

Useful information on crisis resolution/home treatment can be obtained from the Department of Health's NSF Policy Implementation Guide (www.doh.gov.uk/NSF/mentalhealth.htm).

5.4.2 **Anam Cara, Birmingham** offers stays of up to three weeks for people referred by home treatment teams or for former guests who self-refer. This is a user-led initiative providing an alternative crisis service to hospital admission. In an evaluation by the Sainsbury Centre most residents had a diagnosis of schizophrenia. All those interviewed felt the service had met all their needs (Contact: 01213841344).

5.4.3 **Ards Mental Health Day Hospital.** The Ulster Community and Hospitals Trust Mental Health Day Hospital, a purpose-built unit opened in 1989 adjacent to the Inpatient and Outpatient Units, was recently awarded the Charter Mark for its work.

Staffing: Nurses – four full-time and one part-time
Occupational Therapists – two full-time, two part-time and one OT technician
Complementary Therapist – one part-time.

The Day Hospital, which has 40 places, receives 6-15 referrals each week. It functions both as an alternative to admission for patients in the Community, as well as facilitating early discharge from inpatient care. Each service user has an individual plan of care co-ordinated by a named health professional. Each user is assessed prior to admission and treatment is regularly reviewed by the multidisciplinary team.

The Unit is open Monday – Friday and facilitates many individual and group activities outside working hours. In addition to individual programmes of care and therapy there are a number of group activities: Patient advocacy service, Job Clinic, Carers' Group.

Future plans include extending the opening hours from 9.00 am – 9.00 pm seven days a week and providing a base for the Crisis Intervention Team. (Contact: 02891 56115)

5.4.4 **Slievegrane Centre, Downpatrick.** The Centre, recently awarded Charter Mark and Environmental awards, aims to provide a service for people with severe and enduring mental illness. It consists of a six bed residential unit with four supported flats, staffed 24 hours. There are also 7 supported group homes and outreach is provided to individuals who have moved on from the service to independent living. The philosophy of the service is empowerment and normalisation. Residents are encouraged to see the unit as a home and to live as independently as possible, whilst engaged in a structured, tailored rehabilitation programme. The staff team consist of two psychiatrists (one consultant, one staff grade), a unit manager, 8 residential workers, 2 care assistants, 1 consultant clinical psychologist, 1 social worker and 1 occupational therapist. Very positive results have been achieved since opening of the unit in 2000, with many residents moving on to independent living (Contact: 028 4483 9959).

The Cavan/Monaghan Rehabilitation/Recovery Team. This team, established in 1998, takes referrals only from the mental health service. The core philosophy is to provide individualised care for service users and carers based on identified needs and implemented as much as possible in a non-institutional setting. Referrals are made through the team co-ordinator and discussed at weekly team meetings. The protocol for patient care includes: referral, assessment, programme implementation, programme review. Care plans are drawn up by relevant team members once assessments are completed, involving, where possible, the service user. The multidisciplinary rehabilitation/recovery team takes referrals only from within the mental health service and are made through the team co-ordinator and discussed at weekly team meetings. (http://www.monaghanmodel.com/implications.htm).

5.4.5 **Cavan/Monaghan Project.** The Assertive Outreach Team is a component part of the community rehabilitation/recovery team and consists of 11 Assertive Outreach nurses. They take responsibility for all new referrals to the Community Recovery Team. The locus of care for Assertive Outreach is primarily in the patient's home (http://www.monaghanmodel.com/implications.htm).

5.4.6 **Windsor First Episode Service.** This service, based at Belfast City Hospital, was established in 2000 for young people (18-30 years) living within the South Belfast catchment, experiencing a first episode of psychosis. The service consists of a multi-disciplinary, multi-agency team from the Belfast City Hospital Trust, South & East Belfast Community Trust, School of Nursing Queen's University, voluntary and independent sectors including care and user participation. The aim is to provide an up-to-date evidence based range of services including family intervention, social skills development, medication management, cognitive behavioural therapy and family intervention.
(Contact: 028 90 32 9241 ext 2518)

West Midlands IRIS Group have produced guidelines and a 'tool-kit' for the development of Early Intervention Services (www.iris-initiative.org.uk).

5.4.7 **Foyle Health and Social Services Trust** have proposed a new psychological therapies service model within their strategic review of adult mental services (2003). They propose a 21 person Psychological Therapy Team, composed of a number of different professional groups, whose members have expertise in the range of psychological assessment, formulation and intervention skills. The team will be brought together from existing and newly appointed staff
(Contact: 028 71314201).

5.4.8 **THORN.** A notable educational initiative in recent years has been the creation of THORN courses at Queen's University and the University of Ulster. These courses provide training for a range of professionals in psychosocial interventions for people with severe mental illness.
(Contact: QUB 028 90335742 and UU 028 90366336)

The Meriden Project in the West Midlands Region provides in-service, multidisciplinary training aimed at increasing access to evidence-based psychosocial interventions. It is funded by the West Midlands NHS executive and involves training across 17 Trusts within the region in family intervention. A cascade model of training was implemented with trainers being trained in each Trust to run courses and act as supervisors. To date, more than 1500 therapists from all disciplines have been trained and carers' experience of the mental health service in the region has been transformed.
(Contact: 0121 6235500)

5.5.1 **Southwest London and St. George's Mental Health NHS Trust:** In this service OTs act as clinical vocational leads, working with specialist services to increase access to employment and education for clients. There is a vocational support worker on each team. Prior to intervention > 60% clients SMI group were not engaging in any work, education or structured activity. This reduced to 20% after 1 year's experience on the programme. 888 people have specific vocational input in the period from Nov. 01 – Nov. 02. After 1 year 469 were involved in open employment. This scheme is mainstreamed within the Trust, and is being piloted in six different sites across Europe over a three-year period. (Contact: 0208 682692.)

Avon & Wiltshire Mental Health Partnership NHS Trust, Work Development Team. The existing OT service was re-profiled and a model developed to assist people remain in work and re-enter the workforce after a period of mental illness through re-deployment or retraining. The team developed partnerships with local FE colleges, voluntary services and New Deal provisions. Standardised assessment tools are used. Since it inception in 2000, until Jan 2003 over 550 Occupational Action Plans have been completed. 250 people have returned to full-time employment. A job retention service has been developed. Primary evaluation confirms that the JRT is delivering considerable benefits to stakeholders who include, clients, employers and GPs. Key factors in the provision of an effective service were identified; early intervention, a focus on return to work, ongoing support, access and role of case manager. It is recommended that a national network of job retention services should be developed and a longitudinal evaluation conducted. This is a NHS Beacon Service and is now being replicated in over 60 Healthcare Trusts in UK. (Contact: 01179633681.)

Pentreath Industries – Employment Project: Registered charity providing "gateways to employment for people with or recovering from mental ill health in Cornwall" 4 main areas of service delivery: training, employment placement advice, social, firm development and raising awareness of mental health issues. 76 staff provided long-term support for 598 service users in 2000, referred from community mental health teams. An average of 30 people per year move into full-time waged employment. A wide range of opportunities and options are on offer, including 4 social firms.
(Contact: The Sainsbury Centre 0207 403 8790.)

Down & Lisbum Trust has appointed a full-time Senior OT with a specific remit for vocational rehabilitation in the mental health team. They are the only Trust in Northern Ireland to have a specialist vocational mental health post. The postholder works in partnership with Action Mental Health (ACCEPT) (Contact: 028 92665141 ext.2336.)

Causeway Trust has a full-time Senior I with a similar remit. This post is based at the Pavestone Centre, a recently established social enterprise. Although funded through the physical disability programme, the post holder also deals with clients with an SMI diagnosis. Plans have been proposed to develop a vocational assessment and supported employment service at Pavestone. No funding source as yet identified. (Contact: 028 70347875.)

WELL Project:- Well being, Education, Learning and Living Project
This initiative aims to provide a sustainable support service, linking existing statutory and voluntary services, to enable people with enduring mental illness to access a wide range of learning activities, which will enhance quality of life, personal development, skills, opportunities for achievement, social inclusion and reduce stigma. (Contact: 028 44613311 ext. 3292.)

5.5.2 **Clare House Enniskillen** has a six-bedded attached unit, where people with mental health crisis may come for unplanned respite. The unit is staffed by nursing and an Occupational Therapist with consultant back-up. Residents are encouraged to be as independent as possible and prepare their own food and attend to their personal needs with support from staff.
(Contact: 028 6632 6361).

5.5.3 **Homefirst Trust** in partnership with M.U.S.T. hostel in Cookstown provides one bed as an alternative to hospital admission to those to those who have been assessed suitable. This unit is staffed by voluntary sector staff on a 24-hour basis and receive support from the Crisis Team as appropriate.
(Contact: 028 9040 2038).

5.5.4 **First-Step Move-On Accommodation.** There are many examples of statutory hostels across Northern Ireland providing first step move-on accommodation with intensive rehabilitation as a stepping-stone to supported or independent accommodation. Staff come from nursing, social work or NVQ trained background and are supported by Community Psychiatric Nurses, Mental Health Social Workers and consultants or senior registrars. Examples are Norfolk Court Hostel, Rathenraw, Antrim (028 9442 8089); Kintyre Park

Hostel, Ballykeel, Ballymena (028 2565 3755); and Ballymacoss Hostel, Lisburn (028 6632 6362).

5.5.5 **Stamford Avenue, Herts.** A registered mental health nursing home providing client support for people with learning disabilities, mental health needs and/or challenging behaviour. The project is registered to take people detained under the Mental Health Act. It provides intensive support with nursing and project workers and is supported by a Registered Medical Officer and a multidisciplinary team (Contact: 01763 236 167).

5.5.6 **North and West Belfast** under their Health Action Zone have set up a Care Co-ordinator Service for single homeless people in North and West Belfast. The service assists single homeless people and rough sleepers to enhance their health status. (Contact: 02890 755434).

Health and Homeless Guidance (Scottish Executive). There are 15 health and homelessness action plans across Scotland covering each NHS Board area. Discharge protocols have been agreed in many areas, which have ended the practice of people being discharged from hospital without accommodation. Innovative and effective interventions have been developed to encourage health screening for rough sleepers; an example of this is offering veterinary checks for dogs of rough sleepers.
(Contact: 0131 2445132).

5.5.7 **Belfast Homeless Support Team** and hostel, has had a major impact on the homeless mentally ill in the Belfast area. (Contact: 02890 238091).

5.5.8 **Northern Ireland Association for Mental Health Advocacy Service.** The key features of this model are:

- Independence with appropriate funding
- Training and relevant experience
- Good communication skills
- Good understanding of mental health services and legislation
- Ability to empower patients to speak for themselves
- Acceptance and support by professional staff
- Advocacy at the macro level in relation to policy and planning of services
- Advocacy with individual service users

- Access to appropriate administrative information
- Accountability and evaluation
- Education of patients and staff on the nature of the advocacy process.

(Contact: 028 9032 8474).

5.5.9 **C.A.U.S.E.,** a Northern Ireland carers' and families' organisation, provides a broad model of support for carers which includes a helpline, self-help groups, carer advocates, training and education programmes and the representation of carers' views. (Contact: 028 9023 8284).

RETHINK is a national organisation providing support for both service users and carers. Its programme includes self-help groups, training and education, carer advocacy, and the representation of carers' views. It has an informative and useful web-site. (Contact: 028 90402323).

5.5.10 **CESP (Carer Education Support Programme).** A collaboration between Rethink and the Sainsbury Centre. Held over 3 months, this course is co-led by trained carers and mental health professionals. It gives information about schizophrenia and skills training in problem solving, assertiveness, communication and managing symptoms. (Contact: 028 90402323).

PREP (Programme for Relatives: Education and Partnership), developed by Dr. Carole Castles from C.A.U.S.E. with funding from the Mental Health Foundation. The programme aims to alleviate feelings of subjective burden in relatives, to increase their knowledge of serious mental illness and to enable them to improve their quality of life. It is facilitated by trained, experienced carers and has input from mental health professionals.
(Contact: 028 9023 8284).

5.5.11 Professionals trained in the multidisciplinary **Thorn programme** are greatly valued by carers and families. **The Meriden Project** in the West Midlands has expanded this model of support to a very favourable response from carers. (Contacts as at Example 5.4.8 above)

5.5.12 **FACE,** a Northern Ireland organisation, has developed a local programme of support for young carers in the area of mental illness.
(Contact: 028 3833 2261)

Barnardo's Young Carers Project in the Northern Health and Social Services Board area, deals with families with a parent with a disability, including those with mental health problems. They offer the young person counselling, group support, peer support and recreational opportunities, and take a holistic family approach. (Contact: 028 2564 8809).

CHAPTER 6

5.6.1 **Down and Lisburn Trust Community Brain Injury Team.** This team comprises a group of professionals who adopt an interdisciplinary approach in addressing the community based services promoting recovery and reintegration needs of people with acquired brain injury. The team works with the person with brain injury, their families and carers. (Contact: 028 92663572)

5.6.2 **Redford Court, Toxteth, Liverpool.** This is a supported living facility for people with ongoing emotional and behavioural problems, who require intensive support to maintain community living. The facility is run by the Brain Injury Rehabilitation Trust. The Trust offers a range of services for people with brain injury, including residential assessment, rehabilitation and training, transitional living units, individual outreach options and long term care. Each of these services is supported by a specialist multidisciplinary clinical team. (Contact: 0151 2808181).

5.6.3 **Forster Green Hospital Ward / Joss Cardwell Unit.** Provides multidisciplinary inpatient and outpatient brain injury rehabilitation. Plans are ongoing for the development of a purpose built 25 bedded unit on the Musgrave Park Hospital site. (Contact: 028 90793681).

5.6.4 **York House, Brain Injury Rehabilitation Trust, York.** A neurobehavioural service for acquired brain injury. York House is a 14 bedded neurobehavioural rehabilitation unit which provides an intensive neurobehavioural assessment and rehabilitation service for individuals with severe mood disturbance and challenging behaviour following acquired brain injury. The unit specialises in the management of people with challenging behaviour and is able to take referrals for people detained under the Mental Health Act. All clients have access to an intensive programme of rehabilitation and recreational activity, which seeks to restore independence as far as possible. Staffing levels are high and for some people a programme of one to one support is available. (Contact: 01904 412666).

Robert Ferguson Unit, Royal Edinburgh Hospital, Edinburgh Healthcare NHS Trust. This unit is the National Neurobehavioural Rehabilitation Unit for Scotland. It addresses the needs of those people who sufer severe behavioural complications after acquired brain injury. It operates on the basis of a multidisciplinary team, which a high staff-patient ratio and provides slow stream rehabilitation in preparation for community reintegration and continuing care. (Contact: 0131537 6214).

The Kemsley Unit, St Andrews Hospital, Northampton. Provides specialised rehabilitation for adults with non-progressive acquired brain injury, with challenging behaviours, including physical aggression, who are excluded from conventional rehabilitation settings. In addition, physical, emotional and cognitive and other behaviour problems may be present. The service offers a continuum of care ranging from secure facilities and highly structured rehabilitation, hospital based transitional living, community based transitional living and case management for individual clients. (Contact: 01604 29696).

5.6.5 **Nottingham and Bristol** are developing locally based Mental Health Services for deaf people.
(Contact: Nottingham 0115 948 3268 and Bristol 0117955 6098).

5.6.6 **Link Centre, Eastbourne** – provides specialist rehabilitation to deafened adults through intensive rehabilitation programmes. (Contact: 01323 638230).

RNID (NI) Rehabilitation Project – initially targeting people deafened as a result of Northern Ireland Troubles. (Contact: 02866 329849).

5.6.7 **Manchester Metropolitan University** run a five-year distance learning Masters of Arts in Social Work with deaf people. This course is open to both hearing and deaf students. (Contact: 0161 247 2112)

The University of Salford's Deaf People's Access to Nurse Education Project has created an educational environment that has enabled deaf people to become qualified mental health nurses. (Contact: 0161 295 2769)

5.6.8 **Sandyford Initiative in Glasgow .** This project provides drop-in services for transpeople. It has received a very high level of approval by its clientele. Such initiatives may be directly transferable to appropriate locations in Northern Ireland, but due to the small numbers of transpeople, the maintenance of a co-ordinating central service would remain vital for preserving experience and expertise in relation to treatment. (Contact: 0141 211 8137)

CHAPTER 8

5.8.1 **Getting Better Together.** Trent & Northern Yorkshire NHS and the Northern Centre for Mental Health jointly commissioned this Mental Health Collaborative. The aim of the project was to improve service users' experiences of acute inpatient care and achieve better outcomes throughout the process of admission, stay and discharge. The collaborative placed an emphasis on joint working to achieve mutually desirable results. It has made a significant move away from "the hero-innovator" towards a more empowering means of creating sustainable change through the utilisation of shared perspectives of jointly owned goals." There is clear evidence that the collaborative has been successful in improving service users' experience of acute inpatient psychiatric units and achieving better clinical outcomes." Hugh Griffiths, Clinical Lead Mental Health Collaborative. (Contact 0191 370 7760).

ANNEX 6

BACKGROUND ON SERVICES FOR PEOPLE WITH SPECIAL NEEDS, DISCUSSED AT CHAPTER 6

6.1 Services for People with Eating Disorders

The Nature and Extent of the Issues

6.1.1 Eating disorders include anorexia nervosa, bulimia nervosa and the atypical eating disorders such as binge-eating disorder. Obesity may be an associated problem. They can lead to severe physical and psychosocial complications and are associated with significant levels of co-existing psychiatric conditions.

6.1.2 The National Service Framework for Mental Health recognises the potentially serious nature of eating disorders.[1] The Royal College of Psychiatrists has highlighted the need for specialist services and the lack of service provision in many parts of the UK.[2,3] The National Institute of Clinical Excellence (NICE) has recently produced treatment guidelines, setting standards for service delivery.[4]

6.1.3 Within Northern Ireland, the DHSSPS has made the development of eating disorders services a recent priority.[5,6,7] A Regional Eating Disorders Working Group (REDWG) has been in operation to oversee this work. The membership of the group represents the interests of service planners, providers, users and carers.

6.1.4 The estimated prevalence of anorexia nervosa is 6-30 per 60,000 population and of bulimia nervosa is 60 per 60,000 population. The approximate incidence of anorexia nervosa is 4-6 per 60,000 population per year and of bulimia nervosa is 6-30 per 60,000 population per year.[8,9] There is a suggestion that at least as many people present with an atypical eating disorder.[1] A significant number do not seek help for a variety of reasons including denial, shame and the lack of appropriate services being in place.

6.1.5 Using the above figures, it is estimated that in Northern Ireland there would be around 170-510 cases of anorexia nervosa and 1700 cases of bulimia nervosa existing at any one time, and approximately 68-170 new cases of anorexia nervosa and 170-510 new cases of bulimia nervosa per year. The additional service users who suffer from atypical eating disorders as well as those who are not currently seeking help need to be taken into account when planning services.

6.1.6 As part of a local needs assessment, the REDWG commissioned qualitative research which sought the views of carers, sufferers and service providers.[10] The key recommendations arising from this address the problems with awareness and early detection, primary care intervention, the paucity of integrated and equitable specialist services, as well as the need for good health promotion strategies.

6.1.7 The current lack of specialist services in Northern Ireland is evident. Most service users are managed within primary care and generic adult and child and adolescent mental health teams. Voluntary groups play an important role in supporting service users and carers. A specialist outpatient clinic had offered a geographically limited (Greater Belfast) service and received around 12 referrals per month, but the recent retirement of the Consultant in charge has meant that it is now closed to new referrals.

6.1.8 Inpatient interventions may be necessary due to medical/psychiatric emergencies or for more intensive psychotherapeutic intervention. The former group tend to be admitted to local general medical/psychiatric units and one survey suggested that this demand was around 9.5 beds per year. As there is no local specialist inpatient unit, the latter group are sent for treatment outside Northern Ireland, which can be very difficult for the service users as there is separation from their families. These extra-contractual referrals are costly e.g. within the Eastern Health & Social Services Board (EHSSB) in the financial year 2003/2004, 9 patients were sent to England at a cost of around £500,000 (EHSSB, personal communication).

6.2 Services for People with Acquired Brain Injury or Progressive Brain Disease

The Nature and Extent of the Issues

6.2.1 There is growing recognition of the mental health needs of adults with neurological conditions affecting higher cerebral functions, including non-progressive acquired brain injury (e.g. arising from trauma, haemorrhage, anoxia, infections, toxins including alcohol, nutritional deficiency, epilepsy) and progressive brain disease (e.g. Multiple Sclerosis, Parkinsons Disease, Huntington's Disease, early onset Dementias).

6.2.2 Such neurological conditions can lead to a range of impairments in physical functioning (e.g. spasticity, disturbance of gait, sensory impairment), cognitive functioning (e.g. poor concentration, distractibility, failure to learn, rapid forgetting, poor planning and social judgement, difficulties in the understanding of language and in verbal expression) and emotional and behavioural functioning (e.g. anxiety, depression, personality change, irritability).[11] Impairments in functioning can result in reduced independence in personal care and activities of daily living (e.g. hygiene, dressing, cooking, cleaning). They frequently impact negatively on social and family relationships and upon the individual's ability to return to work or engage in socially meaningful activity. [12, 13, 14, 15]

6.2.3 A significant number of people with acquired brain injury and progressive brain disease will have significant and continuing health care needs over a long period of time. [16] Local research estimates the prevalence of people with moderate and severe psychological and physical disability following traumatic brain injury and subarachnoid haemorrhage to be 66 per 100,000 and suggests that the presence of moderate and severe psychological impairment is the best predictor of long term social disability. [17]

6.2.4 Cognitive, emotional and behavioural deficits post injury are key predictors of negative outcome in terms of recovery, rehabilitation and community reintegration. These determine the extent to which an individual is able to adapt to his/her changed functioning and develop a positive quality of life. [18]

6.2.5 People with acquired brain injury and progressive brain disease are at greater risk of mental health problems, particularly depression, anxiety and psychosis. These can go undiagnosed and untreated, impacting negatively on morbidity and mortality. Estimates of incidence and prevalence of various mental health conditions vary widely, reflecting differing definitions adopted in studies. [19-24]

6.2.6 Families of people with acquired brain injury or progressive brain disease suffer considerable emotional distress and burden, which can have a considerable impact on their own mental health. They are at greater risk of mental health problems than the general population. Family stress is associated with coping with personality and behavioural change in a relative, often in addition to coping with physical and cognitive impairments. [25-29]

6.2.7 A biopsychosocial approach to understanding and managing the emotional and mental health problems associated with acquired brain injury or progressive brain disease is essential.[30] A range of treatment options, both pharmacological and psychological, are developing to address mental health needs.[31-34]

Service Provision

6.2.8 In general, the therapeutic interventions, rehabilitation and long-term support needs of people with acquired brain injury and those with progressive brain disease are addressed through separate services. Service planning tends to be separate and in recent years service development has focused narrowly on traumatic brain injury.

6.2.9 At present there is limited provision to meet the mental health needs of people with acquired brain injury or progressive brain disease. Needs are addressed through local mental health services and liaison psychiatry at the Royal Victoria Hospital, Belfast. The mental health needs of adults below 65 years of age with progressive conditions are addressed by older adult mental health services.

6.2.10 Two specialist mental health services operate at a Board/Regional level, but are currently under-developed.

6.2.11 **A Neuropsychiatry Service based at Belfast City Hospital.**
This is mainly an outpatient service, providing both new patient assessment and review clinics. A liaison service is also provided, receiving tertiary referrals, predominantly from psychiatry, neurology and neurosurgery. This service addresses the mental health needs of people with acquired brain injury and progressive brain disease.

6.2.12 **Maine Neurobehavioural Unit, based in Knockbracken Healthcare Park, South & East Belfast Trust.**
This unit has developed to address the needs of people with acquired brain injury or progressive brain disease, who have severe and persistent problems. The unit provides short-term admissions for assessment, slow stream rehabilitation/recovery and long-term care for those whose behaviour cannot be met in other settings. The unit has provided a focus on the subgroup of those with acquired brain injury and progressive brain disease, who present with severe challenging behaviours. It has demonstrated the utility of a multidisciplinary approach in providing a therapeutic environment, individual behavioural management and skills development programmes.

6.2.13 Community brain injury teams play a significant role in addressing mental health needs, although their remit is broader. These teams are at various stages of development within the physical disability programme of care in each of the Boards. They have developed as part of the continuum of rehabilitation and community reintegration services required to meet the needs of people with acquired brain injury. A core aspect of their work is in the assessment, treatment and ongoing management of cognitive, emotional, social and behavioural needs. Given their training and expertise in these areas, clinical neuropsychologists have played an important role in the leadership and development of these teams. An important function of these teams is assessment of need and service development.

6.2.14 A number of non-statutory services provide support to carers, social reintegration programmes, pre-vocational and vocational skills training and supported living. The work of these organisations involves attention to the psychological needs of their clients.

6.2.15 Consultation with service users and carers, local service providers and individual professionals, highlights a number of problems with current service provision in addressing the mental health needs of people with acquired brain injury and those who have progressive conditions. Local experience is consistent with reports concerning service provision and mental health needs throughout the United Kingdom. [35, 36]

6.2.16 A number of common issues arise:

- **Service Requirements.** There is a lack of appropriate residential and supported living options, with appropriate expertise and levels of staffing to deal with emotional and behavioural problems. There is also a lack of ability within services to respond rapidly to crisis situations in the community and a lack of support for families and carers.
- **Specialist Support to Local Services.** There is at present a lack of adequate levels of specialist expertise to support local services dealing with emotional and behavioural problems.
- **Training Needs of Staff.** There is a need for greater education of staff with regard to the emotional, cognitive, behavioural and mental health needs of people with acquired brain injury and progressive brain disease. Lack of awareness of patient vulnerability can lead to poor care planning, inappropriate placements, lack of adequate support, crisis situations and poorly-managed risk.

- **Services Responsibility.** Situations can arise where there is lack of clarity regarding responsibility in terms of local versus specialist services, or where there is co-morbidity, or where an individual's needs cut across programmes of care.

Good Practice Examples

Down & Lisburn Trust Community Brain Injury Team. This team comprises a group of professionals who adopt an inter-disciplinary approach in addressing the community rehabilitation and reintegration needs of people with acquired brain injury. The team works with the person with brain injury, their families and carers.

(Contact: 028 92663572).

Redford Court, Toxteth, Liverpool. This is a supported living facility for people with ongoing emotional and behavioural problems, who require intensive support to maintain community living. The facility is run by the Brain Injury Rehabilitation Trust. The Trust offers a range of services for people with brain injury, including residential assessment, rehabilitation and training, transitional living units, individual outreach options and long term care. Each of these services is supported by a specialist multidisciplinary clinical team. (Contact 0151 2808181).

York House, Brain Injury Rehabilitation Trust, York. York House is a 14 bedded neurobehavioural rehabilitation unit, which provides an intensive neurobehavioural assessment and rehabilitation service for individuals with severe mood disturbance and challenging behaviour following acquired brain injury. The unit specialises in the management of people with challenging behaviour and is able to take referals for people detained under the Mental Health Act. All clients have access to an intensive programme of rehabilitation and recreational activity, which seeks to restore independence, as far as possible. Staffing levels are high and for some people a programme of one-to-one support is available.

(Contact 01904 412666).

Robert Ferguson Unit, Royal Edinburgh Hospital, Edinburgh Healthcare NHS Trust. This unit is the National Neurobehavioural Rehabilitation Unit for Scotland. It addresses the needs of those people who suffer severe behavioural complications after acquired brain injury. It operates on the basis of a multidisciplinary team, which a high staff-patient ratio and provides slow-stream rehabilitation in preparation for community reintegration and continuing care. (Contact: 01315376214).

The Kemsley Unit, St Andrews Hospital, Northampton. This unit provides specialised rehabilitation for adults with non-progressive acquired brain injury with challenging behaviours, including physical aggression, who are excluded from conventional rehabilitation settings. In addition, physical, emotional, cognitive and other behaviour problems may be present. The service offers a continuum of care ranging from secure facilities and highly structured rehabilitation, hospital based transitional living, community based transitional living and case management for individual clients. (Contact: 01604 29696).

6.3 Services for Deaf People with Mental Health Needs

The Nature and Extent of the Issues

6.3.1 It is estimated that 1 in 7 of the general population has some degree of hearing loss.[37] Between 1 in 600 and 1 in 1500 people are profoundly deaf from early life. Although more than 90% are born into hearing families, many grow up to use Sign (British Sign Language, BSL or Irish Sign Language, ISL) as their first or preferred language, and identify themselves as members of the Deaf Community. Deaf children, particularly those in hearing families, can face many obstacles during development. The diagnosis of deafness may be delayed, though the advent of neonatal screening should address this.

6.3.2 The UK Government has recognised British Sign Language as a language in its own right in Great Britain. Similar formal recognition of both BSL & ISL was announced by Paul Murphy, Secretary of State for Northern Ireland on 29th March 2004. This is an important development for the deaf community.

6.3.3 Digital hearing aids, cochlear implants and, vitally, opportunities for early access to sign language should prevent the significant and potentially permanent language delays and deprivations characteristic of the recent past. Many deaf adults have had limited educational opportunities and may have poor literacy, which limits their access to written information, including television subtitles.

6.3.4 **Deaf People and Mental Health.** Deaf people encounter the same range of mental health problems as the general population. However, they are also at increased risk of having complex and organic disorders, as many of the non-genetic causes of deafness, such as maternal rubella, neonatal jaundice, prematurity, birth anoxia and meningitis, can be associated with a range of physical, sight and neurological problems.

6.3.5 A significant minority of deaf people are deaf/blind and their mental health needs are also complex.[38] Psychiatric illnesses such as schizophrenia[39] and affective disorders are the same in deaf as in hearing people, but are associated with difficulties in diagnosis.[40]

6.3.6 The developmental difficulties and social pressures affecting many deaf children give rise to an excess of emotional, behavioural and adjustment problems (40-50% compared with 25% for the general population) which can continue into adult life.[41, 42]

6.3.7 **Mental Health Services for Deaf People.** Deaf people, particularly sign language users, have considerable difficulty in gaining access to health promotion programmes and the whole range of medical services. There are, however, some good examples of good practice in this area.

> **Good Practice Example**
>
> **Deaf Connection** recognised that traditional methods of health promotions were not reaching members of the deaf community effectively and what was required was to work directly with deaf people to identify their health needs and prepare programmes to tackle these. Training and support are provided to enable workers with deaf people to deliver a range of health programmes to the deaf community. (Contact: 0141 4202820)

6.3.8 Prelingually deaf people experience unacceptable rates of mis-diagnosis and unjustified long-term admission in psychiatric hospitals, often without their informed consent, and are additionally afforded inappropriate treatment. Appropriate treatment is dependent upon diagnosis, which in turn is dependent upon accurate communication.[43]

6.3.9 **Communication.** Adequate communication is essential for effective mental health assessment and treatment. Sign language interpreters are essential if clinicians do not sign. Even so, a service user's signing may be poorly developed, idiosyncratic or affected by mood or thought disorder. An interpreter can only say if effective communication is not taking place – he or she is not trained or empowered to assess or comment on a person's signing. Deaf professionals in mental health services, therefore, are the most appropriate people to facilitate or assess communication in these circumstances.

Good Practice Examples

National Deaf Services, South West London & St George's Mental Health NHS Trust, London. (Contact: 020 86826925

National Centre for Mental Health & Deafness, John Denmark Unit Manchester. (Contact: 0161 772 3400)

National Deaf Mental Health Services, Denmark House, Queen Elizabeth Psychiatric Hospital, Birmingham. (Contact: 0121 678 2005)

RNID Community Support Worker, Ulster Community and Hospitals Trust. RNID (NI) in partnership with Ulster Community and Hospitals Trust employs a Deaf Community Support Worker to support deaf people with mental health problems and learning disabilities in the community. (Contact: 02890 239619)

6.4 Services for People with Psychological Trauma

The Nature and Extent of the Issues

6.4.1 This area of need has been identified within the Review because of the rapidly growing knowledge about the impact of traumatic events on individuals and families, the increasing awareness of the consequences of chronic trauma-related disorders and the implications for services, and the particular circumstances in Northern Ireland associated with the civil conflict. Further, the clinical experience in treating trauma-related disorders has contributed to the body of knowledge and skills in both statutory and independent services, as has the development of specialist services that have been established to address both Troubles and non-Troubles related trauma.

6.4.2 Over the last fifty years there has been significant progress in understanding the mental health implications of exposureto life-threatening or other traumatic experiences. There have also been developments in our knowledge of the longer term effects on well-being, economic and social functioning, and significant developments in assessment and treatment. Development and progress in policy, training, the purchasing and delivery of services in relation to psychological trauma, can and should make important contributions to the mental and wider health of the community. In the context of the civil discord and violence of the period since the late 1960's in Northern Ireland, a developing political context has permitted public discourse on the impact of the violence, and local studies suggest that there are significant needs arising from the civil violence to be addressed.

6.4.3 Exposure to traumatic experiences can lead to the development of a range of mental health problems, including post traumatic stress disorder (PTSD), depression, specific phobias, personality disorders such as borderline personality disorder, and panic disorder[44], PTSD defines a group of signs and symptoms that often occur together, forming an identifiable pattern that characterises a recognisable disorder. It is often accompanied by other psychological or mental health problems, such as substance abuse and depression[45] (co-morbidity). Together these characteristics will usually induce levels of distress and disablement. This may, in turn, lead to dysfunction in social, occupational and relationship terms, and the exercising (or omission) of key life choices (based on the helpful appraisals arising from a traumatic experience) that have a long term bearing on the person and his or her family.

6.4.4 Key to understanding the levels of need arising from psychological trauma is knowledge about:

- the level of exposure to traumatic experiences;
- the incidence of psychological trauma following exposure; and
- the rate of recovery.

6.4.5 Whilst the Troubles in Northern Ireland have helped to draw attention to the needs arising from traumatic experiences, it is important to remember that citizens suffer from traumatic experiences which are found in technologically developed societies and which are not associated with political conflict. Accidents (including perhaps most strikingly road traffic accidents), assaults (including child abuse and sexual assault) and other traumatic experiences, such as those associated with suicide or serious illnesses, are well understood to give rise to risks of post trauma psychological implications for those who experience them.

6.4.6 The needs of children (and of adults) who have suffered and continue to suffer psychological and other health-related needs arising from childhood traumatic experiences, including abuse, represent a particular professional challenge. In the terms of the Children (Northern Ireland) Order 1995, children and young people considered to have suffered such experiences, and who as a result have post trauma-related problems, could be deemed to be *children in need*.

6.4.7 The needs of adult survivors of childhood sexual abuse who suffer enduring traumatic reactions and the consequences of their experiences on their development into adulthood are increasingly being recognised and understood. Progress in the development of treatments, the way services are provided, support for partners and other supports (including the contribution of self-help services) and the strategic arrangement of services, need to be maintained and built upon, and shaped by emerging knowledge about the needs of those affected by such experiences.

6.4.8 The relationship between childhood sexual abuse and subsequent mental ill-health problems has been extensively studied and found to be a risk factor for a wide range of disorders of mental health in adult life. Adults who have experienced sexual abuse as children are more at risk of developing anxiety, depression, self-destructive behaviour, self-harm and suicide. Combined sexual and physical abuse is a significant risk factor for adult trauma symptoms, including post traumatic stress disorder. Up to two thirds of people who suffer from eating disorders have a history of sexual abuse [46] Particularly among women, physical and sexual abuse are risk factors for substance misuse including alcohol misuse.[47]

6.4.9 The Heather Report[48] included proposals in relation to:

- Access to appropriate services
- Greater clarity about how and where to access services
- Increasing the level of services available for the current demand
- Greater service co-ordination

6.4.10 The Mental Health Foundation recommend that adults with a history of childhood sexual abuse in contact with mental health services should be offered counselling or psychotherapy as part of therapeutic intervention regardless of diagnosis. The benefits of a group work approach have also been reported. [49]

Good Practice Example

In 1997 the **Western Health and Social Services Board** established an Interagency Group on sexual abuse involving statutory and voluntary agencies working with adult survivors of childhood sexual abuse. The group has been successful in establishing a training programme for people working with adult survivors of sexual abuse. In addition to a directory of services, a website offering details of services available and advice for survivors has been established. (Contact 028 6632 0046)

6.4.11 The Western InterAgency Group in their detailed review of the needs of those who have suffered childhood experiences of abuse drew attention to the needs of those suffering long term consequences. Trust and confidence were identified as particularly important dimensions of the experience of seeking, securing and accepting help. Psychological and mental health services featured as a major area of need, with clear messages emerging from the Report as to the form services should take issues related to accessibility including the costs of non-statutory services, continuity, integration and referral matters.

6.4.12 Kessler and colleagues,[50] who reported upon a major study into the prevalence of PTSD in 1995, concluded, "PTSD is a highly prevalent lifetime disorder that often persists for years. The qualifying events for PTSD are also common, with many respondents reporting the occurrence of quite a few such events during their lifetimes." Among adult Americans aged 15 to 54 years the estimated lifetime prevalence of PTSD is 7.8%, with women (6.4%) twice as likely as men (5%) to have PTSD at some point in their lives. A number of other epidemiological studies have reported on similar findings.[51-54]

6.4.13 Kessler and colleagues found that the most frequently experienced traumas were:

- witnessing someone being badly injured or killed;
- being involved in a fire, flood, or natural disaster;
- being involved in a life-threatening accident; and
- combat exposure.

6.4.14 Other studies have reported on the incidence of development of PTSD after exposure to traumatic events. Green[55] reported an overall incidence of 25% of individuals exposed to traumatic events. In relation to rape, Figley[56] reported between 35% and a striking 92%. Norris[57] found an incidence of 69% in a sample of 600 people exposed to traumatic events. Breslau and colleagues [58] found that the rate of PTSD in those who were exposed was 23.6%. The variation across studies might, in part at least, be due to the changing definitions of PTSD in the 1980s and 1990s and the severity of exposure in some of the studies. Nonetheless, the findings point to significant consequences.

6.4.15 **Recovery from PTSD and the Implications for Treatment.** Kessler's work is also important as it endeavours to describe the recovery rate from PTSD. In short, 40% of sufferers recover (without treatment) by about 30 months after onset of symptoms. At the other extreme, 35% sufer enduring (and what could be taken to be lifetime) PTSD.

6.4.16 **PTSD Risk Factors.** In on overview of a number of studies of PTSD, Brewin, Andrews and Valentine [59] identified three risk factors for PTSD consistently across all studies, namely, psychiatric history, history of childhood trauma and family history of psychiatric disorders. Specific studies point to other pre-existing personal and social circumstances, and post trauma appraisals and coping as also being related to the development or presence of PTSD.

6.4.17 **The Impact of the Troubles.** Of the work that has been carried out in this field, a number of relatively recent studies provide a view of what the impact might be. In a secondary analysis of a nationally representative population survey conducted in 1997, O'Reilly and Stevenson [60] concluded that "The Troubles are a separate and additional [public health] burden and therefore contributes significantly to the higher psychological morbidity in Northern Ireland", and "It is probable that mental health has been significantly affected by the Troubles."

6.4.18 In The Cost of the Troubles Study, [61] the researchers concluded that about 30% of those who participated and who had been exposed to violence associated with the Troubles had needs approximating to PTSD. This finding seems high and might be associated with the methodology used in the study. Cairns and colleagues [62] found that the mean GHQ scores of a sample of 600 adults from across Northern Ireland was 6.05, which was in line with the findings of an earlier study. That study had detected similar or higher rates of psychiatric disorder to that found in inner city London. Cairns and colleagues concluded, "the ceasefires have not led to any notable change in overall levels of psychological well-being in the Northern Irish population".

6.4.19 One Troubles-related incident has been the subject of needs assessment and casts some light on the impact of a single incident. The Omagh bombing of August 1998 killed 29 people and two unborn children. Over 400 were injured, of whom 135 were seriously injured. In the course of the three and a half years following the bombing, over 670 people were seen by the Omagh Trauma and Recovery Team, which was established in the wake of the bombing by the local health and social services provider, the Sperrin Lakeland Trust. In addition, an unknown, but probably very large number of people were provided with support from a range of primary care, mental health, voluntary and occupational health related services.

6.4.20 A major community study (a needs assessment) commissioned by the Sperrin Lakeland Trust (unpublished) suggests that 7 out of 10 of those who were in the immediate vicinity of the Omagh explosion suffered PTSD. The Sperrin Lakeland Staff Study (a needs assessment) revealed that of those staff who were exposed to work associated with the response to the bombing, 38% of staff had developed PTSD in the period 4-17 months after the bombing. [63]

6.4.21 **The implications.** The following key points emerge from the above discussion:

- 25% (minimum) of those exposed directly to traumatic experiences will have developed PTSD;
- for some types of traumatic events the risks of developing PTSD are much higher;
- 8% of the young adult population will experience PTSD in their lifetime;
- whilst 40% of those who develop PTSD will recover to (at least) below threshold levels within about 30 months, a further 35% will have PTSD in the (very) long term.

6.4.22 The above analysis suggests that psychological trauma has, most probably not been sufficiently recognised as a specific health issue, and, by extension, that needs have not been addressed. Further, clinical experience shows that people with PTSD are thought to have other mental (and sometimes physical) health conditions ie instead of PTSD and are treated on that basis, or the link between mental illness and trauma is not made. This results in long-term treatment programmes because the underlying trauma is not being identified and addressed. In the context of the Troubles and the development of post conflict initiatives to build and consolidate a non-violent society, the legacy of the psychological consequences should be faced and addressed as a special public health issue.

6.5 Services for People with Personality Disorders

The Nature and Extent of the Issues

6.5.1 Personality Disorders exact a heavy burden on affected individuals and on wider society. [64, 65] These are common and distressing conditions, prevalent in 1 in 6 of the adult community population and most commonly in those aged 25 to 44, equally among males and females in their child-rearing years. Estimates may be higher in those with learning disability. [66]

6.5.2 These people experience a wide range of psychosocial problems, including high rates of family disharmony, violence, crime, unemployment and homelessness, early unnatural deaths from suicides and accidents, high rates of associated rates of mental illness and worse outcomes for all illnesses, leading to high service utilization and the revolving door phenomenon. [67] They often present in crisis and in danger to themselves or others and are high users of primary care and mental health services. [68 69] Their children can suffer significantly as a result. [70]

6.5.3 In mental health settings, people with Borderline Personality Disorder (BPD) attract most clinical attention, and where 11-20% of psychiatric outpatients may have this disorder. [71] It is strongly associated with co-morbid substance misuse, anxiety and depressive disorders, unexplained medical conditions and eating disorders and has a 9% suicide rate. [72, 73, 74] Psychological autopsy of suicides of individuals with personality disorder suggests that all may have had at least one mental disorder, and were chiefly a depressive syndrome disorder, substance misuse or both.[75]

6.5.4 Personality disorders are generally recognised as derived from within a stress diathesis model of causation. [76] Studies show that genetic vulnerability and early childhood adversity are potent risk factors for the development of personality disorder in adulthood.[70, 77] In adulthood, exposure to frightening and traumatic events may cause change and damage to the personality.[64]

6.5.5 Mental health professionals have a long-standing ambivalence towards the management and treatment of these disorders. Often these people may be regarded as difficult to treat because of lack of awareness of the condition and availability of treatment options. Typically, they present in chaos and often find traditional treatment options either not readily available or difficult to utilize. Inappropriate interventions can even make their situation worse. [76] Brief inpatient admissions can be beneficial.[74] The process of managing the disorder can be taxing for all concerned.

6.5.6 The presence of severe mental illnesses such as schizophrenia and bipolar disorder with personality disorder is common and is one of the most frequent dual diagnoses found in clinical care. Between 36 and 67 % of those with psychotic disorders have a personality disorder[78] and the proportion tends to be higher in inpatient populations.[79]

6.5.7 The outcome for people with a personality disorder as well as mental illness is generally worse than for those with single mental state disorders, with less improvement in symptoms, poorer quality of life and greater dissatisfaction with treatment after 2 years.[80, 81] The dual diagnosis is often not recognised in ordinary practice and thus may lead to poor reliability of assessment in psychotic disorders.[82, 83] A local survey suggests it may be under-recognised in the psychiatric population by as much as a factor of four.[84]

Treatment of Personality Disorder

6.5.8 There is no evidence that personality disorder is untreatable. However, there is no evidence that all personality disordered people would be treatable if only clinicians' attitudes were right and there were enough resources.[84] Present evidence indicates that mild and moderate degrees of personality disorder are treatable with appropriate interventions.[96, 85, 86] These are usually a combination of psychotherapy (psychoanalytic, psychodynamic, cognitive (CBT) and behavioural and dialectical behaviour therapy (CBT combined with Zen practice)) and pharmacological interventions delivered by clinical teams with experience and training.[87, 88]

6.5.9 Treatability may be a function of service availability.[86] People with personality disorders appear to achieve and maintain better outcomes in treatment in specialist services dedicated to care. The process of rejection and failure to identify the pathology itself affects the treatability of the condition, so that each negative encounter makes the condition worse. Some evidence exists that where specialist therapy is offered and completed, the costs are offset by the subsequent reduction of service usage by people with personality disorder.

6.5.10 Most individuals who present with the diagnosis of personality disorder have more than one personality disorder with a predominant type. Different interventions may be indicated for different types of personality disorder.[89]

6.5.11 Psychotropic medications, particularly SSRIs and mood stabilisers, are useful adjuncts to treatment in the management of people with personality disorder.[88, 90] There is a growing body of evidence for the use of the psychotherapies in the treatment of personality disorders, particularly those of borderline type.[91] In a randomised controlled trial of an 18 month psychoanalytically-led day service for people with BPD, significant improvements in symptoms and social functioning were found and maintained at 18-month review.[92, 93] There is some evidence that Cognitive-Behavioural therapy may also be relatively effective in the treatment of these disorders.[94] Dialectic Behavioural Therapy (DBT) has been shown to be effective in the treatment of BPD.[95] A randomised controlled trial of 18 weeks' psychiatric and psychotherapeutic day treatment with 8 month follow-up for people with affective and personality disorders, has shown improvement in social adjustment at the end of treatment.[96]

6.5.12 Lees et al concluded that "there is accumulating evidence of the effectiveness and particular suitability of a therapeutic community model to the treatment of personality disorder, and particularly severe personality disorder".[87]

6.5.13 Those with personality disorders are heavy users of treatment services throughout the NHS. A number of studies have shown that appropriate psychotherapeutic intervention can change Health Service utilisation by people with Severe Personality Disorder before and after inpatient psychosocial treatment.[97, 98] In one study carried out at the Cassel Hospital, using psychosocial and therapeutic community treatments for up to 18 months, use of inpatient and outpatient psychiatric and inpatient medical and surgical usage was significantly less in the post-treatment group, and there was an average per annum saving of £7423 per patient (May 1992 costs). The Henderson Hospital, an inpatient therapeutic treatment with an average length of stay of 7 months, showed that the cost of treatment for patients was recouped in under 2 years[99] through reduced Health Service utilisation. Therapeutic community provision at Regional District levels can offset the costs of acute psychiatric admissions in the 3 years post follow-up.[100]

Current Services

6.5.14 In England, there are currently 60 Therapeutic Communities provided for by statutory and voluntary sectors. 17% of Trusts have a dedicated service for personality disorder, often day hospital or outpatient programmes, 40% have some level of services and 28% have no service at all.

6.5.15 In Northern Ireland, there are no services dedicated to the management and treatment of people with personality disorder. Within general adult psychiatric provision there are isolated attempts at good practice. For example, at South Belfast Day Hospital and Old See House Day Hospital, North Belfast, consultant psychiatrists involved in the care of day patients are analytically trained and provide psychoanalytic / psychodynamic understanding to other staff working with people with BPD or Co-morbid Personality Disorders.

6.5.16 For many years, those involved in the more specialised provision of services for people with eating disorders, addictions and forensic services have recognized the importance of associated personality disorders in the treatment and prognosis of those with mental illness. However currently, they are unable to offer specific treatments to those people who also have a Co-morbid Personality Disorder.

6.5.17 It is likely that the incidence of personality disorder in Northern Ireland is as high, if not higher, than throughout the rest of the UK. Risk factors are increased by the impact of 35 years of trauma, low socio-economic status and increasing numbers of single parent families.

6.5.18 The lack of resources for the management and treatment of severe mental illnesses such as schizophrenia and bipolar affective disorder has meant that those with a personality disorder are viewed as low status patients and do not access readily the limited resources available to people attending psychiatry, psychology and psychotherapy services in Northern Ireland.

6.5.19 The limited development of psychological services in Northern Ireland (psychiatry, psychology and in particular psychotherapy services) has contributed to a limited understanding of the development of personality disorder, its management and treatment. There are no Therapeutic Communities and no-one is trained in Dialectical Behaviour Therapy in Northern Ireland.

Good Practice Examples

Halliwick Unit, Tottenham, London. Comprising a day unit and intensive outreach service, this Unit offers a treatment service tailored to the specific needs of people with severe personality disorder. A package of group and individual treatment is offered within a day hospital over 5 working days, or within an intensive outpatient programme involving three sessions per week. Patients are offered a self-booking psychiatric clinic to discuss medication and a rapid response in emergencies. Engagement of the patient is important and assertive outreach is included in the programme. (Contact: www.halliwick.nhs.uk or 020 8442 6528.)

Winterbourne House, Reading. A therapeutic community as an intensive treatment programme. The district psychotherapy service draws from a catchment population of 800,000, takes 400-500 referrals per year from primary and secondary care and offers therapeutic community work of 18 months to 6%. Outpatient individual psychoanalytic or dynamic treatment for 2 years or group therapy for up to 3 years is offered to others for whom treatment is deemed suitable.

The unit was cited in the 2003 NIMHE "Personality Disorder: No Longer a Diagnosis of Exclusion" policy guide, as a "Notable Practice Site". Service user involvement has always been a guiding principle in the therapeutic approach used, and several of the service users and ex-users participated in the user consultation exercise for the NIMHE guide. It is at the forefront of providing modern, acceptable and pioneering PD services. (Contact: 0118 956 1250 or www.winterbourne.demon.co.uk/news/ecellb.htm). Other internationally renowned units in this category are the Henderson and Cassel Hospital units.

Regional Psychotherapy Service Department, Newcastle upon Tyne: A specialist outpatient service for people with a personality disorder, offering psychoanalytically informed treatments leading to a reduction of self harming behaviour and the frequency and duration of hospital admissions. Patients become more skilled in managing emotions and relationships and improving the quality of their lives.
(Contact: 0191 232 5131.)

6.6 Services for People with Asperger's Syndrome or High Functioning Autism (AS/HFA)

The Nature and Extent of the Issues

6.6.1 Autism is a complex developmental disability, of life-long duration, affecting the way in which an individual perceives his/her environment, behaves, communicates and interacts. Core features of the disorder are impairments in social interaction and social communication, with rigidity and repetition in thought processes, activities and behaviour.[101] The term 'autistic spectrum disorders' (ASD) has been introduced to include the range of presentations from those who are severely affected with a co-morbid learning disability, to the intellectually able ie those with Asperger's Syndrome (AS) or High Functioning Autism (HFA). The latter are often used interchangeably, although increasingly Asperger's Syndrome is used as a short-hand reference for both.

6.6.2 The National Autistic Society [102] (NAS) estimated the prevalence of all autistic spectrum disorders to be 1 in 16 of total population, whilst the Medical Research Council[103] cites 1 in 166. Similarly, there are varying estimates of AS/HFA. Several studies [104, 105, 106] suggest that approximately 1 in 300 people will have 'able autism'. It has been found consistently that significantly more males than females are affected, with reported ratios averaging 4 to 1. [107, 108]

6.6.3 Epidemiological studies continue to support opinion that the majority of people with ASD, possibly more than 75%, are within the 'average' or 'above average' range of intellectual ability.[109] Therefore, most are well outside the remit of services that are commissioned to support those with a learning disability (generally accepted as IQ<70).

6.6.4 Presentation of symptoms may be more subtle than those displayed by individuals with significant intellectual impairment, but are often equally and, indeed, more disabling. As a result of less 'obvious' symptoms, many have been mis-diagnosed during childhood, adolescence and even in adulthood. It is reported that 46% of people with AS/HFA in England and Wales are not diagnosed until over 16 years of age. [110] With improving recognition and increasing expertise, it is evident that substantial numbers of adults with High Functioning Autism/Asperger's Syndrome are already in receipt of existing mainstream mental health services. Experienced mental health professionals generally feel ill-equipped to provide appropriate support and therapeutic intervention for patients/clients with the specific deficits that are characteristic of autism.

6.6.5 Priorities For Action[111] recognised for the first time that intellectually able adults with ASD are presenting to mental health services and require specialist provision to address their needs.

6.6.6 Studies of adults with confirmed diagnoses of Asperger's Syndrome or High Functioning Autism indicate a high level of associated mental health problems, particularly affective disorders, often with onset during adolescence.[112, 113, 114] It is estimated that 15%-20% suffer from significant anxiety disorders[115] and 37% from depression.[116] Frequently, clients present to services due to anxiety or depression that may then initiate further assessment and subsequent diagnosis of a pre-existing ASD. Recent evidence suggests that there is a 1 in 20 prevalence of co-morbid psychotic illness amongst able adults with ASD, frequently precipitated by extreme anxiety. In surveys conducted by Barnard et al,[110] 50% of parents whose son or daughter was not diagnosed until after the age of 30 reported that their child had experienced mental ill-health. Of these, 56% had suffered from, and been treated for depression. A further 11% suffered a 'nervous breakdown' requiring hospital admission, and 8% expressed suicidal ideation or had attempted suicide. It is reported that able adults with ASD fit the high risk 'suicide prone' category.[117, 118]

6.6.7 From the Down Lisburn Trust Pilot Project[119] (total population 180,000) over 16 months, a total of 36 adults with confirmed diagnoses have been identified, almost two thirds of whom were diagnosed after the age of 17. The majority (69%) were referred from, and already in receipt of, mainstream mental health services. Co-morbidity of autism and a mental illness is confirmed in 55% of those participating in the pilot project (N=29), although most experience an anxiety disorder to some degree. 84% reside in the family home, 13% live with their partner, and only 3% are living independently with support at present. Only 13% have full-time employment, 6% part-time work, 16% part-time voluntary work, 9% attend New Horizons, 34% attend College, Training Centre or University. 22% have no meaningful occupation. An additional 94 adolescents, aged 13 to 17, have a confirmed diagnosis of AS/HFA and will require access to adult services in the near future. Many have additional attentional and hyperactivity disorders.

6.6.8 Given the possible total prevalence of ASD, it is evident that many adults do not present for diagnosis and may not require specialist professional assistance, but the extent of need is inevitably difficult to ascertain in the absence of autism specific services and appropriate information systems. For those who do seek help, the following service components are recommended as representing a minimum standard of provision by the NAS.[120]

6.6.9 **Assessment and Diagnosis.** Currently, there is a lack of expertise in the assessment and diagnosis of people with AS/HFA throughout Northern Ireland.

Clinics which specialise in this work are uncommon, not only in a regional context, but nationally and internationally. One local Community Trust has established a diagnostic service, specifically for intellectually able individuals who are referred with a query of ASD. Many adults coming to the attention of services have complex difficulties, often including co-morbid mental illness. It is essential that a comprehensive diagnostic evaluation is undertaken by professionals with expertise in autism and mental illness.

6.6.10 **Support.** Post-diagnostic support is extremely limited in Northern Ireland for all who have ASD, their families or carers. However, people with diagnoses of both autism and a significant degree of intellectual impairment are likely to fare somewhat better than those intellectually able individuals with autism, as the former are 'eligible' for provision by learning disability programmes of care. At present, appropriate support is almost non-existent for adults with AS/HFA as they are usually excluded from learning disability (by virtue of their higher cognitive ability) and from mental health services unless a mental illness is confirmed. Lack of appropriate services greatly increases the likelihood of secondary mental health problems developing.

6.6.11 Some individuals have been accepted by services for people with a learning disability, as providers currently have nothing else to offer. Whilst this is clearly inappropriate for adults with AS/HFA, and draws on already scarce resources, in most areas of Northern Ireland it may be the only help available. These professionals with expertise in learning disability, like their colleagues in mental health, do not feel that they have sufficient knowledge of AS/HFA, the therapeutic skills required, nor an awareness of the types of services that may be needed.

6.6.12 To date, only one Health and Social Services Trust has developed a pilot project designed to assess the needs of individuals with AS/HFA and their carers, to support both, and to provide a therapeutic service specifically for this population. Some voluntary sector services have successfully provided sensitive individual support and accommodation.

6.7 Services for People with Disorders of Gender and Sexuality

The Nature and Extent of the Issues

6.7.1 The Psychosexual Service as a component of mental health services is uniquely positioned to address the emotional and bodily-based derivatives and expressions of disorders of gender and sexuality. The service must offer an expertise that addresses both sides of the mind/body equation within a psycho-physiological developmental framework. Although Northern Ireland has benefited from services located principally at the Belfast City Hospital since the mid 1960s, services throughout the United Kingdom are patchy. For example, in a recent survey[121] only 21% of commissioning authorities provide services at a local level for transpeople (individuals regarded diagnostically as transsexuals).

6.7.2 Psychosexual services provide for people with a diverse range of disorders of gender and non-organic disorders of sexuality. Rather than a spectrum of disorders, the diagnostic categories reflect quite different population groups with specific needs. For example, transpeople have a low prevalence (varying from 1/2900 for male to female and 1/8300 for female to male in Singapore[122] to 1/11900 for male to female and 1/30400 for female to male individuals in the Netherlands[123]) and constitute only 12-14 new referrals each year to the Northern Ireland Regional Service. However, due to the complexity and longevity of their needs, they often require significantly more input from services (on average treatment and follow-up lasting for 5-6 years) compared to individuals with, for instance, sexual dysfunction. Evidence suggests that transpeople demonstrate high levels of mental ill-health (requiring active psychiatric intervention) at the point of accessing services, often with high rates of parasuicidal behaviour and substance misuse,[124] and it seems likely that this is a direct consequence of difficulties with their sexual identity. There is also convincing evidence to support treatment of transpeople,[125] and that regret after sex reassignment is low, ranging from none to 3.8%.[126]

6.7.3 Although individuals with non-organically based sexual disorders constitute most referrals to psychosexual medicine (78% of referrals to the Belfast City Hospital Service) they tend to require shorter and less intensive interventions. This group of disorders appears to be very common throughout the general population, although precise data for Northern Ireland is as yet unavailable. However, studies elsewhere suggest prevalence rates for women may be as high as 43%[127] (a substantial number of which would require the assistance of a psychosexual service), with disorders of female sexual arousal constitute 70%[128] of attendances at psychosexual services. For men, erectile disorders have an incidence of between 7-25%,[129, 130] and 59%[131] have a psychological basis.

6.7.4 Individuals with disorders of sexual preference (paraphilias) constitute the other main category of referral (14% of referrals to the Belfast City Hospital Service).

There are few reliable sources of data in terms of incidence in the general population. Offenders tend to be dealt with through forensic and probation services. However, those who are referred to psychosexual services tend to have complex needs and may require specialist psychotherapeutic involvement over prolonged periods.

Current Services

6.7.5 The Psychosexual Service based at the Department of Psychiatry in the Belfast City Hospital has offered services on a regional level from the mid 1960's. In the 1980's the Western Health and Social Services Board developed a local, consultant-led service in Omagh. Some services for sexual dysfunction are also offered through family planning clinics, by a variety of mental health professionals with an interest in this area. In the voluntary service, similar treatment is available mainly through RELATE.

6.7.6 The largest and most comprehensive service remains that located at the Belfast City Hospital. The Psychosexual Team is led by a Consultant Psychiatrist and is constituted by multidisciplinary therapists including input from social work, nurse and general practice. Although there is access to inpatient places in Windsor House, this is only required on an exceptional basis and the vast majority of work is sessional and outpatient based. Most of the team members have accredited training in a range of psychotherapies.

6.7.7 In addition, through the General Practitioner Therapist there is a skilled focus on the assessment and treatment of certain physical aspects related to psychosexual disorder. Referrals are accepted from General Practitioners and Consultants in other branches of psychiatry, surgery and medicine. There are currently established links with services in Great Britain for the purpose of sex reassignment surgery (as this is not available in Northern Ireland), organised through private medical facilities.

APPENDIX 7

STATEMENT FROM EXPERTS BY EXPERIENCE

PREFACE

We choose to call ourselves Experts by Experience (EBE) rather than Service Users because the term highlights the unique contribution that we, who have direct experience of emotional distress and the mental health services, can make to the Review process and the development of mental health.

Given our distinctive expertise, the EBE Group felt it necessary to take a broader view than the strategy document and address some areas of fundamental concern, which were not explored within the Adult Mental Health Strategy document. The EBE Group identified the topics in this Appendix as central to the recovery process. We are the reason for existence of the mental health services and treatments, and we believe it was necessary for us to develop and publish our position on these issues.

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MISSION STATEMENT

1.1 Everyone who lives has mental health needs. In an imperfect world people become emotionally stressed, depressed and unwell and they seek help and healing. Society's response in the western world is the psychiatric system which some of us have managed to survive with psychological scars and perhaps drug dependency but with a renewed sense of our rights to full citizenship, equality and self-determination.

1.2 We claim our rights to be valued for our dynamic diversity and dignity. As Experts by Experience we want to shape the environment, community and practice of mental health care, legislation and policy. A holistic approach is needed to acknowledge the reality of our emotional, spiritual, intellectual, social and physical being.

1.3 "Professional carers" who work in this field must be trustworthy and listen in an open, non-judgmental way, respecting our views and requests. This is essential to creating a partnership of trust, respect and empowerment.

DYNAMICS

2.1 We choose to call ourselves Experts by Experience (EBE) rather than service users because the term highlights the unique contribution that we as insiders can make to the review process and to the development of mental health.

2.2 The Experts by Experience group of the Review presents this paper because we want to assert that we are not just stakeholders responding piecemeal to the Strategic Framework, but central to the whole review.

2.3 We believe that the dynamics of the Review have been coloured by the fact that we were brought in at a late stage to validate or respond to agreements already in train. This may have reflected our previous status but now it is crucial to the Review that we have partnership, equality and power. We want full participation in a process that is transparent and person-centred throughout.

2.4 Although claims are made that the medical model of health, whereby a "patient" is deemed sick and needs treatment from an expert, has been superseded by newer models, our experience is that the attitude lives on in practice. This approach does not take into account the depth of the person's experience. Practice needs to be holistic and respectful of individual personalities and of social or spiritual aspirations and attainments.

2.5 Every aspect of human behaviour can be classified as a symptom. We want the mental health environment run on needs based criteria rather than being dependent upon divisive labels and symptoms.

2.6 We believe that we as experts hold a wealth of information about the roots of our distress and the process of recovery. Our autobiographical evidence must be given more importance than clinical data. Until our evidence and feedback is included, the quantifiable outcome is flawed and seriously undermined.

2.7 Every one has mental health needs and it is possible that anyone might at some time need mental health services. No one can dispute this. However the legacy of the medical model creates unacceptable divisions between the perceived sick and the healthy, normal and abnormal, good and bad.

2.8 Further divisions are made when labelling "severe and enduring", which in turn leads to unjust prioritisation of needs and services. Divisions also exist amongst professionals, which create unhelpful hierarchies resulting in some workers being undervalued and demoralised.

2.9 We want true partnership in our struggle to recovery, based on transparency and accountability, to a code of good practice that has the agreement of the Experts by Experience group.

PERSON-CENTRED APPROACH

3.1 Within our diverse Experts by Experience group, each of us has our own horror story of the effects of when we were controlled and felt as if we were being treated as objects rather than persons. There is consensus within the group that if only one element could be changed we would wish it to be the prevailing attitudes of those who engage with us.

3.2 The language of the Strategic Framework document is well seasoned with the words "person-centered" and whilst we acknowledge that this is well meant and a good step forward, without definition it loses significance.

3.3 Our definition derives from the Rogerian approach in that we want to be viewed as being at the center of our own universe, which has validity for us. We want to be understood as we are, with our dignity and unique story rather than in relation to preconceived and disempowering concepts. We have faith that everyone and not just users, has the capacity for and tendency towards fuller functioning and self-actualization, if these are nurtured by empathy, congruence and respect. We all have within ourselves vast resources for self-understanding and for being able to learn and change.

Congruence, Empathy and Unconditional Positive Regard.

3.4 As any number of users of mental health services can testify at great length,possession of these skills and the communication of them is not innate in service providers and carers. They have to be taught and learned.

3.5 Training in the person-centered approach is different to all other clinical approaches because it demands that the therapist wholly takes their lead from the client. It is rigorous and rewarding because it is process oriented and based on being rather than doing. It is a very difficult skill to master often depending upon holding back rather than imposing solutions

3.6 We need all professionals in the mental health field to have specific training in the person-centered approach as part of their overall learning.

3.7 At present the only therapy mentioned in the Strategic Framework document is Cognitive Behavioural Therapy. This may be a helpful therapy based on admirable theories but it is only part of the picture. As users of mental health services we want a broader choice of therapies and we want them delivered in a person-centered way.

3.8 Person-centred therapy training and provision is fairly widespread in the rest of the U.K. There are more person-centred training places on British Association for Counselling and Psychotherapy (BACP) accredited training courses than for any other therapeutic modality. An additional interesting statistic is that in terms of the major academic publishers, book sales in the person-centred therapy domain are greater than all of the other therapeutic approaches combined.

3.9 A similar, though not quite so pronounced bias is noted in terms of the employment of counsellors, particularly in the field of primary health care. For example the Lanarkshire Primary Care Trust employs a total of 16 full time therapeutic counsellors to work across 61 general medical practices. This contract is in its ninth year and it operates on a specification laid down by Lanarkshire Health Board which required the employment of person-centred therapeutic counsellors. The view taken was that the evidence for this approach was equal to others, including CBT but a notable factor was the distinct patient preference for the person-centred modality.

3.10 Exactly the same pattern of evidence is reflected in the largest randomised control trial into primary care counselling ever conducted in Britain. The King study found that found equivalence between person-centred therapy and CBT over four month follow-up, but again with clear patient preference for person-centred over CBT[2].

3.11 The consistent representation of CBT as having better evidential base over other approaches is seriously questioned in the latest edition of Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change (Lambert, 2004). A particularly notable paper in this regard is that provided by Elliott, Greenberg and Lietaar[3].

References:

1. Client centred Therapy Carl Rogers1951

   On Becoming a Person Carl Rogers1961

2. King.M.,Sibbald,B., Ward,E/.Bower,P., Lloyd,M.,Gabbay ,M., and Byford,S Randomised control Trial on non directive counselling, cognitive behaviour therapy and ususal general practitioner care in the management of depression as well as mixed anxiety and depression in primary care (Monograph). Health Technology Assessment; 4(19), 1-84 (2000)

3. Elliott, R., Greenberg,L.S. and Lietaar,G Research on Experiential Psychotherapies in Lambert,M.J. (ed) Bergin and Garfield's handbook of Psychotherapy and Behaviour Change (5th edition):pp 493-540 (2004)

RECOVERY

4.1 Recovery needs to be at the very top of the mental health agenda and accepted as an integral and central part of any proposed model of mental health care.

4.2 Taking ownership of the term, we define it from our experience rather than acquiescing to a definition that derives from theoretical sources popular amongst professional mental health workers.

4.3 The concept of recovery is very personal and subjective, as such it must be self-defined. For some it is a journey, with significant landmarks, rather than a destination. Others describe it in terms of:

peace of mind
happiness
accepting who I am
independent living
power to change things in my life
living life to the full
learning to accept the limitations of my relationships
coping with what is rather than what I want
coping with life's obstacles in my own way
I think therefore I am.

4.4 The concept of recovery and empowerment should replace the old notions of maintenance and rehabilitation. For many, rehabilitation is cold and mechanistic and often dehumanising. For some it is redolent of industrial therapy centres, which may still have a role, but do not suit the needs of all people with mental health difficulties.

4.5 Mental health workers and service providers need to be aware of the often negative and disempowering effects of institutionalisation. We need to avoid the creation of a mind-set of controlled conformity and subservient compliance, which has been prevalent in approaches to mental health service users encouraging a form of learned helplessness.

4.6 What is needed is a full and satisfying life as the individual sees it. A range of alternative therapies and life enhancing programmes need to be made available. Some have found benefit in supported employment centres but work needs to be continued to ensure that such centres operate at a high standard, putting service users at the heart of activities.

4.7 The mental health worker's role is to support and respectfully encourage the person in their own journey of recovery. These efforts need to be enhanced by the work of the advocate, in particular the peer advocate, who can aid communication, creating positive relationships of equality.

4.8 The community also has a role to play in recovery by providing safe havens and places of sanctuary in times of crisis as alternatives to acute hospital. Peers, family and friends may also be involved in facilitating recovery.

4.9 Those of us who have experienced recovery, having come through difficult and tortuous journeys, have exceptional authority and insight. This enables us to offer hope and encouragement to others who are still wrestling with their own pain. Having survived, we are a valuable asset to a society struggling with its own brokenness.

PEER ADVOCACY IN MENTAL HEALTH

5.1 The Strategic Framework document acknowledges partnership with service users in service planning and delivery as a fundamental principle in mental health care. We support service user involvement, not in a tokenistic fashion, but with real consideration of the positive contribution we can make to the mental health care services.

5.2 Our experience will be invaluable in the monitoring, quality control, development and delivery of services. One strong and proven route to service user involvement is through the peer advocacy movement which we heartily recommend as being of unique value to all service users and our allies in the mental health statutory and voluntary services.

> "Given that there are no other diagnoses for which laws are passed requiring that patients follow doctors' orders, the ramifications of mental illness encompass a great deal more than the illness itself."
>
> "The peer movement is predicated on the idea that there is a knowledge base of proven, experiential, indigenous wisdom that has come from struggling with the problems of mental illness in concrete ways." [1]

5.3 Peer advocacy challenges the discrimination and stigma attached to "mental illness". It is also a tool for empowerment by which to build, or re-build, well-being for people whose mental health condition has damaged self-esteem and confidence, induced a sense of worthlessness, interrupted careers and contributed to social isolation and poverty. This empowerment and its benefits are experienced by both the advocate and the client of peer advocacy service.

5.4 Peer advocacy involves having an accredited training, a Code of Practice - with confidentiality at its core - and regular supervision. It includes information and peer support in areas such as talking therapy, self-management of one's mental health condition, coping strategies, physical health promotion, general mental health education, anti-stigma support, information regarding medications, green therapy (e.g. doctor's prescription for visit to gym, swimming pool or relaxation) and other alternatives or complements to medication treatments. Peer advocacy services include information and signposting for welfare benefits, housing, access to mental health services and access to education and training.

5.5 Peer advocacy makes a special contribution to recovery from mental ill health by offering hope to the person seeking help. It can be inspirational: the client sees a peer now strong and able, a good role model.

5.6 There is added benefit in service user relating to service user: clients can trust and feel respected. There is no power difference in the relationship. It is often easier to talk to a peer advocate because there is real empathy in the struggle to overcome mental health problems. The client is empowered as peer advocacy challenges dependency and gives them significant control.

5.7 Peer advocacy is truly person-centred: the client is the focus of activity. There is no conflict of interest: the peer advocate will act only upon the wishes of the client. The peer advocate listens empathically and the client can, sometimes for the first time, put their thoughts about their condition into words.

5.8 Peer advocacy aims to promote accountability in the mental health services and to contribute to ongoing improvements in services. In addition, we believe that peer advocacy , through better communication, enables mental health workers to support their clients' involvement in their own recovery.

5.9 Pressures on professional mental health workers limit the amount of time they can spend listening to clients. The client, therefore, frequently doesn't get enough time to describe his/her concerns. This can cause severe additional distress. The peer advocate can dedicate more time which the client finds helpful. Professional mental health workers can benefit from peer advocacy as well as clients because the advocate is well placed to articulate the concerns of the client.

5.10 Supporters of peer advocacy in the mental health services are well aware of these benefits. Peer Advocacy needs more appreciation, rather than the present patchy acceptance or resistance from mental health workers. There is no need for anyone to feel threatened by the peer advocacy movement in terms of power or job demarcation or professionalism. It merits inclusion, promotion and a spirit of partnership, as it is a valuable independent extra resource.

5.11 Professional mental health workers cannot claim to advocate for their "patients" when there is a contradiction inherent in their roles.

5.12 Contributions from the "Experts by Experience" are invaluable where the client has misgivings about their treatment or diagnosis or where the client is being disrespected for example being referred to as their condition.

5.13 Those Health Trusts who have welcomed and monitored peer advocacy know the professionalism of this service in relation to the client and the mental health workers. Clients report less frequent return to hospital, more hope for recovery and less dependence on key workers. Significant numbers of clients choose to return to the peer advocacy service and encourage other service users to do so. It is clear to these Health Trusts that peer advocacy is not simply a complaints or a welfare rights service.

5.14 As there is some resistance to peer advocacy we recognise that there is practical educational work to be done by the peer advocacy movement and its allies in the mental health services.

5.15 There is powerful user-led and experiential evidence to support our claim that peer advocacy is vital to the development of an enlightened mental health service.

Recommendations

1. That the role of the peer advocate, as advocating continually on behalf of people with mental health difficulties, be recognised as an integral part of the service.

2. That peer advocacy be accepted in all Trusts and by all professional mental health workers. That it should be welcomed, supported, resourced and promoted as policy.

3. That a publicly funded user-led advocacy body be established to oversee policies, standards, supervision protocols and codes of practice.

References:

This section is informed by articles in "The Advocate" - Magazine of the UK Advocacy Network, UKAN, 14-18 West Bar Green, Sheffield, S1 2DA. Tel: 0114 2728171

1 Choice Advocacy and Case Management Services, New Rochelle, New York (http://www.choicenr.org)

IN TIMES OF CRISIS

6.1 The consultation document on the Strategic Framework freely admitted (para 4.20) that:

> "People with severe mental illness often experience crisis which may arise through illness relapse or through problems coping with the demands of their social and personal situation".

We strongly contend that difficult or intolerable social and personal situations are very often the cause of the perceived mental illness in the first instance and the "treatment" meted out in the psychiatric system is what makes their illness "severe and enduring". We want to ensure that the evidence of the person concerned is heard and respected rather than dismissed as irrelevant and lacking insight.

6.2 To avoid the mistake of mistreatment arising out of perpetuating labels we recommend that people be given the opportunity for the root causes of their distress to be addressed.

6.3 Those with severe mental illness have what is generally referred to as a "diagnosis". This is a label, which carries a huge weight of so-called "evidence-based" prejudice with it. It also precludes any real possibility of recovery and creates a mentality of negative self-fulfilling prophecy. What we want is a climate of positive optimism and shared determination to find ways of overcoming crises and working towards recovery.

6.4 The consultation document on the Strategic Framework acknowledged (para 4.20) that:

> "in many circumstances admissions are likely to have an underlying social rather than medical cause, the likelihood of being admitted being more strongly correlated with social rather than clinical factors."

We support this statement and suggest that the emotional crisis may be a healthy and rational response to very unacceptable life circumstances

6.5 The consultation document on the Strategic Framework also stated (para 4.20):

> "Present evidence suggests that the majority of inpatients are admitted to psychiatric hospitals as emergencies." At times of perceived crisis it is

important to discern who experiences it as an emergency; the so-called "sick" person or others who find it hard to accept and cope with their behaviour.

6.6 If the cause of the “crisis” is social and emotional, the response needs to address these issues appropriately rather than simply medicating the problem. Close scrutiny of these responses on the ground shows them to be not only inappropriate, but also fundamentally unhelpful and untherapeutic as well as being an "inefficient use of resources". (At a recent conference of mental health professionals, it was asserted that 75% of prescribed medication is never actually taken by the recipient). We contend that this is a poor use of economic resources as well as a challenge to the current psychiatric system.

6.7 Medical responses may be appropriate but often are degrading and dehumanising. Witness instances, not at all uncommon where the "distressed person" experiencing perhaps intolerable social circumstances is subjected to the very clear mistreatment of being forcibly arrested by armed police and uniformed ambulance personnel very often in full public view and driven to an acute hospital ward to be physically dragged along a corridor, held down by uniformed staff (predominately male) and injected with a chemical substance against their will. No treatment could be more degrading, traumatising and dehumanising. The Strategic Framework acknowledges that it is inappropriate and ineffective.

6.8 In a society which claims to be committed to respecting the human rights and dignity of all its citizens we ask for this practice to be abandoned and replaced with more humane and appropriate responses. People in emotional distress must be treated considerately and not like dangerous criminals, detained against their will without a fair hearing and legal representation. It would not be at all acceptable in law for even dangerous criminals to be subjected to enforced drugging. Yet this is allowed to go on daily in our psychiatric hospitals.

6.9 What is needed is respect, care, listening, understanding, gentleness, empathy and the provision of a safe and welcoming environment. Hospitals do not often provide these responses. We, as Experts by Experience, recommend that crisis response should wherever possible be provided in the presence of peer advocates or, if requested, by the person experiencing the “crisis” it should be undertaken by caring and enlightened mental health workers.

6.10 It is paramount that the person in crisis has a choice in the matter of the care received and that it is not a "treatment" imposed with little or no regard for civil rights and liberties and self-determination. Current legislation allows for serious abuses such as those cited already . The response needs to be genuinely person-centred, and to recognise the rights and dignity of all concerned. If there are conflicting interests between the distressed person and the "carers", the person's right to self-determination and equality of opportunity needs to be safeguarded. Sometimes there can be unhealthy "collusion" between carers and professionals leaving the person at the centre of the situation disempowered.

6.11 Mental health crises need responses, which are open, respectful and just, demonstrating accountability and transparency . Home or respite service responses should be the norm. Medication will most often not be appropriate. It is a medicalising of an emotional crisis. A 24 hour telephone service staffed by caring and experienced people (preferably Experts by Experience or trained lay volunteers) would be much more helpful and less intimidating than the typical present treatment. Crises properly handled can actually become opportunities for growth.

TRAINING AND WORKFORCE

7.1 The Experts by Experience group would like to highlight several important issues with regard to training. We feel very strongly that in order for the new vision to be truly inclusive of service users and hence achievable, that the values and principles expressed by this Review must be genuinely upheld and implemented.

7.2 We express disappointment that both self-management training programmes and pro-active service user development initiatives were totally overlooked. Therefore we have genuine concerns about the valuation of our input not only to this Review but also to the future development of the perceived new vision in general. As mental health service users, we have become accustomed to and hence are acutely aware of any denial of the expertise that we have to offer.

7.3 For the proposed partnership to work there must be acceptance of our future role and our expertise and experience of mental diversity, and experience of services provided, all of which give us that extra dimension over head-knowledge and work-related experience. Expertise gained through trial and error, pain and hardship, separation and incarceration has taught us a lot;

- about ourselves,
- about others: we have a deep appreciation of what is happening for other people when they are in distress,
- about service providers, both statutory and voluntary: we have an understanding of what works and what does not work – what is most personal is universal,
- about all other statutory and voluntary agencies: the majority of service users know through actual experience how problematic it can be to have to sort out anything in connection with Social Security, DSD, housing etc. especially just after a time in hospital or when feeling particularly unsettled.

Service user led initiatives provide a safe, confidential and supportive environment among people who are known and trusted and who can help explore relevant issues.

7.4 Whilst we too may have academic qualifications or work related experience these could never equal our skills, relevant to mental health, which accrued through having mental health problems.

7.5 The ultimate goals of all of us involved in mental health care/support, must be partnership rather than authority; empowerment rather than control; personal self recovery rather than an emphasis on being managed/maintained by others.[1] Service users will continue to break down any walls of division; some erected in the name of mental health professionalism, and will work towards genuine inclusiveness in this sphere.

7.6 For this Review to be sincerely committed to the ethos of the new vision, the workforce must be inclusive of all those involved in the process of creating its reality, including service users and carers, in a meaningful way.

7.7 Due to the monopoly, upheld by legislation, that psychiatry has enjoyed and exploited in the arena of mental health in Northern Ireland particularly, serious damage has been done, and still is occurring, due to oppressive practices. The negative impact of institutionalisation - loss of self-identity, loss of independence and traumatisation has resulted in a great number of, especially hospitalised, mental health service users needing to be re-empowered, at various levels. This re-empowerment involves regaining belief in themselves as persons first and foremost, becoming confident again in their own individual abilities and strengths and reclaiming personal responsibility.[2]

7.8 The Experts by Experience group unanimously endorses that all those involved in providing care/support should be adequately and appropriately trained and educated in order effectively to work in true partnership to achieve these goals. Until this vision is truly implemented and is seen to exist, with service users sitting alongside professionals in joint planning, training and education, the existing power imbalance will endure between services users and professionals. In multidisciplinary contexts current practices can be particularly demoralising and destructive for those grass-roots professionals who work in an environment lacking any support from within their own managerial structure. Professional judgements are frequently overruled by clinical judgements. Independent advocacy also in this climate has limited efficacy. The psychiatrist's word is deemed to be final.

7.9 Therefore, responsibility and accountability in ensuring that adequate and appropriate planning, training and education are accessible to all persons involved must be equally embraced by all.

Recommendations

1. The establishment of An Ethical Framework Strategy which is inclusive and applicable to all involved in providing care/ support to people with mental health problems

2. The establishment of a Service User Involvement Planning Group, in collaboration with DHSSPS and Health and Social Services Boards, adequately resourced and appropriately located.

3. Mental health service users' individual life skills be identified, acknowledged, supported, encouraged and incorporated within all aspects of mental health service provision and afforded opportunities for continual development either though service user/professional or jointly led training and education.

4. Service users must be given real opportunities to use and enhance their skills through meaningful involvement in the planning, delivery, evaluation and monitoring of the services.

5. Service users should be actively involved in the recruitment of all personnel seeking involvement at every level in mental health service provision.

6. In order to modernise existing services in Northern Ireland, posts must be created enabling past and present service users to be employed.

7. Peer advocates must also be actively involved in all the multi-disciplinary teams that operate within and outside psychiatric and hospital settings. This is to ensure that the ethical principles established are upheld with the right attitudes

8. Service user involvement must be incorporated within the continuous assessment process throughout the duration of all professional training including psychiatry. Service users must be involved from the beginning of all training courses, including planning, working, in equal partnership at all levels, to ensure that trainees uphold the core values and principles of the agreed ethical guidelines governing the mental heath framework.

9. Service users must be involved in the ongoing education of mental health professionals in order to safeguard maximum efficiency of human resources and good practice.

References

1 Repper J., Perkins R.{2003} Social Inclusion and Recover y Bailliere Tindall, London.

2 Bodman R.,Davies R., Frankel N., Mintol L., Michell L., Pace C., Sayers R., Tibbs N., Tovey Z. and Unger E.(2003} Life's Labours Lost The Mental Health Foundation, London.

TREATMENTS

8.1 As users of mental health services all of us have felt at some point abused by the system of psychiatric "care". Treatment is therefore a very important issue for us. Recovery can only be fully realized in a person centered holistic context not under mined by diagnoses and predicted outcomes, which dictate the perceived "needs" of the individual.

8.2 Our main concerns about a treatment-led mental health service are as follows. The vast majority of research into "mental illness" is supported and funded by pharmaceutical companies, which have an undeniable vested interest. The biological, medical and genetic paradigm therefore predominates within the area of mental health. There is an obvious bias here. Research into the environmental causes and solutions to mental and emotional distress are neglected and often ignored. Alternative and complimentary therapies are undervalued and often unavailable.

8.3 Our experience tells us that choice of medication is rarely if ever given. Negotiation and participation in medical treatments is never encouraged and rarely facilitated. Information on medication is usually provided in an inappropriate form (prescription leaflets) and at times is explicitly withheld. This situation leaves the service user feeling at best disempowered and at worst resentful.

8.4 The mental health professional argues that although medications used to treat mental ill-health have significant side effects, these are regarded as the lesser of two evils: "better to endure the side-effects than become a danger to self or others". Risk of non-compliance becomes the main concern for the mental health professional with coercion and forced treatments taking precedence over therapeutic work. Side effects such as paralysis, involuntary movements, extreme constipation and weight gain with the possibility of heart and kidney failure (to name but a few) are regarded as acceptable to the administering services though often intolerable to the recipient. There is a lack of balance here between the risks posed from the side effects of medications against the risk of relapse. Many people who receive such prescriptions often dispose of their drugs rather than take them and suffer the side effects. This is a great waste of resources that could be better utilized in providing helpful altemative
s.

8.5 Research continually provides evidence on the effectiveness of medications. If these medications are so effective why do so many individuals relapse while remaining on their recommended dose? We have learnt that much of the evidence demonstrating the reliability and validity of medications has been found to be manipulated or misused to support the medical model of mental illness. Our experiences in reporting hitherto unknown side effects have been continually ignored and have only been taken seriously many years after our first reports.

8.6 We therefore have the moral right to question all evidence on the reliability and validity of medications. We have the right to ask questions, criticise when necessary and to be taken seriously. We have the right to all information available on medications and to be part of the monitoring process of the effectiveness of any medications we agree to take. We have the right to refuse medications.

8.7 We want more independent research done on the best methods to reduce medication dosage and the safest ways to eventually become free from all medications prescribed for mental ill-health. This would enable people to make a genuine choice about the use of medication.

8.8 We demand more choice, e.g. therapies and activities that can replace medications. We want more research done on the therapeutic benefits of complementary and talking therapies.

8.9 We have witnessed and endured the over-prescription of medications to crippling and often dangerous levels. We believe it is time that an independent body monitors the prescribing of medications for mental ill health.

8.10 A mental health service that is medically driven will never have the capacity or understanding to facilitate the spiritual journey that is essential for individual recovery.

Reference

The British Psychological Society (2000), Understanding Mental illness. Recent advances in understanding mental illness and psychotic experiences, Leicester.

CONCERNS ABOUT ECT

9.1 We are concerned about the administration and safety of ECT. We abhor the abuse of consent, particularly when nominally voluntary patients refuse consent and then become subject to the threat of detention which is often enforced. This is known as “de facto” detention, whereby a person enters a psychiatric unit voluntarily but is then threatened with being “sectioned” if they attempt to leave the premises or do not comply with the treatment offered (ECT or drugs).

9.2 We are opposed to ECT ever being a first-line treatment. Most of the Experts by Experience Group proposed an outright ban on ECT. An alternative proposal was a moratorium. A minority felt it should be a choice for those who wished it. No one is willing to have it (again) themselves.

9.3 In our presentation of research data our aim is to include compelling user-led and user-approved research to highlight the depth of feeling and concern we hold concerning this issue.

The 2001 MIND Survey: Experts by Experience

9.4 It is striking that most medical research papers on ECT never include reports of the patient's experience of ECT. In March 2001 the respected British mental health organisation, MIND released a nationwide survey of people who had experienced ECT, the "Experts by Experience" [1]. One third of these had ECT in the last 5 years. MIND was appalled at the damage still being done by ECT. This survey did not deal with the issue of calibration of machines or competence in administration, but simply how survivors of this procedure felt:

- 84% of respondents suffered unwanted side effects including permanent short and long term memory loss, reported permanent loss of past memories of skills such as the ability to read, write, play music, or concentrate, as well as headaches, drowsiness and confusion
- 73% of respondents were not given any information about possible side effects
- ECT has a racist aspect; respondents from black and ethnic minority communities were more likely to be detained under the Mental Health Act and to have received ECT without consent
- 72% found ECT unhelpful, damaging or severely damaging in the long term.

- 66% would not agree to have ECT again
- Depression (53%)was the most common diagnosis among respondents
- Over half (52%) were unaware they could refuse this treatment
- Over 40% reported permanent loss of past memories
- 36% reported permanent difficulty in concentrating
- In the long term, 43% of recipients found it was unhelpful, damaging or severely damaging
- One third of recipients felt hopeful before having ECT, but 29% felt terrified and 22% that they were being punished
- Only 8% had the opportunity to consult an independent advocate before making a decision about ECT

9.5 Having noted these findings, the survey acknowledges that some people found ECT helpful and some found it so when antidepressants were not helping, or that ECT worked more quickly. We present the negative findings because they so seldom see the light of day, and if these results can apply to the percentages of people cited, they can happen to anyone.

9.6 The Royal College of Psychiatry itself acknowledges serious concerns with ECT. Since 1980 three audits have been commissioned on the subject of its use[2]. Each of these audits document gross incompetence in the administration of ECT revealing outmoded, improperly adjusted equipment, carelessness, ineptitude and inattentiveness despite new guidelines. One survivor said,

> "Twenty years on, three guidelines, three audits and half a million patients further on, the Royal College still can't ensure decent standards of care in all or even most ECT clinics."

9.7 There is an increase in the number of countries which have banned or are in process of banning ECT. In this country, case law and jurisprudence to ban ECT already exists under Articles 4, 5 and 6 of the European Convention on Human Rights.

9.8 ECT still forms a key treatment strategy in the treatment of some people here and its usage varies greatly from area to area and from one psychiatrist to another.

9.9 We have major concerns about the issue of consent. This can only be freely given if full information is offered about all of the effects of the procedure and with no hint of intimidation should treatment be refused. Only eight percent of respondents in the Mind survey had access to an independent advocate prior to their decision. 73 percent could not remember being given any information about possible side effects. Information about alternatives to ECT are rarely offered, according to the experience of peer advocates.

9.10 Choice is an issue here as there can be no possibility of informed choice when the treatment is presented either as “the last option”, or that by not taking the treatment, the possibility is of lifelong depression. This is tantamount to coercion.

9.11 There are contradictions in the system about which treatments are considered safe and what is a considered risk. Statistics about detained people having ECT describe them as “requiring it” [3]

9.12 We bring a sharp focus to the issue of the ethical right to make such a decision or to take a risk for another person which can carry such dire consequences. A lack of transparency about the numbers of treatments given and their outcomes also impedes decision making. We are strongly of the opinion that the individual should be the one to choose how to treat their body and mind.

9.13 Calls for evidence-based research miss the point that we as Experts by Experience are actually the evidence. The safety of ECT is a huge concern to us. We are concerned about the potential for brain damage, depression from memory loss and other long-term injury and at worst death.

Safety -Research Findings

9.14 These ethical and experiential issues are placed first because the call is always for evidence-based research. We, as Experts by Experience, **are** the evidence in a very real sense. The safety of ECT is a huge matter of concern to us. Medical literature in the English language reported over 400 deaths from ECT in the period 1942-1997[4].

9.15 Last year , NICE (National Institute of Clinical Excellence) published new guidelines restricting the use of ECT to those people with severe rather than moderate symptoms [5]. While MIND, other mental health groups and most importantly users and survivors, welcomed these guidelines, the RCP appealed to NICE to drop the new restrictions. The potential for brain damage, death and other long-term injury has been studied, debated, and the results published by scientists. Rather than reinvent the wheel, we have include a brief literature survey by an ECT review team led by Auckland University Geriatrics and Neurology Professor Craig Anderson [6]. This work forms part of a current submission to the New Zealand government in their campaign to ban ECT. This material is cited because of the abbreviated nature of the paper and so that those who wish may discover some of the reasons ECT is beginning to be discontinued in some countries.

Patient Deaths and Suicide

9.16 Reasonable evidence now exists to support the fact that death may often be a side effect ECT, particularly in elderly patients. Contrary to claims, death from shock therapy is not, as suggested, 1 in 10,000 but closer to 1 in 200.

9.17 A study involving 1,494 patients found no difference in suicide rates between “treated” and non-shocked depressed patients [7]. A close examination of the literature does not support the commonly held belief that ECT exerts long-range protective effects against suicide.

9.18 Memory Loss always accompanies the ECT treated patient. Even the US Food and Drug Administration (FDA) have now declared that ECT may cause brain damage and permanent memory loss. Contrary to the claim made that "patients receiving shock treatment do not suffer long term damage to their memory" and that "only 1 in 200 patients have trouble with memory after shock treatment" one study showed that three years after shock treatment 50 percent of patients complained of poor memory[8]. In fact, the 1 in 200 figure was most probably an estimate.

9.19 A recent Spanish study discovered that depressive patients appear to suffer considerable cognitive dysfunction during maintenance treatment with Electroconvulsive therapy (M-ECT). Researchers maintained "Compared with controls, M-ECT patients showed alterations in verbal fluency, mental flexibility, working memory & visuomotor speed." [9]

Neurological Damage

9.20 We are also convinced that the common statement made, that "ECT does not cause brain damage," is nothing more that psychiatric propaganda of the worst kind. There are many noted experts in the fields of both psychiatry and neurology who have reported brain damage as a direct result of shock therapy. Indeed, some early literature on the subject indicated that brain damage was the source of the "improvement"

Depression

9.21 The idea promoted that ECT treatment is effective in eradicating depression is also very questionable. A study carried out as early as 1978 showed little if any difference at 12 and 26 weeks between patients who received ECT compared to those who received "fake ECT" [10]. A further study carried out in 1984 also showed little difference between shock treated and non-shock treated patients after four weeks. A six-month follow-up also showed no difference[11].

Safety Aspects of ECT

9.22 The philosophy put forward in psychiatry that shock treatment (ECT) is very safe is certainly disputed. A study of death rates showed 23-45 percent higher death rate for elderly patients at one, two and three years after ECT treatment compared to a control group of similarly aged people that received alternative psychiatric treatment[12].

9.23 ECT-enthusiast Dr Coffey and his associate Dr Figiel found that 10 out of 87 (that is 11 percent of) elderly patients getting ECT for depression remained delirious between ECT sessions for no discernible medical reason other than the ECT itself. They documented by brain MRI scans that 90 percent of these unfortunate patients had lesions in the basal ganglia areas of the brain, and 90 percent also had moderate to severe white matter lesions [13].

Patients

9.24 With the continued improvement of drug therapy, the use of ECT in younger patients requires close scrutiny. An article in the American Journal of Psychiatry[14] reported that a 15-year-old girl with schizophrenia received 200 ECTs in 1 year. A 16-year-old girl diagnosed with dementia praecox was treated with 15 unmodified ECTs in 3 days. The girl developed an organic brain syndrome over a period of 3 weeks. Five patients were reported to have ended the course of ECT prematurely because of side effects. These included a depressed teenager who underwent a switch to mania after five ECTs; two whose treatment was discontinued because of increasing agitation; one who showed marked confusion after two treatments; and an 18-year-old female patient with bipolar disorder who developed neuroleptic malignant syndrome following one ECT, after which the course was terminated.

Conclusions

9.25 Mental health treatment, as in any medical procedure, should be about healing. It is time that government policy moved to the elimination of electroconvulsive therapy as an unproven and inherently inhumane procedure.

9.26 Effective humane alternatives to these barbaric and outmoded treatments exist now and should be promoted. An urgent and comprehensive review of ECT is needed.

9.27 The 2003 study, Pharmacotherapy Following Electroconvulsive Therapy[15], (JAMA,14 March 2003), highlights the fact that ECT is a short-term solution to a long-term problem. Although Dr Harold Sackeim said in his opening paragraphs that ECT had a relapse rate of 50 percent or better, his own study showed a relapse rate of 84%- of those who responded to ECT in the first place. The group that received nortriptyline alone had a relapse rate of 60%, and the third group (nortriptyline and lithium) had a relapse rate of 39.1 %. Furthermore, of 290 people who completed ECT, 114 (40%) did not respond.

9.28 While it is often difficult to find information presenting a view differing from that of the psychiatric community, the statistical and anecdotal evidence has become overwhelmingly in favour of banning any form of shock treatment or electro convulsive therapy (ECT) as a preferred treatment. ECT is an invasive, inhuman and extremely degrading treatment, which, when given without a patient's consent, almost certainly breaches human rights. In the same way that we no longer perform prefrontal lobotomies, ECT should now be relegated to the archives of psychiatric medicine.

Recommendations

Considering this information, the Experts by Experience Group has major concerns about ECT, and recommends:

1. That ECT is banned. (A minority opinion favoured it being kept as a matter of choice.)

2. No individual should be given ECT against their will whether they are detained or not. The practice of threatening voluntary patients with de facto detention or full detention unless they consent to ECT must end.

3. Any individual for whom ECT is being considered must have access to an independent advocate of their choice, and be provided with full information about ECT, including all possible unwanted effects. This explanation must be provided in a format accessible to the person and must be agreed.

4. Living Wills, or Advance Directives, made when a person is well and giving instructions on their choice of therapy should they become unwell, must be respected as having full legal status. Copies to be lodged with a solicitor, family doctor or consultant by the person. This would protect people against enforced treatment.

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GLOSSARY

Typical Antipsychotics

Older antipsychotic medication with a higher risk of causing involuntary movements or muscle stiffness. Examples include chlorpromazine, haloperidol, flupentixol

First Generation Antipsychotics

See typical antipsychotic

Atypical Antipsychotics

Newer antipsychotic medication with a much lower risk of causing involuntary movements or muscle stiffness. Examples include clozapine, olanzapine, risperidone and quetiapine

Positive Symptoms

A cluster of symptoms including delusions, hallucinations and disordered thinking that can occur at any time in people with schizophrenia but are more common in the acute phase of the illness.

Negative Symptoms

A cluster of symptoms including apathy, slowness and social withdrawal that can occur at any time in people with schizophrenia but are more common in people with long-term illness

Delusions

Unusual ideas or beliefs that are out of keeping with the person's cultural or social background.

Hallucinations

Disturbances of perception, for example hearing voices when none are about.

Extrapyramidal side effects

A cluster of symptoms that resemble some features of Parkinson's disease. For example, difficulty in initiating movement, slowness of movement, lack of facial expression and muscle stiffness.

Mood Stabiliser

Medicine given to try and prevent excessive mood swings. Examples include lithium, valproate or carbamazepine

Electro-convulsive Therapy (ECT)

A treatment where a small controlled current is passed through the brain with the purpose of causing a seizure

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Transforming Your Care

A Review of Health and Social Care in Northern Ireland

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December 2011

The Review Team would like to thank the Project Team:

Pamela McCreedy – Project Leader
Angela Hodkinson, Elaine Hunter, Seamus Carey – Project Managers
Ffiona Dunbar, Maria Higgins, Jonathan Houston – Project Support

1. INTRODUCTION

The task faced by the Review was both challenging and daunting. Health and Social Care is of interest to everyone in Northern Ireland and the team approached their task fully aware of the responsibility it had been given.

It was also aware that whilst it was important to look to best practice and examine data from outside the province the deliberations had, in the end, to make sense for Northern Ireland. Many drivers exist in this context: the importance of health and social care to the economic wellbeing of NI; the contribution staff make; the shadow of our recent history in NI, particularly in the mental well being of the citizenry; and the very powerful affinity the NI society has to the core NHS principles.

The team approached its task with that knowledge and these matters were reflected exhaustively in their deliberations. However, the overriding desire of the team was to describe and build a system of health and social care which would place the individual, family and community that use it at the heart of how things are done. That meant using evidence to explain why there needs to be change and concentrate on the outcomes that individuals could reasonably expect in a modern system of care and treatment.

The Review is therefore about change; not careless or haphazard change but planned change over a 5 year period that can and should improve care. The report may be contentious to some, but the Review team saw clearly that there are no neutral decisions as it looks to the future. It has taken the view that a managed and transparent change is better than unplanned, disorganised change.

Finally on behalf of the team I should like to thank the very many people, citizens, professionals and representatives of interest groups who gave freely of their time to help the Review. I should also like to extend thanks to the independent panel members for their honesty, challenge and contribution to the Review.

John Compton
Chair of the Review Team

December 2011

EXECUTIVE SUMMARY

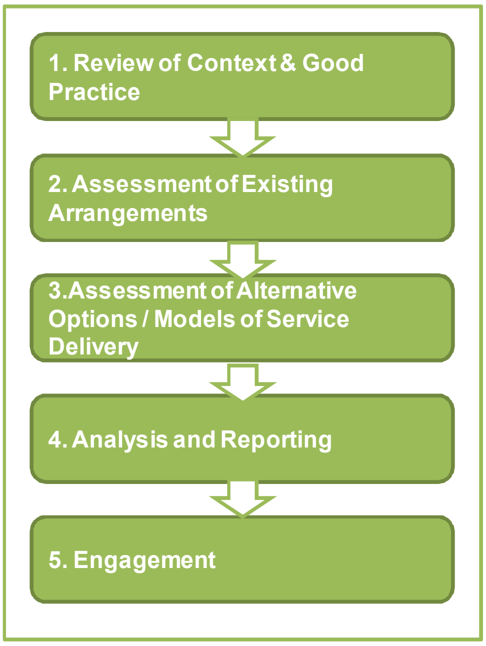
2. EXECUTIVE SUMMARY

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, announced that a Review of the Provision of Health and Social Care (HSC) Services in Northern Ireland would be undertaken. The Review was to provide a strategic assessment across all aspects of health and social care services, examining the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met. Crucially it was to bring forward recommendations for the future shape of services and provide an implementation plan. The Review team was not asked to bring forward proposals which reduced the budget published by the Northern Ireland Executive, but was asked to ensure that it was used to best effect.

The Minister judged that at a time of considerable flux within health and social care and the wider economy it was prudent not to disconnect the service from the Review process. Therefore, he appointed John Compton, Chief Executive of the Health and Social Care Board, to complete the task in an ex-officio capacity. However, the Minister did want a strong independent overview to the process, helping to shape and providing challenge to any proposals. Therefore he also appointed an independent panel comprising: Professor Chris Ham (Chief Executive of the King's Fund), Professor Deirdre Heenan (Provost and Dean of Academic Development at the Magee Campus), Dr Ian Rutter (General Practitioner), Mr Paul Simpson (retired senior civil servant), and Mr Mark Ennis (Executive Chair of SSE Ireland).

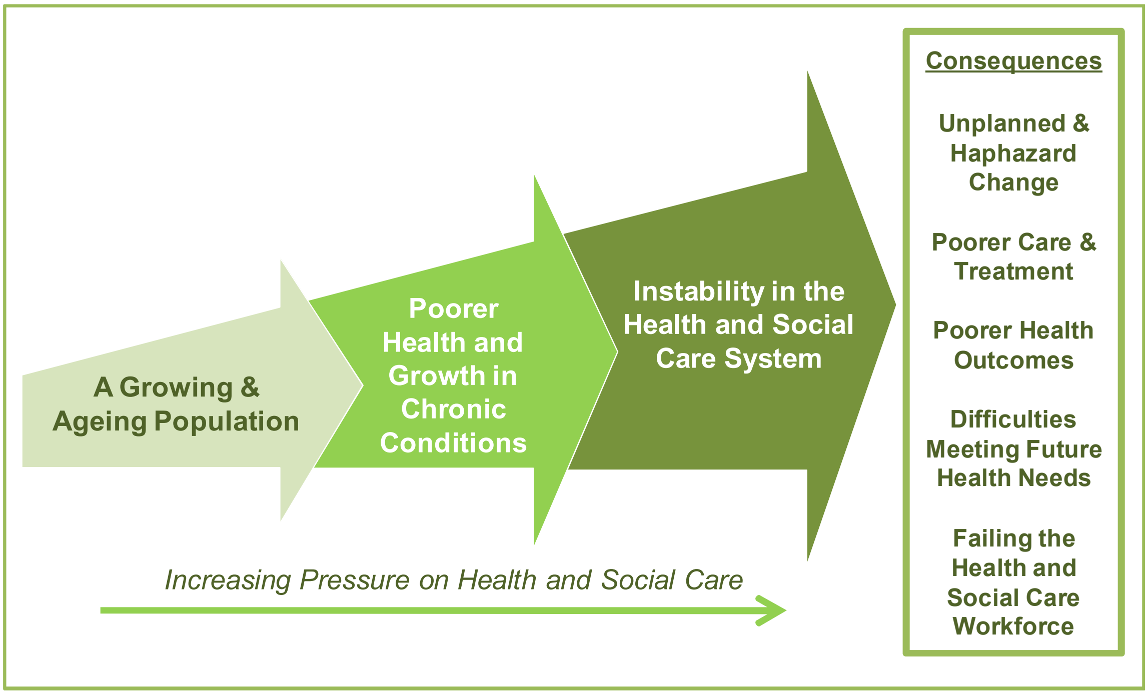
The Review was to complete by 30 November 2011. Within the timescale available, the Minister was keen to ensure maximum engagement with the public, clinical and professional leaders, health and social care organisations and stakeholders in the voluntary, community, private and independent sectors. In particular the Minister highlighted the importance of engaging with the health and social care workforce through the Partnership Forum. Following their appointment in August, the Review team designed its approach as shown below.

Figure 1: Overview of Approach



The Review concluded that there was an unassailable case for change. The figure below illustrates the core of the argument.

Figure 2: Future Model for Integrated Health and Social Care



Responding to these pressures, the Review identified eleven key reasons which support the need for change (summarised in the adjacent box) along with a model of health and social care which would drive the future shape and direction of the service.

Figure 3: Reasons for Change

To be better at preventing ill health
To provide patient-centred care
To manage increasing demand across all programmes of care
To tackle health inequalities
To deliver a high-quality, evidence-based service
To support our workforce in delivering the necessary change

In developing a new model, the Review engaged with over 3000 members of the public, clinicians, providers and interest groups. It also reviewed evidence to ensure that any changes required had at their heart better outcomes for patients and clients and their families.

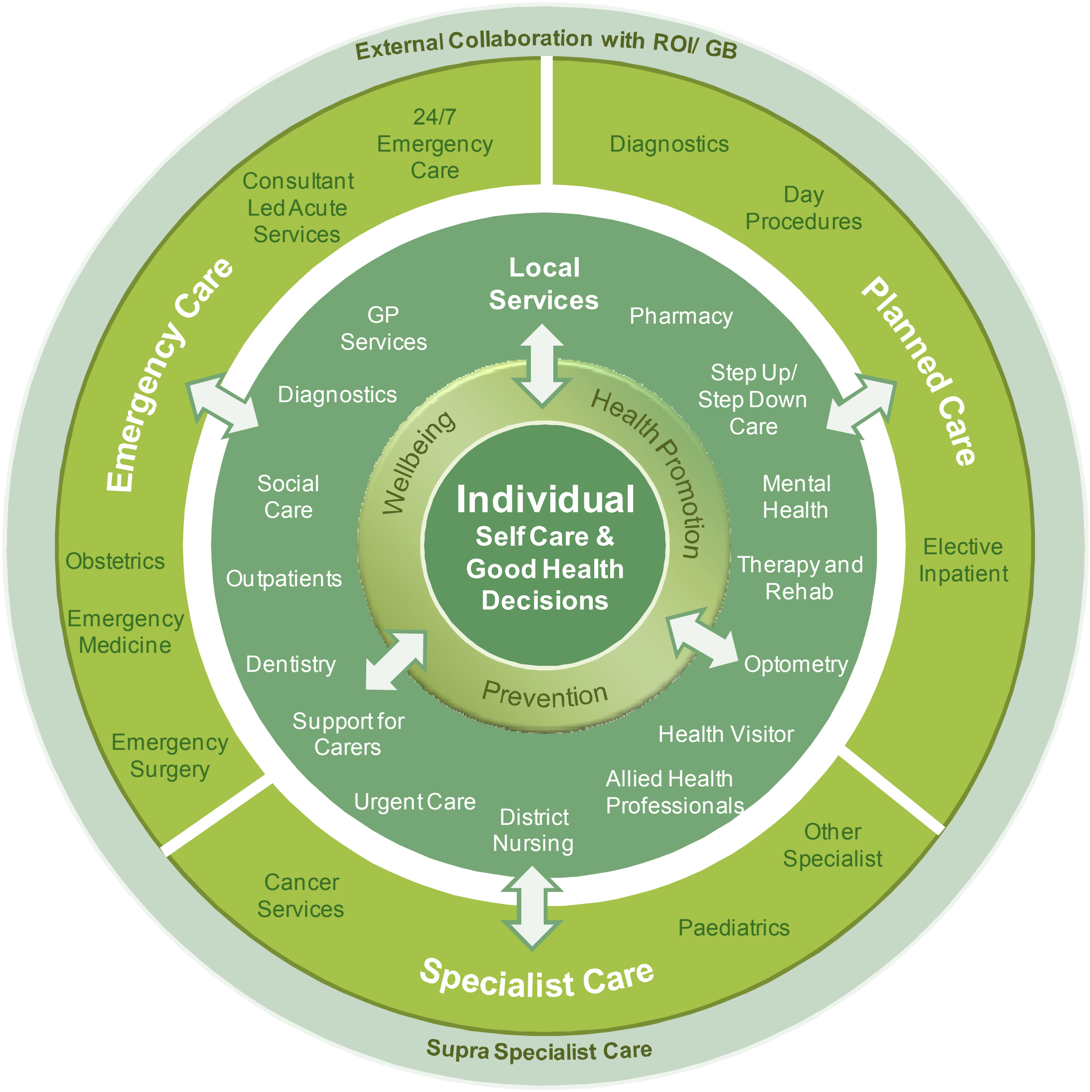
The Review was clear about the purpose of change namely, what changes would make the greatest difference to outcomes for patients, users and carers. In doing so the Review looked beyond the geographical boundaries of Northern Ireland.

The Review identified twelve major principles for change, which should underpin the shape of the future model proposed for health and social care.

1. Placing the individual at the centre of any model by promoting a better outcome for the service user, carer and their family.
2. Using outcomes and quality evidence to shape services.
3. Providing the right care in the right place at the right time.
4. Population-based planning of services.
5. A focus on prevention and tackling inequalities.
6. Integrated care – working together.
7. Promoting independence and personalisation of care.
8. Safeguarding the most vulnerable.
9. Ensuring sustainability of service provision.
10. Realising value for money.
11. Maximising the use of technology.
12. Incentivising innovation at a local level.

The model devised by the Review team is shown in the figure overleaf.

Figure 4: Future Model for Integrated Health and Social Care



Briefly described the model means:

- every individual will have the opportunity to make decisions that help maintain good health and wellbeing. Health and social care will provide the tools and support people need to do this;
- most services will be provided locally, for example diagnostics, outpatients and urgent care, and local services will be better joined up with specialist hospital services;
- services will regard home as the hub and be enabled to ensure people can

be cared for at home, including at the end of life;

- the professionals providing health and social care services will be required to work together in a much more integrated way to plan and deliver consistently high quality care for patients;
- where specialist hospital care is required it will be available, discharging patients into the care of local services as soon as their health and care needs permit; and
- some very specialist services needed by a small number of people will be provided on a planned basis in the ROI and other parts of the UK.

To help illustrate what this would mean, case studies were developed to explain the model. In essence they show it to be simpler to use, clearer about the key worker, and crucially providing an improved outcome for those who use the service.

Following on from this, the impact on ten major areas of care was examined:

Population Health and Wellbeing
Older People
People with Long-Term Conditions
People with a Physical Disability
Maternity and Child Health
Family and Child Care
People using Mental Health Services
People with a Learning Disability
Acute Care
Palliative and End of Life Care

The model was applied to these service areas and each has a series of recommendations. The full list of 99 proposals is provided Section 19 of the report.

The key themes in the recommendations are summarised below.

Quality and outcomes to be the determining factors in shaping services.

Prevention and enabling individual responsibility for health and wellbeing.

Care to be provided as close to home as practical.

Personalisation of care and more direct control, including financial control, over care for patients and carers.

Greater choice of service provision, particularly non-institutional services, using the independent sector, with consequent major changes in the residential sector.

New approach to pricing and regulation in the nursing home sector.

Development of a coherent ‘Headstart’ programme for 0-5 year old children, to include early years support for children with a disability.

A major review of inpatient paediatrics.

In GB a population of 1.8million might commonly have 4 acute hospitals. In NI there are 10. Following the Review, and over time, there are likely to be 5-7 major hospital networks.

Establishment of a clinical forum to ensure professionals are fully engaged in the implementation of the new model.

A changing role for general practice working in 17 Integrated Care Partnerships across Northern Ireland.

Recognising the valuable role the workforce will play in delivering the outcomes.

Confirming the closure of long-stay institutions in learning disability and mental health with more impetus into developing community services for these groups.

Population planning and local commissioning to be the central approach for organising services and delivering change.

Shifting resource from hospitals to enable investment in community health and social care services.

Modernising technological infrastructure and support for the system.

Following from this, the Review considered and presented the methodology to make the change over a 5 year period.

This initially describes a financial remodelling of how money is to be spent indicating a shift of £83million from current hospital spend and its reinvestment into primary, community and social care services. It goes on to describe as integral the need for transitional funding of £25million in the first year; £25million in the second year; and £20 million in the third year enable the new model of service to be implemented

In conclusion, the Review reiterates that change is not an option. It re-affirms there are no neutral decisions and there is a compelling need to make change. The choice is stark: managed change or unplanned, haphazard change. The Review team commends its report to the Minister.

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BACKGROUND TO THE REVIEW

3. BACKGROUND TO THE REVIEW

This part of the report explains the nature and purpose of the Review. It sets out who was involved and why, then describes the objectives set for the Review, the scope of the task and the approach taken to complete it.

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, announced that a Review of the Provision of Health and Social Care Services in Northern Ireland would be undertaken, asking how it should change and requesting an implementation plan to manage the change. The full terms of reference is included at Appendix 1.

The key objectives of the Review were to:

- undertake a strategic assessment across all aspects of health and social care services;
- undertake appropriate consultation and engagement on the way ahead;
- make recommendations to the Minister on the future configuration and delivery of services; and
- set out a specific implementation plan for the changes that need to be made in health and social care.

The Review was not to be fully independent and Mr John Compton, Chief Executive of the Health and Social Care Board, was invited to lead the process. The Minister judged that at a time of considerable flux within health and social care and the wider economy it was prudent not to disconnect the service from the Review process. However he did want a strong independent overview to the process providing challenge to any proposals. Accordingly he appointed five independent panel members:

- Professor Chris Ham (Chief Executive of the King’s Fund);
- Professor Deirdre Heenan (Provost and Dean of Academic Development at the Magee Campus, University of Ulster);
- Dr Ian Rutter (General Practitioner);
- Paul Simpson (retired senior civil servant); and
- Mark Ennis (Executive Chair of SSE Ireland).

The appointments reflected the desire to ensure proper scrutiny was applied to the process.

The Minister's over-riding concern is driving up the quality of care for clients and patients, improving outcomes and enhancing the patient experience. In initiating the Review, the Minister explained that he wanted it to ensure that health and social services are focused, shaped and equipped to improve the quality of care and outcomes for the population, and to provide value for money in financially challenging times. He wants to see a shift in care currently carried out in hospitals into the community with patients being treated in the right place, at the right time and by the right people.

The Minister also made it clear that in deciding to have a Review no criticism was implied about staff working in the current system. Quite the reverse, he concluded that the current model was unsustainable going forward and that he wanted to see a service which was developing not declining, a service which built upon the commitment and expertise of those working in health and social care.

OBJECTIVES

Accordingly the objectives of the Review were to:

- provide a strategic independent assessment across all aspects of health and social care services of the present quality and accessibility of services and the extent to which the needs of patients, clients, carers and communities are being met by existing arrangements in terms of outcomes, accessibility, safety, standards, quality of services and value for money;
- undertake appropriate consultation and engagement on the way ahead with the public, political representatives through the Assembly Health Committee, HSC organisations, clinical and professional leaders within the system, staff representatives through the Partnership Forum, and stakeholders in the voluntary, community, independent and private sectors;
- make recommendations to the Minister on the future configuration and delivery of services in hospital, primary care, community and other settings; and
- set out a specific implementation plan for the changes that need to be made in the HSC, including proposals in relation to major sites and specialities.

SCOPE

In delivering these objectives the Review was to take account of the following:

- extant policy and strategies approved by the Minister, in particular the aims of improving public health, the prevention of illness and of improving outcomes for patients and clients;
- statutory duties on the HSC to improve the quality of services provided, to improve the health and social wellbeing of the population and to reduce health inequalities; and

- primary care, community care, social care and hospital services.

Certain areas were deemed to be outside the scope of the Review:

- the new organisational structures created as a result of the RPA process within Health and Social Care; and
- the Review should work within the constraints of the current level of funding for the coming period. The current Performance and Efficiency Unit (PEDU) review of the scope to make savings in the health and social care sector is separate from the HSC Review and the development of an implementation plan to deliver savings will continue in parallel with this Review.

However, the Minister indicated that if the Review felt it should comment on any of these areas, it should not feel constrained in doing so.

Public health and social wellbeing is at the heart of health and social care. The Review team is aware that there is a separate piece of work being undertaken by the Department of Health Social Services and Public Safety (DHSSPS) and the Public Health Agency (PHA) to create a new public health strategy, as set by the Executive and Minister. Notwithstanding this, the Review considered it appropriate to look at public health and wellbeing in its work.

The Terms of Reference had asked the Review to make recommendation on the future configuration of hospital, primary care, community care and other settings. During the course of the Review, the team proposed to the Minister that it was better to describe a framework for the future of care rather than including specific proposals in relation to sites and specialties. The rationale for this presented to the Minister was the critical need to enable professionals and communities to devise local solutions within a very clear framework and criteria for success. The Minister agreed to this approach to applying the Terms of Reference.

APPROACH

Giving consideration to the Terms of Reference set by the Minister (Appendix 1), a project plan was developed. The approach to the Review involved five key strands of activity, as shown in the figure below.

Figure 5: Overview of Approach

In particular the Minister highlighted the importance of engagement with stakeholders and a comprehensive engagement plan was developed. The objective was to enable informed debate and to present information to the public.

This resulted in more than 3,000 people engaging directly with the Review, and many more being exposed to debate on the key issues affecting health and social care provision through media coverage of the Review on TV, radio, online and by the printed media.

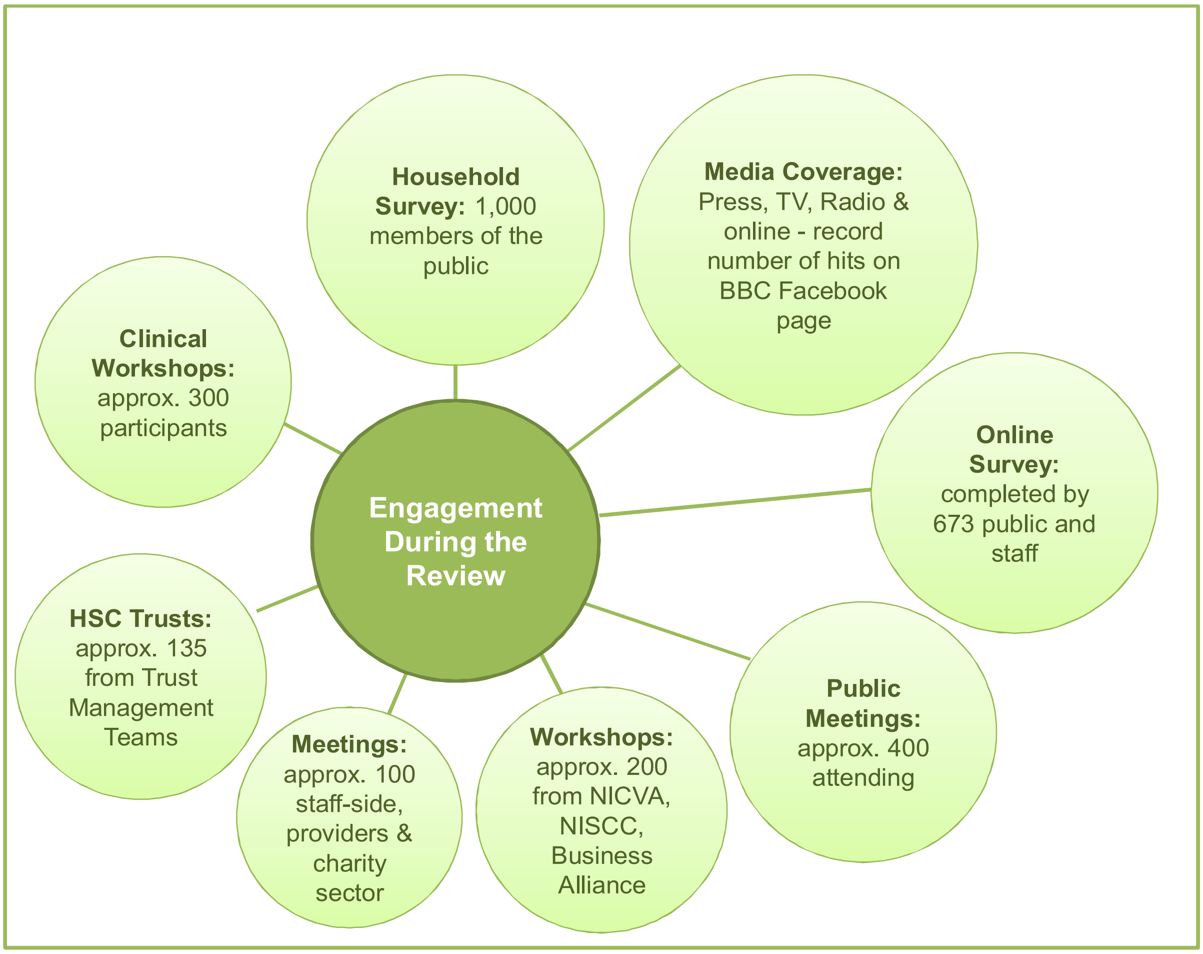
The engagement plan for the Review involved:

- An **online survey** completed by 673 individuals, of which 91% worked for an organisation providing health and social care (see Appendix 2 for a summary of results);
- Engagement with local **media** to promote press, television and radio features on the Review to raise public awareness of the issues involved and stimulate debate. The BBC e-panel received 641 views on aspects of the health and social care system;
- A **household survey** (completed by IpsosMORI) of 1,009 adults aged over 16, selected to be representative of the Northern Ireland population in terms of gender, age, social class and geography (see Appendix 3 for a summary of results);
- Six **public meetings** were held in Londonderry, Omagh, Ballymena, Belfast, Lisburn and Armagh. These were facilitated by the Patient and Client Council (PCC). (See Appendix 4 for details of the questions raised during the meetings);
- A series of **workshops with clinicians** from HSC Trusts, General Practitioners (GPs) and HSC managers to discuss current provision and future needs of specific service areas (see Appendix 5 for details of attendees and areas covered at each workshop);
- A series of **sector workshops**, with representatives from the voluntary and community sector (facilitated by the Northern Ireland Council for Voluntary Action), registered social care workforce (facilitated by the Northern Ireland Social Care Council), and private sector (facilitated by the Business Alliance) (see Appendix 6 for details of attendees);
- **Small group meetings** with a range of stakeholders including HSC arm’s length bodies, trade unions (via the Partnership Forum), professional and regulatory bodies, voluntary and community sector organisations, political representatives, independent care providers, and colleagues within health and social care in other parts of the UK and the Republic of Ireland (see Appendix 7 for a full list of the stakeholders engaged with);
- Submission of **written responses** to the Review (see Appendix 8 for a list of written submissions); and
- Meetings with **HSC Trusts’** Senior Management Teams.

A Glossary is included in Appendix 9.

An overview of the stakeholders engaged with throughout the review is shown in the figure below.

Figure 6: Engagement during the Review



STRUCTURE OF REPORT

This report begins by outlining the reasons why our health and social care system needs to change, based upon the evidence that the Review has collected during the Review process. It then sets out the principles the Review considers should underpin this change.

A new model of care is described and contrasted with the existing model of care using case studies. The report details the impact of the new model across 10 areas of care.

- Population Health and Wellbeing
- Older People
- People with Long-Term Conditions
- People with a Physical Disability
- Maternity and Child Health
- Family and Child Care
- People using Mental Health Services
- People with a Learning Disability
- Acute Care
- Palliative and End of Life Care

It moves on to describe the implications for the health and social care system. This takes account of integrated working across health and social care, workforce issues and enhanced use of technology. Finally, an implementation roadmap outlines how this change will be implemented and delivered over a five year period.

THE CASE FOR CHANGE

4. THE CASE FOR CHANGE

Making the case for change is at the centre of this Review. It is not a critique of the current provision but rather a fundamental recognition that the existing model of care is not fit for purpose as one looks to the future.

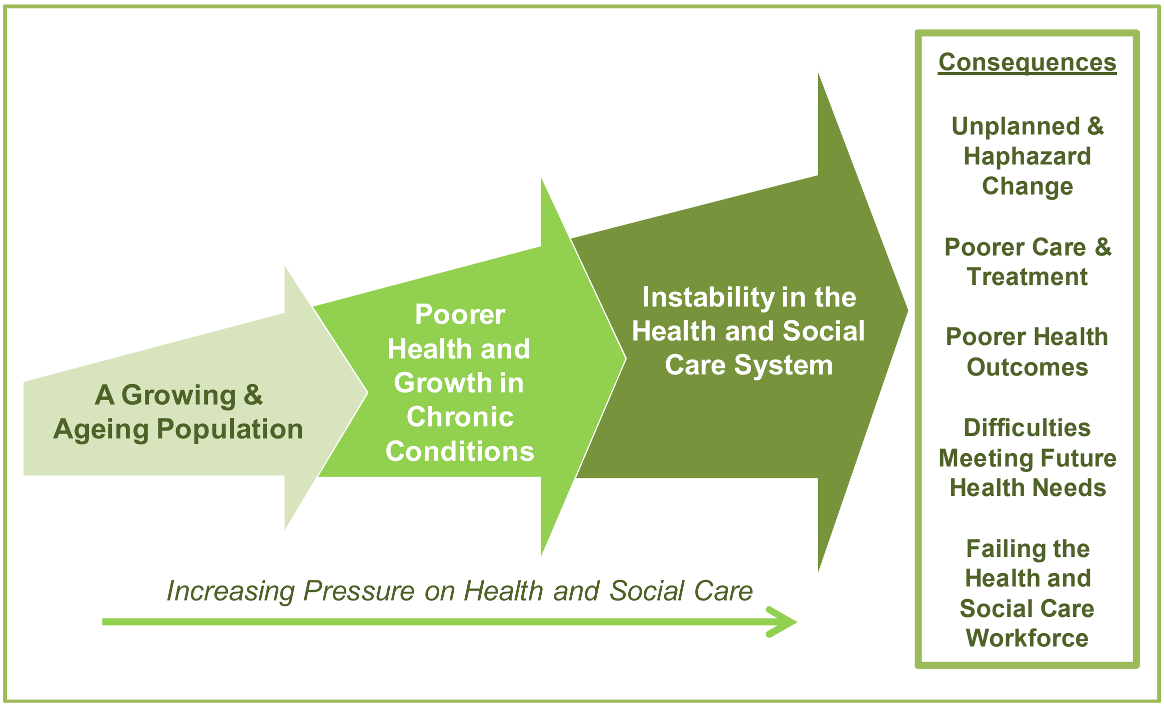
The figure below illustrates the pressures currently facing the system and the potential consequences of doing nothing.

There are no neutral decisions in this regard. If we do nothing, the system will not be able, in its current form, to continue to deliver a high quality service that will meet the needs of the population.

The fundamental changes to our population in terms of age and need are clear. We must design a model which acknowledges this and is based on the needs of this changing population rather than its historic configuration. If we do not plan to change the system we will continue to be faced with unplanned changes that will not be in the best interest of the patient. This will result in a prioritisation of who gets care and a reduction in access to many important services for a large proportion of our population.

We have a highly skilled and dedicated workforce who are being failed by a system which is no longer fit for purpose. This has resulted in staff working within a system which does not deliver the quality

Figure 7: Pressure facing the system



of service to which they strive.

The Review also acknowledges that throughout this process everyone spoken to has asked the Review to promote the **'making it better'** principle and has affirmed that it **can be better**.

WHY DO WE NEED CHANGE?

Despite the many positive aspects of the current model of health and social care, compelling factors reflect the need for change:

- a growing and ageing population;
- increased prevalence of long term conditions;
- increased demand and over reliance on hospital beds;
- clinical workforce supply difficulties which have put pressure on service resilience; and
- the need for greater productivity and value for money.

Against this backdrop, the Review identified 11 keys reasons supporting change. In a new model, how these are responded to will be key to shaping the decisions for the future configuration of specific services.

Reason 1 – The need to be better at preventing ill health

Reason 2 - The importance of patient centred care

Reason 3 – Increasing demand in all programmes of care

Reason 4 – Current inequalities in the health of the population

Reason 5 – Giving our children the best start in life

Reason 6 – Sustainability and quality of hospital services

Reason 7 – The need to deliver a high quality service based on evidence

Reason 8 – The need to meet the expectations of the people of NI

Reason 9 – Making best use of resources available

Reason 10 – Maximising the potential of technology

Reason 11 – Supporting our workforce

Reason 1 – The need to be better at preventing ill health

The population of Northern Ireland can become a healthier society through prevention of ill health and the promotion of health and wellbeing. People wish to be responsible in taking decisions to support better personal health. In this regard it is important to communicate evidence to enable people to choose a lifestyle where healthier outcomes can happen.

Smoking - In Northern Ireland around 340,000 people aged 16 and over smoke. Smoking contributes to not only many cancers, heart disease, bronchitis and asthma, but other illnesses including stroke, which causes around 2,400 deaths per year. These deaths are avoidable. Around 86% of lung cancer deaths in the UK are caused by tobacco smoking and, in addition, the International Agency for Research on Cancer states that tobacco smoking can also cause cancers of the following sites: upper aero-digestive tract (oral cavity, nasal cavity, nasal sinuses, pharynx, larynx and oesophagus), pancreas, stomach, liver, bladder, kidney, cervix, bowel, ovary (mucinous) and myeloid leukaemia. Overall tobacco smoking is estimated to be responsible for more than a quarter of cancer deaths in the UK, that is around 43,000 deaths in 2007.[1] Half of all smokers eventually die from cancer, or other smoking-related illnesses.[2] A quarter of smokers die in middle age, between 35 and 69.

Obesity – in the most recent survey of Northern Ireland's health and wellbeing, 59% of all adults measured were either overweight (35%) or obese (24%)[3]. The impact of this increase has resulted in complications in pregnancy, increase in type 2 diabetes, coronary heart disease, stroke and a number of cancers. It is also known that obese children are more likely to become obese adults. We face a significant challenge in halting the rise in the proportion of the population who are overweight or obese.

Alcohol and drug misuse cost our society hundreds of millions of pounds every year. However, this financial burden can never truly describe the full impact that substance misuse has on many vulnerable individuals including children and young people, families, and communities in Northern Ireland.

Not to act on these facts will condemn the population and the system to failure.

Reason 2 – The importance of patient centred care

Evidence suggests that people are best cared for as close to home as possible. It is also what people have told us through the Omnibus survey - 81% of people

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[1] Cancer Research UK

[2] Mortality in relation to smoking: 50 years' observations on male British doctors, Doll et al, 2004

[3] NI Health and Social Wellbeing Survey 2005/06, DHSSPS

surveyed said that more health and social care services should be delivered in GP surgeries, local centres and in people's homes.

Inpatient hospital care will always be an important part of how care is provided, but it is only best for a patient with acute medical needs. There are many benefits associated with delivering care within people's homes and in their local communities. Providing patient choice about where they are cared for is critical. Integrated teams working together in the community provide this opportunity and would deliver better quality.

A central theme of 'Quality 2020 - a 10 year Strategy to protect and improve Quality in Health and Social Care in NI[4]' is to ensure the patient and client receives the right care, at the right time in the right place, with the best outcome. The 'High Quality Care for all NHS: Next Stage Review Final Report' also identified the need to bring care closer to home, to ultimately deliver better care for patients. This was also a central focus of the 2006 White Paper 'Our health, our care, our say', and it has become clear that a health and care economy-wide approach is needed for an effective and sustainable model of care that is more convenient for patients.

A bed utilisation audit of 2011 showed that, on the day in question, up to 42% of the inpatients reviewed should not have been in hospital.[5] Furthermore in 2009/10, 28% of the deaths of people admitted from a nursing home, occurred within 2 days of admission into hospital[6].

The care closer to home approach is not about challenging hospital provision, but about defining the role of hospitals in meeting the needs of the population. The real prize is to provide community alternatives which improve patient/ client care and experience. The evidence again points to a need for change.

Reason 3 – Increasing Demand

The evidence of increasing demand is compelling whether from a population or disease perspective.

Demography

Northern Ireland has a population of approximately 1.8m people. It has the fastest growing population in the UK and it continues to grow. The number of people over 75 years will increase by 40% by 2020. The population of over 85 year olds in NI will increase by 19.6% by 2014, and by 58% by 2020 over the 2009 figure (see the figure below).

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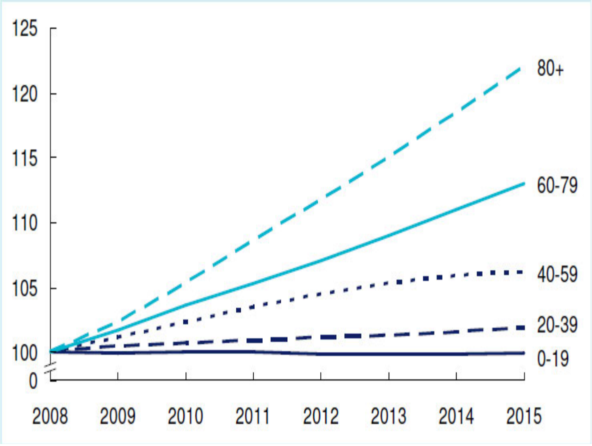
[4] Quality 2020, A 10-year Strategy to Protect and Improve Quality in Health and Social Care in NI, DHSSPS

[5] Bed Utilisation Audit of 8 acute hospitals in NI, April – September 2011

[6] HIB, DHSSPS, 2011

Figure 8: Northern Ireland Population Projections



Source: NI Neighbourhood Information Service

Longer life expectancy is something to celebrate. Many older people enjoy good health and continue to make a significant contribution to society as carers, learners, workers and volunteers. In particular, older people are identified as important social resources in rural areas, providing informal care and supporting the cultural and social lives of their communities.[7] The health and social care system has a role in enabling older people to live as full and healthy a life as possible and caring for the most vulnerable when needs change.

There is however, a high level of dependence on institutional and hospital care for older people, and inconsistencies in the quality and range of services provided across Northern Ireland. Services are not currently meeting expectations and, since they account for a large proportion of health and social care expenditure, defining a new model to successfully meet the needs of older people is an overwhelming priority. Older people have said they want care, support and treatment in or close to home. Services must therefore continue to reform and modernise to respond to growing demand with an increased emphasis on personal, community based services.

Disease Prevalence

There are increasing numbers of people with chronic conditions such as hypertension, diabetes, obesity and asthma. The disease prevalence levels reported via the Quality Outcomes Framework (QOF) are summarised below[8].

- QOF reported prevalence for hypertension has increased year on year across all UK regions, with the rates reported in NI lowest of the 4 UK countries at 12.54%, showing an absence of managing this condition.
- Diabetes is an increasingly common condition. Prevalence in the UK is rising. NI prevalence is 4%.

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[7] Commission for Rural Communities (2008) The Personalisation of Social Care

[8] Source: PHA Health Intelligence Briefing on QOF 2009/10).

- QOF reported prevalence of Atrial Fibrillation is increasing year on year across the whole of the UK. In NI, rates have increased from 1.25% in 2006/07 to 1.33% in 2009/10, equating to an additional 1,500 patients with AF.
- Stroke/ Transient Ischaemic Attack (TIA) reported prevalence has increased yearly across the UK. In NI prevalence has increased from 1.37% in 2004/05 to 1.71% in 2009/10, representing over 6,400 additional patients.
- NI has the lowest QOF reported prevalence of asthma at 5.86 per 1,000 patients compared to the rest of the UK. Notwithstanding this prevalence has increased in the last 5 years.
- QOF reported prevalence of Chronic Obstructive Pulmonary Disease has risen steadily since records began in 2004. The prevalence in NI was 1.63% for 2009/10.

All of this describes the unremitting increase in chronic conditions in NI. Individuals with long-term conditions very often have multiple conditions – around a quarter of those in the UK with a long-term condition have three or more conditions[9]. Our system often does not deal with multiple conditions in an integrated way, which for the individual can mean having to engage with multiple clinicians and services which are not well joined up. The consequent personal experience is often very frustrating.

Keeping Pace with Developments

Best practice in health and social care provision is developing all the time. There are new technologies, new care pathways, new partnerships, new drugs and new levels of regulation. Our population will expect access to these improvements. The need to understand demand patterns and work with providers in primary, community and secondary care to ensure more effective management of demand will be a central issue in the future.

It is estimated that the demand for services could grow by around 4% per year by 2015[10]. Examples of the potential consequences without change are listed below:[11]

- 23,000 extra hospital admissions;
- 48,000 extra outpatient appointments;
- 8,000 extra nursing home weeks; and
- 40,000 extra 999 ambulance responses.

If we were to continue to deliver services in the way that we do today, we would

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[9] NHS Scotland (2005) National Framework for Service Change. Long Term Conditions Action Team Report.

[10] Reshaping the System (2010) McKinsey

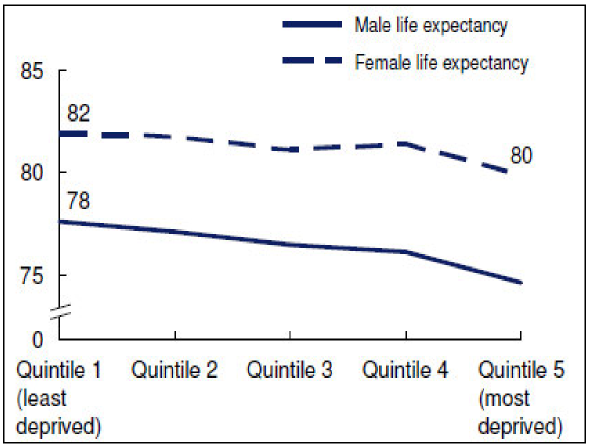
[11] NI Confederation for Health and Social Care: Areas for Action for Health and Social Care in Northern Ireland 2011-2015

quite simply fail the popula#tion as the system struggled to cope. The quality of outcome for the individual and their family would inevitably decline.

Reason 4 – Current inequalities in the health of the population

In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 years for women. However, against this positive overall trend, inequalities are evident when mortality rates are compared across geographical areas. People who live in the 20% most deprived areas are 40% more likely to die before 75 than the NI average. Life expectancy against deprivation level is shown in the figure below.

Figure 9: Life Expectancy and Deprivation in Northern Ireland



Source – NISRA: Independent Review of Health and Social Services Care in Northern Ireland

For example, along the bus route from Donegall Square to Finaghy Road South, there is an increase in life expectancy of 9 years, as shown in the figure overleaf. Similar patterns exist in rural areas.

Across NI there is also variability in the health of the public. Belfast had the highest rate of births to mothers aged 19 or under in 2004 (25.9 per 1000) compared to other Local Government Districts in Northern Ireland. Indeed there is considerable variation even within the Greater Belfast area. In 2009, of the 349 births to teenage mothers in Belfast Trust 37% were in west Belfast, 28% in north Belfast, 15% in east Belfast, 11% in south Belfast and 8% in Castlereagh.

The most deprived group of the population has an admission rate to Neonatal Intensive Care of 19% above the regional average for Northern Ireland.

Some of the most common characteristics associated with being born into poverty rather than more affluent circumstances are highlighted below:[12]

- lower life expectancy;
- 23% higher rates of emergency admission to hospital;
- 66% higher rates of respiratory mortality;
- 65% higher rates of lung cancer;
- 73% higher rates of suicide;

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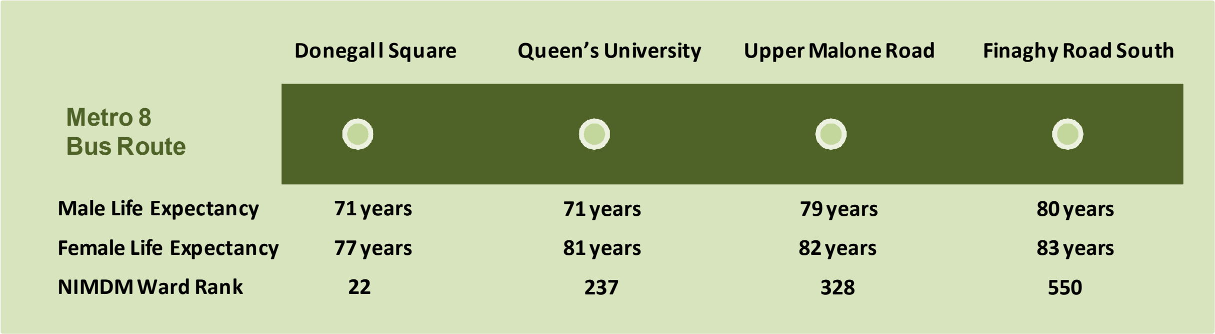
[12] NISRA Inequalities Monitoring Report 2010

Figure 10: Life Expectancy, Donegall Square to Finaghy Road South



	Donegall Square	Queen's University	Upper Malone Road	Finaghy Road South
Metro 8 Bus Route	●	●	●	●
Male Life Expectancy	71 years	71 years	79 years	80 years
Female Life Expectancy	77 years	81 years	82 years	83 years
NIMDM Ward Rank	22	237	328	550

- self harm admissions at twice the Northern Ireland average;
- 50% higher rates of smoking related deaths; and
- 120% higher rates of alcohol related deaths.

Health and Social Care alone cannot fully address the inequalities issue. If we are to deliver effectively on improving the health of our population, we need meaningful partnerships and a common agenda to be developed with local government, housing, education, the environment, and our local communities. Making joined up government more tangible is essential. However, it is incumbent on health and social care to look to change and how it can contribute to better outcomes for the citizen.

Reason 5 – Giving our children the best start in life

The 2007 Unicef review of Children and Wellbeing ranked the UK 21 out of 21 developed countries.[13]

There is growing evidence that a child's early years of development have a significant impact on their health in later life.

The Californian Adverse Childhood Experience study (1998) linked childhood maltreatment and later-life health and well-being.[14] The consequences for society include: adult mental health

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[13] UNICEF (2007) *Child Poverty in Perspective: An overview of child well-being in rich countries*, Innocenti Report Card 7, UNICEF Innocenti Research Centre, Florence.

[14] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS, 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med.;14(4):245-58

problems, poor physical health and high health expenditure.

Early Intervention: Good Parents, Great Kids, Better Citizens report argues 1 in 8 children are currently growing up in an environment of unacceptable risk.[15] Neglect and abuse in early years creates emotionally, mentally and physically damaged adults thus perpetuating problems into the next generation. An early intervention approach counteracts this outcome. The study identified the need to respond differently to the childhood years through structured early intervention.

The review of research found that targeted, intensive programmes such as the Family Nurse Partnership can help improve outcomes for vulnerable children and families, for example: reduced child abuse and neglect, reduced crime, reduced drug and alcohol abuse, and reduced school grade repetition.[16] These result in reduced victims' costs and increased earnings, highlighting a ratio of return of £3 for every £1 invested.

The Review noted that it has been acknowledged by several independent authors that the level of investment in Children and Families Services in NI is approximately 30% less than in other parts of the United Kingdom. It had been predicted that the number of births in Northern Ireland was to decline but in fact birth rates have remained broadly static. This overall position has led to an increased demand, particularly for family support services.

Given this evidence, failure to do better will prevent any opportunities to break the cycle of poor life outcomes for many in our society.

Reason 6 – Sustainability and quality of hospital services

Given the increasing and changing nature of the population, changing practices in medicine and increased expectations of the public, the gap between demand for services and current provision is widening. If we were to continue to provide services as they currently are, it would lead to unplanned and unmanaged collapse of key services. This would ultimately lead to detrimental impact on patients and clients. The choice is stark: it is not principally about money but about sustainability and clinical evidence. The conclusion is clear: plan and manage the transition or accept a more haphazard set of changes. In this regard there are no neutral decisions.

Historically, in Northern Ireland, there has been an over-reliance on hospital services. Given its rurality and based on recognised norms, a population the size of NI is likely to have between 5 and 7 major acute hospital networks, each

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[15] Good Parents, Great Kids, Better Citizens. Graham Allen MP and Rt Hon Iain Duncan Smith MP, Centre for Social Justice and Smith Institute 2008

[16] The Family Nurse Partnership Programme, Department of Health, http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128402.pdf

serving a population of some 250,000 to 350,000. Currently we have 10 hospitals for a population of 1.8million, in other words one per 180,000. The rurality of Northern Ireland has historically influenced the number of hospitals provided, and this must also be taken into consideration when developing a new model of care. There is however evidence to show that whilst important in a Northern Ireland context that travel per se does not create worse outcomes. For example the Rural Trauma Outcome Study in Scotland[17] showed that longer pre-hospital travel times did not increase mortality or length of stay.

The Royal College of Surgeons has stated that in a fragmented emergency surgical set-up a patient is four times more likely to have a poorer outcome than in a more organised model. It goes on to say that where the model is not organised, patients have prolonged hospital stays with significant cost implications, both physical and emotional to the patient and their family[18].

Trying to maintain acute services across the current number of sites has proved increasingly difficult. Scarce staffing and other resources are spread too thinly, making it impossible to ensure that permanent senior medical cover for emergencies is available at all sites, on a 24/7/365 basis (24 hours a day, seven days per week and 365 days per year). Currently, many sites rely on a combination of junior doctors and temporary locums to provide much of the cover required, particularly out of hours. This inevitably impacts on quality and cost. It also creates service fragility.

The Chairman of the British Medical Association's Council in Northern Ireland stated that "the present situation is untenable: we cannot maintain top flight A&Es in every town. Reconfiguration... is currently happening by crisis rather than by taking difficult decisions". He goes on to cite recent changes at the Mid-Ulster, Whiteabbey and Belfast City Hospital as examples of how reconfiguration is currently occurring by crisis rather than in a structured and planned approach.[19]

More people are admitted to our hospitals than in other areas of the UK and lengths of stay are significantly longer.

In simple terms, we know it is possible and better to provide services closer to home but we have continued to use hospitals. This is an unsustainable model which will deliver poorer outcomes for the patient in the future.

Reason 7 – The need to deliver a high quality service based on evidence

The responsibility of the HSC is to deliver a high quality, safe and accessible service

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[17] Scottish Urban v Rural Trauma Outcome Study, J Trauma September 2005

[18] The Higher Risk General Surgical Patient: Towards Improved Care for a Forgotten Group, Royal College of Surgeons of England and Department of Health

[19] News Letter, November 7 2011

to the population of Northern Ireland, with good outcomes. Currently there are indications that there is room for improvement in how things are done.

There are increasing numbers of people with chronic conditions such as hypertension, diabetes, obesity and asthma. Yet evidence suggests lower than appropriate access to general practice is achieved.

Although improving, daycase rates are lower when compared to England at 64.7% compared to the England average of 75.5%.

The number of registered suicides rose from 146 in 2005 to 313 in 2010. The rates per 100,000 of the population vary greatly across the region with a rate of 24.9 in the most deprived area compared to 7.6 in the least deprived area.

Treatment for cancer has been revolutionised over the past decade with survival rates improving across a range of cancers, but we still fall behind European survival rates in a number of cancers, so further work needs to be done. A study[20] funded by Cancer Research UK and the Department of Health, England was carried out by researchers from a number of institutions in Australia, Canada, Denmark, Norway and the UK that were the focus of the study. Survival rates were found to be “persistently lower” in Denmark, England, Northern Ireland and Wales.

In obstetric services, 55.6% of deliveries are normal, compared with 61.2% in England and 61% in ROI. Our caesarean section rate is high at 30.2% compared to 24.1% in England and 25% in ROI.

Investment in Mental Health, Learning Disability and Children and Family Services in NI is up to 30% less than in other parts of the UK because our model over consumes resource in hospital provision.

At March 2010 there were 2,606 looked after children in Northern Ireland, up by 6% (143) from 2009 (2,463). 11% (about 270) of these children were in residential care, where the outcomes are likely to be very poor, and 65% were foster care placements.[21] The recruitment of foster carers to meet rising demand continues to be a challenge to ensure choice and the matching of carer skill to the needs of the child.

Every year in Northern Ireland around 3,000 people suffer a stroke. Stroke is the third biggest killer and the leading cause of severe disability in Northern Ireland. Up to 40 per cent of strokes are preventable.[22]

The Royal College of Physicians, National Sentinel Audit 2010, found NI had a higher length of stay of 21.3 days (to

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[20] The study was published in the peer-reviewed medical journal The Lancet.

[21] Children Order Statistical Tables for NI 2009/10

[22] National Stroke Association 2005

discharge or death) compared to the National average of 19.5 days.[23]

Looking at general Surgery, the chance of a patient dying in a UK hospital is 10% higher if he or she is admitted at the weekend rather than during the week, where the service is not well organised. Provision of services, particularly of theatre access, critical care and interventional radiology, is often incomplete, and the correct location of patients after surgery is often not given sufficient priority. Furthermore, the clinical response for patients who deteriorate is often poorly thought through and, at times, ad hoc[24].

Dr Foster, a UK provider of comparative health and social care information, also reported that it found a worrying 10% spike in deaths at weekends compared with weekdays across 147 hospital trusts.[25] Too often our services do not respond to 7 day a week working.

PCI (Percutaneous Coronary Intervention) is a treatment to reduce or eliminate the symptoms of coronary artery disease including angina, dyspnea and congestive heart failure. A pilot carried out by the Belfast HSC Trust (Feb10 – Mar11) showed low mortality rates associated with PCI that were largely predictable and could be improved if PCI was better organised.

While significant improvements have been secured, NI continues to spend significantly more per head on prescription medicines than the rest of the UK at £232 per head of population, compared to Wales £194, Scotland £187 and England £165 (2009/10).

All this has informed the Review that the current model does not provide as high quality care as it could.

Reason 8 – The need to meet the expectations of the people of NI

Whilst the Review acknowledges it is difficult methodologically to get a full consensus on a population view, there are however factors which need taken into account.

A structured Omnibus survey to inform the Review was conducted in October 2011 in which 1009 people were surveyed from across Northern Ireland. This was supplemented by the online public survey. The online survey was completed by 673 persons, 91% of whom work for an organisation providing HSC services.

The high level results of the surveys are highlighted within this section with more detail throughout the body of this report and within Appendices 2 and 3.

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[23] RCP National Sentinel Clinical Audit of Stroke 2010

[24] Aylin P, Yunus A, Bottle A *et al*. Weekend mortality for emergency admissions. A large,multicentre study. Qual Saf Health Care 2010; 19: 213–217

[25] Dr Foster – Hospital patients ‘more likely to die at weekends’, November 2011

There were positive comments about the existing service, 22.6% of the people interviewed in the omnibus survey stated that they were very satisfied with health and social care provision in NI and 54.8% were fairly satisfied.

However, the Omnibus survey results went on to highlight dissatisfaction with:

- accessibility of services;
- the quality of services to older people; and
- the quality of services for people with mental health problems and learning disabilities.

A need for improvement was identified across each of these areas.

Access

- In regard to GP services: 65% felt that improvement is required including 23% who stated that a lot of improvement is required (22% in the online survey).
- Looking at assessment for home nursing or residential care: 79% felt that some improvement is required (including 21% who felt that a lot of improvement is required). This was supported by the online survey findings where 86% felt improvement is required (including 26% who felt that a lot of improvement was required).
- Appointment with a hospital consultant: 82% (and 91% in the online survey) felt some improvement is required, including 36% (30% in the online survey) who felt that a lot of improvement was required.
- Non emergency operations: 88% (91% in the online survey) felt some improvement was required including 36% (and 34% online) who felt that a lot of improvement is required.
- Time waiting in Accident and Emergency (A&E): 91% (96% online) felt improvement was needed, including 56% (and 47% online) who felt a lot of improvement was required.
- Access to Mental Health Services: 93% of people (online survey) stated that improvement was required to the availability of mental health services (43% stated that a lot of improvement was required).

Quality of Care for Specific Groups

- Older People: 89% (98% online) felt that improvement is required in the quality of care for older people, including 35% (35% online) who felt a lot of improvement is required.
- People with a Mental Health problem: 93% (88% online) felt improvement is required including 43% (28% online) who felt that a lot of improvement is required.
- People with learning disability: 70% (91% online) felt that improvement is required, including 30% (32% online) who felt a lot of improvement is required.

The online survey also highlighted the following:

- Quality of hospital services: this was not highlighted as an issue within the omnibus survey, but the online survey results showed that 92% felt there was some improvement required, with 18% feeling a lot of improvement is required; and
- Support for Carers: 97% of the online survey stated that improvement is required, including 45% who felt a lot of improvement is needed.

Further reinforcement of these results is expressed in the Patient and Client Council Priorities for HSC in Northern Ireland, November 2011. Some of the key priorities identified were:

- hospital care;
- care of the elderly (including domiciliary and community care);
- waiting times;
- cancer services;
- mental health and learning disability;
- health and social care staffing levels;
- access to GPs and primary care;
- children's services;
- reducing the costs of administration and management; and
- quality of care.

This evidence indicates strongly that the current system of health and social care is not meeting citizens' expectations.

Reason 9 – Making best use of resources available

This review is not about money per se and any discussion on resources produces strong views. It is, however, entirely valid to look at how we could use resources and the consequent productivity. In that regard it is difficult not to conclude that, with the overall level of resources available, we have the ability to provide a better service. The budget cycle has indicated annual expenditure of £4.65billion by the end of this Assembly period (2014/5). The Review was not asked to reduce this figure but knows that with annual pressure of 4% from residual demand and changing population,[26] change is non-negotiable. The challenge presented to the Review is simply how best to spend the resource to achieve maximum benefits.

Best Use of Estate: we currently have 10 acute hospitals, 5 local hospitals and 30 community hospital facilities, with 4,361 beds in acute and local hospitals, and 1,924 community beds. In addition there are 60 statutory residential and nursing homes for older people, 39 residential homes for children, as well as a range of daycare centres and health centres. There is an over reliance on buildings to

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[26] Reshaping the System (2010) McKinsey

provide care rather than support its delivery.

Any future models of care will have to take into consideration the best use of the estate that is currently available. It will not however concentrate on the preservation of the existing building stock but rather present a new service model which delivers care on a 24/7/365 basis.

Best Use of Staff: the HSC currently employs 78,000 people either full-time or part-time, which equates to 53,209[27] whole time equivalents across all specialties comprising:

- 33% nursing staff;
- 7% medical and dental;
- 12% social services;
- 5% Allied Health Professionals;
- 4% home helps;
- 2% ambulance services staff;
- 7% other professional and technical staff; and
- 26% admin and clerical staff (including medical secretaries ward clerks); and
- 4% managers (being Band 7 or above).

Our staff mix is primarily structured to support the existing care model which is institutionally based. For example, Northern Ireland has a higher proportion of qualified nursing staff (across all settings) compared with England, at 77% compared with 73%. Nursing care has 3.5 times the activity per weighted population than England and Wales. The driver appears to be elderly patients, with NI having 3 per 1000 weighted population compared to 0.16 per 1000 population in England.[28]

Appleby[29] stated that indicative data suggests Northern Ireland produces between 17% and 30% less inpatient, outpatient, day case and A&E activity per head of hospital and community staff than England and that hospital activity per member of staff is 19% lower than the UK average. These efficiency figures are very closely aligned to our current hospital model.

Best Use of Money: In the US, currently the care costs for 5% of the population account for 50% of health care spending.[30] This fact can be applied to any western health economy including Northern Ireland. Addressing the reason for this will require changes to be made which ensure resources are focused in the right areas.

If we were to continue providing health and social care in the same way as we do today, some suggest we would need £5.4

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[27] DHSSPS NI Health & Social Care Census, March 2011

[28] Reshaping the System, McKinsey 2010

[29] Independent Review of HSC Services in Northern Ireland, 2005

[30] Research in Action, Issue 19, 2006

billion of funding by 2014/15 to cope with this combination of growing demand for care and inflating costs. Given that this is unrealistic, from both an economic and delivery perspective, we need to reshape services. Adopting a new model which is efficient, patient centred and providing high quality evidence based services, would enable a legitimate debate in the future on how much funding health and social care should receive, compared with other public services.

Much of the significant management, administrative and overhead efficiency savings potential in health and social care has already been captured through the Review of Public Administration (RPA), and the potential for further savings is limited. Instead, fundamental change is required in how we deliver care in the future.

Reason 10 – Maximising the Potential of Technology

Technological change is both a driver and enabler for the future. The pace of change is incredible and our current model does not promote its absorption or benefit as it should. For example, NI has now one of the most sophisticated radiological systems anywhere but we need new ways of working to maximise the potential of this technology. The technology that enables 24/7 intervention in the care of strokes and coronary conditions can revolutionise the outcome for patients but to deliver it our current service pattern must change.

There is overwhelming evidence that organising emergency care separate from elective care makes better use of the infrastructure in hospitals. Information is key. As a system we have a huge amount of data but poor data analysis, preventing professionals from having the evidence that is central to their work. For example, information from patient records could be used more effectively to monitor our local health needs and to assess what treatments are working well. Data needs to be used in a more effective way to ensure it is translated into information that we can use to plan our services.

Communication with the public is not as modern as it should be, for example in arranging appointments, in explaining how to use the service and giving timely information. This leads at times to disorganisation in our response to the individual and inefficiency.

The technological infrastructure in NI is good and it can promote more care closer to home but our service has not yet fully embraced the opportunity that exists. Connected health projects exist but have emerged in an ad hoc manner. If the service is to derive maximum benefit in this regard, development of connected health needs to be more coherent. Changes therefore will need to build upon the existing Memorandum of Understanding between Invest NI and DHSSPS in relation to connected health. A clear commitment to maximising the technological potential to service provision will be essential.

Reason 11 – Supporting Our Workforce

Problems being experienced by staff trying to deliver services within the HSC were highlighted in the HSC Staff Survey carried out in 2009. Over 2 in 5 staff (43%) felt that they cannot meet all the conflicting demands on their time at work, and only 34% agreed that there are enough staff at their organisation to do their job properly. The most common reason stated for staff having been injured or feeling unwell in the last 12 months was work-related stress (31%). When the Review team met with staff to discuss the future there was not a single voice which argued for the preservation of the existing model of service.

The Review acknowledged the willingness of staff to make change and heard clearly that they wanted to be closely involved in how change should happen.

CONCLUSION

It is clear that we need to act now both to improve our system's quality and productivity, and to better manage the demand on our services. Fundamental change is required in how we deliver care in the future. There are no neutral decisions: every decision will have consequences and opportunity costs for patients and clients. More simply put, we need a new model of care.

We are not different. Whilst there are unique factors at play in Northern Ireland impacting on the demand for services, a number of the issues with the HSC in NI are common in other areas of the UK.

Healthcare for London, A Framework for Action was a review into the healthcare delivered to the population of London, led by Prof. Lord Ara Darzi. This review set out similar issues in terms of the need to focus on improving the quality of services delivered, meeting the expectations of the public, addressing the inequalities in the system, delivering the right care in the right place at the right time, issues with the configuration of specialist services and making better use of resources available, both in terms of the workforce, the infrastructure and taxpayers' money.

The Scottish Government's Shifting the Balance of Care framework set out a programme of changes across health and care systems intended to: bring about better health outcomes for people; provide services which reduce health inequalities; promote independence; and provide services that are quicker, more personal and closer to home.

NHS Wales also recently published a report setting out its 5 year vision for the NHS in Wales, Together for Health. This review identified largely common issues, including challenges with a rising elderly population, enduring inequalities in health, increasing numbers of patients with chronic conditions, rising obesity rates and a challenging financial climate.

Consequently NI cannot insulate itself from the need for change.

The Review presents an opportunity to consider a more integrated model for the HSC system that allows us to deliver an excellent health and social care service to the population of Northern Ireland.

THE PRINCIPLES FOR CHANGE

5. THE PRINCIPLES FOR CHANGE

The Review team has concluded that the Case for Change is unassailable. It highlights the pressures currently faced by our health and social care system and the demands that will be placed upon it in the future. If we continue to deliver services as we currently do, they will not meet the needs of our population and will not be sustainable for the years to come. Therefore, changes are needed to meet future health and social care needs.

In looking to recommend a new model, the Review has engaged widely with the public, clinicians, providers and interest groups, and reviewed research evidence to inform the changes that are required. It started with the 'user first' principle rather than considering the structures in our health and social care system. The aim throughout has been to consider what changes would make the greatest difference to outcomes for patients, users and carers.

The Review has developed a set of principles that will underpin the shape of the future model for health and social care. Later, in the document, when the implementation pathway is described, these principles will be important determinants in the change process. They build upon the three core objectives upon which the National Health Service (NHS) was founded:

- to meet the needs of everyone;
- to be free at the point of delivery; and
- to be based on clinical need, not ability to pay.

The Minister, in his statement on 27th September 2011, said that he believed the Assembly was fully committed to those principles, but had to recognise the fact that the rising level of need in health and social care services, the need to focus on outcomes and the constrained financial context made it increasingly difficult to hold onto those principles. The ability to continue to deliver these principles is only possible through the support of a radical programme of service change and reconfiguration.

The Review has concluded that there are twelve major principles that should guide changes to health and social care.

KEY PRINCIPLES

1. Placing the individual at the centre of any model by promoting a better outcome for the user, carer and their family.
2. Using outcomes and quality evidence to shape services.
3. Providing the right care in the right place at the right time.
4. Population-based planning of services.

5. A focus on prevention and tackling inequalities.
6. Integrated care – working together.
7. Promoting independence and personalisation of care.
8. Safeguarding the most vulnerable.
9. Ensuring sustainability of service provision.
10. Realising value for money.
11. Maximising the use of technology.
12. Incentivising innovation at a local level.

WHAT DO THE PRINCIPLES MEAN?

1. Placing the Individual at the Centre of any Model

The individual must be at the centre of the health and social care system. The model must be built around what will produce the best outcomes for individual users, carers and families. Clarity about communicating this principle is essential.

2. Using Outcomes and Quality Evidence to Shape Services

All services should demonstrate that they are able to meet well understood measures of quality. This must include taking account of an evidence base of existing and emerging research on what produces the best outcome, both within Northern Ireland and beyond.

In NI, Service Frameworks[31] have been developed for 4 service areas, and a further 3 are under development. The Frameworks promote and secure better integration of service delivery along the whole pathway of care from prevention, diagnosis, treatment and rehabilitation, and on to end of life care. These include:

- cardiovascular services;
- respiratory services;
- cancer prevention, treatment and care;
- mental health;
- learning disability (under development);
- older people's health and wellbeing (under development); and
- children and young people's health and wellbeing (under development).

This is the best way to ensure that our limited human, financial and physical resources are used in the most effective way to produce the best possible patient and client outcomes.

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[31] Service Frameworks, DHSSPS

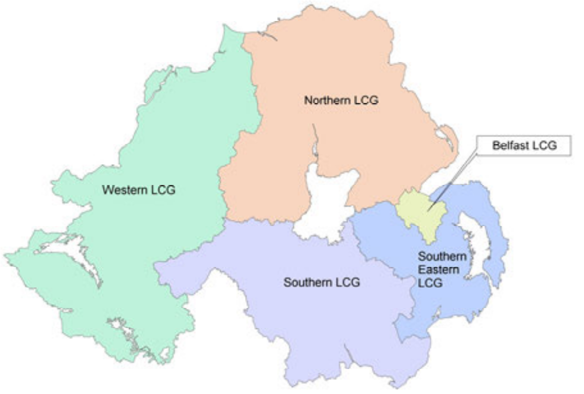
3. The Right Care in the Right Place at the Right Time

Care should be provided at home or as close to home as possible. Many of the services currently provided in an acute hospital or institutional setting should be provided in the community or in people's homes, making them more accessible. Where it is not safe and effective to provide services locally they should be provided more centrally or regionally. More simply put, the health and social care system should provide local services for local people, but safe, sustainable and accessible services for populations.

4. Population-Based Planning of Services

Services should be planned on the basis of the needs of a defined population or 'health and social care economy'. The Review team recognises population boundaries can be artificial but the starting point is to use the existing local health and social care economy populations, which are synonymous with the current Local Commissioning Areas (as in the figure below).

Figure 11: Local Commissioning Areas



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When necessary this should incorporate joint planning between these populations to deliver local or more central services. For some services this would require planning to take account of a NI wide perspective. However, with a population of 1.8million it is simply not feasible to provide every health and social care service that may be required, e.g. in these cases planning should be done jointly with other UK countries or the Republic of Ireland. The levels of planning are illustrated in the figure below.

Figure 12: Levels of Planning

5. A focus on Prevention and Tackling Inequalities

Prevention is always better than cure whether primary, that is avoiding the problem occurring, or secondary, that is arresting the problem. Such measures should be embedded into every service area. Services should support people to take good decisions about their health and wellbeing, with a particular focus on the needs of those groups that typically have poorest health outcomes. The factors impacting on health and wellbeing are diverse but well known and this will require partnership working across government and between the public and voluntary, community and independent sectors. Health economies will need to pay particular attention to achieving these outcomes demonstrating how in practice this approach expresses itself to the individual.

6. Integrated Care – Working Together

Services provided by different parts of the health and social care system should be better integrated to improve the quality of experience for patients and clients, safety and outcomes. This starts with making it simpler to use the system. It will require clinicians to organise care around the individual, with better communication and networking across primary, secondary and tertiary care, that is doctors talking to doctors, and professionals jointly reaching decisions about patients' and clients' care in partnership with them. Closer working together will be mandatory, illustrated by demonstration of full support of the various constituent parts of the service as to how services are organised. Underpinning this will be the requirement for improved technology and information sharing.

7. Promoting Independence and Personalisation of Care

Greater control by those in receipt of the service is a necessity. Flowing from this, as much diversity as practical should be available. To deliver this there should be a mixed economy of providers. In the majority of instances, this will be provided by statutory services but joint working with the independent sector will be expected. Services should aim to meet the needs of individuals, with care personalised in terms of their specific requirements. Patients, service users and their carers should be helped to take the important decisions about their own care, and importantly, enabled and empowered to take ownership of their own health. The vital contribution carers make to support the health and social care system should be recognised and carers' needs should be fully assessed and supported in this process.

8. Safeguarding the Most Vulnerable

Throughout the health and social care system, appropriate safeguards should be in place to protect the most vulnerable in society.

9. Ensuring Sustainability

Providing services requires significant attention to be spent in ensuring workforce sustainability. More simply put it means service models need to be robust. In this regard endorsement of regulatory and training bodies such as NIMDTA is essential. While locum and agency staff may be used to support a service where necessary and appropriate, they should not be inextricably linked to a service's ability to remain. Services organised this way are quite simply not sustainable.

10. Realising Value for Money

Any service models taken forward as a result of this Review must take cognisance of financial resources available to the HSC and secure value for money. Therefore there is a need for financial realism.

11. Maximising the Use of Technology

Changes should be supported by up to date technology to ensure vital information can be shared quickly among professional staff, duplication eliminated and that the latest diagnostic and treatment tools are available.

Changes should take account and build upon the Memorandum of Understanding between the DHSSPS and Invest NI on "Connected Health and Prosperity".

12. Incentivising Innovation at a Local Level

Making changes on the scale indicated in the following model will require devolved decision making and an incentive culture within health and social care, its workforce and the population. This is a direct response to the question 'why would I do it?'. Changes will need to show how they make things better, starting first with their positive impact on those using the service. The incentives of more local control in decision making, better training and development for the workforce and innovative ways of using resources will all be integral to the change process.

In this regard partnership working will be central, whether between populations in NI or with jurisdictions outwith NI. It will also be essential to explore in this context working with others, for example, the voluntary and independent sectors and the pharmacy industry to fully deliver the new model of care.

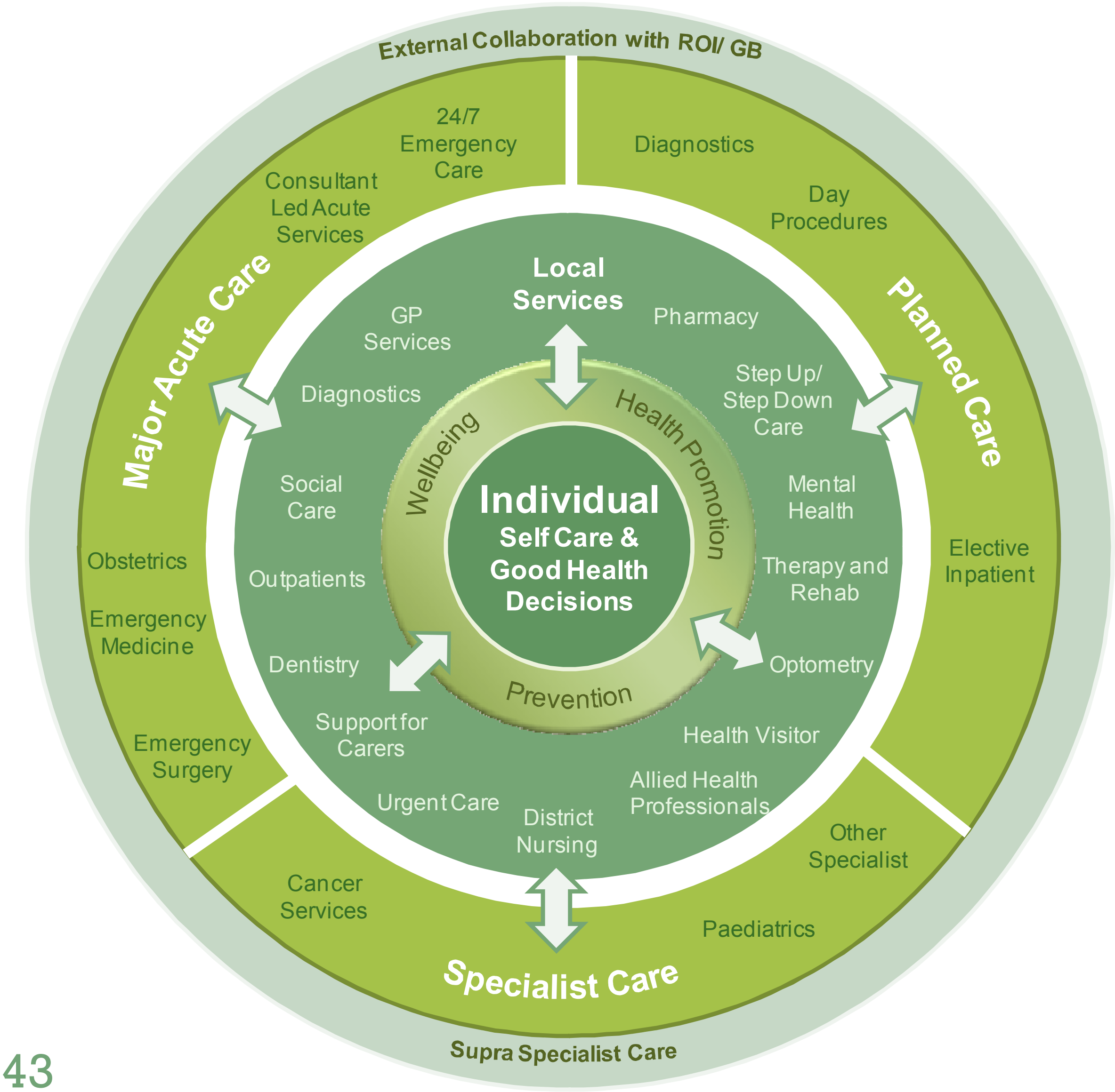
A FUTURE MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE

6. A FUTURE MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE

Following from the key principles outlined above and the Review's assessment of the opportunities that exist to do things better, a future model for integrated health and social care has been developed. This is illustrated in the figure below.

The future model is designed with the individual at the centre, with health and social care services built around them. Health and social care begins with the individual who is supported to care for themselves and make good health decisions.

Figure 13: Future Model for Integrated Health and Social Care



THE INDIVIDUAL

Every individual has a responsibility to make decisions that help maintain good health and wellbeing, prevent the onset of illness, and minimise deterioration as a result of any existing conditions they may have. People are supported to do this by health and social care professionals, their community, health and social care initiatives and regional health promotion, health protection and prevention initiatives. For example, this may include family support programmes run in community centres, smoking cessation programmes in pharmacies, screening in GP clinics (e.g. for cervical cancer), health visiting for newborns, healthy eating initiatives in community centres, and exercise programmes in local leisure centres. Fundamentally, people need to be supported to take responsibility.

LOCAL SERVICES

Integrated Local Services

For most people, much of what is needed from health and social care services will be increasingly accessible in their local area, either in their own home or in a local facility.

In many ways this may not seem much different to the way services are currently provided. The professionals providing local health and social care services, (for example GPs, district nurses, dentists and social workers) will continue to operate in local surgeries, health centres and high street practices, and to visit people's homes where needed. However, the way that they work with each other will be different.

GP practices will work together as federations of practices, enabling consistently high quality care for their patients. Additionally, Integrated Care Partnerships will be set up to join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent and voluntary sector. The Integrated Care Partnerships will have a role in determining the needs of local population and planning and delivering integrated services. Seventeen Integrated Care Partnerships will cover Northern Ireland.

For the individual, this will mean that GPs and all the other health and social care providers in an area, including from the voluntary and community sector, will be able to work together to deliver the services needed by their local population. As a consequence people will deal with fewer professionals and be at the centre of the decision making about their care and treatment.

Technology will support this integrated working. Electronic Care Records will allow health and social care teams to see patient records including details of medications, results of tests and any hospital treatment. This will help ensure that professionals have access to the information they need to treat a patient effectively, including in an urgent care situation. Patients will also have improved information on their personal circumstances.

More Services Provided In the Community

The public told the Review that there should be a greater range of services available in the community. Therefore, under the new model, more of the services that currently require a hospital visit will be available locally. This may include for example, X-rays and other diagnostic tests, and oral surgery. GPs will be enabled to undertake minor procedures in their surgeries. Outpatient appointments in many instances will be provided in the community rather than in hospital. In some specialties, care will be organised directly by the Integrated Care Partnership. New facilities will be developed to support this model, which may be similar to the health and care centres currently in some areas. This model will improve accessibility to health and social care services for the individual.

More specialist care will be provided in the community. Specialist hospital clinicians will support GPs and other community clinicians, working closely with them to plan how services are delivered. More specialists will also be employed in the community, for example, specialist nurses and GPs with a Special Interest. Providing outpatient appointments in the community will become the norm, with some of these being run by GPs and others by hospital specialists. This will reduce the number of follow-up visits to hospital required by patients.

These changes will be very important for people with long-term conditions, for example diabetes, cardiac illness or respiratory problems. For these patients, community-based support programmes will be put in place where multi-disciplinary teams work with patients to help them manage their condition. This will include:

- dedicated community-based clinics where patients can access a range of health and social care services, including inputs from community pharmacy, Allied Health Professionals such as podiatry and physiotherapy, nursing care and social work support as well as from GPs with a Special Interest and hospital specialists;
- better use of telehealth equipment to help people monitor their own conditions and alert health professionals when an individual's condition deteriorates;
- a named contact person for patients to call when they need assistance – this may be the GP, a specialist nurse or another member of the integrated care team; and
- direct admission to hospital care when needed as agreed between the GP and hospital specialist, with no need to

pass through the hospital emergency department.

Working in this way will also benefit groups who can face barriers in accessing care. For example, the new model will support the provision of enhanced community health services for people with a learning disability.

There will be a consistent approach to the provision of mental health services through the stepped care model, with most services being provided in the community by community mental health teams and voluntary and community sector partners.

More Support Available at Home

Throughout the Review people expressed their preference for care at home or as close to home as possible. In response to this, the new model will provide more support to help people who are sick or frail to maintain their independence and stay in their own homes for as long as possible. This applies whether that home is the family home, supported housing, a nursing home or residential home. However, there will be much greater emphasis on enabling people to remain in their chosen home. Providing care, treatment and support in this way will change the current model, perhaps most noticeably in terms of the number of residential homes.

As part of this approach, more tailored support will be provided to meet people's needs. People will have access to specialist equipment, nursing care, telehealth and telemonitoring support, and other therapeutic support at home, e.g. physiotherapy, podiatry or occupational therapy.

Social care will also be a central part of the support provided to enable independent living. This will include access to a diverse range of provision to meet people's social and emotional needs and tackle social isolation. Voluntary and community sector organisations will provide this support as well as community health and social care teams.

Virtual wards will also be developed. Under this model, individuals are admitted into the care of specialist teams, and provided with similar care as would be available in a hospital ward, but remain in their own home. Mental health treatment services will also be available at home, provided by Crisis Response and Home Treatment teams. This will result in reductions in inpatient care.

Intermediate care will be an important component of the new model, with greater provision of step-up and step-down beds in the community for people needing extra care for a short period of time. Step-up beds provide locally-based short-term support to avoid the need for individuals to be admitted into an acute hospital. Those leaving hospital may spend time in a step-down bed for rehabilitation before returning home. A reablement model will be introduced to provide people with the support they need to return to their homes following a stay in hospital, an accident or other crisis.

There will be a need to provide more respite care and short breaks in the community, to support individuals and carers. This will include accommodation and other short break options. All of this intervention is designed to respond to the patient's and carer's needs.

How people are cared for at the end of life is a key indicator of the values expressed by the HSC. Under the new model, services for those approaching the end of life will be provided that enable people to die at home, where that is clinically appropriate and consistent with their wishes. GPs and other community health services will provide in-reach to support people at end of life. This will apply in nursing homes as well as family homes.

Urgent Care

An urgent care model will be implemented in every area to provide 24/7 access to urgent care services. These services will be planned in accordance with local need. Whilst the model will take account of local circumstances, the outcomes will be consistent. The system of urgent care will ensure each community has local access to urgent health and social care services, variously provided by GPs, urgent care specialist nurses, mental health crisis response teams and emergency social workers.

EMERGENCY, SPECIALIST CARE, AND PLANNED CARE

Emergency care, specialist care, and planned care services will be provided in hospitals for people whose health and care needs cannot be met in their own homes or their own communities.

People needing specialist and acute care will be admitted to hospital. This may be on a planned basis, for example, for a pre-arranged procedure or as a result of an emergency.

The model aims for those admitted to hospital to be discharged to home or a community facility as soon as their health and care needs can be met there. Once individuals are discharged, follow-up care will be provided by the integrated care teams in the community with support from hospital specialists as required. As well as meeting the needs of patients and their families more effectively, this is a more efficient approach which will result in greater productivity.

Triage services and patient transport will be critical to ensuring that individuals access the care appropriate to their needs on a timely basis.

EXTERNAL COLLABORATION AND SUPRA-SPECIALIST CARE

Some services that are only needed by a very small number of people will be provided outside of Northern Ireland. This is necessary to ensure the quality of provision. Networks will be set up between the HSC in Northern Ireland and health and care providers in the ROI and other parts of the UK.

CONCLUSIONS

The proposed model has been designed to address the challenges presented in the Case for Change and the concerns expressed by those engaged with throughout the Review, both clinicians and the public.

The key differences between the current model of care and that proposed by the Review will be:

- care will be organised around the individual and not the institution;
- greater involvement in decision making will be afforded for the patient / client;
- the model provides a new way to look at the traditional model of GP and community health and social care services;
- home or close to home will be the centre of health and social care provision;
- there will be responsible access to emergency and hospital care; and
- new arrangements will be put in place to support provision outside the jurisdictions.

Overall, the model builds on evidence of what produces good outcomes, and supports the resilience and flexibility of the health and social care system for the future.

CASE STUDIES

The Review team considered it important to describe how it might be different for those using the service and offers the following examples to illustrate the change.

Older People	
Current Model	**Future Model**
Jean is a 79-year old woman, who lives alone in her house. She suffers from osteoarthritis, diabetes, bronchitis and heart disease. Because she is not as mobile she finds it difficult to get to hospital appointments. Jean was assessed on several occasions by various professionals, including a social worker, physiotherapist, occupational therapist, and a specialist diabetes nurse. She had to provide the same information each time she was assessed, which Jean found frustrating. The outcome of the assessments deemed that Jean required support from a range of professionals and adaptations to the steps up to her house. Jeans gets confused who is coming to her each day. Furthermore, no-one noticed that she might have a cataract. While Jean was waiting on the adaptations to her steps she fell and fractured her hip. She was taken to hospital and underwent emergency surgery. Jean had to stay in hospital while discharge planning was undertaken and a care package arranged. After some time, she was transferred to a rehabilitation ward where she underwent physiotherapy to assist her recovery, prior to returning home. Jean now worries that she will not be able to cope in the longer term and that she may need to begin thinking about residential care.	Jean's needs were assessed using the Northern Ireland Single Assessment Tool (NISAT), which allowed for all the information necessary to establish her health and social care needs to be collected in one assessment. All of those supporting Jean use this information so she doesn't have to provide the same information several times to various different professionals. Jean sees the specialist looking after her diabetes at her local which is more convenient. Further to the NISAT, the adaptations were made to Jean's steps. The assessment also identified that Jean required a cataract operation – both these interventions happened quickly preventing her fall. Jean was provided with details of the budget available to meet her care needs. The Trust explained that they could manage how this budget would be used or she could receive the budget via a Direct Payment and use it to purchase services herself. Jean chose not to take a Direct Payment, and instead to agree jointly with the Trust how her care budget would be used. They agreed that she would get support with going shopping and attending a local lunch club.

Case Study – Long Term Conditions

Current Model	Future Model
Tom is a 75 year old man suffering with heart problems. He lives on his own but is visited regularly by his daughter. He experiences regular breathing difficulties and his condition is exacerbated by regular chest pains which results in recurring episodes. After waiting in A&E to see a junior doctor and explained his circumstances he has been admitted to a ward where he receives the appropriate treatment required to treat his condition and symptoms. He does not require a referral to see cardiologists. He is discharged when stable after 5 days with appropriate advice on medications and life style. The next time he experiences the same symptoms he is worried and he phones his GP. His GP recognises that this is an exacerbation of his heart failure and sends an ambulance to take him to A&E where he is admitted again. This cycle is repeated again and again and Tom visits A&E 10 times that year.	Tom's GP referred him directly to the community heart failure team who contact him the day following discharge. The nurse arranges to come out to see him in a few days and ensure he understands all the medication he has been prescribed. His daughter is included in these discussions. They are educated about his symptoms and lifestyle and left a number to phone if the symptoms get worse. Tom visits the nurse in two weeks while his medications are increased in line with his clinical presentation. The Heart Failure nurse in secondary care provides specialist telephone advice as necessary. A referral to cardiology will be made if deemed necessary. The nurse takes every opportunity to educate Tom on his condition in order to ensure he knows how to manage his condition. If Tom feels that his symptoms are getting worse he can phone the heart failure nurse help line number who arranges to see him quickly. This proactive contact continues as appropriate for four years during which time Tom only needs to be admitted once to hospital for stabilisation of treatment. This admission is planned by the specialist heart failure team and Tom does not have to present to A&E.

Case Study – People with a Physical Disability	
Current Model	**Future Model**
Gary is a 23-year old man who has cerebral palsy. As a result of his condition, Gary has been in a wheelchair for most of his life. Gary spends most of his time at home or at the local day centre. He has a care worker who visits his home for 30 minutes each morning to assist his mother getting him out of bed and dressed. He then goes to the local day centre. Each evening, his care worker returns to assist his mother in putting Gary to bed. Gary is concerned that he does not receive enough stimulation at the day centre and the activities which he participates in are very limited. Gary would be keen to spend more time with people of his own age group and expand his social networks, as the only people he truly engages with at present are his close family members.	Gary is a 23-year old male with cerebral palsy. His care worker visits his home for thirty minutes every morning and evening to assist his mother with getting him in and out of bed and getting dressed. Gary would prefer to have more control over his daytime activities. He decides to receive some of the budget available for his care in the form of a Direct Payment from the HSC Trust. He uses the Direct Payment to buy the support of a care-worker two days per week. Gary now attends the local college one day per week, where he has joined a committee for students with a disability. On another day his support worker helps him with leisure activities such as swimming. Gary still spends three day per week at the day centre. To help manage his Direct Payment, he receives help from a voluntary sector organisation on being an employer, including how to recruit and pay someone.

Mental Health	
Current Model	**Future Model**
Joe is an unmarried, 25-year old man who lives at home with his mother. He worked for three years as an engineer in a production factory, but unfortunately one year ago he was made redundant from his job. Over the period since his redundancy, Joe has become increasingly depressed. He feels hopeless, experiences disturbed sleep, has lost interest in playing football and has become withdrawn from his friends. Joe's mother has encouraged him to visit his GP for some help, but Joe feels too embarrassed to do so. Joe has also started to drink heavily in an attempt to self-treat his depression. When his mother would encourage him to stop drinking, he would become aggressive towards her, which made him feel guilty. Joe has started to self-harm and have suicidal thoughts. The physical injuries caused by Joe's self-harming became so serious that he had to be admitted to hospital for treatment. Joe was also assessed by a psychiatrist at this time. Once the physical injuries had been dealt with, Joe was discharged from hospital and prescribed antidepressants to assist in the management of his illness.	Joe feels increasingly depressed having been made redundant from his job. He feels disconnected from his friends and experiences disturbed sleep. Joe picks up a booklet in a local takeaway produced by a local community organization. It encourages young men to look after their mental health and explains how to get help if necessary. Joe had been worried that there would be a social stigma attached to seeking help for mental health problems, but when he sees this advice he feels reassured that he could seek help. Joe went to his GP who listened to his problems and advised that he should attend cognitive-behavioural therapy sessions. Joe now meets his therapist once per week at the local health centre, and also has regular review appointments with his GP to monitor his progress. Joe was glad that he had heard the advice about seeking help with mental health problems at an early stage. He is now feeling much better and his illness is under control.

Case Study – Urgent Care	
Current Model	**Future Model**
Abby is 32 and is a keen cyclist. As she travelled home one afternoon, Abby was forced onto a curb by an oncoming car and crashed her bicycle which left her in considerable pain. On further inspection, Abby needed medical attention as her arm was bleeding badly and she was unable to move her wrist or put any pressure on it. Abby called her husband who took her to the nearest A&E department. She explained her situation and gave her details and waited to see a consultant. A serious traffic accident requiring urgent attention meant that Abby waited 4 hours for an assessment while continuing to be in distress. Eventually Abby saw a doctor where she was given stitches and some pain relief, as well as a splint to secure the arm and prevent any further damage. Abby was then referred for an X-ray to identify any fractures. After another lengthy wait of two hours for the X-ray and then the results, the X-ray showed that no major damage had been caused. Abby was free to return home and told to make an appointment with her GP to get her stitches removed.	When Abby called her husband to tell him what had happened, he remembered the new number to call for all urgent care enquiries which he had learnt from a leaflet which had come in the post. After ringing the helpline, he was advised to take Abby to the local Health and Care Centre. When Abby arrived at the Health and Care Centre she waited for a specialist nurse who saw her almost immediately. The nurse investigated the injury and identified that stitches were required but an X-ray would confirm whether further treatment was required. Abby received some pain relief and went for an X-ray which was taken in the same facility within half an hour. The X-ray showed no fracture and Abby was free to return home after the nurse applied some stitches. Abby was advised to make an appointment with her GP to organise the removal of her stitches.

7. POPULATION HEALTH AND WELLBEING

INTRODUCTION

Prevention is integral to the delivery of sustainable health and social care. It enables individuals to make better health and wellbeing decisions. Additionally it is an important determinant in optimising health outcomes for the citizen. Investment in prevention also makes economic sense, for example, inequalities have been estimated in England to cost £5.5billion to the NHS alone.[32]

Total annual inpatient costs to health and social services in Northern Ireland as a result of smoking were estimated at £119million in 2008/9.[33]

Loss to the local economy as a result of obesity is estimated at £500million, with 59% of the population being either overweight or obese. This includes, for example, some £24.5million spent on prescribed anti-diabetic medication alone.[34]

The impact of alcohol on the health and social care system is estimated at some £250million. The additional social costs are estimated at almost £900million. Furthermore, it is estimated that alcohol is a significant factor in 40% of all hospital admissions, rising to 70% of Accident and Emergency attendances at weekends.

Given the significant impact of these issues on the health of the population and the costs of care, strategic and bold action is required. No system can withstand the pressure of doing nothing, and the HSC has a duty to address the health inequalities in our population.

THE CHALLENGES

The starting point is to acknowledge that population health and wellbeing is not just a matter for the health and social care system. It begins with the individual and the choices they make, but improving health and reducing health inequalities also requires joint action across government and partnership working. One area brought to the Review's attention was rural isolation and transport. The Review would suggest this is an area in which joint working could be piloted, including joint sharing and control of resources.

No-one disagrees with the concept of health and wellbeing, the challenge is to deliver a programme of change. Financial pressures will undoubtedly increase within HSC budgets, and often there is

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[32] NICE (2009) Using NICE guidance to cut costs in the downturn.

[33] RCP (2000) Nicotine Addition in Britain: A report of the tobacco advisory group of the RCP applied to 2008/9 HRG costs. In: Ten Year Tobacco Control Strategy for Northern Ireland Consultation Document.

[34] N Gallagher, Presentation QUB Centre of Excellence 2011, Source BSO.

consequent pressure to defer investment in prevention.

LIFESTYLE CHOICES

Alcohol Consumption in Northern Ireland

Given the link between alcohol consumption and harm, and evidence that affordability is one of the drivers of increased consumption, price has become an important feature of prevention strategies. Alcohol is now 44% less expensive in the UK than it was in 1980. It is possible today to exceed the maximum weekly recommended intake of alcohol for men (21 units) for around £4.

A University of Sheffield report, used by the Scottish Government, suggests that a minimum price of 45p and a complete ban on promotions would save about 50 lives in year one, rising to 225 lives in year ten. Moreover, it has been estimated for Scotland that the 45p per unit minimum price would have a total value to health, crime and employment in year one of more than £50million and over ten years of more than £700million.

The submission to the Review from the Royal College of Psychiatrists in Northern Ireland also highlights its view that alcohol price control could be the single biggest act that Government could undertake to improve health and wellbeing in Northern Ireland.

As NICE states: “There is extensive international and national evidence (within the published literature and from economic analyses) to justify reviewing policies on pricing to reduce the affordability of alcohol".

Over the last ten years, it has become increasingly socially unacceptable to drink and drive. This has been via a mixture of enforcement, education and diversion. In this context, it is proposed that a reduction in hazardous and harmful drinking becomes a priority for Northern Ireland with associated targets such as a reduction in A&E attendances helping to drive performance. This could be supported by focused media campaigns to change behaviours/ culture along with evidence based interventions for reducing harmful and hazardous drinking across Northern Ireland.

Smoking

As detailed in the Case for Change, around 340,000 people aged 16 and over smoke in Northern Ireland. Half of all smokers eventually die from cancer, or other smoking-related illnesses.[35] A quarter of smokers die in middle age, between 35 and 69. These deaths could be avoidable.

Reducing smoking is a high priority for public health and there is an ongoing programme of action to encourage people who smoke to stop and discourage people from starting to smoke. This includes public information campaigns and

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[35] Mortality in relation to smoking: 50 years’ observations on male British doctors, Doll et al, 2004

smoking cessation services. The model of care proposed by the Review offers the opportunity to take an integrated, area-based approach to these actions, targeting groups facing particular risks, such as pregnant women, and locations where smoking rates are known to be higher, for example colleges.

Obesity

The Case for Change highlighted the rate of obesity in Northern Ireland and the challenges this presents. An estimated 59% of all adults are either overweight (35%) or obese (24%),[36] which has a very significant impact on our population's health and wellbeing. We face a significant challenge in halting the rise in the proportion of the population who are overweight or obese.

A regional Obesity Prevention Framework is being developed to set out the actions needed to reduce the rate of obesity. These include supporting the individual to take responsible decisions and helping to create an environment that supports healthy decisions about diet and physical activity.

In relation to the lifestyle factors of diet, physical activity, smoking and alcohol consumption, it is important that we provide citizens with good information and that we create environments which make it easier for people to make healthy choices.

To support this, the Review would encourage the Northern Ireland Executive to consider the wider role of the state in taking decisions impacting on health outcomes. In addition to considering the emerging evidence on the potential benefits of minimum pricing for alcohol (for example, taking account of the outcomes of the Scottish alcohol pricing initiative), the Executive may wish to consider the issue of pricing of alcohol and 'junk' food and further controls on tobacco usage.

SCREENING AND PREVENTION

Population screening programmes enable the early detection of disease. They involve testing people who do not have any particular symptoms of a disease to see if they have the disease or are at risk of getting it. Screening allows earlier intervention which contributes to improved outcomes for individuals. The current programmes include screening for breast, cervical and bowel cancers, diabetic retinopathy, antenatal infection screening and a programme of screening for newborns.

Immunisation is the most effective public health intervention for preventing ill health and saving lives. It provides people with vaccinations to protect them against serious infections. Many of these are provided in childhood, for example primary vaccinations for diseases including polio, whooping cough, diphtheria, and the MMR vaccine for measles, mumps and rubella. Uptake rates for childhood vaccination are very

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[36] NI Health and Social Wellbeing Survey 2005/06, DHSSPS

high in Northern Ireland and above the UK average. The uptake rates for the flu vaccination, which targets groups at risk of serious harm from the winter flu virus, are also higher than the UK average in Northern Ireland.

The Public Health Agency is responsible for screening and immunisation programmes. Key priorities are to maintain and expand existing programmes and to introduce new programmes where there is good evidence that they can be effective.

SOCIAL WELLBEING

The role of social support in preventing illness and enhancing individuals' quality of life is well recognised. For example, Section 8 which focuses on care for older people, describes how loneliness and social isolation have been proven to have a negative impact on physical health.

The voluntary and community sector plays a significant role in supporting the social needs of vulnerable groups, often working in partnership with health and social care, housing and other statutory services. This role should be expanded.

THE ROLE OF INTEGRATED CARE PARTNERSHIPS IN HEALTH PROMOTION

The Integrated Care Partnerships proposed under the new model, will have a leading role to play in promoting health and wellbeing. They should be incentivised to support evidence-based health and wellbeing promotion and embed prevention into health and social care services.

This should include:

- expansion of screening and immunisation programmes in the community where evidence exists to support them. Where possible, screening and immunisation should be provided in the community;
- an enhanced role for community pharmacists in health promotion, for example, in relation to information and advice around obesity and weight management, alcohol use and minor ailments;
- support for the role of Allied Health Professionals in secondary prevention, particularly as regards older people, for example, the role of podiatry care in falls prevention, and occupational therapy in rehabilitation;
- support from clinicians for community-based education programmes; and
- local community and voluntary organisations supporting the social and emotional needs of vulnerable groups.

SUMMARY OF KEY PROPOSALS

1. Renewed focus on health promotion and prevention to materially reduce demand for acute health services.
2. Production by PHA of an annual report communicating progress on population health and wellbeing to the public.
3. Maintenance of existing and implementation of new screening and immunisation programmes where supported by clinical evidence.
4. Consideration by the Northern Ireland Executive of the wider role of the state in taking decisions impacting on health outcomes, for example: in relation to pricing of alcohol and 'junk' food; and further controls on tobacco usage.
5. Incentivisation of Integrated Care Partnerships to support evidence-based health promotion, for example, clinician-led education programmes in the community.
6. Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.
7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community.
8. Support for the health promotion and prevention role played by Allied Health Professionals, particularly with older people.

8. OLDER PEOPLE

INTRODUCTION

As highlighted in the Case for Change, Northern Ireland has the fastest growing population in the UK and it is an ageing population. By 2020, the number of people over 75 years is expected to increase by 40% from that in 2009, and the number of people aged over 85 is expected to increase by 58%.

Longer life expectancy is something to celebrate and many older people enjoy good health. However, among the 'older old', rates of ill health and disability increase dramatically. For example, dementia mostly affects people over the age of 70[37], and the rate of disability among those aged over 85 is 67% compared with only 5% among young adults[38]. The health and social care system cares for the most vulnerable when their needs change. Older people are significant users of health and social care services, and almost a fifth of the Health and Social Care budget (19% or £616million) is allocated to services for older people[39].

- Around 60% of acute hospital beds are typically occupied by people over 65.[40] Many arrive at hospital because there is no viable alternative in the community (more specific information on this follows later).
- Approximately 23,389 people receive domiciliary care, equating to some 233,273 hours of care each week.
- 9,677 people aged over 65 live in nursing or residential care.

Many excellent health and social care services are provided for older people by dedicated staff, volunteers and unpaid carers. But there is a high level of dependence on institutional and hospital care, and inconsistencies in the quality and range of services provided across Northern Ireland. Services are not currently meeting expectations in terms of quality and consistency. Too often they tend to focus on acute events and crises rather than providing the range of proactive and preventative support that can maintain the health and wellbeing of older people.

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[37] DHSSPS (2011) Improving Dementia Services in Northern Ireland. A Regional Strategy.

[38] DHSSPS (2010) Physical and Sensory Disability Strategy. A Consultation Document 2011-2015.

[39] HSCB Social Care Directorate Submission to the Review (October 2011)

[40] HSCB figures for 7/12/11 identified 60% of emergency and elective admissions excluding obstetrics, sick babies, the Children's Hospital and mental illness.

HOME AS THE HUB OF CARE FOR OLDER PEOPLE

Residential and Nursing Home Care

The proportion of older people in Northern Ireland living in nursing homes is 3.5 times higher than in England and Wales[41] and is increasing. Between 2007/8 and 2009/10, the number of nursing home places increased from 6,392 to 6,694. This reflects the growing complexity of needs and high dependency levels among some of the older population – for example the growth in cases of dementia where currently there are an estimated 19,000 cases. [42]

Meanwhile, the number of residential care places is slowly declining, reflecting the growth in supported housing schemes provided by Housing Associations which have replaced residential homes. Over the same period 2007/8 to 2009/10, the number of residential places fell from 3,096 to 2,983. Many of those using residential care are no longer permanent residents.

The policy aim for some time has been to shift care from institutional settings to home and community settings. The current Health and Social Care Board (HSCB) target (from April 2011) is for at least 48% of care management assessments to recommend a domiciliary care package rather than a nursing home or residential care. However, the majority of expenditure still relates to institutional care. In 2009/10 residential and nursing home provision accounted for £190million, with domiciliary care accounting for £138million and hospital care for £115million. Suggestions on how to improve care, from the online survey, included more community services, person centred care and in-reach services.

Following from the key principle that home should be the hub of care, the Review recommends that steps are taken to support greater provision of services for older people at home and in the community.

The Review supports the trend towards independent living – at home or in supported accommodation – and expects to see a very significant reduction in provision of long-term residential places in the next five years. This will inevitably

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[41] Reshaping the System, McKinsey 2010

[42] DHSSPS (2011) Improving Dementia Services in Northern Ireland. A Regional Strategy.

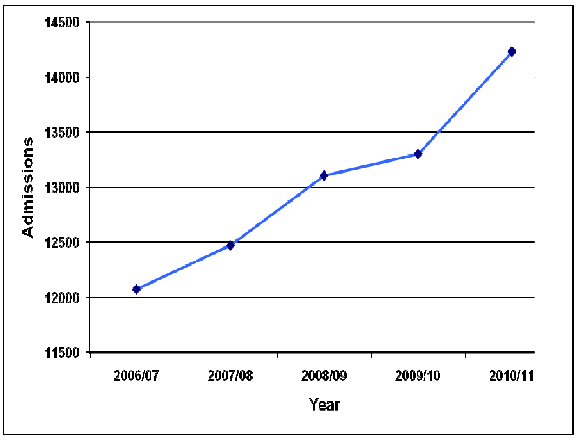
lead to the closure of existing facilities in a planned manner with resources transferred to home care or where appropriate to new models such as respite care.

Hospital Care

Increasing numbers of older people are being admitted to hospital on an unplanned basis and when they are admitted, older people tend to have longer stays and are more likely to face delays in waiting for discharge.

Over the five years to 2010/11, the number of admissions of older people into hospital increased by 18%, as shown below.

Figure 14: Total Admissions to HSC Hospitals in NI under the Elderly Care Programme of Care (2006/07 - 2010/11)



Source: NI Hospital Statistics: Inpatient Activity 2010/11

Many older people arrive at hospital because there is no viable alternative in the community, for example, due to lack of appropriate nursing and medical interventions available in nursing homes or at home.

Once admitted, older people tend to have longer stays in hospital. During 2010/11, the longest average length of stay across all specialties in Northern Ireland was under the rehabilitation specialty where admissions lasted for an average of 30.9 days. Longer lengths of stay for older people can be associated with cases involving a complex range of physical and mental health issues and therefore a requirement for a robust package of care to be agreed before discharge into the community.

Since April 2010, a target has been in place stating that the HSC Board and Trusts should ensure that 90% of complex discharges take place within 48 hours of the decision to discharge, with no discharge taking longer than seven days. As at the end of 2010/11, 86% (13,009) of complex discharges were within 48 hours regionally. The most common reasons for delay recorded were:

- no domiciliary package available;
- essential equipment / adaptations not available or assessment not completed; and
- no nursing home bed available in the chosen facility.

Research by the Alzheimer's Society found that people with dementia stay longer in hospital than other people undergoing the same procedure, and stays in an acute hospital environment can have a detrimental effect on the symptoms of dementia.[43] Admissions to hospital can also result in reduced confidence of older people and their families to live independently, and can lead to a move into residential and nursing care[44].

The Health and Social Care Board will begin to introduce a reablement model of care across Northern Ireland from 2012. This approach involves providing older people with intensive, time limited support with everyday tasks with the aim of enabling the individual to do the task as independently as possible at the end of the process. It has been shown to be an effective means by which to keep people independent for longer. The Southern HSC Trust has already begun implementing a streamlined assessment and care planning approach built around the reablement model.

It is also known that older people are often admitted to hospital at the end of life. A recent report by DHSSPS showed that 82% of people dying in hospital were over 65 years of age. Of these people, 18% (2010/11) had a length of stay of less than 2 days. The report also looked at the number of people dying in hospital within 2 days of admission who were admitted from a nursing home. In 2009/10, 28% of the deaths of people admitted from a nursing home occurred within 2 days of admission into hospital.[45]

Suggestions for improved care for people nearing the end of life, from the online survey, included more home support to allow people to die in their preferred location.

To help avoid unnecessary admissions of older people into hospital and encourage independence, the Review endorses the plan to introduce a reablement model across Northern Ireland. The Review also recommends that there should be better integration of hospital and community services. With the establishment of the 17 Integrated Care Partnerships there is a tremendous opportunity to:

- improve communication between GPs providing out of hours care and hospital specialists;
- provide in-reach into nursing homes by specialists and GPs;
- have clear specification of the care and interventions to be provided in a nursing home environment including, for example, administration of intravenous therapy and catheterisation;
- provide the management of end of life care in nursing homes – being transferred to hospital at the end of life can be distressing and the Review recommends that other than for sound

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[43] DHSSPS Dementia Strategy

[44] Stilwell and Kerslake (2003) What makes older people choose residential care, and are there alternatives?

[45] DHSSPS Hospital Information Branch (2011)

clinical reasons or family preference, nursing homes should manage end of life care;

- create greater provision of intermediate care, increasingly using the independent sector to provide:
  - step-down beds for short-term rehabilitation following a stay in hospital;
  - step-up beds that provide short-term support to prevent an admission into hospital; and
  - short-term reablement support to enable people to learn or relearn the skills necessary for independent living.

The Review suggests that whilst some intermediate care beds will be statutory, there will be an increased role for the independent sector in providing beds.

Patient and User Experience

The public place a high priority on the availability of good care for older people. In November 2011, the Patient and Client Council (PCC) engaged with its members on the future priorities for HSC in Northern Ireland. Of the top ten priorities identified, Care of the Elderly, including domiciliary care was second. Those consulted raised concerns about both the quality and quantity of social care provided, and the need for appropriate care in the community to help people live in their own homes. The need for better support for older people living in rural areas was identified.

Those consulted with by the PCC raised concerns with the PCC about the length of time that is allocated to those delivering domiciliary care.

Appropriate discharge planning for older people leaving hospital was also highlighted as a concern. Those consulted expressed a view that a holistic approach to discharge planning should be undertaken and that the patient, carers and community and primary care providers should all be involved in this process.

The quality and availability of respite care was highlighted as an issue, in particular for people with dementia. Consultees emphasised the importance of respite to support individuals and their families and carers.

The public survey conducted for this Review also found evidence of concerns with the quality and accessibility of care for older people:

- 35% of respondents felt that there was a ‘lot of improvement’ required in the health and social care services provided to older people overall;
- 24% of respondents stated that a ‘lot of improvement’ was needed in the quality of residential care for older people;
- 36% of respondents stated that ‘a fair amount of improvement’ or a ‘lot of

improvement' was required in home help or home nursing care; and

- strong concerns were expressed about the waiting time for an assessment for home help, nursing or residential care - 33% felt that a 'little improvement' was needed, with 24% and 21% respectively, stating that a 'fair amount' or a 'lot of improvement' was required.

Workshops with clinicians confirmed public concerns in relation to care for older people. Clinicians highlighted the increasing demand for nursing and residential care due to the ageing population. They expressed the view that the capacity and capability of staff within nursing and residential care settings to provide care to the increasing numbers of patients with complex care requirements needs to be addressed. Quality issues were identified including poor nutrition of older people in hospital, nursing and residential care.

A 2008 UK-wide nutrition screening survey in hospitals, nursing homes and mental health units found that people in these care settings had a higher risk of malnutrition on admission and that the risk was much higher again for older people being admitted to care. For example, it estimated the rate of malnutrition for those aged 65 in the community at 14% compared with 32% for those being admitted to hospital and 42% for those being admitted to care homes[46].

Clinicians also highlighted a perceived lack of continuity and integration between hospital care and community based care. The limitations of IT and communications systems to support sharing of information between hospitals, primary care settings and residential and nursing homes was noted.

They expressed the view that greater rehabilitation and intermediate care is needed to prevent hospital admissions and support timely discharge.

The Review was persuaded of the need for, and its new model supports, a shift in services from hospital settings to closer to home. This will require more personalised care and diversity of service provision. Advocacy will be important in providing safeguards to vulnerable individuals. Telecare support will enable the greater management of risk and improving personal confidence.

PROMOTING HEALTHY AGEING

Throughout the Review, the public and clinicians expressed a desire for a more preventative model of care and one which enables better quality of life for older people. This is supported by research that suggests that preventative approaches can deliver better outcomes

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[46] DHSSPS - Promoting Good Nutrition A strategy for good nutritional care for adults in all care settings in Northern Ireland.

for older people, with fewer hospital admissions, shorter lengths of stay and greater satisfaction with service provision.

Preventative approaches aim to take a more holistic view of older people's needs, by addressing issues other than health which impact on wellbeing but require intervention from other areas of public service. The Joseph Rowntree Foundation's Older People's Inquiry[47] identified the areas that are valued by and thus important for the wellbeing of older people as:

- comfortable and secure homes;
- an adequate income;
- safe neighbourhoods;
- getting out and about;
- friendships and opportunities for learning and leisure;
- keeping active and healthy; and
- access to good, relevant information.

This emphasises the need for a more joined-up approach to assessing the care needs of older people, recognising the role of multiple providers of health and other services across the public, voluntary and community, and private sectors. The Northern Ireland Single Assessment Tool (NISAT) aims to provide a joined-up approach to assessing the needs of older people and carers, but rollout of the tool is at an early stage and it is not yet in use in all HSC Trust areas.

The Partnerships for Older People Projects (2009) in England tested more integrated approaches to supporting older people. Its evaluation suggests that low intensity practical support services that

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[47] Raynes, N et al (2006) Evidence submitted to the Older People's Inquiry into 'That Bit of Help.' York, Joseph Rowntree Foundation.

help older people to live well in their own homes (e.g. cleaning, care of pets, gardening, befriending, help with managing bills and DIY) had by far the greatest impact on health-related quality of life[48].

There is also good evidence of the effectiveness of interventions to reduce loneliness and social isolation and improve health and wellbeing. Social exclusion is associated with poor physical and mental health outcomes for older people, and social isolation has been identified as a particular risk for older people in rural areas.[49] A review of a rural intervention to address social isolation among older people in Northern Ireland concluded that health and wellbeing of older people can be profoundly influenced by geographical location and that interventions informed by local needs are likely to be more successful.[50]

A recent report by the Social Care Institute for Excellence (SCIE) illustrates the emerging evidence that one to one interventions such as befriending and outreach can reduce loneliness and depression, and are cost effective[51]. Such initiatives are often provided by community organisations. In this regard care services are more important than health services.

Ultimately, older people want to stay at home, living independently for as long as possible, and the current model of care does not always provide the support needed to do so. Too often this results in reliance on institutional care with crisis intervention as the order of the day. This is not consistent with a shift to the wellbeing model the public expects.

Personalised budgets refer to the greater involvement of those qualifying for health and social care services in how they are provided. Needs assessment identifies the amount of care funding available for each individual and a joint decision is taken between the service user and the provider on how that funding will be used.

This includes the option to access a Direct Payment which involves the provision of funding directly to patients and clients who then purchase directly the services they feel best meet their needs. Direct Payments are available to older people who need support, individuals with physical disabilities, learning disabilities or mental health issues.

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[48] Windle, K et al (2009) National evaluation of Partnerships for Older People Projects: final report. Canterbury, Personal Social Services Research Unit.

49 Commission for Rural Communities (2008) The Personalisation of Adult Social Care in Rural Areas.

[50] Heenan (2009) How Local Interventions Can Build Capacity to Address Social Isolation in Dispersed Rural Communities: A Case Study from Northern Ireland. Aging International, vol 36, no 4, 475-491

[51] Windle, Francis and Coomber (2011) Preventing loneliness and social isolation: interventions and outcomes. Social Care Institute for Excellence.

When people are provided with information and advice on the services that are available to them, they are in a position to make an informed choice as to the most appropriate care delivery for their particular needs. Those choosing to take a Direct Payments are able to choose who provides their care, when they deliver it and what they do to meet their particular needs. This may mean reduced uptake of core social care services provided directly by the HSC Trusts and uptake of a more diverse range of provision including that of the voluntary sector. Direct Payments users may also employer support workers directly.

Promotion of personalised approaches and the uptake of Direct Payments has been Government policy across the UK for some time. However, research has shown that there may be variation in the benefits experienced by patients and clients receiving direct payments, especially for older people and those with mental health problems. The most recent figures indicate that a total of 687 older people are in receipt of Direct Payments and 34 carers receive Direct Payments on behalf of an older person[52].

During the Review, the Direct Payments process was highlighted as being bureaucratic and of limited appeal to older people and their families. The need for independent provision of advocacy and coordination was identified as a method to facilitate and support service users in using personalised budgets.

Where individuals do not wish to take financial control, they should be given the option of advocacy to act on their behalf or a financial statement of the cost of their assessed support to enable greater choice on their part.

The Review concludes that there should be a focus on promoting healthy ageing, individual resilience and independence among older people.

Care for older people should be underpinned by a consistent assessment process, and a more holistic approach to planning and delivering support taking account of physical, social and emotional needs. Budgets within health and social care should be pooled, with joined up assessment and planning of needs using NISAT. The Review would also recommend pilots to explore budgetary integration beyond health and social care so as over time, the support funding managed by other parts of the public sector e.g. for housing support, could be integrated into a single care budget.

Support planning should take account of a diverse range of health, social and other support services appropriate to the needs of the individual, whether provided by statutory health and social care providers, the independent sector or voluntary and community sector providers. Service user involvement models for adult social care are being developed in other parts of the

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[52] HSCB Statutory Monitoring Returns May 2011

UK as a basis for more collaborative 'co-production' of services.[53]

The role of care users and their families as partners in care should be recognised, and support should be personalised to deliver the outcomes care users and their families want to achieve. This should include control over and clear information about budgets, whether through Direct Payments or involvement in personalised budgets where HSC procures services on behalf of and as directed by the individual. Advocacy and support should be available if needed to help make this a reality.

A diverse choice of provision should be available to meet the individual health and social care needs of older people, with appropriate regulation and safeguards in place to protect the vulnerable. The Review recommends overhauling the current financial model to drive this objective within the statutory, voluntary and private sector.

SUPPORTING CARERS

Informal care from family and friends is vital to enabling a large number of older people to continue to live in the community. Across the UK, this informal care is estimated to equate to £87billion per year[54]. Carers UK estimate that there are 207,000 carers in Northern Ireland (a substantial increase from the DHSSPS figure of 185,000 quoted in 2006) and that the value of the care they provide is more than £4.4billion per year.

Carers can suffer poor physical and emotional health themselves, either directly because of the strains of their caring role or because their caring role restricts their ability to access health care. Carers UK report that carers are twice as likely to be permanently sick or disabled than the average person. The Princess Royal Trust for Carers research 'Always on Call, Always Concerned' found that 69% of carers surveyed reported a negative impact on their physical health from their caring role, and the same percentage reported that caring had a detrimental effect on their mental or emotional health.

Frequently the Review heard from carers the centrality of their role and their sense of being taken for granted.

The Caring for Carers Strategy (DHSSPS 2006) was designed to recognise, value and support the role of carers. Each HSC Trust has a nominated carer co-ordinator and is developing new ways of supporting the needs of carers. An assessment of carer needs is an integral part of the NISAT approach which is beginning to be rolled out across all HSC Trust areas.

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[53] Needham and Carr (2009) Queen Mary University of London, SCIE Research briefing 31: Co-production: an emerging evidence base for adult social care transformation Social Care Institute for Excellence.

[54] Valuing Carers – Calculating the Value of Unpaid Care, Carers UK 2007.

Different carers are likely to need different types of support and their needs will change over time. Carer support interventions may include:

- programmes designed to educate carers about the care-recipient's condition and treatment;
- peer or professionally led carer support groups;
- respite services to provide carers with 'time away' from their caring responsibilities, including within the home, daycare or residential / inpatient provision;
- psychological therapy for carers; and
- care recipient training to promote confidence, self management and empowerment.

Evidence indicates that carer interventions such as these are effective in reducing carer depression and in some cases can have a positive impact on the condition of the care-recipient. Interventions which exist over a longer period of time have been found to be more successful than short-term initiatives[55]

The Review recommends a policy review to improve the outworkings of the carer assessment to better respond to their needs. There should be better recognition of carers' roles as partners in planning and delivering care for older people, and more practical support including, in particular, improved access to respite provision.

THE COSTS OF CARE FOR OLDER PEOPLE

Those engaging with the Review raised the issue of funding for adult social care and the potential future mix of funding sources including health and social care funding, social security benefits, and the patient or user's income. Current legislation in Northern Ireland enables charging of those being admitted to institutional care or receiving home care, but at present charging is not enforced for home care. The Review's role is not one of recommending charging but suggests it is a debate in which Northern Ireland society must fully engage.

The Review acknowledges that the independent sector is a major local resource in providing care for older people. It recognises that the relationship with government, particularly over pricing can be difficult. Consequently, the Review recommends the DHSSPS undertakes a policy review to consider:

- the benefits or otherwise of independent price regulation within the sector;
- the feasibility of the introduction of a certificate of need scheme ahead of

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[55] Tommis, Zinovieff, Robinson and Morgan (2009) Carer Interventions Assessed Final Report. All Wales Alliance for Research and Development in Health and Social Care

the development of new premises with upper size limits;

- much more due diligence checking on any organisation entering the market, including exploring the concept of a financial bond for new entrants to minimise risk on all sides; and
- ongoing financial appraisal to ensure the robustness of facilities in the sector.

SUMMARY OF KEY PROPOSALS

9. Home as the hub of care for older people, with more services provided at home and in the community.

10. A major reduction in residential accommodation for older people, over the next five years.

11. Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.

12. A greater role for nursing home care in avoiding hospital admissions.

13. More community-based step-up/step-down and respite care, provided largely by the independent sector.

14. A focus on promoting healthy ageing, individual resilience and independence.

15. More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond health and social care.

16. A holistic and consistent approach to assessment of older people's needs across Northern Ireland and an equitable range of services.

17. A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.

18. Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to advocacy and support if needed.

19. A policy review of carers' assessments and more practical support for carers including improved access to respite provision.

20. An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for new entrants.

9. LONG TERM CONDITIONS

INTRODUCTION

Long-term conditions (LTCs) refer to patients who have a condition that cannot, at present, be cured but can be controlled by medication and/or therapy for example diabetes, asthma or hypertension. These conditions affect both adults and children.

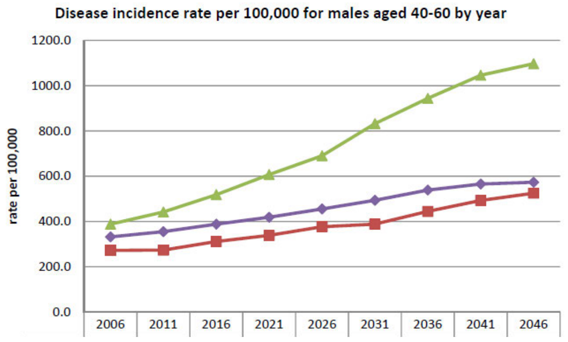
International studies have found that the cost of care for only 5% of the population makes up nearly 50% of the healthcare budget.[56] The majority of the 5% are made up of the elderly and people with long term conditions. Incidence of long-term conditions are on the rise.

A report[57] by the Royal College of GPs has identified that individuals with long term conditions account for more than 50% of all GP appointments, 65% of outpatient appointments and over 70% of in-patient beds in England. It also advocates that GPs are better placed to help individuals manage the issues associated with their condition.

It is clear that people with LTCs require high levels of care. It naturally follows that the health and social care system needs to focus its efforts on how to deliver high quality care to these individuals. The objective is to ensure better outcomes for patients. It is also important to understand that better organisation of care pathways will improve quality and value for money. The recent policy framework Living with Long-term Conditions[58] set out a number of principles and actions for the overall approach to the treatment and care of adults with LTCs.

The figure below illustrates the disease incidence rates for adult males.

Figure 15: Disease Incidence Rates



Source: National Heart Forum: Obesity Trends for Adults. Analysis from the Health Survey for England, (2010)

The Review recognises and celebrates advances made in modern treatments, but is also cognisant of the implications to future well-being. Major advancements in treatments for illnesses such as cancer have improved the life expectancy of sufferers. Increasingly cancers are becoming LTCs. Health and Social Care needs to ensure that it is ready to manage

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[56] Research In Action, Issue 19, 2006

[57] Care Planning: Improving the Lives of People with Long Term Conditions, 2011

[58] DHSSPS (2011) Living with Long-Term Conditions A Policy Framework Consultation Document

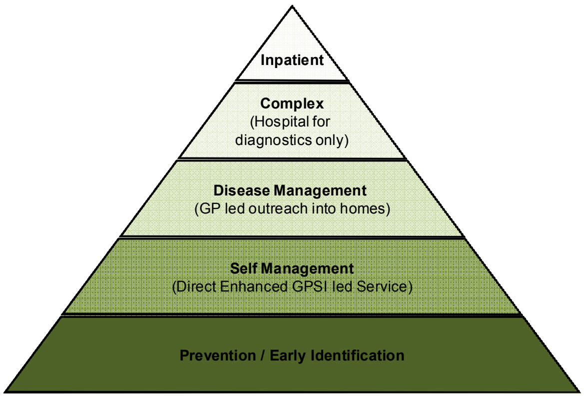
the LTCs that often develop as a result of progress in treatment.

The reality of the current system is that on many occasions individuals with a LTC are admitted to hospital after completing a complicated journey through A&E because there is no alternative.

In recent years, an emphasis has been placed on increasing the role of primary care and the community supporting LTCs. It is the Review's view that this current role can be expanded and based around the principle of 'home as the hub of care'.

The approach to the management of long term conditions should be based on the theory that the majority of effort is in prevention, early identification and self management with as little as possible care delivered within an inpatient setting, as shown in the following diagram.

Figure 16: Approach to management of Long Term Conditions



FOCUS ON PRIMARY AND SECONDARY PREVENTION

Whilst not all conditions are preventable, evidence indicates prevention has a key role in tackling:

- the increase in the percentage of children and adults who are overweight or obese;
- the increase in the number of people with long term conditions, such as diabetes;
- the higher frequency of risk factors for heart, stroke, vascular and respiratory diseases in more disadvantaged communities; and
- the higher death rates from conditions such as coronary heart disease, stroke, vascular and respiratory diseases in our society, particularly in more disadvantaged communities.

Although not all long term conditions are preventable, steps can be taken by individuals to decrease their chances of developing a condition. These include:

- promoting healthy lifestyles;
- reducing alcohol related problems;
- reducing overweight/ obesity levels;
- increasing a focus on psychological well-being; and
- decreasing incidences of falls among older people.

For many conditions, early case identification can be the key to limiting the effects of an illness.

There is a link between the prevalence of some conditions and deprivation, in particular for Chronic Obstructive Pulmonary Disease and asthma where rates are highest in the most deprived wards.[59]

The first focus is therefore to enable much greater self care to avoid chronicity. Integrated partnership working between clinicians in primary and secondary settings can produce real benefits for patients, for example in the treatment of diabetes. Support therefore begins with the GP, integrated community teams and community pharmacy.

The online survey included early intervention and use of community pharmacists as suggestions for better care for people with long term conditions and the Review supports this approach.

The Review considers Integrated Care Partnerships, that is professionals working together providing services for a population, as the way forward. In this regard the GP list acts as a building block for creating populations to enable this to happen. The data already known has the potential to be warehoused to inform best practice and intervention methods.

PERSONALISATION OF CARE PLANNING

At present personalised care planning is not practised in every area of NI. Consequently, care provision for people with a long term condition often lacks cohesion and consistency. This is a real source of frustration for the individual as they are managed simultaneously by a series of health professionals. This system results in the duplication of information reporting, which impedes analysis and treatment of the problem. All too frequently this results in overuse of hospitals.

Evidence shows that where information is readily available and accessible to all parties concerned with the treatment of LTCs, including the individual, patient experience outcomes are through a better managed system of delivery. This is enhanced even further if the individual has been involved in the planning of their care. Working in a more integrated system enables a more easily understood and straightforward care contract with individuals and their family to be created.

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[59] PHA Health Intelligence Briefing, QOF, 2011

Flexible care packages should make arrangements more responsive for individuals, particularly those with changing circumstances.

Evidence suggests that with the correct support, individuals suffering from a long term condition can have an important role in the management of their condition.[60]

Self management enables individuals to take control of their own care plan, acquiring the skills required to manage them through the education they have received.

The Stanford University Model designed by Professor Lorig, recognised that issues faced by individuals with chronic conditions were often exacerbated by a number of factors including pain management, stress, low self esteem and depression.

To tackle this, better planning of self-care management will need to be introduced and replicated across the region.

Social and emotional issues can be supported within the community by establishing links between the individual and clubs, societies, transport and other amenities which will have a direct impact to the overall well-being of the person.

The Expert Patient programme[61], led by fellow sufferers aims to empower people to:

- feel confident and in control of their life;
- manage their condition and its treatment in partnership with healthcare professionals;
- communicate effectively with professionals and be willing to share responsibility for treatment;
- understand how their condition affects them and their family; and
- use their skills and knowledge to lead a full life.

An important part of the individual's ability to manage their LTC will be the strength of the support they receive from family and friends. Carers should be respected as partners in care in regard to the overall provision of services.

Working within Integrated Care Partnerships, community pharmacies have an important role in the support of individuals with a LTC, particularly in medicines management as discussed below.

Predominately referring to diabetes care, but applicable to the management of all long term conditions, a 2007 report described how organised and proactive

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[60] Patient and family participation – What difference should it make to the quality of care?

[61] NHS England

services in partnership with engaged, empowered patients would ultimately provide better outcomes.[62]

One example of this in action has been the introduction of insulin pumps. The Public Health Agency reports the case of a 14 year old girl who was previously admitted to hospital 99 times from 2001-2010, but since the introduction of an insulin pump has had no diabetic related admissions. As a result her attendance at school and level of academic achievement has increased.[63]

The North West London Integrated Care pilot introduced greater use of multidisciplinary teams working within the community as well as having a direct link into secondary care.[64]

In the new model of care recommended by the Review, multidisciplinary teams will form the essential nucleus of health care professionals supporting patients in their own homes and community.

The integrated team is likely to include:

- General Practitioner;
- General Practitioner with a Special Interest (GPSI);
- Specialist Nurse;
- Occupational Therapist;
- Physiotherapist;
- Dietician;
- Social Worker; and
- Support Care Workers.

The composition of these teams should reflect the needs of the local population and be flexible to adapt to the nature of individual cases. All GP surgeries should indicate the lead professional for that practice. It may not always be that individual who treats or supports but they should be the first point of reference for patient and colleague professionals.

MEDICINES MANAGEMENT

People with LTCs often have multiple medicines to help manage their symptoms. Pharmacy errors are a very common risk factor for these patients. Compliance with the directions for use is key to the successful use of the medicines. The community pharmacy plays a key role is assisting people with LTCs.

The community pharmacist will form part of the multi-disciplinary approach to the management of LTCs. Pharmacies are ideally placed within local communities to provide advice without appointment. [65]

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[62] Roberts S, Working together for better diabetes care: Clinical case for change, Department of Health, 2007

[63] PHA, 2011

[64] North West London Integrated Care Pilot : Business Case, 2010

[65] Supporting people with long term conditions to self care: A guide to PCTs in developing local

This new model seeks to keep the focus on the patient, providing alternative options to being admitted to hospital, and providing opportunity to prevent such occurrences wherever possible.

In the new model General Practitioners with a Special Interest (GPSI), will assess the individual to determine the correct treatment needed and where the most appropriate setting is. Where an individual requires secondary care, the GPSI will contact a specialist directly for admittance to hospital. Case records will be fully available to the hospital which will improve efficiency and reduce length of stay.

Making the home the hub of care, multi-disciplinary teams would provide the primary source of intervention. These health care professionals will be known to the individual, and likewise to each member of the team, allowing quick response and effective treatment delivered locally.

Community led teams should also be responsible for helping individuals to prevent their condition worsening. Regular contact with the individual is essential, along with practical support and education.

DIRECT ADMISSIONS TO HOSPITAL FOR PEOPLE WITH LTCS

Early prevention and self managed care supported by multidisciplinary teams will help stem the demand for hospital care. However, there is still a real need for high quality, responsible acute care for those who need hospital care.

In the event of an individual requiring emergency treatment, there should be greater integration between community teams and secondary care clinicians.

The GPSI will be able to contact the hospital directly once it has been determined that acute care is required. Direct admission will ensure a better experience for the patient and ultimately a better outcome.

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strategies and good practice, Department of Health, 2006

TECHNOLOGY

A key enabler in the introduction of the new model is technology. Greater support can be given to individuals and health care professional through telehealth monitoring.

An individual will have the ability to better manage their own condition through a combination of assistive technology and access to information.

The current duplication along with poor patient records slows down the system and causes frustration to the individual when forced to continually relay their particular situation and treatment. A solution to this would be the creation of a single Electronic Care Record (ECR) which follows the individual through different care settings and Trust boundaries.

SUMMARY OF KEY PROPOSALS

21. Partnership working with patients to enable greater self care and prevention.
22. Personalised care pathways enabling home based management of the LTC with expanded support from the independent sector.
23. Patients to have named contacts for the multi-disciplinary team in each GP surgery to enable more straightforward communication.
24. Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.
25. A stronger role for community pharmacy in medication management for LTCs.
26. Development of admission protocols between secondary care specialist staff and those in the community.
27. Maximising the opportunities provided by telehealth in regard to LTC patients.

10.PEOPLE WITH A PHYSICAL DISABILIITY

INTRODUCTION

Between 17-21% of the Northern Ireland population have a physical disability and around 37% of households include at least one person with a disability[66]. While many disabled people have no greater need for health and social care support than the rest of the adult population, some draw on specific support services provided by the statutory and voluntary and community sectors. At March 2010 there were 7,527 people with a physical or sensory disability (aged up to 65 years) in contact with HSC Trust disability services. In budgetary terms, adult disability services account for a small proportion of health and social care spend - 2.8% of the HSCB budget or £91million.

PERSONALISATION AND PROMOTING INDEPENDENCE

Personalisation, independence and control are at the heart of the Review and for those with a physical disability. A Physical and Sensory Disability Strategy for Northern Ireland is in the final stages of development. It will formalise in policy terms the changes to the model of support for disabled people. Traditionally, a limited range of support services such as daycare and residential care have been provided for people with a disability.

The current service-led approach should be replaced by a more person-centred model in which statutory health and social care acts as an enabler, working in partnership with the disabled person and their family / carers to help people access the support that meets their individual needs. This may include some of the traditional residential and daycare services, but will increasingly reflect a wider range of needs. For example, a personalised support package might include:

- personal care support at home;
- specialist equipment such as a wheelchair or adaptations to the home;
- occupational therapy, speech and language therapy and physiotherapy;
- assistive technology; and
- assistance with day to day activities such as cooking, travel or work.

Voluntary and community sector organisations play a vital role in providing this much wider range of support and in acting as advocates for disabled people, promoting the control and independence agenda. Other parts of government have an important role to play in promoting independence for people with a disability,

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[66] NISRA 2007, referenced in DHSSPS Physical and Sensory Disability Strategy A Consultation Document 2011-2015. December 2010.

notably housing, education, employment, and culture, arts and leisure.

This approach is supported by the findings of the online survey conducted by the Review which recommended a multi-disciplinary and person centred approach.

PROVIDING THE RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME

As independent living options become more readily available there has been a gradual decline in the number of people with a disability living in long-term residential care (from 92 in 2005 to 80 in 2010) and there are only three statutory residential homes solely for people with a disability. However, the number of disabled people living in nursing homes has increased over the same period, from 284 in 2005 to 319 in 2010, reflecting the complex support needed by some which is not currently being met in the community.

There continues to be around 400 people with a disability living in long-term care settings. Care could be provided closer to home with more intensive treatment and rehabilitation when needed. Despite the drive to provide more home-based support, the number of people receiving a home-help service actually decreased by 30% between 2004/5 and 2008/9. This may reflect higher thresholds to access services and a focus on providing services for those with the highest level of need or the increase in uptake of Direct Payments which allow individuals to purchase their own support.

There is an increasing population of young disabled people with complex needs who are surviving into adulthood because of improvements in therapies and medical care and who require more intricate and costly packages of care, particularly during the transition to adulthood.

Provision of equipment is vital to allow people with a disability to live well at home. A third of the respondents to the Review's omnibus survey reported that 'a lot of improvement' was required to reduce waiting times for equipment such as wheelchairs and hoists. This issue was also raised at the clinical workshops where clinicians noted concerns surrounding the provision of adequate resources and equipment for patients and clients with physical disabilities. Clinicians also highlighted the need for inter-departmental working to address matters which patients and clients with physical disabilities experience, such as ensuring that housing is suitable for individual needs.

While it will be challenging to balance the increasing complexity of needs and requirement for significant nursing and personal care support, with more independent living, this is essential to promoting the rights of people with disabilities.

New service models will be needed to meet this challenge including continued development of respite and short break care to support disabled people and their families/carers. At present much of this continues to be provided in the traditional residential and daycare settings, but home-based respite services are beginning to be developed and should be further developed.

PERSONALISATION AND INDEPENDENCE

There has been little change in the number of people using statutory daycare facilities, although their role has changed somewhat, for example, provision of short-term respite support. Results from the omnibus survey indicated that 24% of respondents felt that ‘a fair amount of improvement’ was required with regard to the range of day provision for people with a disability, and a further 22% of respondents stated that ‘a lot of improvement’ was needed.

Participants at the clinical and voluntary sector workshops and many individuals engaging with the Review focused on the need to shift from a medical model of care and treatment for individuals with physical disabilities, towards a more user-centred care model, which delivers the right care to meet that patient or client’s needs. The potential of personalised budgets to improve choice and control was highlighted by many as a means to ensure that the care patients and clients receive meets their particular needs i.e. addresses the question “what would make my life better?”

Direct Payments have been embraced by many people with a physical disability who welcome the greater control they allow. Between September 2007 and September 2010 the number of Direct Payment recipients within the Physical Disability programme of care increased from 312 to 587. Encouraging uptake of Direct Payments has been a target for several years and mechanisms have been put in place to promote uptake and support people with managing their own budgets to purchase services or employ support directly.

While the uptake of Direct Payments is growing, in particular among people with a physical disability, there is potential to grow this and other self-directed support approaches considerably within this group. Feedback from some indicates that bureaucracy is a barrier to uptake of

Direct Payments and a regional approach is needed to tackle this issue and encourage greater uptake.

Set against the endorsement of the forthcoming Physical and Sensory Disability Strategy, the Review proposes the following:

SUMMARY OF KEY PROPOSALS

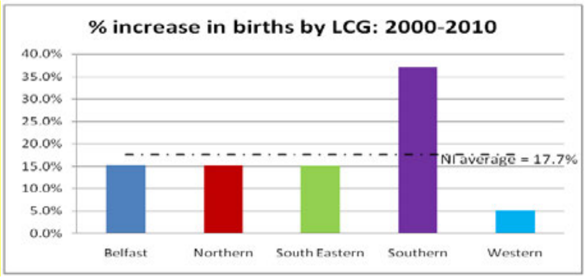
28. Promoting independence and control for people with a disability, enabling balanced risk-taking.
29. A shift in the role of the health and social care organisations towards being an enabler and information provider.
30. Joint planning of services for disabled people by the statutory, voluntary and community health and social care providers, and other relevant public services (e.g. housing) to ensure a wide range of services across NI.
31. Better recognition of carers' roles as partners in planning and delivering support, and more practical support for carers.
32. More control for service users over budgets, with continued promotion of Direct Payments, and a common approach to personalised budget with advocacy and brokerage support where required.
33. More respite and short breaks provision.

11.MATERNITY AND CHILD HEALTH

MATERNITY

The Review is cognisant of the current consultation on Maternity Services[67] and has factored that work into its thinking. In 2010 there were over 25,000 live births registered in Northern Ireland. During the last decade (2000-2010) the birth rate in Northern Ireland has increased by almost 18%. There are significant differences in birth rates across the province, as illustrated in the figure below.

Figure 17: Increase in births by LCG: 2000-2010[68]



Almost all births (99%) took place in hospital, and most mothers (91%) gave birth in their nearest consultant led unit.[69] Less than 1% of mothers are choosing to give birth at home. In recent years the proportion of births to teenage mothers has decreased (5.0% in 2010). Projections indicate that birth rates are likely to decrease over the next decade to approximately 23,500 by 2022/23.

There are a range of consultant led, co-located midwifery led, and freestanding midwifery units in NI. The capacity of the service to provide the recommended level of staffing cover for intra-partum care and to sustain inpatient paediatric services across all existing sites presents challenges, particularly for smaller units.[70]

Maternity care is of a high standard and according to recent surveys, women are happy with the standard of care they receive[71]. However there is increasing potential for variation in the provision of maternity care across Northern Ireland. In addition there are significant inequalities in maternal and infant outcomes, particularly amongst women from socio-economically deprived backgrounds.

The level of caesarean sections is generally higher than in the rest of the UK. There is increasing complexity arising from lifestyle for expectant mothers, most notably the increased rate of obesity, which provide both challenge and risk, across the population. Additionally many

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[67] Maternity Strategy for Northern Ireland, September 2011. DHSSPSNI, 2011

[68] NISRA in Health Intelligence briefing Trends in Northern Ireland Births and future projections, Public Health Agency 2011

[69] Births in Northern Ireland (2010), A Statistical Bulletin, Northern Ireland Statistics and Research Agency, March 2011

[70] Draft Commissioning Plan (Health and Social Care Board and the Public Health Agency – June 2011)

[71] Parental Views on Maternity Services. Parents' views on the Review of Maternity Services for Northern Ireland. Patient and Client Council, 2010.

women now choose to start their families later in life.

Challenges for maternity services into the future include:

- give a realistic choice of birth location for women;
- need for more continuity of care throughout pregnancy;
- reducing unnecessary interventions;
- dealing with the public health issues facing women of child bearing age to reduce ill-health and disability of mother and child; and
- supporting the expectant mother in her ante-natal care and connecting that support to the early years of parenthood.

The Review therefore expects change to follow the pattern set out in the forthcoming Maternity Strategy, from pre-conception, through pregnancy, birth and the post-natal period. In addition it recommends a specific regional plan for supporting the small number of mothers with serious psychiatric conditions.

CHILD HEALTH

Child health problems are often diverse in nature, severity and duration. The causes are often multi factorial and sometimes poorly understood. Effective interventions are often complex and time consuming, requiring a range of skills to be tailored to the needs of individual children.

Following the principle of care at or close to home, the Integrated Care Partnerships will be vital. However it was also clear to the Review that communities and the independent sector should be enabled to support families with ill children where appropriate.

When children need hospital care they need prompt access to skilled staff. There are challenges in providing a full range of paediatric sub specialties to a population of 1.8 million. Given this, there is a need to have clear pathways and consequent consistency of treatment.

In this field workforce issues and multiple service locations have the potential to threaten service resilience. Single handed specialties are difficult to sustain unless networked with other centres, whilst scarce skilled resources need carefully managed in the hospital setting. Notwithstanding this, community paediatrics should become a key resource working alongside integrated care partnerships enabling most care to be provided at or closer to home. The Review also saw potential for more formal links to larger centres in the UK or Republic of Ireland for this service area.

During its deliberations the Review team received a strong plea to examine, as a specific task, the nature, function and shape of in-patient paediatric services. The Review was persuaded this merited a separate piece of work. In this regard it also had drawn to its attention the very specific issue of palliative care for children.

Although there is a Children's Strategy for Northern Ireland there is no strategy for child health and no specific arrangements for palliative and end of life care for children. One of the Review proposals is that palliative and end of life care for children should be considered as part of the proposed review of Paediatric Services.

SUMMARY OF KEY PROPOSALS

Maternity

34. Written and oral information for women to enable an informed choice about place of birth.

35. Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.

36. Services in consultant-led obstetric and midwife-led units available dependent on need.

37. Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of unnecessary interventions.

38. Continuity of care for women throughout the maternity pathway.

39. A regional plan for supporting mothers with serious psychiatric conditions.

Child Health

40. Further development of childhood screening programmes as referenced in the Health and Wellbeing section.

41. Child health included as a component of the Headstart programme referenced in the Family and Childcare section.

42. Promotion of partnership working on children's health and wellbeing matters with other government sectors.

43. Close working between hospital and community paediatricians through Integrated Care Partnerships.

44. Completion of a review of inpatient paediatric care to include palliative and end of life care.

45. Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.

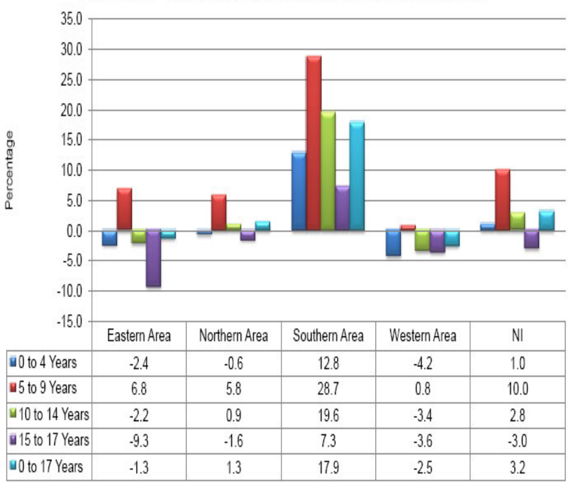
12.FAMILY AND CHILD CARE

INTRODUCTION

Approximately 24% of the Northern Ireland population is aged between 0 and 17 years. Population projections indicate this sector of the Northern Ireland population is set to increase by 3% by 2020.[72]

As the figure below illustrates, percentage increases between geographical areas is variable but the overall increase will bring increasing demands on family support services.

Figure 18: Percentage population change 2008-2023 by Area and Age Band



	Eastern Area	Northern Area	Southern Area	Western Area	NI
🟦 0 to 4 Years	-2.4	-0.6	12.8	-4.2	1.0
🟥 5 to 9 Years	6.8	5.8	28.7	0.8	10.0
🟩 10 to 14 Years	-2.2	0.9	19.6	-3.4	2.8
🟪 15 to 17 Years	-9.3	-1.6	7.3	-3.6	-3.0
🟦 0 to 17 Years	-1.3	1.3	17.9	-2.5	3.2

Source: NISRA 2008 Population Projections

Between 2005 and 2010 the number of Looked After Children per 1,000 children increased in Northern Ireland, England and Wales. The number of children on the child protection register per 10,000 children aged 0-18 is higher in Northern Ireland than in England, Scotland or Wales. Overall, the number of children on the child protection register has increased between 2006 and 2010 in all regions of the UK.

In 2010 there were 2,606 Looked After Children in Northern Ireland, up by 6% from 2009. The greatest proportion (65%) was in foster care. Between 2005 and 2008 the number of children in foster care decreased. Since then, this figure has increased by almost a quarter (23%) to 1,687. The total number of children on the child protection register has increased by almost 48% from 1,593 in 2005 to 2,357 in 2010.[73]

EARLY INTERVENTION

As discussed in Section 7, early intervention is an important focus in addressing population health and wellbeing.

It has been recognised by a number of independent reviews that, compared to other parts of the UK, there is a significant under investment in children's services

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[72] NISRA (2011) Population projections

[73] Social Briefing, Research and Information Service Briefing Paper, Northern Ireland Assembly, 83/11 NIAR 217/11, July 2011.

within Northern Ireland. Society will benefit from a coordinated effort to support and promote positive development of the intellectual, emotional and social skill of young children. There is a major incentive in getting this right. On a practical level, early engagement pays a very high rate of return. The dividend is 12%-16% per year for every £1 of investment – a payback of four or five times the original investment by the time the young person reaches their early twenties and the gains continue to flow throughout their life[74].

Key to this is promoting and supporting positive, engaged parenting particularly in those families where parenting skills are limited.

Children's services are heavily prescribed by legislation and associated guidance and regulations. These services operate within an infrastructure premised on the growth of partnerships which promote inclusivity and collaboration. These partnerships have enabled an increase in capacity and facilitated the improvement of outcomes.

The overarching principle set out within the Childrens (NI) Order 1995[75] that children are best cared for within the family of origin will continue to shape interventions and service delivery. The Review supports the development of advocacy, information services and training in the support of kinship care.

International best practice demonstrates that the health and social care needs of children and young people cannot be addressed by any single agency. A key example of this is the Children and Young People's Strategic partnership, which is a multi agency partnership whose purpose is to put in place integrated planning and commissioning aimed at improving the wellbeing of children in Northern Ireland.

The strategic direction over the past few years has recognised the importance of early intervention. The focus has been heightened through the publication of Families Matter[76], Healthy Child-Healthy Future[77] and the Family Nurse Partnership Initiative. The concept of Family Support Hubs is developing and the Family Support NI database provides an information and signposting resource for families, communities and professionals.

Child and Adolescent Mental Health Services (CAMHS)

The overall direction of Child and Adolescent Mental Health Services (CAHMS) will continue to be shaped by the Bamford Review of Mental Health and

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[74] (0-5): How small children make a big difference –The Work Foundation 2007

[75] The Children NI Order 1995, Legislation.gov.uk

[76] Families Matter: Supporting Families in Northern Ireland Regional Family and Parenting Strategy March 2009, DHSSPSNI

[77] Healthy Child, Healthy Future, A framework for the Universal Child Health Promotion Programme in Northern Ireland Pregnancy to 19 Years. DHSSPSNI, May 2010

Learning Disability. The needs of children with a disability remain a priority for commissioners and providers alike.

A Review of CAMHS in Northern Ireland was published in 2011 by the Regulation and Quality Improvement Authority[78]. A number of work streams are underway which will address many of that report's recommendations:

- progressing the Bamford Action Plan 2009;
- a review of Tier 4 services; and
- the appointment of a Commissioner for CAMHS.

Overall it is clear that child and adolescent services are continually improving and developing. However there is much work to do to develop and improve services further. It is estimated that to fully implement the RQIA recommendations may cost around £2million per annum. In the current financial climate this will require a prioritised approach.

Residential care

Approximately 11% of Looked After Children are in residential care. A number of issues have been identified:

- there is an increasing complexity of needs being presented by young people particularly in relation to mental health, drug and alcohol abuse, sexually harmful/vulnerable behaviours and criminality;
- it is difficult to provide flexible residential accommodation to meet the needs of a small number of young people; and
- young people aged 16+ are being excluded from their homes/ community as result of difficult behaviours.

Families

Families Matter: Supporting Families in Northern Ireland (Regional Family and Parenting Strategy 2009) moves parents into a central position in policy terms and strives to provide strategic direction on how best to assist parents in Northern Ireland to be confident and responsible in helping their children to reach their potential.

The wider vision of family support has been articulated in the Northern Ireland Family Support Model, which enables a 'whole system' approach to service planning. Its focus is on early intervention, ensuring that appropriate assistance is available to families at the earliest opportunity at all levels of need.

This model details four levels of need: all children and young people; children who are vulnerable; children who are in need and looked after children, illustrated in the figure below.

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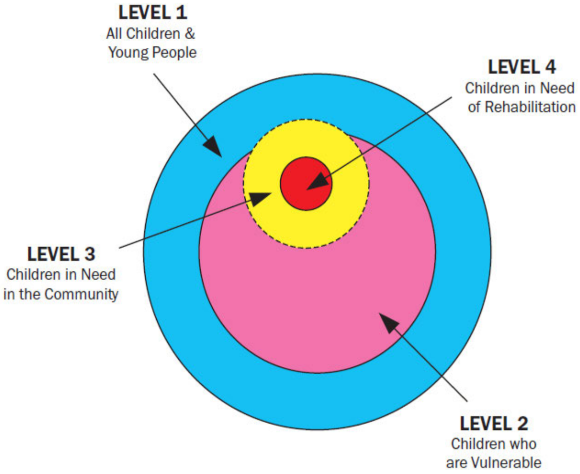
[78] RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland February 2011.

Figure 19: Northern Ireland Family Support Model[79]



It is widely acknowledged that early intervention produces positive dividends for children and families. The learning and experience from the Sure Start model which targets “children who will benefit most” and other similar initiatives here and elsewhere needs to be understood and extended where benefit can be demonstrated.

The Review acknowledges and endorses the streamlining and improving processes in regard to Children’s Services as being taken forward through the Children’s Services Improvement Board and Review on Co-operating to Safeguard Children. In addition the Review also makes the recommendations below.

SUMMARY OF KEY PROPOSALS

46. Re-structuring of existing services to develop a new ‘Headstart’ programme focusing on 0-5 year olds.

47. Exploration through pilot arrangements of budgetary integration for services to this group across Departments, under the auspices of the Child and Young People’s Strategic partnership.

48. Completion of a review of residential care to minimise its necessity.

49. Promotion of foster care both within and outwith families.

50. Development of a professional foster scheme for those hardest to place.

51. Implementation of the RQIA recommendations in relation to CAMHS.

52. Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS services.

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[79] Families Matter: Supporting Families in Northern Ireland, Regional Family and Parenting Strategy. DHSSPS 2009

13. PEOPLE USING MENTAL HEALTH SERVICES

INTRODUCTION

Northern Ireland has higher mental health needs than other parts of the United Kingdom.[80] Based on the Northern Ireland Health and Social Wellbeing Survey (2001), 24% of women and 17% of men in Northern Ireland have a mental health problem – over 20% higher than the rates in England or Scotland.

Factors contributing to these rates include persistent levels of deprivation in some communities in Northern Ireland and the legacy of Northern Ireland’s troubled history. For example, a recent study of the families of victims of Bloody Sunday found persistent effects of these traumatic events on the individuals concerned, with evidence of psychological distress still being found more than 30 years after the event.[81]

The incidence of suicide in Northern Ireland has been a particular concern in recent years. Suicide rates increased by 64% between 1999 and 2008, mostly as a result of the rise in suicides among young men. In 2008, 77% of all suicides were males and 72% were 15-34.

The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The Bamford Review, which completed its work in 2007, has set the agenda for the transformation of these services. The Review heard nothing which challenged Bamford but did hear frustration at the speed of implementation.

Although there is frustration there is also progress with actions that lay the foundations for modernising and improving services, for example the development of new strategies and agreeing new models of care for particular conditions. However, it remains the case that tangible services on the ground are the touchstone by which those using the service judge its success.

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[80] DHSSPS (2004) The Review of Mental Health and Learning Disability (Northern Ireland). A Strategic Framework for Adult Mental Health Services. Consultation Report.

[81] McGuigan, K., & Shevlin, M. (2010). Longitudinal changes in posttraumatic stress in relation to political violence (Bloody Sunday). Traumatology, 16, 1–6

PROMOTION AND EARLY INTERVENTION

Raising awareness of mental health issues and reducing the stigma associated with mental ill-health continues to be a key objective of the reform and modernisation programme. In terms of primary prevention, a suicide prevention strategy Protect Life[82] was launched in 2006 and is currently being refreshed. A new five-year Mental Health and Wellbeing Strategy is being developed to support the whole population to maintain good mental health. The Review endorses these actions.

The Royal College of Psychiatrists' submission to the Review highlights that early intervention in psychoses can be effective and emerging evidence supports a similar approach for depression and anxiety. It therefore encourages development of a system capable of early intervention. The Stepped Care model (see figure below) promotes early intervention at the first stages of mental illness and the Psychological Therapies Strategy made recommendations as to how people with mild to moderate mental health problems could access psychological support. However, lack of investment has constrained the implementation of this strategy and feedback during the review suggested concern with the level of provision at Tiers 1 and 2.

Access to information about mental health services was raised by several of those with whom the Review engaged, including the Bamford Monitoring Group and registered social care workers. The Bamford Action Plan included plans to map available services and provide this information to service users, but progress has been slow in this regard. Users and carers told the Review how important it is to be able to easily access information on services that meet their particular needs.

PROVIDING THE RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME

The model of mental health care has evolved which promotes greater care at home and in the community rather than in hospital. A stepped care approach has been adopted, providing a graduated range of care to meet the patient's needs:

Figure 20: Stepped Care Model

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[82] Protect Life, A Shared Vision – The NI Suicide Prevention Strategy and Action Plan 2006-2011, DHSSPS

Each of the HSC Trusts has developed Crisis Response and Home Treatment models that provide services for acutely ill people at home and in the community rather than in psychiatric hospitals. The role, number and location of psychiatric inpatient units are also changing and Trusts are developing streamlined pathways for urgent mental health care.

However, these services have evolved differently in each area in terms of how people in crisis contact services, how they are triaged (by phone or in person at a hospital or other facility) and how they are treated in emergency departments. Whilst the Review acknowledges that there will be solutions for local areas, there is now a need to ensure that there is a consistent outcome for those who use the service. Additional home treatment services are still to be developed for particular client groups including children and young people, people with a learning disability and older people.

Despite the shift underway in care provision from the hospital to community setting, the Review noted that the objective to shift expenditure to a ratio of 60% community and 40% hospital has not yet been achieved.

PROMOTING INDEPENDENCE AND PERSONALISATION OF CARE

At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives. The Review strongly endorses this approach.

The voluntary and community sector plays a crucial role in providing the diverse range of support that may be needed. Recognising this, the Review recommends greater involvement of these organisations in planning provision for local populations. It also acknowledges this will be a challenge in some parts of the independent sector.

Provision of Direct Payments is one approach to support personalisation of care. However, among people with mental health issues, the uptake of Direct Payments has been lower than among other groups. At May 2011, a total of 81 people were in receipt of Direct Payments. The Review was told that perceived bureaucracy and inconsistent promotion of Direct Payments have been constraining factors.

A regional approach should be implemented to promote the uptake of Direct Payments among mental health service users including involvement of current recipients to share their experiences, and the provision of advocacy and support where needed should be considered. As a minimum, clear information on the financial package available should be given to those using the service.

INSTITUTIONAL CARE

A critical element in changing how things are done for this client group is to end long-term residency of people in mental health and learning disability hospitals. To date, 181 long-stay mental health patients have been discharged to the community. There are currently 150 long stay psychiatric inpatients who should be resettled into the community.

The model designed by the Review makes it clear that care should be provided at home or as close to home as possible. Fresh impetus into delivering the closure of long stay institutional care is required.

The Review urges an absolute commitment to completing the resettlement process by 2015 as planned, and ensuring that the required community services are in place to prevent the emergence of a new long-stay population. This should include developing models of treatment for children and young people, and those with specialist mental health needs, for example in the areas of learning disability and psychiatry of old age.

Attempts to shift the balance of spend between hospital and community expenditure should continue with reinvestment of any savings achieved in the hospital setting into community services.

The proposals below are set in the context of making tangible changes for mental health service users and their families and assessing the impact of that change on quality of life.

SUMMARY OF KEY PROPOSALS

53. Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.

54. Establishment of a programme of early intervention to promote mental health wellbeing.

55. Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.

56. A consistent, evidence-based pathway through the four step model provided across the region.

57. A consistent pathway for urgent mental health care including how people in crisis contact services, triage and facilities in emergency departments.

58. Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.

59. Further shift of the balance of spend between hospital and community, with reinvestment of any hospital savings into community services.

60. Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.

61. Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.

62. Close long stay institutions and complete resettlement by 2015.

14.PEOPLE WITH A LEARNING DISABILITY

INTRODUCTION

A learning disability is a lifelong condition and requires long-term support. Provision of services for people with a learning disability requires a multi-agency and integrated approach – it is not solely a health issue. The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland.

In regards to this care programme the Review heard nothing which challenged Bamford, but as with mental health services, did hear frustration at the speed of implementation. Despite this frustration there is progress, with actions being completed that lay the foundations for further change, for example, the development of new strategies and agreeing new models of care. Ultimately though, those who are supported judge it by changes to services on the ground. In this regard the Review heard of the need for more rapid progress.

EARLY INTERVENTION AND PROMOTION

The importance of early years intervention to support positive life outcomes was highlighted throughout the Review's engagements with the public, clinicians and others. While children with a learning disability and their families may be able to avail of early years support this is variable across the region. Consistent with the proposals set out in Section 12 on Family and Childcare, the Review considers that early years support for children with a learning disability should be part of a coherent and consistent programme of support for 0-5 year olds.

Many learning disabilities have associated physical health conditions, for example complex mobility or personal care needs, whilst the rates of early onset dementia are much higher among those with Down's Syndrome than among the general population. Evidence was presented to the Review on the challenges for people with a learning disability in accessing the full range of healthcare provision enjoyed by the general population. In particular, accessing health services such as occupational therapy, physiotherapy and speech and language therapy was highlighted as being important. People with a learning disability also identified a need for disability awareness training for clinical staff in the community who do not always deal appropriately with them, for example, not providing enough time and not speaking directly to the disabled person. The Review considered improvement in this area as fundamental.

Programmes are in place in each population area to enhance access to primary healthcare services for people with a disability including annual healthchecks and employment of health facilitators in the community. The Review endorsed this approach but was clear that a consistent outcome for all is important. In this regard it was made aware of particular problems in accessing Dentistry.

As services are planned Integrated Care Partnerships should be asked to ensure that clinicians are facilitated to respond more appropriately to the needs of people with a learning disability.

PROMOTING INDEPENDENCE AND PERSONALISATION

Promoting independence and personalisation is a key principle underpinning the model proposed by the Review. Feedback provided to the Review indicates that achieving this objective for people with a learning disability will require particular focus on the following areas:

- Day services - the diversity and age-appropriate nature of day services remains an issue for people with a learning disability. While there has been progress made in reforming the day centre-based model and providing more community based options, there is further work to be done in this regard. A one size fits all service will be less relevant in the future;
- Respite and short breaks - provision has increased but service users and carers indicate that much remains to be done to meet current needs. Services are frequently accommodation based. While these are important more flexibility in the home or local day placement should be explored. Respite care is not always age appropriate, for example, respite provision in nursing homes primarily for older people has limits. New models need to be created;
- Direct Payments – the number of people with a learning disability taking up Direct Payments has increased from 218 in June 2008 to 561 at May 2011 but the Review heard that service users and carers need more information and support with Direct Payments. Sharing the experiences of current recipients is recommended, along with provision of advocacy and support where needed. As a minimum clarity about the financial commitment should be available;
- Information – in general, users and carers consider it remains difficult to access information on the services available for people with a learning disability. Information on housing options was highlighted as an issue. Many carers are also unaware of their right to a carer’s assessment and access to support to meet their physical and emotional needs; and
- Advocacy – people with a learning disability expressed the need for peer and independent advocacy to support

them in making decisions and protecting their rights.

The Review considered voluntary and community sector organisations have a crucial role in providing support to people with a learning disability. In some instances these are organised and run by parent groups. This should be supported.

INSTITUTIONAL CARE

A critical element in changing the model of care and support for people with a learning disability is to end long-term residency in hospitals. Since 2008, 642 long-stay learning disability patients have been discharged to the community. There are currently around 200 long-stay inpatients in learning disability hospitals who should be resettled into the community.

The majority of learning disability services are already provided in the community as opposed to hospitals. The ratio of spend is 82% in the community to 18% in hospital. New community facilities are being developed for assessment and treatment for people with a learning disability which will support the resettlement programme. The Northern Ireland Housing Executive's Supporting People Programme also plays an essential role in developing a range of supported living options in the community for people with a learning disability. Supporting People has enabled 23,000 people (including both mental health and learning disability service users) to live independently.

The proposals below are set in the context of making tangible changes for people with a learning disability and their families and assessing the impact of that change on quality of life.

SUMMARY OF KEY PROPOSALS

63. Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds as referenced in the Family and Childcare section (Section 12)

64. Further development of the current enhanced health services on a Northern Ireland basis.

65. Support from Integrated Care Partnerships to improve clinicians' awareness of the needs of individuals with a learning disability.

66. Better planning for dental services should be undertaken.

67. Further development of a more diverse range of age-appropriate day support and respite and short-break services.

68. Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.

69. Development of information resources for people with a learning disability to support access to required services.

70. Advocacy and support for people with a learning disability, including peer and independent advocacy.

71. Commitment to closing long stay institutions and to completing the resettlement process by 2015.

15.ACUTE CARE

Acute care is often perceived as synonymous with hospitals. However it also includes elements of primary care such as Out of Hours. This part of the report comments upon:

- unscheduled care;
- planned care;
- ambulatory care and diagnostics; and
- regional services.

UNSCHEDULED CARE

Unscheduled care includes such services as accident and emergency, emergency surgery, intensive care, coronary care, stroke services, urgent care and medical admissions. Trauma and orthopaedic services are integral to emergency care.

Ambulatory care, where patients can walk in and walk out on the same day can also be unscheduled care.

The Review does not propose to extensively define each component of service but considers it prudent to share its thinking about urgent care, emergency departments or A&E services. Three broad levels exist:

- Major trauma, which is dealt with regionally;
- Emergency intervention most commonly associated with the 999 ambulance service; and
- Urgent care/ Out of Hours care where a difficulty exists but it does not initially present as life threatening and includes minor injuries.

Unscheduled care is currently delivered via 10 Accident and Emergency Departments (9 of which are 24/7 consultant led), 8 Minor Injuries Units and 19 GP Out of Hours facilities and supported by the NI Ambulance Service.

Evidence suggests the system is increasingly not fit for purpose in the 21st century.

For example the HSC is failing to deliver acceptable A&E waiting times of 95% of patients waiting no more than 4 hours and no patients waiting for more than 12 hours. Overall, performance against these standards has been poor other than in the Southern Trust, both in relation to the 12-hour and four hour standards. Regionally, there were 7,386 breaches of the 12-hour standard in 2010/11 (compared to 3,883 during 2009/10) and cumulatively only 82% of patients were treated and discharged, or admitted within 4 hours of their arrival in A&E during 2010/11.

As discussed in the Case for Change, the Royal College of Surgeons' evidence is that better organised care equals better outcomes for the patient.

New treatments and associated technology for stroke and coronary care are a challenge to deliver in the existing model. Maintaining the supporting infrastructure necessary for high dependency or intensive care in our current model also presents a challenge. Additionally difficulties in retaining appropriately trained staff creates sustainability issues and remains a frequent challenge.

Organisational resilience is a recurrent problem. Each year the current model cannot appropriately staff its A&E service with all of the quality and financial issues that flow from this.

The public in a different way expresses similar problems:

- 91% of the people involved in the omnibus survey felt that improvement was needed to the time spent waiting in A&E, of which 56% stated that a lot of improvement is needed.
- 68% of people surveyed in the Omnibus survey agreed or strongly agreed that they would be prepared to travel a further distance for hospital services if it means they don't have to wait as long. There was no significant difference in the response from people from an urban area (67%) compared to those in a rural area (70%).

EMERGENCY SERVICES

Proximity to acute facilities is often perceived as the determining factor as to whether the local health and social care service will adequately provide for their needs. Increasingly, however, it is not only the distance to the appropriate facility that may determine outcome for the patient, but also the timeliness of the initial intervention.

For example, a person with a stroke needs to get access to the staff and technology to diagnose the stroke as quickly as possible, as explained:

Best Practice Guidance - Stroke Care

Evidence shows that people with an ischaemic stroke who receive thrombolytic treatment within 3 hours of onset are more than twice as likely to have favourable outcomes (such as reduced disability and lower mortality rates) after three months.[83] However, this treatment would harm people with haemorrhagic stroke. Therefore, it is essential that suspected stroke patients are transferred directly to an acute setting with the staff with appropriate skills and access to diagnostics which will allow accurate diagnosis (and therefore appropriate treatment) as quickly as possible.

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[83] Best Practice in Stroke Care 2007, Buchan, A (sourced from Healthcare for London: A Framework for Action report

The Omnibus survey showed that 70% of people surveyed agreed or strongly agreed that they would be prepared to travel a further distance for hospital services if it means they get the best treatment and 71% agreed or strongly agreed that ambulance staff should take seriously ill people to a hospital with the specialist services they need even if it is not the closest hospital.

The Rural Trauma Outcome Study in Scotland[84] showed that longer pre-hospital travel times did not increase mortality or length of stay.

The omnibus survey also highlighted the fact that the majority of the public are aware of where to attend in a number of circumstances, for example 74% of people said that they would attend the GP Out of Hours service if they had a child with a high temperature after 10pm.

However, it appears that the public do not actually attend the most appropriate setting for their needs. Of the activity recorded within the accident and emergency departments across NI, 50% of these are for conditions rated as standard cases without immediate danger or distress (Category 4 based on the Manchester Triage Categories). It can be assumed that a large proportion of these cases could be cared for in an urgent care setting without the need to attend an accident and emergency department.

Furthermore, for less common emergencies it is essential to maintain the required skills to enable the best patient outcome.

A model of care has been set out which delivers best outcomes to patients with major trauma and ensures a resilient service for the population of NI.

Regional Trauma Service

Major Trauma is the single biggest potential cause of death of people under 35 years of age. Due to the relatively small population of Northern Ireland (circa 1.8m) and the low incidence of major trauma cases (approximately 0.02% of the total population per annum), it is impractical to equip and staff all hospitals to the required level to provide optimal care for patients with major trauma.

The DHSSPS has recommended that the Royal Victoria Hospital becomes a regional trauma centre acting as the hub of the NI trauma network. Protocol dictates that patients should be transferred to the Royal Victoria Hospital directly, provided they are able to withstand the journey. If a patient is not able, they will be taken to the nearest major acute hospital within the network with the intention of transferring them to the Royal Victoria Hospital when they are able. Staff employed at the acute hospitals within the network receive appropriate training to maintain their skills.

This Review concluded that a similar model could be considered for other

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[84] Scottish Urban v Rural Trauma Outcome Study, J Trauma September 2005

emergency conditions which do not present in sufficient numbers for services to be maintained at all acute sites.

The result of networking services will be a model which includes a major acute hospital supported by a network of hospitals providing services to meet the needs of the local population. There are ten acute hospitals in Northern Ireland. In Great Britain populations of 1.8million are supported by maybe only four large hospitals. The Review accepted that by 2016/7 the model of major acute hospitals for Northern Ireland's more dispersed population will reconfigure to a more appropriate scale.

This will mean change at several of the current acute hospital sites, and the Review recommends that the key test for any future service configuration must be that it is sustainable and resilient in clinical terms. We recommend that each Local Commissioning Group should draw up specific proposals, taking account of the potential to provide service to the ROI. The Review's view is that it is only likely to be possible to provide resilient sustainable major acute services on five to seven sites, assuming that the Belfast Trust hospitals are regarded as one network of major acute services.

The Role of the Northern Ireland Ambulance Service

The role of the NIAS will be key in ensuring that people are treated in the right place at the right time. Patients should be transferred to the correct location first time where possible, to avoid further transfers at a later stage. It will be important that the NIAS can transfer people not only to Accident and Emergency Departments but also to Urgent Care Centres, Minor Injuries Units or GP Out of Hours. Bypass protocols will be required which clearly define which location patients should be transferred to for each type of condition.

Better management of unscheduled care in partnership between the HSC Trusts and the NIAS offers potential for improving care, patient flows efficiency and patient satisfaction.

Alongside all of this, it will be essential that the public are provided with information about the correct procedures in an emergency.

Quality of Outcome

Quality of outcomes requires that senior clinical decision makers are available at all accident and emergency departments 24/7/365. The model will be capable of delivering this outcome.

For the model to be successful it will need the support of urgent care centres, minor injuries units and GP in and Out of Hours services.

Delivering this model will require clinicians to be networked as one workforce pool for its population to ensure that training and good organisational opportunities are available to deliver a safe, high quality service.

URGENT CARE SERVICES

The clinical advances that result in a more specialised workforce create tension between local accessibility of urgent care services and the need to provide high quality services in acute hospital settings.

The current model includes a small number of Minor Injuries Units and GP Out of Hours to support Accident and Emergency Departments. Given the high volume of attendances at A&E which are Category 4[85] and below, there is potential to do things differently and achieve consistent outcomes. Accident and Emergency Departments can and should be supported more locally through an integrated urgent care model.

The urgent care model is not a 'one size fits all' approach. It is an approach which looks at the needs of the local people and tailors the provision to meet their urgent care needs. This model could, for example, look very different for an urban area compared to a remote rural area. Urgent care should be available on a 24/7/365 basis, including some on-call arrangements where necessary. The services to be provided to a population would be minor injuries, specialist nurses trained in urgent care, urgent care GPs, specialist teams such as mental health crisis response teams and urgent care social workers. The key is that these services are delivered in an integrated fashion.

These services will be supported by diagnostics available in the local community and the ability for GPs to directly admit patients into beds where necessary. Many of these services, other than beds, could all be available within a health and care centre setting, like the Health and Care Centre at Holywood Arches for example.

GP Out of Hours services are currently available for urgent care outside of the normal GP practice opening hours.

GP Out of Hours services should work as an integrated model of care with other urgent care services. A good local example of this working in practice is Downpatrick Hospital. In the UK the Shropshire approach has merit, as outlined below.

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[85] Cases without immediate danger or distress, Manchester Triage

Good Practice Example

Shropshire Doctors Co-operative Ltd (Shropdoc) provides urgent medical services for patients when their own surgery is closed and whose needs cannot safely wait until the surgery is next open, i.e. evenings, weekends and bank holidays.

The service also supported Out of Hours nursing arrangements. Shropdoc doctors carried ‘Rapid Response Boxes’ for palliative care, catheterisation, resuscitation, syringe drivers and controlled drugs and therefore undertook much of the night-time care that might otherwise have been referred to district nurses or resulted in patients being admitted.

Shropdoc also ran the Care Coordination Centre. This provided a single point of access for GPs to other services between 8am and 6pm and included physiotherapy triage for some referrals.

This model has been working well and has the potential further to develop.

CLEAR PROTOCOLS FOR THE POINT OF CONTACT FOR EMERGENCY AND URGENT CARE

There is evidence that the options available to the public in dealing with emergency and urgent cases are limited or not well known. As outlined above, it is important that people are referred to the place that is best suited to meet their medical needs. This will require clear communication with the public as to the types of facilities available, where they are located and under what circumstances they should be used.

To allow this, it will be important that the public can get access to the right advice at the right time. At present this is through the 999 emergency telephone number. The introduction of an urgent number to work alongside the emergency 999 number would allow people to talk to a trained professional who will be able to advise them on the best route for them, be that to an Accident and Emergency Department, an Urgent Care Centre, Minor Injuries Unit, GP Out of Hours service or to wait for a GP appointment the following day. The NIAS will play a pivotal role in managing unscheduled care into the future.

Dedicated Care pathways should be developed for children and people with long term conditions that will allow direct contact with a trained team available to support them in an emergency or when requiring urgent care. This should involve the ability to directly admit these patients to beds hospitals.

PLANNED CARE

INTRODUCTION

Planned or Elective care includes inpatient admissions which happen with prior planning, sometimes at relatively short notice. Often these services cover major treatments or interventions, for example cancer surgery, diagnostics, testing to assist diagnosis, for example blood tests or X-ray and planned ambulatory care, where patients can walk in and walk out on the same day.

Planned care is currently delivered largely from our 10 acute hospitals, 5 local hospitals and a number of community hospitals. There are approximately 6,646 (average 2010/11) hospital inpatient beds in NI (3,683 acute beds and 2,963 non acute beds).

Increasing demand has evidenced itself through rising numbers of inpatient Finished Consultant Episodes. This reflects the increasing subspecialisation as well as absolute demand.

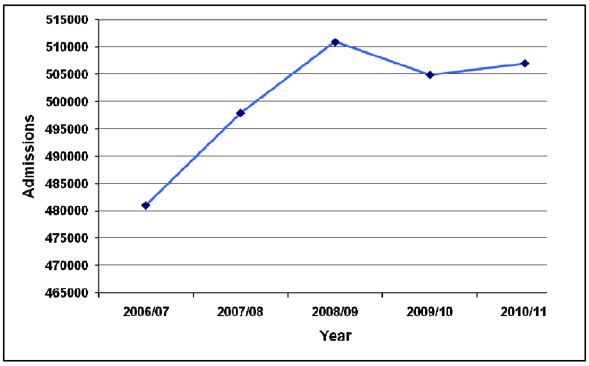
Some changes to service patterns have occurred, for example in cancer and urology, to improve outcomes. Whilst the role of some hospitals has also changed, more is required. However such change cannot happen without recognition of the impact on our current model. Partial change simply pressurises the existing system.

As stated in the Case for Change for both planned and emergency inpatient stays the length of stay is above UK levels.

During 2010/11, a total of 1,502,611 patients were seen at consultant led outpatient services within HSC hospitals in Northern Ireland.

The Total Admissions to HSC Hospitals in Northern Ireland under the Acute Programme of Care are shown in the figure below.

Figure 21: Acute Admissions



Source: DHSSPS Hospital Statistics

Our daycase rates are lower than they should be at 64% (2010/11) compared to the target of 75%. This means that the service is over reliant on inpatient beds when carrying out the procedures which could be carried out as a daycase.

The current target determines that at least 50% of inpatients and daycases are treated within 13 weeks and that all cases are treated within 36 weeks. At present, the current system is failing to meet these targets. Concern about increasing waiting times was highlighted as one of the

People's Priorities by the Patient and Client Council.

In the future planned care will be treating more older people. Planned care needs to be organised separately from emergency care. It gives better patient outcomes and enhances productivity. The Review therefore wishes to see better organisation of planned care.

Where there are planned specialist treatments, which are highly specialised, they will need to continue to be provided in one centre in Northern Ireland or via an agreement with a tertiary centre elsewhere (e.g. GB or ROI).

Diagnostics is an integral part of planned care. It assists the diagnosis of illness, for example blood tests, X-ray, MRI scans etc. These services are currently delivered within major acute hospitals and health and care centres. The review of Pathology Services in NI recommended there should be a managed clinical network for pathology. The Review strongly reinforces the expeditious implementation of this recommendation.

The current target determines that no patient waits longer than 9 weeks for a diagnostic test. In 2010/11 there were 23,518 breaches of this target.

Given all of this, it is impossible not to come to the conclusion that change needs to happen to improve outcomes for patients.

Evidence[86] shows that separating emergency and planned care improves outcomes in terms of continuity of care for patients, improved training for staff and faster access to senior opinion. The organisation of planned care should be clinically led and supported by the appropriate infrastructure.

Inpatient Activity

Key to the delivery of effective services is to ensure that people are given the right care in the right place at the right time. For planned care this means ensuring that people who need to be seen urgently are done so, that people who can wait do and that they are seen within a reasonable period of time.

Better organisation of planned services was supported by the Omnibus Survey which highlighted the following:

- waiting times for an appointment with hospital consultant: 82% felt some improvement is required, including 36% who felt that a lot of improvement was required; and

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[86] Separating Emergency and Elective Care: Recommendations for Practice, The Royal College of Surgeons of England, March 2007.

Delivering surgical services: Options for maximising resources. The Royal College of Surgeons of England, March 2007.

- waiting times for on emergency operations: 88% felt some improvement was required including 36% who felt that a lot of improvement is required.

In supporting the principle that care should be closer to home it will be important to ensure that referrals to acute hospitals and inpatient beds are for sound medical reasons.

Similarly when people are admitted as an inpatient, appropriate discharge protocols must be in place to ensure timely discharge.

This can be supported by multi-disciplinary teams in the community and the availability of intermediate care (care between home and hospital), including step-up and step-down facilities.

Outpatient and Diagnostics

Evidence suggests that GPs and nurses could carry out a proportion of outpatient appointments without the need for a consultant appointment. The location of these types of appointments does not need to be in an acute setting.

The National Primary Care Research and Development Centre[87] identified a number of approaches which resulted in effectively reducing demand for specialist outpatient treatment without impacting on quality or safety. These included primary care clinics for chronic diseases; discharging hospital outpatients to no follow up (patient initiated follow up only); and direct access by GPs to hospital-based diagnostic tests, investigations and treatments.

Case Study

In NHS Stracathro hospital in Scotland acute medical services are being concentrated in larger hospitals that have a full range of support services and technology. Smaller hospitals were reconfigured to provide a wider range of other services including: the management of chronic illness, community rehabilitation, provision of diagnostics and therapy and more local outpatient clinics delivered more locally than ever. The relatively small number of patients who require specialist inpatient treatment are managed in acute hospitals capable of meeting quality and safety standards.

A large proportion of diagnostics could be carried out within facilities closer to people's home. Diagnostics should be available alongside GP practices with the ability for GPs to directly refer patients.

Day cases where possible

Advances in surgical and medical techniques have meant that more procedures can be done as day cases. The Review recommends a better organised response to making sure the individual is referred to the most appropriate location for the best outcome.

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[87] Can Primary Care reform reduce demand on hospital outpatient departments? (March 2007)

The HSC should continue to work towards the 75% rates of day cases for surgical procedures for the basket of 24 procedures. This will assist the move away from inpatient care unless medically necessary.

While there is a strong argument for locally accessible services and care closer to home, this cannot be at the cost of quality and safety. There is recognition than any transfer of services must maintain the levels of both quality and safety.

HOSPITAL NETWORKS

To ensure good patient outcomes no hospital in the future can work other than as part of a network.

In order to provide complex healthcare safely and allow professionals to keep their skills and knowledge up to date they need to treat sufficient volumes of patients with particular conditions. Safe treatments are therefore difficult to deliver at every hospital because there are not enough patients to maintain the skills of the professionals.

Networks should be established to ensure that accessible and safe services are available to all citizens. For common conditions there will be sufficient demand to allow those services to be delivered as locally as possible, either through local hospitals or community facilities. For less common conditions, there will be a need to centralise services on major acute sites to ensure that a resilient workforce is available to support that service.

Planned services provided in hospitals should be organised to meet the needs of that population.

No facility or department should operate as a standalone unit. Professionals should work in networks across hospitals and Trusts to deliver the best care to the patient by working together. This can also help to sustain local services with staff in local hospitals networking with larger acute hospitals, or through provision of nurse-led facilities supported by appropriate medical backup and working with effective transfer protocols for patients requiring acute medical care.

Care Pathways

Care pathways are an important route map for how people will experience treatment and are clinically led.

While there has been some progress in developing tailored care pathways for specific conditions and to address the issue of resilience in the service, there needs to be more consistency of approach across the region to ensure the best quality care is provided, the service is resilient and sustainable and that people are treated in the right place at the right time.

Specialist Provision

The Review has already offered its thinking on the implications of the overall population size of 1.8million for sustaining the viability of specialist hospital services. Consequently this leads to vulnerable services which are difficult to attract staff to work in and if not effectively networked have the potential for poorer outcomes.

The sustainability of these services will best be delivered through networking with other tertiary centres, either in GB or ROI. This allows for consultants to gain the sufficient experience required and allows for multi-disciplinary team discussions on patients. Networks already exist for paediatric cardiac surgery (with the ROI), adult intensive care, cancer and pathology services.

The HSC sent 336 patients to hospitals in GB and ROI in the 6 months to September 2011 to be treated. Where services are so specialist the HSC cannot deliver these in NI, either in isolation or within a network. These types of specialist services will continue to be sent to specialist tertiary centres either in GB and ROI.

The Review recommends the development of joint planning arrangements with colleagues in the Republic of Ireland. In the first instance this would look at:

- shared opportunities in tertiary and specialist care,
- procurement,
- services in the New Hospital in the South West, and
- services which straddle the Border areas.

This would include a regular planning interface between the two jurisdictions to ensure areas of mutual interest are explored. These arrangements would be in addition to Co-operation and Working Together (CAWT), the existing partnership between the Health and Social Care Services in Northern Ireland and ROI, which facilitates cross border collaborative working in health and social care.

TECHNOLOGY

Technology will be a major enabler of networked working and care closer to home.

Investigations and treatment have become much more sophisticated requiring 24-hour access to increasingly complex technology – CT (Computerised Tomography) and MRI (Magnetic Resonance Imagery), sophisticated blood tests etc.

Technology will be required to support the changes in delivery of unscheduled care. Technology will allow all parts of the HSC to be linked in, allowing them to share live information on patients regardless of their location.

There is emerging evidence of the potential for telemedicine to support timely and appropriate inter-hospital transfer as well as better networking between hospitals. Some examples are shown below.

Example of Technology Working in the HSC

The Southern Trust currently operates a tele-dermatology service in which a specialist nurse sees the patient in an outreach clinic with a consultant remotely verifying the skin condition (via a high resolution photograph of the skin condition electronically sent to their location) and providing guidance on the most appropriate nurse or doctor-led pathway for the patient to follow.

The opportunities for technology to support the new model of care are explored further in the Implications section of this report.

CONCLUSION

All of this leads to a conclusion doing nothing is not an option and that planned and organised change is essential to achieve the following objectives:

- Right Care, Right Place, Right Time, Right Outcome;
- Organising Sustainable Inpatient Care;
- Improving Diagnostics;
- Engaging Primary Care;
- Creating a Sustainable Service;
- Being responsive to the public;
- Balancing local and central demand with quality and safety; and
- Providing clear information to the public about how to access services.

SUMMARY OF KEY PROPOSALS

72. Reinforce the full development of the Regional Trauma Network set out in the DHSSPS document.

73. Over time, move to a likely position of five to seven major acute hospital networks in Northern Ireland.

74. Ensure urgent care provision is locally available to each population.

75. Set targets for the reduction of hospital admissions for long-term admissions and end of life care.

76. Set targets for the reorganisation of outpatient and diagnostic services between hospitals and Integrated Care Partnerships.

77. Ensure the transition takes full account of Service Frameworks and clinical pathways.

78. Expeditious implementation of a managed clinical network for pathology.

79. Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements.

16. PALLIATIVE AND END OF LIFE CARE

INTRODUCTION

Palliative and end of life care is an important service in our system, expressing the essence of the values of the NHS. Palliative Care is defined as: “the active, holistic care of patients with advanced progressive illness”. End of life care is a component of palliative care.

The Review heard no reason to challenge the Northern Ireland Palliative Care Strategy ‘Living Matters, Dying Matters’[88], outlines an approach to improve the quality of palliative and end of life care for adults in Northern Ireland, irrespective of condition.

Approximately 15,000 people die in Northern Ireland each year. The main causes of death are circulatory diseases (35%), cancer related deaths (26%) and respiratory diseases (14%). Over two thirds of deaths occur in hospitals and nursing homes. The death rates in NI are falling and improving life expectancy means that the population of Northern Ireland is becoming ‘older’. The profile of older people requiring care is becoming more complex, with many people now living with multiple chronic illnesses. Recent predictions suggest that one third of people over the age of 65 will be living alone by 2020.

Given that the prevalence of chronic conditions and dementia increases with age, demand for palliative and end of life care services is likely to increase.

As a society we need to have open and honest discussions with all age groups about the processes of dying, death and bereavement. We also need to understand the significance of planning ahead to avoid having to react in a crisis as well as planning for a death with dignity. Using some of the questions outlined in models such as in the Gold Standards model[89] can enable increased awareness and preparedness. We need to increase our understanding of when the palliative care phase ends and the end of life phase begins. These phases can move backwards and forwards and it may be difficult to determine when someone is dying. This can assist people in coming to terms with death and dying including the aspiration of planning for a good death.

Although the Palliative Care approach has traditionally been used for people mainly with a cancer diagnosis, it is applicable to other causes of death. The Review heard of a recognised inequity of access to palliative care for non cancer patients. General palliative care is delivered by a range of professional staff in primary, hospital and community settings.

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[88] Living Matters Dying Matters – A Palliative and End of Life Strategy for Adults in Northern Ireland - DHSSPS March 2010

[89] Gold Standards Framework

Specialist palliative care including complex psychosocial, end of life and bereavement issues is provided within HSC and by voluntary sector organisations that make a valuable contribution in this area of care.

It is estimated that two thirds of all deaths in Northern Ireland (9,570) would benefit from the palliative care approach in the last year of life, but do not receive it. 20,000 bed days are used in NI for people dying in hospital from cancer conditions alone. There is currently no strategy that directly addresses the palliative and end of life needs of children.

We correctly invest a large volume of resource in the last year of life, but often provide poor quality which does not meet patient and carer wishes. The Review concluded it can be improved with greater coordination of care in order to ensure that people die with dignity.

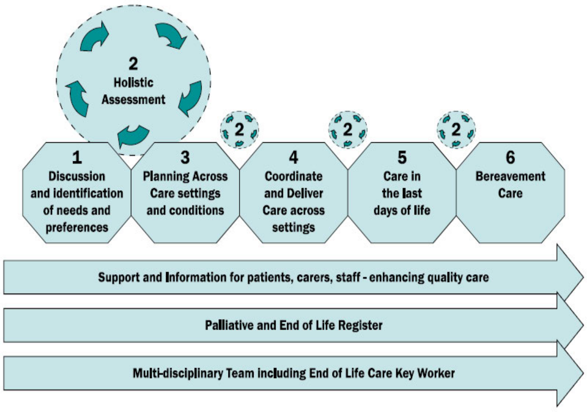
We also know that many more people than currently do would prefer to die at home. At the same time there are too many unnecessary, unwanted and costly end of life hospital admissions. We need to shift more care to the community where it can be more appropriately delivered.

Nursing homes are increasingly becoming the place where older people live and die with shorter average lengths of stay between 18-24 months. Complexity and higher dependency levels within nursing homes have implications for staff development to meet residents' end of life needs.

Frontline staff in general often lack training in delivering end of life care. There is a need to improve education and training for those providing palliative and end of life care.

The Review supports the model[90] below illustrating a continuous, holistic assessment of palliative and end of life care, co-ordinated by a key worker.

Figure 22: Palliative and End of Life Model



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[90] Living Matters, Dying Matters, An End of Life Care Strategy for Adults in Northern Ireland, DHSSPSNI, March 2010.

SUMMARY OF KEY PROPOSALS

80. Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.

81. Enhanced support to the Nursing Home Sector for end of life care.

82. Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.

83. Electronic patient records in place for the patient, their family and staff.

84. Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.

85. Palliative and end of life care for children considered as part of the proposed review of Paediatric Services as referenced in the Maternity and Child Health section.

IMPLICATIONS FOR THE SERVICE

17.IMPLICATIONS FOR THE SERVICE

The changing model of care which moves care as close to home as possible, will only work if the way in which we deliver services also changes.

With a change in the model of care delivered by hospitals, the support required to deliver services in the community and at home, there will be a shift of services that will impact on the type of facilities which we require and the workforce that will deliver the service.

This section sets out an overview of the guiding criteria to be used when considering the new model of service delivery:

- infrastructure;
- technology;
- workforce; and
- resources.

INFRASTRUCTURE

CARE AT HOME

As has been outlined in the sections above, there will be a major shift to care delivered within people's homes, throughout people's lives, whether it be management of long term conditions, support to people with mental health or learning disabilities or end of life care.

In some cases people's homes are nursing homes or residential facilities. The care delivered to individuals in these facilities should enable residents to remain in the facility provided their needs can be met there. The package of care will be based on personal needs, not based on location.

Personalised budgets will encourage diversity of service. Where there is reluctance to take charge through personalised budgets, advocacy and clear information on the financial implications of any assessment will promote this outcome.

An overview of the services that will be delivered in the home, through Integrated Care Partnerships, is as follows.

Services in your home
Access to specialist teams for long term conditions will be developed
Support for Specialist care for cancer
Rehabilitation services
Domiciliary Care, including home nursing
End of Life Care
Access to a range of support services for example daycare or respite
Health and Wellbeing support for vulnerable groups
Enabling good outcomes for those using the service - for older people this is best described as the reablement model. In mental health, the recovery model and in child care, the rescue model.

CARE IN THE LOCAL COMMUNITY

People will have access to a greater package of services within the community.

Services will be focused on the needs of the local population. Local planning will ensure that services are delivered that meet their needs and work towards tackling health inequalities, for example multidisciplinary teams to deliver a package of care to someone with a long term condition or more than one condition.

The types of services that will be delivered within the community, through Integrated Care Partnerships, will include:

Services in your local community
GPs with enhanced services
Pharmacy
24/7 Urgent Care including GP, mental health crisis response and minor procedures
Outpatients
Diagnostics
Access to therapy and rehabilitation
Social support
Links to Voluntary and community organisations to support care
Advocacy services
Antenatal and postnatal care
Health and Wellbeing Advice
Optometry
Dentistry
Cross Departmental working groups to support social needs
Beds used for step-up/ step-down from hospital managed by GPs
Support to carers
Re-ablement

Our 353 GP practices will work within networks based on the already established 17 Primary Care Partnerships. These should be on a formal basis as ‘federations of practices’. This should result in GPs working together in a consistent manner.

The GPs currently within Primary Care Partnerships will form part of the Integrated Care Partnership along with representatives from other HSC bodies, as outlined above. Consideration should be given to the potential for these ICPs to form the basis for a multidisciplinary mutual organisation or to have social firm status.

Pharmacy will deliver an enhanced role in medicines management and health promotion to the local community and will be part of the multidisciplinary team supporting individuals with complex needs.

The ambulance service will have the ability to transfer patients to urgent care settings rather than defaulting to a major acute hospital if this is the most appropriate type of care required for the patient. The ambulance service will also be able to refer patients back to their GPs if they do not see the need to transfer the patient to other services such as urgent care or emergency care.

The focus of care will be reablement where possible. Support at home will be: increased availability of respite care; step up and step down beds between home and hospital; and rehabilitation beds. This will be supported by outpatients services, diagnostics and minor interventions being available closer to home.

The current decline in the demand for residential care homes will continue. In NI, we also have a higher use of supported accommodation than the rest of the UK. This trend is also likely to continue leading to a major reshape of this service.

People who require 24 hour nursing will be cared for within nursing homes.

The move away from residential care provision towards care at home will require a joined up approach to service delivery between the Department for Social Development and DHSSPS.

There will also be a move of dental services closer to home. For example, oral surgery can be carried out within the community at dental practices rather than within a hospital setting as is often the case.

The pathway for referral to hospital optometry services from practices has led to unintended high volumes of referrals. Clinical protocols for direct referral should be considered.

HOSPITAL SERVICES

Introduction

In the future hospitals will work as a system with each facility contributing to the provision of a total service to its population.

The Review is aware that there will be a considerable interest in the current hospital sites and their future role. However, as has been indicated early in the report, the final functionality of each of the facilities will be based on population need and the principles set out above.

The Review recommends that the commissioning system using its local communities should bring forward proposals for hospital services for each of the five populations by June 2012.

Evidence presented to the Review persuaded it that local populations and in particular professionals should design the way forward rather than impose a top down approach of specifying a function for each hospital.

In accepting this approach it wishes to make clear that there will be, as a consequence, change on all sites over a five year period. With change of this magnitude, the system and those working within it must enable, not disable, the change process. The following clearly articulates **what** should be provided. The **how** is for those working in the system.

Hospital Services

All current hospitals will have an integral role in the delivery of services to their localities. They will be essential in contributing to what a local population requires from a hospital service.

The Review is not prescriptive about the service configuration in these facilities but it is expected to include the following profile of services.

Services in your hospital
Urgent Care – doctor led assessment
Out of Hours – GP led
Elective Surgery – daycase and selective inpatient
Inpatient medical care on the basis of agreed pathways designed between primary and secondary doctors
Rehabilitation
Diagnostics
Midwife Led Obstetrics, where feasible based on demand

Hospitals will be networked with the GPs/ GPSIs and staff from the major acute centres. The preferred route for treatment is at home or within the community. Where people cannot be cared for in their own homes or within their community, they will be referred to hospital. Decisions on where to admit will be determined by clinical protocols and designed to ensure the best outcome for the patient.

Hospitals will be expected to separate elective surgical procedures from emergency procedures so that the system of care leads to better clinical outcomes and productivity, without one detrimentally affecting the other.

Patients may also be transferred within the network depending upon clinical need.

Major Acute Hospitals Services

Major acute hospitals provide care and treatment that requires centralisation to ensure that services are delivered by senior staff and that those services are resilient to demand pressures and provide the best outcomes for patients.

Each major acute hospital service must be capable of delivering and sustaining the following profile of services.

Services
24/7 Emergency Department
Emergency Surgery available 24/7
Complex Elective Surgery
Some non-complex elective surgery
Undifferentiated inpatient Medicine, e.g. coronary care and stroke
Paediatrics (Inpatient) available 24/7
Critical care available 24/7
Specialist Diagnostics available 24/7
Outpatients
Consultant led obstetrics
Midwife Led Unit, where appropriate

Since resilience is essential to the provision of hospital services, critical clinical staff will be employed to work in the hospital system and be a resource for each population working as necessary across hospital services and facilities.

Where inpatient provision is currently regional, such as cardiac surgery or sub regional, such as urology, clear clinical pathways which ensure equal access to populations will be required.

Specialist Services

Specialist hospitals will continue to deliver specialist services to the population of Northern Ireland including complex medicine, complex surgery and the associated outpatients service.

These services will be networked as necessary with ROI and GB to ensure that the highest quality services are delivered and that the staff are well trained and experienced.

Supra-Regional Services

Services which have such a low volume that they cannot be sustained to a high quality in NI, even without networking to other tertiary centres, should continue to be delivered outside of Northern Ireland. These include for example transplantations and rare disease management.

The Northern Ireland Perspective

The Review recognises that the future model must take into consideration the Northern Ireland dynamic. Given the rural nature of the West, and its close links to the ROI, the new model will require two major acute facilities in the West. The ROI has expressly indicated it wishes to maximise the opportunity for its population in the new hospital in the West.

Altnagelvin and Belfast hospitals have already well established working arrangements with ROI around some of its services which will continue.

There is currently a level of use of Daisy Hill Hospital by residents of the north east region of ROI. The future configuration of major acute services in Newry will be impacted upon by the potential demand for services from the ROI.

Conclusion

As a consequence of re-profiling services in this way there will be change on all existing sites.

The Review anticipates a major restructuring of how services are delivered by our current hospitals. As previously described, for NI this is likely to mean between five and seven major acute hospital facilities or networks.

The Review also wishes to make clear that maintaining an ‘as is’ model cannot be successful in delivering against the key principles or the guidelines already described. Furthermore, systems which are overly reliant on locum and agency staff are not acceptable.

Impact on the Northern Ireland Ambulance Service

The role of the NIAS is of central importance to the ability to deliver the new model of care. The NIAS has been going through some major changes in modernising its service to meet the needs of the HSC in the 21st century. This modernisation is planned to continue. The plans of the NIAS will support the implementation of the Review, in particular:

- supporting the new care pathways for unscheduled, in particular urgent care;
- training of NIAS paramedic staff to support the model;
- provision of an alternative to the 999 emergency number and availability of medically trained staff to triage patients to the most appropriate service;
- supporting the focus on prevention and wellbeing through information and advice; and
- continuing to support the move of care closer to home through diagnosis and treatment of minor illnesses and injuries in the community.

The NIAS will be involved in the planning and implementation process following the Review, alongside the representatives from across health and social care.

TECHNOLOGY

Technology is a key enabler of the delivery of the new model of care, in particular in supporting care closer to home and the ability of staff to work as an effective integrated multi-disciplinary team.

A forum should be established to take forward how technology will support the new model of care linking the service to industry and academia to ensure the optimum and best value for money solutions are taken forward and opportunities are identified and considered. Where appropriate, development of technological support will be through a collaboration approach with the Department of Enterprise, Trade and Investment (DETI) in line with the Memorandum of Understanding agreed between the Minister for Health, Social Services and Public Safety and the Minister for Enterprise, Trade and Investment.

The plans for technology to support the new model will come in the form of regional projects as well as technology solutions that will support the delivery of services to meet the specific needs of patients in a certain area. The population based planning approach will include plans for the use of technology to support how the model of care is delivered for that population.

Availability of Information at the Point of Care Delivery

Today, records are kept in all the places where you receive care. These places can usually only share information from your records by letter, email, fax or phone. At times, this can slow down treatment and sometimes information can be hard to access.

By making more health records electronic, there will be quicker ways to get important information to HSC healthcare staff treating patients, including in an emergency

Electronic Care Records (ECR) can be used to allow the sharing of information between the many systems currently used to store information across the HSC. This would result in all information held on each patient being available together through the use of the ECR platform.

An ECR pilot is currently underway. This has involved sharing of information within a Trust (i.e. acute, community and primary care information). The Review endorses the roll out of ECR across Northern Ireland with the ultimate aim of sharing information, not just within a Trust, but also across Trusts such that the service will provide an individual electronic care record for every patient in NI. Any patient could then attend any facility across NI and the health records and information will be available.

Information sources will include:

- GP records;
- Community Information Systems (also see below);
- pharmacy records (medicines management); and
- hospital records, including results of diagnostic tests.

Mobility of Staff

Mobile working by community staff allows for better use of resources.

With the shift of care into the community, consideration should be given to the merits of mobile technology to support staff working in the community.

The National Mobile Health Worker Project findings were that mobile devices loaded with office and clinical software allowed clinicians working within the community to make nearly 9% fewer referrals and avoid 21% of admissions.

GP Records

The Review also endorses the approach of developing a data warehouse for GP records in order to deliver information which is of a high quality and consistent across practices resulting in reduced variation and a safe and secure method of storing and sharing patient information.

The data warehouse will protect the confidentiality of patients and will provide timely, anonymised patient-based data and information for purposes other than direct clinical care, including:

- planning and commissioning;
- public health and research;
- clinical audit and governance;
- benchmarking; and
- performance improvement.

Data would be routinely extracted from GP systems and loaded into the data warehouse. The data warehouse would be used by staff at Trust, HSCB and DHSSPS levels. Access to the data would be strictly controlled and where necessary the data would be anonymised. Each "type" of user would have access only to the data for which they have authorised access.

Supporting People to Self-Manage their Care

Technology should be harnessed to support patients in managing their own care through, for example:

- supporting patient education;
- direct patient monitoring and support (telemedicine);
- clinical information and management systems; and
- promoting healthy living and disease prevention.

Telemedicine can be used to provide care closer to home such that the patient does not need to be in a hospital to receive care.

Connected Health

Connected Health is used to describe a model for healthcare delivery that uses technology to provide healthcare remotely. It provides a strategic opportunity for a different business model of procuring and delivering care around the needs of the patient. Through the use of technology patients are able to monitor their own condition, within the parameters set by their GP, thereby enabling them to take greater responsibility for managing their own health and well being. This should lead to a reduced need for patients to visit their GP Practices for monitoring of their condition. Variations to their clinical condition will be monitored remotely and they can be triaged to the relevant area of the health service as appropriate to their need at that time. This will result in patients visiting their GPs about their condition only when they need to and will lead to more appropriate and timely referrals to secondary care.

Connected Health sits well with government health strategies at many levels. It supports patient choice by allowing patients to remain within their own homes with effective self-management. It also supports the move of services from secondary to primary care settings and the ability to deliver a more cost effective, better quality service.

Supporting the principle of Right Care, Right Place, Right Time

One contact number for urgent care will allow triage of patients and ensure that they are directed to the best place of care as discussed in the NIAS section below.

A single robust community information system is required to support the increase in care to be delivered within the community.

WORKFORCE

The new model of service delivery requires a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated, integrated and at home or close to home.

New care model – Workforce implications

Some of the key implications include:

- more people will receive care in their own home, or close to home; which is more integrated with hospital clinicians working closely with GPs and other community staff to plan care delivery, along with increased clinical support provided in the home;
- multi professional community integrated teams will form the essential nucleus of health and social care professionals supporting patients in their own homes;
- increasing use of networks to coordinate care and share good practice and greater emphasis on partnership working within and across sectors; and
- the need to accelerate the pace of change.

The proposed changes will require staff to develop different skills and capacities. For example, GPs with Special Interests in emergency medicine or paediatrics, specialist long-term condition nurses and emergency care practitioners. It is likely that there will be more overlap and networking between services, and it is proposed that there will be an increase in outpatient follow-up appointments being carried out by GPs and nurses. Furthermore there is potential to explore new and extended roles as part of future care provision including the potential to introduce further multi-skilling alongside the use of assistive technologies to maintain older people in their homes.

Role change

Our expectations for what it means to be a health and social care professional are changing. They go beyond clinical practice itself, precisely because high quality care is delivered by a team in a system, not alone in a vacuum. To reach its full potential health and social care needs to harness the skills of professionals working together in making decisions in the clinical arena and bringing that expert judgement to bear on difficult resource and management decisions that impact on patients. Patients, the public and staff expect to see visible leaders making the case for those changes to services which evidence shows will improve patient care.

We need to be clear about what HSC organisations expect and need from tomorrow's clinicians and managers. Workforce planning and development is a critical building block in ensuring that staff are appropriately trained and confident in their roles. In light of the range of external factors likely to impact on health and social care our workforce planning needs to focus on demand signals from the local health economy and patients/ clients rather than just supply side inputs; linked to service planning and needs and underpinned by financial plans making it more robust and linked to patient needs. There needs to be close working between all education and training providers and the HSC to ensure continued high quality of education and training, based on service needs.

Extending GP leadership: Using the building block of Clinical Leads recently appointed to lead the recently formed PCPs, we need to identify and develop GPs will assume a critical leadership role in the new Integrated Care Partnerships. Clarity around roles and expectations will be critical to ensure they are able to engage with twin challenges of professional and management responsibilities.

Resilience

The ability to deliver good outcomes to patients is inextricably linked to workforce and in particular the medical workforce. In recent years the allocation of junior doctors has been problematic. Two matters are pertinent, access to good training and individual choice about workplace. Both will remain into the future. Failure to take full account of this has created many problems for the current model. It is likely that workforce availability over the next 3 years will be numerically less than required for the existing model but much more importantly the training experience that the current model provides, and ultimately the quality of outcome for patients, means that continuation of the current model is unsustainable. Any attempt to sustain the current model would simply flounder.

Engagement with staff organisations

Within the HSC a process of active engagement has been developed over a period of time, incorporating not only regular consultation on matters of concern to both HSC organisations and the staff representatives, but also partnership working on issues of joint concern to the service and the members they represent. It is vital that we remain committed to ongoing, close working with staff organisations and their representatives going forward.

NIAS

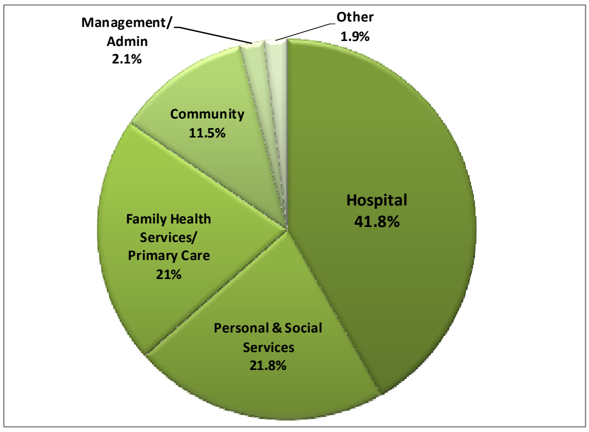
The Ambulance Service is a key part of the new service delivery model. Training of ambulance staff in the new model and best location of care will be required as well as ensuring that bypass protocols are in place.

RESOURCES

Revenue Budget

The current revenue budget for DHSSPS in 2011/12 is £4,383million. The Health and Social Care element is £3,904million and is split as follows:

Figure 23: Current HSC Revenue Budget, 2011/12

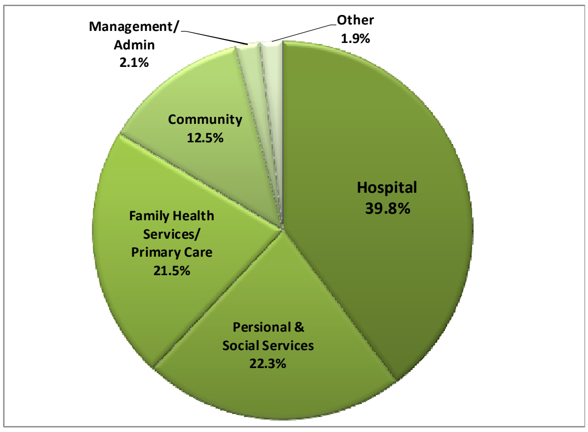


To allow the implementation of the new model of care the funding available for HSC services will be re-allocated. There will be a shift of care from hospital settings into the community. Some of the key changes that will be seen in the community will be:

- more care delivered in the home;
- changing care packages for people in nursing homes;
- increased role of the GP;
- increased role of Pharmacy in medicines management and prevention;
- a strong focus on prevention;
- increased use of community and social care services to meet people's needs; and
- outreach of acute services into the community.

The revenue budget for DHSSPS in 2014/15 is £4,659million. The Health and Social Care element is £4,150million. The projected allocation, applying the new model, is illustrated in the figure below.

Figure 24: Projected Allocation of HSC Revenue Budget, 2014/15

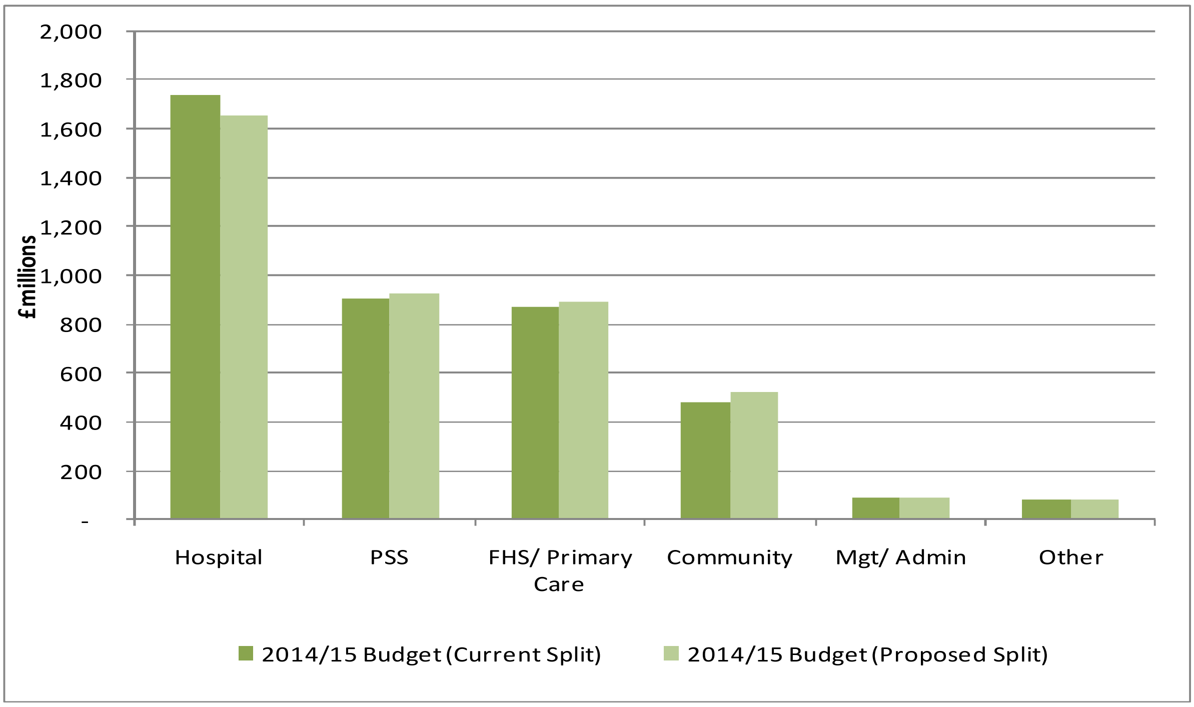


The impact on investment of the potential redistribution of the budget is illustrated in the figure overleaf and is as follows:

- reduction of the budget in hospital services, from £1,733million to £1,650million. This represents a £83million reduction, equating to 5% of the hospital services budget;

- increase in Personal and Social Services (PSS), from £903million to £924million. This represents a £21million increase, equating to a 2% increase in the PSS budget;
- increase in Family Health Services and Primary Care Services, from £871million to £892million. This represents a £21million increase, equating to a 3% increase in the FHS budget; and
- increase in Community Services, from £477million to £518million. This represents a £41million increase, equating to a 9% in the Community Services budget.

Figure 25: Projected Allocation of HSC Revenue Budget, 2014/15



A shift of care from hospital settings into the community reflects the principles, as outline in section 5, by which the Local Commissioning Groups will develop their population plans. The re-allocation of resource, illustrated in figures 23 and 24 is indicative; however it does reflect the anticipated level of change required to effect the change.

Consideration will also need to be given to the capital investment required to enable the change process to occur.

TRANSITION AND IMPLEMENTATION

This change will not be straight forward. It will require fundamental changes to the way we deliver services and will require substantial re-training of staff.

In addition it is estimated that transitional funding of approximately £25million in the first year; £25million in the second year; and £20 million in the third year will be required to enable the new model of service to be implemented.

We recommend this should be invested in:

- Integrated Care Partnerships, with a focus on older people and long term conditions;
- service changes; and
- voluntary early release scheme.

It is anticipated that after 2014/15 the model would be self-financing.

The principles for implementation are set out in section 18 overleaf. Detailed implementation plans will be developed following this review to reflect the complexity of changes required.

Income Generation

Often a parallel is drawn with other UK regions in regards to NI. Citizens contrast availability of services elsewhere with those that they have access to. This is sharply focused when there is discussion about income generation. Other regions have access to resources from charging which is not available in NI. The Review does not offer an opinion on how this should be addressed but would state there are no neutral decisions.

While income generation was not a matter for the Review, there needs to be a sensible debate about growing income within the spirit of the NHS principles. The Review recommends that this debate commences in NI in 4 areas:

- Non-emergency transport – for example car parking for visitors and staff and travel to day centres;
- Domiciliary care – DHSSPS has never applied the ability to charge for domiciliary care in the home;
- Prescriptions – consideration of a contribution towards the cost of prescriptions; and
- Social Bonds and their ability to support more diversity in community service provision.

The Review would wish to restate that it is not supportive of any move away from core NHS principles.

SUMMARY OF KEY PROPOSALS

86. Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital and community services.

87. Development of population plans for each of the five LCG populations by June 2012.

88. Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/AHPs, and social care.

89. Development of clear patient pathways for networked and regional services.

90. Establishment of a forum to take forward how technology will support the new model of care linking the service to industry and academia.

91. Full rollout of the Electronic Care Record programme.

92. Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.

93. Introduction of a single telephone number for urgent care.

94. Introduction of a single robust community information system.

95. Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home.

96. Development of GPs to assume a critical leadership role in the new integrated care teams.

97. More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.

98. Re-allocation of resources estimated to equate to a 4% shift of funds from hospitals into the community.

99. Initiation of a sensible debate about growing income within the spirit of the NHS principles.

ROADMAP FOR THE FUTURE

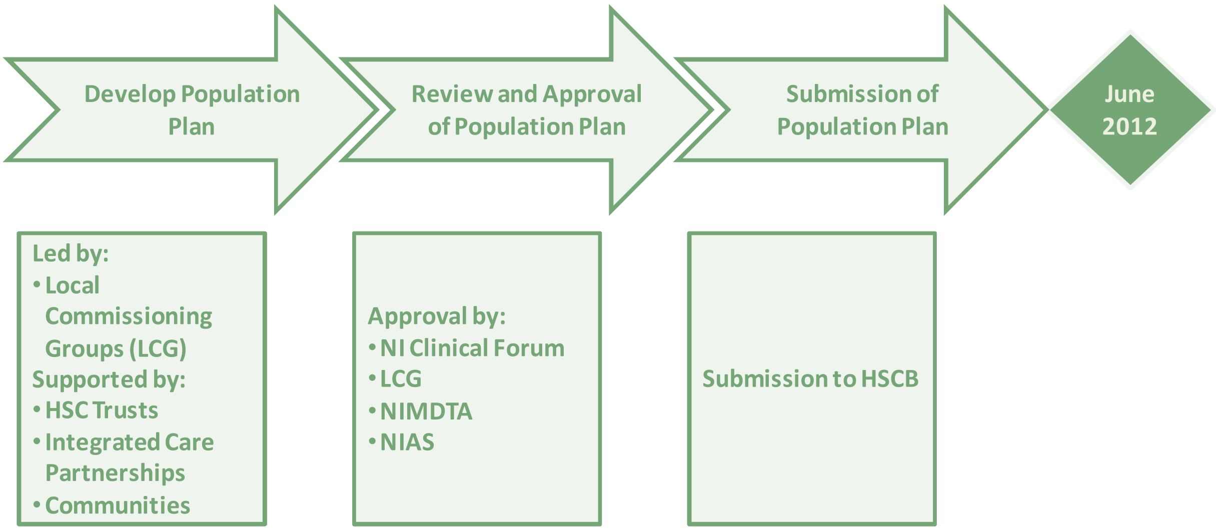
18.ROADMAP FOR THE FUTURE

Key to the successful delivery of the new model is a clearly defined roadmap for the future which sets out the steps needed to move from the current model of care to the new model of care. It is essential that a clear direction of travel is set out. This should be in the form of a clear implementation and engagement plan. The engagement plan will be an essential tool in setting out how the changes will affect users, families and staff. To support the implementation clear governance and reporting arrangements must be established. An answer to the 'who's in charge' question must be clear and accountabilities easily understood by all.

This section sets out a proposed response to this challenge. It comments upon governance arrangements for the programme, presents an approach to create an implementation plan and identifies the key actions and milestones for implementation of the recommendations of the Review. Additionally it describes a plan for engagement with staff and users. The Review recommends that detailed implementation and engagement plans are developed and published by June 2012 following this Review, as illustrated below.

In addition, the Review recommends paying particular attention to achieving sign off from the 17 Integrated Care Partnerships, NIMDTA and the NI Ambulance Service when the Local Commissioning Groups put forward the models for their population.

Figure 26: Population Planning Process



Develop Population Plan

Review and Approval of Population Plan

Submission of Population Plan

June 2012

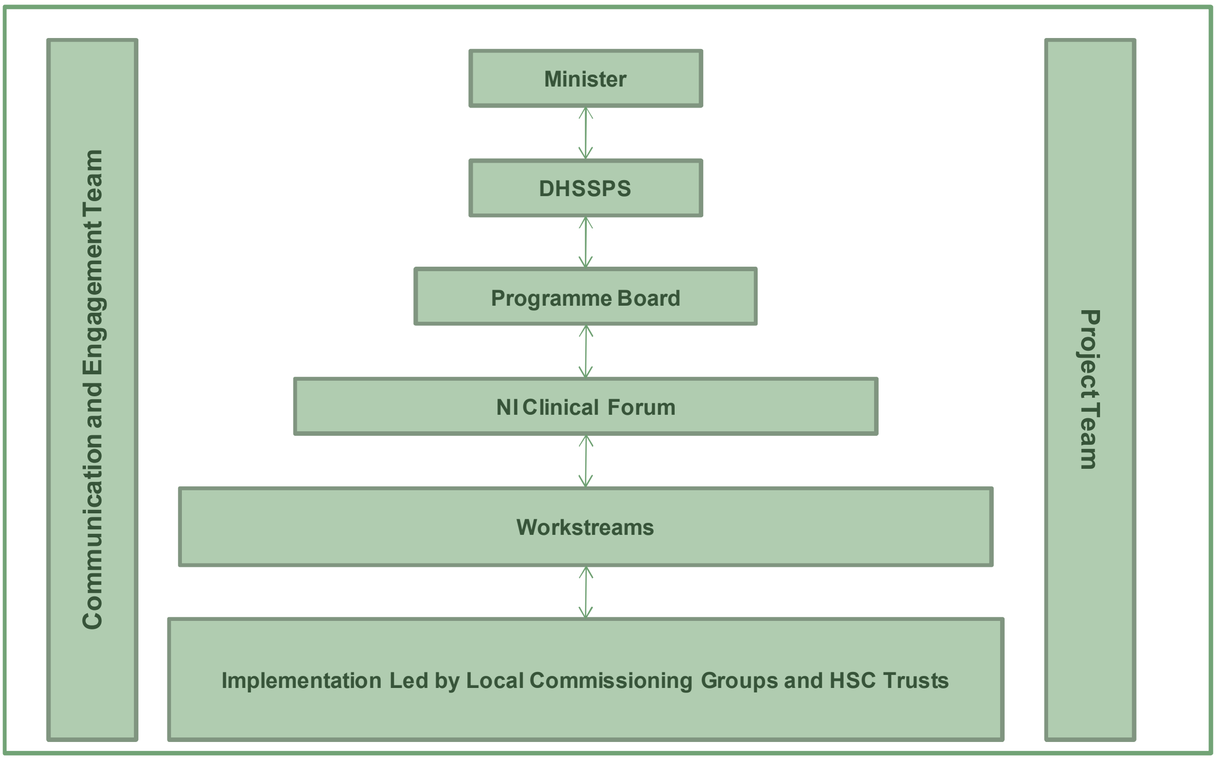
Led by:
- Local Commissioning Groups (LCG)

Supported by:
- HSC Trusts
- Integrated Care Partnerships
- Communities

Approval by:
- NI Clinical Forum
- LCG
- NIMDTA
- NIAS

Submission to HSCB

Figure 27: Programme Structure



The programme of change will be led by the Minister for Health, Social Services and Public Safety. A Programme Board will be set up to report to the DHSSPS and Minister on the implementation of the Review. The Programme Board will be supported by the Northern Ireland Clinical Forum, a project team and workstream leads. The roles of each of the bodies included in the programme will be as follows.

Minister for Health, Social Services and Public Safety

The Minister is responsible for the roll out of the programme of change. The Minister will approve all major decisions about service changes, policy or legislation. The Programme Board will report to the Minister on progress of the implementation through the DHSSPS.

DHSSPS

The DHSSPS will advise the Minister on extant policy or new policy and will support the Minister in making decisions relating to the programme of change. In addition, the DHSSPS will ensure close collaboration with the Programme Board as it discharges its responsibilities.

Programme Board

The Programme Board will be chaired by the HSCB and made up of representatives from the HSCB and HSC Trusts. The Programme Board will be responsible for steering the implementation using the commissioning process. It will also be responsible for reporting to DHSSPS and the Minister on progress.

NI Clinical Forum

A NI Clinical Forum will be established in 2012 to provide strong professional advice to the Programme Board and give robust clinical advice in taking forward the changes. Additionally the Patient and Client Council will be invited to describe how best to ensure users and carers are engaged.

Workstreams

A number of workstreams will be set up for each area that is seen as key to leading the implementation. These workstreams will lead the implementation of the agreed plans for each population. They will report to the Programme Board on the progress under each workstream.

Delivery

The actual implementation of the changes agreed will be taken forward as a joint approach between commissioners and providers. The Local Commissioning Groups will work with the HSC Trusts and other providers in taking forward the plans. The LCGs will report to the Programme Board on the progress of the implementation.

Project Support

The Programme Board will be supported by a Project Team. The Project Team will use Project and Programme Management principles to monitor the progress of the implementation of the programme of change based on the plans approved by the Programme Board, the DHSSPS and the Minister. The Project Team will report directly to the Programme Board on the progress. The tools used to monitor progress will include:

- detailed Project Plan;
- key responsibilities for taking forward actions and associated timescales;
- actions and milestones;
- targets for measuring success; and
- development and management of project risks.

Communication and Engagement

The delivery of the programme will rely greatly on the ability to successfully communicate changes to the public and staff working in the HSC as well as successfully engaging with these groups and achieving their buy-in to the process. This will require communication and engagement support from a team with experience in taking forward major change programmes.

The suggested structure of the programme is shown in Figure 18 overleaf.

These arrangements should be in fully place by June 2012 to support the roll out of the population plans submitted at that time.

IMPLEMENTATION PLAN

A detailed implementation plan overleaf will be required to take forward the project. This will be based on population plans. Each of the population areas, led by Local Commissioning Groups, will be expected to produce population plans by the end of June 2012.

The figure overleaf sets out the high level actions associated with the recommendations of this Review.

The Review team acknowledge that many of the recommendations require policy change, as well as necessary equality, human rights and rurality impact assessments. In addition a number may also require legislative change to enable implementation. These will be taken forward in the implementation process.

ENGAGEMENT PLAN

The implementation of this programme of change is much more likely to deliver sustained transformational change through commitment than through compliance.

An engagement plan will be a key tool in taking forward the programme. The engagement plan will include:

- identification of the key stakeholders to be consulted with;
- how the stakeholders will be engaged with; and
- plan for engaging with stakeholders.

Stakeholders to be engaged with will include representatives from DHSSPS, HSC Board, HSC Trusts, Voluntary and Community Sector organisations, users and carers.

Stakeholders are expected to be engaged through a number of approaches, both targeted to specific stakeholders and those which are stakeholder wide. This will be via a number of methods which may include already established forums, workshops or one to one meetings.

Regular updates on engagement should be reported to the Programme Board.

COMMUNICATION PLAN

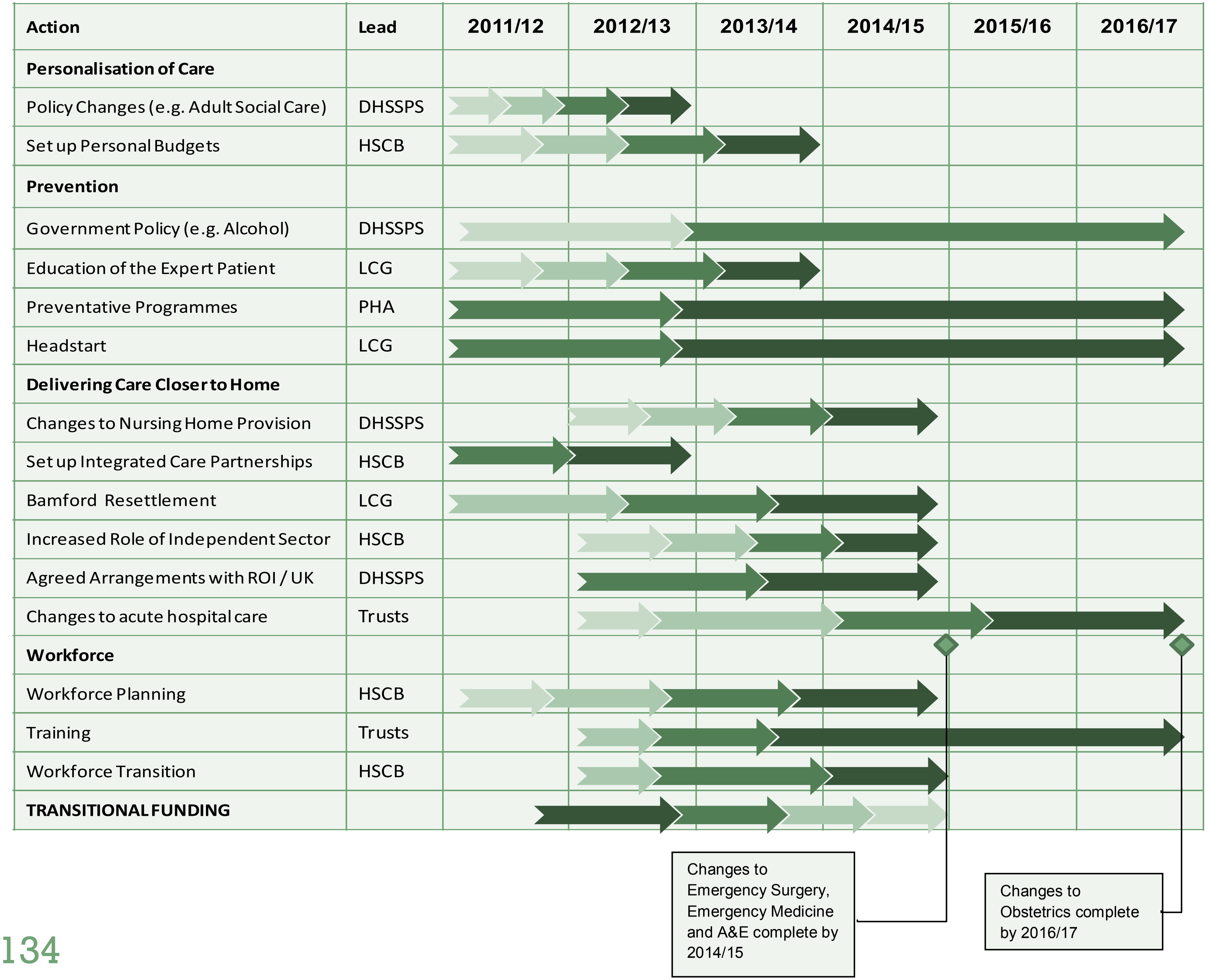
The major changes envisaged by this Review will impact on all residents of NI both those using the HSC service and those working in it.

To manage the effective implementation of the programme it will be essential that the changes are communicated effectively to those who will be affected, both from the perspective of understanding how the changes will affect care, changes in how to access care and a clear understanding of what is expected from the public in delivering the programme of change.

The communication plan should include details of:

- the key messages to be communicated;
- the target audience for communication;
- the approach to communication; and
- the forum and tools to be used when communicating with the groups identified.

Figure 28: Timeline for Completing Key Actions



19.SUMMARY OF PROPOSALS

POPULATION HEALTH AND WELLBEING

1. Renewed focus on health promotion and prevention to materially reduce demand for acute health services.
2. Production by PHA of an annual report communicating progress on population health and wellbeing to the public.
3. Maintenance of existing and implementation of new screening and immunisation programmes where supported by clinical evidence.
4. Consideration by the Northern Ireland Executive of the wider role of the state in taking decisions impacting on health outcomes, for example: in relation to pricing of alcohol and 'junk' food; and further controls on tobacco usage.
5. Incentivisation of Integrated Care Partnerships to support evidence-based health promotion, for example, clinician-led education programmes in the community.
6. Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.
7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community.
8. Support for the health promotion and prevention role played by Allied Health Professionals, particularly with older people.

OLDER PEOPLE

9. Home as the hub of care for older people, with more services provided at home and in the community.
10. A major reduction in residential accommodation for older people, over the next five years.
11. Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.
12. A greater role for nursing home care in avoiding hospital admissions.
13. More community-based step-up/step-down and respite care, provided largely by the independent sector.

14. A focus on promoting healthy ageing, individual resilience and independence.

15. More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond health and social care.

16. A holistic and consistent approach to assessment of older people's needs across Northern Ireland and an equitable range of services.

17. A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.

18. Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to advocacy and support if needed.

19. A policy review of carers' assessments and more practical support for carers including improved access to respite provision.

20. An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for new entrants.

LONG-TERM CONDITIONS

21. Partnership working with patients to enable greater self care and prevention.

22. Personalised care pathways enabling home based management of the LTC with expanded support from the independent sector.

23. Patients to have named contacts for the multi-disciplinary team in each GP surgery to enable more straightforward communication.

24. Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.

25. A stronger role for community pharmacy in medication management for LTCs.

26. Development of admission protocols between secondary care specialist staff and those in the community.

27. Maximising the opportunities provided by telehealth in regard to LTC patients.

PHYSICAL DISABILITY

28. Promoting independence and control for people with a disability, enabling balanced risk-taking.

29. A shift in the role of the health and social care organisations towards being an enabler and information provider.

30. Joint planning of services for disabled people by the statutory, voluntary and community health and social care providers, and other relevant public services (e.g. housing) to ensure a wide range of services across NI.

31. Better recognition of carers' roles as partners in planning and delivering support, and more practical support for carers.

32. More control for service users over budgets, with continued promotion of Direct Payments, and a common approach to personalised budget with advocacy and brokerage support where required.

33. More respite and short breaks provision.

MATERNITY AND CHILD HEALTH

Maternity

34. Written and oral information for women to enable an informed choice about place of birth.

35. Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.

36. Services in consultant-led obstetric and midwife-led units available dependent on need.

37. Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of unnecessary interventions.

38. Continuity of care for women throughout the maternity pathway.

39. A regional plan for supporting mothers with serious psychiatric conditions.

Child Health

40. Further development of childhood screening programmes as referenced in the Health and Wellbeing section.

41. Child health included as a component of the Headstart programme referenced in the Family and Childcare section.

42. Promotion of partnership working on children's health and wellbeing matters with other government sectors.

43. Close working between hospital and community paediatricians through Integrated Care Partnerships.

44. Completion of a review of inpatient paediatric care to include palliative and end of life care.

45. Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.

FAMILY AND CHILD CARE

46. Re-structuring of existing services to develop a new 'Headstart' programme focusing on 0-5 year olds.

47. Exploration through pilot arrangements of budgetary integration for services to this group across Departments, under the auspices of the Child and Young People's Strategic partnership.

48. Completion of a review of residential care to minimise its necessity.

49. Promotion of foster care both within and outwith families.

50. Development of a professional foster scheme for those hardest to place.

51. Implementation of the RQIA recommendations in relation to CAMHS.

52. Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS services.

MENTAL HEALTH

53. Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.

54. Establishment of a programme of early intervention to promote mental health wellbeing.

55. Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.

56. A consistent, evidence-based pathway through the four step model provided across the region.

57. A consistent pathway for urgent mental health care including how people in crisis contact services, triage and facilities in emergency departments.

58. Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.

59. Further shift of the balance of spend between hospital and community, with reinvestment of any hospital savings into community services.

60. Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.

61. Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.

62. Close long stay institutions and complete resettlement by 2015.

LEARNING DISABILITY

63. Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds as referenced in the Family and Childcare section (Section 12)

64. Further development of the current enhanced health services on a Northern Ireland basis.

65. Support from Integrated Care Partnerships to improve clinicians' awareness of the needs of individuals with a learning disability.

66. Better planning for dental services should be undertaken.

67. Further development of a more diverse range of age-appropriate day support and respite and short-break services.

68. Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.

69. Development of information resources for people with a learning disability to support access to required services.

70. Advocacy and support for people with a learning disability, including peer and independent advocacy.

71. Commitment to closing long stay institutions and to completing the resettlement process by 2015.

ACUTE CARE

72. Reinforce the full development of the Regional Trauma Network set out in the DHSSPS document.

73. Over time, move to a likely position of five to seven major acute hospital networks in Northern Ireland.

74. Ensure urgent care provision is locally available to each population.

75. Set targets for the reduction of hospital admissions for long-term admissions and end of life care.

76. Set targets for the reorganisation of outpatient and diagnostic services between hospitals and Integrated Care Partnerships.

77. Ensure the transition takes full account of Service Frameworks and clinical pathways.

78. Expeditious implementation of a managed clinical network for pathology.

79. Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements.

PALLIATIVE AND END OF LIFE CARE

80. Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.

81. Enhanced support to the Nursing Home Sector for end of life care.

82. Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.

83. Electronic patient records in place for the patient, their family and staff.

84. Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.

85. Palliative and end of life care for children considered as part of the proposed review of Paediatric Services as referenced in the Maternity and Child Health section.

IMPLICATIONS FOR THE SERVICE

86. Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital and community services.

87. Development of population plans for each of the five LCG populations by June 2012.

88. Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/AHPs, and social care.

89. Development of clear patient pathways for networked and regional services.

90. Establishment of a forum to take forward how technology will support the new model of care linking the service to industry and academia.

91. Full rollout of the Electronic Care Record programme.

92. Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.

93. Introduction of a single telephone number for urgent care.

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95. Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home.

96. Development of GPs to assume a critical leadership role in the new integrated care teams.

97. More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.

98. Re-allocation of resources estimated to equate to a 4% shift of funds from hospitals into the community.

99. Initiation of a sensible debate about growing income within the spirit of the NHS principles.

20.CONCLUSION

The Review team was impressed and enthused by the opportunity offered by the Minister to bring forward coherent changes for HSC in NI. Change is always difficult, but in looking at change the Review was determined to keep the individual, their family and the evidence of what works at the fore-front of its deliberations.

Looking towards the next 5 years there is real potential with the implementation of the Review to see a service much improved and fit for the future. The Review cannot be impervious to the present wider economic climate and how that might impact on HSC. However the Review Team was firmly of the view that the best defence to such an eventuality was to be clear about the direction of travel, namely:

- starting with the individual;
- looking to a greater focus on prevention;
- maintaining care close to home;
- re-designing primary care; and
- re-shaping hospitals.

Planning for taking decisions and creating a new model for the future is at the core of the Review. The Review is convinced failure to plan will cause detriment to the health and wellbeing of the population

21.APPENDIX

1. Terms of Reference
2. Online survey summary of results
3. Household survey summary of results
4. Questions raised at public meetings
5. List of attendees at clinician workshops and areas covered at each event
6. List of attendees at sector workshops
7. List of stakeholders engaged with at small group meetings
8. List of written submissions
9. Glossary

Appendix 1

Terms of Reference

Review of the Provision of Health and Social Care services in Northern Ireland

1. The Review should take account of:

- the Minister's statement of vision and strategy for the HSC;
- the statutory duties on the HSC to improve the quality of services provided to individuals, and to seek to improve the health and social well-being of the population, and to reduce health inequalities;
- all extant statements of policy and strategy approved by the Minister, and in particular the aims of improving **public health**, the **prevention** of illness, and of improving **outcomes** for patients and clients. Other major themes of policy and strategy are the quest for better early intervention and chronic condition management, and the strategic shift of all suitable services towards a primary and community context;
- the organisational structure of the HSC as established in the 2009 Reform Act, and in particular the responsibility to secure a clear focus on public health, and increasingly effective local commissioning of services and to exercise good governance and provide clear accountability – the Review will need to ensure that its analysis and recommendations are practical and applicable within this statutory framework;
- the resources available in the Budget settlement for 2011-12 to 201415 approved by the Executive and the Assembly in March 2011, given the overriding obligation on all HSC bodies to manage services within the level of resources approved by the Assembly;
- best practice guidance of regulatory and advisory bodies affecting the provision of safe and effective services, notably the National Institute for Health and Clinical Excellence, the Social Care Institute for Excellence and the Royal Colleges;
- evidence of how arrangements for the delivery of health and social care in the Republic of Ireland and Great Britain and cooperation for mutual benefit with service providers there, might contribute to the objectives of the Review;
- the established framework of terms and conditions for HSC staff including Agenda for Change and the Consultants' Contract, and the contractual arrangements in respect of primary care;
- recent previous studies and analysis of the HSC including the Appleby Reports of 2005 and 2011, the McKinsey Report of 2010 and the forthcoming PEDU Review; and
- evidence-based good practice on the delivery of services from within Northern Ireland from elsewhere.

2. On that basis, the Review is asked to:

- Provide a strategic independent assessment across all aspects of health and social care services of the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met by existing arrangements, taking account of the issues of outcomes, accessibility, safety, standards , quality of services and Value For Money;

- Undertake appropriate consultation and engagement on the way ahead with the public, political representatives (primarily through the Assembly Health Committee), HSC organisations, clinical and professional leaders within the HSC, staff representatives (through the Partnership Forum), and stakeholders in the voluntary, community, independent, private and local government sectors;
- Make recommendations to the Minister on the future configuration and delivery of services in hospital, primary care, community or other settings. The essential task of the Review is to set out a specific implementation plan for the changes that need to be made in the HSC in the context set out above, including proposals in relation to major sites and specialties;
- To identify, at an early stage, potential areas of concern, specific priorities for Ministerial focus and potential issues of public/political/media concern;
- To prepare a Report incorporating its analysis, findings and recommendations.

3. The new organisational structures within Health and Social Care have delivered major efficiencies already. They are currently the subject of a further review as part of a wide ranging review by the Executive of all Arm's Length Bodies and are outside the scope of this Review.

4. The issue of overall funding levels available to meet the needs of Health and Social Care now and in the years ahead is also outside the scope of this Review as that is a matter for the Executive collectively drawing on the advice of DFP. The current PEDU review of the scope to make savings in the Health and Social Care sector is separate from the HSC Review and the development of an implementation plan to deliver savings will continue in parallel with this Review.

5. Where the Review finds major tension, or contradiction, between its emerging view of the best way ahead and the extant constraints listed at paragraph 1 above, this should be raised for consideration by the Department as soon as possible, so that the Minister can be advised of the issue and give a specific steer as to how the Review should proceed.

6. The Review should complete its Report by 30 November 2011.

Appendix 2
Online Survey Summary of Results

Online Survey Results

In total there were 1107 responses.

However many of the responses were incomplete and in many cases only demographic information was captured.

The final sample was **673** responses although for some of the 'Quality' questions the sample was reduced further.

Summary of findings:

Demographic Profile

- **91%** of respondents said they work for an organisation providing health or social care services in NI
- **81%** said they work for an HSC Trust
- **95%** were providing the response on their own behalf

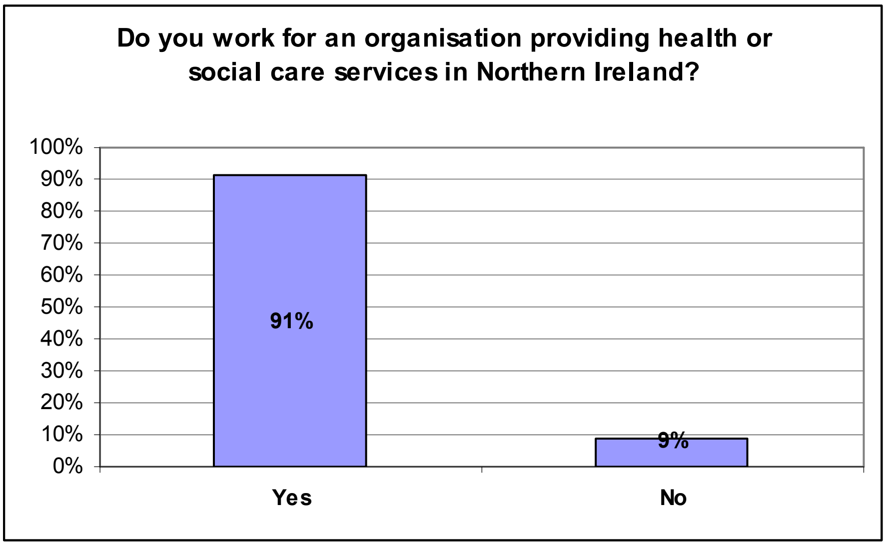
Service Usage in the last Year

Top 3 services reported by most respondents

- **94%** of respondents (or their families) have used GP services
- **54%** of respondents (or their families) have had an appointment with a hospital consultant
- **40%** of respondents (or their families) have used A&E services

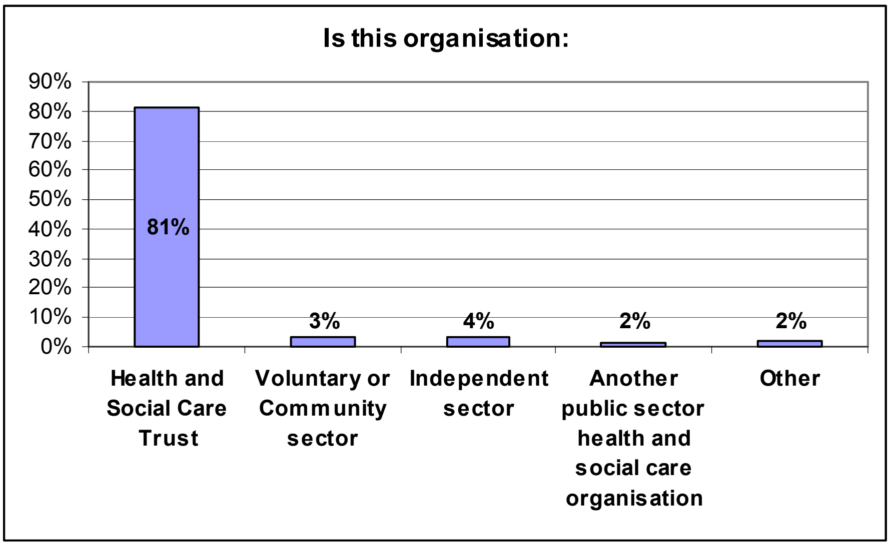
Profile

Do you work for an organisation providing health or social care services in Northern Ireland?

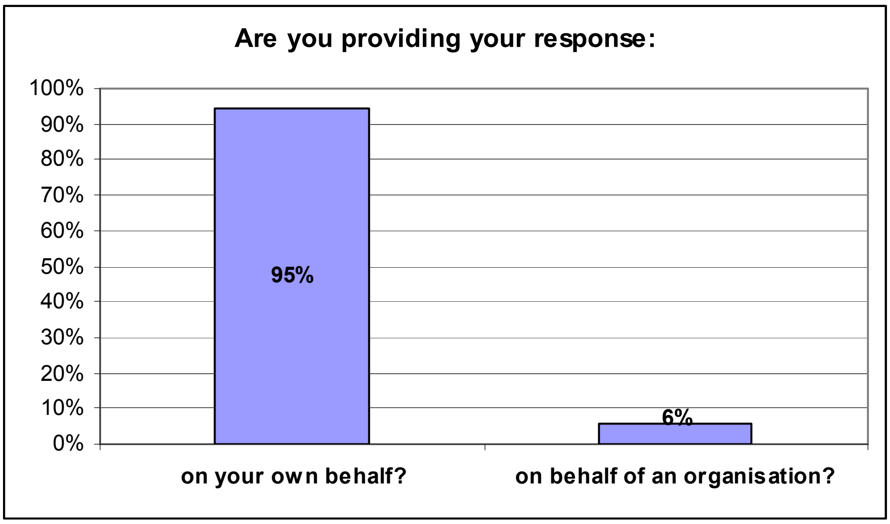


Is this organisation:

-A Health and Social Care Trust
-Another public sector health and social care organisation
-A voluntary or community sector organisation
-An independent sector organisation
-Other



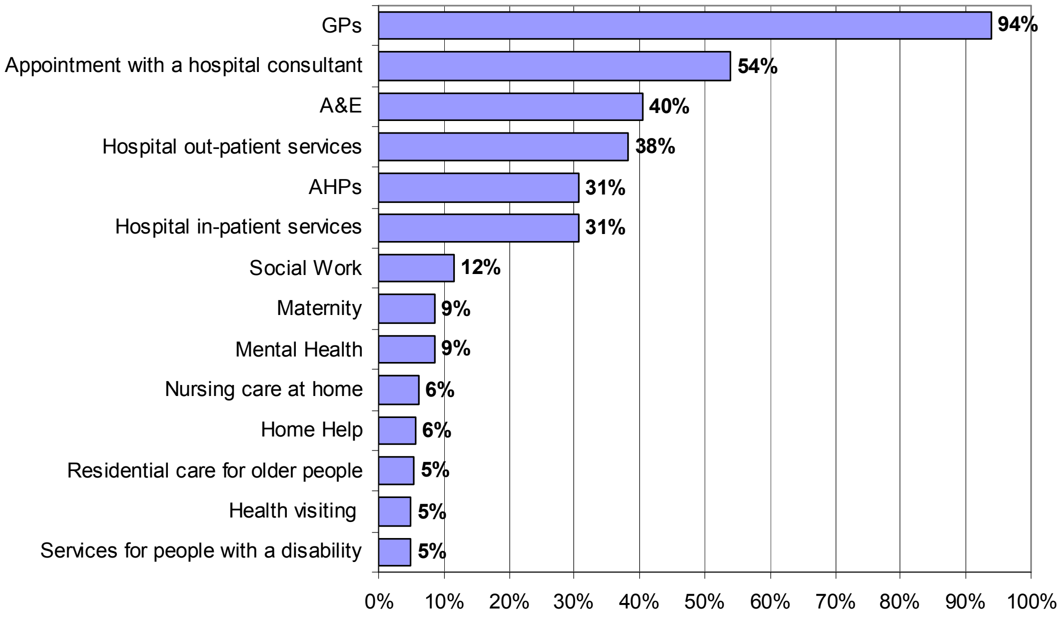
Are you providing your response
- On behalf of an organisation or
- On your own behalf?



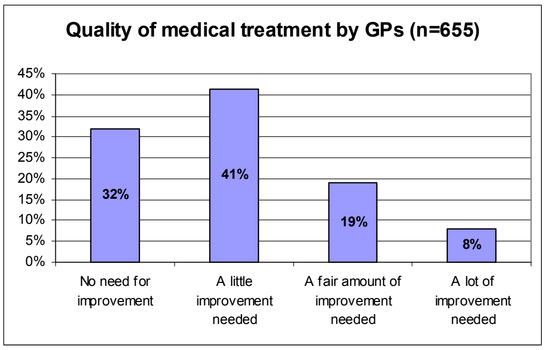
What is the name of the organisation you are sending your response on behalf of?

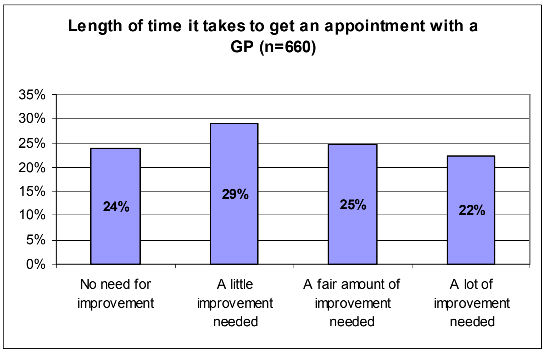
Action Mental Health
Autism NI (PAPA)
Bradleys Pharmacy
Castleview Private Nursing Home, Carrickfergus
Community Organisations of South Tyrone & Areas Ltd (COSTA)
Contact a Family
Dundela Pharmacy Ltd
FAITH HOUSE
Fermanagh Cardiac Support Group
Fold Housing Association
Foyle Parents and Friends Association
Home-Start Craigavon
Home-Start East Belfast
Home-Start In Northern Ireland
Kennedy's Pharmacy (Rasharkin and Dunloy)
Maria Mallaband Care Group Ltd
Mencap in Northern Ireland
MindWise New Vision for Mental Health
Newry & Mourne Carers Limited
Orchard House Private Nursing Home
Phoenix Healthcare
Shalom Care
Strandburn Pharmacy
The Dry Arch Children's Centre
The Stroke Association Northern Ireland
Wilson Group (Nursing Homes)

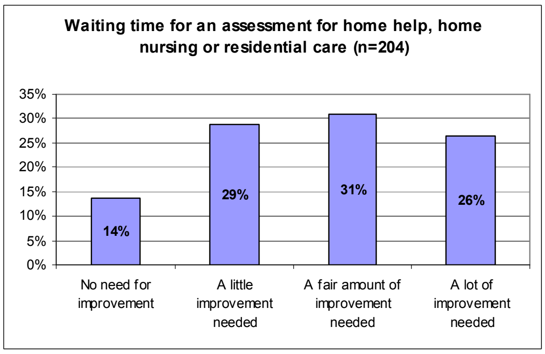
Have you or your family used any of these health and social care services in the last year?

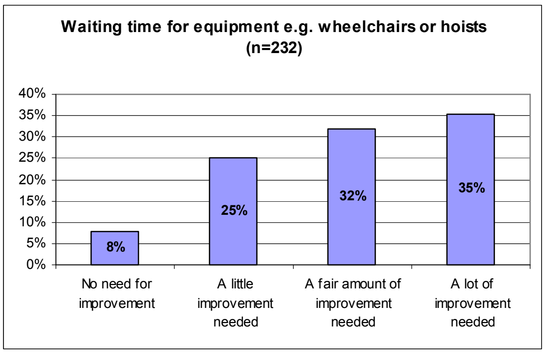


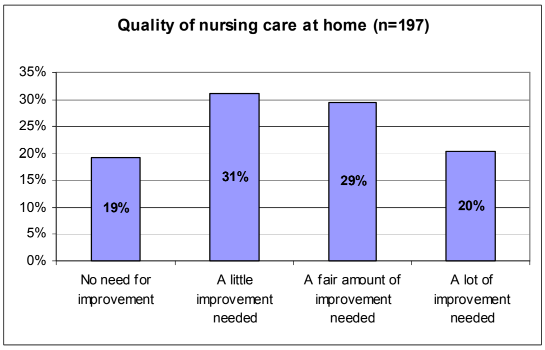
How would you rate the following aspects of Health and Social Care in Northern Ireland in terms of whether they require improvement or not?:

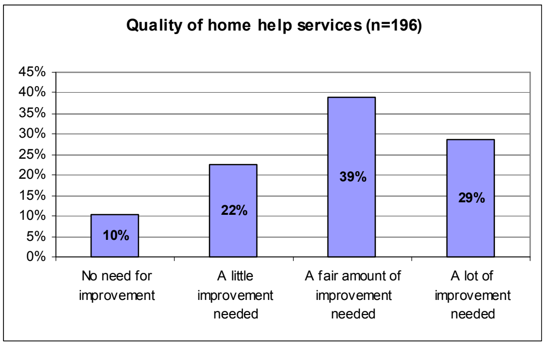


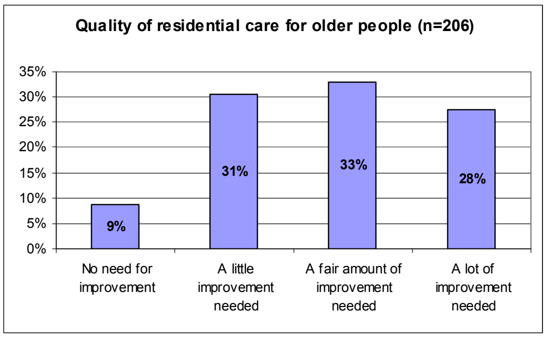


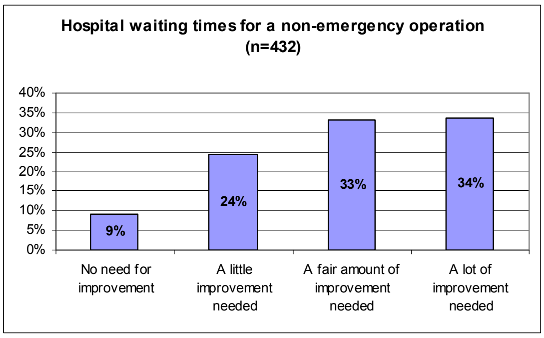


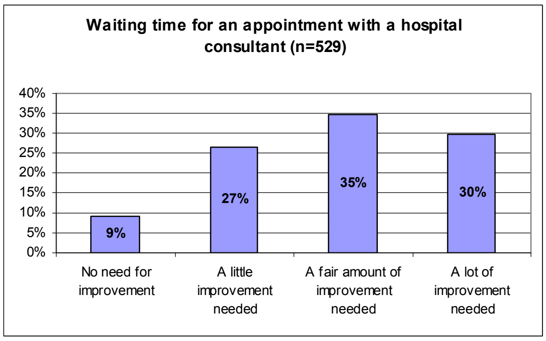


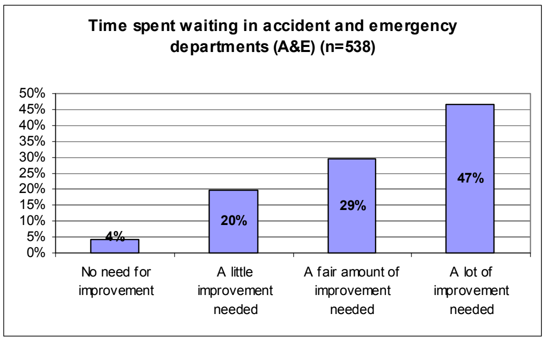


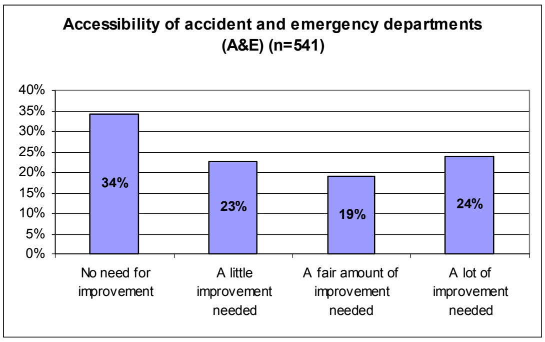


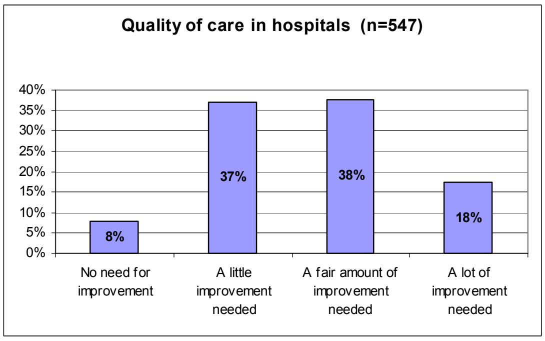


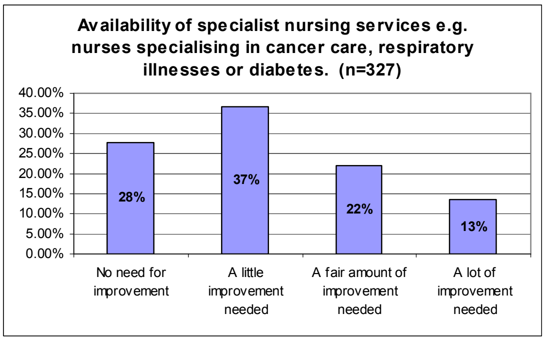


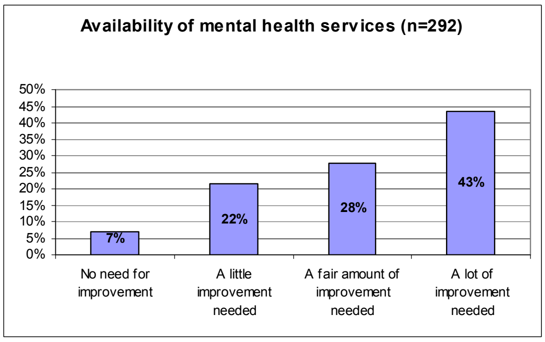


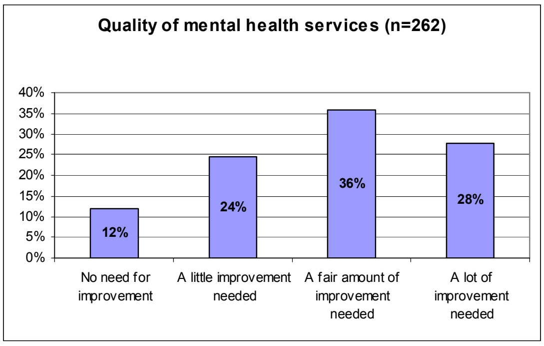

Time spent waiting in accident and emergency departments (A&E) (n=538)

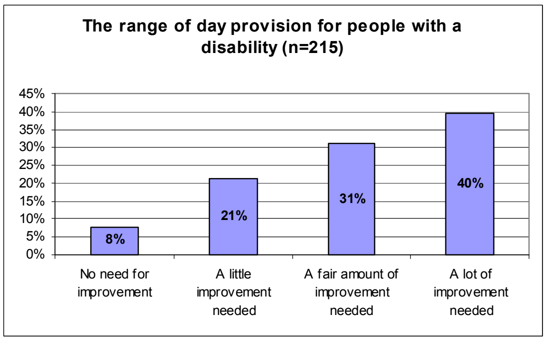

Accessibility of accident and emergency departments (A&E) (n=541)

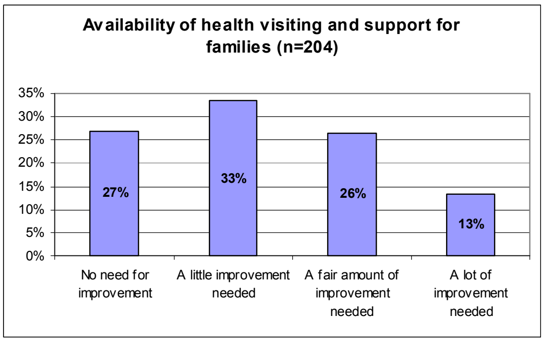

Quality of care in hospitals (n=547)

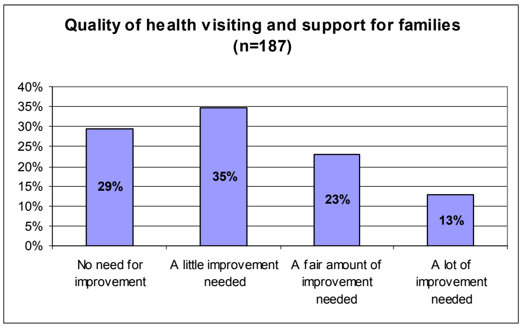

Availability of specialist nursing services e.g. nurses specialising in cancer care, respiratory illnesses or diabetes. (n=327)

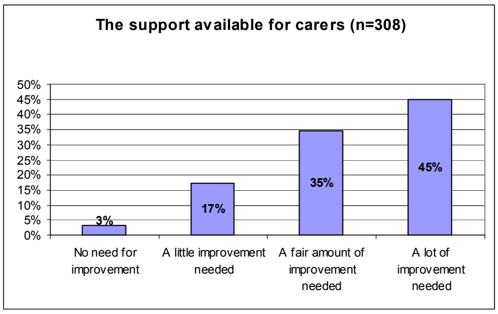

Availability of mental health services (n=292)

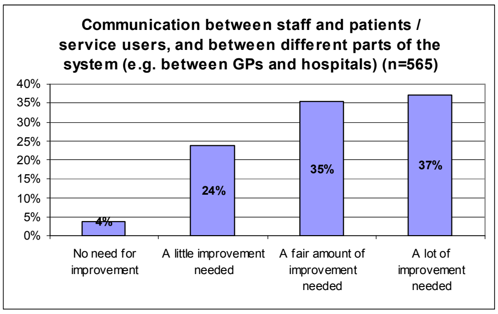

Quality of mental health services (n=262)

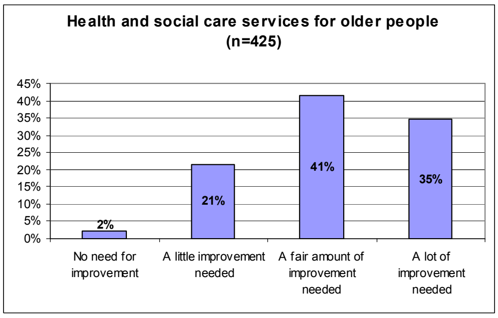

The range of day provision for people with a disability (n=215)

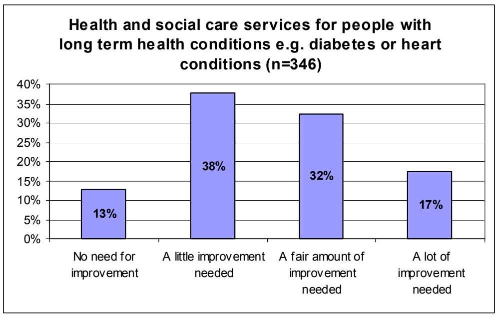

Availability of health visiting and support for families (n=204)

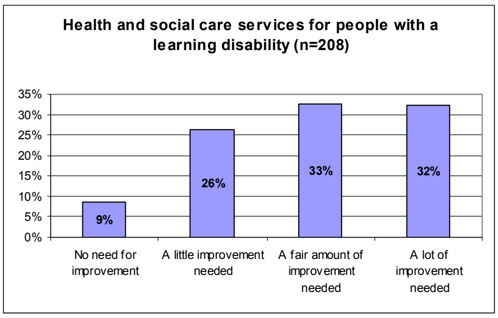

Quality of health visiting and support for families (n=187)

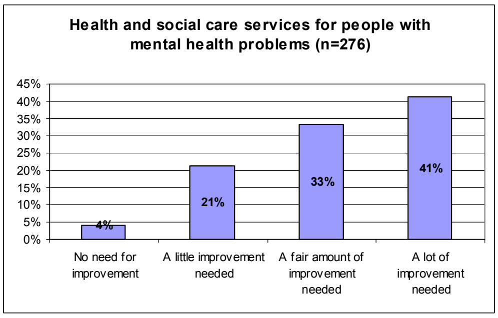

The support available for carers (n=308)

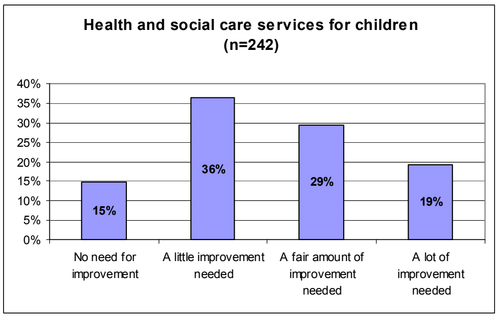

Communication between staff and patients / service users, and between different parts of the system (e.g. between GPs and hospitals) (n=565)

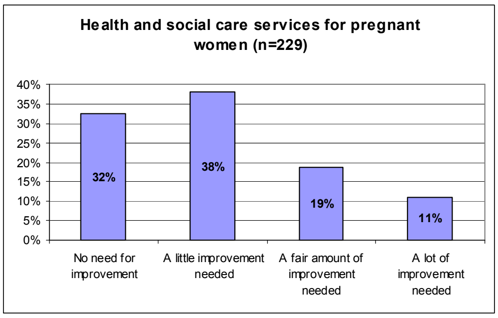

Health and social care services for older people (n=425)

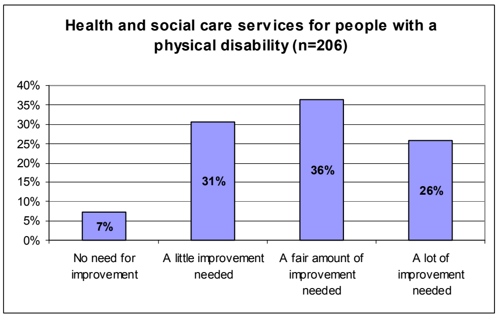

Health and social care services for people with long term health conditions e.g. diabetes or heart conditions (n=346)

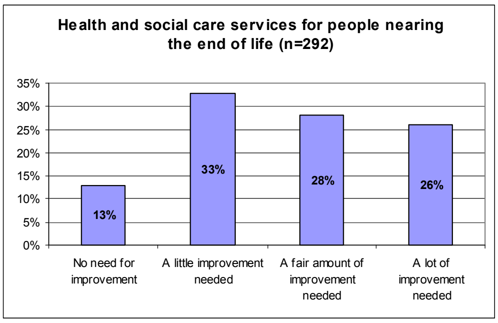

Health and social care services for people with a learning disability (n=208)


Health and social care services for people with mental health problems (n=276)


Health and social care services for children (n=242)


Health and social care services for pregnant women (n=229)


Health and social care services for people with a physical disability (n=206)


Health and social care services for people nearing the end of life (n=292)

Suggestions for Improvement

Quality of Medical Treatment by GPs

- Promote use of IT / access of information from other systems / electronic records for better decision making
- Improve communication across primary and secondary care / GP to GP / with patients & families
- Increase accessibility (extend opening hours) - evening and weekend clinics
- Training - skilling up especially in relation to Mental Health & Learning Disability, depression; keep skills up to date
- Improve interpersonal / customer care skills – especially listening skills, empathy
- More time for each appointment
- Continuity of GP
- More GPs
- Provide advice service - Use of other systems to provide advice e.g. telephone system, emails
- Use of Nurse to triage

Length of Time to get an appointment with a GP

- Increase accessibility (extend opening hours) - evening and weekend clinics
- Walk in Clinics (no appointments required)
- More GPs (and more Female GPs)
- Penalties for patients who ‘Did Not Attend’ (DNA) – use of reminder system
- Use of Community Pharmacist for minor ailments (German / Austrian Model)
- Provide help lines (may reduce demand for appointments)
- Increase role of the Practice Nurse / Triage Nurse / Triage service
- Improved system for making appointments (EMIS / online systems)
- Train receptionists re customer care skills
- Better sharing of information

Waiting time for assessment of home help home nursing or residential care

- Increase staff / resources / fill vacant posts
- More efficient use of resources
- Better process for assessment and implementation of services
- More funding
- Review ‘need’ – this may change / decrease
- Less bureaucracy
- Person centred / holistic approach

Waiting time for equipment

- Better procedures required for tracking and return of equipment e.g. central register of equipment; Trusts set target for return / recycling; patients pay deposit or application of financial sanctions for damage / non return (seems to be big issues with respect to trying to return equipment)
- More staff required particularly Occupational Therapists (OTs) and improved management of teams
- More resources for equipment purchase
- Faster appointment process

Quality of nursing care at home

- More time allocated per call
- More staff / resources
- Training of staff
- Increased use of Community Pharmacy
- Continuity
- Random audits / inspections and better regulation required
- Sign posting

Quality of home help services

- More time allocated per call – 15 minutes is not enough
- Training – a wider skills remit by staff and care plans to be held at home to indicate what carer has to do
- Increased use of Community Pharmacy
- Continuity
- More staff/ more resources / better pay = better service
- Increased funding – possibility of patient contribution
- Regulation
- Implement a register of carers - Trust service better than private.

Quality of Residential Care for Older People

- Improve regional standards of care especially for Dementia
- More staff
- Person-centred / holistic approach to provision including assessment on admission
- Random inspections
- More space / activities including crafts, stimulation to keep minds active etc
- Staff training especially re stroke
- More homes
- More money
- Better facilities including hygiene
- Direct payments – enable patient to make own decisions re care

Hospital waiting times for a non emergency operation

- Increased use of Community Pharmacy
- More staff (= more appointments) / more investment in staff to do scans etc
- Increased funding / use of Integrated Clinical Assessment and Treatment Services (ICATS)
- Prioritise waiting list using emergency and non emergency
- Up-skill staff
- Use/make better use of cancellation lists; deposit system (fines for DNAs)
- Improve, maximise theatre efficiency (including number of slots / evening and weekend appointments)
- NHS do NHS work - stop NHS consultants doing private work
- Employ Cardiac Paediatrician and stop sending to Birmingham and Dublin
- Improve communication
- Implement IEAP properly
- Bigger A&E departments and less of them
- St Thomas's

Waiting times for an appointment with a hospital consultant

- More consultants / specialists/ clear backlogs / increased training for these; more staff generally
- No private work
- More appointments (evening and weekends)
- Improved coding on new/review system / clarity on partial booking system
- Use of ICATS
- Expand Nurse led appointments /clinics
- Penalties for DNAs
- Improve communication
- Training for community specialists
- Telemedicine

Time spent waiting in A&E departments

- Reduce inappropriate referrals / attendances - educate public re appropriate use of A&E
- Use of specialist teams for improved triage – redirect to community as appropriate
- More staff and resources
- Improve communication re how long can expect to wait
- Long waiting times may be ameliorated through use of walk in centres / extended GP hours
- Use of a nurse led helpline to signpost public to correct department

Accessibility of A&E departments

- Improve local accessibility - stop closing local A&E Departments
- Address car parking including for disabled
- 24/7 opening hours including for Minor Injury Units
- Delivery of X-rays etc in other settings

Quality of care in Hospitals

- Improve hygiene
- Person centred care – more assistance with basic care e.g. eating, drinking, (dieticians), toileting
- Bring back matrons, senior nursing staff
- Address staffing shortages / more frontline staff doing the ‘nursing’
- Ensure all are treated with dignity and compassion – improve staff attitudes and morale
- Improve communication
- No mixed wards
- Look at OASIS system in South Australia for IT

Availability of specialist nursing services e.g. nurses specialising in cancer care, respiratory illness or diabetes

- More specialist nurse are required – more training
- Ensure equity of access geographically and for conditions – same as for cancer, and 24/7
- Roll out concept of Expert patient

Availability of Mental health Services

- Implement Bamford
- Investment needed for respite services
- Home treatment teams
- Improve access (for all age groups; 24/7; Learning Disabled) and signposting
- More resources (in the community) & staff
- Increased co-ordination
- Targeted resources
- Enhance understanding by GP

Quality of mental health services

- More investment & staff (Community Psychiatric Nurses (CPN), Cognitive Behavioural Therapists, Psychologists etc))
- Bamford
- Continued emphasis on recovery
- Holistic, multidisciplinary approach must be adopted
- Increased role of Community Pharmacy

- Improve Child and Adolescent Mental Health Services (CAMHS) and Older People's services
- More community initiatives
- Early intervention
- Reduce waiting times

The range of day provision for people with a disability

- Improve the range of activities including daily living skills / increased provision and more choice / appropriate activities
- Remove the age link with this service / increase the opportunity for younger people / for those aged over 65yrs
- Increase capacity provision and choice
- Person-centred
- More availability for brain injury
- Alternatives to daycare e.g. employment schemes; day therapy sessions / community development approaches
- Personalised budgets

Availability of health visiting and support for families

- Need for more health visitors
- Need for more resources
- Increase support provided by health visitors especially in first few weeks for new mums
- More links with Surestart
- Targeted approach for those in need (or at risk) of the service
- Health visitors directly employed by GPs

Quality of health visiting and support for families

- More staff, resources, training
- Provision of more support for families with young children and families, families with disabled children
- Improve communication

The support available for Carers

- More respite opportunities (more respite, regularly) / more funding for respite that is adequate and suited to needs
- Implement carers strategy
- Training for Carers
- Befriending schemes
- Financial reward
- Use of a key worker / advocate
- Use of voluntary sector to provide support
- Bank staff to cover illness
- Increase the awareness of support available to carers

Communication between staff and patients / service users, and between different parts of the system (e.g. between GPs and hospitals)

- Greater use of Technology and electronic methods for communication, prescribing etc
- Use of central information systems (1 system) / files / online patient notes
- Use of patient passports for some conditions
- Electronic Care Record
- Timely communication / openness and honesty
- System link up
- Proactive sharing of information
- User forums

Health and social care services for older people

- Increased use of private sector
- More community services
- Proactive in reach services
- More Nursing homes (to cope with changing demographics); more home help / care packages
- Explore cross border models
- More staff / more resources / more funding
- Person-centred care
- Community development / healthy lifestyles
- Right service, right time, right place

Health and social care services for people with long term health conditions e.g. diabetes or heart conditions

- Self management
- Education on risk management / healthy lifestyles and choices
- Early intervention
- Use of Community Pharmacists (for blood tests/fasting glucose etc)
- Specialist clinics, management by GPs, patients and Nurses in community / 24/7 availability
- Incentives such as paid gym memberships, slimming world etc
- Use of / explore alternative drugs
- Same level of services as for Cancer
- More community based rehab teams
- Rapid access to tests, treatments and surgery to prevent co-morbidities

Health and social care services for people with a learning disability

- Forward planning for individuals with a Learning Disability
- Use of Community Pharmacy

- Review of services for Learning Disability required including those provided by private sector
- More resources including rehabilitation, OT, and respite
- Improve communication and listening
- Multi-disciplinary and person-centred approach
- Implement Bamford
- Training for staff
- More community based services, including day care opportunities, befriending schemes, domiciliary care, training schemes and workshops.
- More support for families and carers
- Improved provision of supported housing for independent living

Health and social care services for people with mental health problems

- Improved access to services generally (24/7) and with respect to Clinical Psychology services
- Involve family
- Involve community services including Pharmacy and CPN
- Better training for mental health nurses
- More resources and staff (including specialists and CBT therapists), to aid early diagnosis and prevention, and continuity of care
- Better acute care provision
- Improved communication
- Implement Bamford – more funding
- More support for 18-25 year olds

Health and social care services for children

- Education / accessibility
- OT in CAMHS services
- Early intervention / prevention
- Inclusive policies /services
- Acknowledge extra support needed for disabled children /more services for Autistic children
- Listen to children and families / Involve parents
- More money/staff
- More school nurses
- More support through Allied Health Professionals (AHPs)
- Locally available services

Health and social care services for pregnant women

- Provide more comprehensive advice e.g. risk behaviour / health improvement / healthy choices – smoking cessation campaigns / alcohol / breast feeding etc
- Continuity of care for individual; consistency across region

- Support for women in general, and for those with mental illness
- More Midwives /direct access in community
- Targeted services for young expectant mothers
- Tailored accessible services for women with a learning disability
- Customer care training for Midwives
- Regular timely access to scanning throughout pregnancy – women should not be allowed to go over due dates
- Patient choice – but safety comes first.
- A little negativity re Midwife led units

Health and social care services for people with physical disability

- Multi-disciplinary and client-centred approach
- Care / Care teams should cater for individuals not age groups / consider children aged 14-18 who sits between paediatrics and adults
- Improved access to AHPS
- More resources / more respite services
- More accessible appointments
- Look at good practice / models e.g. Cedar Model

Health and social care services for people nearing the end of life

- More home support e.g. care packages to die at home or preferred place
- Open honest debate / listening to needs / wishes of patients / choice / allow patients to be part of the end of life plan
- More resources including hospice beds, District Nurses
- Use of Pharmacists
- Provision of Palliative Care teams to all people and allow to die with dignity
- Multidisciplinary approach /Specialist Nurses
- Palliative care for Learning disability
- Training for all involved
- More support for families / bereavement
- Same level of services as is for cancer
- Signposting – who to contact
- More staff –e.g. Palliative nurses
- More co-ordination –palliative nurses used as key workers

If you could make 3 changes to improve health and social care in Northern Ireland, what would they be?

Main themes

- More staff generally, more nurses and AHPs
- Reduce waiting times
- Improve communication
- Improve access to GPs
- Focus on health promotion / prevention; address alcohol as a public health issue
- Improve communication
- Increase local accessibility of services
- Improve hospital and community services for older people
- Reduce the number of managers and reduce paperwork
- Introduce charges for prescriptions, other services including meals in hospital, missed appointments,
- Improve services for learning disabled and their families carers including respite care
- Improve mental health services
- Staff training
- Better use of technology
- Bring back matrons
- Community Pharmacy
- Improve roads infrastructure
- More money
- Educate people to support themselves
- Fewer managers and less bureaucracy
- Decentralise where possible
- Enhance staff morale
- Interworking - enhance cross border working
- Increase involvement of community and voluntary sector
- Family support services
- More hospice and palliative care

Do you have any other suggestions for the future provision of health and social care services in Northern Ireland? For example this may relate to how accessible services are, the quality and safety of services, or the health outcomes achieved.

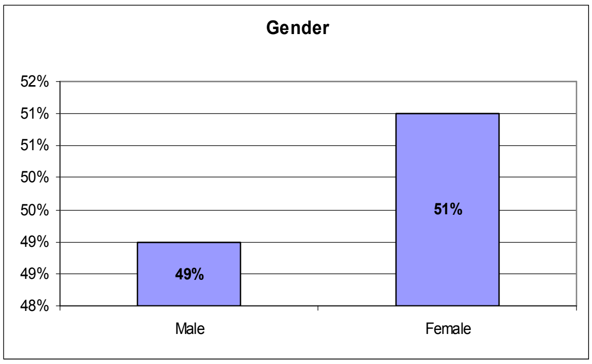
The responses given were variable and quite detailed. A very high level summary of some of the emerging themes are listed below:

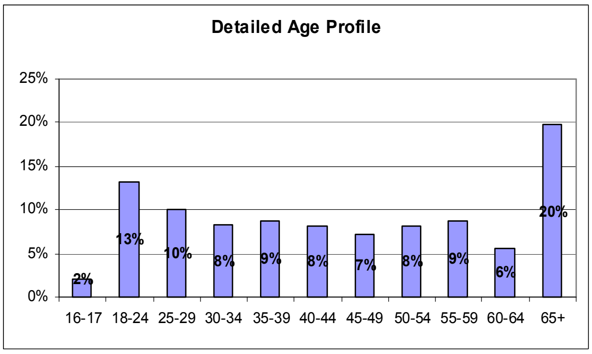
- Improve services for learning disabled and their families /carers
- Address alcohol as a public health issue
- Promote the use of Independent sector
- Reduce waiting lists
- Better use of Community Pharmacy services; more funding for Community Pharmacy services
- Better use of available services and facilities
- Promote / establish links within communities to combat loneliness
- Investment in resources / equipment
- More local services
- Introduction of charges (e.g. prescription charges)
- Equality of access for all in NI
- Invest in carers
- Invest in health promotion / prevention – make public responsible for their own health, start early; educate in schools to get public health message across
- Increase range of services offered by GPs / GP practice teams
- Stop closing A&E departments
- Reduce emphasis on targets and re focus on patient
- Fewer Managers
- Health care planning at local level
- Improve roads infrastructures thereby improve access to a range of services
- Enhance skills mix
- Improve GP accessibility
- Provision of quality training and communication
- More OTs
- Optimise use of technology
- Reconsider current location of some hospitals
- National health service for older people and those with disabilities
- Improve reporting times for diagnostic tests
- Less focus on waiting lists targets / find better ways to monitor waiting lists
- Reduce waste; reduce wastage with regard to pharmaceuticals
- Utilise skills in the community such as GPs, Pharmacists
- Better utilisation of AHPs
- More use of voluntary sector / community based services who can do the job for less
- Improve appointment systems
- More money needed

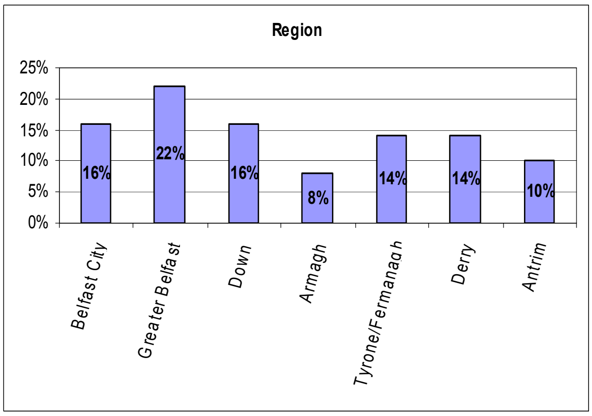
- Improve access to services for at risk youth
- Longer home help sessions
- Mobile clinics for hard to reach areas

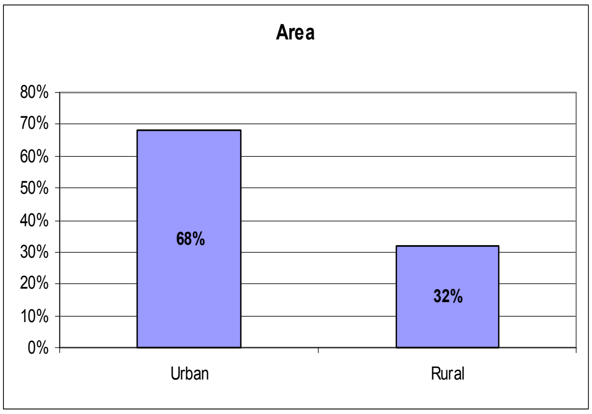
Appendix 3
Household Survey Summary of Results

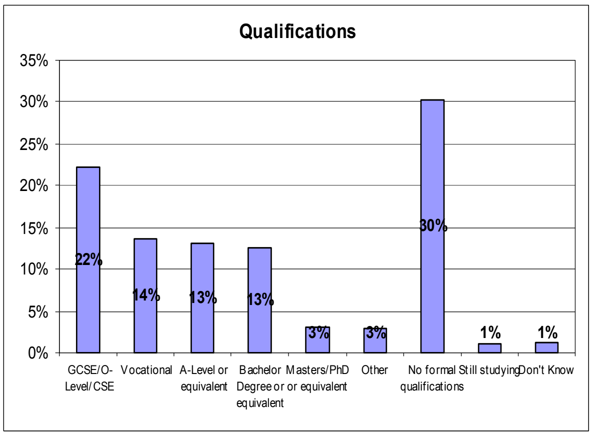
Profile Data

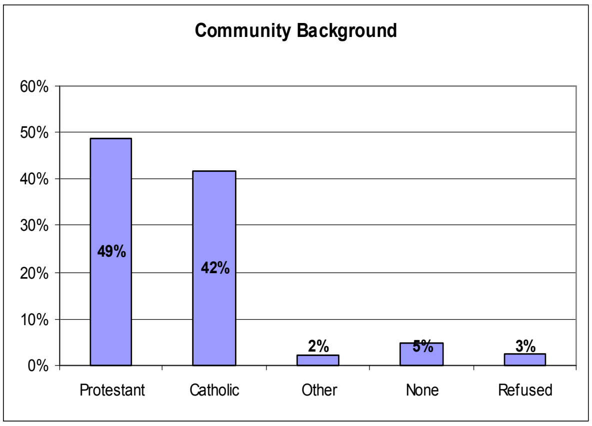


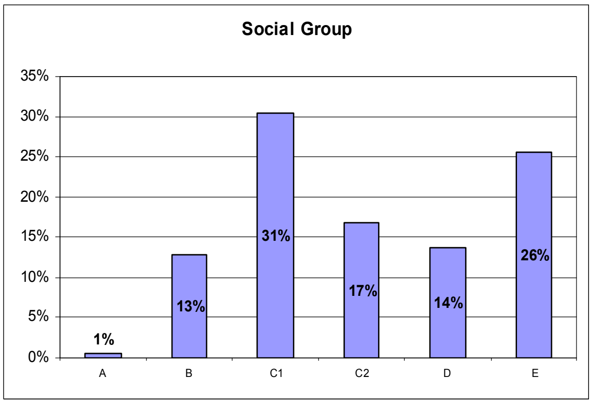


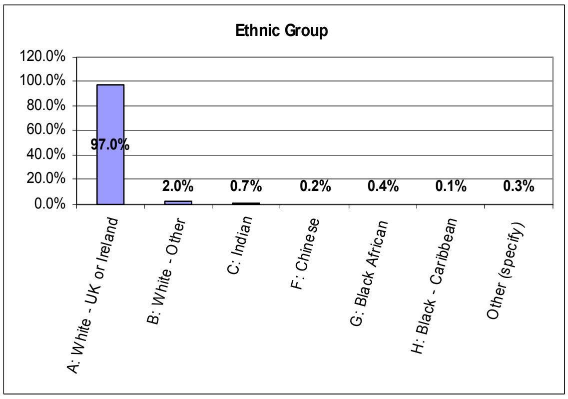






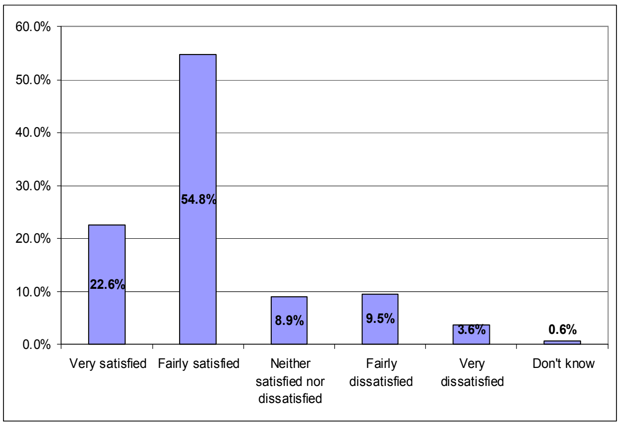


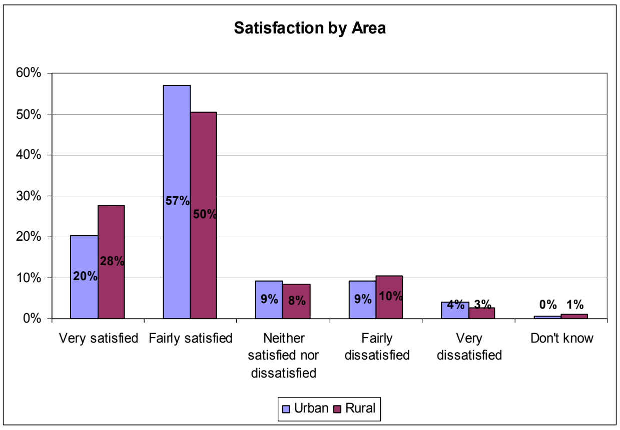


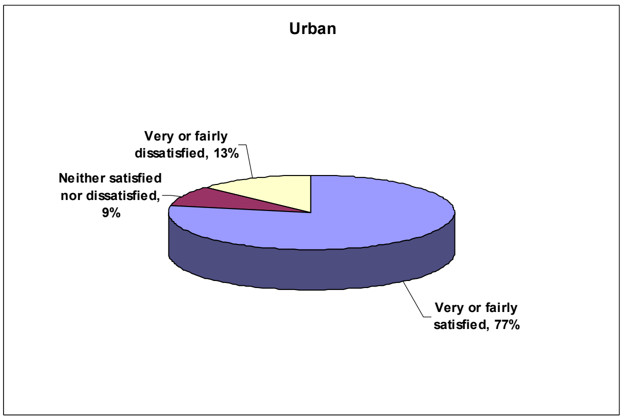


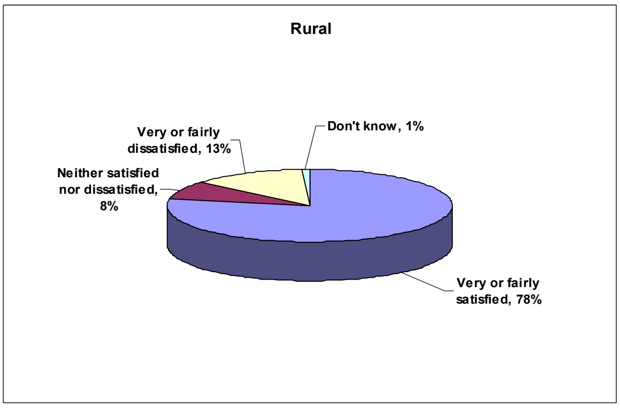
Question Responses

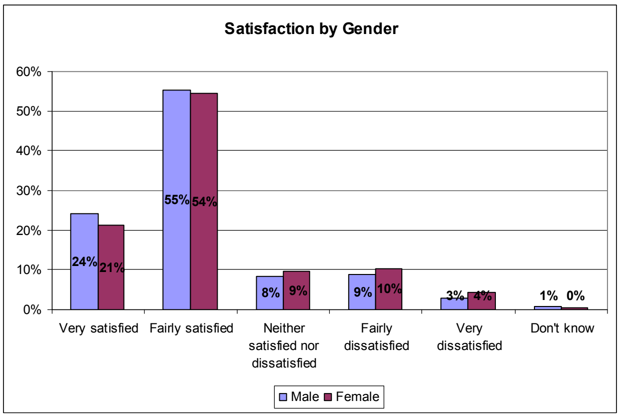
1. Overall, how satisfied or dissatisfied are you with health and social care provision in Northern Ireland at present?

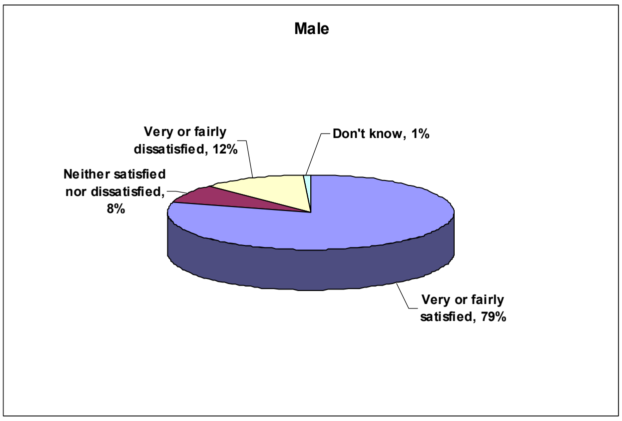


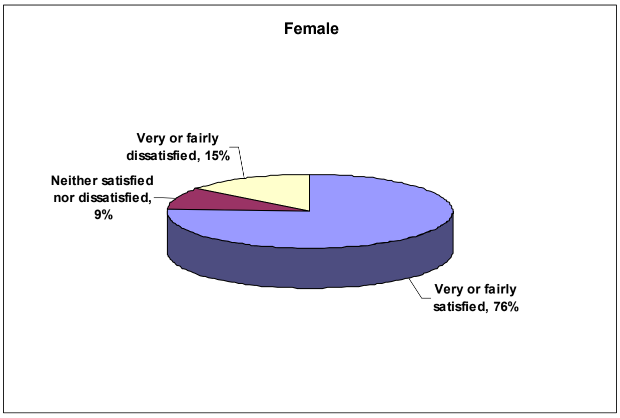


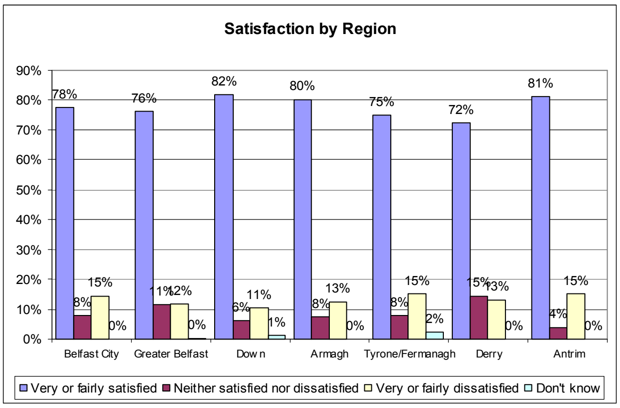




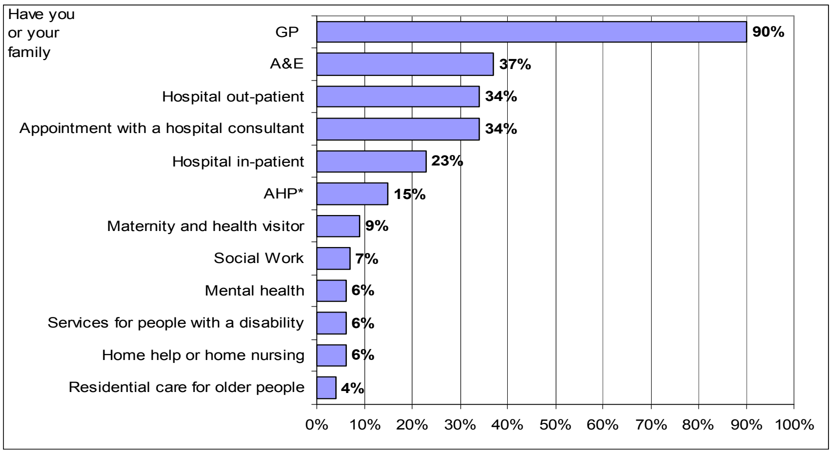




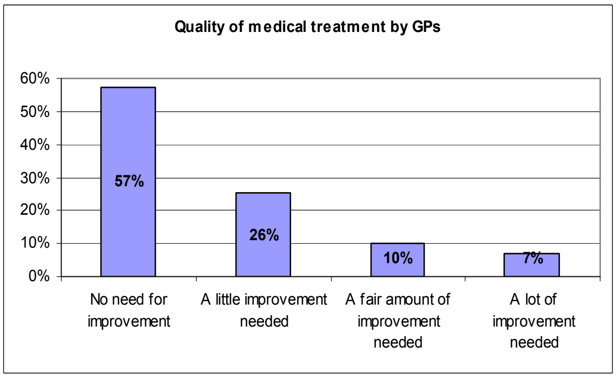


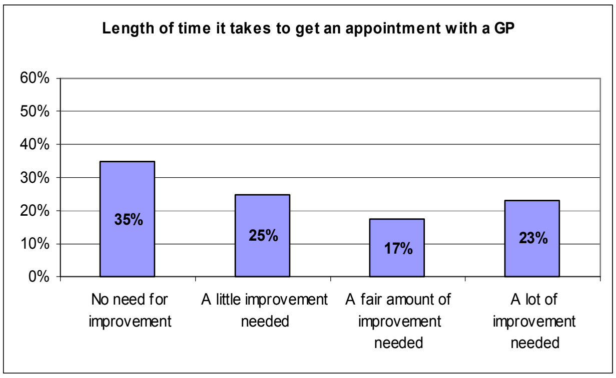


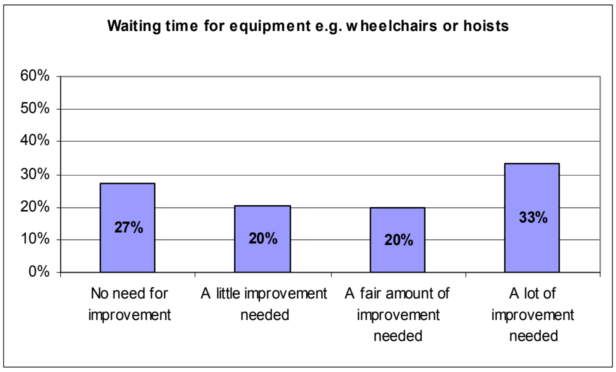
2. Have you or your family used any of these health and social care services in the last year?

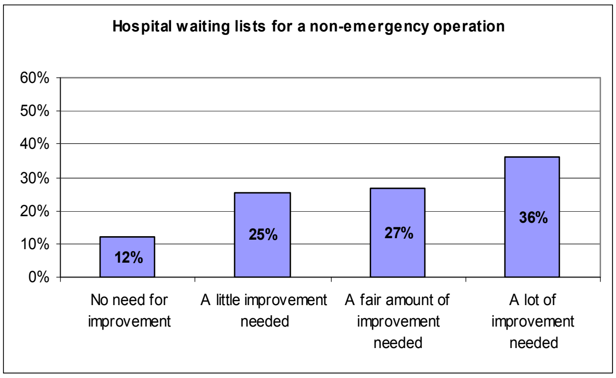


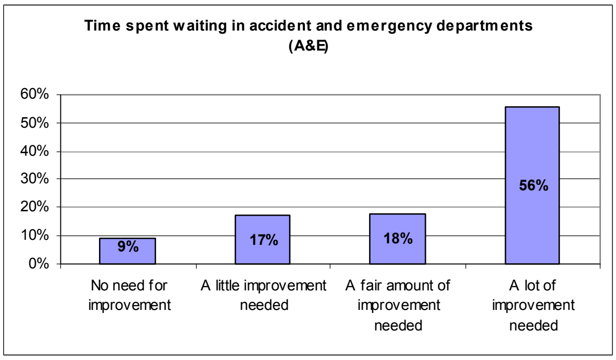
3. How would you rate the following aspects of Health and Social Care in Northern Ireland in terms of whether they require improvement or not?

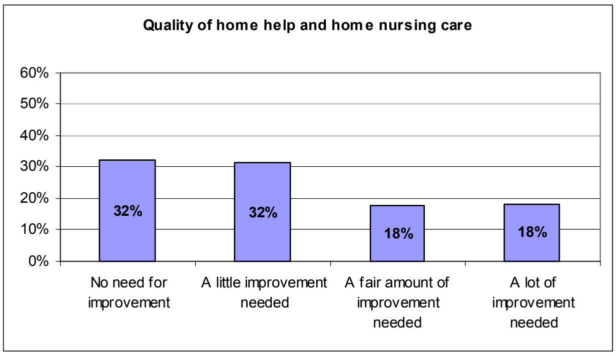

Quality of medical treatment by GPs

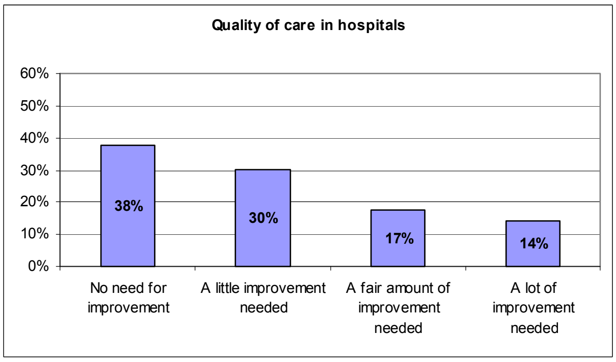

Length of time it takes to get an appointment with a GP

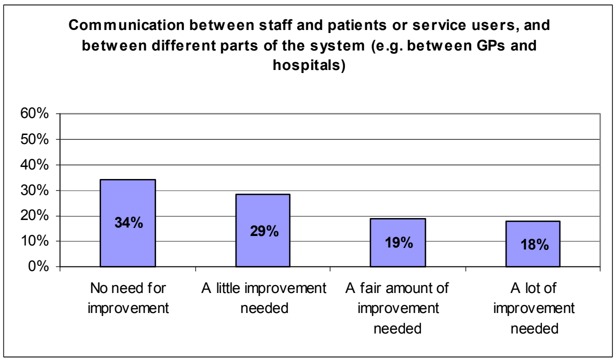

Waiting time for equipment e.g. wheelchairs or hoists

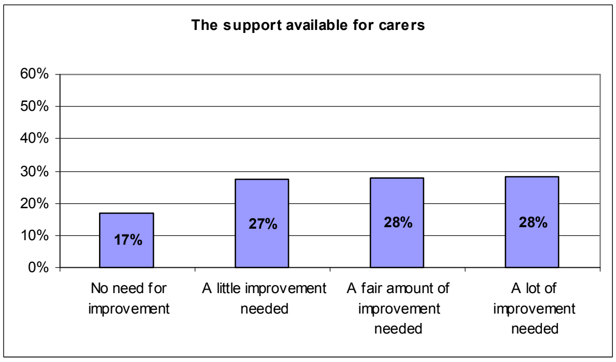

Hospital waiting lists for a non-emergency operation


Time spent waiting in accident and emergency departments (A&E)

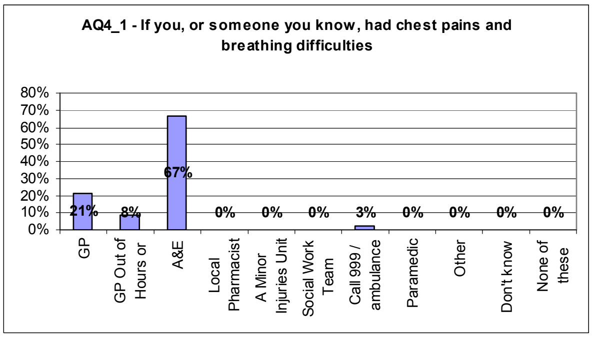

Quality of home help and home nursing care

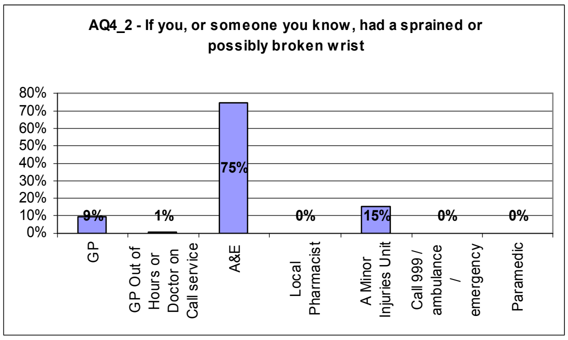

Quality of care in hospitals

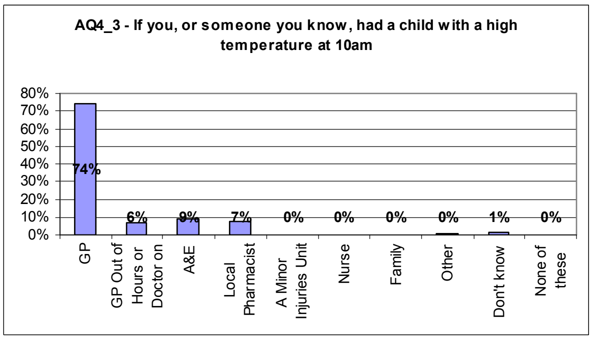

Communication between staff and patients or service users, and between different parts of the system (e.g. between GPs and hospitals)

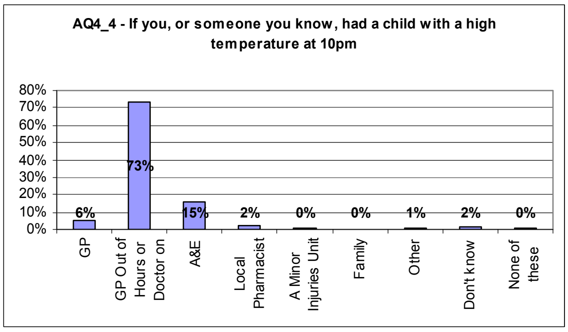

The support available for carers

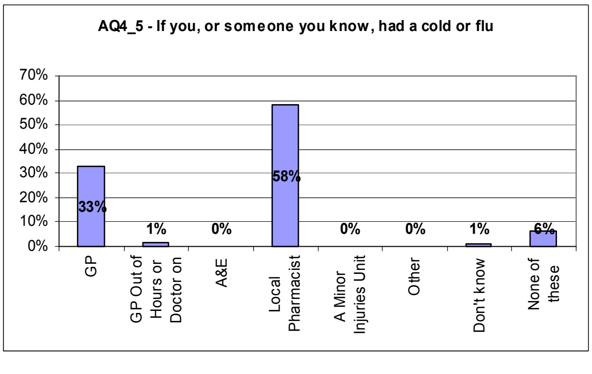
4. Which one of these services would you be most likely to go to in the following circumstances?

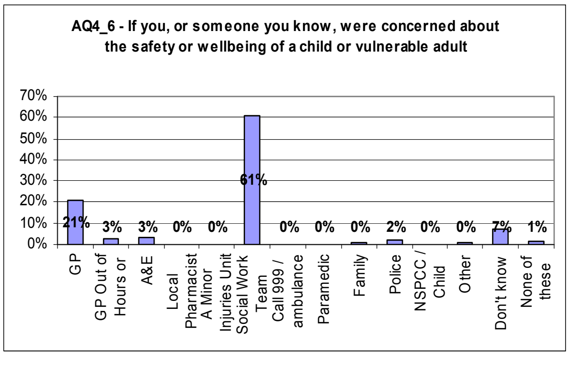

AQ4_1 - If you, or someone you know, had chest pains and breathing difficulties


AQ4_2 - If you, or someone you know, had a sprained or possibly broken wrist

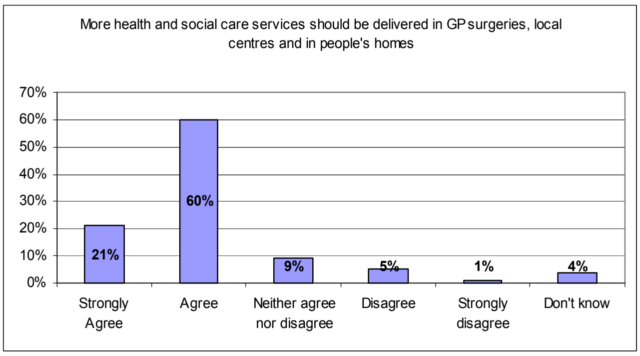

AQ4_3 - If you, or someone you know, had a child with a high temperature at 10am

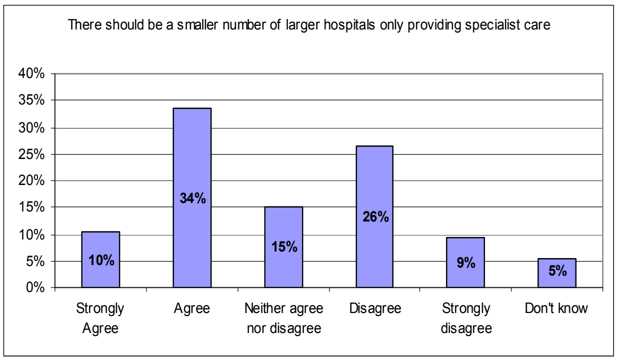

AQ4_4 - If you, or someone you know, had a child with a high temperature at 10pm

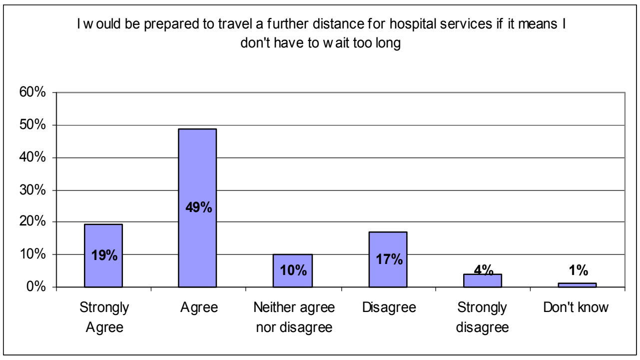

AQ4_5 - If you, or someone you know, had a cold or flu

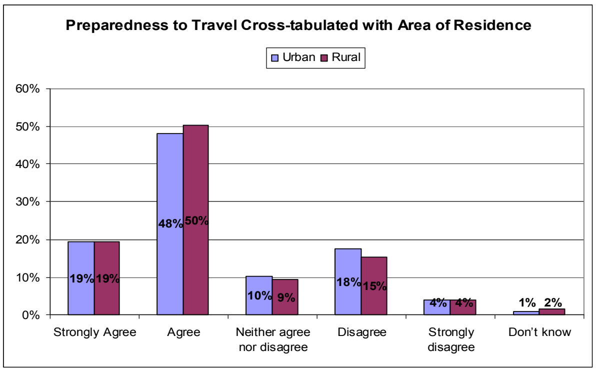

AQ4_6 - If you, or someone you know, were concerned about the safety or wellbeing of a child or vulnerable adult

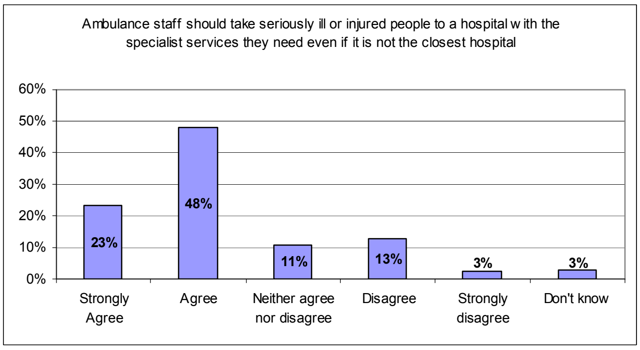
5. To what extent do you agree or disagree with the following statements?

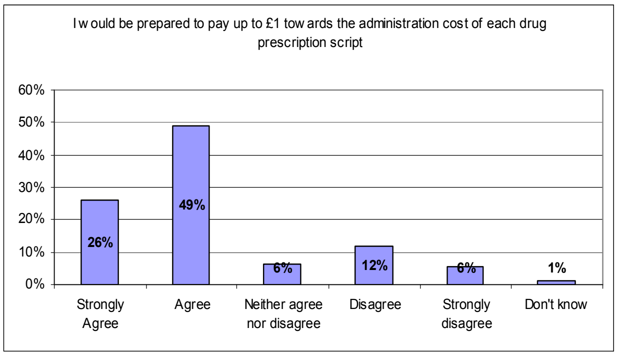

More health and social care services should be delivered in GP surgeries, local centres and in people's homes


There should be a smaller number of larger hospitals only providing specialist care

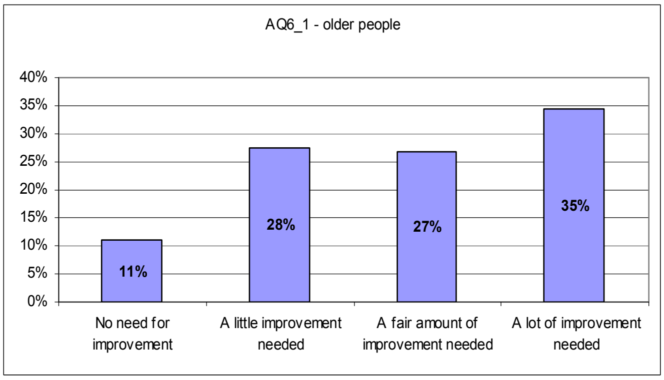

I would be prepared to travel a further distance for hospital services if it means I don't have to wait too long

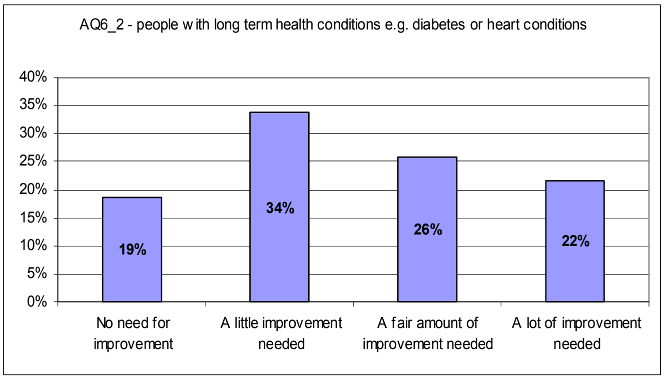

Preparedness to Travel Cross-tabulated with Area of Residence

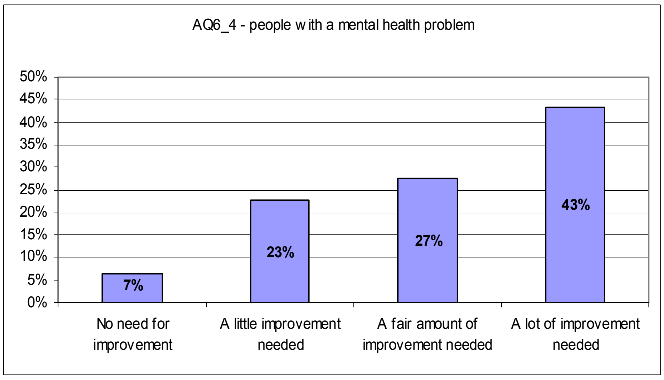

Ambulance staff should take seriously ill or injured people to a hospital with the specialist services they need even if it is not the closest hospital

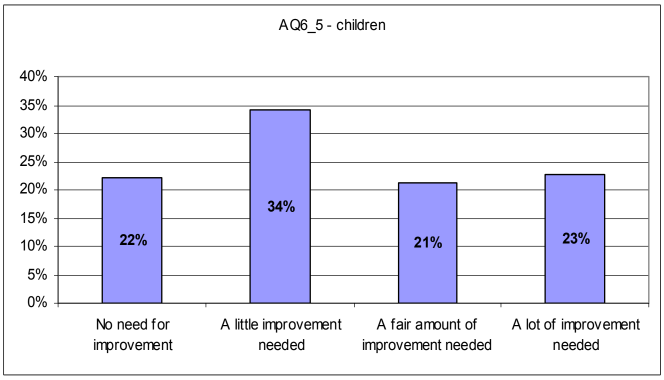

I would be prepared to pay up to £1 towards the administration cost of each drug prescription script

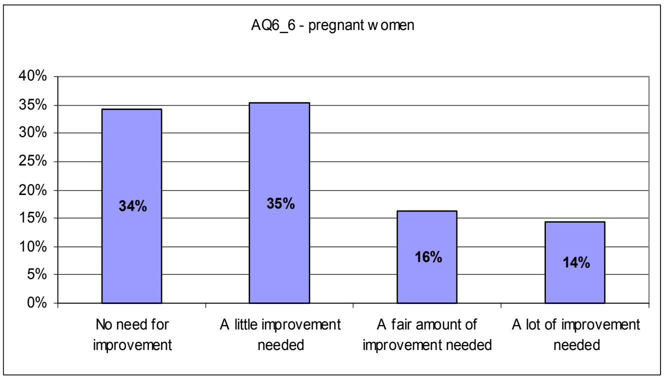
6. How would you rate the health and social care services provided for these groups in terms of whether they require improvement or not? Health and Social Care Services for:



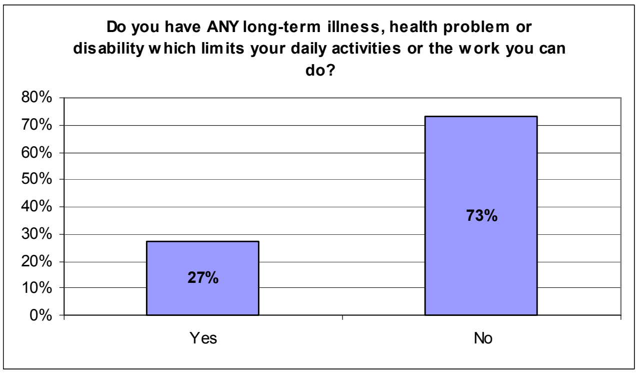


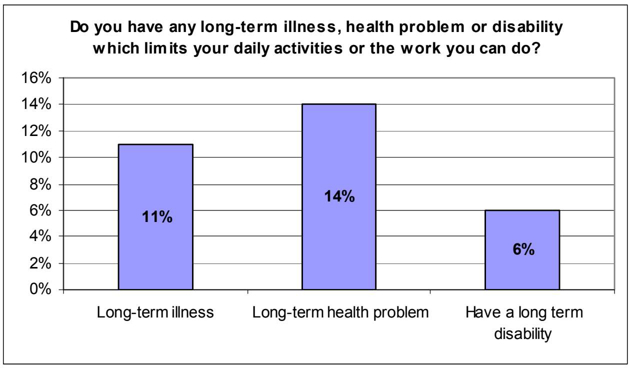




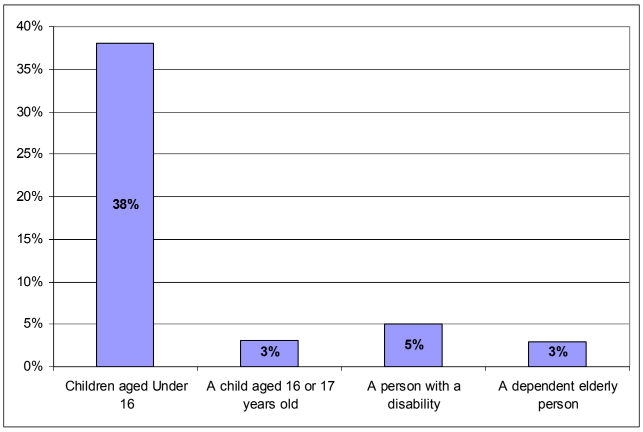


10. Do you have any long-term illness, health problem or disability which limits your daily activities or the work you can do?

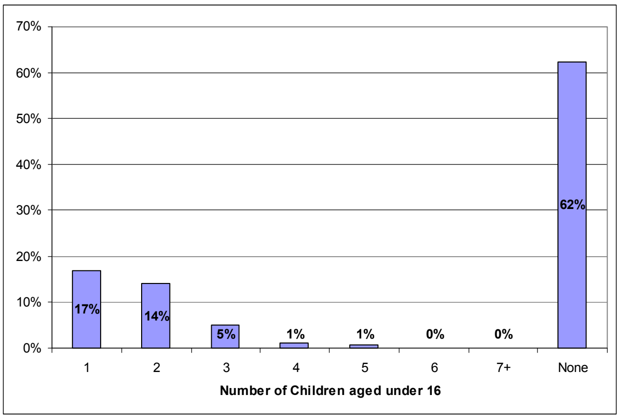




11. How many Children aged under 16 are there in your household, and do you have personal responsibility for the care of any of the following:



How many children aged under 16 are there in your household?



If you could do one thing to make health and social care services better what would it be?

Theme	No of responses	% of Total
More staff / no cutbacks on staff	126	11%
Don't know	120	11%
More money / spend money more wisely	81	7%
Shorter waiting times for GP / hospital appointments	77	7%
Reducing waiting times (general)	77	7%
Other	64	6%
Nothing	62	6%
Cut back on managers	41	4%
Keep services local / accessible	37	3%
Shorter waiting times at A&Es	34	3%
Better care for the elderly	29	3%
Improved care	24	2%
Cut down on bureaucracy / admin	23	2%
GP/doctor more accessible	23	2%
Better communication with patients / more information	22	2%
Better qualified staff / improve training	21	2%
Better mental health provision	17	2%
More flexible / longer opening hours for GPs	16	1%
More / better equipment / services	15	1%
Improve pay for nurses/doctors	14	1%
Improve A&E services	14	1%
Improve efficiency	14	1%
Keep hospitals open / more hospitals	13	1%
Bring back matrons	13	1%
Improve communication between GPs and other departments	11	1%
Cleanliness of facilities	11	1%
Making people more aware of services	10	1%
More services for children	10	1%
Keep A&Es open 24/7	9	1%
Longer opening hours for hospitals	8	1%
More beds in hospitals	7	1%
Access to specialists	7	1%
Penalties for missed appointments	6	1%
More community care / voluntary services	6	1%
Avoiding further cuts	6	1%
Consult with the public	5	0%
Fee for prescriptions / money wasted on prescriptions	5	0%
Open A&E at Lagan Valley	5	0%
More coverage in rural areas	4	0%
Improve follow-up care	4	0%
The way HSCNI is run	4	0%
Consistency of care	3	0%

Improve ambulance services	3	0%
Improving services for people with disabilities	3	0%
More time spent with patients	3	0%
More call outs	2	0%
Access to medical records	2	0%
Better working conditions	1	0%
Best practice in other countries	1	0%

Appendix 4
Questions Raised at Public Meetings

Questions Raised at Public Meetings

Tuesday 8th November 2011 at 7pm
Great Hall, Magee Campus, University of Ulster

- Mental health services have always been the "Cinderella" and are currently ten years behind UK funding levels. Will the Review Panel bring this to the notice of the Minister?

- How can the Review Team ensure relevant follow-up after care for services which take place elsewhere and are not sustainable in NI e.g. follow up for transgender people who have had surgery in other parts of the UK?

- The necessity for provision of respite care to go someway to alleviate massive carer stress and in order to allow carers to continue looking after loved ones in the community.

- How can you ensure quality of care with continual use of locum/agency staff when so many qualified practitioners/service providers are desperately seeking employment?

- Does the Panel feel that it may be time for a shift to a more social, rather than medical model of care, due to the ageing population?

- What consideration will the Health and Social Care Board be giving to building working relationships with the Health Service Executive in the Republic of Ireland in order to secure efficiencies in Service Delivery?

- Does the Panel have a view on the impact of the poor infrastructure in NI (i.e. lack of adequate rail link) on health care provision for people in the North West?

- How should the Department commission services for uncommon/rare conditions?

- Is there any recognition that we have just come out of 'conflict' and that health (especially mental health) is affected?

- Regarding mental health services, are there any plans to shift some of the budget to address the "Cinderella" service?

- Why do mental health patients go through A&E – why not have a mental health emergency room?

- How can commissioners support research to gauge the effectiveness of community interventions, which often do the most to promote inclusion but struggle to attract secure resources?

Wednesday 9th November 2011 at 7pm
Omagh Enterprise Centre, Omagh

- Why are there going to be hospital cut backs – particularly when new ones are being built but there is no money to run them?

- There is a growing emphasis on children's rights at the expense of the wishes and consent of parents. What protection will there be for the rights of parents?

- In the light of funding being withdrawn from the A5 (Derry – Aughnacloy Rd), can the Review Team use its influence to transfer the funding to the Omagh – Enniskillen (Hospital) Rd?

- Transport services to and from hospital is very poor. Older people refuse to go into hospital as they have no service to bring them home once discharged. Are there any plans to address this?

- What will the Review do to address Mental Health services as funding at present is inadequate?

- What are your greatest frustrations as a GP in a rural area (Dr. Gallagher) and what anxieties have you for our services over the next 5 years?

- The Review Team suggested a further shift of care from secondary into primary/ community care. How are planning to address the issue that primary care is already absorbing the bulk of care and there is no slack to be taken up?

- Why do we need a Board, and why do we need Trusts which have been allowed to become too powerful?

- Hospitals are not placed in the correct areas or take into account hospital across the border.

- How are hospitals going to be run? For example, the Erne has had its services cut back from what was promised.

- Communication is inefficient everywhere in the system. How does the Review plan to address this?

- Why are we not looking to innovation to reduce costs?

- Why don't the Patient and Client Council get a report from every patient after they visit a hospital?

- Can we have a nurse led midwifery stand alone unit at Enniskillen hospital?

- The Review should be carried out for the right reasons and not for an easy option. For example, safeguarding services to put another service in danger.

- Can the Review look at equity of service provision? For example, maternity services.

- Will the Review be based on an identified needs approach?

- Can we have assurances that our Health Service will remain public and free?

- Will all new initiatives be equality checked?

- Can we have assurances that the UK Health and Social care Bill will not be introduced?

- Will the Review look at statistics from the Trust Delivery Plans?

- How does the Review plan to reduce hospital bed waiting times at A&E?

Monday 14th November 2011 at 7pm
Ballymena Showgrounds, Ballymena

- There is a lack of good transport links for rural areas. How can equality be achieved for the socially poor who are left with no access to acute hospitals?

- How can HSC and society do more to protect the most vulnerable people e.g. victims of domestic violence, young and old?

- Has the Review looked at oral surgery services in primary and secondary care?

- Have there been any pilots set up to trial the emerging themes?

- How do you tackle resistance from consultants who use waiting lists to fund private practice?

- In the Northern Trust, the number of attendances and review attendances has dropped while there has been a massive increase in inpatients and daycases. We want to know what services are being given to us rather than taken away.

- The recommendations from the Comprehensive Spending Review were found to be untrue. How will you ensure this will not happen again?

- Has the Review Team engaged with community pharmacy and will it give a commitment to do so?

- With the planned closure of 100 pharmacies across the Province, how will this fit with the proposed move to primary care? What additional roles will community pharmacy have to take on?

- Will the Mid Ulster hospital receive the build and services it requires as stated in Developing Better Services?

- Are acute hospitals in the correct location to best serve patient need?

- Does the Review Team belie that a Rapid Response Vehicle is sufficient to fill the gap left by the closure of acute services in the Mid Ulster Hospital?
- Is it inevitable that fund shortages equal longer waiting times?

- What improvements can be made to case waiting times and welfare reports in relation to child abuse and acrimonious parental separation?

- Will the Review recommend making social workers give evidence under oath?

- Are there any plans to change the Dalriada Doctor on Call services within the Northern Trust i.e. move them to hospital sites?

Tuesday 15th November 2011 at 7pm
Assembly Buildings Conference Centre, Belfast

- What provision is in place in the Ulster Hospital, should it have to close, due to a super bug outbreak?

- What is the status of the McKinsey Report on/within the Review?

- Does the Panel see an expanded role for Multiple Sclerosis carers and would they be prepared to allocate some funding or shift in resources?

- The mandate is growth of domiciliary care. Is there any development in the funding?

- Do you feel that day care within the HSC Trusts is too cheap at £1.35 per day? Private day care is priced at £8 per hour.

- Out of 100 young people with severe learning disabilities leaving school each year in Northern Ireland, 20% with more complex needs have no choice but to attend a day centre – where is their choice for lifelong learning?

- Do the Panel feel that the cutting of jobs from Learning Disability services and not replacing day care workers is correct?

- Does the Review Team plan to address the short fall in Mental Health, as it is already underfunded by 44%?

- As an adult who has been diagnosed with a personality disorder, where is the promised help that the Bamford Report said was coming?

- During the Review is any thought given to the fact that we have 30% less cars here than the UK mainland and a transport system that stops at 9pm?

- What is the point in having a centre of excellence if it is located in an area unattainable to the public?

- What principles is the Review Team considering for the number of hospitals in Belfast and the services they provide? Will their funding be cut?

- What will be the acute status of all Belfast hospitals after the Review?

- Is the right to a second opinion still available?

- When one is a patient, can they be provided with a card that shows relevant standards for the service/treatment at issue? Patients don’t generally know what they can expect.

- Pharmacy is not mentioned in the Review. Has the Panel considered the benefits and quality outcomes that could be achieved in Primary Care by fully engaging with Community Pharmacy?

- As the Minister has indicated he wants to close 100 Pharmacies, how will that impact on Community Pharmacy’s ability to play its part in Primary Care?

- The Minister is on record of saying that there are 100 too many Pharmacies in NI. Has any consideration been given by this Review Team on the impact to the public if this was enacted?

- Why has Community Pharmacy not been covered by the Review?

- As Community Pharmacy is an integral part of the Primary Care team, has the Review Team any plans to engage with their representatives to obtain their view?

- Will the Review Team follow the Health Minister’s stated intention of privatising social care services?

- You discussed ‘evidence’ of health inequalities in our society. Do you have plans as to how to address these in lower socio-economic groups with shorter life expectancy? What does that mean in relation to services?

- Does the panel believe in the principles of the NHS i.e. free at the point of need for all?

- What criteria is the there for the quality of care for the elderly in nursing homes where business people are requesting staff to cut incontinence pads?

- There is often mentioned ‘interdepartmental working/interagency working’. Describe what that would look like if it were being done successfully across all government departments. What needs to change to make it happen?

- How innovative is this Review going to be e.g. in other parts of the UK there have been introductions for playgrounds for over 60s. Will this Review be as far ranging and looking at a whole systems approach to tackling health and social care?

- When you say the workforce needs to be ‘less professionally driven’ and be shaped more towards services, what do you mean?

- What are the plans to ensure that OT services should be developed as a core element of Child and Adolescent Mental Health provision as recommended by Bamford in 2006?

- Has the Review recognised the need to resource an already stretched frontline service with the means to treat individuals ‘in the right place, at the right time and by the right people’?

Thursday 17th November 2011 at 7pm
Lagan View Enterprise Centre, Lisburn

- Who cares for the carers with health?

- How is the Downe A&E organised overnight? Is this a model that could be adopted for Lisburn?

- If the City hospital is going to become a specialist centre for chronic conditions within Belfast, could Lagan Valley become a specialist centre in the South Eastern Trust area in the same way?

- Do the panel agree that transparency is key to any planned changes and what is being done to ensure this takes place?

- What are the likely outcomes of the Review for (a) patients/users and (b) health care professionals?
- What preventative measures can be taken to reduce the obesogenic nature of our environment?
- Providing screening and enhanced services in community pharmacy can reduce NHS costs through early detection and treatment. This can remove pressure from our secondary care sector. Does the Review agree?
- Will the Review take account of the work of voluntary sector organisations and the value for money that these organisations provide?
- The N.I Assembly budget ensured that there would be no cut to Learning Disability budget. Can you confirm that this review completely safeguards this?
- Can the Review Team ensure that the recommendations made in the Bamford Review will be implemented?
- With nursing posts not being replaced and sick leave and maternity leave not being covered – how can we ensure delivery of patient-centred care?
- Why are hospitals still run on a Monday to Friday basis with skeleton staff working at weekends?
- In other parts of the UK (e.g. Scotland), community pharmacy plays a much greater role in the provision of both core and enhanced pharmaceutical services. Does the Review envisage this as the way forward in N.I?
- There is clear evidence that O.T. led reablement services deliver positive outcomes. Can the Review Team ensure that such services will be available to all service users in N.I?
- What is the potential for 24hr cover again in Lagan Valley A&E? Can local GPs help to ‘man’ the department?
- How is the RVH coping with the extra patients from LVH and BCH?
- With an annual intake of 135 medical students in QUB, where have all the doctors gone?
- Is it possible to use GP trainee doctors to staff local A&E departments as part of their training?

- There must be concern at the much lower resource spend on children in NI than elsewhere in the UK. Can the Review identify ways to increase the priority of services for children?

- How will the system deliver a more caring service to cancer patients who are terminally ill and at home? Will you work collaboratively with other depts. e.g. DSD for better housing conditions?

- What interventions can be made to ensure much needed improvements in the delivery of home care packages?

- Does the Lagan Valley hospital have a future?

Wednesday 23rd November 2011 at 7pm
St Patrick's Trian, Armagh

- How many more reports do we need? What are you going to do differently?

- The Department of Education is planning a 0-5 Early Years' Strategy – will the Review seek to link in the Department of Health, Social Services and Public Safety's pregnancy-5years provision with the Department of Education strategy?

- Are LCGs fit for purpose and how much money has been used to date? Are we getting Value for Money?

- Is there an assurance that Allied Health Professions staff will still be valued as integral to the process of effective/safe discharge planning from the acute setting into community care, as the focus appears primarily to be on community sector?

- There is a lot of talk on radio of proposed Pharmacy closures – what is the timescale for these closures?

- Would the Panel consider it a missed opportunity that the role Community Pharmacy could play in bringing health to the community is not mentioned in the Review?

- Will the Review recommend extended roles for Community Pharmacy in managing patients in the community, services to prevent ill health, health promotion etc?

- What plans are in place for more supported living accommodation in Newry? It is badly needed within the next two years.

- Are there any plans in place to build more long-term accommodation in the Newry area?

- Carers are for many the backbone of the health and social care system. In return the system has promised to deliver support to carers when it is needed. This is supposed to be achieved by offering each qualifying carer a Carers Assessment. This requirement is one of the statutory functions of the HSC Trusts. However, many Trusts do not fulfil this requirement and many carers continue to carry out their caring role without adequate support. How will the Review ensure that Trusts will no longer be able to neglect this statutory duty and how will the Board guarantee widespread compliance with this duty?

- Should service users, carers and members of the public have more say in how health and social care budgets are spent, via the use of scrutiny committees or citizen juries to ensure the public have real and meaningful input to service provision? The welcome initiative of Patient and Personal Involvement was introduced without direct funding for the development of this strategy. Will the initiative fail if health and social care fails to properly fund its development across the sector?

- What is your opinion of the proposals which include ‘older people’ receiving funds to pay their carers? Will this not further confuse the elderly?

- The BBC carried an article on the huge predicted increase in elderly population and the demand this will place on domiciliary care and social services. What is the Panel’s view on the impact this will have on acute services for hospital admissions?

- Following speculation in the press – do you plan to close Accident and Emergency and acute services in Daisy Hill Hospital?

- With less acute hospitals how will service users access treatment from rural areas with insufficient public transport?

- Where is the infrastructure that will support a reduced number of hospitals, which is widely rumoured to be the outcome of the Review? There is no use modelling ourselves on urban environments without appropriate support and access.

- What impact will this Review have on jobs within the HSC?

- In light of the recent publicity in the press, radio and TV, is there any point in this meeting as the Review has already been written?

- What would you do to encourage appropriate restructuring of resettlement teams to include Occupational Therapists with unique skills to assess and advise on support needs equipment and adaptations in line with a number of Bamford recommendations?

- Would the Panel agree that GPs should be left to treat their patients thus leaving the complex range of other care to Trusts and other staff?

- Do the Panel believe that the independent/private sector can run services better and/or cheaper than the Trusts currently do?

- The shift in community based care – is this not more idealistic than realistic? Are the people/relatives expected to do this because of economic resources?

- Can Mr Compton give an assurance that A&E and emergency surgical services will be maintained at Daisy Hill Hospital?

- Leaks about the downgrading of Daisy Hill Hospital have already affected staff morale – can you reassure us about the future of Daisy Hill Hospital and that the level of services will be maintained?

- Commenting on a leaked report of 29/06/2011, will the Review result in: 2000 jobs lost; £40 cut from locum doctors and doctors; £30million cut from Pharmacy budget; a recruitment freeze; and the number of acute hospitals cut by 50%?

Appendix 5
List of Attendees at Clinical Workshops & Areas Covered

Workshop 1: Unscheduled Care, Specialist Services (including Cancer), Elective Care
Wednesday 12th October 2011 at 4pm
Ballymena Showgrounds, Warden Street, Ballymena, BT43 7DR

Name	**Organisation**
Jennifer Welsh	BHSCT
Dr Patricia Donnelly	BHSCT
Dr Dermot Maguire	GP
Dr Garth Logan	GP
Dr Sloan Harper	HSCB
Beth Malloy	HSCB
Jeff Featherstone	HSCB
Louise McMahon	HSCB
Paul Leyden	NHSCT
Tom Morton	NHSCT
Margaret O'Hagan	NHSCT
Stephanie Greenwood	NHSCT
Dr Olivia Dornan	NHSCT
Joanne McKee	NHSCT
Sean Donaghy	NHSCT
Martin Sloan	NHSCT
Jackie Elliott	NHSCT
Brenda McConville	NHSCT
Denise Quinn	NHSCT
Valerie Jackson	NHSCT
Liam McIvor	NIAS
Dr David McManus	NIAS
Liz Henderson	NICAN
Eleanor Ross	PHA
Dr Miriam McCarthy	PHA
Paul Kavanagh	PHA
Kevin McMahon	PHA
Dr Janet Little	PHA
Chris Allam	SET
Joe Toner	SET
Sean McGovern	SET
Mark Armstrong	SET
Dr Tim Harding	SET
Stephen Hall	SHSCT
Dr John Simpson	SHSCT
Seamus O’Reilly	SHSCT
Robert Carlile	SHSCT
Gillian Rankin	SHSCT
Heather Trouton	SHSCT
Charlie McAllister	SHSCT
Dr Bassam Aljarad	SHSCT

Paula Clarke	SHSCT
Phillip Murphy	SHSCT
Robin Brown	SHSCT
Ron Thompson	WHSCT
Geraldine Hillick	WHSCT
Dr Padhraig Conneally	WHSCT
Dr Brendan Devlin	WHSCT
Dr Paul McSorley	WHSCT
Stephen Clanaghan	WHSCT
Dr Caroline Mason	WHSCT
Dr Fergal McNicholl	WHSCT
Gerard Daly	WHSCT
Michael Riley	
Gloria Mills	

Workshop 2: Long Term Conditions, Care for Older People, Physical Disability, End of Life Care
Thursday 13th October 2011 at 4pm
Lisburn Civic Centre, Lagan Valley Island, Lisburn, BT27 4LR

Name	Organisation
Dr Ken Lowry	BHSCT
Dr Alister Taggart	BHSCT
Dr John McCann	BHSCT
Denise Killough	BHSCT
Dr Bernie Corcoran	BHSCT
Una McAuley	BHSCT
Bernie Kelly	BHSCT
Dr Grainne Bonnar	GP
Dr Paul McGerrity	GP
Iain Deboys	HSCB
Dr Sloan Harper	HSCB
Margaret O'Brien	HSCB
Fiona Gilmour	NHSCT
Yvonne Duff	NHSCT
Wendy Longshawe	NHSCT
Ann Orr	NHSCT
Fergal Tracey	NHSCT
Patrick Graham	NHSCT
Wendy Magowan	NHSCT
Hazel Winning	NHSCT
Adele Kennedy	NHSCT
Sean Falls	NHSCT
Melanie Phillips	NHSCT
Brian Serplus	NHSCT
Debbie Gillespie,	NHSCT
Liz Knight	NHSCT
Liam McIvor	NIAS
Brid Farrell	PHA
Siobhan McIntyre	PHA
Dr Walter Boyd	SELCG
Charlotte McArdle	SET
Janice Colligan	SET
Sarah Browne	SET
Bridie McKeating	SET
Bria Mongan	SET
Ray Elder	SET
Dr Simon Coulter	SET
Paula Clarke	SHSCT
Angela McVeigh	SHSCT
Francis Rice	SHSCT
Pat McCaffrey	SHSCT

Miceal Crilly	SHSCT
Roisin Toner	SHSCT
Cynthia Cranston	SHSCT
Dr Angela Garvey	WHSCT
Mr John McGarvey	WHSCT
Mr Brendan McGrath	WHSCT
Mr Garry Hyde	WHSCT
Dr Joe McElroy	WHSCT
Alison Cook	

Workshop 3: Family and Child Care, Maternity and Child Health
Friday 14th October 2011 at 4pm
Malone House, Barnett Demesne, Belfast, BT9 5PB

Name	**Organisation**
Brian Barry	BHSCT
Ann Moffett	BHSCT
Liz Bannon	BHSCT
John Growcott	BHSCT
Lesley Walker	BHSCT
Clifford Mayes	BHSCT
Paul Jackson	BHSCT
Dr Brian Patterson	GP
Dr Reggie McAuley	GP
John Duffy	HSCB
Dr Ursula Brennan	HSCB
Louise McMahon	HSCB
Mary Maxwell	NHSCT
Brenda McConville	NHSCT
Dr Michael Ledwith	NHSCT
Ian Allen	NHSCT
Martin Sloan	NHSCT
Sean Donaghy	NHSCT
Grace Edge	NHSCT
Heather Reid	PHA
Denise Boulter	PHA
Deirdre Webb	PHA
Fiona Kennedy	PHA
Joanne McClean	PHA
David Glenn	SET
Marian Robertson	SET
Heather Crawford	SET
Jackie McGarvey	SET
Ian Sutherland	SET
Elaine Madden	SET
Zoe Boreland	SET
Marian Campbell	SET
Paul Morgan	SHSCT
Geraldine Maguire	SHSCT
Patricia McStay	SHSCT
Peadar White	SHSCT
Colm McCafferty	SHSCT
Julie McConville	SHSCT
Michael Hoy	SHSCT
Janet McConville	SHSCT

Appendix 6
List of Attendees at Sector Workshops

Review of Health & Social Care Services in Northern Ireland
Northern Ireland Council for Voluntary Action Workshop
Tuesday 1st November at 10am
NICVA, 61 Duncairn Gardens, Belfast, BT15 2GB

Name	Organisation
Claire Armstrong	Addiction NI
David Barnes	Royal National Institute for the Blind NI
Paula Beattie	Trauma Recovery Network
Bernadette Best	Action Mental Health Central Office
Patricia Boyd	Shankill Women's Centre
Myrna Brown	Northern Ireland ME Association
Pauline Brown	British Red Cross (NI) Belfast
Ann Cooney	Southern Area Hospice Services
Carmel Costello	Carers UK Belfast Central Branch - Newtownabbey
Judith Cross	Age NI
Chris Deconink	East Belfast Community Development Agency
Karen Diamond	NI Music Therapy Trust
Geraldine Fennell	Carers UK Belfast Central Branch – Newtownabbey
Helen Ferguson	Carers Northern Ireland
Pauline Ferguson	Positive Futures for People with A Learning Disability
Dolores Finnerty	Caring Breaks Limited
Kate Fleck	Arthritis Care Northern Ireland Regional Office
Nicola Gault	Compass Advocacy Network Limited
Nigel Hampton	Enable NI
Claire Anne Irvine	Stratagem (NI) Limited
Dympna Johnston	Greater Shankill Partnership
Neil Johnston	NI Chest Heart & Stroke
Tom McEneaney	Aware Defeat Depression Belfast Office
Joe McGrann	Bryson Charitable Group
Joseph McKane	Forum for Action on Substance Abuse – Belfast HQ
Linda McKendry	Compass Advocacy Network Limited
Esther McQuillan	Parkinson's UK
Brian Mullan	North Belfast Partnership
Iain Neill	MACS Supporting Young People
Mary O'Hagan	Community Development Health Network
Ronnie Orr	Public Health Agency
Caitlin Reid	TinyLife
Kirsty Richardson	Greenway Womens Centre
Eddie Rooney	Public Health Agency
Mark Shepherd	Stratagem (NI) Limited
Patricia Short	Open College Network Northern Ireland
Alicia Toal	Voice of Young People in Care Ltd HQ
Anne Townsend	CRUSE Bereavement Care NI
Clare Watson	MS Society NI
Heather Woods	Dundonald Family & Community Initiative
Trevor Wright	Extern

Review of Health and Social Care Services
Business Alliance Event
Thursday 3rd November 2011 at 3pm
Boardroom, Equality Commission, Equality House, 7-9 Shaftesbury Square, Belfast, BT2 7DP

Name	Organisation
Mr John Compton	Review HSCNI
Mr Mark Ennis	Review HSCNI
Mr Mark Gibson	BT
Mr Mark Hopkins	BT
Mr Alan Irwin	BT
Ms Anne McGregor	NICC
Mr Mark Regan	Kingsbridge Private Hospital
Mr Michael Caulfield	Connected Health
Mr Nevin Ringland	Praxis Care
Mr Roger McMillan	Carson McDowell
Ms Aoife Clarke	CBI NI
Mr Bob Barber	Centre for Competitiveness

Northern Ireland Social Care Council
Registrant Engagement Event
Tuesday 8th November at 2pm
The Pavilion, Stormont, Upper Newtownards Road, Belfast, BT4 3TA

Name	Organisation
Norma Blair	Ardmonagh Family & Community Group
Avery Bowser	Centre for Effective Services
Margaret Burke	BHSCT
Clare Burke	Care Circle
Veronica Callaghan	NHSCT
Lynne Calvert	BHSCT
Janet Carter Anand	Queen’s University Belfast
Martin Creed	BHSCT
Julie Cunningham	Community Nurse
Patrick Curry	NHSCT
Sharron Cushley	Salvation Army
Martin Doran	Care Circle
Rosemary Edgar	
Lorraine Gibson	NHSCT
Nuala Gorman	SHSCT
Alan Hanna	Autism Initiatives NI
Michaela Herron	Salvation Army
Linda Hook	Salvation Army
Marita Magennis	SHSCT
Fiona McCartan	Youth Justice Agency
Valerie McConnell	HSCB
Siobhan McCormac	Ardmonagh Family & Community Group
Margaret McCrudden	Newington Day Centre
Gillian McGalliard	NHSCT
Ann McGlone	Willbank Community Resource Centre
Zara McIlmoyle	NHSCT
Mary McIntosh	SHSCT
Joyce McKee	HSCB
William McKnight	BHSCT
Kerry McTeague	NHSCT
Margaret Monaghan	BELB
Seaneen Pettigrew	NHSCT
Gail Saunders	Homecare Independent Living
Joan Scott	SEHSCT
Paula Smyth	Leonard Cheshire Disability
Janene Swain	Rodgers Community Care

Northern Ireland Social Care Council
Registrant Engagement Event
Thursday 10th November at 10.30am
MDEC Building, Altnagelvin Area Hospital, Glenshane Road, Londonderry, BT47 6SB

Name	Organisation
Linda Beckett	Glen Caring Services
Fiona Devlin	NHSCT
Jean Doherty	WHSCT
Marian Doherty	WHSCT
Kitty Downey	Slievemore House
Sheena Funston	WHSCT
Vanessa Hegarty	WHSCT
Louise Horner	Leonard Cheshire Disability
Jonny Hoy	Simon Community NI
Moia Irvine	WHSCT
John Jackson	Slievemore House
Geraldine Jones	Limavady Community Development Initiative
Robin Kennedy	WHSCT
Bryan Leonard	Leonard Cheshire Disability
Elizabeth Logan	Partnership Care West
Martina McGuinness	Extra Care
Paul McLaughlin	WHSCT
Pat McMenamin	WHSCT
Dolores Moran	WHSCT
Rhonda Murphy	Action for Children
Sinead Murphy	Leonard Cheshire Disability
Stephen O'Connor	Seymour Gardens Residential Home
Michelle O'Neill	Praxis Care
Lorraine O'Kane	Slievemore House
Liam Quigley	Northern Ireland Association for Mental Health
Carol Scoltock	WHSCT
Paul Sweeney	Extern
Teresa Sweidan	WHSCT
Anne Weir	Probation Board for Northern Ireland

Appendix 7
List of Stakeholders Engaged with at Small Group Meetings

List of Stakeholders Engaged with at Small Group Meetings

Age NI
Alliance Party
Assistant Director of Allied Health Professions and Public Involvement, Public Health Agency (PHA)
Assistant Director of Human Resources, Business Services Organisation (BSO)
Assistant Director of ICT, Health and Social Care Board (HSCB)
Assistant Director of Integrated Care, Head of General Medical Services, HSCB
Assistant Director of Social Care and Children, Mental Health, HSCB
Assistant National Director for Disabilities, Health Service Executive (HSE), Republic of Ireland
Assistant National Director for Mental Health Services, HSE, Republic of Ireland
Assistant National Director for Older Persons, HSE, Republic of Ireland
Assistant National Director for Primary Care, HSE, Republic of Ireland
Bamford Monitoring Group
Belfast Health and Social Care Trust (BHSCT)
British Medical Association
Business Services Organisation
Department of Health, Social Services and Public Safety (DHSSPS)
Chair & Chief Executive, Patient and Client Council
Chairman, HSCB
Chartered Society of Physiotherapists
Chief Dental Officer, DHSSPS
Chief Economist, Health Policy, The King's Fund
Chief Executive, BSO
Chief Executive, PHA
Chief Legal Adviser, BSO
Chief Medical Officer, DHSSPS
Chief Nursing Officer, DHSSPS
Chief Pharmaceutical Officer, DHSSPS
Chief Social Services Officer, DHSSPS
Chief Officers 3rd Sector
College of Occupational Therapists
Community Pharmacy Northern Ireland
Communications Manager, HSCB
Democratic Unionist Party
DHSSPS Partnership Forum
Bishop of Down and Connor, Diocese of Down and Connor
Director General, Department of Health and Children, Republic of Ireland
Director General, Department of Health, Social Services and Children, NHS Wales
Director of Cabinet Operations, Scottish Government
Director of Commissioning, HSCB
Director of Finance, HSCB
Director of Human Resources, DHSSPS

Director of Integrated Care, HSCB
Director of Nursing and Allied Health Professionals, PHA
Director of Performance Management and Service Improvement, HSCB
Director of Planning and Redevelopment Services, BHSCT
Director of Social Care and Children, HSCB
Disability Social Care Forum
Equality Commission for Northern Ireland
Equality Manger, Business Services Organisation
Four Seasons Health Care
Head of Corporate Services, HSCB
Head of Information and Analysis Directorate, DHSSPS
Health and Social Care Board Members
Health Service Executive, Republic of Ireland
Independent Health and Care Providers
Junior Ministers, Office of the First Minister and Deputy First Minister
Law Centre – Rights in Community Care Group
Medical Adviser, HSCB
Northern Health and Social Care Trust
Northern Ireland Ambulance Service
Northern Ireland Association for Mental Health
Northern Ireland Confederation for Health and Social Services
Northern Ireland General Practitioners Committee
Northern Ireland Human Rights Commission
Northern Ireland Social Care Council
Northern Ireland Practice and Education Council for Nursing and Midwifery
Northern Ireland Public Sector Alliance
Northern Ireland Medical and Dental Training Agency
Open University
Pharmaceutical Society of Northern Ireland
Professor the Lord Darzi of Denham PC
Programme Director, European Centre for Connected Health, PHA
Regional Director of Operations, HSE, Republic of Ireland
Regulation and Quality Improvement Authority
Royal College of General Practitioners
Royal College of Midwifery
Royal College of Nursing
Senior Adviser, Special Delivery Unit, Department of Health and Children, Republic of Ireland
Sinn Fein
Social Democratic and Labour Party
South Eastern Health and Social Care Trust
Southern Health and Social Care Trust
Trust Chief Executive Forum
Trust Directors of Social Work
Ulster Unionist Party
UNITE
Western Health and Social Care Trust

Appendix 8
List of Written Submissions

List of Written Submissions

Age NI
Aisling Centre
Alliance for Choice
Alzheimer’s Society
Association of the British Pharmaceutical Industry
Belfast Health and Social Care Trust (BHSCT)
British Medical Association
British Red Cross
Business Services Organisation
CBI Northern Ireland
Centre for Effective Services
Centric Health
College of Occupational Therapists
Consultant Paediatric Surgeons, Royal Belfast Hospital for Sick Children, (BHSCT)
Co-operation and Working Together
Craigavon Lipreading Class
Cyclist Touring Club Right to Ride Network
Diabetes UK
Domestic Care
Dr Julian Kennedy
Fermanagh District Council
General Practitioners in Fermanagh (collective response)
Global Diagnostics Ireland and Ennis General Hospital
Health and Social Care Board
Independent Health and Care Providers
Intelesens Limited
Lisburn City Council
Macmillan Cancer Support
Mater Hospital Community Forum
Mencap
Mr Ian Houston
Mrs Valerie Rosenberg
National Confidential Enquiry into Patient Outcome and Death
Neurological Conditions Service User and Carer Reference Group
Northern Health and Social Care Trust
Northern Ireland Ambulance Service
Northern Ireland Confederation for Health and Social Services
Northern Ireland Hospice
Northern Ireland Practice and Education Council for Nursing and Midwifery
Omagh Hospital Campaign Group
Pharmaceutical Society for Northern Ireland Professional Forum
Princess Royal Trust for Carers
Professor AP Passmore, Professor of Ageing and Geriatric Medicine, Queen’s University Belfast
Regulation and Quality Improvement Authority
Royal College of Nursing

Royal College of Psychiatrists
Save the Mid Campaign
South Eastern Health and Social Care Trust
Southern Health and Social Care Trust
Sustrans
TF3 Consortium
Trust Chief Executives Forum
United Kingdom Homecare Association
Volunteer Now
Western Health and Social Care Trust

Appendix 9
Glossary

Glossary

A&E – Accident and Emergency

CAMHS – Child and Adolescent Mental Health Services

DETI – Department of Enterprise, Trade and Investment

DHSSPS – Department of Health, Social Services and Public Safety

ECR – Electronic Care Record

GP – General Practitioner

GPSI – General Practitioner with Specialist Interest

HSC – Health and Social Care

HSCB – Health and Social Care Board

LTCs – Long-term conditions

MLA – Member of the Legislative Assembly

MRI – Magnetic Resonance Imaging

NHS – National Health Service

NIAS – Northern Ireland Ambulance Service

NICE – National Institute for Health and Clinical Excellence

NISAT – Northern Ireland Single Assessment Tool

PCC – Patient and Client Council

PCI – Percutaneous Coronary Intervention

PHA – Public Health Agency

QOF – Quality and Outcomes Framework

RQIA – Regulation and Quality Improvement Authority

HSC Health and Social Care