MUCKAMORE ABBEY HOSPITAL INQUIRY

WITNESS STATEMENT

Third Statement of Aidan Dawson

Date: 16 June 2023

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

The statement is made on behalf of the Public Health Agency (PHA) supplemental to my statements of 16 March and 26 May 2023. This is my third statement to the Inquiry. It is made for the purpose of providing further clarity and context to the role of the PHA in relation to policy and procedure as per Module Three.
There are 23 EXHIBITS produced with my statement.

1. Introduction

1.1 The Department of Health ("the Department" or DoH) is responsible for developing policy in respect of health and social care and wellbeing. The HPSS (Quality, Improvement and Regulation) (Northern Ireland) 2003 Order, established the right of the Department to make (or commission) standards for health and social care services and also introduced the statutory duty of quality for HSC bodies responsible for the quality of care they deliver and commission.

1.2 The process of policy making in Northern Ireland is set out in the Good practice in policy development in the NI Executive document "Making a Difference" (Exhibit 1). The policy journey/policy cycle is:

- Identify and analyse problems;
- Develop, design and assess solutions;
- Advise on options and make recommendations;

- Implement and monitor the agreed policy;
- Explain and account for the delivery of the policy; and
- Review and refine the policy using the circular methodology outlined above.

1.3 As a key stakeholder with specific responsibilities and roles in respect of public health and wellbeing, the PHA is engaged in policy development and implementation across a number of government areas. Policy is not developed in isolation by departments, but they are primarily responsible. DoH develops policy in a collaborative way – involving key stakeholders including the PHA to ensure that policy is meaningful, realistic and achievable. My second statement to the Inquiry provides information by way of example of how the Agency has been involved in the delivery of policy and the implementation thereof within the context of Learning Disability.

1.4 Significant policy is subject to public consultation and departments must ensure that appropriate screenings have been undertaken (equality, rural impact, environmental, regulatory, financial, human rights amongst others). Departments must ensure consultation is meaningful and be able to show that due regard has been paid to responses arising from public consultation.

Implementation Planning, Monitoring and Risk

1.5 Issues such as implementation planning, reporting, risk assessment, monitoring and review are covered in the usual policy cycle outlined above.

1.6 Risk assessment is a key part of the process with risks being considered and mitigated during policy development, but also during the implementation phase. Formal reviews would be expected to take cognisance of risks identified and mitigated in order to improve in the next cycle.

1.7 Implementation is considered in parallel to the policy development phase. When a policy is launched it is common for an implementation lead(s) to be

identified and expectations for action plans and commencement to be established.

1.8 Reporting and monitoring mechanisms will also be set out at this point. Given the architecture of the HSC, the Health and Social Care Board was most often appointed lead agency for monitoring implementation of policy through its performance management role. DoH may have retained an oversight role, receiving reports against action plans in some cases (for example where a policy was developed in response to a Ministerial priority) and holding providers to account through various channels including accountability processes or discrete programme or project boards which they may have chaired.

1.9 The PHA is responsible for implementing policy relevant to its role and functions as set out in its Management Statement and Financial Memorandum. The PHA also provided professional input, guidance and advice to the HSCB in the discharge of its functions. PHA plays an important role in informing policy development through membership of a number of working groups across a range of policy areas where expertise in health protection, improvement and service development is required.

1.10 For ease of reference the following sections of this statement will deal sequentially with the policy and procedure areas (a) to (m) specified by the Inquiry in the description of Module 3 in the Evidence Modules 2023 publication.

2 Policies for Delivering Health and Social Care to Learning Disability Patients 1999-2001

2.1 The PHA was established by statute in 2009 with the purpose of protecting and improving the health of the population of Northern Ireland and bringing a renewed focus to addressing health inequalities. Within these parameters the Agency plays an important role in informing policy development through membership of a number of working groups across a range of policy areas in

particular where its expertise in health protection, improvement and service development is required.

2.2 The Bamford Equal Lives was published in 2005 which predates the PHA being established. The PHA has worked within this pre-established policy framework. My statement of 26th May 2023 contains an overview of the Bamford Review and the subsequent Bamford Action Plan as the principal policy drivers relating to people with a learning disability during the period since the Agency was established. It also describes the role played by Agency staff as part of the commissioning arrangements in the delivery of the Bamford actions. Outwith of Bamford policy, the Agency, in the context of its role in the implementation of policy, and in pursuit of its mandate to address health inequalities, undertakes to ensure that the needs of the most marginalised in society are reflected within emerging policy and in the planning and procuring of health and social care services across Health and Social Care. I discuss some examples in section 2 of my statement of 26 May 2023. Policies and services that pertain to the population of Northern Ireland include <u>all</u> marginalised groups including those with a learning disability. It is vital that their needs are addressed within implementation and delivery plans.

3 Nursing Care Delivery Model

<u>Delivering Care</u>

3.1 Delivering Care (Exhibit 2) was launched as a policy by Minister Poots in 2014 and is a policy framework for nursing and midwifery in Northern Ireland. It was designed to promote a shared understanding of workforce planning principles associated with nurse staffing levels to provide safe, effective and person-centred care. It is founded on the Quadruple Aim approach:

- To improve the health of our people;
- To support and empower staff;
- To ensure sustainability of our services; and
- To improve the quality and experience of care.

3.2 The aim of the Delivering Care Policy Framework is to support the provision of high-quality care, which is safe and effective in hospital and community settings, through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities.

3.3 The Delivering Care Policy Framework should inform both Health and Social Care Trusts and the Commissioner to promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments, and when commissioning new services, detail any investment which may be required to provide safe, effective, person centred care.

Prioritisation and Implementation

3.4 Priorities for implementation under the Framework are agreed through the Chief Nursing Officer (CNO) in discussion with Directors of Nursing in Trusts and the PHA. These decisions are made on consideration of a combination of local intelligence and regional priorities. CNO then commissions the Phase formally, in writing, to the PHA Directors of Nursing.

3.5 The PHA has delegated authority through the CNO to lead on each Phase of Delivering Care, but as outlined above, CNO is responsible for the order of the phasing.

3.6 Once commissioned by CNO, the PHA Director of Nursing, Midwifery and Allied Health Professionals (DNMAHP) formally write out to each Trust Executive Directors of Nursing, Midwifery and Allied Health Professionals to request Senior Nursing representation for the respective Delivering Care Phase. Subsequently these representatives constitute an Expert Reference Group (ERG) facilitated by the PHA. The PHA has the following resources working within Delivering Care: Assistant Director of Nursing, Nurse Consultant (in post since May 2023) and Programme Manager. Other Nurse consultants with skills in the required clinical area will also be involved in particular Expert Reference Groups.

3.7 The PHA works in partnership with Health and Social Care Organisations, including the Northern Ireland Practice & Education Council for Nursing & Midwifery (NIPEC), to develop and agree Terms of Reference for the respective Delivering Care Phase under review. There are currently 18 phases commissioned to date, all at various stages of development, implementation and review.

Oversight

3.8 The PHA's Directors of Nursing and the Deputy CNO jointly chair the Delivering Care Oversight Board which receives progress reports and updates for all aspects of the policy and its outworkings. The PHA Assistant Director for Nursing Workforce chairs the Operational Working Group responsible for implementation of the policy. Both groups meet quarterly.

Investment

3.9 As at March 2019 investment (since 2014) of £15.24 million was allocated for Delivering Care. The funding planning processes associated with Delivering Care are led by the PHA, in conjunction with Strategic Performance and Planning Group (SPPG)/ (formerly the Regional Health & Social Care Board (HSCB)) finance colleagues but services are commissioned via SPPG through normal commissioning processes.

3.10 In early 2020, following a period of industrial action, Minister Swann, through a Framework agreement, committed to a safe staffing investment of £60m over a period of 5 years which commenced in the financial year 2020/21To date £25m of the additional £60m has now been allocated, with £35m still expected but has been impacted on the known budgetary constraints and lack of Executive decisions.

3.11 In 2020/21 £5 million was issued and provided 70 whole time equivalent posts across Emergency Departments, District Nursing and Mental Health as decided by the then CNO and Directors of Nursing regionally. The allocation process was led by the PHA Assistant Director Nursing workforce. The

allocation of the funding was transacted by Commissioning within SPPG. A small number of Regional Infrastructure posts were also recruited with the 20/21 investment.

3.12 In 2021/22, a further £20m was received. The priorities for this funding were determined by the then Delivering Care Steering Group and in line with DoH. A Strategic Investment Plan (SIP) was developed, led by the PHA, in partnership with and approved by CNO, Directors of Nursing, SPPG Finance and Commissioners. This £20 million investment provided approximately 293 posts in the five HSC Trusts across identified priority clinical areas, in order to stabilise the workforce. There were 20 Learning Disability posts within the 21/22 allocation and these were divided equally (4 each) across the 5 geographical HSC Trusts, who then had local responsibility to recruit. They ranged from Band 7 to Band 8b posts in line with service need and the Nursing and Midwifery Task Group recommendations.

3.13 Consideration of any Delivering Care allocation is now aligned to the strategic themes of the Nursing and Midwifery Task Group (2020), which are aimed at maximising the contribution of Nursing and Midwifery to the health of the population. The Nursing and Midwifery Task Group Report, launched by the Minister in March 2020, and in keeping with Health & Wellbeing 2026: Delivering Together 2026 Vision, set out an ambitious roadmap that would provide direction in achieving world class nursing and midwifery services, in a reconfigured Health and Social Care system over the next 10-15 years. This was accompanied with a 5-year costed action plan. The consideration for the allocation of Delivering Care is now closely aligned to the strategic themes of the Nursing and Midwifery Task Group, which are aimed to:

- Maximise the contribution of Nurse’s and Midwives in Public Health and Wellbeing.
- Maximise the role Nurses and Midwives make in the transformation of health and social care delivery.

- Develop the capacity and capability for nurses and midwives to lead at all levels

Through:

- **S**tabilising the nursing & midwifery workforce, therefore ensuring safe and effective care.
- **A**ssuring the public, the minister, DoH of the effectiveness and impact of person-centred nursing and midwifery care.
- **F**acilitating the adoption of a population health approach across nursing and midwifery practice, resulting in improved outcomes for people across the lifespan.
- **E**nabling the transformation of HSC service through enhancing the roles of nursing and midwives within and across a wide range of MDT's / services.

3.14 Agreement was made at inception that all completed Phases of Delivering Care would be monitored twice yearly to ensure that the investments made were being utilised within the agreed model of safe staffing. The PHA in partnership with HSCB Finance led the development of templates (Exhibit 3) to capture funding levels, staff in post, vacancies and absences against Delivering Care investment made and progress towards the agreed staffing models for completed phases of Delivering Care.

3.15 These templates were completed by Trusts and returned to the PHA who subsequently analysed, in partnership with HSCB (SPPG) finance and produced a summary Monitoring Report (Exhibit 4) for CNO to provide detail on:

- Met / unmet targets;
- Vacancy rates;
- Bank and Agency usage;
- Discrepancies in funding levels.

Post Project Evaluations are also received and therefore would include the monitoring and review of agreed KPIs.

3.16 In 2021/22, due to the significant investment of £20 million, a new monthly process of monitoring was introduced to track and monitor recruitment to the 293 identified posts.

Phase Nine

3.17 Phase 9A and 9B of this work were to focus on Learning Disability Nursing in specialist learning disability services (inpatient (A) and community (B)). In May 2019 CNO requested that the PHA progress the next phase of the Delivering Care framework focusing on Learning Disability Nursing in both Hospital and Community settings. A robust literature search was progressed to review current evidence and literature on Learning Disability Nursing workforce tools. The literature review concluded that there was a dearth of evidence pertaining specifically to LD nursing workforce and in particular relating to 'sustainable safe staffing'.

3.18 The DNMAHP also convened a workshop in September 2019 and invited an expert Associate Professor of Nursing who had completed a report for NHS Improvement to inform the development of a 'sustainable safe staffing' improvement resource in learning disability (LD) services. This workshop led to the creation of the Expert Reference Group (ERG) for Delivering Care Phase 9A LD inpatient units.

3.19 The Expert Reference Group (ERG) - led by PHA Nurse Consultants – was established in November 2019. Membership comprised of representatives from the three HSC Trusts that had inpatient units (including MAH) along with a LD nursing expert from DoH. The ERG met in November 2019; November 2020 and February 2021. The Covid-19 pandemic impacted on the ability to progress this phase to completion. Communication and various drafts and versions of the Phase 9a paper were shared with all members of the ERG via email. Version 1 on 20th May 2019 until the final draft Version 16 was shared on 21st June 2022.

3.20 Delivering Care Phase 9 draft version 16 was reviewed in June 2022. The work was developed based on the current models of inpatient services. However, in acknowledgement that models of care were changing, it was agreed that Phase 9 needed to take account of the wider learning disability nursing workforce and service reform.

3.21 As indicated, whilst initial work on Phase 9 was done in the context of the historical model of delivery; the direction of Phase 9 has shifted towards creating a normative staff model for the provision of high intensity care (in-patient, crisis and intensive home care, behavioural support and forensic). Additionally, whilst Phase 9 development was paused during the Covid-19 pandemic, DoH had also commissioned a review of learning in Nursing Models, and it was subsequently determined that Phase 9 would also need to reflect the findings of this work.

3.22 Version 16 remains in draft format as of July 2022 (Exhibit 5). CNO requested a 'whole system' approach to Learning Disability and delegated this task to NIPEC. A Nursing Model is to be developed and the work on Phase 9a would be built into the workforce piece (currently ongoing). The PHA Assistant Director of Nursing (Mental Health & Learning Disability), Nurse Consultant Workforce and Delivering Care Programme manager are members of the workforce workstream.

3.23 In February 2023 CNO held a regional workforce planning workshop. The purpose of the workshop was to undertake a thorough review into workforce and workload planning to meet population health needs with the aim of building a shared understanding of the current position, setting objectives and strategizing to attain those objectives. This included consideration and clarification of responsibilities and roles as well as an opportunity to consider next steps in terms of policy. It was agreed through this workshop that the Delivering Care Policy Framework should be reviewed. This piece of work is being undertaken by DoH and the PHA awaits the establishment of a Task and Finish Group and Terms of Reference for this work.

4 Restraint and Seclusion

4.1 Guidance on the use of seclusion is available in the form of The Mental Health (Northern Ireland) Order 1986 Code of Practice and associated Guide. This guidance included requirements and standards for recording, reporting and monitoring this area of HSC activity. Many health and social care organisations had their own governance systems to monitor the use of seclusion, however there was no agreed regional approach to this area of practice. The Mental Health (Northern Ireland) Order, 1986 still applies, and as such this guidance is still relevant.

4.2 In August 2005, the Human Rights Working Group on Restraint and Seclusion issued Guidance (Exhibit 6) on Restraint and Seclusion in Health and Personal Social Services. The working group was commissioned and issued by the Department of Health. This guidance pre-dates the formation of the PHA.

4.3 In the period since the 2005 guidance was issued, the issue of restrictive practices, including restraint and seclusion in health and social care services, has continued to be under discussion. In that context and as part of the Mental Health Action Plan published on 19 May 2020 (Exhibit 7), DoH committed to review restraint and seclusion and to develop a regional policy on restrictive practices and seclusion as well as a regional operating procedure for seclusion (Mental Health Action Plan, Action 6.5).

4.4 On 23 March 2023 DoH published a regional policy (Exhibit 8) to minimise the use of restrictive interventions, restraint and seclusion in health in social care settings. The regional policy is the conclusion of this work. This policy 'Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and regional operational procedure for the use of seclusion' applies across all areas in which health and social care is delivered in Northern Ireland and is applicable across the lifespan to all staff within health and social care services.

4.5 The policy provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland. The emphasis is on elimination of the use of restrictive practices and on minimising their use.

4.6 The PHA contributed to the development of this policy as members of the project board. The PHA were represented by Executive Director of Nursing and Assistant Director for Mental Health & Learning Disability.

4.7 The PHA has a specific role in this policy as outlined at page 8 action 11 – 'The Public Health Agency (PHA) through its safety and quality functions, will support analysis of incident reporting for the purposes of learning and service improvement and develop regional quality improvement initiatives informed by that data analysis and learning'. The PHA awaits further direction from DoH in respect of expectations around this action.

5 Safeguarding

5.1 In 2010, the Department and the NI Office (NIO) issued a joint guidance document 'Adult Safeguarding in Northern Ireland – Regional and Local Partnership Arrangements' (Exhibit). This guidance established the Northern Ireland Adult Safeguarding Partnership (NIASP) and five Local Adult Safeguarding Partnerships (LASPs) operating at Trust level. The role of NIASP was to determine strategy for safeguarding vulnerable adults, disseminate guidance/operational policies, monitor trends and outcomes through collation/analysis of data returns from Trusts, monitor/evaluate effectiveness of partnership arrangements.

5.2 Adult Safeguarding is relevant across all Adult groups in all settings. *Adult Safeguarding Operational Procedures for Adults at Risk of Harm and Adults in Need of Protection* (NIASP Sept 2016) noted that people in crisis can include people with learning disabilities.

5.3 The NIASP was responsible for promoting and supporting a co-ordinated and multi-agency approach. It was also responsible for creating a culture of continuous improvement in adult safeguarding practice and service responses, promoting ownership of adult safeguarding issues within all partner organisations, and across all professional groups and service areas.

5.4 The PHA representation from Nursing and AHP provided expert professional advice in delivery of all the above objectives; collaborating to make people safe; verbal advice in meetings; and commenting on documents ensuring alignment with Strategic Direction, for example 'Making Life Better'. Where appropriate the PHA representative (Assistant Director of Nursing) took forward work specific to the Nursing and AHP workforce such as the development and implementation of the Adult Safeguarding Nursing Competency Framework (2018) (Exhibit 9).

5.5 In 2020 a public consultation on adult protection led to DoH progressing work to introduce an Adult Protection Bill to be supported by new Statutory Guidance. The Bill, when enacted, will establish an Adult Protection Board (APB).

5.6 In August 2020 NIASP was stood down and an interim APB was established by DoH in February 2021. This is chaired by the SPPG Director of Social Care and Children's Services with a remit to progress a number of priorities in advance of the new Bill being enacted. This includes developing a plan to improve adult protection arrangements by developing new Multi-Agency Adult Protection Procedures, putting in place a substructure to support the broader prevention and awareness raising agenda, overseeing and facilitating a change in management process in relation to Adult Protection and developing arrangements for introducing serious case reviews.

The IAPB reports to the DoH Adult Safeguarding Transformation Board chaired by the Chief Social Worker. The PHA is a core member of this Board. Where relevant and appropriate the PHA Director of Nursing will present papers to the PHA Agency Management Team (AMT).

6 Medication and Medication Audits

6.1 The PHA has contributed to a range of policy development in the context of the World Health Organisation "Medication Without Harm" global safety challenge (Exhibit 10). Medication safety is a population-level issue and whilst the PHA has not been involved in specific policies for people with a learning disability; we would expect all medicine safety policies to be relevant to all populations.

6.2 The PHA has been involved in several groups relating to medicines safety including inter alia:

- Regional Safer Medicines group (Nov 2020 to present) – attended by a Nurse Consultant;
- Integrated Prescribing Oversight Board (IPOB) (2022 to present) – attended by the Assistant Director of Safety and Quality and the lead Allied Health Professional (AHP);

Going forward a new Transforming Medication Safety Northern Ireland (TMSNI) Advisory Group (instigated in June 2023) will be attended by the Assistant Director of Safety and Quality.

6.3 These groups all meet quarterly and, whilst they are not responsible for medicine policy per se, they take forward pieces of work to inform safer medication practice. PHA officials (officers from the Directorate of Nursing, Midwifery and Allied Health Professionals and the Directorate of Public Health) provide advice relating to their areas of expertise. In the case of IPOB this particularly relates to non-medical prescribing expertise.

7 Patients' Property and Finances

7.1 Our understanding is that the PHA does not have a role in relation to policies and procedures concerning patients' property and finances. HSC Trusts are primarily responsible for the development and implementation of policies and procedures relating to patients' property and finances. RQIA also have a role under article 116 of the Mental Health (Northern Ireland) Order, 1986.

8 Psychological Treatment, Speech and Language Therapy, Occupational Therapy and Physiotherapy

General

8.1 The AHPs are autonomous practitioners which means they assess, diagnose, treat and discharge in their own right. They are regulated by the Health and Care Professions Council (HCPC). The HCPC is in place to protect the public by maintaining a register of health professionals who meet their standards for training, professional skill, behaviour and health. Policies and procedures for AHP interventions are based on best practice guidance and standards issued from HCPC, professional bodies, relevant guidelines, eg NICE, and HSC policies.

Dysphagia

8.2 An example of AHP regional work led by the PHA is in relation to dysphagia. The PHA has led significant regional work in respect of dysphagia which is a recognised risk for people with learning disabilities. In 2017 the PHA established the Regional Dysphagia Group. In 2018 the PHA and HSCB facilitated a thematic review of the analysis of Adverse and Serious Adverse Incidents of adults choking on food. A number of key messages relating to the areas below are identified within the report.

- Raising awareness
- Communication to staff delivering care directly
- Terminology
- Roles and responsibilities
- Education and Training
- Reporting
- Support to staff.

The Regional Dysphagia Group was asked to take forward the next steps outlined in the report.

8.3 Following the review, temporary Transformation Funding was secured to develop Dysphagia Teams in PHA and HSC Trusts to bring forward recommendations of the review. Dysphagia NI Partnership group was established as an entity to replace

the original group. The PHA received funding for one Band 8A Dysphagia Coordinator and two project managers (Band 6). Each HSC Trust was offered funding to support the recruitment of Band 8A Dysphagia Coordinator, two Band 7 professional leads (SLT and Dietitian) and two Band 4 support workers. Recruitment was challenging due to the temporary nature of funding and not all posts were filled.

8.4 In February 2021 the HSCB and PHA jointly issued a Safety and Quality Reminder of Best Practice Guidance letter entitled 'Risk of serious harm or death from choking on foods' (SQR-SAI-2021-075) (Exhibit 11). In response, the Chief Medical Officer wrote to HSCB/PHA requesting that they bring forward an assessment of further regional interventions deemed necessary. The PHA and HSCB undertook a rapid review of SAIs and AIs related to choking from 2016 – 2021 (Exhibit 12) as the key driver for the identification of further regional interventions. The 'Report of Choking Serious Adverse Incidents and Adverse Incidents in Northern Ireland (2016-2021) and Regional Learning from the work of Dysphagia NI and service user and carer experience' was submitted to the Department of Health in July 2021. The resulting regional 'Choking Improvement Plan' (CIP) (Exhibit 13) has been under regional implementation since July 2021.

8.5 Further communications were issued (22 October 2021) requesting more detailed assurances to ensure that actions as detailed within the Safety and Quality Alert (SQA) have been taken forward to prevent and mitigate the risks of choking incidents reoccurring.

8.6 The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report "Hard to Swallow" (July 2021) was a review of the quality of dysphagia care provided to patients with Parkinson's disease aged 16 years and over who were admitted to hospital when acutely unwell. On foot of this report, CMO wrote (Exhibit 14) to Trusts, HSCB, the PHA, NIMDTA and RQIA with two actions:

- HSC Trusts, the Public Health Agency (PHA) and Health and Social Care Board should consider the key findings and recommendations of this report, bring these to the attention of relevant staff and take appropriate action.

- The HSC Board and PHA will report progress on implementation of the findings set out in this report through the existing arrangements for 6-monthly updates on Clinical Outcome Review Programme (CORP) Reports.

8.7 I received updates from the Director of Nursing in my capacity as Chief Executive and my assurance role. The RQIA published the Review of the recommendations to prevent choking incidents across Northern Ireland (19 May 2022). Regional Eating Drinking and Swallowing recommendations were issued in a standardised format for SLTs in February 2023.

8.8 Dysphagia NI has demonstrated impactful whole systems working across the seven objectives set by the 2018 Thematic Choking Review to reduce the risk of choking for adults in Northern Ireland as well as an exploration of user-based perspectives of care and living with dysphagia (10,000 More Voices: Your Experience of Living with a Swallowing Difficulty; The lived experiences of people with swallowing difficulties living in Northern Ireland (2021)) (Exhibit 15). It has developed regional safeguards and interventions to reduce the risk of death by choking. Transformation Dysphagia NI is an outcomes report with links to supporting practice guidance, outcomes and reports with regional recommendations to safeguard against the risk of death by choking. Examples of outputs include:

- Improving public awareness of dysphagia
- Regional Resources
- Access to Dysphagia Awareness online Training
- Animation
- Service User Video

8.9 In September 2021, the PHA issued a Learning Matters communication to the HSC dedicated to dysphagia. (Exhibit 16)

9 Psychological Treatments

9.1. The Department of Health, Social Services and Public Safety's 2010 Psychological Therapies Strategy defines the term psychological therapies as *"an interpersonal process designed to modify feelings, cognitions, attitudes and behaviour which have proved troublesome to the person (or society) seeking help from a trained professional (STRUPP)). They encompass a range of interventions, based on psychological theory and evidence, which help people to alter their thinking, behaviours and relationships in the present, and process trauma and disturbance from the past, in order to alleviate emotional distress and improve psychosocial functioning."*

9.2 This strategy goes on to state *"Psychological therapy provision is a multi-professional and multi-agency endeavour. Psychiatrists, psychotherapists, psychologists, counsellors, nurses, social workers, occupational therapists, arts therapists and many other groups are involved, all of whom need to communicate and co-ordinate effectively with one another. Therapy can also be provided by a range of practitioners in the voluntary and independent sectors."*

9.3 Since 2009, PHA has had a lead role in implementing the 'Protect Life' Suicide Prevention Strategy under which a range of community based services have been commissioned that provide psychological interventions and support services for people who need help. PHA commissioned services, have primarily focused on supporting people who are on steps 1 and 2 of the care pathway (Exhibit 17), where the primary focus is on working with people who are have difficulty carrying out or have occasional distress in one or two activities in one or more vital areas of functioning including health, choice, personal care, occupation, relationships and participation. Services commissioned range from: Family Support; Talking Therapies; Stress Control, Self harm intervention; specialist Bereavement Support for adults, Children and Young People; and, community based support programmes. PHA also commissions a range of training programmes that aim to address mental and emotional wellbeing and the prevention of suicide by raising

awareness and improving individuals understanding, knowledge, confidence resilience and skills.

10 **Resettlement and Provision for Monitoring Resettlement**

10.1 The regional resettlement process has been in existence since the 1990s, and involved several hundred clients/patients and their families. It was driven by the Bamford Vision that advocated a desire for community-based living and a values-based philosophy of care. The Department set targets through the Minister's Priorities for Action / Commissioning Directions process in respect of completing the resettlement of all long stay learning disability patients. These were superseded in 2015 by new targets relating to timely discharge from hospital settings. Trust performance in meeting the resettlement targets was performance managed by the HSCB. It is my understanding that responsibility for resettlement lies with the SPPG and the HSC Trusts.

10.2 From 2009, oversight of the resettlement process was taken forward by the Bamford Taskforce Commissioning team, ie. the specific LD sub-group. This was chaired by the HSCB social care Assistant Director, with input from Assistant Directors from the PHA. Through the IPT (Investment Proposal Template) process PHA staff provided professional advice on the identified qualitative benefits for patients and potential constraints regarding the resettlement programme e.g. staff recruitment, time scales.

10.3 The Regional Learning Disability Operational Delivery Group (RLDODG) was established in 2019 to provide the DoH, through the HSCB, with assurance regarding actions arising from 'A Way to Go' (Review into Safeguarding at MAH) (Exhibit 18) as well as to provide oversight regarding commitments on resettlement made in December 2018. The group is also overseeing the development of enhanced community services. The PHA Assistant Director for MHLD is a member of this group. RLDODG was convened by HSCB and is responsible to the Muckamore Abbey Assurance Group (MDAG) through the MH and LD Improvement Board.

11 Complaints and Whistleblowing and Mechanisms for Identifying and Responding to Concerns

11.1 Context

11.1.1 The PHA has primary responsibility for providing professional and clinical leadership across the regional SAI/ complaints process and are accountable for overseeing the dissemination and application of regional learning across the health and social care system in partnership with SPPG Directors.

11.1.2 It is important to note the responsibilities of the PHA as outlined above are governed by the PHA Chief Executive through the Director of Public Health and the Director of Nursing, Midwifery and AHPs.

11.1.3 Each organisation including the PHA has its own policy for complaints and whistleblowing (Exhibit 19 and Exhibit 20).

11.2 Complaints

11.2.1 In addition to the information provided in my statement of 26 May 2023 under the heading of **Safety, Quality and Learning**, I wish to confirm that the PHA has in place a Complaints Procedure (Standards and Guidelines for Handling and Monitoring of Complaints) which sets out the procedure for staff on how complaints relating to the PHA, its actions and decisions are to be managed and monitored. These procedures reflect the new arrangements for dealing with complaints which became effective from 1 April 2009 as required by the *Directions to the Regional Agency for Public Health and Social Wellbeing on procedures for dealing with Health and Social Care Complaints* - (The Directions) (Exhibit 21) and the DoH Guidance in relation Health and Social Care Complaints Procedure (updated April 2023) (Exhibit 22).

11.2.2 A review of PHA complaints records has confirmed that no complaints were received in relation to Muckamore Abbey Hospital. In the context of Learning Disability one complaint was received in relation to respite and learning disability day care services and why these were stood down during Covid-19. Complaints received by the PHA are reported in the PHA Annual Report.

The PHA is currently in the process of reviewing and updating its Complaints Procedure to ensure compliance with the above guidance issued April 2023.

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11.3 **Whistleblowing**

11.3.1 Minister Poots, in his letter to HSC bodies dated 22 March 2012, asked organisations to bring to the attention of all staff the organisation's Whistle Blowing Policy along with his letter (Exhibit 23). His letter expressed his commitment to ensuring the highest possible standards of conduct, openness, honesty and accountability in HSC services and his wish that staff are confident that managers will respond positively to expressions of concern about any ethical or safety issue.

11.3.3 The PHAs Whistleblowing Procedure, along with Minister Poots letter, is available to all staff via the internal website (Intranet). If an individual wishes to whistleblow about a HSC organisation (other than the PHA) then they do this through their own organisation's policy or via a prescribed organisation which for HSC is either the Department of Health or RQIA.

11.3.4 The PHA would expect to be made aware of any issues of concern pertaining to other HSC organisations where appropriate, through other measures such as Serious Adverse Incident reporting.

12 **Further Training for Staff and Continuing Professional Development**

12.1 The PHA, in common with all HSC bodies, has internal mechanisms to ensure that staff are trained and skilled in order to effectively carry out their jobs. As well as a series of mandatory training, staff and their line managers are expected to identify and address training needs as part of the cycle of appraisal. Training should be linked to specific objectives in the employee development plan and can be accessed through the HSC Leadership Centre or in some cases via independent providers.

12.2 Additionally, all PHA medical, nursing and AHP staff are required to maintain training and CPD in line with the requirements set out by their regulatory body and are given time to do so.

12.3 Clinical training is provided by the Clinical Education Centre (CEC), NIPEC and the Northern Ireland Medical and Dental Training Agency (NIMDTA).

13 **Personal and Public Involvement**

13.1 The principle of patient and public involvement was established in the 2009 Reform Act and applies to HSC bodies who must ensure that patients, service users, carers and their representatives are involved in matters pertaining to the planning and delivery of their care. The PHA has a lead responsibility for the oversight of the implementation of PPI policy across the HSC. The PHA acts in an enabling and supportive capacity, helping the HSC in its endeavours to embed involvement into the culture and practice of the system. It does this in the main through its work with the Regional HSC PPI Forum.

13.2 Any key pieces of work or products which are developed in the Forum are shared with the PHA Director of Nursing & AHPs and, subject to their agreement, are taken through the PHA Agency Management Team (AMT). There is also currently a twice-yearly update to the Board of the PHA on PPI, developed by the PHA PPI team, that is submitted via AMT to the Board for their consideration and approval. DoH is a member of the Forum and contributes to its operation and future planning.

13.3 In addition, DoH has a programme of professional meetings with PHA PPI Staff and strategic oversight meetings with the Deputy Director and the Regional HSC PPI Lead**.**

13.4 The PHA - working through the Forum in a collaborative manner - takes forward the advancement of Involvement and supports its embedding into the culture and practice of the HSC in a number of ways:

- **Forum** operates as a platform for sharing of issues, challenges, best practice.
- **Standards**. Development of a generic set of Standards for Involvement (March 2015) covering key areas, such as Leadership, Governance, Opportunities & Support for Involvement, Knowledge and Skills and Measuring Outcomes, with associate KPIs.
- **Monitoring**. A mechanism for undertaking monitoring to provide indicative insight into progress in regards to adopting PPI was co-designed and was operational from 2015 to 2018/19. Subsequently reviewed, updated and re-introduced in 2022.
- **Training**. A range of Involvement related training programmes have been commissioned, designed, developed, and delivered. These have included “Engage & Involve” a detailed seven module training programme made available along with delivery guides for the HSC; an e-learning module for Involvement available on HSC Learn; the Leading In Partnership Programme, which is a Leadership development programme with a focus on advancing Involvement, (this has had 8 cohorts with some 174 HSC staff, service users & carers in the last 3 years). A series of webinars has been run since 2021, covering a range of Involvement related subjects and are open and accessible to the wider HSC, service users and carers with in excess of 700 people participating since inception.
- **Engage & Guides**. The PHA has led on the establishment and subsequent redevelopment of the Engage website as the go-to online place for a range of information, advice, guidance, best practice and details on Involvement opportunities.

- **Advice & Guidance**. Where there are Involvement-related matters which are cross organisational, strategic, high profile or sensitive in nature, if approached, the PHA endeavours to support the initiative in question. This is done mainly through the provision of advice, and guidance, be that on conducting stakeholder analysis, development of an Involvement plan, establishing a reference group, conducting a consultation etc.
- **Administration of Small Grants**. Over several years the PHA, operating via the Forum ran a small grants programme funded via slippage, which enabled HSC partners to identify and run projects aimed at targeting areas for development, testing different approaches and advancing the concept and practice of involvement.
- **Investment in expertise**. The PHA secured Transformation monies to enable the five geographic HSC Trusts to invest in their staff expertise in Involvement, co-production & partnership working, via the recruitment and employment of a permanent, full time Band 7 Partnership Working Officer.

13.5 All of these and other related developments are important foundations developed under the leadership of the PHA, to support and build on the momentum to advance and open up involvement for HSC organisations, staff, service users and carers and the wider public. These products / enablers help support the HSC to embed meaningful involvement into the culture and practice of the system. It is vital to note however, that HSC organisations retain direct accountability themselves, for their compliance against the statutory duty to involve and consult. The concepts, practices, approaches and rights which PPI introduce, have relevance to all staff, to service users, carers, advocates, the third sector and the wider public.

14 Patient Client Experience

14.1 In 2009 DHSSP launched *"Standards to help improve the experience of patients and clients receiving services in Health and Social Care Northern Ireland*

(HSCNI)". The five standards include – respect, attitude, communication, behaviour, privacy and dignity.

14.2 In 2010 The Experience Led Commissioning Project was established in response to ensure the Commissioning Plan for HSCNI makes specific reference to the collection and learning from patient stories. This resulted in the development of Regional Patient Client Experience forums and 10,000 Voices initiative. This is the precursor to the Regional Patient Client Experience Programme.

14.3 The core role of the PHA within the Regional PCE Programme is to coordinate and enable services within HSCNI to engage with patient experience through proactive collection and analysis of patient stories/narrative. The PHA oversees the workplan for the Regional Patient Client Experience Programme, now encompassing both Care Opinion and 10,000 More Voices.

14.4 The newest initiative within the Regional Patient Client Experience Programme, Care Opinion is widely promoted for service users, families and carers to share experience of any service within HSCNI. Local promotion and implementation is taken forward by each trust through organisational implementation plans. Wider promotion across C&V is coordinated by PHA.

14.5 Since 2019 accessibility has been a priority within the Regional PCE Programme – this involves developing processes to support everyone to share their story. Every project within 10,000 More Voices is now translated into Easy Read format in collaboration with the group "Tell It Like It is" (TILII) to support people with Learning Disabilities to complete the relevant survey.

14.6 In relation to Care Opinion all members of the PCE team (including Trusts) are now trained in Talking Mats to support people with 3-word cognition to share their stories on Care Opinion. Promotional material has been developed through NIPEC with support of TILII and new videos designed to enable people with learning Disabilities to share their experiences. This is now an identified campaign with 23/24 to generate stories and identify learning to support people with Learning Disabilities in their experience of any service in HSCNI.

15 **Statement of Truth**

15.1 The contents of this witness statement are true to the best of my knowledge and belief. Previously, PHA has produced the relevant documents which it believes are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

Date: 16 June 2023

NICS Policy Profession
Here to help you grow

Making a Difference

THE NICS GUIDE TO MAKING POLICY THAT WORKS

The Person-Centred Policy Challenge

We live at a time of change in which events are moving ever more quickly. Reasons for this include the accelerating role of technology and the economic and social cultural changes arising from a highly globalised and interconnected economy. People, communities and regions are struggling to survive and thrive in an environment where the only real certainty is that what is true for today is unlikely to be true tomorrow, in a year or in ten years.

Our overarching aim is to improve the **wellbeing** of all our people. The Outcomes Framework describes an inclusive society in which people of all ages and backgrounds are respected and cared for and in which we all prosper: a society which has no barriers to prevent people from living fulfilling lives.

Our people and communities need government that is fit for purpose, that can help them to thrive and can meet their needs when they cannot help themselves. Helping people to transform their lives and circumstances requires an approach that puts the person at the centre of what we do. It means creating and delivering policy *with* people rather than to people. That in turn means a wide range of organisations working together and with the public, informed by evidence and best practice.

If we are to have the government that people need and deserve, then we need policies and delivery programmes which can support that aim. Policy is at the heart of what we do. It has the power to change lives for the better, and for the worse.
This guide is designed as a central resource to be used by people starting on the journey of policy development, as well as those practitioners who need to refresh their understanding. It is not a definitive guide but should be used alongside a range of factsheets, detailing specific aspects of the policy development process.

What is policy?

There is no single, universally accepted definition of policy in the government context. At its very simplest, **a policy is a position that is deliberately taken**. In government, the policy decision usually belongs to the responsible Minister, or to the Executive collectively.

Public policy is the position in order to achieve a particular goal or objective. Sometimes that objective is to make things better, sometimes it is to stop things getting worse. Sometimes it is aspirational and long-term, sometimes it is very specific and achievable in a shorter timescale. Sometimes it is to fulfil a political commitment, sometimes it is to fulfil a legal obligation, sometimes it is to respond to an emerging situation.

It is important to be aware that our government seeks to support positive outcomes. This is a very different way of thinking about what we do compared with traditional forms of government.

Outcomes at their simplest level can be defined as **the way that something turns out**. Outcomes could for example include improved life expectancy, higher levels of educational attainment, people working in more and better jobs and improved quality of life.

Using an outcomes approach means understanding what actions we can take to cause something to happen in society. In particular, it means understanding and accepting that we in government cannot make good things happen without the help of partners ranging from other governments, public sector organisations, businesses and community organisations through to the public.

The **outcomes framework** that informs the Programme for Government is the highest tier of public policy. The population-level outcomes have been deliberately chosen as the objectives towards which the Executive is committed to work over a long period of time and with the widest impact.

An Executive or departmental **strategy** – a plan to deliver change on a broad scale and usually affecting many people – is also a type of policy. The policy is to effect that particular change, and to do it in that particular way.

A strategy of this kind will then usually be accompanied by an action plan, setting out a number of more specific **actions, services or interventions**, also being deliberately undertaken. These are also policies.

The way in which a programme or a service is delivered – the steps to take or the rules to be followed – is also policy, usually referred to as operational policy. (In some cases, Ministers do not have, or deliberately do not take, responsibility for operational policy.) At the very opposite end of the scale, it could be the policy of a Minister simply to say that they approve or disapprove of something.

It can even be the policy **not** to have a written policy but to leave the official position unspoken or undecided. Even then, that represents a policy position, whether deliberate or not; it may be to avoid committing to a particular course of action at a particular time, or to avoid confrontation.

The Policy Journey

The work of policy officials is to advise their Minister on what policy to adopt, and to implement that policy. This function has many aspects:

(a) identifying and analysing problems;
(b) developing, designing and assessing solutions;
(c) advising on options and making recommendations;
(d) implementing the chosen policy, monitoring its impact and effectiveness, managing risks and addressing flaws;
(e) explaining the policy and accounting for its effectiveness and impact;
(f) Reviewing and refining the policy in order to ensure that the policy is having the intended effect and to address ongoing issues; and
(g) back to identifying and analysing problems.

This is the framework around which this guidance material is framed. It is not always clear that there is a starting point or end point, because the kinds of issues that governments have to address are almost never completely resolved.

Traditionally, in recognition of this, the above points have been represented as a cycle. In reality, however, the policy journey can take many different forms and directions. The key here is to ensure that the policy journey reflects the specific needs to be addressed along with the associated evidence base. The value of the journey, and the value for taxpayers' resources needed to travel that journey, will depend on the ability of the policy to deliver the desired outcomes.

It is also important to remember that policy development is rarely straightforward. This guide may make it sound like there is a natural, logical route that you can expect to travel. In reality, you can expect twists and turns, and you can sometimes wonder how you go to your destination. This guide is an attempt to impose some order upon an often unavoidably messy process.


Identify and analyse problems
Develop, design and assess solutions
Advise on options and make recommend-ations
Implement and monitor the agreed policy
Explain and account for the delivery of the policy
Review and refine the policy
The Policy Journey

Remember our values

No guide can cover every eventuality. When in doubt, however, about how to move ahead, try to remember the NICS Values which we all need to apply in our working lives, namely:

Things may go wrong, but if you stick to these values you should be able to retrieve most situations. Every experience is valuable, especially those experiences gained when something goes wrong.

Strategies and action plans

In developing and delivering public policy, some core principles apply. Depending upon the type of policy, however, those principles are applied in different ways and to different degrees. The rest of this Guide will cover the process of policy development and delivery in general terms. Sometimes, though, it is helpful to differentiate between the approaches to be taken when we are developing policies at different levels.

This takes the policy cycle described above and develops it further. A more elaborate version is set out below.

Although there are no hard and fast boundaries, it can be helpful to distinguish between a strategy and an action plan. A **strategy** is typically a plan to effect change at a population level. A **population** in this case is the whole population of a place (a settlement, a district or the whole of Northern Ireland), or an entire section of the population (e.g. an age-group, or a defined community).

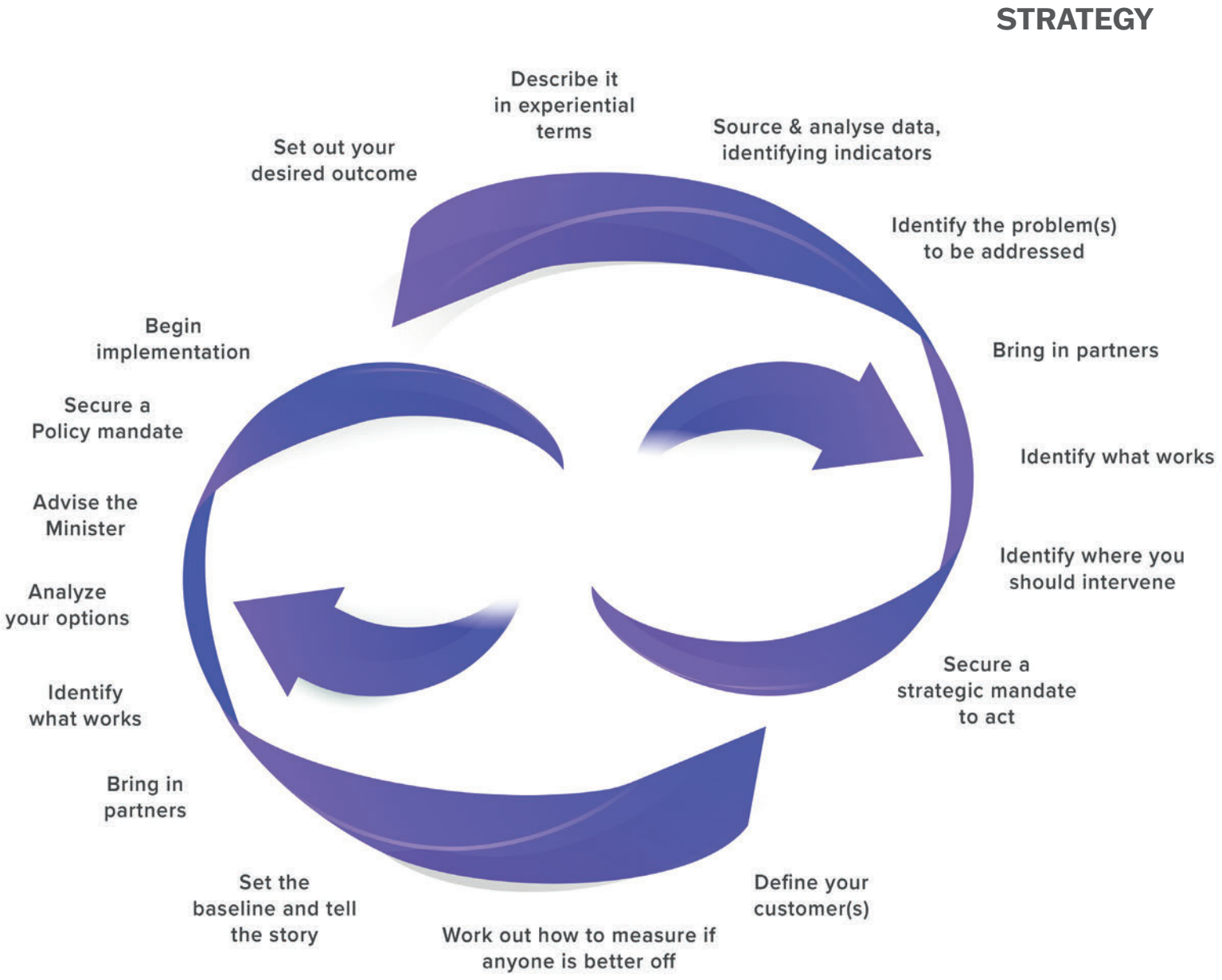
A strategy will usually aim to achieve certain **outcomes** for that population, so that in the future they enjoy positive benefits. Those benefits are measured by the improvement in specific indicators. And a strategy will usually describe what must **change** in order to achieve those outcomes.

A strategy is usually accompanied by an **Action Plan**, which explains what will actually **be done**, described in terms of discrete actions. These actions may be specific projects, services or interventions. Each action will usually be aimed at changing things for the better for a particular group of **people** whether those people use our services or experience the impact of our work in another way.

In this case, 'customers' may be people, but may equally be organisations, environments, other creatures, even structures. And the effectiveness of the action is measured in terms of who is better off and how well the action was delivered.

- A **Policy** answers the question ***what is our position?***
- A **Strategy** answers the question ***what must we change?***
- An **Action Plan** answers the question ***what are we going to do?***

Action Plan Cycle



Where do we want to get to?

A policy will have a purpose. It may be to get to a better place, or to avoid ending up in a worse place. It may be to turn around a long-standing challenge, or it may be to respond to a newly-emerging problem.

For policy to be effective, it is very important to understand its purpose or the problem it is intending to solve. We often try and explain what we are trying to achieve by describing this better place to which we are aiming, where the problem has been solved. If we have measurable data, we should use it to illustrate where we want to see improvement.

At the strategic level, we ask ourselves what **outcome** we are seeking to achieve. What would that outcome be like to experience? What would its features be? We identify the measurable **indicators** we would look at to know that we are headed in the right direction.

In an **Action Plan**, we ask ourselves who needs to **be better off**, and in what ways those specific **customers** need to be better off. We use data to set targets to ensure that that improvement is happening in line with our expectations and intentions. As well as the specific features of the improvement we want to see, we must also remember that there are some common objectives towards which we are always heading:

(a) the protection of human rights;
(b) increased equality of opportunity;
(c) sustainable growth;
(d) the rule of law;
(e) maintenance of the institutions of democracy; and
(f) good value for money.

Your policy may not directly contribute to all of these, but they must not work against them.

Where are we now?

In order to develop effective policies, we need to understand the current position and the current problem. This requires access to evidence relating to the here and now. A wealth of data is available about Northern Ireland from the Northern Ireland Statistics and Research Agency (NISRA), individual Departments, the Assembly and its Committees, and the universities.

Other key sources for evidence will be:

(a) professional advisors within the Civil Service: for example, statisticians, economists, medical officers, inspectors, technical and professional officers, scientists, and social researchers;
(b) front-line managers and staff in public bodies;
(c) organisations in the policy field, some of which may commission or have access to information of particular importance or relevance; and
(d) the citizens, customers or consumers to whom the policy is directed.

This kind of evidence may come from Northern Ireland, or from neighbouring and similar jurisdictions.

As well as quantitative evidence, these partners will often have a clearer idea than policy officials about what the problems are, why the situation is as it is and why previous initiatives did or did not work.

Good-quality policy making depends on high-quality information, derived from a variety of sources.

We need to ask key questions when considering whether to use a piece of evidence:

(a) is it relevant?
(b) is it good quality?
(c) which data provides the best information about the issue we want to address; and
(d) in combination, what data sets will inform us most clearly about the situation?

How are we doing?

It is important to analyse the data, to make **sense and meaning** for everyone involved in, and effected by, the policy. There is no point in collecting data for its own sake. Does the data show that we have a problem that needs to be solved, and if so, what exactly is the problem?

(a) are we doing well or badly in comparison with others?
(b) are people's perceptions of the problem borne out by the evidence of what is actually happening?
(c) do the data show evidence of inequalities between different groups;
(d) does the evidence show improvement, or decline, or are things holding steady?
(e) what factors are informing the direction of travel?

International and inter-regional comparisons are important for **benchmarking** Northern Ireland's performance against that of other places.

Partners and collaborators

All areas of public policy involve other people, and we need to engage them at the earliest stages. These may be colleagues in our own department, or in other departments; other public bodies; representative bodies and campaigning groups; organisations in the private sector and the voluntary / community sector; communities and private individuals.

Departments will very often have delivery partners: agencies or other kinds of arm's-length bodies whose remit is to put departmental policy into effect. They know best how existing policy works, how it could be better, and what might happen if you change aspects of policy in different ways.

Our partners will have information and evidence that we do not have. They have insights and perspectives that we need in order to identify the problems we are facing and to develop the solutions that may make a difference. They will have resources we do not have. They may have a physical or online presence where the Department has none. They may be able to convey messages to people we cannot reach or in ways we cannot attempt.

Very rarely, if ever, does a Department have all the means needed to make the intended changes. In fact, it is impossible to imagine that any strategy worthy of the name can be delivered without the participation of partners. To be effective, public policy needs to get partners involved.

Policy officials need to be able to identify partners in any policy field; analyse how important they are to the delivery of the policy; assess how interested or willing they are to collaborate; and work out how best to involve them.

Departments will as a matter of course work closely with partners with shared interests in achieving similar outcomes. In some cases, we can directly support bodies which are collaborating with us. Even when partners also have their own interests, which may not align with the Department's interests or the wider public interest, we can work with them; we need to understand and use the different forms of leverage we have. Finding some shared interest, we can find ways to cooperate, but we must be circumspect and be careful not to compromise our own objectivity or good stewardship of public resources.

How do we get from here to there?

Once we have described where we want to get to, and where we are now, we need to have a plan of how we are going to get from here to there.

- A strategy will set out **what needs to change**.
- An Action Plan will set out **what we need to do** to make, or encourage, that change.

(A Strategy without an Action Plan is just wishful thinking. An Action Plan without a Strategy is a recipe for chaos.)

The first question should be '**should we do anything at all?**' The evidence may suggest that things are already heading in the right direction, or that intervening will make things worse. Experience elsewhere may point to the only thing that might work actually being worse than the problem we are trying to solve. It may be perfectly reasonable for a Minister or the Executive to choose not to act.

If it is right to intervene, we will need a plan.

To construct our plan, **we need to know what works**:

(a) We can look at **what has worked in other places**. We may look at examples of good practice in Northern Ireland, or in other parts of the UK and Ireland, or further afield. There may be communities and administrations more or less similar to our own where the same issues have been addressed effectively.

(b) Practitioners and partners in front-line positions may be able to tell us about **what they know works in practice, and about the lived experience of existing policies**.

(c) We should also look at **what has worked in the past**, at home or elsewhere. There should be evaluations of existing policy interventions available. Sometimes it is worth looking at whether we are now trying to solve a problem that has occurred because we have stopped doing something.

(d) Universities and think-tanks will be exploring what works. Sometimes they draw conclusions from **real-life examples**, and sometimes they can put forward **theories**.

Once we know what might work, we have to analyse the options more closely to understand whether and how they might work here and now. If we look at what has worked in another time or place, we need to know why it worked there, in case our own circumstances are so different that it would not work here and now.

We need to consider how different policies interact; we can make significant changes in one place, only for the effect to be limited by the impact of some other policy.

We should consider both radical change and small-scale change, and we must always give serious consideration to low-cost and no-cost actions.

Ministers often can choose whether their policy **aligns** with the equivalent policy in a neighbouring jurisdiction. Sometimes they might choose alignment for practical purposes, especially if it makes the policy easier or quicker to design or simpler to implement; sometimes all the expertise lies elsewhere, and the NICS does not have the capacity to develop our own, unique policy solution. Ministers can also choose alignment for political purposes. It is sometimes the case that a policy position here needs to align with a policy in another jurisdiction for legal reasons, especially as a consequence of the NI Protocol following the UK's departure from the EU.

If we are presenting policy options to a Minister here that **diverge** from related policies in other jurisdictions, we may need to make sure we can explain the consequences of that divergence and the impact (including the cost) of addressing those consequences.

There are a number of standard ways in which Departments can intervene to put their policy into effect. We can:

(a) encourage and/or require people to act in a particular way, for instance by:

i. communicating the reasons for a particular behaviour or change of behaviour;
ii. educating people and building their capacity to act in a particular way;
iii. making a service or some other kind of provision available for people to use;
iv. 'nudging', that is to say subtly or indirectly encouraging a particular behaviour;
v. subsidizing or incentivizing a positive behaviour;
vi. mandating it in law;

(b) discourage or prevent (all or some) people from acting in a particular way, for instance by:

i. penalising or disincentivising a negative behaviour;
ii. granting permission to act only on those able to fulfil stringent (or costly) conditions;
iii. making something illegal.

When exploring policy solutions, it is worth considering which of these would work, and what risks or challenges are involved in each. We should remember that low-cost and no-cost options are often preferable, as long as they are effective; legislation is time-consuming and resource intensive, and should only be undertaken when necessary.

We also need to recognise that sometimes there is little or nothing that we ourselves can do. In these cases, we must explore how we can **effect change indirectly**. We look to others who can effect change, and what **leverage** we have to help secure that change.

We may have willing partners, and even unwilling partners, who can be persuaded through our own actions to put in place interventions to help achieve our overall objective.

At the same time, we should keep our eyes open to see where positive outcomes can be achieved through our own policy development that we had not, perhaps, been expecting or working towards. If our engagement with partners is wide enough we might find we can do some good as a secondary outcome of our work.

Where a policy will impact upon a range of partners and stakeholders, it can be most effective to design the policy in conjunction with those partners. **Co-design** ensures that the problem is understood, and the proposed policy options are informed by multiple perspectives. It also secures early buy-in to a particular policy solution, which in turn is therefore more limits within which feasible options can be identified and considered, and the degree to which the final policy decision will be the Minister's.

Analysis of Options

Once we have identified a number of options, we need to test them in order to ensure that we can **recommend the best option** to the Minister. There are some tests or appraisals that we must always apply, and some which are good practice, or which are relevant to certain types of policy but not to all.

Proportionality

Some policy solutions may be highly effective, but completely inappropriate because they would be disproportionately intrusive or expensive. The policy development process may show these up, but it should be possible to rule out inappropriate options at an early stage.

Capacity

As a relatively small administration, it is important that an objective assessment is made of whether we are able to develop and deliver each new policy by ourselves. Proper consideration must be made of whether a policy should be developed and/or delivered in partnership with another authority, including a neighbouring administration, which is addressing the same policy challenge. There are times when the best solution is to follow the pattern of an existing policy.

Legality

We must consider whether the solution can be implemented within the law as it currently stands. If not, the Minister can introduce legislation to change the existing law. We should also examine whether a solution is compatible with **human rights law**, with which any other law must be compatible. (It is also worth checking the ambit of the vote for your Department, which defines what the Department can commit resources to; this should be sufficiently wide to cover most things but if you are doing something new it is best to check and make sure that it is covered.)

Secondary Consequences

Many policies will have secondary consequences – effects that are not the immediate objective being pursued. Some secondary consequences can be beneficial, but some will have a negative effect. Part of the policy-design process should be to identify and analyse secondary consequences.
As well as the general practice of identifying secondary consequences, there are some formal processes for analysing secondary consequences.

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1 the Ambit of the vote for your Department can be found in Main Estimates and Supplementary Estimates.

Policy options ought to be examined in line with a range of **impact assessments** – some are mandatory and others are optional but reflect good practice.

Mandatory:

- Equality Impact
- Regulatory Impact
- Rural Needs Impact
- Data Protection Impact

Advisory:

- Health Impact
- Climate Change
- Children's Rights Impact

Modelling

It is advisable to model a small number of policy solutions, to demonstrate how they would stand up to different circumstances, including extreme circumstances. This can be useful to examine what would happen if, for instance, take-up was especially high or especially low, or if costs increased or decreased within a likely range.

Future-proofing is a particular form of modelling where policy options are tested against different future scenarios based upon the greatest external risk factors. Modelling allows us to recognise the risks associated with certain options, and to identify the indicators that a policy, once implemented, is starting to fail.

Value for Money

Public money is the public's money and can only be spent in line with the rules that ensure that it is not wasted or used inappropriately. If a policy action will involve the allocation of public money, a proportionate **business case** will be required.

The point at which the business case should completed is not always clear. If it is possible to distinguish between the development of your Strategy and your Action Plan, then the economic appraisal would be conducted as an aspect of the development of the Action Plan, which sets out where specific interventions will be needed.

Detailed guidance is available for the development of the business case and the economic appraisal of options (see DoF's Better Business Cases NI website). The guidance outlines the importance of seeking the input of specialists throughout the development of the business case; this applies as much to the development of business cases for individual policies as it does to project or programme business cases.

The key point to remember is that the development of the business case is an exercise in appraising and testing options to make a decision which is likely to be the most effective use of resources and ensure value for money. It is not a tool for retrospectively justifying policy decisions already taken in line with other, less formal, assessments.

Done properly, the business case will help to ensure that intended results are delivered, and will enable teams to measure policy success and value for money during and at the end of the policy delivery. So it is important it is kept up to date. If the circumstances change during the life cycle of the policy then the business case should be revisited to ensure that it remains sound.

A Note about Political Acceptability

We may know that certain options would not be politically acceptable to the Minister. It should be possible to include such options for illustrative purposes, even while acknowledging that they are unlikely to be politically acceptable; it is important that we maintain our own political impartiality.

What else might happen?

When we analyse what might effect the change we want, we must also bear in mind that not everything is within our control. Changing things for the better is not always easy; it is because it can be challenging that government will sometimes need to intervene.

We must consider the potential impact of factors outside our control. There may be risks that relate to your specific policy area, but there will also be some risks that are quite common to public policy:

(a) the risk that there are **insufficient resources** (money, staff, expertise) available to implement the policy in full or on time;
(b) the risk that **partners are unwilling or unable to commit** to fulfilling their role in effecting change. This may relate to an organisation or individual, but can equally relate to whole populations. And sometimes partners are being expected to respond to new demands upon their resources from more than one direction;
(c) the risk that **environmental factors**, including the weather, natural events, disease, etc. disrupt the delivery of the policy;
(d) the risk that **decisions taken by other authorities**, including other administrations, counteract or undermine the effectiveness or relevance of our own policies; and
(e) the risk that even our own Department's policies can compromise the proposed new policy.

We need to consider the secondary consequences of our actions, including negative consequences (as above). While we can anticipate and prepare for some secondary consequences, and work to mitigate their negative impact, we must also be ready to respond to **unexpected negative consequences**, and have monitoring systems in place to be able to spot problems as they arise.

Advising and Recommending

The way in which officials advise their Minister will depend upon the Minister's preferences and upon the nature of the policy issue. In advising Ministers, you **must** ensure that you adhere to the NICS values of **Honesty, Integrity, Objectivity and Impartiality**.

There are, however, some key points to remember about policy advice:

(a) it should reflect how and to what extent the policy contributes to wider strategic outcomes, including the Programme for Government, and how it relates to connected policies, including any rubbing points;
(b) it must be an honest account of your analysis of the evidence, and must not hide or misrepresent inconvenient data or material;
(c) it should present the options that have been analysed in an objective and impartial way;
(d) where the implementation of a policy will require dedicated resources, it should include (to an appropriate level of detail) the outcome of the appraisal conducted in the development of the business case;
(e) it should be candid about the risks associated with the options;
(f) it should set out what further stages may be required to reach the point of implementation – e.g. getting Executive agreement, legislating, to securing funding, etc.
(g) it should set out how the policy would be implemented, with costs and timescales set out as far as possible;
(h) it should set out what impact the policy is expected to have, how success would be measured, when the intended change(s) should become apparent,
(i) it should set out what arrangements will be in place so that the Minister has the assurance that the policy is proving effective and that risks are being managed; and
(j) it should make a clear recommendation, and explain the basis for that recommendation.

The decision of the Minister gives us a **mandate** to act, so it is important that the mandate is clear, and is based upon a clear recommendation. For the development of policy from scratch, there can be as many as four distinct mandates:

(a) approval of the intended strategic outcome or outcomes;
(b) approval of the strategy to achieve the outcome;
(c) approval of an action plan; and
(d) (in some cases) approval of an operating policy or protocol.

Are we ready for lift off?

One of the most important lessons from what has worked, and what has failed to work, is the need to be prepared. Some questions to consider from the outset include:

- Are we **clear about what we are doing and why** – and can we explain it in simple terms?
- Has an effective process been undertaken to determine whether the **necessary skills and resources** are in place to deliver the policy safely and competently?
- Do we have the **necessary specialist skills** or can we access them; for example, commercial skills?
- Are the necessary **approvals and supporting documents** in place before expenditure is incurred on the development and implementation of the policy?
- Is the policy new and untested, and has it therefore been **scrutinised appropriately** (well ahead of ministerial and business case approval)?
- Has an independent **starting point review** (typically termed a Gateway) been undertaken and an assessment of feasibility been signed off and completed by the Department's Accounting Officer?
- Do we have appropriate structures in place to develop the policy, including a **Project or Programme Board**?
- Are there particular **risks** associated with a new policy and are we clear about their **likelihood and impact** if they materialise?
- Have risks been **clearly and realistically stated** to senior management and Ministers, with an account of the implementation challenges and how the policy will work on the ground?
- Have risks been **mitigated** or can they be mitigated before moving ahead? (For example, could demand for services exceed supply and can this be controlled to ensure that budgets are not exceeded?)
- Will **regular and accurate information** be in place about how implementation is working in practice, especially when a third party is involved in implementing and/or administering the policy?
- Have professional advisers (such as **economists, finance colleagues, statisticians, lawyers, procurement professionals, etc.**) and as necessary the **Department of Finance** been consulted and how will they be involved going forward?
- Have we **experiences and lessons** from earlier experiences, including **proper handover arrangements** if you are coming new into a policy development exercise?

If you are worried about anything, speak with your colleagues and line management, before moving ahead. Trust any gut feelings that something is not right.

Implementation

The implementation of a policy decision will be determined by the nature of the policy. The **implementation of a strategy** will, in the first instance, be the development of an action plan to address the things that need to change. The **implementation of an action plan** may include:

(a) **changing the law**, including making regulations;
(b) issuing guidance or **communicating** key messages;
(c) commissioning **a new service or product**; and
(d) initiating a **programme of work**.

If it is not clear how you are going to implement your action plan, there must be a problem with the action plan; an action plan, by definition, sets out what you and your partners are going to do. The Minister may be directly involved in implementation (for instance, taking legislation through the Assembly, or communicating policy through speeches or publications), but could equally be at arm's length from implementation. The Minister should sign off the arrangements for implementation and for the degree to which he or she is involved.

In many areas of policy, implementation will involve **partnership** with others. The terms of that partnership need to be very clear from the outset, and robust arrangements put in place to ensure that everyone knows what is expected of each party to the partnership. The policy team does not relinquish responsibility for the success of the policy (or the risk of failure) just because implementation has been passed to a partner.

As a relatively small administration, we should always give proper consideration to whether we can work in **partnership with neighbouring administrations** in the delivery of policy interventions.

Project Delivery

In many cases, implementation of a policy action will be through the establishment of a project or programme. Project or programme methodology enables you and your Minister to have confidence that the implementation of the policy will be properly organized and managed, that the outcomes will be delivered in line with the policy intent, and that the risks will be appropriately addressed.

Even if a formal project or programme structure is not deemed to be appropriate or necessary, many of the principles behind project management should inform the process of implementation.

(a) Are you clear about what you are trying to achieve and can you explain it in simple terms without resorting to jargon or technicalities – would it sound like common sense to a person in the street? If not you may not understand it yourself.
(b) Does your SRO, project team and relevant partners have the necessary capacity, training and skills to deliver?
(c) Are roles and responsibilities clear and in line with good practice?
(d) Do you have an agreed critical path and project plan in place, with agreed timetable, milestones and clearly assigned responsibility?
(e) Have the key dependencies been identified?
(f) Have the risks been identified and dealt with?
(g) Have you subjected the programme or project to **independent scrutiny** in the form of a Gateway Review?

There are many resources to help you to apply programme and project management processes. In particular, you should check out the **Department of Finance website** for guidance and resources. Also speak to your line manager.

When things go wrong, stop

The most important single lesson in implementing policy when things go wrong is that you need to…

STOP

Do not proceed if you have concerns that your policy is set up to fail. In particular:

(a) Do you have the necessary people in place?
(b) Do you have the necessary skills and experience?
(c) Do you have the support you need?
(d) Are Ministers aware of the risks of proceeding?
(e) Has the proposed approach been independently scrutinised?
(f) Are you worried about anything to do with the project, and have you talked to someone about it?

If you are worried about anything, speak with your colleagues and line manager. (In extreme cases, if you feel that colleagues are proceeding recklessly, you should raise this as a concern.)
It is worth saying here that when problems occur in a project there can be a lot of pressure to proceed and indeed to accelerate the approach taken to date. When things are going wrong this is the wrong thing to do.

Sometimes the delivery of the policy is time critical (in response to an emergency, for instance), but it is better to conduct a very quick review than no review at all. You should:

(a) **Stop** what you are doing;
(b) **Review** the work, and even better get someone independent to review it for you;
(c) **Build** the necessary capacity and expertise into the programme of work and/or redefine the programme to deliver a more achievable set of objectives; and when content:
(d) **Proceed** again but with caution and subject to further review.

Remember, there is **nothing wrong** with admitting that something needs to be fixed. There is everything wrong with not admitting there is a problem and trying to fix it yourself. Never be afraid to ask for help.

Measuring Impact and Accounting for Performance

In the same way that it is important to use objective evidence to develop policy actions, it is also essential to use appropriate data in order to ensure that the policy is having the intended effect. Policy is designed to effect change – a strategy effects change for a whole population, action plans effect change for specific 'customers'.

In order to have confidence that the change is happening, it is important that you are able to measure and demonstrate that change. As long as you have developed your policy on the basis of an existing evidence base, you will know how you will measure progress; you will be using the same measurements that you used to identify where you should intervene. You may, additionally, have included some further measurements to round out the picture of progress.

The success of strategy is measured in terms of improvement in the **indicators** that describe the future you want to see. In order to ensure that an action plan is being properly implemented, it is also important to measure how the policies are being delivered, using **performance measurements**.

The most important of these is whether anyone (the customer) is better off. Performance measurements also include management information metrics to tell you how many and what proportion of relevant customers or interactions or responses, etc. the policy has involved.

There are, therefore, three questions that need to be answered in the monitoring of any action plan:

(a) How much have we done?
(b) How well have we done it?
(c) Is anyone better off?

The third question is the most important, but the other two cannot be ignored. Performance accountability has multiple functions:

(a) it tells you how well the policy is working;
(b) it enables you and your Minister to account for performance to the Assembly, to the public and to the media;
(c) it can give you early indications if things are going wrong; and
(d) it allows you to review and revise your policy so that it is more effective in future.

Listening to Concerns

It is also important to listen to others' concerns about policies; you may not be able to foresee where problems might emerge, so the measurements you choose may not be the only ones that matter. People must, therefore, feel confident to highlight concerns, not fear any penalty for doing so, and be supported when they speak up.

Value for Money

Where a policy involves the spending of public money, a specific element of monitoring and accountability is the monitoring of value of money. It is essential to be able to compare costs and benefits (quantitative and qualitative; tangible and intangible) to ensure good results from public expenditure.

The intended value for money of any policy will have been identified as part of the policy development process, specifically in the economic appraisal of the business case. Done properly, this will ensure that attention has been given to measuring value for money at an early stage. It will also ensure the right information and evidence is being collected throughout the implementation process in order to enable its monitoring and reporting. Ongoing monitoring allows changes to be made throughout implementation in order to secure value for money over time.

Evaluation

As well as ongoing monitoring of delivery of any policy intervention, the whole policy development and delivery process will need to be reviewed at an appropriate point, in order to learn lessons. Policy evaluation helps improve the policy being evaluated by identifying strengths and weaknesses; it also helps improve the policy function in the business area and across the service.
Public policy tends to be focused on addressing long-standing and intractable challenges; if it were easy, someone else would already have addressed it. So there is no shame in a policy evaluation identifying ways in which the policy was not successful; that assessment will inform the development of the policy in the future.
By the time you are evaluating your policy, you are likely to be updating your strategy, developing new approaches to making those strategic changes, and preparing a new action plan. These activities form part of the ongoing policy function cycle, and many occur simultaneously.

A Final Word

We wish you all the best on your policy journey and hope that you find this guide, and the material associated with it, to be helpful to you on your way. There is nothing to be afraid of in starting this journey, so long as you follow the principles here. The idea is not to be trapped in meaningless process, but to understand in straightforward terms what you are doing and why. Policy development can become complex, and that is all right too. Just take a step back, especially if you are becoming overwhelmed, and ask for advice.

We all had to learn, and no matter how experienced each of us is in policy development, that process of learning continues throughout our career. Do not be afraid to reach out for help and do not be afraid to admit when you don't know; there are experienced policy officials in all departments who will be happy to work with you or give you a steer. Everyone needs to do that no matter how experienced they are. Policy is challenging, but it is also a lot of fun, especially when it is done well in partnership with others. It is an opportunity to meet new people, learn new skills, understand the place in which we live and make a real difference in the world. So, get out there and give it a go.

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The guidance will be reviewed annually by the Policy Profession Steering Group
The owner of this guidance is the Head of the Policy Profession ***pp*** the Secretary to the Policy Profession

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

Delivering Care: Nurse Staffing in Northern Ireland

Section 1: Strategic Direction and Rationale for general and specialist medical and surgical adult in-hospital care settings

This Section sets out the policy context and rationale for the work of the *Delivering Care* Project in Northern Ireland and includes the following elements:

- Background, context and strategic drivers for developing staffing ranges
- Assumptions of the framework
- Nurse Staffing ranges.

CONTENTS

Preface

A message from the Minister for Health and Public Safety

I am delighted to introduce, *Delivering Care: Nurse Staffing in Northern Ireland*. The document focuses on General and Specialist Medical and Surgical Adult In-hospital Care Settings and is the first in a series which will in time cover all care settings.

This document is a further step in the modernisation of Health Services within Northern Ireland and it is the first time we will measure the inputs of Nurse Staffing against the outputs of Key Performance Indicators of good quality care and patient experience.

Whether a commissioner or a provider of care, you must draw upon this policy document to assist you to understand the environment of care and how that environment demands the application of a particular range of nurse staffing.

The people of Northern Ireland are rightly demanding that they and their relatives are cared for by a workforce which has sufficient nurses, with the right skills, in the right place to ensure the delivery of a compassionate, person centred, safe and effective service which we can be proud of.

My goal has always been to have a world class nursing workforce able to provide world class care and I believe this document better prepares us to ensure that continues to happen.

Edwin Poots, MLA
Minister for Health and Public Safety

Foreword and Acknowledgements

I am pleased to introduce *Delivering Care: Nurse Staffing in Northern Ireland* approved by Edwin Poots, Minister for Health, as the agreed policy direction for formulating the nursing profile of a unit or area. In the Nursing and Midwifery Workforce Planning Project report[1] (SEHDa, 2004), professional judgement was identified as the foundation for nursing and midwifery workload and workforce planning. The approach is subjective and as other objective approaches become available they should be used in conjunction with the *Delivering Care* framework to provide further assurance that the right numbers of staff are available to deliver quality person centred care in Northern Ireland.

This document focuses particularly on medical and surgical units and is the first in a series which will expand to cover a range of major specialties across all programmes of care. As nurses we all have a duty to ensure staffing levels are appropriate and adequate, to provide a high standard of practice and care at all times under the responsibilities outlined within the code of the Nursing and Midwifery Council. This Framework is intended to support Ward Sisters/Charge Nurses, professional and general managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth and in developing new services. Staffing can never be viewed in a vacuum and there is no one perfect tool to define what the staffing profile should be in any particular unit, so it is vital that a number of elements are taken account of such as, the activity within the unit, the requirement to support annual leave, statutory learning and professional regulatory activity, the mix of skill within the workforce, timely recruitment to vacant posts and other factors which might impact on workforce planning, such as the length of stay of patients and the environment. In addition to these elements there must also be an understanding of Key Performance Indicators (KPIs) such as the clinical indicators of good quality care and patient experience. This document should not be viewed in isolation and it will become part of a Nursing KPI Dashboard where the workforce will be one element viewed alongside Clinical Indicators and Patient Experience Indicators. I believe a triangulated approach looking not only at the inputs required to deliver Person Centred Care but also interrogating the outputs which are the quality indicators and the patient experience are essential to improving care within Northern Ireland.

Delivering Care sets out principles for commissioners and providers of Health and Social Care services for planning nursing workforce requirements. Securing sufficient numbers of staff with the appropriate skills and deploying them effectively is a highly complex challenge, and one that I recognise is all the more important as we move through one of the most difficult periods in the history of the Health and Social Care sector in Northern Ireland. The publication of this first piece, in a series of work on staffing ranges, is intended to promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments when commissioning new services to ensure safe, effective, person centred care.

The timing of this framework coincides with the implementation of *Transforming Your Care,* the review of Health and Social Care in Northern Ireland*,* which sets out a range of proposals for the future of services in the region; concluding that there is

[1] Scottish Executive Health Department (2004a) *Nursing and Midwifery Workload & Workforce Planning Project.* Edinburgh: SEHD.

an unassailable case for change and strategic reform. The Nursing and Midwifery workforce must be ready to meet the challenges of Transforming your Care and I believe this framework will assist in those preparations.

I would like to express my sincere thanks to the members of the Steering Group and Working Group who committed their time energy and expertise in the development of this framework document.

I would also like to thank all of the key stakeholders across the Health and Social Care system who took part in the various consultations and workshops during the development of the Framework. A particular word of thanks goes to the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) for the significant project management, co-ordination, facilitation, and contribution to drafting of documents provided during the development of the framework.

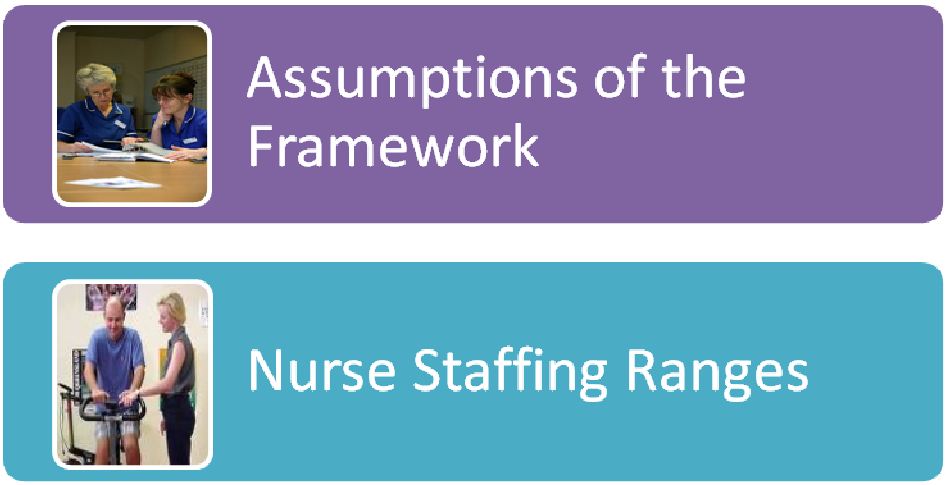
Finally, I would like to thank Professor James Buchan, School of Health, Queen Margaret University, Edinburgh, for reviewing the documents and providing valuable feedback to support the final production and publication of Sections 1 and 2 of the Framework.

This document should now be shared with Health and Social Care Trust Boards and mechanisms established to ensure workforce planning processes are in place throughout Northern Ireland to support safe, effective, person centred care.

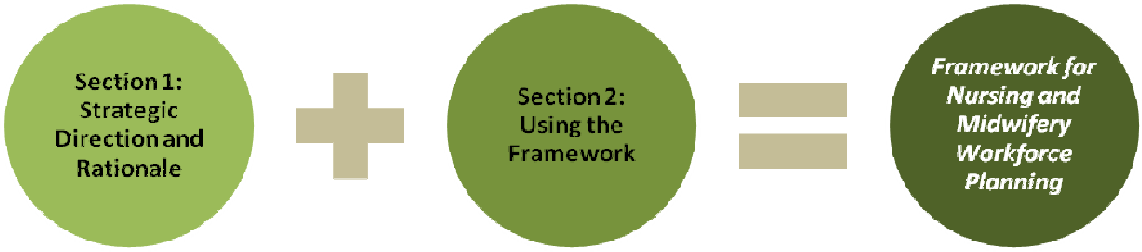
Chief Nursing Officer

Delivering Care: Nurse Staffing in Northern Ireland.

The framework is made up of the following constituent elements:



And is made up of two complimentary documents:



GLOSSARY OF TERMS

Term	Meaning
Hospital Care	The utilisation of a hospital bed during an episode of in-patient treatment or care
Regional Services	Specialist services which are provided from one or two hospital sites for people throughout the region
Framework	This document describes a series of steps which incorporate a number of elements that impact on workforce planning such as nursing: bed ratios, Planned and Unplanned Absence Allowance and influencing factors which can be used to describe the optimum workforce required to support safe, effective, person centred care.
Ward	A group of hospital beds, with associated treatment facilities, managed as a single unit. A ward may function for the full 24 hour period in a 7 day week or within a variation of this pattern. This includes for example: day procedure units, elective surgical units, short stay wards.
Professional Regulatory Requirements	Activity within nursing and midwifery roles which is a professional regulatory requirement, but not necessarily an element of direct care provision. This includes: compliance with standards set by the regulatory body, supervision, and compliance with governance arrangements.
Classification of Clinical Care Settings	
Medicine	A general medicine care setting is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions. This includes, for example: acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units for example: Medical Assessment Units.
Specialist Medicine	A specialist medicine care setting is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, where a higher degree of acuity is anticipated. This includes, for example: specialist respiratory medicine, neurology, coronary care, acute stroke/lysis (general stroke care may often be located within the general medical normative staffing range). This also includes short-stay units, for example, Medical Assessment Units.
Surgery	A general surgery care setting is defined as comprising: adult surgical patients admitted for elective or emergency surgery. This includes, for example: urology, gynaecology, breast and endocrine surgery, orthopaedic surgery, vascular and general surgery.
Specialist Surgery	A specialist surgery care setting is defined as comprising: adult surgical patients admitted for elective or emergency surgery where a higher degree of surgical acuity and/or progressive recovery is anticipated. This includes, for example: neurosurgery, plastics, cardiac and head and neck surgery.

EXECUTIVE SUMMARY

Delivering Care: Nurse Staffing in Northern Ireland has been developed to support the strategic vision identified in *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*[2]. This framework will inform the Public Health Agency's duties detailed in the Health and Social Care Framework, the Department of Health Social Services and Public Safety Commissioning Directions and Health and Social Care Board Commissioning Plan.

The framework should inform Health and Social Care Trusts and Commissioners –

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments and when commissioning new services to provide safe, effective, person centred care
- To support general and professional managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth
- As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

The framework documents incorporate a range of sections that will address a variety of settings across hospital and community care. It should be noted that elements of Section 1 will have relevance to a number of settings and subsequent phases, such as Planned and Unplanned Absence Allowance, Influencing Factors and the requirement to triangulate workforce planning processes with quality information such as Key Performance Indicators (KPIs). In addition, it is anticipated that midwifery staffing levels will be reviewed by the Project Groups as part of the evolving Project Plan.

This framework is based on the best evidence available including a range of recognised workforce planning tools, and has been produced in consultation with a wide range of stakeholders including commissioners and service providers, nurse managers, front-line staff and personal and public involvement, professional and staff side organisations. A core element is the development of a staffing range. This approach has been taken in preference to the simple application of an absolute number or ratio, as individual ward staffing is influenced by a range of factors all of which must be considered.

The importance of this framework is underpinned by regional policy and strategy, evidence base related to staffing levels and patient outcomes, and evidence from public inquiries[3]***.***

The first phase of publication of the framework includes two sections relevant to nurse staffing levels in the first instance:

Section 1: Strategic Direction and Rationale

This Section sets out the policy context and rationale for the work of the *Delivering Care* Project in Northern Ireland and includes the following elements:

- Background, context and strategic drivers for developing staffing ranges
- Assumptions of the framework
- Nurse Staffing ranges.

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[2] Department of Health Social Services and Public Safety. (2008). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.

[3] Please see pages 1 - 3 of this document.

The document is a brief summary of the elements of the framework, how they were agreed and how they might be applied in the context of the changing healthcare settings nurses work in currently.

Section 2: Using the Framework for Medical and Surgical Care Settings

This Section sets out how the elements of the framework might be used practically by Ward Sisters, Charge Nurses, general and professional managers to facilitate constructive conversations around nurse staffing ranges for a particular clinical setting. It includes the following elements:

- Nurse staffing ranges for general and specialist medical and surgical adult care hospital settings
- Factors which influence the point within a staffing range which is appropriate for an individual service or care setting
- Guidance on 'How to Use' the framework.

The products of the *Delivering Care* Project aim to provide all staff, but particularly nurses, both in front line practice, management and commissioning with a framework which will assist workforce planning processes and support constructive conversations about nurse staffing levels in Trusts.

It is anticipated that Health and Social Care Trusts will take account of the recommended staffing ranges contained in this document when developing:

- Proposals to meet the objectives within Transforming Your Care
- New proposals for additional resources to support service innovation and reform
- Developing efficiency and productivity plans for current services.

Over the last number of years changing patterns of service delivery, modernisation of care pathways, increased use of technology, increased patient acuity and higher throughput levels in wards have resulted in changes to staffing levels in Northern Ireland.

The outcome has been a combination of investment in new services and efficiencies in existing services. Executive Directors of Nursing have worked throughout this period of change to ensure staffing levels are maintained at a level that enables the provision of safe, effective person centred care.

This framework will provide a policy context to assist Trusts and commissioners to plan more effectively particularly during this time of transition. Commissioners will as a result, have a regional framework within which they can agree and set consistent ranges for nursing workforce requirements for Health and Social Care Trusts in Northern Ireland.

SECTION 1: STRATEGIC DIRECTION AND RATIONALE

1.0 INTRODUCTION

1.1 The subject of nurse staffing in hospital wards and community settings has been a topic of debate and discussion for a number of years. Ensuring appropriate staffing has been referenced in inquiries and investigations, shown in research evidence and is viewed by patients and their carers as a key element in influencing the quality of care.

1.2 The Independent Inquiry into the failings of the Mid Staffordshire National Health Service (NHS) Foundation Trust[4] highlighted the need for appropriate staffing levels to support safe, effective, person centred care.

Speaking at the publication of his final report, Robert Francis QC said:

> *"The Inquiry found that a chronic shortage of staff, particularly nursing staff, was largely responsible for the substandard care."*
>
> *"The evidence shows that the Board's focus on financial savings was a factor leading it to reconfigure its wards in an essentially experimental and untested scheme, whilst continuing to ignore the concerns of staff."*
>
> *"People must always come before numbers. Individual patients and their treatment are what really matters.....This is what must be remembered by all those who design and implement policy for the NHS."*

2.0 BACKGROUND AND CONTEXT

2.1 There are a number of drivers which have informed the development of the *Delivering Care f*ramework. They include:

Regional Policy and Strategy

2.2 A number of key strategic documents underpinned the development of this framework including:

Transforming Your Care

The strategic review of Health and Social Care (HSC): *Transforming Your Care*[5] sets out the direction of travel for HSC services in Northern Ireland over the next five years. This is supported by the Commissioning Plan[6], which details year on year service provision, priorities and standards that services must meet. The implications of the changes to services in the next five years are significant, particularly in the development of new service models and the response the workforce will be required to make in support of these changes. Examples include:

- A reduction in length of stay for patients in hospital environments resulting in a higher concentration of acutely ill older patients with complex co-existing long term conditions, who require more care and treatment and therefore more intensive nursing care
- Changing Hospital services, more care being provided in patients/clients own homes, community and domiciliary settings
- Technology increasingly used in support of care delivery

[4] Francis, R. (2009). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*. London, HMSO.
[5] Department of Health Social Services and Public Safety/Health and Social Care Board. (2011). *Transforming Your Care. A Review of Health and Social Care in Northern Ireland*. Belfast, DHSSPS.
[6] Health and Social Care Board and Public Health Agency. (2011). *Commissioning Plan 2011/12*. Belfast, HSCB.

› Greater emphasis on the prevention of ill health.

Quality 2020

HSC service provision in Northern Ireland is underpinned by the three key components of: safety, effectiveness and patient/client focus as defined through *Quality 2020*[7]*. Quality 2020* refers to 'Strengthening the Workforce', as one of its strategic goals, elements of which include the continuous need to develop the knowledge and skills of the HSC workforce, measured through improved outcomes for patients and clients.

The People's Priorities

Nurses and midwives are the largest staff group in the HSC system providing general and specialist care and treatment in all HSC environments. Nurses and midwives are central to the provision of quality care and are highly valued by the public in Northern Ireland, a view expressed in the Patient Client Council report: *The People's Priorities*[8] which identified the protection of front-line staff, particularly nurses, as the top priority for the HSC organisations.

A Partnership for Care

The need to develop a framework to support effective workforce planning was identified in *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*[9] and as part of the Health and Social Care Board (HSCB)/Public Health Agency (PHA) Commissioning plan 2011/12[10].

Evidence Base Related to Staffing Levels and Patient Outcomes

2.3 Significant research has been undertaken into the issues of both nurse staffing levels and skill mix, thereby providing a wide literature base in relation to the association between lower numbers of registered nurses and significant reduction of the quality of patient outcomes[11]. Examples include:

› Fewer registered nurses, increased workload, and changing nursing teams in care environments were linked to negative patient outcomes including falls and medication errors on medical/surgical units in a mixed method study combining longitudinal data (5 years) and primary data collection[12].

› Features of the hospital work environment, such as better staffing ratios of patients to nurses, nurse involvement in decision making, and positive doctor-nurse relations, are associated with improved patient outcomes, including mortality and patient satisfaction[13].

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[7] Department of Health Social Services and Public Safety. (2011). *Quality 2020, A 10 Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland*. Belfast, DHSSPS.

[8] Patient Client Council. (2010). *'The People's Priorities. A View from Patients, Service Users, Carers, and Communities on Future Priorities for Health and Social Care in Northern Ireland'*. Belfast, PCC.

[9] Department of Health Social Services and Public Safety. (2010). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.

[10] Health and Social Care Board and Public Health Agency. (2011). *Commissioning Plan 2011/12*. Belfast, HSCB. Available for download at: http://www.hscboard.hscni.net/publications/Commissioning%20Plans/490%20Commissioning%20Plan%202011-2012%20-%20PDF%20993KB.pdf

[11] Flynn, M. and McKeown, M. (2009). 'Nurse staffing levels revisited: a consideration of key issues in nurse staffing levels and skill mix research'. *Journal of Nursing Management*. 17, 759 – 766.

[12] Duffield, C., Diers, D., O'Brien-Pallas, L., Aisbett, C., Roche, M., King, M., Aisbett, K. (2011). Nursing staffing, Nursing workload, the work environment and patient outcomes. *Applied Nursing Research*. 24(4), pp 244 – 255.

[13] Aiken, L.H., et al. (2011). Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *British Medical Journal*. 344, e1717.

- Links have been demonstrated between lower numbers of registered nurses and increased length of stay and associated cost.[14]
- The Health Care Commission following an investigation into links between nursing workforce and patient outcomes concluded that staffing levels appeared to be based on traditional and/or costs constraints rather that patient need or outcomes.[15]

Evidence from Public Inquiries

2.4 As previously mentioned, a number of public inquiries have highlighted the need for appropriate staffing levels in health and care settings. Examples include:

Mid Staffordshire NHS Foundation Trust

The recommendations of the Francis Inquiry[1617] identified the importance of including nursing staff at all levels in discussions related to standards of care and the resources required to deliver safe and effective, person centred care. Referring to the long term failures of the Trust, Robert Francis QC stated: *'The quality of nursing during that period suggested that staffing levels had been acknowledged to have been too low as long ago as 1998.'*[18]

Public Inquiry into the Outbreak of Clostridium Difficile

The *Public Inquiry into the Outbreak of Clostridium Difficile*[19] raised a number of issues in relation to the ability of the organisation to provide safe and effective standards of care regarding infection prevention and control, linked to historic staffing levels. The Final Report stated: *'Underfunding within nursing and domestic services had been a particular difficulty for many years, and had been raised frequently with the Northern Health and Social Services Board, the main commissioner of services in the Trust.'*[20]

NHS Review

The NHS review into the quality of care and treatment provided by 14 hospital trusts in England[21] by Professor Sir Bruce Keogh recommended that '*nurse staffing levels and skill mix'* should *'appropriately reflect the caseload and the severity of illness of the patients they are caring for.'* This recommendation was made in light of the fact that the review teams found inadequate numbers of nursing staff in a number of ward areas, which was compounded by an over-reliance on unregistered support staff and temporary staff.

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[14] Cho, S.H., et al (2003). The effects of Nurse Staffing on Adverse Events: Morbidity, Mortality and Medical Costs. *Nursing research*. 52, pp 71-79.
[15] Health Care Commission. (2005). *Ward Staffing*. London, Health Care Commission.
[16] Francis, R. (2009). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*. London, TSO.
[17] Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London, TSO
[18] *Op Cit*, n 16, page 396.
[19] Hine, D. (2011). *Public Inquiry into the Outbreak of Clostridium Difficile in Northern Trust Hospitals.* Available for download at: http://www.cdiffinquiry.org
[20] *Ibid*, page 76.
[21] Keogh, B. (2013). *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. Available for download at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

Why Develop a Range?

2.5 It was anticipated from the outset of this work that the process of developing staffing ranges would be progressed in a phased approach to address other areas of clinical practice such as: emergency department, district nursing, health visiting, mental health and learning disability care settings.

Aim

2.6 The overarching aim of the work was:

To support the provision of high quality care, which is safe and effective in hospital and community settings, through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities.

Scope and Objectives

2.7 The scope of Phase 1 was to: *Develop a staffing ranges framework related to general and specialist adult hospital medical and surgical care settings.*

2.8 Objectives were designed to enable completion of a framework and achieve the required outcomes of Phase 1 which included: the production of a regional descriptor of a range of staffing levels for general and specialist medical and surgical adult care hospital settings; development of a list of factors which influence or impact upon the appropriate staffing range for defined general and specialist adult hospital medical and surgical care settings; a format of presentation for a framework which would include user guidance. A summary of the process used to develop the framework can be found at Appendix 1, page 19 of this document.

Range not Ratio?

2.9 There are a number of questions which could arise in relation to the rationale for defining a range, rather than an absolute number or ratio[22]. This framework describes a range of nurse staffing which would normally be expected in specific specialities. It provides, therefore, a reasonable starting point for discussions about the appropriate staffing in a particular ward. **It does not** prescribe the staff numbers that should be on every ward and at every point in time, as this must be developed in discussion with staff, managers and commissioners and is dependent on a range of factors which influence planning processes. It is also important that planning processes will include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPIs) for safe, effective, person centred care.

2.10 It is anticipated that on occasion nurse staffing may be outside the policy range. In such cases the Executive Director of Nursing must provide assurances about the quality of nursing care to these patients, and the efficient use of resources through internal and external professional and other assurance frameworks, including KPI dashboards.

2.11 It is expected that HSC Trusts will take account of the staffing ranges contained in this framework in developing proposals to meet the objectives within *Transforming Your Care*, in supporting new proposals for additional resources and when developing efficiency and productivity plans.

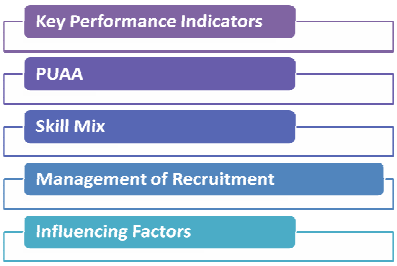
[22] Buchan, J. (2005). A certain ratio? The policy implications of minimum staffing ratios in nursing. *Journal of Health Services Research and Policy*. 10, 4: 239 – 244. This article reviews the strengths and weaknesses of using an absolute defined ratio, concluding that there are potential inefficiencies if wrongly calibrated, coupled with relative inflexibility.

2.12 In addition, commissioners will be able to use the framework within which they can agree and set consistent ranges for nursing workforce requirements for providers of health and social care in Northern Ireland.

ASSUMPTIONS OF THE FRAMEWORK

3.0 Introduction

3.1 The framework refers to staffing ranges expressed as nursing: bed ratios reflecting the view that the family of nursing comprises both registered and unregistered staff, included collectively within the ratios.



3.2 A number of underpinning assumptions must be considered when understanding how a range is set and might be used within the context of this framework. These assumptions are outlined below.

ASSUMPTION 1:
ASSURANCE OF SAFETY, QUALITY AND EXPERIENCE THROUGH KEY PERFORMANCE INDICATORS

3.3 The first assumption underpinning the use of the framework is the requirement to provide assurance across a number of quality outcomes for people receiving care and treatment through Key Performance Indicators (KPIs) which have been regionally agreed as sensitive to nursing care. The evidence base referred to at paragraph 2.3, page 2, of this document supports the view that the use of nursing sensitive KPIs can demonstrate either effective workforce planning, or conversely, a need for review of a nursing workforce staff complement.

3.4 A regional Project Group in Northern Ireland has led the development of high level KPIs for nursing and midwifery to measure, monitor and evidence the impact and unique contribution the nursing has on the quality of patient and client care. There are three domains within which indicators have been presented for organisations to monitor: Organisational, Safe and Effective Care and Patient Experience. Many organisations in Northern Ireland are currently presenting some of this information via HSC Trust 'dashboard' systems, which allow data sets to be viewed collectively across all wards and departments. It is intended that as more indicators are agreed regionally, they will be added to the existing governance data systems in each Trust. Examples of the current indicators within each domain are:

Organisational: absence rates within nursing and midwifery teams; normative staffing ranges which will include vacancy rates.

Safe and Effective Care: incidence of pressure ulcers, falls, omitted or delayed medications.

Patient Experience: consistent delivery of nursing/midwifery care against identified need; involvement of the person receiving care in decisions made about their nursing care; time spent by nurses with the patient.

It is recognised that such quality information, which is being continuously monitored, will demonstrate the efficacy of staffing levels in a particular clinical area. Where the

staffing complement meets the demand of the service being provided, quality indicators should demonstrate that safe, effective, person centred care is being delivered. Should quality indicators begin to fall below the accepted level of achievement, staffing levels should be reviewed as one of the lines of enquiry of attributable causes.

ASSUMPTION 2:
PLANNED AND UNPLANNED ABSENCE ALLOWANCE

3.5 Planned and Unplanned Absence Allowance (PUAA) refers to periods of absence from work, which can be described as anticipated and, therefore, must be factored into the workforce planning process. This comprises annual leave, sickness[23], and mandatory study leave. It was necessary, therefore, when describing nurse or midwifery[24] staffing to agree an allowance which could be factored in to any subsequently developed range.

Rationale

3.6 Telford (1979)[25] remains the extant nurse workforce planning tool in use in Northern Ireland and the United Kingdom. This methodology recognises the need for 'allowances and amendments for sickness, absence, holidays, in-service training and nursing education'[26] in any method of effective workforce planning.

3.7 In 2006, the Royal College of Nursing recommended a PUAA of 25%[27]. Similarly, the Healthcare Commission recommended a minimum of 24% in 2005[28], prior to the implementation of Agenda for Change[29].

3.8 Other professions have reflected a requirement to build in allowances for planned and unplanned leave. For example, the medical profession referred to the necessity of 'supporting professional activities' within the Consultant Contract Framework (2003)[30]. *Professional activities* were identified as: training, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local governance activities. Leave is also directed to be built into weekly job planning for consultant teams, including an average of 10 days per year of professional activity[31]. It should be noted that sickness absence was not accounted for within the Consultant Contract framework.

3.9 In 2002, the Auditor General for Scotland[32] identified a requirement for Planned and Unplanned Leave Allowance to be taken into account within nursing workforce planning processes, outlined in **Table 1**, page 7.

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[23] 'Sickness' refers to both short and long term sick leave, with long term defined as 20 days or over and up to six months.
[24] It should be noted that this element of the assumptions of the framework is applicable to nursing and midwifery.
[25] Telford, W.A. (1979). *A Method of Determining Nursing Establishments*. Birmingham, East Birmingham Health District.
[26] *Ibid*, page 2 of the referenced document.
[27] Royal College of Nursing Policy Unit. (2006). *Setting Appropriate Ward Nurse Staffing levels in NHS Acute Trusts*. London, RCN.
[28] Health care Commission. (2005). *Ward Staffing*. London, Health Care Commission.
[29] Department of Health. (2004). *Agenda for Change - Final Agreement*. Available for download at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4099423.pdf
[30] Department of Health, Social Service and Public Safety. (2003) *Consultant Contract Framework*. Available for download at: http://www.dhsspsni.gov.uk/scu-consultantcontract.pdf
[31] Department of Health, Social Service and Public Safety. (2008). *Regional Guidance on Job Planning for Medical and Dental Consultants in Northern Ireland*. Available for download at: http://www.dhsspsni.gov.uk/regional-guidance-on-job-planning-for-medical-and-dental-consultants-in-northern-ireland.pdf Page 15 - 16.
[32] Audit Scotland. (2002). *Planning ward nursing – legacy or design?* Edinburgh, Auditor General.

Table 1:

Planned and Unplanned Absence Allowance, Auditor General Scotland[32].

Year	Annual Leave:	Sick Leave:	Study Leave:	Total Allowance
2002	13.5%	5.5%	3%	22%

Annual Leave

3.10 The implementation of Agenda for Change[33] provided an increase from 25 to 33 days' leave for staff with a service record of 10 years or over. This substantial increase would, therefore, require that the allowance for annual leave calculated within PUAA is increased from that adopted in 2002. A reduction in the number of public holidays from 12 to 10 provided an overall net increase of 16%.

3.11 For the purposes of the framework, annual leave is calculated at the mid point of the Agenda for Change[34] leave allocation, which is 29 days + 10 days public holidays = 39 days. There are 260 working days per year for a full time/37.5hr person. This equates to 39/260 = **15%.**

Sickness Absence

3.12 *Priorities for Action*[35] outlined the regional target for 'absenteeism' in 2011 at 5.2%. The 5% level set within the PUAA is below this regional target recognising the need for continuous improvement in this area.

Mandatory Study Leave

3.13 In response to the increased intensity and complexity of patient care and the need to support the continuing provision of safe, effective, person centred care, mandatory training needs have significantly increased for the nursing and midwifery workforce in the last 10 years from 2002. This includes regulatory requirements such as: meeting the Nursing and Midwifery Council (NMC) Standards for Learning and Assessment in Practice[36], statutory midwifery supervision and the Chief Nursing Officer's standards for supervision in nursing[37], as well as a range of clinical competencies which are required to comply with national and regional policy or standards. Examples of the types of training required for all staff and professional staff and associated hours required are outlined in **Table 2**, page 9. There is a regulatory requirement for professional updating, elements of which may be undertaken in a registrant's own time. As more robust revalidation models are progressed in light of the Francis Inquiry[38], it is essential that PUAA can accommodate this.

3.14 The nursing and midwifery workforce has a high percentage of individuals that choose part-time working arrangements - 56% full time, 44% part time[39]. Training must be provided on the basis of headcount as opposed to Whole Time Equivalents, which considerably increases the overall number of staff requiring training.

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[33] Department of Health. (2004). *Agenda for Change - Final Agreement*. Available for download at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4099423.pdf

[34] The NHS Staff Council. (2014). *NHS terms and conditions of service handbook*. Available for download at: http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook

[35] Department of Health, Social Service and Public Safety. (2010). *Priorities for Action 2010 - 2011*. Belfast DHSSPSNI.

[36] Nursing and Midwifery Council. (2010). *Standards for Pre-registration Nursing Education*. London, NMC.

[37] Chief Nursing Officer for Northern Ireland. (2007). *Standards for Supervision in Nursing*. Belfast, DHSSPSNI.

[38] Francis, R. (2009). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*. London, TSO.

[39] *Ibid*.

Future Allowances

3.15 It was therefore proposed that the average level applied in 2002 of 22% should be reviewed to reflect the changes to annual leave allowances, and statutory and mandatory training requirements for professional and non-professional staff within a ward team.

3.16 The revised allowances, stipulated at **Table 3**, below, have been agreed by the Nursing and Midwifery Leaders in Northern Ireland, using those defined by the Auditor General (2002)[40] as a starting point, taking into consideration the elements mentioned in paragraphs 3.10 – 3.14, page 7. It should be noted that the defined percentage will be subject to ongoing review and potential amendment by relevant professional forums, reflecting developments in training requirements and training delivery methods. The ranges incorporate a Planned and Unplanned Absence Allowance of 24%.

Table 3: Comparative Planned and Unplanned Absence Allowances

Year	Annual Leave:	Sick Leave:	Study Leave:	Total Allowance
2002	13.5%	5.5%	3%	22%
2013	15%	5%	4%	24%

3.17 This agreement should enable discussions between commissioners and service providers to take place in relation to workforce planning for the future.

3.18 It should be noted that an agreement was reached through the *Delivering Care* Project Groups, that Planned and Unplanned Absence Allowance should not include absence for maternity leave. The Nursing and Midwifery Leaders in Northern Ireland recognise that Maternity Leave is a particular challenge for service providers due to the predominance of females in the workforce.

[40] Audit Scotland. (2002). *Planning ward nursing – legacy or design?* Edinburgh, Auditor General.

TABLE 2

EXAMPLES OF STATUTORY[41] AND MANDATORY[42] TRAINING FOR NURSING AND MIDWIFERY STAFF[43]

	Annual commitment (average in hours)	One off commitment (average in hours)	
Core skills – all staff*			
Equality, diversity and human rights	-	7.5	To include complaints handling
Fire Safety	2	-	
Health and Safety	2.5	3.75	To include COSHH / waste management
Infection prevention and control	3.75	-	
Moving and handling	3.75	-	
Safeguarding adults	3.75	-	Increased training required as per role and responsibility
Safeguarding children	3.75	-	Increased training required as per role and responsibility
Resuscitation	3.75	-	Basic life support to Advanced Life Support dependent on need
Information governance	-	3.75	To include record keeping, data protection etc.
Statutory and mandatory training for nursing and midwifery			
Clinical policy and guidelines updates	7.5	-	MUST nutrition tools / tissue viability / NEWS / haemovigilance etc.
Nursing / Midwifery specific training	15	-	Includes statutory supervision & obstetric emergencies for midwives / mentorship etc. for nurses
Clinical skills	11.25		Includes end of life care / violence and aggression etc.
New equipment / technologies	7.5		New equipment training needs including Point of Care Testing
Total	**64.5**	**15**	

79.5 hours / 7.5 hours per day = 10.6 days per year

10.6 days / 260 working days per year = **4.07% allocation for training**

*Ref: UK Core Skills and Training Framework, Skills for Health 2012

[41] **Statutory Training:** is training that an organisation is legally required to provide, as defined in law (and consequently a legal paper can be referenced), or where a statutory body has instructed organisations to provide training on the basis of legislation.

[42] **Mandatory Training:** is a training requirement that has been determined by an organisation (i.e. in policy). Mandatory training is concerned with minimising risk, providing assurance against policies, and ensuring that the organisation meets external standards, for example: Zero Tolerance Violence and Aggression training.

[43] It should be noted that unregistered staff do not attend training which is in place as a result of a professional or regulatory requirement.

ASSUMPTION 3:
SKILL MIX

3.19 This term refers to the ratio of registered to unregistered nursing staff working within a complement of staff in an individual care setting. The level of skill mix required for any particular clinical setting may vary. The agreed skill mix for a particular clinical setting must be applied when using this framework. For example, in critical care settings a skill mix comprising mostly registered staff is required to facilitate safe and effective person centred care; this is due to the complexity and acuity of the patient profile of people cared for in such environments. Conversely, where there are high levels of dependency but a lower level of acuity[44], a skill mix comprising a higher level of unregistered staff may be appropriate. A level of skill mix will be determined regionally for a variety of care settings by the Nursing and Midwifery Leaders in Northern Ireland, based on best available evidence such as recognised workforce planning tools, related to the care setting under consideration. The skill mix relevant to a particular setting will be included within the subsequent '*Using the Framework for..*' sections. To reference the skill mix for general and specialist medical and surgical adult hospital care settings, please see page 3 of Section 2.

3.20 Skill mix should take account of an allocation of 100% of a Ward Sister's/Charge Nurse's time to '*fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward.*'[4546]

3.21 An appropriate number of Agenda for Change Bands 6 – 7 within a ward setting is also required to have sufficient grade mix to ensure availability of a senior decision maker(s) – Band 6 or above – over the seven day week.

ASSUMPTION 4:
MANAGEMENT OF RECRUITMENT

3.22 It is recognised that due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained.

3.23 Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements:

- Maintenance of staffing levels, which support the delivery of safe and effective, person centred care
- Avoidance of overuse of temporary staff, for example, bank and agency staff
- Matching of staff skill and band mix to patient acuity and dependency within approved guidelines[47]
- Timely and ongoing review of risk assessments linked to service reconfigurations.

[44] For definitions of acuity and dependency please see Influencing Factors, *Delivering Care*, Section 2.
[45] Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN. P 18.
[46] Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary*. London, TSO. Recommendation 195, p 106.
[47] For information related to skill mix for medicine and surgery, please see *Delivering Care* Section 2, page 3.

ASSUMPTION 5:
INFLUENCING FACTORS

3.24 It is acknowledged that workforce planning for nursing staff is both complex and diverse[48]. The application of processes or approaches to gauge the number of individuals required with the right level of competence, to provide the appropriate level of care for a particular patient/client group, can be a challenge to those tasked with accurately defining workforce requirements. Triangulation[49] is required of a number of relational factors which impact on the workforce, for example: patient/client dependency, environmental factors, proximity to other services. The Steering Group of the Staffing Ranges Project has defined these factors within four domains:

- Workforce
- Environment and Support
- Activity
- Professional Regulatory Requirements.

3.25 It is important, therefore, that these factors are taken into consideration when workforce planning discussions take place, to adopt an appropriate ratio within the defined range for a care setting. Further information on factors which influence workforce planning in medical and surgical settings can be found in Section 2, pages 7 - 13.

NURSE STAFFING RANGES

4.0 Nurse Staffing Ranges for General and Specialist Medicine and Surgery

MEDICINE

4.1 A **general medical care setting** is defined as comprising adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, including acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units for example: Medical Assessment Units.

4.2 A **specialist medical care setting** is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, where a higher degree of acuity is anticipated, including for example: specialist respiratory medicine, neurology, coronary care, acute stroke/lysis (general stroke care may often be located within the general medical normative staffing range). This also includes short-stay units, for example: Medical Assessment Units.

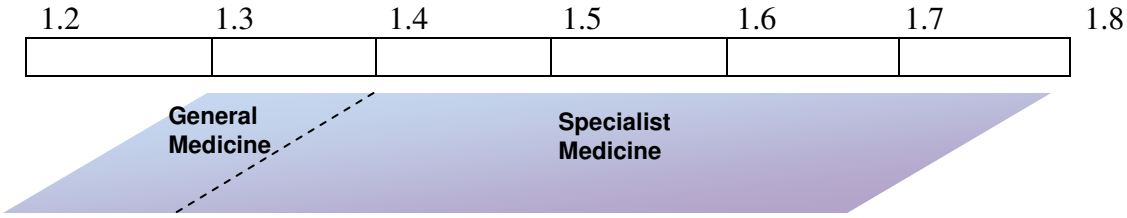
4.3 In some general ward areas, existing ***in both medical and surgical settings***, a cohort of dedicated beds for specialist services may exist, for example: 8 specialist respiratory care beds within a 24 bed general respiratory ward. As models of care for general medicine move towards specialisms, the number of specialist beds may increase. Where this occurs, a number of calculations will need to be made on two or more cohorts of patients to determine an overall appropriate nursing/bed ratio.

4.4 **Figure 1,** page 12, pictorially represents the range for general and specialist medicine, the majority of general medical wards defined between 1.3 and 1.4, recognising that small number may fall below 1.3 to 1.2 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist medicine, fewer wards being defined at the top end of the range (1.8) and

[48] Ball, J. (2010). *Guidance on Safe Nurse Staffing Levels in the UK*. London, RCN. Page 6.
[49] *Ibid.*

lower end of the specialist range (1.3). The range stipulated includes an allowance of 24% for PUAA.

Figure 1: Nurse Staffing Range for General and Specialist Medicine.



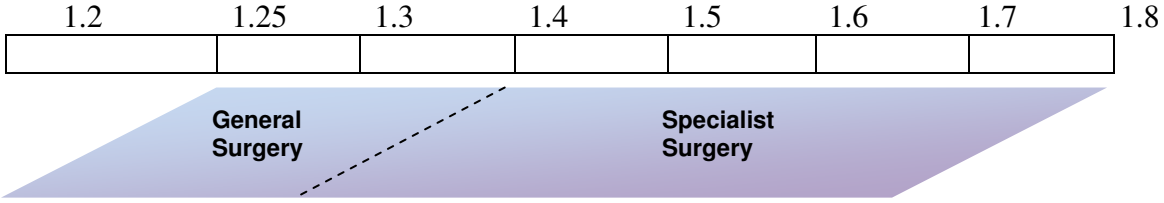
SURGERY

4.5 A **general surgical care setting** is defined as comprising adult surgical patients admitted for elective or emergency surgery, including for example: urology, gynaecology, breast and endocrine surgery, orthopaedic surgery, vascular and general surgery.

4.6 A **specialist surgical care setting** is defined as, comprising adult surgical patients admitted for elective or emergency surgery where a higher degree of surgical acuity and/or progressive recovery is anticipated, including for example: neurosurgery, plastics, cardiac and head and neck surgery.

4.7 **Figure 2** below, pictorially represents the range for general and specialist surgery, the majority of general surgical wards defined between 1.25 and 1.4, recognising that a small number may fall below 1.25 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist surgery, fewer wards being defined at the top end of the range and lower end of the range. The range stipulated includes an allowance of 24% for PUAA. For further information as to how the ranges were described and agreed, please go to page 19 of this document.

Figure 2: Nurse Staffing Range for General and Specialist Surgery.



4.8 Providing an example: The Ward Sister of a 24 bed medical ward has used a Telford Exercise, coupled with the use of influencing factors to determine that her ward should be staffed at 1.3 on the nursing: bed range.

This equates to: 24 x 1.3 = 31.2 Whole Time Equivalents (WTE) to provide safe, effective person centred nursing care.

Adding in the requirement for the 100% (1 WTE) allocation of Ward Sister time for supervision/ management responsibilities, this equates to a Funded Establishment of 32.2 WTE, in this example.

With a skill mix of 70:30 this allows for:

- 21.84 WTE registered staff (0.7 x 31.2)
- 9.36 WTE unregistered staff (0.3 x 31.2)
- 1.0 WTE Ward Sister.

ILLUSTRATIVE EXAMPLE

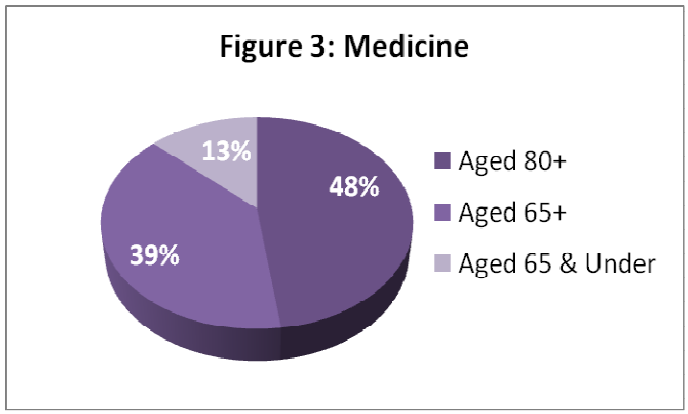
The illustration contained within pages 13 - 16 highlights a snapshot of the activity in an *actual* medical ward in Northern Ireland.

Along with an overview of activity within the snapshot, the numbers of staff that the range for general medical settings represents are described. It is also worthy of note that in addition to the demonstrated workload element, there are a number of activities which are part of the professional role of nursing staff, which are not outlined within the illustration, including, for example: professional supervision, preceptorship, or mentorship of pre-registration students. For further information, refer to the *Influencing Factors* section of the framework outlined within Section 2, and, para. 3.13, page 7, of this document.

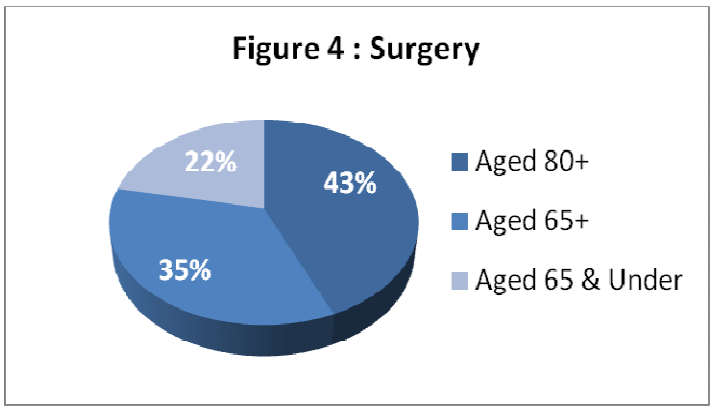
This illustration depicts an adult general medical ward, with 24 beds divided between 1 x 4 bedded bays, 2 x 6 bedded bays and 8 single rooms. The profile below provides a picture of the type of person nurses are currently caring for in hospital-based care. **Figures 3 and 4,** also below, demonstrate the age demographics of people within acute care services, from a snapshot of a medical and surgical ward in a Trust in Northern Ireland.

Patient Profile

John's story is typical of someone who is being cared for within adult hospital-based acute medical services in Northern Ireland. John is 81 years old. He lives on his own and has recently been experiencing difficulty breathing. 17 years ago, he suffered a number of small strokes from which he fully recovered and he now remains on medication to prevent further deterioration. Two years ago he had his right kidney removed because a malignant tumour had been found. He is usually independent, but suffers from severe pain from osteoarthritis in both knees which means he walks with a stick. His mobility is quite limited as a result and recently he has been increasingly unsteady.

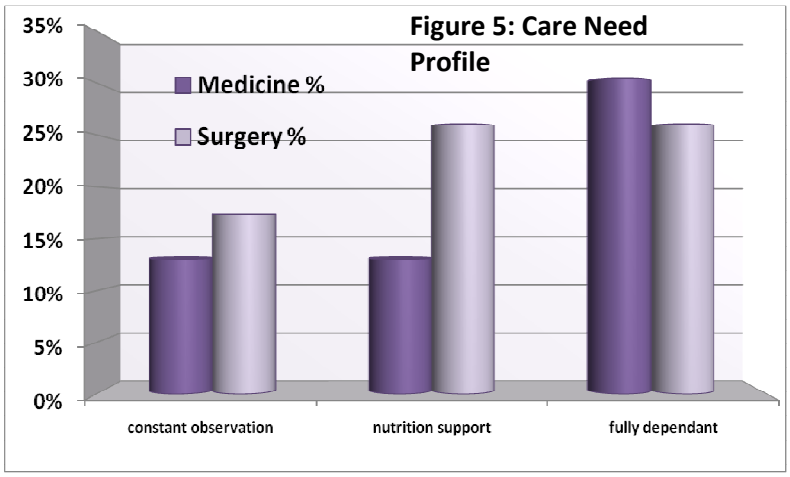


John's daughter, who lives 20 miles away from him, has told staff that she thinks he has fallen at home when on his own because of bruises and cuts on his face and limbs. She also feels he has not been eating sufficiently at home. When he reaches the ward, he is tired and distressed, and makes it clear to staff he does not want to be in hospital. The change of environment along with an abnormal blood chemistry and increasing shortness of breath means he becomes disorientated and confused, requiring constant observation. His breathlessness is diagnosed as being a symptom of congestive cardiac failure, for which he receives an intravenous drug which increases his urinary



output. This intervention has the effect of John wanting to walk to the toilet frequently. He also requires a number of investigations outside of the ward area all of which he has to be accompanied by one member of staff because he is at high risk of falling or accident. His lethargy means he has no interest in eating, is unable to take care of himself, and needs assistance to eat, drink and wash.

Figure 5, below, presents a profile of some of the types of care needs that the people identified in **Figures 3 and 4**, page 13, present with during an episode of care in hospital. The graphs correspond to percentages of the total number of people in a medical or surgical care setting. Nurses are caring for an increasingly significant number of people, who are like ***John***, with multiple care needs, unable to care for themselves and requiring a high level of support. It should be noted that this is not exhaustive of the totality of care provided.

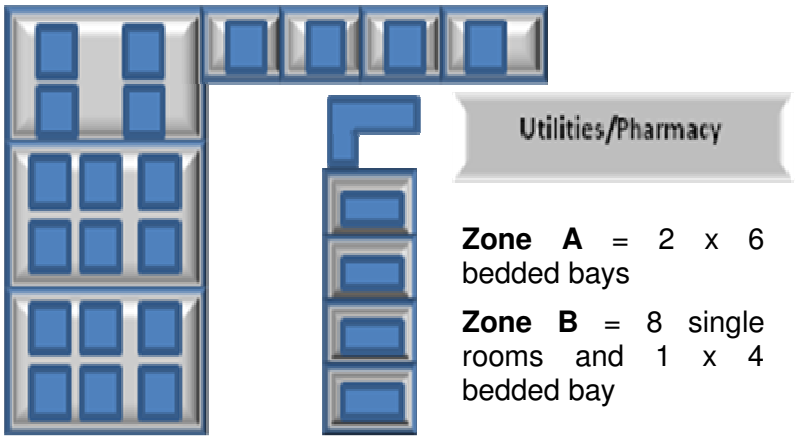


It should be noted that the profile of people being admitted for care within general/specialist medical and surgical settings is changing all the time.

Northern Ireland has a population of approximately 1.8 million people and is the fastest growing population in the UK. The number of people over 85 years old is predicted to increase by 19.6% by 2014, and those over 75 years increasing by 40% by 2020. More people are living longer, with long term conditions and disabilities, which can be further complicated by more than one condition in some cases[50] and a requirement for complex drug regimen.

A recent audit of practice carried out in a HSC Trust in 2013 demonstrated that 73% of people in an acute medical ward required Intravenous medications (IVs). This percentage equated to a total of 96 doses required in a 24 hour period, which require two registered nursing staff to check, prepare and administer per HSC Trust policy, with an average preparation and administration time of 9 minutes per patient per dose. This represents 29 hours of time spent by registered nurses in the management and administration of complex drug regimes in a 24 hour period.

Diagram 1: Ward Layout.



Zone A = 2 x 6 bedded bays

Zone B = 8 single rooms and 1 x 4 bedded bay

Environment

Diagram 1, right, depicts a typical ward layout. This environment of care means nurse staffing is divided into two teams Zone A

[50] Department of Health Social Services and Public Safety/Health and Social Care Board. (2011). *Transforming Your Care. A Review of Health and Social Care in Northern Ireland*. Belfast, DHSSPS.

and Zone B. The design of the ward environment is an important element in the consideration of staffing complements. A number of factors relating to the care environment may impact on the ability of the nursing team to deliver safe, effective, person centred care such as: vision, travel distances to supplies and utilities, creating cohorts of beds and use of technology.

For example, direct lines of vision for nursing staff into the patients' room(s) from a corridor are essential to allow for maximum patient observation, which requires large vision panels. Beds should be clustered in appropriate groups to maximise staff efficiency and to reduce travel distance to supplies and utilities. In addition, provision of decentralised staff bases in all ward environments provides uninterrupted lines of sight to patients and also allows the patients to see staff.

Appropriate location of storage for clinical supplies, equipment and consumables, including the location of utilities can positively influence productivity of nursing staff. This can be further enhanced by the provision of local daily supplies dedicated to bed clusters thereby reducing the travel distance within a ward.

This also applies to the location of departmental adjacencies such as x-ray and diagnostics particularly important when nursing staff are required to escort patients to other clinical areas/settings for diagnostics/ interventions/treatments.

Staffing Profile

Table 4 below, presents the required staffing complement that cares for the people outlined in the patient profile in **Figures 3 - 5**, pages 13 - 14.

Table 4: Staffing Complement

	Mon	Tues	Wed	Thu	Fri	Sat	Sun
Morning							
Registered	5	5	5	5	5	4	4
Band 3	1	1	1	1	1	1	1
Band 2	2	2	2	2	2	1	1
Afternoons							
Registered	5	5	5	5	5	4	4
Band 3	1	1	1	1	1	1	1
Band 2	1	1	2	2	1	1	1
Evening							
Registered	4	4	4	4	4	4	4
Band 3							
Band 2	1	1	1	1	1	1	1
Night Duty							
Registered	3	3	3	3	3	3	3
Band 3							
Band 2	1	1	1	1	1	1	1

This equates to a nursing:bed ratio of 1.3 and a skill mix of 70:30% registered/unregistered staff. Not included in calculations in this illustration is 1 WTE (100%) allowance for leadership and management /supervisory responsibilities of the Ward Sister/Charge Nurse and 24% Planned and Unplanned Absence Allowance.

5.0 IMPLEMENTING AND MONITORING THE FRAMEWORK

5.1 HSC Trusts will be monitored in relation to implementation of *Delivering Care: Nurse Staffing in Northern Ireland* year-on-year through the indicators of performance measures across Health and Social Care. In addition, staffing levels will also be monitored through the Chief Nursing Officer's Professional Assurance Framework. Nursing Key Performance Indicators (KPIs) currently being developed in Northern Ireland should assist in providing feedback related to the quality of care within care settings. This should provide useful information about the quality of care particularly in relation to those settings which have been benchmarked with the framework. In addition to KPIs and other indicators related to the nursing workforce, this information should assist in determining the efficacy of the framework and the way in which it is being used.

6.0 CONCLUSION

6.1 This document sets out the strategic direction and rationale for the development of a framework to support nurse workforce planning in Northern Ireland, beginning with general and specialist acute adult hospital medical and surgical care settings.

6.2 The framework should be used by HSC Trusts to take account of the recommended staffing ranges when developing:

- Proposals to meet the objectives within *Transforming Your Care*
- New bids for additional resources to support service innovation and reform
- Developing efficiency and productivity plans for current services.

6.3 It will inform both the Health and Social Care Trusts and commissioners:

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments and when commissioning new services to provide safe, effective, person centred care
- To support general and professional managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth
- As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

6.4 Commissioners will, as a result, have a regional framework in which they can agree and set consistent ranges for nursing workforce requirements for HSC Trusts in Northern Ireland.

Appendices

Appendix 1 - METHODOLOGY OVERVIEW AND PROCESS SUMMARY

Methodology Overview

The work undertaken by the Steering Group of this project took place from May 2011 to September 2012. Membership and Terms of Reference of the Steering Group are included at Appendix 2, page 21. A Working Group was also established, Membership and Terms of Reference included at Appendix 3, page 22.

At the outset of the project, it was recognised that determining appropriate staffing ranges was a complex process, dependent on a variety of factors, including the complexity of illness; level of co-morbidities; case mix; throughput; length of stay; and geographical layout of the environment. During 2009/10, a 'task and finish' group, supported by the Department of Health Social Services and Public Safety (DHSSPS), took forward work to scope a range of nursing/bed ratios for a number of general and specialist, medical and surgical areas within the acute care sector. The work of this group informed the approach used within the project.

The Steering Group agreed and implemented a project plan for Phase 1 to achieve the aim and objectives, which included a work programme encompassing the following components:

- Two time-limited literature reviews were conducted to determine:
  a. Methodologies for defining staffing ranges in general care settings, which have been reported nationally and internationally
  b. Available evidence-based staffing ranges or ratios which have been developed for adult hospital medical and surgical specialties
- A range of interviews were conducted with HSC Trust partners to gather information in relation to staffing ranges work which had been taken forward
- Using the work completed by the DHSSPS in 2010, a Glossary of Terms was agreed
- Development and agreement of a suite of factors within four domains, which should support nurses to determine where, along a continuum available within a staffing range, the needs of the people they care for may be met safely and effectively
- Information from available national expertise was gathered to inform the work of the Project.

Process Summary

Two time-limited literature reviews were undertaken to inform the work of the project. The first was conducted by the Business Services Organisation, Clinical Education Centre, and reviewed methodologies for defining staffing ranges in general care settings, which have been reported nationally and internationally. The conclusions from this review were that existing knowledge and practice in relation to staffing ratios and workforce planning remained relevant. In addition, there has been the recent development in England of an electronic tool to assist workforce planning – the Safer Nursing Care Tool[51]. The second literature review focused on available evidence-based staffing ranges or ratios, which have been developed for adult hospital medical and surgical specialties. This review, carried out by the PHA, confirmed that little work had been reported in relation to evidence-based staffing ranges/ratios for particular adult hospital medical and surgical specialties.

Between May and July 2011, a NIPEC Senior Professional Officer, undertook a number of face-to-face interviews with the nursing and midwifery workforce leads in each of the five HSC Trusts. These interviews informed the project by facilitating the revisiting and refreshing of data captured during the 2009/10 task and finish exercise, and identified a list of factors which could influence the point within a staffing range at which a nursing team might be set. In

[51] Information regarding the Safer Nursing Care Tool is available for download at: http://www.institute.nhs.uk/quality_and_value/introduction/safer_nursing_care_tool.html

addition, work to establish agreed staffing ranges for general adult hospital medical and surgical care settings was supported. During the completion of this work, it became apparent that it would be helpful to agree staffing ranges for specialist medical and surgical care settings, to support the generalist ranges, given that many general clinical settings currently exist with cohorts of beds dedicated to other types of services in specialist care.

The ranges for the data refreshing exercise provided a continuum measurement from which a range might be set, based on existing staffing complements within Northern Ireland. It should be noted that HSC Trust organisations had previously reviewed funded establishments based on a range of workforce planning tools including Telford[52] and the Association of United Kingdom University Hospitals[53]. Given that Planned and Unplanned Absence Allowances (PUAA) were included in historical funding within legacy Health and Personal Social Services Boards of between 18% to 23%, ranges were set to reflect the recommended 24% PUAA (please see page 14 of this document).

Following this exercise, the Working Group agreed a list of core influencing factors, set within four domains, from which definitions of terms and impact were developed.

Throughout the progress of the project work, a number of sources of expertise were available to the Steering and Working Groups, both regionally and nationally. In particular, contact was made with the Institute for Innovation and Improvement in relation to the Safer Nursing Care Tool, and the Central Manchester University Hospitals National Health Service (NHS) Foundation Trust in relation to the development of a simplified version of an electronic nursing workforce planning tool. The learning from these exercises informed the approach to the staffing ranges, which were agreed regionally and which constitute an element of this phase of the Framework.

The outcomes achieved by the completion of Phase 1 of the Project were:

i. A relevant Glossary of Terms

ii. Definition of staffing ranges in relation to general and specialist adult hospital medical and surgical care settings

iii. Definition of a Planned and Unplanned Leave Allowance

iv. Definition of a number of Influencing Factors, which impact upon the delivery of safe and effective care, and which determine the ratio within a staffing range at which a nursing team might be set.

It should be noted that, whilst the overarching aim of this project encompassed nursing and midwifery staff, the first two documents, Sections 1 and 2 were directed towards nursing staff only, due to the areas for which staffing ranges have been defined. It is acknowledged, however, that there are elements of Section 1 which will have relevance to midwifery settings, such as Planned and Unplanned Absence Allowance and Influencing Factors.

[52] Telford, W.A. (1979). *A Method of Determining Nursing Establishments*. Birmingham, East Birmingham Health District.
[53] Association of UK University Hospitals (2009) *Patient Care Portfolio. AUKUH acuity/dependency tool: implementation resource pack*, London: AUKUH. Tool and related literature are available for download from www.aukuh.org.uk

APPENDIX 2 - MEMBERSHIP OF STEERING GROUP

Representation for	Representative
PHA	Pat Cullen, Director of Nursing and Allied Health Professions, Chair, from April 2012 to present day. Mary Hinds, Director of Nursing and Allied Health Professions, Chair from April 2011 – April 2012.
HSC Trust Executive Directors of Nursing	Alan Corry-Finn, Executive Director of Nursing, WHSCT.
Human Resources	Myra Weir, Assistant Director of Human Resources (from April 12), SEHSCT.
HSC Trust Nursing and Midwifery Workforce Leads	Nicki Patterson, Co-Director of Nursing (Workforce) replaced by Allison Hume (August 2013).
PHA	Siobhan McIntyre, Regional Lead Nurse Consultant, Chair of Working Group.
DHSSPS	Kathy Fodey, Nursing Officer, Workforce replaced by Caroline Lee (September 2013).
Regional Partnership Forum	Rita Devlin, Senior Professional Development Officer (RCN).
HSCB	Paul Turley, Assistant Director Commissioning, (non-registrant).
Patient Client Council	Maeve Hully, Chief Executive.
NIPEC	Maura Devlin, Interim Chief Executive (to August 2011) Glynis Henry, Chief Executive (from Sep 2011).
NIPEC	Angela Drury, Senior Professional Officer (Lead Officer).

Administrative Support: Mrs Linda Woods (NIPEC)

TERMS OF REFERENCE

Terms of Reference for the Steering Group are as follows:

TOR1 To agree a project plan, timescales and methodology for the project
TOR2 To contribute to the achievement of the project aims and objectives
TOR3 To undertake ongoing monitoring of the project against the planned activity
TOR4 To receive progress reports from the Project Lead and agree actions arising
TOR5 To contribute to the final report for submission to the PHA
TOR6 To adhere to principles of confidentiality in relation to communication and dissemination of information regarding the project
TOR7 To approve appropriate communiqués for wider dissemination
TOR8 To review the impact of the tool 12 months after development and implementation.

Membership of Steering Group is non-transferrable, other than in exceptional circumstances and with prior agreement of the Chair.

APPENDIX 3 - MEMBERSHIP OF THE WORKING GROUP

Organisation	Representative
PHA	Chair – Siobhan McIntyre, Regional Lead Nurse Consultant.
NIPEC	Angela Drury, Senior Professional Officer NIPEC (Lead Officer).
DHSSPS	Kathy Fodey, Nursing Officer, Workforce replaced by Caroline Lee (September 2013)
DHSSPS	Mary Maguire, Health Estates replaced by Gillian Kelly (June 2013).
SHSCT	Glynis Henry, Assistant Director of Nursing (Workforce Lead) until August 2011, replaced by Lynn Fee (February 2012).
NHSCT	Allison Hume, Assistant Director of Nursing (Workforce Lead).
SEHSCT	Caroline Lee, Assistant Director of Nursing (Workforce Lead) replaced by Sharon McRoberts (September 2013).
WHSCT	Brendan McGrath, Assistant Director of Nursing (Workforce Lead).
BHSCT	Nicki Patterson, Co-Director Nursing (Workforce Lead) replaced by Moira Mannion (August 2013).

Administrative Support: Mrs Linda Woods (NIPEC)

TERMS OF REFERENCE

Terms of Reference for the Working Group are as follows:

TOR1 To contribute to the achievement of the project aims and objectives.

TOR2 To participate in the agreement and testing of a tool to define staffing ranges in general and specialist adult medical and surgical hospital care settings.

TOR3 To participate in the amendment and testing of the tool in other general and specialist hospital care settings.

TOR4 To participate in the amendment and testing of the tool in mental health and learning disability inpatient and community care settings.

TOR5 To contribute to reports offered to the Steering Group.

TOR6 To contribute to the interim and final reports for submission to the PHA.

TOR7 To adhere to principles of confidentiality in relation to communication and dissemination of information regarding the project.

TOR8 To approve appropriate communiqués for wider dissemination.

TOR9 To review the impact of the tool 12 months after development and implementation.

APPENDIX 4 - ABBREVIATIONS

Abbreviation	Meaning
BHSCT	Belfast Health and Social Care Trust
DHSSPS	Department of Health, Social Services and Public Safety
FE	Funded Establishment
HCSW	Health Care Support Worker
HSC	Health and Social Care
HSCB	Health and Social Care Board
KPI	Key Performance Indicator
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NI	Northern Ireland
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
PHA	Public Health Agency
RCN	Royal College of Nursing
WHSCT	Western Health and Social Care Trust
WTE	Whole Time Equivalent

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

Delivering Care: Nurse Staffing in Northern Ireland

Section 2: Using the Framework for general and specialist medical and surgical adult in-hospital care settings

This Section sets out how the elements of the framework might be used practically by Ward Sisters, Charge Nurses, general and professional managers to facilitate constructive conversations around nurse staffing ranges for a medical and surgical care settings. It includes the following elements:

- Nurse staffing ranges for general and specialist medical and surgical adult care hospital settings
- Factors which influence the point within a staffing range which is appropriate for an individual service or care setting
- Guidance on 'How to Use' the framework.

CONTENTS

Preface

A message from the Minister for Health and Public Safety

I am delighted to introduce, *Delivering Care: Nurse Staffing in Northern Ireland*. The document focuses on General and Specialist Medical and Surgical Adult In-hospital Care Settings and is the first in a series which will in time cover all care settings.

This document is a further step in the modernisation of Health Services within Northern Ireland and it is the first time we will measure the inputs of Nurse Staffing against the outputs of Key Performance Indicators of good quality care and patient experience.

Whether a commissioner or a provider of care, you must draw upon this policy document to assist you to understand the environment of care and how that environment demands the application of a particular range of nurse staffing.

The people of Northern Ireland are rightly demanding that they and their relatives are cared for by a workforce which has sufficient nurses, with the right skills, in the right place to ensure the delivery of a compassionate, person centred, safe and effective service which we can be proud of.

My goal has always been to have a world class nursing workforce able to provide world class care and I believe this document better prepares us to ensure that continues to happen.

Edwin Poots, MLA
Minister for Health and Public Safety

Foreword and Acknowledgements

I am pleased to introduce *Delivering Care: Nurse Staffing in Northern Ireland* approved by Edwin Poots, Minister for Health, as the agreed policy direction for formulating the nursing profile of a unit or area. In the Nursing and Midwifery Workforce Planning Project report[1] (SEHDa, 2004), professional judgement was identified as the foundation for nursing and midwifery workload and workforce planning. The approach is subjective and as other objective approaches become available they should be used in conjunction with the *Delivering Care* framework to provide further assurance that the right numbers of staff are available to deliver quality person centred care in Northern Ireland.

This document focuses particularly on medical and surgical units and is the first in a series which will expand to cover a range of major specialties across all programmes of care. As nurses we all have a duty to ensure staffing levels are appropriate and adequate, to provide a high standard of practice and care at all times under the responsibilities outlined within the code of the Nursing and Midwifery Council. This Framework is intended to support Ward Sisters/Charge Nurses, professional and general managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth and in developing new services. Staffing can never be viewed in a vacuum and there is no one perfect tool to define what the staffing profile should be in any particular unit, so it is vital that a number of elements are taken account of such as, the activity within the unit, the requirement to support annual leave, statutory learning and professional regulatory activity, the mix of skill within the workforce, timely recruitment to vacant posts and other factors which might impact on workforce planning, such as the length of stay of patients and the environment. In addition to these elements there must also be an understanding of Key Performance Indicators (KPIs) such as the clinical indicators of good quality care and patient experience. This document should not be viewed in isolation and it will become part of a Nursing KPI Dashboard where the workforce will be one element viewed alongside Clinical Indicators and Patient Experience Indicators. I believe a triangulated approach looking not only at the inputs required to deliver Person Centred Care but also interrogating the outputs which are the quality indicators and the patient experience are essential to improving care within Northern Ireland.

Delivering Care sets out principles for commissioners and providers of Health and Social Care services for planning nursing workforce requirements. Securing sufficient numbers of staff with the appropriate skills and deploying them effectively is a highly complex challenge, and one that I recognise is all the more important as we move through one of the most difficult periods in the history of the Health and Social Care sector in Northern Ireland. The publication of this first piece, in a series of work on staffing ranges, is intended to promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments when commissioning new services to ensure safe, effective, person centred care.

The timing of this framework coincides with the implementation of *Transforming Your Care,* the review of Health and Social Care in Northern Ireland*,* which sets out a range of proposals for the future of services in the region; concluding that there is an unassailable case for change and strategic reform. The Nursing and Midwifery

[1] Scottish Executive Health Department (2004a) *Nursing and Midwifery Workload & Workforce Planning Project.* Edinburgh: SEHD.

workforce must be ready to meet the challenges of Transforming your Care and I believe this framework will assist in those preparations.

I would like to express my sincere thanks to the members of the Steering Group and Working Group who committed their time energy and expertise in the development of this framework document.

I would also like to thank all of the key stakeholders across the Health and Social Care system who took part in the various consultations and workshops during the development of the Framework. A particular word of thanks goes to the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) for the significant project management, co-ordination, facilitation, and contribution to drafting of documents provided during the development of the framework.

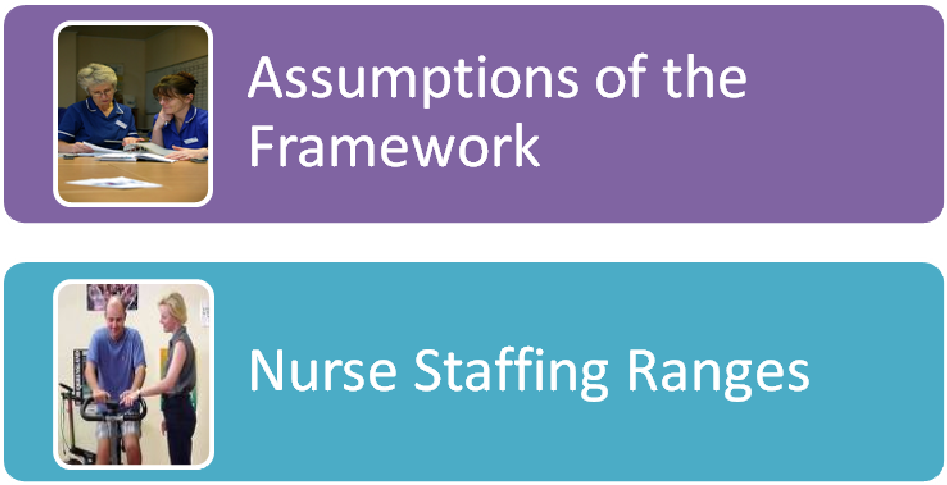
Finally, I would like to thank Professor James Buchan, School of Health, Queen Margaret University, Edinburgh, for reviewing the documents and providing valuable feedback to support the final production and publication of Sections 1 and 2 of the Framework.

This document should now be shared with Health and Social Care Trust Boards and mechanisms established to ensure workforce planning processes are in place throughout Northern Ireland to support safe, effective, person centred care.

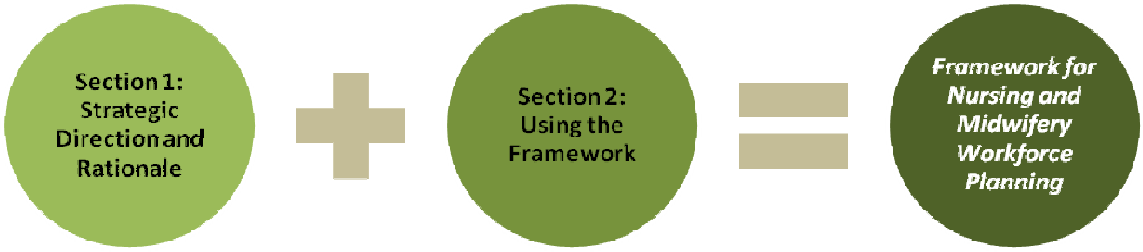
Chief Nursing Officer

Delivering Care: Nurse Staffing in Northern Ireland.

The framework is made up of the following constituent elements:



And is made up of two complimentary documents:



GLOSSARY OF TERMS

Term	Meaning
Hospital Care	The utilisation of a hospital bed during an episode of in-patient treatment or care
Regional Services	Specialist services which are provided from one or two hospital sites for people throughout the region
Framework	This document describes a series of steps which incorporate a number of elements that impact on workforce planning such as nursing: bed ratios, Planned and Unplanned Absence Allowance and influencing factors which can be used to describe the optimum workforce required to support safe, effective, person centred care.
Ward	A group of hospital beds, with associated treatment facilities, managed as a single unit. A ward may function for the full 24 hour period in a 7 day week or within a variation of this pattern. This includes for example: day procedure units, elective surgical units, short stay wards.
Professional Regulatory Requirements	Activity within nursing and midwifery roles which is a professional regulatory requirement, but not necessarily an element of direct care provision. This includes: compliance with standards set by the regulatory body, supervision, and compliance with governance arrangements.
Classification of Clinical Care Settings	
Medicine	A general medicine care setting is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions. This includes, for example: acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units for example: Medical Assessment Units.
Specialist Medicine	A specialist medicine care setting is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, where a higher degree of acuity is anticipated. This includes, for example: specialist respiratory medicine, neurology, coronary care, acute stroke/lysis (general stroke care may often be located within the general medical normative staffing range). This also includes short-stay units, for example, Medical Assessment Units.
Surgery	A general surgery care setting is defined as comprising: adult surgical patients admitted for elective or emergency surgery. This includes, for example: urology, gynaecology, breast and endocrine surgery, orthopaedic surgery, vascular and general surgery.
Specialist Surgery	A specialist surgery care setting is defined as comprising: adult surgical patients admitted for elective or emergency surgery where a higher degree of surgical acuity and/or progressive recovery is anticipated. This includes, for example: neurosurgery, plastics, cardiac and head and neck surgery.

EXECUTIVE SUMMARY

Delivering Care: Nurse Staffing in Northern Ireland has been developed to support the strategic vision identified in *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*[2]. This framework will inform the Public Health Agency's duties detailed in the Health and Social Care Framework, the Department of Health Social Services and Public Safety Commissioning Directions and Health and Social Care Board Commissioning Plan.

The framework should inform Health and Social Care Trusts and Commissioners –

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments and when commissioning new services to provide safe, effective, person centred care
- To support general and professional managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth
- As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

The framework documents incorporate a range of sections that will address a variety of settings across hospital and community care. It should be noted that elements of Section 1 will have relevance to a number of settings and subsequent phases, such as Planned and Unplanned Absence Allowance, Influencing Factors and the requirement to triangulate workforce planning processes with quality information such as Key Performance Indicators (KPIs). In addition, it is anticipated that midwifery staffing levels will be reviewed by the Project Groups as part of the evolving Project Plan.

This framework is based on the best evidence available including a range of recognised workforce planning tools, and has been produced in consultation with a wide range of stakeholders including commissioners and service providers, nurse managers, front-line staff and personal and public involvement, professional and staff side organisations. A core element is the development of a staffing range. This approach has been taken in preference to the simple application of an absolute number or ratio, as individual ward staffing is influenced by a range of factors all of which must be considered.

The importance of this framework is underpinned by regional policy and strategy, evidence base related to staffing levels and patient outcomes, and evidence from public inquiries[3]***.***

The first phase of publication of the framework includes two sections relevant to nurse staffing levels in the first instance:

Section 1: Strategic Direction and Rationale

This Section sets out the policy context and rationale for the work of the *Delivering Care* Project in Northern Ireland and includes the following elements:

- Background, context and strategic drivers for developing staffing ranges
- Assumptions of the framework
- Nurse Staffing ranges.

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[2] Department of Health Social Services and Public Safety. (2010). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.

[3] Please see pages 1 - 3 of this document.

The document is a brief summary of the elements of the framework, how they were agreed and how they might be applied in the context of the changing healthcare settings nurses work in currently.

Section 2: Using the Framework for Medical and Surgical Care Settings

This Section sets out how the elements of the framework might be used practically by Ward Sisters, Charge Nurses, general and professional managers to facilitate constructive conversations around nurse staffing ranges for a particular clinical setting. It includes the following elements:

- Nurse staffing ranges for general and specialist medical and surgical adult care hospital settings
- Factors which influence the point within a staffing range which is appropriate for an individual service or care setting
- Guidance on 'How to Use' the framework.

The products of the *Delivering Care* Project aim to provide all staff, but particularly nurses, both in front line practice, management and commissioning with a framework which will assist workforce planning processes and support constructive conversations about nurse staffing levels in Trusts.

It is anticipated that Health and Social Care Trusts will take account of the recommended staffing ranges contained in this document when developing:

- Proposals to meet the objectives within Transforming Your Care
- New proposals for additional resources to support service innovation and reform
- Developing efficiency and productivity plans for current services.

Over the last number of years changing patterns of service delivery, modernisation of care pathways, increased use of technology, increased patient acuity and higher throughput levels in wards have resulted in changes to staffing levels in Northern Ireland.

The outcome has been a combination of investment in new services and efficiencies in existing services. Executive Directors of Nursing have worked throughout this period of change to ensure staffing levels are maintained at a level that enables the provision of safe, effective person centred care.

This framework will provide a policy context to assist Trusts and commissioners to plan more effectively particularly during this time of transition. Commissioners will as a result, have a regional framework within which they can agree and set consistent ranges for nursing workforce requirements for Health and Social Care Trusts in Northern Ireland.

SECTION TWO: USING THE FRAMEWORK FOR MEDICAL AND SURGICAL CARE SETTINGS

1.0 INTRODUCTION

1.1 This document is the second section of *Delivering Care: Nurse Staffing in Northern Ireland.* It is designed to assist all staff, but particularly nurses, both in front line practice, management and commissioning, in the process of nursing workforce planning.

1.2 This section contains the following elements of the framework:

- Nurse staffing ranges for general and specialist medical and surgical adult care hospital settings
- Factors which influence the point within a staffing range which is appropriate for an individual service or care setting
- Guidance on 'How to Use' the framework.

1.3 For further information relating to the background, context and process of the work surrounding the development of the framework please refer to Section 1 of *Delivering Care*.

Range not Ratio?

1.4 There are a number of questions which could arise in relation to the rationale for defining a range, rather than an absolute number or ratio[4]. This framework describes a range of nurse staffing which would normally be expected in specific specialities. It provides, therefore, a reasonable starting point for discussions about the appropriate staffing in a particular ward. **It does not** prescribe the staff numbers that should be on every ward and at every point in time, as this must be developed in discussion with staff, managers and commissioners and is dependent on a range of factors which influence planning processes. It is also important that planning processes will include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPIs) for safe, effective, person centred care.

1.5 It is anticipated that on occasion nurse staffing may be outside the normal range. In such cases the Executive Director of Nursing must provide assurances about the quality of nursing care to these patients, and the efficient use of resources through internal and external professional and other assurance frameworks, including KPI dashboards.

1.6 It is expected that HSC Trusts will take account of the recommended staffing ranges contained in this framework in developing proposals to meet the objectives within *Transforming Your Care*, in supporting new proposals for additional resources and when developing efficiency and productivity plans.

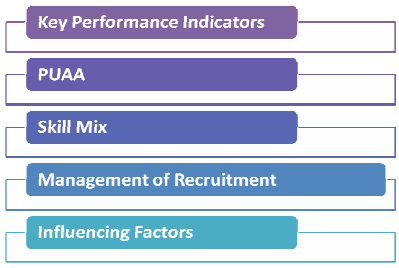
1.7 In addition, commissioners will be able to use the framework within which they can agree and set consistent ranges for nursing workforce requirements for providers of health and social care in Northern Ireland.

[4] Buchan, J. (2005). A certain ratio? The policy implications of minimum staffing ratios in nursing. *Journal of Health Services Research and Policy*. 10, 4: 239 – 244. This article reviews the strengths and weaknesses of using an absolute defined ratio, concluding that there are potential inefficiencies if wrongly calibrated, coupled with relative inflexibility.

ASSUMPTIONS OF THE FRAMEWORK

2.0 Introduction

2.1 The framework refers to staffing ranges expressed as nursing: bed ratios reflecting the view that the family of nursing comprises both registered and unregistered staff, included collectively within the ratios.



2.2 A number of underpinning assumptions must be considered when understanding how a range is set and might be used within the context of this framework. These assumptions are outlined below.

ASSUMPTION 1:

ASSURANCE OF SAFETY, QUALITY AND EXPERIENCE THROUGH KEY PERFORMANCE INDICATORS

2.3 The first assumption underpinning the use of the framework is the requirement to provide assurance across a number of quality outcomes for people receiving care and treatment through Key Performance Indicators (KPIs) which have been regionally agreed as sensitive to nursing care. The evidence base referred to at paragraph 2.3, page 2, of Section 1, supports the view that the use of nursing sensitive KPIs can demonstrate either effective workforce planning, or conversely, a need for review of a nursing workforce staff complement.

2.4 A regional Project Group in Northern Ireland has led the development of high level KPIs for nursing and midwifery to measure, monitor and evidence the impact and unique contribution the nursing has on the quality of patient and client care. There are three domains within which indicators have been presented for organisations to monitor: Organisational, Safe and Effective Care and Patient Experience. Many organisations in Northern Ireland are currently presenting some of this information via HSC Trust 'dashboard' systems, which allow data sets to be viewed collectively across all wards and departments. It is intended that as more indicators are agreed regionally, they will be added to the existing governance data systems in each Trust. Examples of the current indicators within each domain are:

Organisational: absence rates within nursing and midwifery teams; normative staffing ranges which will include vacancy rates.

Safe and Effective Care: incidence of pressure ulcers, falls, omitted or delayed medications.

Patient Experience: consistent delivery of nursing/midwifery care against identified need; involvement of the person receiving care in decisions made about their nursing care; time spent by nurses with the patient.

It is recognised that such quality information, which is being continuously monitored, will demonstrate the efficacy of staffing levels in a particular clinical area. Where the staffing complement meets the demand of the service being provided, quality indicators should demonstrate that safe, effective, person centred care is being delivered. Should quality indicators begin to fall below the accepted level of

achievement, staffing levels should be reviewed as one of the lines of enquiry of attributable causes.

ASSUMPTION 2:
PLANNED AND UNPLANNED ABSENCE ALLOWANCE

2.5 The ranges incorporate a Planned and Unplanned Absence Allowance of 24%. This allowance refers to periods of anticipated absence from work and should, therefore, be factored into the workforce planning process. This includes annual leave, sickness[5], and mandatory study leave. This element is further defined in *Section 1* of the framework, page 6. It should be noted that the defined percentage will be subject to ongoing review and potential amendment by relevant professional forums, reflecting developments in training requirements and training delivery methods.

ASSUMPTION 3:
SKILL MIX

2.6 This term refers to the ratio of registered to unregistered nursing staff working within a complement of staff in an individual care setting. The level of skill mix required for any particular clinical setting may vary. The agreed skill mix for a particular clinical setting must be applied when using this framework. For example, in critical care settings a skill mix comprising mostly registered staff is required to facilitate safe and effective person centred care; this is due to the complexity and acuity of the patient profile of people cared for in such environments. Conversely, where there are high levels of dependency but a lower level of acuity[6], a skill mix comprising a higher level of unregistered staff may be appropriate.

2.7 The Nursing and Midwifery Leaders in Northern Ireland have defined skill mix for an adult hospital-based general medical or surgical care setting as 70:30 registered:unregistered staff, based on best available evidence such as recognised workforce planning tools, related to this care setting. Some flexibility within the stated skill mix in any given area will be tolerated, to maximise the use of support staff, where higher levels of dependency and lower levels of acuity exist and there is evidence to demonstrate that safe, effective, person-centred care is being provided. The skill mix should not, however, fall below 65:35 registered:unregistered staff.

2.8 Skill mix should take account of an allocation of 100% of a Ward Sister's/Charge Nurse's time to '*fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward.*'[7][8]

An appropriate number of Agenda for Change Bands 6 – 7 within a ward setting is also required to have sufficient grade mix to ensure availability of a senior decision maker(s) – Band 6 or above – over the seven day week.

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[5] 'Sickness' refers to both short and long term sick leave, with long term defined as 20 days or over and up to six months.
[6] For definitions of acuity and dependency please see Influencing Factors, *Delivering Care*, Section 2.
[7] Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN. P 18.
[8] Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary*. London, TSO. Recommendation 195, p 106.

ASSUMPTION 4:
MANAGEMENT OF RECRUITMENT

2.9 It is recognised that due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained.

2.10 Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements:

- Maintenance of staffing levels, which support the delivery of safe and effective, person centred care
- Avoidance of overuse of temporary staff, for example, bank and agency staff
- Matching of staff skill and band mix to patient acuity and dependency within approved guidelines[9]
- Timely and ongoing review of risk assessments linked to service reconfigurations.

ASSUMPTION 5:
INFLUENCING FACTORS

2.11 It is acknowledged that workforce planning for nursing staff is both complex and diverse[10]. The application of processes or approaches to gauge the number of individuals required with the right level of competence, to provide the appropriate level of care for a particular patient/client group, can be a challenge to those tasked with accurately defining workforce requirements. Triangulation[11] is required of a number of relational factors which impact on the workforce, for example: patient/client dependency, environmental factors, proximity to other services. The Steering Group of the Staffing Ranges Project has defined these factors within four domains:

- Workforce
- Environment and Support
- Activity
- Professional Regulatory Requirements

2.12 It is important, therefore, that these factors are taken into consideration when workforce planning discussions take place, to adopt an appropriate ratio within the defined range for a medical or surgical setting. The tables contained at pages 7 - 13 outline the Influencing Factors within the four identified domains, including the following descriptions:

- A definition of what the factor means in terms of using the framework
- An indication of how the factor impacts on staffing ranges, with related guidance
- A list of helpful resources in relation to the factors described.

[9] For information related to skill mix please see assumption 3, page 3.
[10] Ball, J. (2010). *Guidance on Safe Nurse Staffing Levels in the UK*. London, RCN. Page 6.
[11] *Ibid*.

5.4 The Influencing Factors should be used to inform service providers, commissioners, and Ward Sisters/Charge Nurses to set or review the point at which a facility falls within the continuum of a nurse staffing range. The factors presented will be used to influence the point at which a facility falls within the continuum.

5.5 Two practical examples of how the Influencing Factors might be used to guide workforce planning are included in this document at pages 15 - 16 and 19 - 20 of this document.

NURSE STAFFING RANGES

3.0 Nurse Staffing Ranges for General and Specialist Medicine and Surgery

MEDICINE

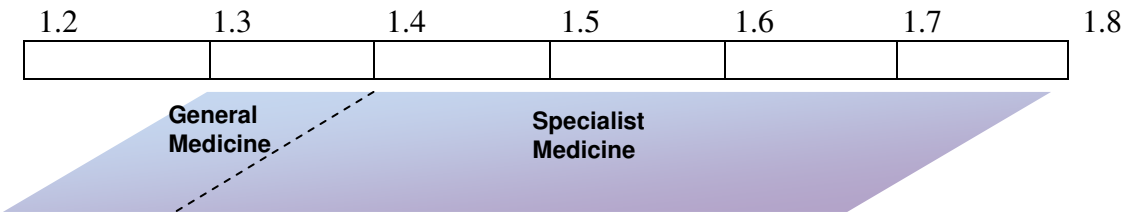
3.1 A **general medical care setting** is defined as comprising adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, including acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units for example: Medical Assessment Units.

3.2 A **specialist medical care setting** is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, where a higher degree of acuity is anticipated, including for example: specialist respiratory medicine, neurology, coronary care, acute stroke/lysis (general stroke care may often be located within the general medical normative staffing range). This also includes short-stay units, for example, Medical Assessment Units.

3.3 In some general ward areas, existing ***in both medical and surgical settings,*** a cohort of dedicated beds for specialist services may exist, for example: 8 specialist respiratory care beds within a 24-bed general respiratory ward. As models of care for general medicine move towards specialisms, the number of specialist beds may increase. Where this occurs, a number of calculations will need to be made on two or more cohorts of patients to determine an overall appropriate nursing/bed ratio.

3.4 **Figure 1**, below, pictorially represents the range for general and specialist medicine, the majority of general medical wards defined between 1.3 and 1.4, recognising that small number may fall below 1.3 to 1.2 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist medicine, fewer wards being defined at the top end of the range (1.8) and lower end of the range. The range stipulated includes an allowance of 24% for Planned and Unplanned Absence Allowance (please see page 6, *Delivering Care*, *Section 1*). For further information as to how the ranges were described and agreed, please go to page 19 of *Delivering Care*, *Section 1*.

Figure 1: Nurse Staffing Range for General and Specialist Medicine.



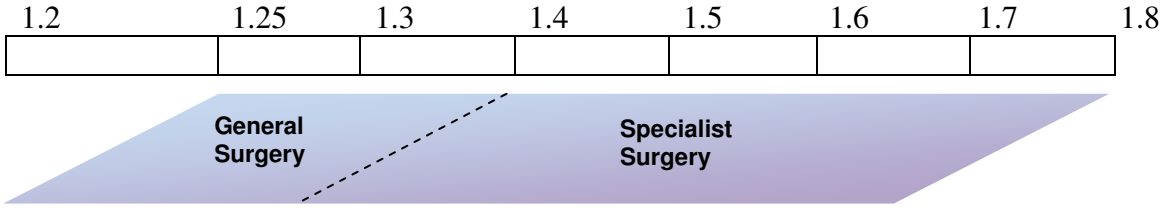
SURGERY

3.5 A **general surgical care setting** is defined as comprising adult surgical patients admitted for elective or emergency surgery, including for example: urology, gynaecology, breast and endocrine surgery, orthopaedic surgery, vascular and general surgery.

3.6 A **specialist surgical care setting** is defined as, comprising adult surgical patients admitted for elective or emergency surgery where a higher degree of surgical acuity and/or progressive recovery is anticipated, including for example: neurosurgery, plastics, cardiac and head and neck surgery.

3.7 **Figure 2**, below, pictorially represents the range for general and specialist surgery, the majority of general surgical wards defined between 1.25 and 1.4, recognising that a small number may fall below 1.25 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist surgery, fewer wards being defined at the top end of the range and lower end of the range. The range stipulated includes an allowance of 24% for Planned and Unplanned Absence Allowance (please see page 6, *Delivering Care*, *Section 1*). For further information as to how the ranges were described and agreed, please go to page 19 of *Delivering Care*, *Section 1*.

Figure 2: Nurse Staffing Range for General and Specialist Surgery.



3.8 Providing an example: The Ward Sister of a 24 bed medical ward has used a Telford Exercise, coupled with the use of influencing factors to determine that her ward should be staffed at 1.3 on the nursing: bed range.

This equates to: 24 x 1.3 = 31.2 Whole Time Equivalents (WTE) to provide safe, effective person centred nursing care.

Adding in the requirement for the 100% (1 WTE) allocation of Ward Sister time for supervision/ management responsibilities, this equates to a Funded Establishment of 32.2 WTE, in this example.

With a skill mix of 70:30 this allows for:

- 21.84 WTE registered staff (0.7 x 31.2)
- 9.36 WTE unregistered staff (0.3 x 31.2)
- 1.0 WTE Ward Sister.

WORKFORCE

Term Used	What does this mean?	How does this impact on a Staffing Range?
Rostering and Shift Patterns	Rosters provide a structured process of matching available staff, and their skills, to the variations in workload to ensure patient safety. Within a roster system, the arrangement of start and finish times known as 'shifts', plus the sequence of working days available per staff members' contract over an agreed period of time, ensure that available numbers of staff are deployed to manage the workload demands.	Optimal rostering of staff supports effective management of the staffing resource available to a manager to deliver on the workload demands of a ward or department. An imbalance in the numbers and skills of staff available to meet the care demands of patients can present greater risks to patient safety. Appropriate shift patterns are key factors in delivering safe and effective care, and maintaining staff morale.
Planned and Unplanned Absence Allowance	Periods of absence from work, which are expected or unexpected and, therefore, factored into the workforce planning process. This includes sickness (both short and long term, with long term defined as 20 days or over and up to six months), study leave, as a minimum for mandatory training, non clinical working, e.g. management time.	Planned and Unplanned Absence Allowance acknowledges that staff have particular requirements and rights that render them unavailable to be rostered. This allowance needs to be agreed and funded to ensure effective workforce planning and efficient deployment of staffing resources.
Ward Sister's/ Charge Nurse's time	An agreed allocation of 100% of a Ward Sister's/Charge Nurse's time to fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward.	The absence of an agreed allowance of time for Ward Sisters and Charge Nurses to address the management and supervisory responsibilities of their role can result in such essential responsibilities being neglected and failure to provide leadership at ward level. Currently, a ward sister/charge nurse manages a staffing complement in excess of 32 staff with associated appraisal, supervision, regulatory, human resource responsibilities and budgetary management including salaries and wages and goods and services.
Skill mix	The percentage ratio of registered to unregistered nursing staff working within an individual care setting.	An inappropriate skill mix can result in a mismatch of duties and responsibilities to roles. This can present greater clinical risks to patients or, conversely, inefficient deployment of expensive staffing resources.

Management of Recruitment	Due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained. Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements: › Maintenance of staffing levels, which support the delivery of safe and effective, person centred care › Avoidance of overuse of temporary staff, for example, bank and agency staff › Matching of staff skill and band mix to patient acuity and dependency within approved guidelines › Timely and ongoing review of risk assessments linked to service reconfigurations.	Vacancy rates must continue to be carefully managed to avoid destabilising a department or team and increasing the risk to patient care through inappropriate staffing levels and skills.
Management of absenteeism/ sickness	The management process through which periods of sickness/absence are managed for all employees, with the aim of maintaining the lowest level achievable.	Effective approaches to the management of periods of staff absence support the continuity of services, provision of safe and effective person centred care, patient safety and good staff morale.
Competence skill set to work flexibly	The level to which the workforce has developed a knowledge base and transferable skill set to enable practice within a particular care setting and be capable of addressing a broad range of demands.	The absence of a core set of transferable skills can limit the capacity of staff to meet a broad range of demands in a given department. To ensure that the essential clinical skills are developed within a team demands careful identification of learning needs and development opportunities for all staff.

Helpful Resources:

The HSC Trust Roster Policy should provide information on appropriate rostering practice.

Planned and Unplanned Absence Allowance Guidance at page 6 of *Delivering Care*: *Section 1*.

RCN Publication: *Making the business case for ward sisters/ team leaders to be supervisory to practice*: http://www.rcn.org.uk/__data/assets/pdf_file/0005/414536/004188.pdf

Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN**.** http://www.rcn.org.uk/__data/assets/pdf_file/0009/287784/003312.pdf

ACTIVITY

Term Used	What does this mean?	Impact?
Ward Attendees	Persons who attend a clinical setting for a planned or unplanned visit to seek advice, review or treatment e.g. wound review following surgery.	Ward attendees must be captured as a workload indicator at all times. Incremental growth in ward attendances can place increasing demands on ward nursing teams, without appropriate increases in staffing levels to manage same, and could potentially become an unfunded service development if not appropriately managed.
% Bed Occupancy	A measurement of the percentage of time that beds are occupied, measured at midnight. Day cases and ward attendees are excluded from the calculation. **Average Daily Occupied Beds** **---------- x 100** **Average Daily Available Beds**	Capturing bed occupancy at 12.00 midnight only can result in substantial activity and workload being omitted. Comparing bed occupancy at 12.00 midday and 12.00 midnight can provide valuable management information. The Government's Emergency Services Action Team (ESAT) report in 1997 included analyses showing that in acute hospitals, average bed occupancy rates over 85% are associated with rapidly growing problems in handling emergency admissions[12].
Throughput	Is the average number of patients per bed during a calendar month. This can include deaths, discharges and transfers to other wards. Day Cases and ward attendees are excluded from the calculation. **Total Inpatients** **----------** **Average Number of Available Beds**	With managed shorter lengths of stay in many hospital beds, throughput is an important workload indicator in the service. In settings where the admissions rate is high e.g. Acute Medical Admissions Units have a high, volume of people being admitted to the care setting, therefore, a high throughput, there is a requirement for higher numbers of staff to support the ongoing care needs.
Patient Dependency/ Acuity	An assessment of the care demands of each patient, incorporating physical and psychosocial needs, using a validated and credible tool.	Appropriate workload measurement tools can lead to appropriate staffing levels for wards and departments, thus supporting safe and effective care.
Length of Stay	A measurement of the average length of time spent in hospital. Day Cases and ward attendees are excluded from the calculation. **Average Daily Number of Occupied Beds x Days in Year** **----------** **Total Inpatients**	The trend in Health and Social Care services has been towards shorter lengths of stay. This also results in more complex discharge processes, as people are provided with ongoing treatment and care in the community setting. These factors ultimately contribute to an increase in the throughput and a resultant increase in the workload demand for staff.

Seasonal Variations	Patients commonly present with a range of conditions and chronic illnesses which may be dependent on the time of the year, or become exacerbated at certain times of the year. This provides a particular case mix of conditions and/or increased volume of admissions which may require more intensive nursing input due to the critical nature of the care required.	Seasonal variations are likely to present a greater workload burden on nursing staff. It is important that increased workload demands are supported by appropriate staffing levels.
Specialities/ Case Mix	The range and variation of patients' health conditions managed in a particular clinical setting	A broader range of specialties and case mix being managed in a care setting presents a greater demand on the nursing team in terms of knowledge, skills and complexity.
Number of Beds	The actual number of beds in a clinical setting.	The number of beds and design of a ward environment can have an impact on the efficiency of a ward or department. There would appear to be an optimal number of beds per ward to maximise efficiencies.
Assessment of Risk	Nurses must assess and manage risk within a clinical environment to ensure the delivery of safe and effective, person-centred care[13]. This includes, risk to people in their care, members of staff and other members of the public.	By adopting an anticipatory approach nurses can proactively support the minimisation of risk and provide a quality service that meets patient/client needs. Opportunities to act on lessons learned and drive improvements in the quality and safety of services ensure that practice is informed and improved. Time is required from the nursing team for this activity to carry out ongoing risk assessments for people within their care environments.
Incremental Service Improvements / Development	This is activity concerned with testing ideas, sustaining and sharing best practice to make a tangible difference in outcomes and experience for staff and service users. (Department of Health, 2008)[14].	Incremental service improvements are designed to implement improvements in patient care and/or outcomes. This can result in improved working conditions for staff. Alternatively, unrelenting service improvements can also have a disruptive impact on individuals and contribute to low staff morale.

[12] Department of Health (2000). *Shaping the Future NHS: Long Term Planning for Hospitals and Related Services.* London, DoH.
[13] Department of Health Social Services and Public Safety. (2008). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.
[14] Department of Health (2008). *Making the difference: The Pacesetters beginner's guide to service improvement for equality and diversity in the NHS.* London, DoH.

ENVIRONMENT AND SUPPORT

Term Used	What does this mean?	Impact?
Technological and Equipment Support	The support provided within a clinical area by Information Technology and other mechanised systems and sufficient equipment maintained and stored appropriately which may assist registrants in caring for people.	Access to available software which links to a range of data systems can enable efficient transfer of information, which assists at many stages of the patient care pathway. Efficient systems may reduce workload requirement and conversely, inefficient systems may add to the workload e.g. staff spending time sourcing equipment.
Geographical Layout/ Room Structure	The arrangement of the physical clinical environment, including whether or not there are single roomed facilities. The physical arrangement of a clinical setting has an impact on workforce planning, in that it may require greater numbers of staff where there are areas of poor visibility or require staff to work in discrete teams.	A well designed/engineered layout for a clinical environment, with optimal employment of relevant technologies, can support enhanced observation of patients and consequently decrease risks to patients/clients, thus reduce the impact upon staffing requirements. Where single rooms restrict visibility and therefore compromise clinical and care observations this will have an impact on staffing levels in wards.
Ward Size	The 'average' 24-bedded[15] clinical area can be constructed of 24 beds, configured within a mixture of multiple bed areas and/or single rooms.	In clinical settings where the bed complement is substantially smaller, nursing: bed ratios will be significantly higher to support the provision of safe and effective care on a 24 hour basis. Similarly, where a ward is significantly larger than 24 beds, there will be a requirement for appropriate levels of senior staff to support the provision of safe and effective care on a 24 hour basis.
Departmental Adjacencies in relation to Areas for Patient Transfer	The physical distance required to be covered when escorting patients to and from other service areas, e.g. radiology, theatre(s). Where there is likely to be a significant number of patients requiring a nurse escort*, the workforce planning impact needs to be taken into account in determining staffing levels to support safe, effective person centred care.	Nursing staff may be required to escort patients to diagnostic testing/theatre, thus removing the member of staff from the team and the team ability to share the workload.
Supportive Staff Infrastructure	The support provided within a clinical area by other members of staff, who are not registrants or within the family of nursing e.g. administration or housekeeping staff.	There are a range of tasks which can be completed by individuals who are not identified as working within the family of nursing e.g. administrative staff, housekeeping staff.

Escorting refers to the professional role of attending to a patient when in transit from one care environment to another (i.e. the patient requires care).

[15] Ball, J. (2010). *Guidance on Safe Nurse Staffing Levels in the UK*. London, RCN. Page 24. The 'average' NHS ward has 24 beds.

PROFESSIONAL REGULATORY ACTIVITY

Term Used	What does this mean?	Impact?
Indirect care	This is activity which is linked with care delivery but is not a direct element of the process of care delivery, e.g. multi-professional case meetings.	The level of this activity and requirements for delivery of such can impact on the workload of nursing teams. This requires definition as to what elements are present within the nursing workload and how much time is expended on them.
Compliance with professional regulatory standards	This is activity concerned with ensuring that professional standards issued by the NMC are embedded and maintained within a clinical environment, such as those for learning and assessment in practice/mentorship. This may include ongoing monitoring of these standards.	High ward activity levels without adequate staffing can negatively impact upon the ability of nurses to comply with regulatory standards.
Supervision	This is a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety. (NIPEC, 2007)	An element of the time required to train nurses and those within the family of nursing is included in the Planned and Unplanned Absence Allowance of 24%.
Accountability and governance requirements	The impact of nurse staffing levels on the quality and safety of patient care is well documented. The Executive Director of Nursing is accountable for ensuring that nurse staffing levels are sufficient to deliver safe, effective, high standards of nursing care to all who use services. Governance has been defined as 'systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community, and partner organisations' (DoH Integrated Governance Handbook 2006). Accountability embodies three key attributes: • recognisably high standards of care • transparent responsibility and accountability for those standards • a constant dynamic of improvement.	In order to provide safe, effective, person centred care, appropriate staffing levels are required to impact positively upon the professions' ability to deliver effectively to governance requirements indicated through good performance in Key Performance Indicators. This type of activity can include collecting information about the standard of practice and care through, for example, audit, complaint review and benchmarking practice against an evidence base. Following such activity, action plans are required to enable development of practice or service improvement work to ensure the ongoing delivery of safe, effective, person-centred care. All of this activity requires the time of the team to engage effectively and facilitate ongoing accountability, governance reporting arrangements and improvement of care.

References and Helpful Resources:

Department of Health (2006). *Integrated Governance Handbook: A handbook for executives and non-executives in healthcare organisations.* Available for download at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4129615.pdf

Chief Nursing Officer for Northern Ireland (2007). *Standards for Supervision for Nursing*. Belfast, DHSSPS.

Northern Ireland Practice and Education Council (2007). *The Review of Clinical Supervision for Nursing in the HPSS 2006 on behalf of the DHSSPS*. Belfast, NIPEC.

Department of Health Social Services and Public Safety. (2011). *Framework Document*. Available for download at: http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf

http://www.nmc-uk.org/Publications/Standards/

6.0 HOW TO USE THIS FRAMEWORK

6.1 This framework has been designed to promote a shared understanding of workforce planning principles associated with nurse staffing levels to provide safe effective, person centred care. As Trusts reform and modernise their services, the nurse staffing ranges and planned and unplanned absence allowance outlined in this document must be taken into account prior to releasing funding from nurse staffing for efficiency/productivity savings.

6.2 Use of the framework will inform both HSC Trusts and the Commissioner for a range of purposes, some of which are presented below:

HSC Trusts

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments, and when commissioning new services, to provide safe, effective, person centred care.
- › To support general and professional managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth.
- › As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

Commissioner

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing proposals for commissioning general and specialist services to provide safe, effective, person centred care.
- As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

6.3 Commissioners will as a result have a regional framework in which they can agree and set consistent ranges for nursing workforce requirements for HSC Trusts in Northern Ireland.

6.4 Pages 15 - 20 contain a number of practical examples illustrating how to use the Framework to assist nursing workforce planning processes. There is also a worked example of a 'Telford Exercise' at page 17, using the Telford model of nursing workforce planning, which remains the extant nurse workforce planning tool in use in Northern Ireland and the United Kingdom[16].

[16] Telford, W.A. (1979). *A Method of Determining Nursing Establishments*. Birmingham, East Birmingham Health District.

Scenario No. 1

Preparing for a Discussion

A Ward Sister has been in post for 4 years in an acute adult in-hospital medical care setting in Northern Ireland Health and Social Care Trust (NIHSCT). During this time, the acuity and dependency of the patients her team cares for had increased, along with increased bed occupancy and decreased length of stay. The number of part-time staff within her team complement has also increased significantly.

Sister decides to use *Delivering Care* to have an informed, evidence-based discussion with her Line Manager, about the nurse staffing requirement for her ward to support the provision of safe and effective person centred care.

Steps for discussion:

1. This ward is an acute adult in-hospital medical care setting. Using the Staffing Range for medicine, the lower end of the ratios is 1.3.
2. Sister undertakes a 'Telford' exercise (please see page 17) using her own professional judgement and information from the day-to-day running of the ward, identifying when staff are required to manage optimally the service provided.
3. Sister then looks at the Influencing Factors, pages 7 - 13. Through reading the information, she realises that:
    - it would be helpful to have in place an e-rostering system to assist with the optimum management of the staffing resource
    - the sickness absence rate in the ward she manages is currently 6.5% excluding maternity leave.
4. In order to prepare for the discussion with her line manager, Sister contacts a colleague who contacted her recently to raise awareness regarding the implementation of the e-rostering system within NIHSCT. She is informed that her ward will be included in year two of implementation. She also has a discussion with colleagues within Human Resources and Occupational Health departments to identify if there are any further steps she might take to best manage the sickness absence rate in her ward team.
5. Having identified these areas for action, Sister has several other issues for discussion with her line manager arising from the Influencing Factors:
    - a review of the skill mix within the ward is required as currently it is 68:32 and not the recommended 70:30 registered: unregistered staff
    - the significant increase in part-time staff has a particular relevance in relation to training, as each member of staff, whether full or part-time, requires the same amount of training as regards mandatory and statutory requirements
    - shorter lengths of stay have increased the workload for nursing staff, particularly in relation to complex discharge planning
    - verbal feedback from her team within the last six months has indicated that staff are having difficulty on occasions in finding time to mentor pre-registration nursing students and in meeting the mandatory supervision requirements of two supervision sessions per nurse per year.

Meeting with Ward Sister and Line Manager.

Sister begins the meeting with her Line Manager by talking about the action she has taken in relation to the e-rostering system and enhanced management of sickness/absence rates in her ward as a starting point when considering the staffing complement. Having discussed these issues, the Line Manager identifies a number of other approaches which might help Sister to review the processes within the ward she manages, such as the Productive Ward[17], or Lean Thinking[18]. Sister agrees that further work could be done within the ward team, in relation to streamlining some of the processes.

She outlines that the ward, being an acute adult in-hospital medical care setting, starts at a ratio of 1.3, using the staffing range for medicine within *Delivering Care Section 2*. The 'Telford' exercise indicated that the complement of staff required was within the lower end of the range; the skill mix required, however, was 70:30, higher than what was currently included in Sister's Funded Establishment (FE). She also identifies that the significant increase in part time staff has a particular relevance in relation to training, as each member of staff, whether full or part-time, requires the same amount of training as regards mandatory and statutory requirements.

She also discusses that shorter lengths of patient stay have increased the workload for nursing staff, particularly in relation to complex discharge planning, and verbal feedback from her team within the last six months has indicated that staff are having difficulty on occasions in finding time to mentor pre-registration nursing students and in meeting the mandatory supervision requirements of two supervision sessions per nurse per year.

Sister and her Line Manager consult with the Assistant Director for Nursing and Midwifery Workforce within the Trust, to reach an agreement that the point within the range at which the FE currently falls: 1.3 is appropriate; there is, however, a question in relation to the skill mix of the FE. There are currently 24 beds in the ward.

This equates to 1.3 x 24 = 31.2 WTE

Using the skill mix of 70:30 registered:unregistered staff, this is calculated as:

31.2 x 0.7 = 21.84 registered

31.2 x 0.3 = 9.36 unregistered

Sister currently has 21.2 registered staff and 10.2 unregistered staff members as part of her team.

She agrees with her Line Manager and Assistant Director of Nursing and Midwifery Workforce that an additional 0.64 WTE registered staff should be added to her staff complement and 0.84 WTE unregistered staff be redeployed to another ward area to provide safe, effective, person centred care.

Factoring in additional time for the Ward Sister leadership/supervisory role at the agreed set level of 100 % WTE of a Band 7; this brings the total funded establishment to be calculated at 32.2 WTE.

[17] The Productive Ward focuses on improving ward processes and environment to help nurses and therapists spend more time on patient care, thereby improving patient safety and efficiency. For further information, please go to: http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

[18] Lean thinking is an approach which is about getting the right things to the right place, at the right time, in the right quantities, whilst minimising waste and being flexible and open to change. For further information, please go to: http://www.institute.nhs.uk/quality_and_value/lean_thinking/lean_thinking.html

Example Outline of a 'Telford' Exercise

Please note: the 'Telford' exercise outlined within these pages demonstrates the use of one workforce planning tool which involves a degree of professional judgement. A number of workforce planning tools exist, which use a range of different approaches to the activity, some of which have been referred to in *Delivering Care, Section 1*.

1. Define the length of the shift patterns over a 25 hour period, which includes one hour in total for handover (two half hour periods). For example: that the morning shift is 5 hours long, afternoon shift is 5 hours long, evening shift is 4 hours and night shift 11 hours. These hours are recorded in column **B** in **Table 1,** page 18.
2. Identify the number of registered and unregistered staff required for each shift based on professional judgement; regarding appropriate numbers to provide safe, effective, person centred care.
3. Add up the number of staff for each band to reach a total for the week for each shift – see column **A.**
4. Calculate the number of hours required for each staff group by multiplying columns **A** and **B** to reach the answer located in column **C.**
5. Add all the hours up in column C to provide a total number of staff hours. Multiply this number by 1.24 to add the required 24% Planned and Unplanned Absence Allowance.
6. Divide this number by 37.5 to reach the number of Whole Time Equivalents (WTE) required to staff the ward.
7. You will see from the three columns to the far right of Table 1, it is also possible to calculate numbers by band and therefore calculate skill mix using the same method of:

   Sub-total of hours x 1.24 / 37.5 = Number of WTEs

8. This example provides a total of 31.51 WTEs of all bands. This includes 22.25 of registered staff and 9.26 of unregistered staff. To calculate the skill mix:

$$\frac{\text{Total number of registered staff}}{\text{Total number of staff}} = 70.6\%$$

$$\frac{\text{Total number of unregistered staff}}{\text{Total number of staff}} = 29.4\%$$

9. Finally, to calculate the nursing to bed ratio, divide the total staff complement by the number of beds:

$$\frac{31.51}{24} = 1.31 \text{ nursing: bed ratio}$$

10. It should be noted that these calculations do not include the allocated 100% of a Ward Sister's/Charge Nurse's time to fulfil his/her leadership/supervisory role within the care setting. Adding this allocated time brings the Funded Establishment to 32.51

Table 1

	Mon	Tues	Wed	Thu	Fri	Sat	Sun	Total for week A	hours per shift B		Weekly hours per shift per level C	Registered	Band 3	Band 2
Morning														
Registered	5	5	5	5	5	4	4	**34**	**5**		**165.00**	165.00		
Band 3	1	1	1	1	1	1	1	**7**	**5**		**35.00**		35.00	
Band 2	2	2	2	2	2	1	1	**12**	**5**		**60.00**			60.00
Afternoon														
Registered	5	5	5	5	5	4	4	**33**	**5**		**165.00**	165.00		
Band 3	1	1	1	1	1	1	1	**7**	**5**		**35.00**		35.00	
Band 2	1	1	2	2	1	1	1	**10**	**5**		**45.00**			45.00
Evening														
Registered	4	4	4	4	4	4	4	**28**	**4**		**112.00**	112.00		
Band 3	0	0	0	0	0	0	0	**0**	**4**		**0.00**		0.00	
Band 2	1	1	1	1	1	1	1	**7**	**4**		**28.00**			28.00
Night Duty														
Registered	3	3	3	3	3	3	3	**21**	**11**		**231.00**	231.00		
Band 3								**0**	**11**		**0.00**		0.00	
Band 2	1	1	1	1	1	1	1	**7**	**11**		**77.00**			77.00
										Sub total	953.00	673.00	70.00	210.00
										add 24%	228.72	161.52	16.80	50.40
										Total	1194.12	834.52	86.80	260.40
										WTE	**31.51**	22.25	2.31	6.94
								Total WTE			**31.51**	**22.25**		**9.25**
								Nursing To Bed Ratio			**1.31**			
									Total Beds	**24**				
Totals									**Skill Mix %**			**70.62**		**29.38**

Scenario 2

Preparing for a Discussion

The Assistant Director (AD) for Acute Services, Northern Ireland Health and Social Care Trust (NIHSCT), has been informed that one of the wards within his service group, an acute adult in-hospital general surgical care setting, will be closing 2 beds in the next financial year due to some of the surgical interventions previously carried out as in-patient procedures now being undertaken as day surgery admissions. In addition, two beds currently used for patients returning from surgery and staffed outside of the upper limits of the specialist end of the staffing ranges, are being stepped down to general surgical beds. The care of those patients will be moving to a newly configured unit located elsewhere in the Trust. The AD is aware that this will have an effect on the staffing complement within this ward and decides to use *Delivering Care Part 1* to have an informed, evidence-based discussion with the Lead Nurse for surgery and the Charge Nurse responsible for the ward.
Steps for discussion:

1. The Charge Nurse's ward is an acute adult in-hospital general surgical care setting. There are currently 26 beds, the staffing ratio currently set at 1.25 for 24 of the beds and 2.5 for two of the beds. The Funded Establishment (FE) in his clinical setting is 36.2 Whole Time Equivalents (WTE) with a skill mix of 70:30, registered:unregistered staff.
2. Using the staffing range for surgery, the lower end of the ratios is 1.25. It is likely that this will be applied to all 24 beds, following the service redesign and reconfiguration of bed usage.
3. The AD calculates that this would provide a FE of 30 WTE. Whilst reading through the framework document, he notes that there are a number of areas which need to be considered during the meeting with the Lead Nurse for surgery and the Charge Nurse. He raises the potential use of the framework to guide discussions with the Lead Nurse, and encourages her to have a conversation with the Charge Nurse to think about areas of preparation in advance of the meeting. He also contacts the NIHSCT Nursing and Midwifery workforce lead, to explore possibilities for reconfiguration of the ward team staffing complement using the Delivering Care Framework. Following that discussion, he asks the Workforce Lead to attend the meeting with the Lead Nurse for surgery and Charge Nurse.
4. The Lead Nurse for surgery and Charge Nurse discuss the framework document in order to prepare for the meeting. The Charge Nurse subsequently agrees to carry out a 'Telford' exercise (please see page 17) to estimate the likely need for staff at particular times of the week when the service in his ward area becomes particularly busy.
5. They also consider the Influencing Factors, pages 7 - 13. Through reading the information, they realise that:
    - 3 recently registered staff have joined the team in the last month; they need development of their skill set in relation to the type of service being provided in the ward, and a period of preceptorship
    - Over the last two years, the length of stay of patients in the ward has been decreasing and the throughput increasing
    - The geographical layout of the ward has always presented a difficulty for

- Staff have reported that Key Performance Indicator (KPI) scores collected for nursing and midwifery organisationally have recently fallen compared with previous scores across three out of the five measurements within AHSC Trust. Staff have also reported that there is difficulty in getting time to conduct audits for KPI measurement.

Meeting with Assistant Director for Acute Services NIHSCT, Assistant Director Nursing and Midwifery Workforce NIHSCT, Lead Nurse for surgery and Charge Nurse.

The AD begins the meeting by offering an opportunity to the Lead Nurse for surgery and Charge Nurse to present their thinking in relation to identified areas for discussion from *Delivering Care Part 1*. In terms of the geographical layout of the ward, Charge Nurse has identified a need to review the storage systems. The Lead Nurse has offered the opportunity to work with him to implement the Productive Ward[19], which has successfully helped other areas review ward-based systems and increase efficiency for the ward team.

Charge Nurse outlines the results of the 'Telford' exercise, which indicated that the complement of staff required was within the lower end of the range for general surgery. He acknowledges that the skill mix at which the ward operates is 70:30. The Lead Nurse and Charge Nurse discuss the impact of the decreased length of stay and increased throughput, coupled with a registered staff complement that has a proportion of recently registered staff, who are still within the requirements for induction and preceptorship. The impact of this increased workload on staff is demonstrated through the evidence provided in the falling KPI scores and anecdotal evidence that staff are finding it difficult to find time to collect audit information.

After much debate during the meeting, it is agreed to review the 'Telford' exercise, providing additional staff numbers at busy times in the working week to allow for the extra workload identified. It is agreed that this should be reviewed again in 6 months' time, during which staff will have been provided with some of the required development to build confidence/new competence to provide the service, thus reducing the requirement for extra staffing. When the 'Telford' exercise is repeated, the range is calculated at 1.3. It is also agreed that Charge Nurse will retain the existing Band 6 staff team members, who will not be redeployed in the first instance, to support the development of the ward team.

This equates to 1.3 x 24 = 31.2 WTE

Using the skill mix of 70:30 registered:unregistered staff, this is calculated as:

31.2 x 0.7 = 21.84 registered

31.2 x 0.3 = 9.36 unregistered

Charge Nurse currently has 24.5 registered staff and 10.5 unregistered staff members as part of his team.

He agrees with those attending the meeting that 2.66 WTE registered staff and 1.14 WTE unregistered staff should be redeployed to another ward area to provide safe, effective, person centred care.

Factoring in additional time for the Charge Nurse leadership/supervisory role at the agreed set level of 100% WTE of a Band 7, this brings the total funded establishment to be calculated at 32.2 WTE.

[19] *Op cit*, n 17.

ABBREVIATIONS

Abbreviation	Meaning
BHSCT	Belfast Health and Social Care Trust
DHSSPS	Department of Health, Social Services and Public Safety
FE	Funded Establishment
HCSW	Health Care Support Worker
HSC	Health and Social Care
HSCB	Health and Social Care Board
KPI	Key Performance Indicator
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NI	Northern Ireland
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
PHA	Public Health Agency
RCN	Royal College of Nursing
WHSCT	Western Health and Social Care Trust
WTE	Whole Time Equivalent

Notes and Guidance on completion and quality

Only fields highlighted in yellow should be completed

Note	Heading
1	Funded Staffing Level 21/22
2	Band 7 Ward Manager wte
3	Band 6 wte
4	Band 5 wte
5	Unreg SIP
6	Permanent Vacancies (WTE)
7	Maternity Leave (WTE)
8	Career Breaks (WTE)

9	100% Ward Manager (Y/N)
10	Sickness Absence (%)
11	Comments

assurance of template

by Trusts

Description / guidance
PLEASE UPDATE AS REQUIRED. The FSL should include **ALL** recurrent investments e.g. 21/22 Delivering Care investments, Demography, LCG etc. **The detail should include source of funding and wte staffing including band and be provided in the comments box.**
Number of Band 7 ward Manager staff in post as at 31st March 22. Do not include staff who are currenlty on Maternity leave or Career break.
Number of Band 6 staff in post as at 31st March 22. Do not include staff who are currenlty on Maternity leave or Career break.
Number of Band 5 staff in post as at 31st March 22. Do not include staff who are currenlty on Maternity leave or Career break.
Total number of all unregistered staff in post as at 31st March 22.Do not include staff who are currently on Maternity Leave or Career Break
The number of whole time equivalent (WTE) permanent vacancies within this area as at 31st March 22
The number of whole time equivalent (WTE) on Maternity Leave within this area as at 31st March 22
The number of whole time equivalent (WTE) on Career Breaks within this area as at 31st March 22

Is this role 100% a ward manager role
The percentage of staff who are on sickness absence within this area as at 31st March 22
Please use this column to detail any funding which has been included in the FSL during 21/22 . Include detail of the funding source. Also include any other comments which will add value to the return.

MAHI - STM - 127 - 119

ing Requirement and Staff in Post - as at 31st March 2022

Required Nursing wte and Agreed Model							March 22 Staff in Post wte												Total Variance		
Bed Compliment	Required Normative NBR	Normative % Reg (excluding Ward Sister backfill)	Band 7 Ward Manager wte	Total Band 6 + Band 5 Registered Requirement (including Backfill for Ward Manager) wte	Total Unregistered Requirement wte	Funded Staffing Level 21/22 wte	Band 7 Ward Manager wte	Band 6 wte	Band 5 wte	Total Reg SIP wte	Unreg SIP wte	Total SIP wte	Permanent Vacancies wte	Maternity Leave wte	Career Break wte	100% Ward Manager (Y/N)	Sickness Absence Rate %	% Reg per SIP (excluding Ward Sister backfill)	FSL - SIP	SIP % Reg (excluding Ward Manager) v Required Normative Reg %	Comments
35	1.30	70%								-		-							0.00		
21	1.35	70%								-		-							0.00		
30	1.30	70%								-		-							0.00		
20	1.30	70%								-		-							0.00		
21	1.35	70%								-		-							0.00		
23	1.35	70%								-		-							0.00		
21	1.50	74%								-		-							0.00		
18	1.40	70%								-		-							0.00		
18	1.30	70%								-		-							0.00		
25	1.30	70%								-		-							0.00		
18	1.40	70%								-		-							0.00		
10	1.30	70%								-		-							0.00		
10	1.70	70%								-		-							0.00		
25	1.30	70%								-		-							0.00		
60	1.60	80%								-		-							0.00		
39	1.54	74%								-		-							0.00		
										-		-							0.00		
26	1.30	65%								-		-							0.00		
18	1.30	65%								-		-							0.00		
20	1.30	65%								-		-							0.00		
24	1.30	65%								-		-							0.00		
24	1.30	65%								-		-							0.00		
26	1.30	65%								-		-							0.00		
21	1.30	65%								-		-							0.00		
20	1.37	70%								-		-							0.00		
18	1.30	70%								-		-							0.00		
591							-	-	-	-	-	-	-	-	-				**0.00**		
57	1.40	74%								-		-							0.00		
13	1.30	78%								-		-							0.00		
4	2.25	90%								-		-							0.00		
21	1.40	70%								-		-							0.00		
30.71	1.30	70%								-		-							0.00		

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Required Nursing wte and Agreed Model							March 22 Staff in Post wte												Total Variance		
Bed Compliment	Required Normative NBR	Normative % Reg (excluding Ward Sister backfill)	Band 7 Ward Manager wte	Total Band 6 + Band 5 Registered Requirement (including Backfill for Ward Manager) wte	Total Unregistered Requirement wte	Funded Staffing Level 21/22 wte	Band 7 Ward Manager wte	Band 6 wte	Band 5 wte	Total Reg SIP wte	Unreg SIP wte	Total SIP wte	Permanent Vacancies wte	Maternity Leave wte	Career Break wte	100% Ward Manager (Y/N)	Sickness Absence Rate %	% Reg per SIP (excluding Ward Sister backfill)	FSL - SIP	SIP % Reg (excluding Ward Manager) v Required Normative Reg %	Comments
27	1.70	79%								-		-							0.00		
25	1.70	79%								-		-							0.00		
29	1.50	70%								-		-							0.00		
23	1.50	70%								-		-							0.00		
34	1.67	70%								-		-							0.00		
27	1.25	70%								-		-							0.00		
20	1.25	70%								-		-							0.00		
20	1.25	70%								-		-							0.00		
										-		-							0.00		
20	1.25	70%								-		-							0.00		
20	1.42	70%								-		-							0.00		
370.71							-	-	-	-	-	-	-	-	-				**0.00**		
13	1.89	80%								-		-							0.00		
4	2.86	85%								-		-							0.00		
20	2.23	80%								-		-							0.00		
8	2.50	70%								-		-							0.00		
26	1.60	74%								-		-							0.00		
23	1.60	74%								-		-							0.00		
										-		-							0.00		
11	1.70	74%								-		-							0.00		
28	1.70	74%								-		-							0.00		
12	1.90	70%								-		-							0.00		
13	2.55	81%								-		-							0.00		
158							-	-	-	-	-	-	-	-	-				**0.00**		
25	1.30	70%								-		-							0.00		
23	1.35	70%								-		-							0.00		
24	1.45	70%								-		-							0.00		
26	1.60	70%								-		-							0.00		
98							-	-	-	-	-	-	-	-	-				**0.00**		
1,218	-	**#DIV/0!**					-	-	-	-	-	-	-	-	-				**0.00**		

Bank & Agency wte across all wards	
Total wte (SIP and Bank & Agency)	-
Total Bank & Agency Expenditure	

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Required Nursing wte and Agreed Model							March 22 Staff in Post wte												Total Variance		
Bed Compliment	Required Normative NBR	Normative % Reg (excluding Ward Sister backfill)	Band 7 Ward Manager wte	Total Band 6 + Band 5 Registered Requirement (including Backfill for Ward Manager) wte	Total Unregistered Requirement wte	Funded Staffing Level 21/22 wte	Band 7 Ward Manager wte	Band 6 wte	Band 5 wte	Total Reg SIP wte	Unreg SIP wte	Total SIP wte	Permanent Vacancies wte	Maternity Leave wte	Career Break wte	100% Ward Manager (Y/N)	Sickness Absence Rate %	% Reg per SIP (excluding Ward Sister backfill)	FSL - SIP	SIP % Reg (excluding Ward Manager) v Required Normative Reg %	Comments

Delivering Care Monitoring Returns Report

Sept 22

As part of the Policy Framework for Nursing and Midwifery Workforce Planning in Northern Ireland

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

HSC Health and Social Care

Introduction

As you are aware, progress with the implementation of completed Phases 1 – 5a of Delivering Care continues with Trusts providing updates to the PHA on a bi-annual basis. The mid-year returns submission for September 2022 has been received from Trusts and analysed. A detailed report based on this data has been provided below.

As more phases of Delivering Care are completed they will be monitored using the same process.

Phase 1 – Acute Medical and Surgical

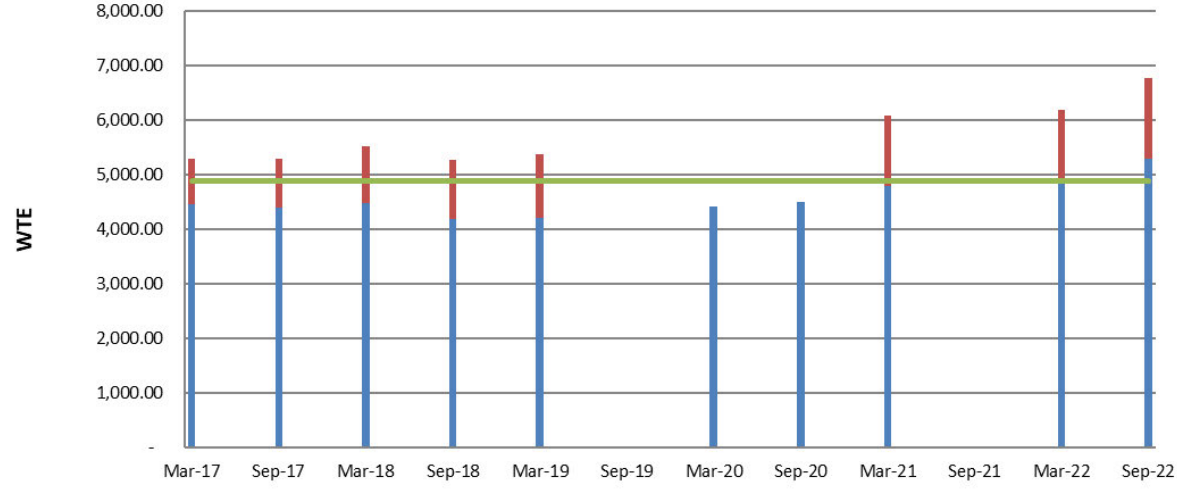
Regional

The target position for Acute Medical and Surgical was set at 4,893.34 wte in 2015. This was the largest area of nursing within the monitoring returns. This target was met by March 2022 when the Staff in Post (SIP) was 4,910.01 wte but yet, to keep up with a reported increase in acuity and demand a further 1,272.3 wte Bank and Agency staff were required in the same period. The SIP increased to 5,237.29 wte in September 2022 with a further 1,498.45 wte Bank and Agency staff being utilised to fill gaps where sickness and vacancies arose.

There has been no additional Delivering Care funding for Phase 1 since its implementation in 2015.

Following agreement with the Delivering Care Oversight Board, a review of Delivering Care Phase 1 commenced in October 2022. The Nursing and Midwifery Taskgroup (NMTG) Report 2020 outlined recommendations proposed to reflect a new vision to maximise the contribution of nursing and midwifery. A new approach would be taken to incorporate additional senior roles and establish career pathways which would help to retain staff within their fields of expertise. This work would consider new standards, benchmarking, evidence and influencing factors to develop an updated model.

Table 1.1



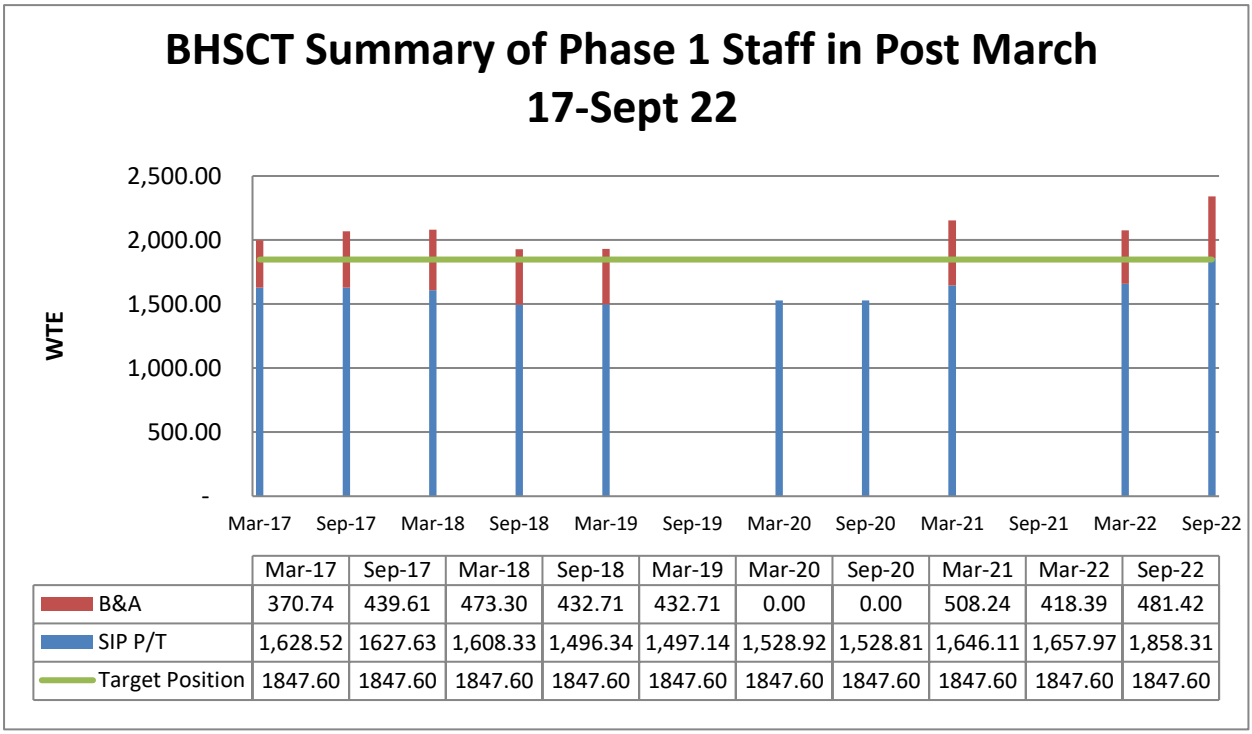
	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	835.06	906.91	1,058.67	1,085.44	1,156.11	0.00	0.00	1,310.25	1,272.31	1,498.45
SIP P/T	4,464.16	4,396.64	4,470.58	4,187.09	4,217.36	4,420.95	4,504.52	4,785.31	4,910.01	5,286.57
Target Position	4,893.34	4,893.34	4,893.34	4,893.34	4,893.34	4,893.34	4,893.34	4,893.34	4,893.34	4,893.34

Belfast Trust

Due to the continued requirement to support safe staffing a higher number of Bank and Agency staff have been used to provide workforce solutions due to a number of factors e.g. greater acuity of patients, sickness levels and reset after COVID. The Trust continues to support the Delivering Care programmes internally through a number of actions and would like to highlight the amount of work which carries beyond commissioned beds and services. Belfast Trust would appreciate the review of the monitoring templates used to capture the appropriate level of detail in this area.

The SIP alone met the target but the factors, some of which have been highlighted above, would indicate that the target may need to be much higher. The review of Phase 1 has been welcomed.

Table 1.2



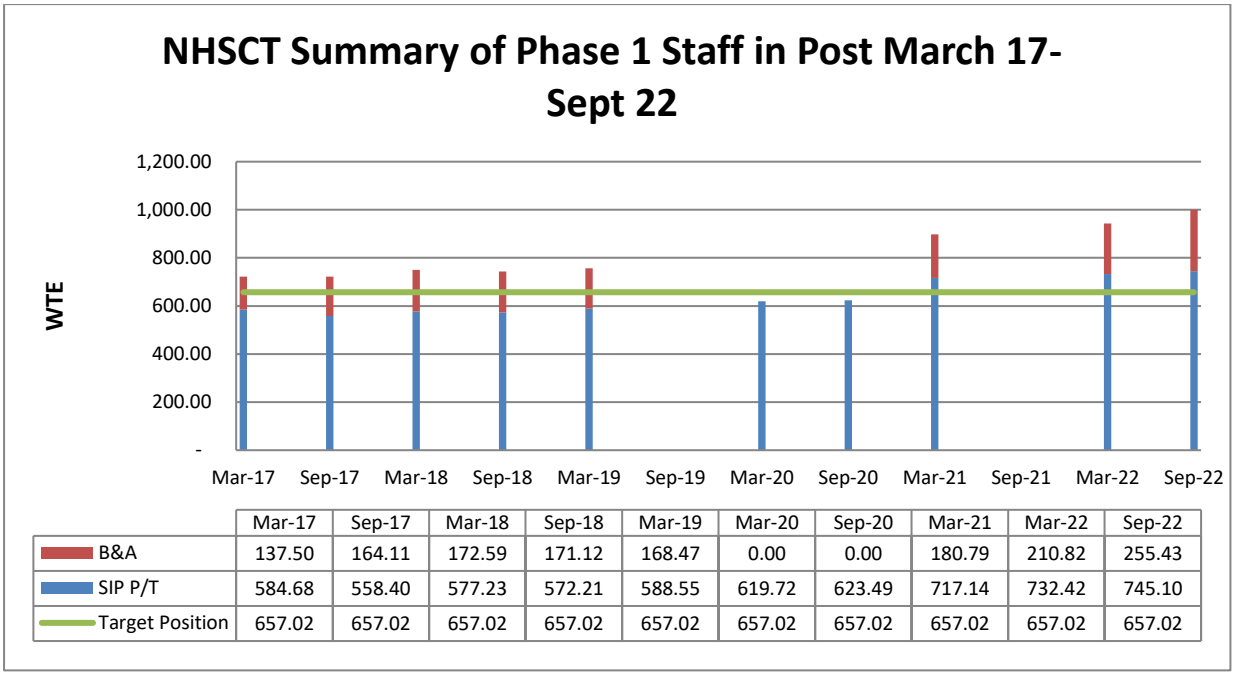
	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	370.74	439.61	473.30	432.71	432.71	0.00	0.00	508.24	418.39	481.42
SIP P/T	1,628.52	1627.63	1,608.33	1,496.34	1,497.14	1,528.92	1,528.81	1,646.11	1,657.97	1,858.31
Target Position	1847.60	1847.60	1847.60	1847.60	1847.60	1847.60	1847.60	1847.60	1847.60	1847.60

Northern Trust

Acute medical and surgical continue to have significant workforce pressures resulting from high acuity patients and high sickness and vacancy levels. This has resulted in higher usage of Bank and Agency.

The Funded Staffing Level (FSL) in the Northern Trust is 778.50 wte and the target was set at 657.02 wte which would indicate that the staffing exceeds requirements. The SIP is also higher than the target by 88.08 wte. The large number of Bank and Agency staff (255.43 wte) brings the total staffing to 1,000.53 wte. The review of Phase 1 will amend future monitoring returns.

Table 1.3

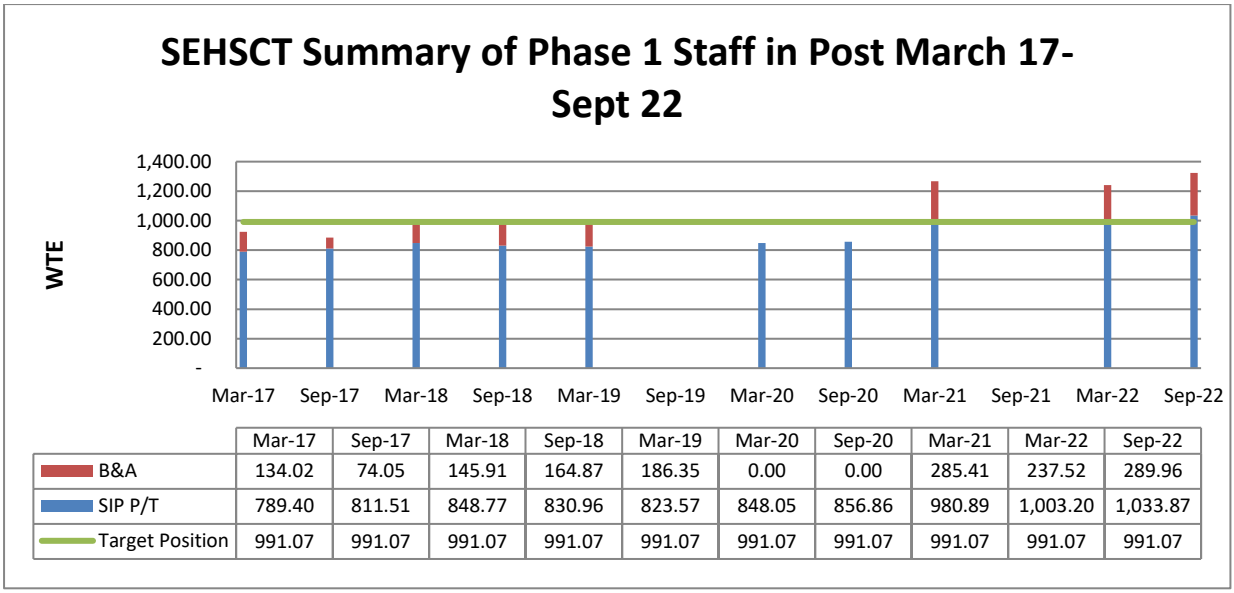


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	137.50	164.11	172.59	171.12	168.47	0.00	0.00	180.79	210.82	255.43
SIP P/T	584.68	558.40	577.23	572.21	588.55	619.72	623.49	717.14	732.42	745.10
Target Position	657.02	657.02	657.02	657.02	657.02	657.02	657.02	657.02	657.02	657.02

South Eastern Trust

South Eastern Trust recruited a higher number of staff than their FSL of 945 wte. The total SIP of 1,033.87 wte with a high number of staff currently on maternity leave (66.8 wte) and an average sick leave percentage of 7.9%. The Trust also used a high number of Bank and Agency staff, possibly for the same reason described by Belfast Trust.

Table 1.4



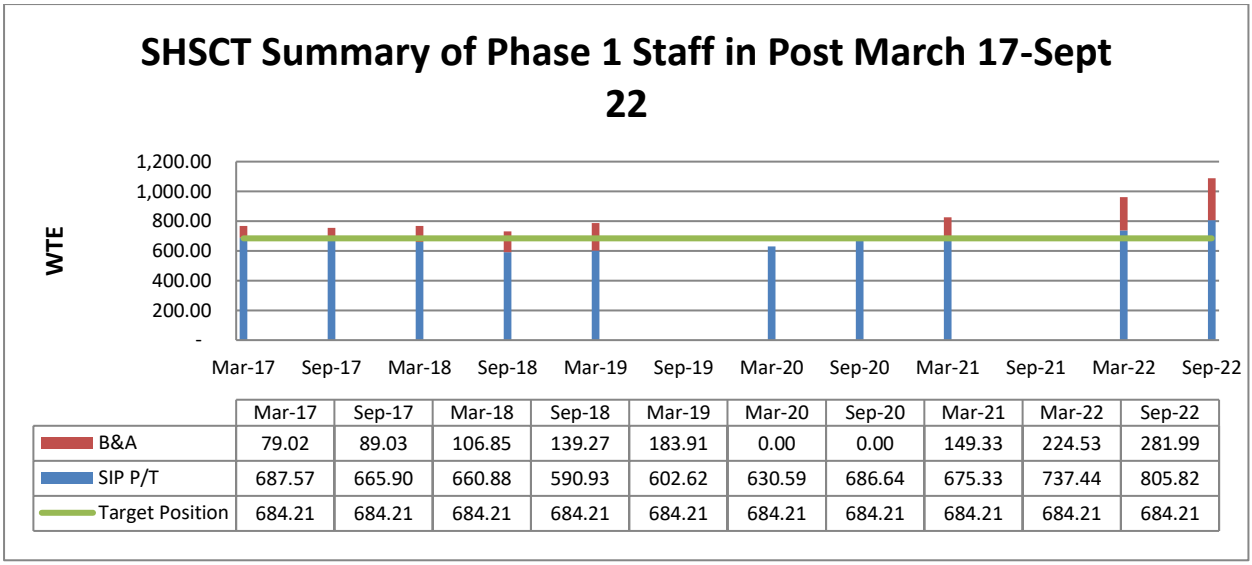
	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	134.02	74.05	145.91	164.87	186.35	0.00	0.00	285.41	237.52	289.96
SIP P/T	789.40	811.51	848.77	830.96	823.57	848.05	856.86	980.89	1,003.20	1,033.87
Target Position	991.07	991.07	991.07	991.07	991.07	991.07	991.07	991.07	991.07	991.07

Southern Trust

Southern Trust are currently dealing with very high levels of maternity leave (49.28 wte). The current FSL of 705.78 wte has exceeded the target of 684.21 wte, set in 2015. The combination of SIP and Bank and Agency equates to 1,087.81 wte and is 403.6 wte above the target. The review of Phase 1 will review this target and, based on the factors outlined previously, may be increased.

Similar to other Trusts the higher number of Bank and Agency staff utilised reflects the continued requirement to support safe staffing due to increased demand, higher acuity of patients, sickness levels and reset after COVID. Additionally, Bank and agency usage can be contributed to staffing the high number of uncommissioned beds within the CAH and DHH sites.

Table 1.5

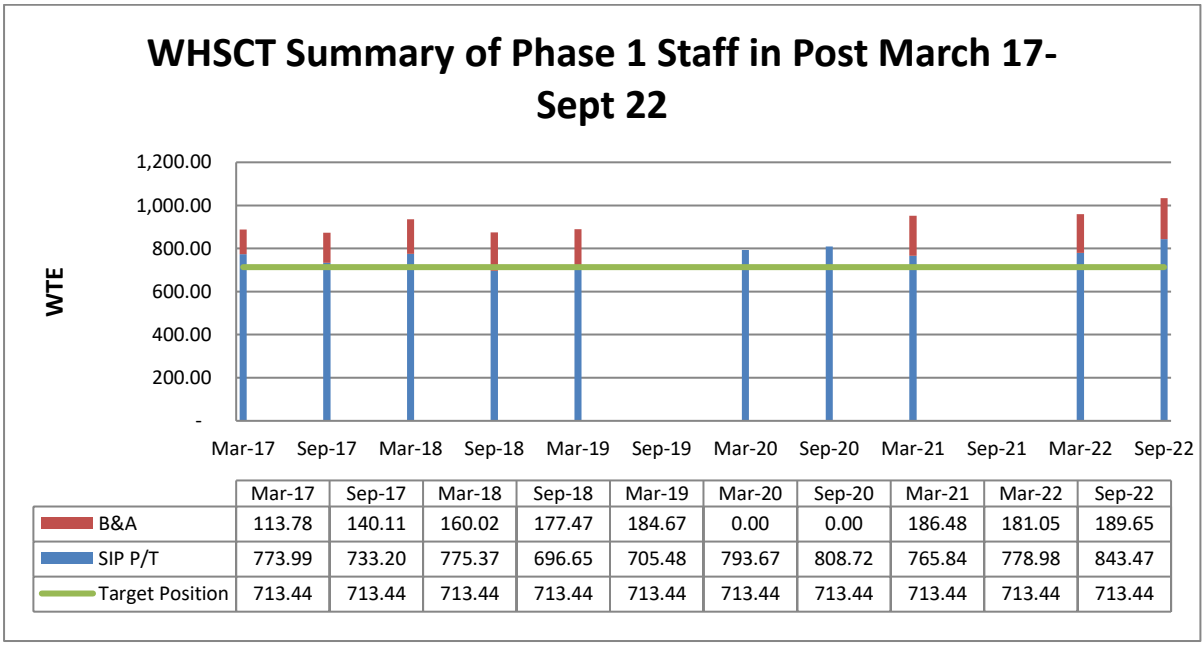


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	79.02	89.03	106.85	139.27	183.91	0.00	0.00	149.33	224.53	281.99
SIP P/T	687.57	665.90	660.88	590.93	602.62	630.59	686.64	675.33	737.44	805.82
Target Position	684.21	684.21	684.21	684.21	684.21	684.21	684.21	684.21	684.21	684.21

Western Trust

The FSL currently sits at 817.74 wte. The SIP is 843.47 wte which, along with Bank and Agency of 189.65 wte exceeds the original target of 713.44 wte by 280.8 wte. There are currently high levels maternity leave but it should also be noted that this return was completed prior to adult nurse graduates taking up post. There are also 15.86 wte on career breaks. The need for escalation beds has also increased the number of staff required to maintain patient safety.

Table 1.6



	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	113.78	140.11	160.02	177.47	184.67	0.00	0.00	186.48	181.05	189.65
SIP P/T	773.99	733.20	775.37	696.65	705.48	793.67	808.72	765.84	778.98	843.47
Target Position	713.44	713.44	713.44	713.44	713.44	713.44	713.44	713.44	713.44	713.44

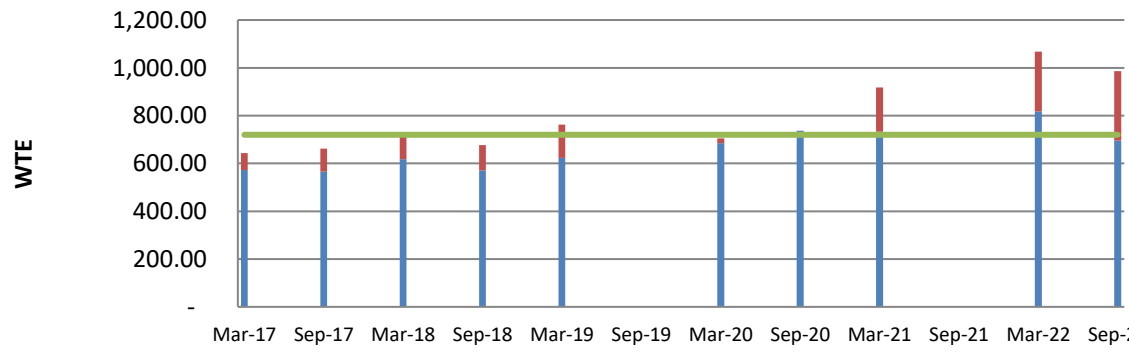
Phase 2 – Emergency Department

Regional

The Target positions for Phase 2 of Delivering Care were set in 2016. The regional target agreed at that time was 719.9 wte. Table 1shows the number of Staff in Post (SIP) is currently 695.98 wte. This has increased by 123.26 wte since March 2017 through various funding streams including Delivering Care (10wte B6 in 20/21 and 20wte B6 in 21/22). The SIP is close to the original target of 719.90 wte, however due to many factors there was an increase in demand within ED settings, a variance in the type of attendances and a number of patients with a Decision To Admit (DTA) who remain in ED when no beds are available which has led to a higher number of staff being required to cover the Department in a safe and effective way. This has meant that there has been an increase in the number of Bank and Agency staff being utilised within the Department (290.71wte). This figure has almost doubled since Mar 21(184.16wte) and quadrupled since Mar 2017(70.3wte).

A review of Delivering Care Phase 2 commenced in October 2022. The Nursing and Midwifery Taskgroup (NMTG) Report 2020 outlined recommendations proposed to reflect a new vision to maximise the contribution of nursing and midwifery. A new approach to be taken to incorporate additional senior roles and establish career pathways which would help retain staff within their fields of expertise. This work would consider new standards, benchmarking, evidence and influencing factors to develop a new model.

Table 2.1



	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	70.93	96.26	104.10	107.02	138.54	20.39	0.00	184.16	250.61	290.71
SIP P/T	572.72	566.09	618.36	570.28	623.22	685.05	736.41	733.24	817.24	695.98
Target Position	719.90	719.90	719.90	719.90	719.90	719.90	719.90	719.90	719.90	719.90

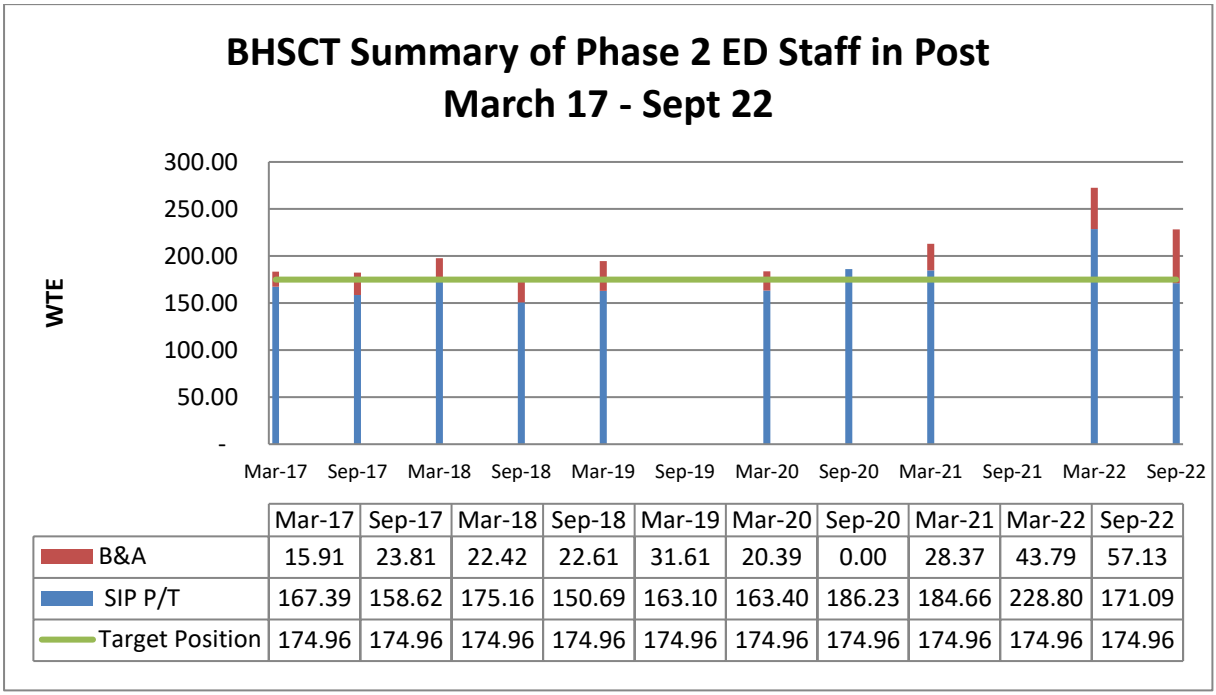
Belfast Trust

Funding from No More Silos this year has allowed Belfast Trust to increase Band 3 staffing by 9 wte, and Band 6 by 20 wte. This will help staff the Urgent Care Centre. Delivering Care funding provided 6 wte Band 6 posts during 20/21 and 21/22.

There are a large number of Band 5 vacancies (43 wte) which Belfast Trust are working on through the implementation of their Nursing Workforce Strategy, and in particular a focused Bespoke International Nurse Recruitment programme.

Approximately ¼ of staff currently in Belfast Trust Emergency Departments are from Bank and Agency. Belfast Trust are working continuously to review expenditure on Bank and Agency. Please see Table 2 below.

Table 2.2

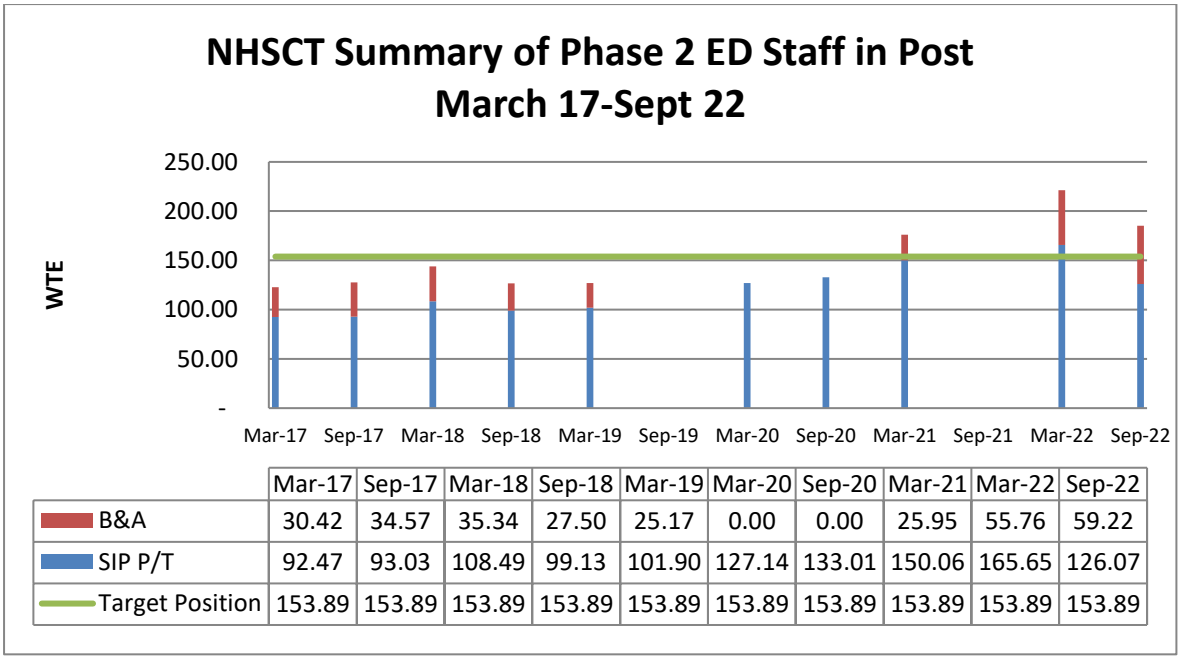


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	15.91	23.81	22.42	22.61	31.61	20.39	0.00	28.37	43.79	57.13
SIP P/T	167.39	158.62	175.16	150.69	163.10	163.40	186.23	184.66	228.80	171.09
Target Position	174.96	174.96	174.96	174.96	174.96	174.96	174.96	174.96	174.96	174.96

Northern Trust

The FSL in Sept 2022 was 130.51 and the staff in post was126.07wte. Table 3 below reflects a high number of Bank and Agency staff (59.22 wte, approx. 33% top up) being utilised to deal with the current pressures within the Department. Northern Trust target was set at 153.89 wte and only with the use of Bank and Agency are they exceeding this (185.29 wte) which reflects the demands and pressures. Reports show a high sickness level within Band 3 staff (17.6%) and Band 6 staff (14.26%).

Table 2.3



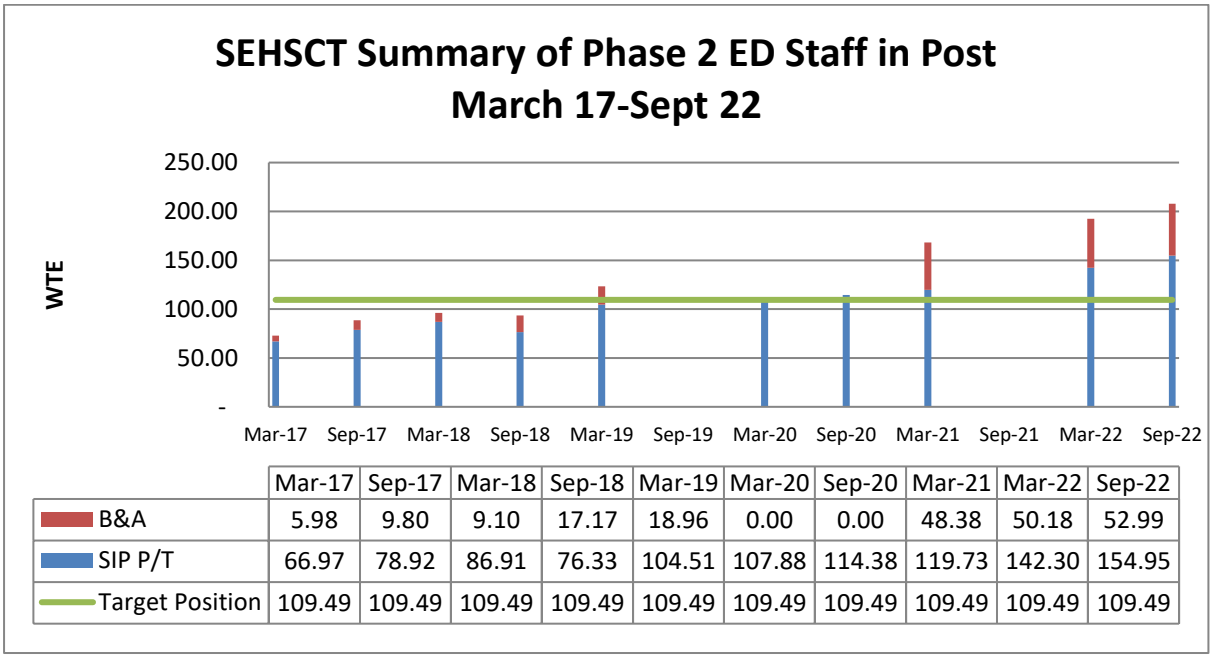
	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	30.42	34.57	35.34	27.50	25.17	0.00	0.00	25.95	55.76	59.22
SIP P/T	92.47	93.03	108.49	99.13	101.90	127.14	133.01	150.06	165.65	126.07
Target Position	153.89	153.89	153.89	153.89	153.89	153.89	153.89	153.89	153.89	153.89

South Eastern Trust

The FSL at Sept 22 was 139.65 wte. Table 4 below shows the SIP was154.95 wte which exceeded the target of 109.49 by 45.46. With the increased demands on the Emergency Department, 52.99 wte staff were required from Bank and Agency (10 times the additional required staffing used in Mar 17).

South Eastern Trust had gone at risk to recruit to a number of Band 3 and Band 7 posts. Additional recruitment in this area is in anticipation of the new ED opening.

Table 2.4

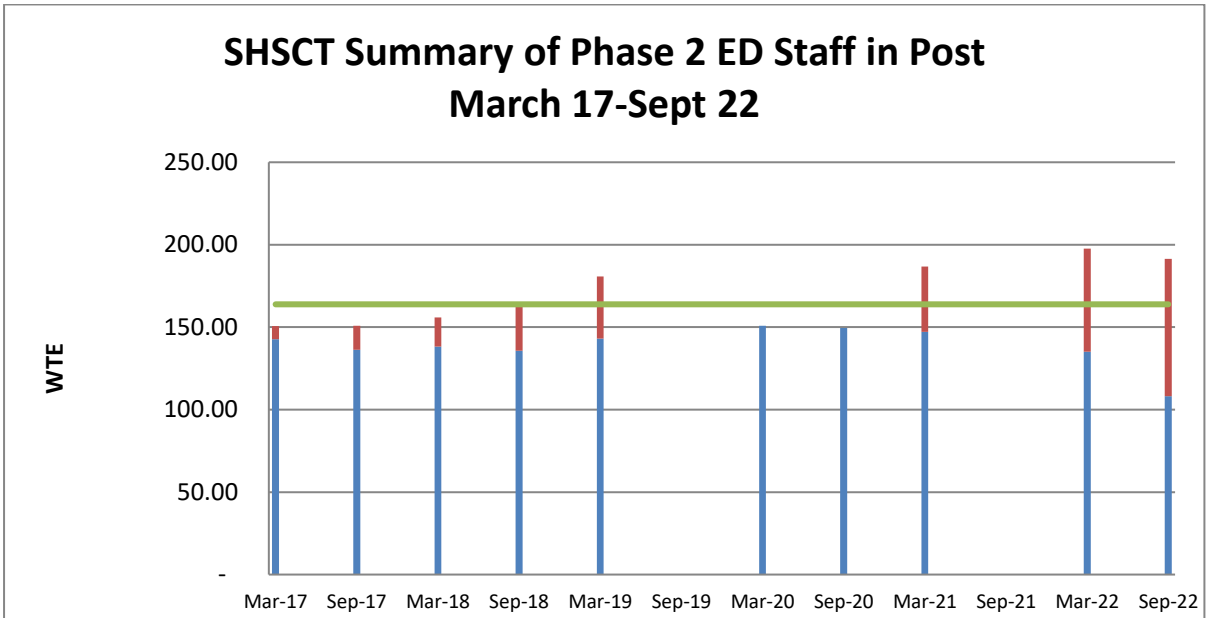


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	5.98	9.80	9.10	17.17	18.96	0.00	0.00	48.38	50.18	52.99
SIP P/T	66.97	78.92	86.91	76.33	104.51	107.88	114.38	119.73	142.30	154.95
Target Position	109.49	109.49	109.49	109.49	109.49	109.49	109.49	109.49	109.49	109.49

Southern Trust

Table 5 below shows the Target agreed was 163.86 wte. The total SIP was 108.11 which is 55.75 wte under the target but with the increase of demand and pressures within the Department a further 83.325 wte Bank and Agency staff were utilised to provide a safe and efficient service. This meant that approximately 40% of the staff working within the Department were Bank and Agency staff.

Table 2.5



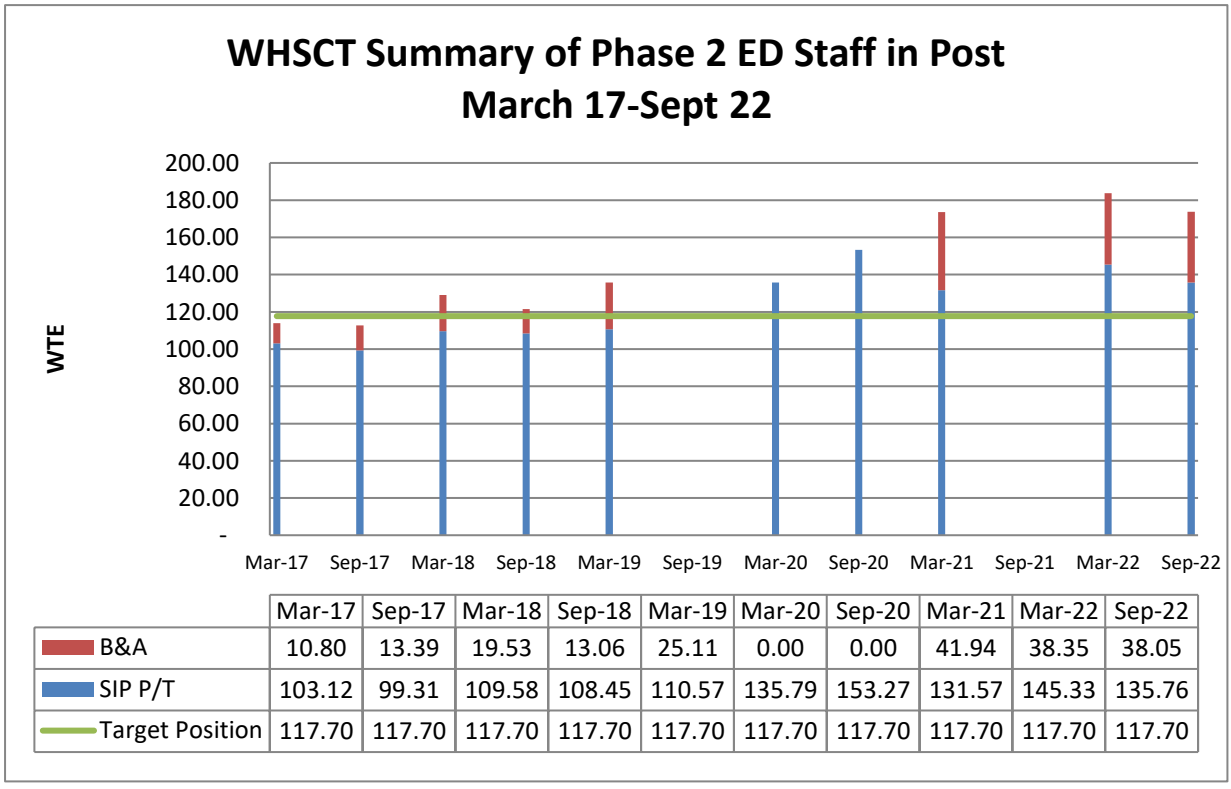
	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	7.82	14.69	17.71	26.68	37.69	0.00	0.00	39.52	62.53	83.32
SIP P/T	142.77	136.21	138.22	135.68	143.14	150.84	149.52	147.22	135.16	108.11
Target Position	163.86	163.86	163.86	163.86	163.86	163.86	163.86	163.86	163.86	163.86

Western Trust

The FSL in Western Trust is 139.31 wte and the current SIP is 135.86 wte. The target for Western Trust was agreed at 117.70 therefore they have exceeded their target by 18.16 wte. This is due to various funding streams as well as Trust investment in additional staff. However, due to the increase of demand and the number of patients being cared for in Emergency Departments while waiting on a bed to become available, the Trust have utilised a further 38.05 wte from Bank and Agency to provide a safe and effective level of cover in the Department.

Western Trust indicated a reduction in salary expenditure but an increase in Bank and Agency spend which they feel is due to the trend of staff leaving Trust employment to join Agency. Western Trust show a low level of vacancies but quite a high maternity leave number. Please see Table 2.6 below.

Table 2.6



	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	10.80	13.39	19.53	13.06	25.11	0.00	0.00	41.94	38.35	38.05
SIP P/T	103.12	99.31	109.58	108.45	110.57	135.79	153.27	131.57	145.33	135.76
Target Position	117.70	117.70	117.70	117.70	117.70	117.70	117.70	117.70	117.70	117.70

Phase 3 – District Nursing

Regional

The target position for District Nursing was agreed as 1472.40 wte in 2017. It was understood that this would be a long term plan and good progress has been made with an increase of 166 wte SIP since March 2017. Although please note that the SIP wte has decreased in all Trusts since March 2022.

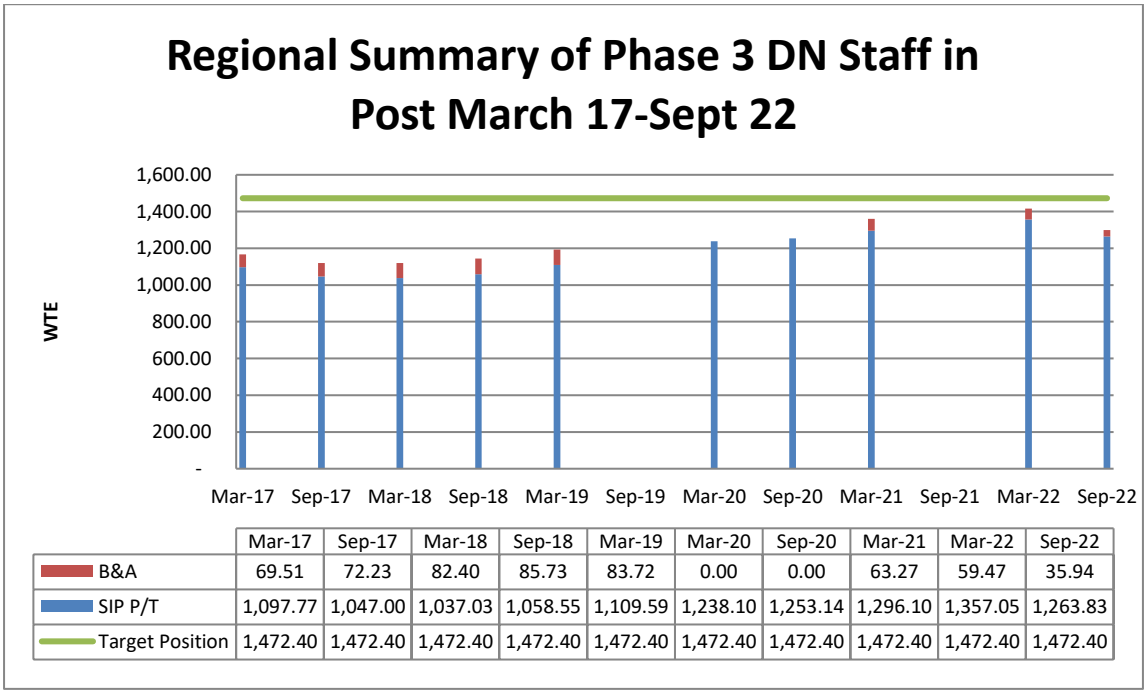
Other funding streams in this area included MDT (approx. 60 posts recurrently funded in 21/22) and Neighbourhood District Nursing (NDN) (approx. 9 posts recurrently funded in 21/22). Along with 30 Delivering Care posts in 20/21 and 55 posts in 21/22 there has been significant funding provided to this area of Nursing although the current SIP of 1263.83 wte is still 208.57 wte short of the original target.

There is minimal input from Bank and Agency to District Nursing within all Trusts.

A review of the District Nursing paper was completed in June 2022 which took other new policy drivers into consideration such as; New Decade new Approach (2020) and also the Nursing and Midwifery Task group Report (2020). The review also picked up the learning from the original phase completed in 2017.

The review paper has identified an overall gap of 693.43 wte with a proposed wte of 2,006.94 wte based on 10 wte for a 10,000 GP Federation population. This review paper is with CNO for final sign-off.

Table 3.1

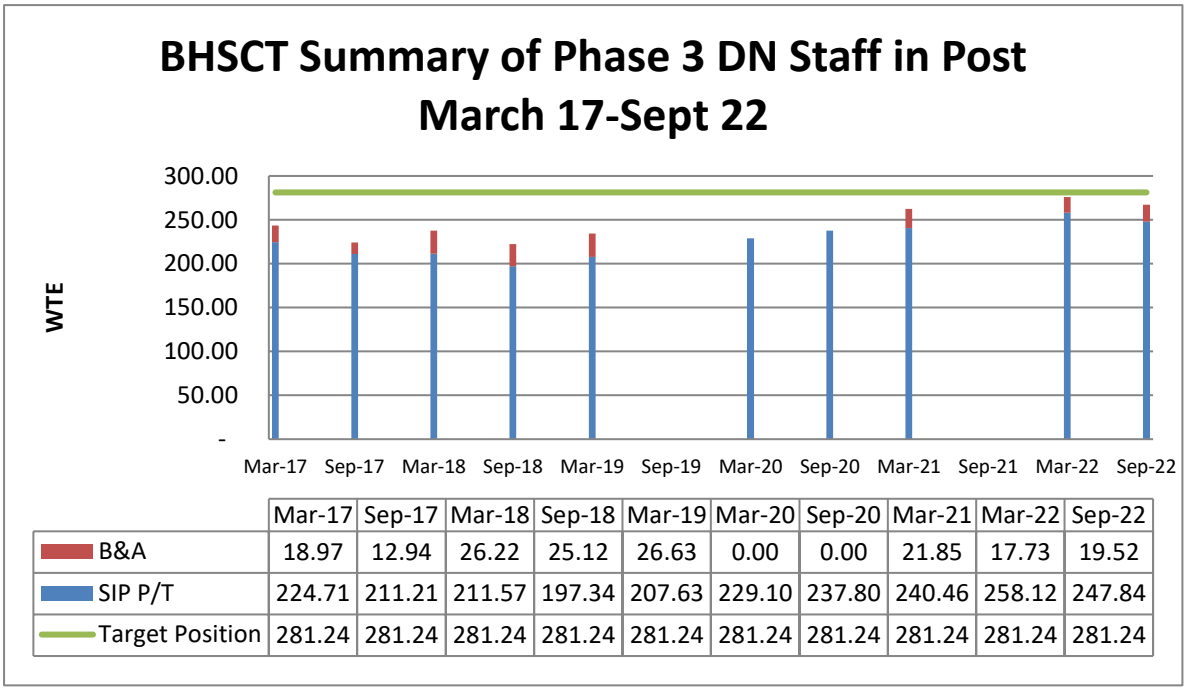


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	69.51	72.23	82.40	85.73	83.72	0.00	0.00	63.27	59.47	35.94
SIP P/T	1,097.77	1,047.00	1,037.03	1,058.55	1,109.59	1,238.10	1,253.14	1,296.10	1,357.05	1,263.83
Target Position	1,472.40	1,472.40	1,472.40	1,472.40	1,472.40	1,472.40	1,472.40	1,472.40	1,472.40	1,472.40

Belfast Trust

Belfast Trust have a current FSL of 311.95 wte and a current SIP of 247.84 wte. This shows quite a high number of vacancies (64.11wte) so even though they have had investment to fund another 33 posts in the last 2 years they are experiencing some difficulty with the recruitment of staff, mostly at Band 6 level.

Table 3.2



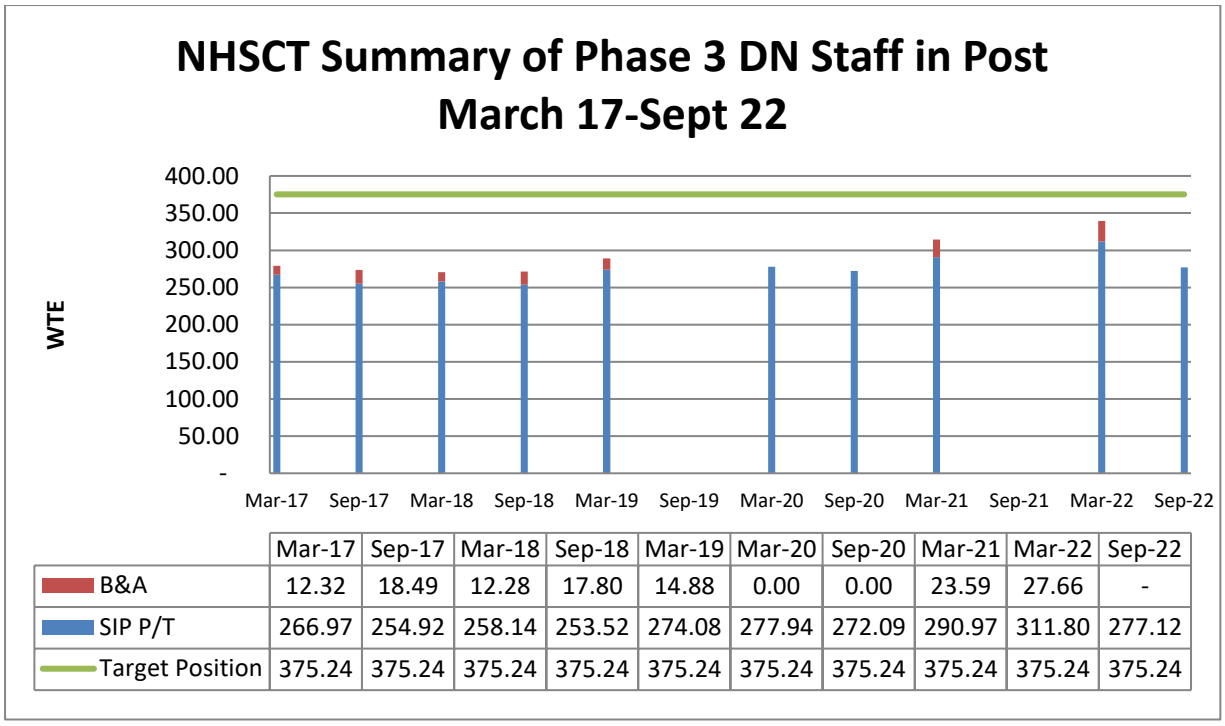
	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	18.97	12.94	26.22	25.12	26.63	0.00	0.00	21.85	17.73	19.52
SIP P/T	224.71	211.21	211.57	197.34	207.63	229.10	237.80	240.46	258.12	247.84
Target Position	281.24	281.24	281.24	281.24	281.24	281.24	281.24	281.24	281.24	281.24

Northern Trust

As you can see from Table 3.3 below Northern Trust SIP is almost 100 wte short of the original target. The SIP has decreased by 34.68 wte since Mar 22. They have not indicated any Bank and Agency usage in this return. Twenty posts have been funded since 20/21 but yet they are experiencing difficulty with a high number of vacancies, mainly in Band 5 posts (26.08 wte).

The SIP figure of 277.12 includes the HDNT service workforce (approx. 33wte) whilst only a relatively small % of HDNT activity is District Nursing.

Table 3.3

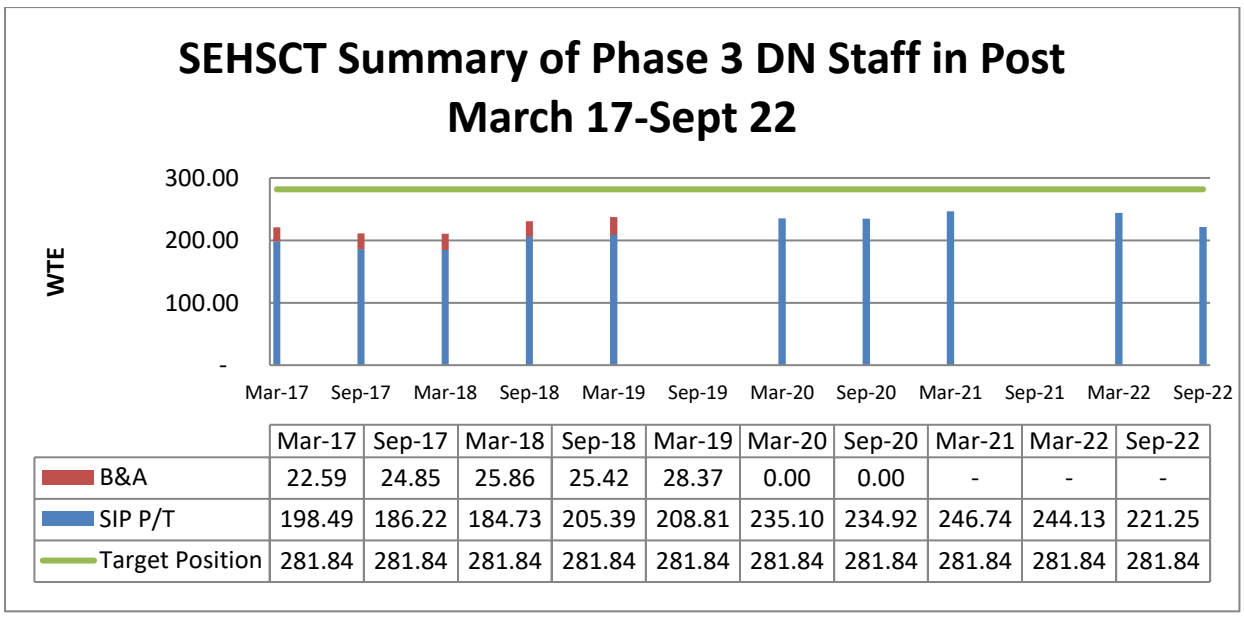


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	12.32	18.49	12.28	17.80	14.88	0.00	0.00	23.59	27.66	-
SIP P/T	266.97	254.92	258.14	253.52	274.08	277.94	272.09	290.97	311.80	277.12
Target Position	375.24	375.24	375.24	375.24	375.24	375.24	375.24	375.24	375.24	375.24

South Eastern Trust

The FSL of 271.21 wte almost reached the target of 281.84 wte while the SIP was 221.35 wte, with no vacancies identified. South Eastern Trust have not provided any figures on Bank and Agency wte usage but did indicate an expenditure of £567,991. The Trust may have gone 'at risk' to uplift a number of their Band 5 posts to Band 6. Approximately 35 new posts were funded since 20/21 through the various funding streams. The SIP has reduced slightly from March 2022.

Table 3.4



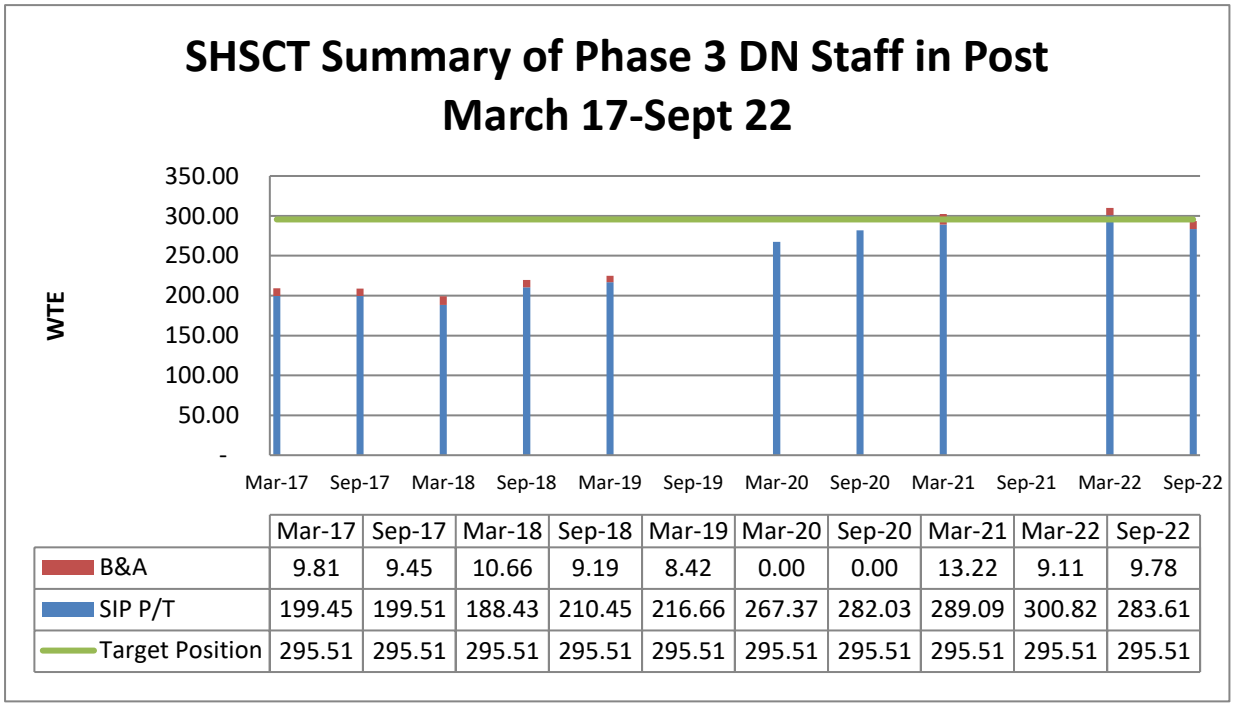
	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	22.59	24.85	25.86	25.42	28.37	0.00	0.00	-	-	-
SIP P/T	198.49	186.22	184.73	205.39	208.81	235.10	234.92	246.74	244.13	221.25
Target Position	281.84	281.84	281.84	281.84	281.84	281.84	281.84	281.84	281.84	281.84

Southern Trust

Southern Trust target was set at 295.51wte and their FSL exceeds this by 2.95 wte. Their SIP is currently 283.61 wte and with the usage of 9.78 wte Bank and Agency they are very close to reaching their original target. Southern Trust have a small number of vacancies (19.18 wte) mostly at Band 5 level. Approximately 31 posts have been funded in Southern Trust since 20/21 which has greatly helped them reach their target although, like other Trusts, their SIP has reduced from 300.82 wte in March 22 to 283.61 wte in Sept 22.

Whilst very welcome, the range of funding sources being allocated to increase the DN Staffing resources, are by their nature creating differences across postcodes in the levels of service provision. This has not been the subject of a complaint as yet, however there could be an issue of equity raised by someone at some point.

Table 3.5

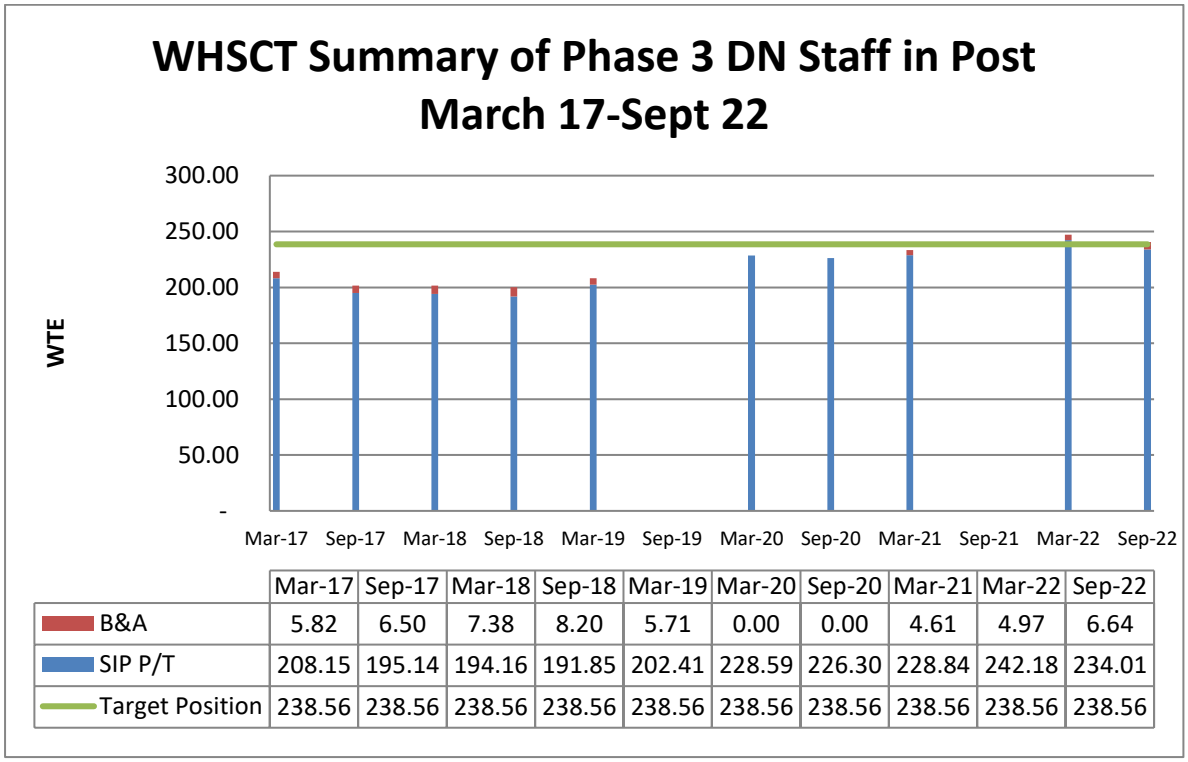


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	9.81	9.45	10.66	9.19	8.42	0.00	0.00	13.22	9.11	9.78
SIP P/T	199.45	199.51	188.43	210.45	216.66	267.37	282.03	289.09	300.82	283.61
Target Position	295.51	295.51	295.51	295.51	295.51	295.51	295.51	295.51	295.51	295.51

Western Trust

The target position for Western Trust was set at 238.56 wte and their SIP is 234.01 wte. With the small addition of 6.64 wte through Bank and Agency they have exceeded their original target. Please see table below for some of this data.

Table 3.6



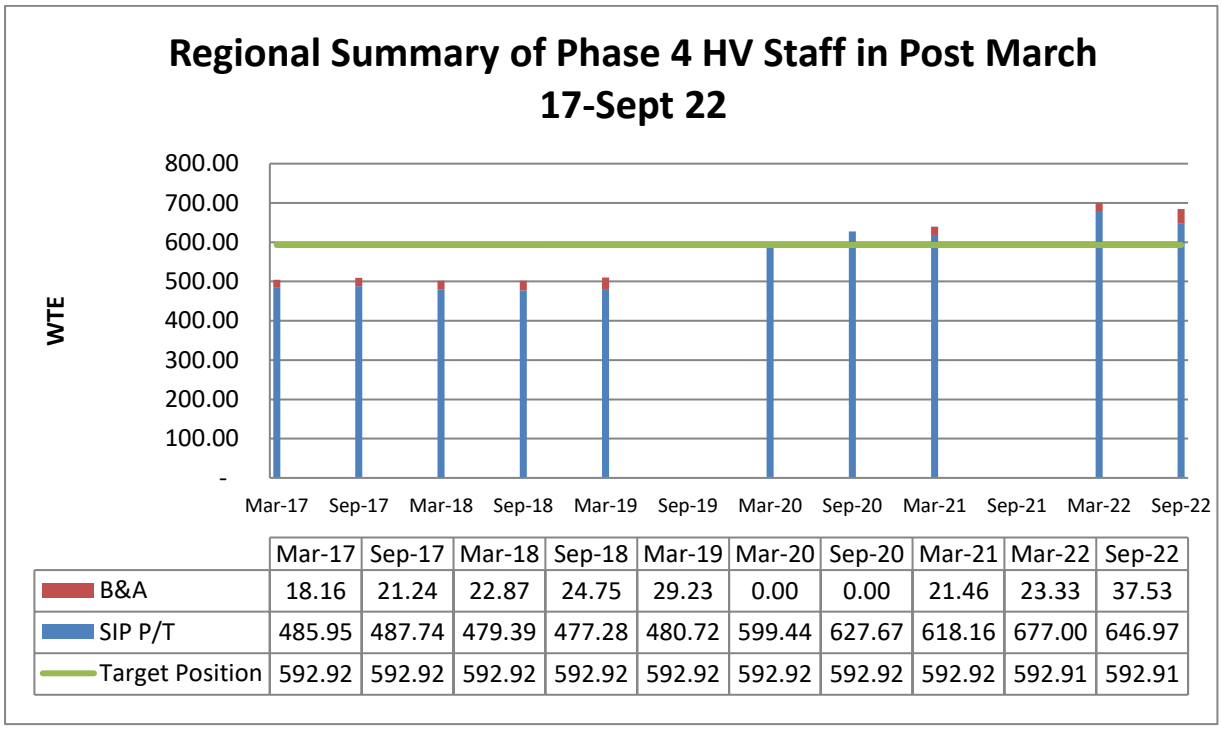
	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	5.82	6.50	7.38	8.20	5.71	0.00	0.00	4.61	4.97	6.64
SIP P/T	208.15	195.14	194.16	191.85	202.41	228.59	226.30	228.84	242.18	234.01
Target Position	238.56	238.56	238.56	238.56	238.56	238.56	238.56	238.56	238.56	238.56

Phase 4 – Health Visiting

Regional

As a result of the initial Delivering Care Phase 4 monies, regional Health Visiting funding increased by £2.4 million (recurrent) from 2016 with a further additional allocation of £1.6 million in 2021/22. Multi-Disciplinary Teams were introduced in 2019 and currently provide £2 million recurrent funding to Health Visiting along with a few smaller investments. The overall position for Health Visiting shows that they reached their target of 592.91 wte by March 2020 and are now exceeding their target by 54 wte. A review of Phase 4 has just been completed and the Delivering Care paper is ready for submission through the Governance process. This review indicates that the target should be increased.

Table 4.1

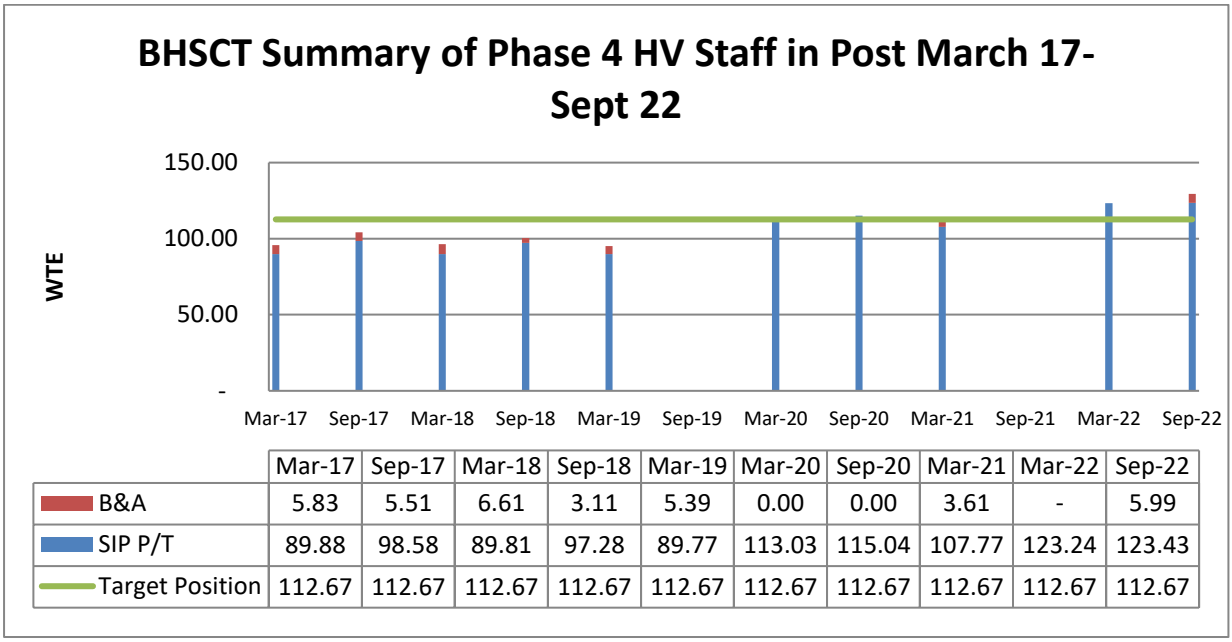


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	18.16	21.24	22.87	24.75	29.23	0.00	0.00	21.46	23.33	37.53
SIP P/T	485.95	487.74	479.39	477.28	480.72	599.44	627.67	618.16	677.00	646.97
Target Position	592.92	592.92	592.92	592.92	592.92	592.92	592.92	592.92	592.91	592.91

Belfast Trust

Belfast Trust have no issues with vacancies or sickness and are currently exceeding their target of 112.67 by 10.76 wte. They have, however, used a small amount of Bank and Agency to top their staff numbers up by a further 5.99 wte.

Table 4.2



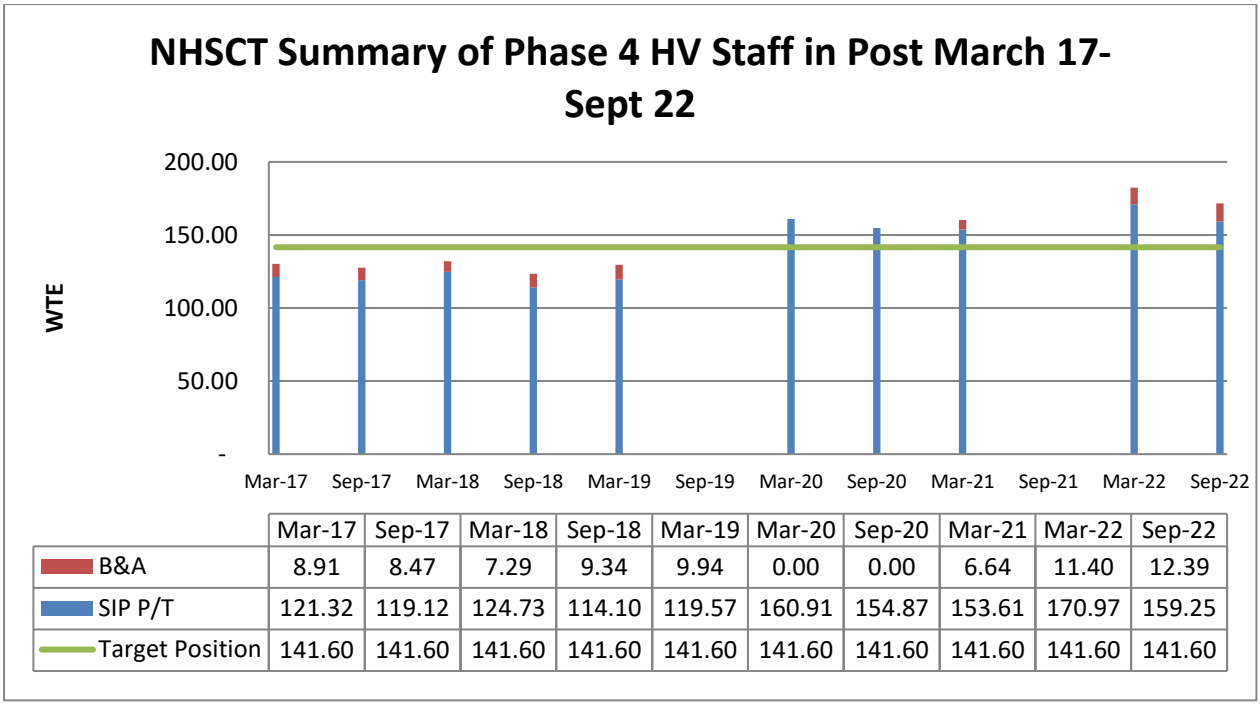
	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	5.83	5.51	6.61	3.11	5.39	0.00	0.00	3.61	-	5.99
SIP P/T	89.88	98.58	89.81	97.28	89.77	113.03	115.04	107.77	123.24	123.43
Target Position	112.67	112.67	112.67	112.67	112.67	112.67	112.67	112.67	112.67	112.67

Northern Trust

Northern Trust have a FSL of 154.65 wte. They currently have SIP of 159.25 wte. Both of these figures are above the target of 141.60 wte. Northern Trust currently have a number of staff on maternity leave (10.24 wte) and 3 wte on career break.

NHSCT continues to have significant permanent WTE vacancies and sick leave in the HV core staffing (Band 6).

Table 4.3

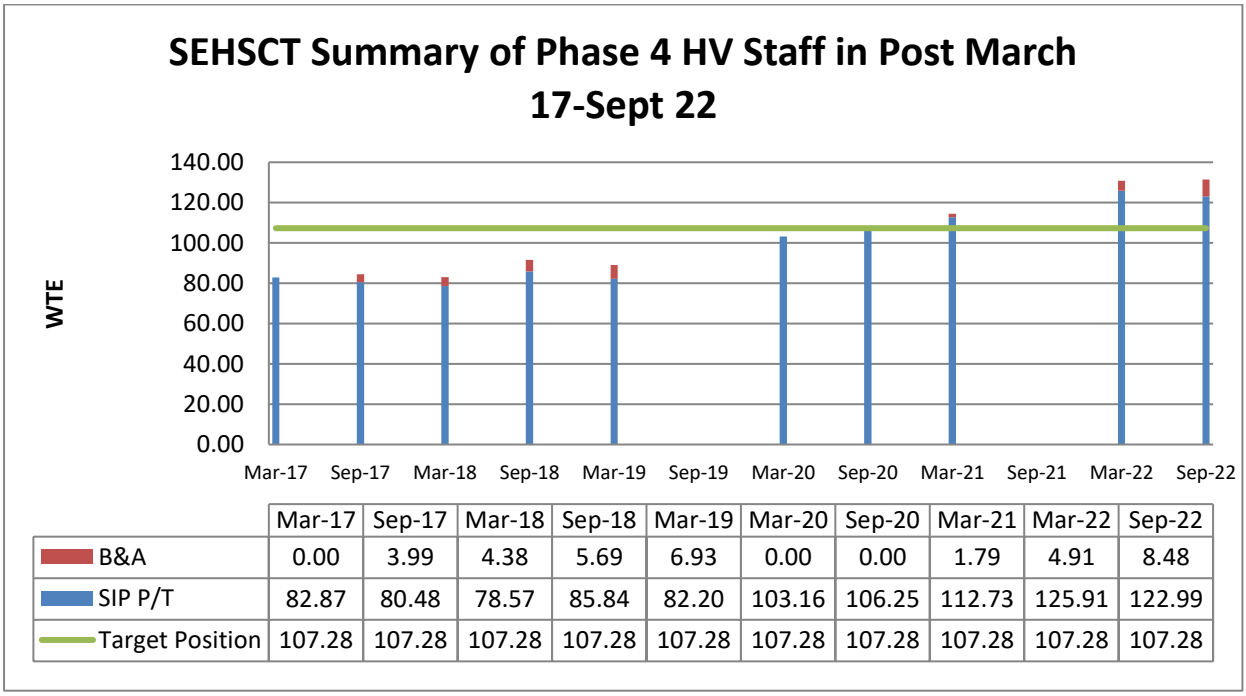


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	8.91	8.47	7.29	9.34	9.94	0.00	0.00	6.64	11.40	12.39
SIP P/T	121.32	119.12	124.73	114.10	119.57	160.91	154.87	153.61	170.97	159.25
Target Position	141.60	141.60	141.60	141.60	141.60	141.60	141.60	141.60	141.60	141.60

South Eastern Trust

South Eastern Trust have 15.71 wte SIP more than their target of 107.28 and they also used a small number of Bank and Agency staff. Their current sickness level rate is 15.51% which is above average. There are also 4 wte on maternity leave and 3.63 wte on career break.

Table 4.4

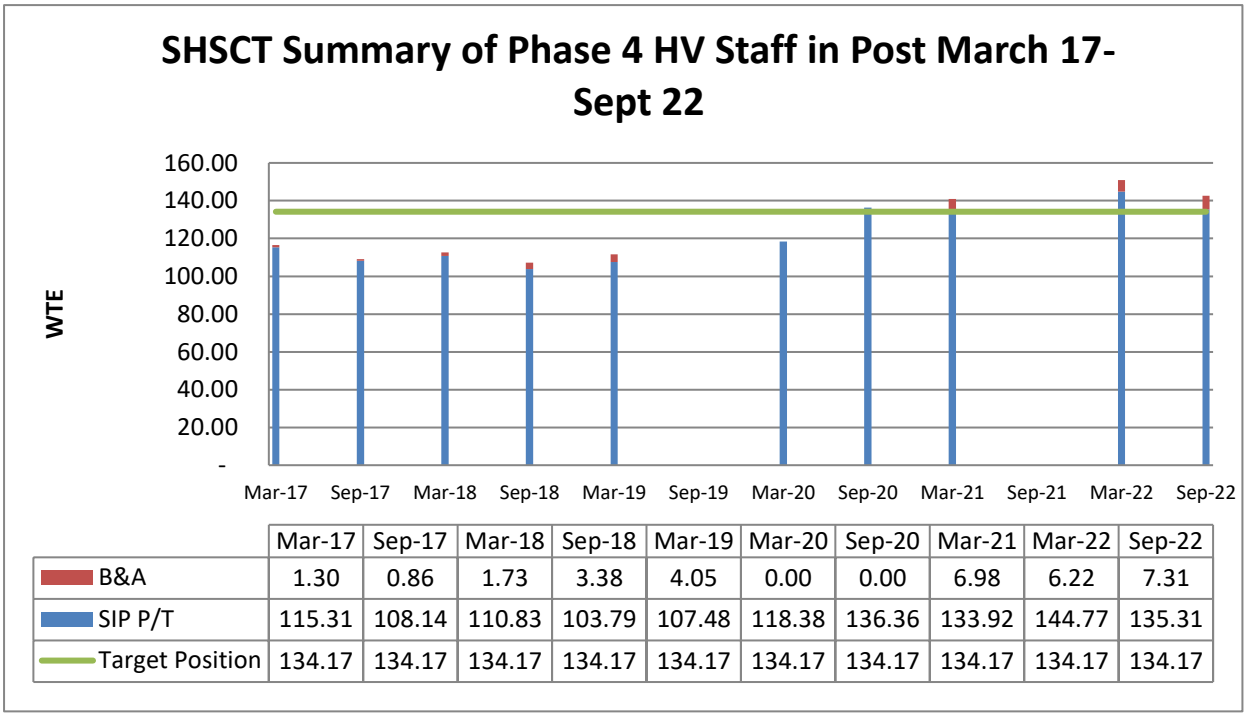


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	0.00	3.99	4.38	5.69	6.93	0.00	0.00	1.79	4.91	8.48
SIP P/T	82.87	80.48	78.57	85.84	82.20	103.16	106.25	112.73	125.91	122.99
Target Position	107.28	107.28	107.28	107.28	107.28	107.28	107.28	107.28	107.28	107.28

Southern Trust

Southern Trust have just reached their target on having 135.31 wte SIP where their target is 134.17 wte. Southern Trust FSL is 140.13 wte. They are currently experiencing a high number of maternity leaves. Southern Trust have funded (non-recurrently) 10.41 wte Student Health Visitors this year.

Table 4.5

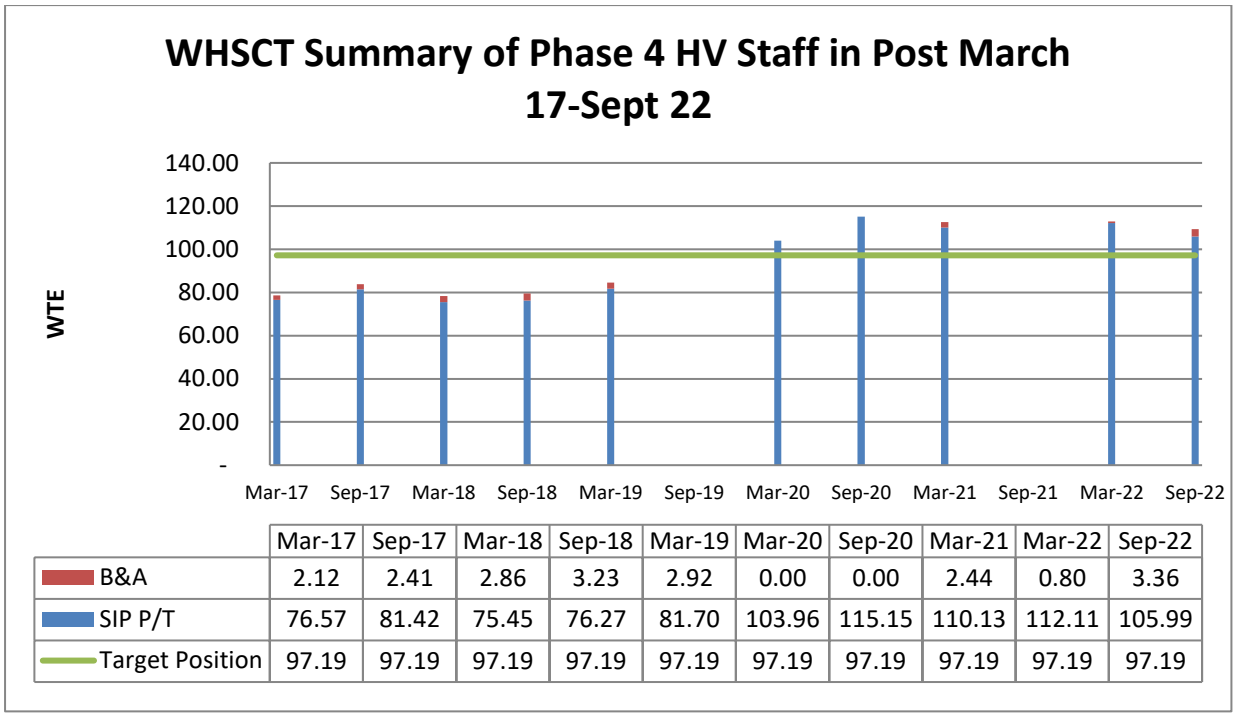


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	1.30	0.86	1.73	3.38	4.05	0.00	0.00	6.98	6.22	7.31
SIP P/T	115.31	108.14	110.83	103.79	107.48	118.38	136.36	133.92	144.77	135.31
Target Position	134.17	134.17	134.17	134.17	134.17	134.17	134.17	134.17	134.17	134.17

Western Trust

Western Trust had reached their target of 97.19 wte by Mar 20 and currently have SIP of 105.99 wte but they also used a small number of Bank and Agency staff (3.36 wte). Health Visiting students have not been included in Western Trust figures.

Table 4.6



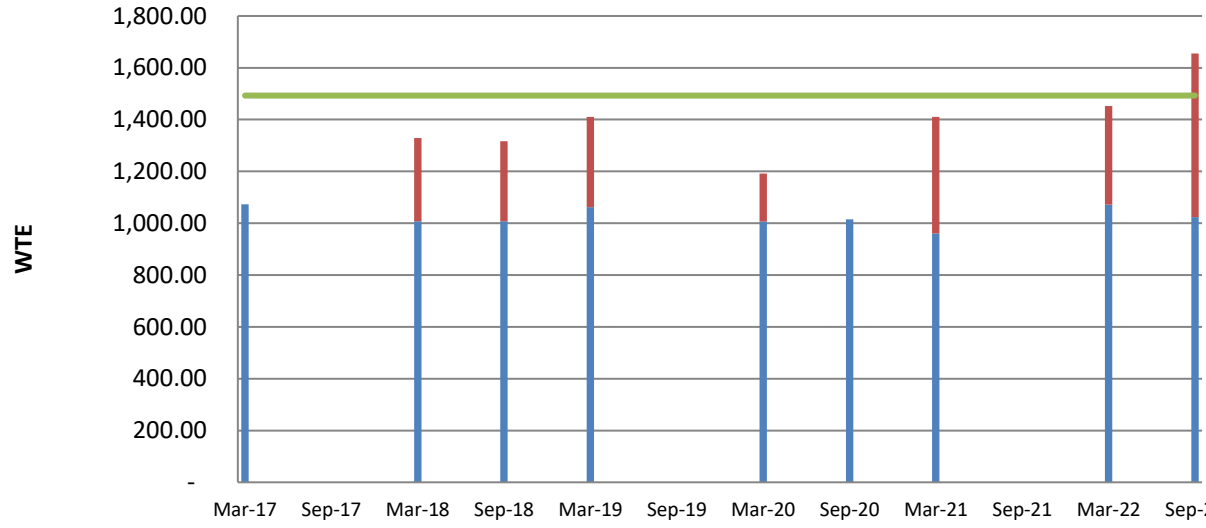
	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	2.12	2.41	2.86	3.23	2.92	0.00	0.00	2.44	0.80	3.36
SIP P/T	76.57	81.42	75.45	76.27	81.70	103.96	115.15	110.13	112.11	105.99
Target Position	97.19	97.19	97.19	97.19	97.19	97.19	97.19	97.19	97.19	97.19

Phase 5a – Mental Health Inpatients

Regional

In 20/21 Delivering Care provided recurrent funding for 30 Band 6 nurses at a cost of £1,674,245. A further 40 posts (half of which were at senior level) were recurrently funded through Delivering Care in 21/22 with an investment of £2,627,106. Even though these posts have been funded the overall SIP is not increasing which may indicate issues with recruitment and retention of staff in this area. Bank and Agency use has increased greatly over the years and is currently reported as 631.28 wte across the region.

Table 5.1

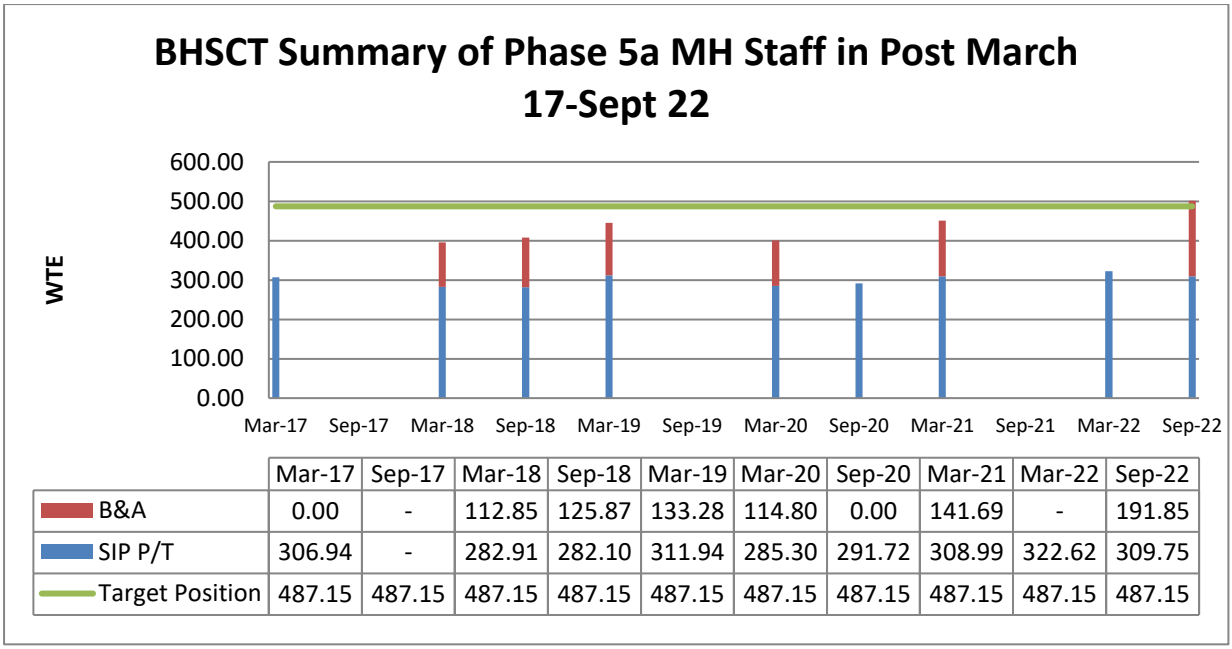


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	0	0	320.22	309.06	348.3	186.12	0	449.56	379.9	631.28
SIP P/T	1,072.8		1,008.2	1,007.4	1,062.2	1,006.2	1,015.1	960.43	1,072.1	1,023.9
Target Position	1,492.89	1,492.89	1,492.89	1,492.89	1,492.89	1,492.89	1,492.89	1,492.89	1,492.89	1,492.89

Belfast Trust

Belfast Trust have a current FSL of 385.96 wte but their SIP is 309.75 wte. This area has a high number of vacancies (mainly within CAMHS) and a high level of sickness. The target position set in 2017 was 487.15 wte and they require significant input from Bank and Agency to ensure they meet this target.

Table 5.2

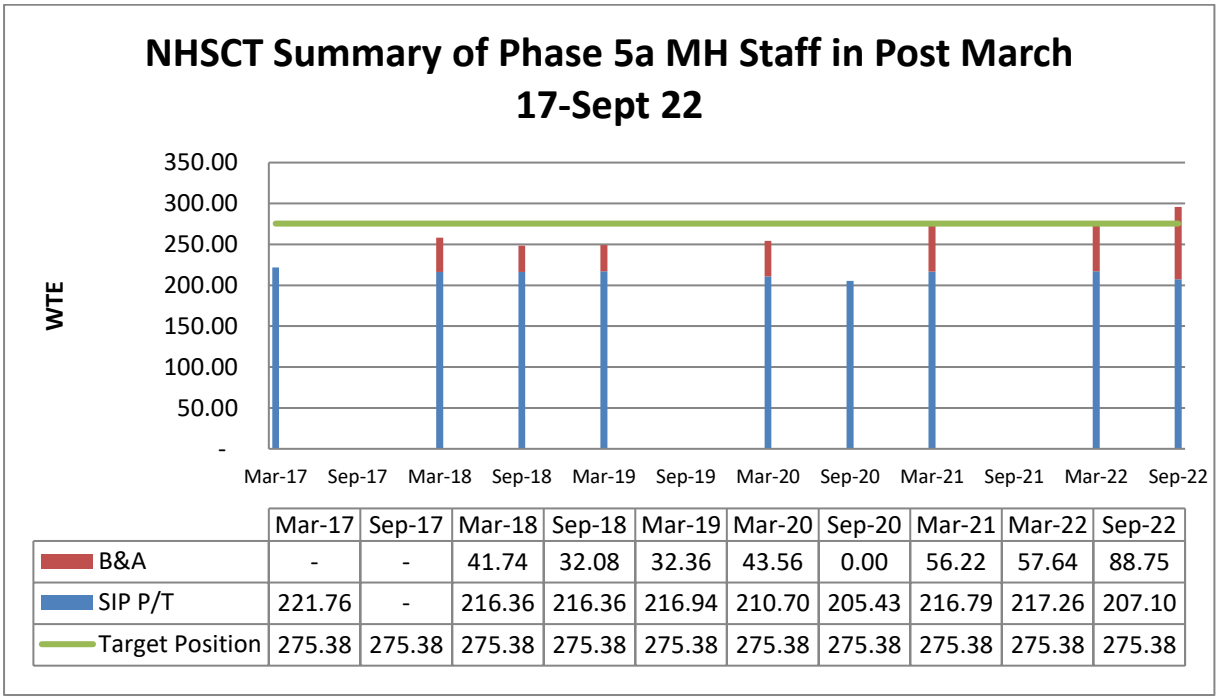


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	0.00	-	112.85	125.87	133.28	114.80	0.00	141.69	-	191.85
SIP P/T	306.94	-	282.91	282.10	311.94	285.30	291.72	308.99	322.62	309.75
Target Position	487.15	487.15	487.15	487.15	487.15	487.15	487.15	487.15	487.15	487.15

Northern Trust

The target for Northern Trust is currently 275.38 wte and SIP is 207.10 wte. With the addition of 88.75 wte Bank and Agency staff Northern Trust meet the target. With the additional funding over the past few years the FSL has increased to 257.82 wte but there is a large number of vacancies especially in Category 1 – Acute Inpatients including Addictions.

Table 5.3

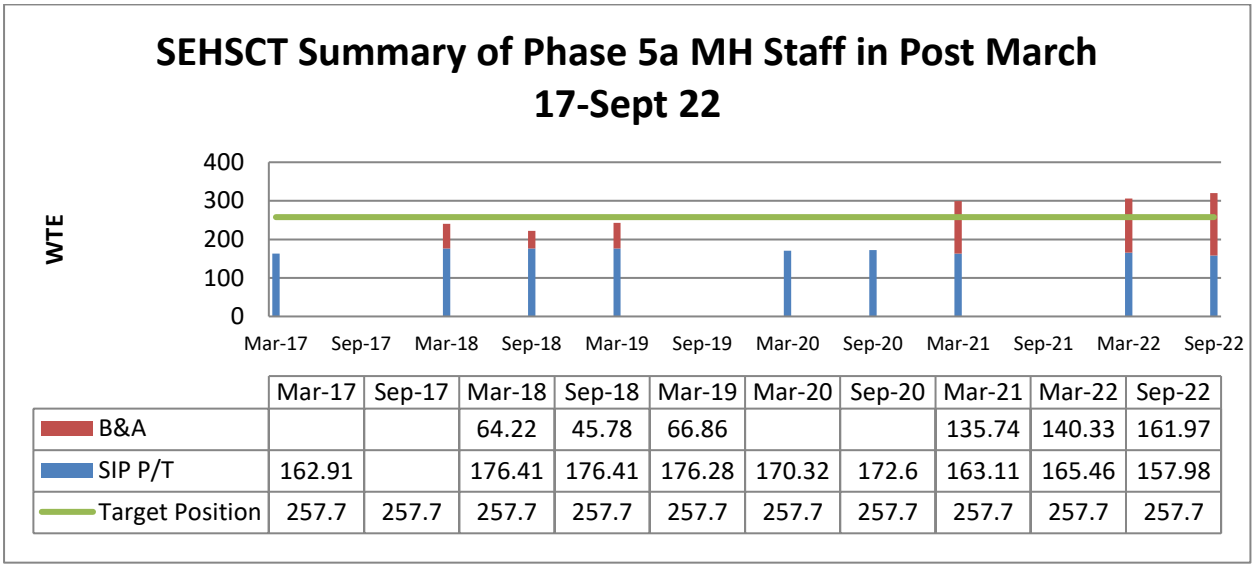


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	-	-	41.74	32.08	32.36	43.56	0.00	56.22	57.64	88.75
SIP P/T	221.76	-	216.36	216.36	216.94	210.70	205.43	216.79	217.26	207.10
Target Position	275.38	275.38	275.38	275.38	275.38	275.38	275.38	275.38	275.38	275.38

South Eastern Trust

FSL in South Eastern Trust is 201.5 wte. The current SIP is 157.98 wte which along with a very high number of Bank and Agency staff exceeds the target (257.7 wte) by 62.25 wte. South Eastern Trust have not provided details on vacancies in this area and sickness is at an average rate. Considering the number of posts funded in the last 2 years the SIP has not increased.

Table 5.4



	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A			64.22	45.78	66.86			135.74	140.33	161.97
SIP P/T	162.91		176.41	176.41	176.28	170.32	172.6	163.11	165.46	157.98
Target Position	257.7	257.7	257.7	257.7	257.7	257.7	257.7	257.7	257.7	257.7

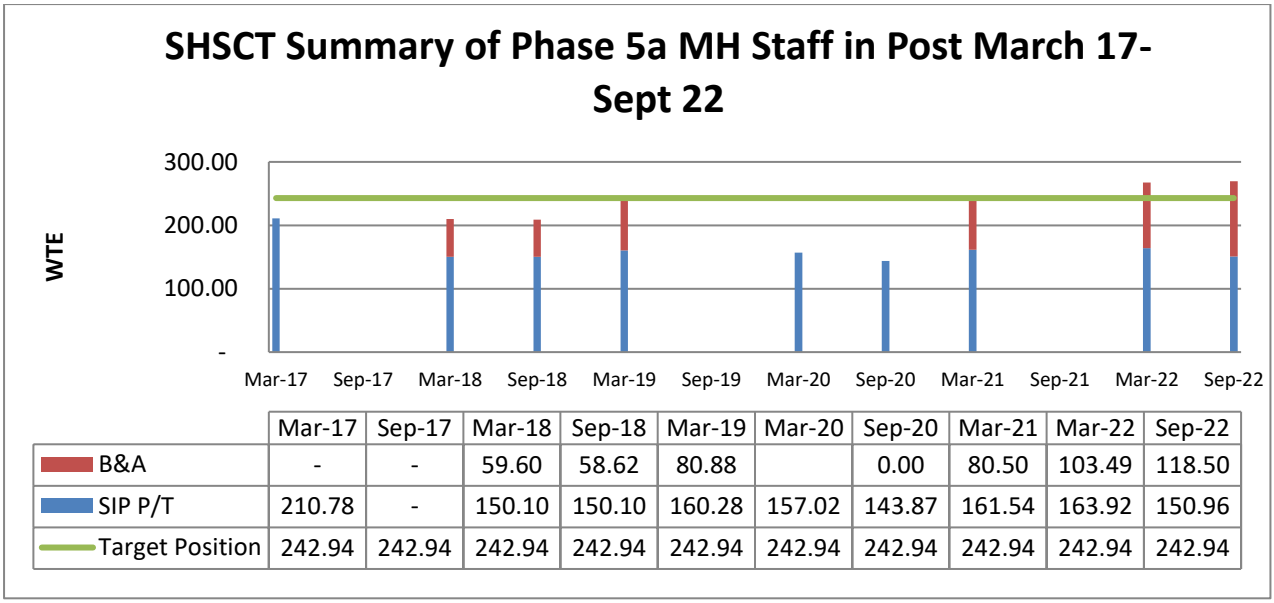
Southern Trust

The Target position in the Southern Trust of 242.94 wte is only being met through the use of a high number of Bank and Agency nurses (118.5 wte). The SIP has decreased since March 22 and there are a high number of vacancies within Category 2. The current FSL is 188.85 wte but the current SIP is 150.96 wte.

With the Increased regional demand for services there is sustained over occupancy and contingency utilisation within each ward. This coupled with rising demands on occasion results in additional beds (undesignated) being added to the unit to accommodate patients. Therefore, this has a direct impact on the use of bank and agency in order to ensure safe staffing levels

To note the Southern Trust has the lowest number of adult acute mental health beds per 100,000 population in the five Northern Ireland Trusts as per NHS Bench Marking Report 2018/19 and the 2nd highest number of admissions to the adults' acute mental health units.

Table 5.5

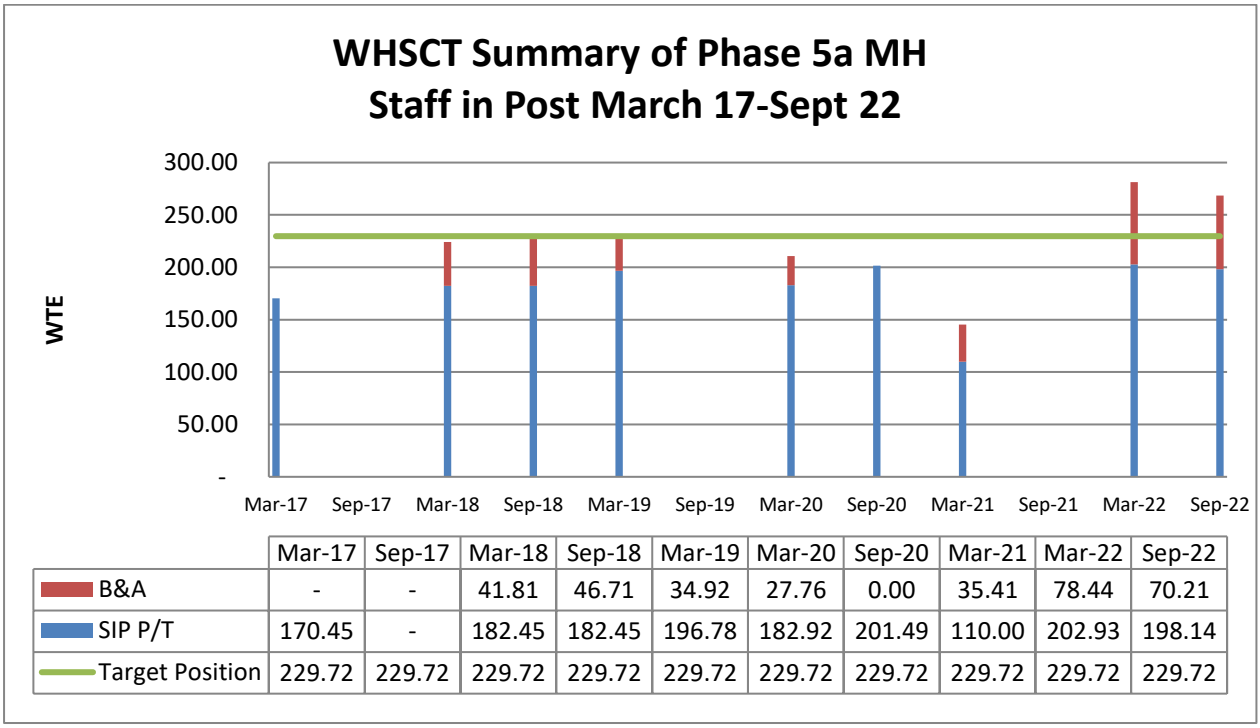


	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	-	-	59.60	58.62	80.88		0.00	80.50	103.49	118.50
SIP P/T	210.78	-	150.10	150.10	160.28	157.02	143.87	161.54	163.92	150.96
Target Position	242.94	242.94	242.94	242.94	242.94	242.94	242.94	242.94	242.94	242.94

Western Trust

The Target position in the Western Trust was set at 229.72 wte. Their current FSL is 233.97 wte but SIP is currently 198.14 wte therefore they have used Bank and Agency to meet (and exceed) their target. As with other Trusts, there are a number of vacancies across the area. The SIP has increased by almost 90 wte since March 21.

Table 5.6



	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19	Mar-20	Sep-20	Mar-21	Mar-22	Sep-22
B&A	-	-	41.81	46.71	34.92	27.76	0.00	35.41	78.44	70.21
SIP P/T	170.45	-	182.45	182.45	196.78	182.92	201.49	110.00	202.93	198.14
Target Position	229.72	229.72	229.72	229.72	229.72	229.72	229.72	229.72	229.72	229.72

SUMMARY

END OF YEAR RETURNS SEPT 22

PHASE 1 - ACUTE MEDICAL AND SURGICAL

TRUST	FSL	REQUIREMENT	SIP (include ML)	VARIANCE	B&A WTE
BELFAST	1848.6	1847.6	1858.31	-9.71	481.42
NORTHERN	778.5	657.02	745.1	33.4	255.43
SOUTH EASTERN	945.00	991.07	1033.87	-88.87	289.96
SOUTHERN	705.78	684.21	805.82	-100.04	281.99
WESTERN	817.74	713.44	843.47	-25.73	189.65
TOTAL	5095.62	4893.34	5286.57	-190.95	1498.45

PHASE 2 - EMERGENCY DEPARTMENT

TRUST	FSL	REQUIREMENT	SIP (inc ML)	VARIANCE	B&A WTE
BELFAST	224.92	174.96	171.09	53.83	57.13
NORTHERN	130.51	153.89	126.07	4.44	59.22
SOUTH EASTERN	139.65	109.49	154.95	-15.3	52.99
SOUTHERN	161.71	163.86	108.11	53.6	83.32
WESTERN	139.31	117.7	135.76	3.55	38.05
TOTAL	796.1	719.9	695.98	100.12	290.71

PHASE 3 - DISTRICT NURSING

TRUST	FSL	REQUIREMENT	SIP (inc ML)	VARIANCE	B&A WTE
BELFAST	311.95	281.24	247.84	64.11	19.52
NORTHERN	298.95	375.24	277.12	21.83	-
SOUTH EASTERN	271.21	281.84	221.25	49.96	-
SOUTHERN	298.46	295.51	283.62	14.84	9.78
WESTERN	247.38	238.56	234.01	13.37	6.64
TOTAL	1427.95	1472.39	1263.84	164.11	35.94

PHASE 4 - HEALTH VISITING

TRUST	FSL	REQUIREMENT	SIP (inc ML)	VARIANCE	B&A WTE
BELFAST	127.15	112.67	123.43	3.72	5.99
NORTHERN	154.65	141.6	159.25	-4.6	12.39
SOUTH EASTERN	120.16	107.28	122.99	-2.83	8.48
SOUTHERN	140.13	134.17	135.31	4.82	7.31
WESTERN	106.45	97.19	105.99	0.46	3.36
TOTAL	648.54	592.91	646.97	1.57	37.53

PHASE 5A - MENTAL HEALTH

TRUST	FSL	REQUIREMENT	SIP(inc ML)	VARIANCE	B&A WTE
BELFAST	385.96	487.15	309.75	76.21	191.85
NORTHERN	257.82	275.38	207.1	50.72	88.75
SOUTH EASTERN	201.55	257.7	157.98	43.57	161.97
SOUTHERN	188.85	242.94	150.96	37.89	118.5
WESTERN	232.97	229.72	198.14	34.83	70.21
TOTAL	1267.15	1492.89	1023.93	243.22	631.28

CONCLUSION

- Despite funding of £25million from Delivering Care alone there are still staffing pressures, not least due to workforce supply and staff work life choices.
- A number of the targets set are outdated and need to be reviewed in line with service developments, NMTG recommendations and longterm strategic direction.
- Retention of staff is an issue which has been highlighted and being addressed through other colleagues.
- Recruitment to particular areas is a challenge.
- Use of Bank and Agency is adding significant pressure to the system.

Delivering Care Phase 9A (Inpatients) Learning Disability

As part of the Policy Framework for Nursing and Midwifery Workforce Planning in Northern Ireland

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

HSC Health and Social Care

Dated 21.06.22

Draft 16

Introduction

Delivering Care aims to support the provision of high quality care which is safe and effective in hospital and community settings, through the development of staffing models and ranges for the nursing and midwifery workforce within the Delivering Care policy framework.

Phase 9A and 9B of this work will focus on Learning Disability Nursing in specialist learning disability services (inpatient (A) and community (B)).

This paper is intended to build on the key principles and assumptions that have been agreed in previous phases for Delivering Care. This phase will reflect the methodology agreed with the regional Steering Group and governance arrangements for the overall project, as they relate to **Phase 9A specialist learning disability inpatient environments**.

It is recognised that workforce planning processes include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPIs) for safe, effective, person-centred care. This work has been developed in the context of the principles of Quadruple Aim[1], which combines a focus on population health and wellbeing, safety, quality and experience, cost and value with the added experience of care givers.

Context

The subject of nurse staffing continues to be a matter for debate. Ensuring appropriate nurse staffing is in place has been referenced in inquiries and reviews[2], highlighted in research and evidence[2] and is viewed by families and carers as a key element in influencing the quality of care[2]. Phase 9 (Learning Disability Nursing, specialist inpatient and community settings) of the Delivering Care framework builds on the methodologies and learning from previous phases.

The Bamford Review of Mental Health and Learning Disability in Northern Ireland[3]

At the heart of the Northern Ireland (NI) Mental Health Strategy is the vision to deliver a service which gets the best results at the earliest opportunity.

The Bamford vision for Mental Health and Learning Disability strongly supports the following principles:

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[1] Bodenheimer, T., (2014) From Triple to Quadruple Aim: Care of the Patient requires care of the Provider, Annals of Family Medicine, University of California

[2] Public Health Agency (2017) Delivering Care: A Literature Review for Workforce Planning for Learning Disability Nursing In Northern Ireland, PHA

[3] Bamford Review of Mental Health and Learning Disability https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/bamford-action-plan-2012-15.pdf

- Good Mental Health should underpin all aspects of health and wellbeing and should be everyone's responsibility.
- People with Learning Disability needs should be valued. This includes the right to full citizenship, equality of opportunity and self-determination.
- There is a need for society to address the challenges facing people with Learning Disability needs
- There should be a process of reform, renewal and modernisation of services that will make a real and meaningful difference to the lives of people with a Learning Disability and to their carers and families.

Within Learning Disability services, a person-centred approach is endorsed which is community and family-orientated with with users and carers at the centre. In addition, the Bamford strategic policy focus is on the development of leadership, teamwork, workforce and training, acknowledging that reform is dependent upon a sufficient and competent workforce within specialist Learning Disability services.

At all levels of the Bamford Mental Health and Learning Disability Strategy there is a requirement for adequate resources, including support for recommended staffing levels to ensure the effectiveness of the Health and Social Care (HSC) workforce. This requirement will be progressed under the key work streams across Mental Health and Learning Disability strategies to reform services into the future.

Recommendations of Bamford

Since the inception of the Bamford vision there have been a number of improvement initiatives, including practice development for staff, introduction of new services and ways of working and improved patient experience. Listed below are some of the key recommendationsof the Bamford vision:

- The resettlement of the majority of patients out of hospital to the community;
- Services should be evidence based and subject to ongoing evaluation;
- Early intervention should be a guiding principle to prevent behaviours becoming long-standing and difficult to treat;
- Specialist mental health teams for people with a Learning Disability might be developed and staff trained in understanding the mental health needs of these people;
- Functional analyses should be undertaken to determine the causes of behaviours that challenge, to identify antecedents or consequences that maintain behaviour with a view to introduce adjustments;
- Medicines should be used to supplement other interventions rather than as a stand-alone treatment;

- Annual health checks that include cognitive and behavioural assessments should be provided for people with Learning Disability from as early as 35 years old in addition to the promotion of healthier lifestyles and surveillance of health risks;
- Development of high quality older person day-care, respite and recreational services for older people with LD within both LD services and mainstream older people's services should be put in place and used;
- The development by the Public Health Agency (PHA), Health and Social Care Board (HSCB) and the Department of Health (DoH) of an education and learning framework for Learning Disability professionals.

Key Drivers for the Future Learning Disability Nursing Service

A range of strategic and operational drivers have been considered within this phase of Delivering Care that will have a significant impact on the future of Learning Disability Nursing services. The following policy drivers have been considered:

- **Health and Wellbeing 2026: Delivering Together[4] -** This document was produced in response to the report by Professor Bengoa. Delivering Together puts people first and focuses on enabling people to stay well for longer. Where care or support is needed, it will be, wherever possible provided in a community setting.
- HSC (NI) **Workforce Strategy** 2018[5].
- **Quality Care[6]** -The Q2020 Strategy aims to protect and improve the quality of health and social care in Northern Ireland and to be recognised as a leader for excellence. Through its key strategic goal 'strengthening the workforce', the Q2020 strategy is committed to ensuring that we provide the right education, training and support to deliver a high quality service. This is fundamental to the delivery of safe and effective services.
- The **Bamford[7]** vision for Learning Disability services, which called for continued emphasis on promotion of positive Mental Health, reform of Mental Health legislation and a continued shift from hospital to community based services with the development of specialist services.
- **Strengthening the Commitment[8]** is the Department of Health's Strategy **(2014)** for Learning Disability Nursing.

[4] Department of Health (2016) Health and Wellbeing 2026 Delivering Together, DoH 2016
[5] Department of Health, Social Services and Public Safety (2015), Evolving and Transforming to Deliver Excellence in Care. A Workforce plan for Nursing and Midwifery in Northern Ireland (2015-2025) DHSS&PS
[6] Department of Health, Social Services and Public Safety, (2014) Quality 2020: An Attributed Framework for Health and Social Care, DHSS&PS
[7] Bamford Review of Mental Health and Learning Disability https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/bamford-action-plan-2012-15.pdf
[8] *Department of Health (2014) Strengthening The Commitment*

- **Dementia Strategy[9] -** Recommendations aimed at improving the services and support arrangements currently available for people with dementia, their families and their carers, with an emphasis on early diagnosis.

- **Population health[10]** – Increased focus on enabling health promotion, prevention and self-management. The "Making Life Better" NI Public Health framework (DHSSPS 2013) seeks to create the conditions for individuals and communities to take control of their own lives and move towards a vision of NI where all people are enabled and supported in achieving their full health and wellbeing potential and to reduce inequalities in health.

- **Care enabling technologies[11]** - Building on the "Regional eHealth and Care Strategy" (DHSSPS 2015) it is imperative that there are systems and processes to support timely and consistent sharing of patient information. This should include real time access to all Mental Health and social care information for all relevant care providers to enable them to work effectively and safely with their patients. This will be achieved through the development and implementation of an electronic record in common for all citizens in NI over the next 5 - 10 years.

- A priority for **unscheduled care[12]** in NI is to have effective, integrated arrangements, organised around the needs of individual patients, in place in community settings to provide care for people at home and in their local communities. The intention is to avoid the need for hospital admission for Mental Health services and to support safe and effective discharge planning arrangements when a period of hospital admission is required.

- The **Nursing and Midwifery Task Group[13]** (NMTG) was brought together to consider the challenges to nursing and midwifery in the face of rising demand which far exceeds the resources available. It states that the transformation of nursing and midwifery services is essential to the stability and sustainability of the NI health and social care system. The recommendations in the report will facilitate the adoption of a population health approach and put prevention and early intervention at the heart of nursing and midwifery practice. The stabilisation of the nursing and midwifery workforce and transformation of health and social care through enhancing the roles that nurses and midwives play within and across mulit-disciplinary teams.

[9] Department of Health, Social Services and Public Safety (2011) Improving Dementia Services in Northern Ireland- A Regional Strategy, DHSS&PS

[10] Department of Health, Social Services and Public Safety (2014), Making Life Better 2012-2023, A Whole System Strategic Framework for Public Health, DHSS&PS (2002) Investing for health Strategy 2002-2012, DHSS&PS

[11] Department of Health, Social Services and Public Safety (2015) Regional eHealth and Care Strategy, DHSS&PS

[12] Department of Health (2016) Health and Wellbeing 2026 Delivering Together, DoH 2016

[13] nursingandmidwifery@health-ni.gov.uk

- **Demography**[14] - The population of NI is increasing, and within this overall increase the size of the older population is increasing more quickly. Around 1.5 million people in the UK have a learning disability. It's thought up to 350,000 people have a severe learning disability. This figure is increasing. With increasing complexity of need and challenging behaviour, high levels of intensive support and observation are often necessary.

- **Increasing Profile of Demand** - Due to the rapidly changing health and social care landscape increasing numbers of people with a Learning Disability are being cared for in the community, which includes from birth across the age spectrum to those living to a very old age.

Current Services

Descriptors and Category of Care Environments

Currently Northern Ireland's Specialist Learning Disability services include both inpatient services and community based services.

At present specialist learning disability inpatient services are delivered by three of the five HSC Trusts in Northern Ireland.

BHSCT are responsible for Muckamore Abbey Hospital which is commissioned to provide specialist learning disability in-patient services for the population of three HSC Trusts, the Belfast, South-Eastern and Northern Trusts. The Hospital also provides regional specialist learning disability forensic inpatient services.

Southern Health and Social Care Trust (SHSCT) provides specialist learning disability inpatient services for their population in Dorsey Ward at Bluestone Unit, Craigavon Area Hospital.

Western Health and Social Care Trust (WHSCT) provides specialist learning disability inpatient services for their population in Lakeview Ward on the Gransha Hospital site.

Inpatient units

Phase 9A will incorporate inpatient units across the three Trusts that currently deliver specialist inpatient services. For the purposes of this phase of Delivering Care, each inpatient unit will be described within the following categories of care environment.

Categories of Care Environments.

[14] nidirect Government Services

Specialist Learning Disability Assessment and Treatment Wards are clinical environments where patients are admitted in the acute phase of an illness, or require an immediate Mental Health and /or behavioural assessment and/or treatment. Admission may be due to a number of reasons such as displaying self-injurious or aggressive behaviour, which is not related to mental ill health or displaying risk behaviours which may put them or others at risk.

Psychiatric Intensive Care Wards

These wards are for people experiencing acute mental illness and provide short term intensive care and treatment in a more restricted environment . Individuals who require this type of care are usually subject to the provisions of the Mental Health (NI) Order 1986. There are usually higher than normal staff to patient ratios: locked areas: and other environmental restrictions such as windows with restricted opening,and controlled access to areas such as the kitchen and garden.

Resettlement Unit

Forensic Ward

Specialist forensic inpatient services are usually provided for those between 18 and 65 and are subject to the provisions of the Mental Health (NI) Order 1986. The ward will care for those patients needing specialist forensic assessment and treatment in a low secure setting due to their behaviours and the associated levels of risk this represents to them and others.

Case studies for each Category of Care Environment

In order to give some understanding of the types of patients and conditions admitted to the various inpatient Learning Disability settings, a number of anonymised case studies can be found at ***Appendix 1.***

The Learning Disability Nursing Workforce in Northern Ireland

A Registered Nurse for Learning Disability (RNLD) is a Registered Nurse (RN) who is regulated by the Nursing and Midwifery Council (NMC), under Part (1) of the NMC Register. For the purposes of this paper, Phase 9 will include RNLD's who work in H&SC Trusts in specialist learning disability healthcare services.

The Registered Nurse for Learning Disability is uniquely placed to undertake a biopsychosocial assessment of need and develop and formulate a plan to deliver evidence based interventions to meet the health and social care needs of the individual across a range of settings. Registered Nurse for Learning Disability are the corner stone in the assessment and formulation of needs, in managing risk and in delivering 24 hour therapeutic care. The Chief Nursing Officer for Northern Ireland has commissioned a review of Learning Disability nursing with a view to enhancing

and maximising the role the Registered Nurse for Learning Disability can play in delivering better outcomes. The output of this review will shape and inform the pre and post registration programme content, the model of care and support the development of a career framework for Learning Disability nursing across care settings.

In planning services, organisations should consider the role and function of the Registered Nurse for Learning Disability, where care and treatment, through a bio-psycho-social approach, is required to prevent ill health, address health inequalities, and to improve and maintain health and wellbeing. To enable the effective delivery of care, it is essential to have an appropriate professional skill mix of nurses within specialist learning disability services, to provide safe and effective care and support, and leadership to provide evidence based therapeutic interventions and care.

The Significance of the Profile of the Learning Disability Nurse

Nurses are central to the provision of quality care and are highly valued by the public in NI, a view expressed in the *Patient and Client Council Report (2010).*[15]

The Nursing and Midwifery Council (NMC) has recently published new education[16] and proficiency[17] standards for pre-registration nursing programmes. The NMC as the professional regulator exists to protect the public. The education framework contains the standards and requirements that together signify what effective professional education and training looks like. Similarly, the standards of proficiency reflect the anticipated future needs of the public for expert nursing care and provides guidance on what the newly registered nurse should know and be able to do at the point of registration in order to practise safely and effectively.

Learning Disability Nurses gain an in-depth knowledge of the health needs of children, adults and older people with learning disabilities and their care and support needs. This knowledge and skills is gained through a 3-year undergraduate programme leading to NMC registration as a Registered Nurse Part 1 (Learning Disability). The education programmes combine a blend of theory, skills simulation and practice learning, regarding the care and support needs of children, adults and older people with learning disabilities. All nurse education programmes comprise 50% university based study, focusing on the current evidence of the care and support needs of people with learning disability across the lifespan and clinical skills

[15] Patient and Client Council (2010) The People's Priorities, A View from Patients, Service Users, Carers and Communities on Future Priorities for Health and Social Care in Northern Ireland

[16] Nursing & Midwifery Council (2017) Education Framework: Standards for Education and Training, NMC

[17] Nursing & Midwifery Council (2017) Standards of Proficiency for Registered Nurses, NMC

preparation. 50% of the programme involves supervised practice learning with internationally recognised training partners in a wide range of clinical and community settings throughout Northern Ireland. (Queen's online description of LD nursing course 14.10.19)

On completion of the programme, Registered Nurse for Learning Disability will possess a distinct set of knowledge, skills and expertise of the health and wider education and social care needs of people with a Learning Disability and their families and carers in the context of person-centred care that promotes and maintains health and well-being.

Ulster University provides a Specialist Practice Qualification at Postgraduate Diploma level in Community Learning Disability Nursing. This programme prepares Learning Disability Nurses to practice in a wide range of community settings. Queen's University provides a MSc in Advanced Professional Practice with a pathway in Intellectual Disabilities, which provides Learning Disability Nurses with education of the changing needs of children, adults and older people with learning disabilities and the implications for service delivery now and in the future.

Within their practice role the Registered Nurse for Learning Disability nurse adopts a life span approach to nursing assessment, treatments, interventions, health education and care and support across a diverse range of settings. These include home, in-patient settings, nursing homes, secure settings, schools, day care and residential care homes to contribute to the care needs of people with learning disabilities and their families and carers.

"Learning Disability Nurses are highly skilled, highly motivated, cost-effective and highly-valued person centred nurses. Wherever they work they have a proven record for improving outcomes, reducing the impact of health inequalities and improving people's lives. They have unique, enhanced communication and interpersonal skills, are important educators and can be part of the essential reasonable adjustments needed to reduce morbidity and unnecessary premature deaths of people who have a Learning Disability" (FoNS, Celebrate Me, 2019)

Registered Nurses for Learning Disability nurses have an important Public Health Role in considering the physical, psychological and social needs of children, adults and older people with learning disabilities. This element of the Learning Disability Nursing role is important as too often people with learning disabilities do not have the same access to health services and care and support within the community. As a result, a mortality gap exists whereby people with a learning disability die decades earlier than the rest of the populations from avoidable causes. To contribute to addressing these needs, Registered Nurses for Learning Disability play important roles in relation to health assessment and health screening, working collaboratively with people with learning disabilities, their families, carers and other professionals to develop plans of care and support. Registered Nurse for Learning Disability provide a crucial role in facilitating and enabling equality of access to services and health education programmes based on the assessed needs of the individual. Within

primary and acute hospital care, Registered Nurses for Learning Disability provide support to enable informed decision making on many issues effecting their health and wellbeing and life choices, thereby supporting community integration and reducing the impact of health inequalities.

Within a multi-disciplinary team, in an in-patient setting, Registered Nurses for Learning Disability are the professional group which spend the most time in a direct care role with patients. They form a therapeutic relationship with patients, and develop a detailed understanding that creates a dynamic which cannot be under estimated.

The therapeutic credentials of the Registered Nurse for Learning Disability are well established and recognised within their health, social and behavioural competencies, in supporting access to services and care and support that contributes to the improvement and maintenance of their health and wellbeing and social inclusion to support lives that are full and as productive as possible.

Evidence

Determining the appropriate skill mix and caseload size for all Learning Disability nurses is a complicated process due to a range of variables that impact on health and social care needs. These include:

- Workforce;
- Environment;
- Activity (Clinical);
- Professional Regulatory Activity

These are further described as influencing factors in ***Appendix 2.***

Within specialist Learning Disability inpatient settings in NI, the current method that is used to calculate staff is the Telford method. This approach is underpinned by the clinical judgement and experience of registrants and is often used with other methods of workforce calculation in order to provide a degree of triangulation.

Within Community Learning Disability Teams the capacity method that is used is a "workforce utilisation tool," the "Choice and Partnership Approach" (CAPA)[18]. This model combines collaborative and participatory practice with service users bringing together active involvement of patients, supporting the recovery ethos of care, essentially managing demand and capacity within the existing workforce. Further review of caseloads based on populations for NI will be explored in Phase 9B.

[18] York, A., & Kingsbury, S., (2013) The Choice and Partnership Approach: A Service Transformation Model, Short Run Press, Exeter

A literature review was carried out as part of the Phase 9 framework in 2019 to ascertain the evidence base for Learning Disability nursing workforce planning. The key findings are highlighted in ***Appendix 3***.

Methodology

The methodology for this phase of Delivering Care follows on from the previous phases. This approach is based on a range of workforce intelligence information, best available evidence, literature reviews, benchmarking, application of the core assumptions of the framework and scoping exercises with Trusts. Engagement with key stakeholders on the proposed staffing recommendations for the current workforce requirements has been done in collaboration with the expert reference group, working group and steering group. The methodology is aligned to the agreed governance arrangements for the project.

Approach

The approach is based on best evidence and promotes a quadruple aim methodology (see **Figure 1)**, and includes reference to recognised workforce planning tools.
The 'Triple Aim' was developed in 2008 to guide the redesign of healthcare systems with an emphasis on population health, patient experience of care and reducing costs. In recognising that the backbone of any effective healthcare system is an engaged and productive workforce, a 4th aim was added - *Improving the experience of providing care*.

This 4th aim holds particular importance within the delivering care process. Nurses are often central to the teams of health and social care professionals charged with delivering health and service improvements. Effective workforce planning is vital, not only in ensuring the availability of sufficient numbers of skilled staff but also in providing structures and support so that each member of the nursing workforce can realise the sense of accomplishment and success that results from meaningful work.

Figure 1 The Quadruple Aim Method

The outputs of the approach for Phase 9A have been produced in consultation with a wide range of key stakeholders including planners, service providers, professional managers, senior nurses and expert reference group. Following a review of baseline data, modelling the data during the development of Phase 9A, it has been proposed that the core elements will be the development of a guide for a nursing staff to bed (range) for staff based across the categories of care environments, in inpatient settings in Learning Disability services.

The financial analysis and data collection templates, for the recommended model follow the same methods as for previous phases. Each phase has a review date to ensure the framework is refreshed regularly.

Assumptions

The following assumptions of the framework are built into the principles of the recommended staffing range for Learning Disability Nurses in inpatient settings. Outcome indicators for monitoring the Learning Disability Nursing workforce have also been built on the assumptions of the framework.

a) Assurance of safety, quality and experience through the following key performance indicators (to be agreed regionally)

- Organisational; absence rates, vacancy rates, staff in post, skill mix via Delivering Care monitoring returns.
- Safe and effective care, e.g. incidence of SAIs which will be agreed regionally.

- Patient experience, e.g. involvement in person-centred decision making re: care needs and decisions in relation to treatments and direct patient contact.

b) Planned and unplanned absence allowance

Planned and unplanned absence allowance (PUAA) refers to periods of absence from work which can be described as anticipated and therefore must be factored into the workforce planning process. This includes annual leave, sickness and mandatory study leave. The allowance agreed for NI is set out in **Table 1**. It should be noted that the agreement throughout the phases of the policy for Delivering Care does not include a specific mandatory allowance for maternity leave.

Table 1: Percentage uplift for planned and unplanned absence

Annual leave	Sick leave	Study leave Mandatory	Total allowance NI
15%	5%	4%	24%

c) Skill mix

The skill mix refers to the ratio of registered to non-registered nursing staff working within Learning Disability teams across inpatient and community settings. The level of skill mix may vary across both these settings. A level of skill mix has been recommended for the funded establishment of each category of care environment, based on best evidence and the use of recognised workforce planning tools. In addition, the skill mix should take into consideration the allocation of the 100% ward sister/charge nurse/nurse team leader role across all Learning Disability settings. There is also a requirement to ensure that senior nursing posts make up part of the registered nurse skill mix requirement, in Learning Disability care environments. These posts will ensure the delivery of nurse led, psychological therapeutic interventions and drive forward evidence based practices.

Following a review of evidence and current baselines and benchmarks, the proposed skill mix for inpatient units will range from 70:30 - 80:20.

d) Management of recruitment

Whilst there are recognised challenges around nurse recruitment in NI it will be essential that all Nursing vacancies across Learning Disability services are filled within a prompt timescale by registered and unregistered nursing staff respectfully to ensure that Nurse staffing levels support safe and effective person-centred care as set out in the framework recommendations.

Employers must ensure that a risk-based approach is adopted to managing recruitment, taking into consideration the maintenance of safe nurse staffing levels against the recommended range within the framework. Every effort should be made to avoid the overuse of temporary, bank and agency staff. This is a regional priority across Northern Ireland.

Matching skill mix to band mix to patient acuity and dependency within recognised professional standards and guidelines will be a fundamental requirement to ensure that professional judgement is incorporated to reviewing required staffing levels.

The availability of senior nursing posts across inpatient units as part of the workforce requirements should support the proposed staffing model.

Regional Review

In October 2019, a review was carried out of all Learning Disability services across Northern Ireland. As a result there is much discussion regarding how best Learning Disability services should be configured in future, with an emphasis on more resources in the community. There is an acknowledgement of the enormous challenges faced by inpatient units due to increased acuity and dependency of the patients being admitted. This is possibly due to a lack of community infrastructure and places a significant strain on staff and staffing levels. The outworkings of the Regional review are still being considered at Department, HSCB and Trust level.

Benchmarking of Inpatient Nurse to Bed Ratios across the UK

In *Building the right support*[19], NHS England predicts the need for a reduction in learning disability bed numbers to about 40 per million population (15 assessment and treatment and 25 secure beds). Staff with appropriate skills will be needed in sufficient numbers to deliver setting-specific services.

There are no comparable figures for Northern Ireland. However, it is acknowledged that caring for people in the community is linked to an improved quality of life, suggesting that the majority of care for this group of patients, in the future will be delivered in the community.

Benchmarking for this phase of Delivering Care proved challenging. Benchmarking data was sourced from a Foundation Trust in the North East of England and data supplied by Keith Hurst. Hurst developed a 'ward multiplier tool' for learning disability inpatient settings. The tool is based on the UK Database system from which the 'safer nursing care tool acute multipliers were developed. In NHS England the preferred model for inpatient workforce is based on the time spent on activity matched with the acuity of patients.

[19] www.england.nhs.uk/wp-content/uploads/2017/02/model-service-spec-2017.pdf

The units in England had a higher percentage of Band 6 and 7 posts, covering managerial and clinical therapist posts. The therapist posts provide a clinical leadership role for complex cases, service development and team development. This allows scope for career progression. The skill mix varies across inpatient environments from 31:69 to 25:75 registered to unregistered staff. Some Band 7 posts exist as "supervisory" but not all. The model in England includes 22.5% uplift for planned and unplanned absences (PUAA). It should be noted that the daily measurement of acuity of patients determines the recommended staff ratios across many inpatient units in the UK.

The table in the next section provides an example of the nurse to bed ratio (NTBR) reviewed as part of the benchmarking exercise across Learning Disability inpatient environments in the UK.

Staffing Model – Phase 9A Inpatient Units- changes accepted

In order to provide good governance and in keeping with the ethos of the NMTG there should be a range of nursing posts at senior level to ensure good leadership and clinical expertise for more junior staff. Such a hierarchy of staff would promote, encourage and ensure staff are supported and facilitated to deliver high quality, safe, efficient and person-centred care in accordance with the NMC Code. It would ensure that care and treatment of the highest possible standard is delivered and would allow a clear pathway for career progression. This range of staff would include posts at Band 8b Consultant Nurse, Band 8a Advanced Nurse Practitioner with possible managerial responsibilities, and a Band 7 Specialist Practice Nurse overseeing supervision and the maintenance of high standards of care. **Appendix 4**. The skill mix will also include Band 6 and Band 5 posts. The spectrum of posts from 8a to Band 5 will constitute 70-80% of registered nursing staff. This will be complemented by Band 3 making 20-30% of unregistered staff.

Based on the application of the assumptions/influencing factors, the Benchmarking information and a peer review of staffing levels, which included Telfords in each Trust for inpatient Learning Disability Services, the recommended nurse to bed staffing ranges, are outlined below in **Table 2**.

Table 2: Category of Care Environments Phase 9A

Category of Care Environment	Inpatient facility	Proposed Nurse to Bed Ratio Range	Proposed Skill Mix

1	**Learning Disability Assessment and Treatment**	**1.75-3.50**	**70:30**
2	**Psychiatric Intensive Care Unit**	**1.75-3.50**	**80:20**
3	**Low Secure/Resettlement**	**1.75-3.50**	**70:30**
4	**Forensic**	**1.75-3.50**	**80:20**

The figures for the nurse to bed staffing ratios were provided by each Trust which accommodates a Learning Disability in-patient facility. The broad range of staffing from 1.75-3.50 is reflective of the current challenging situation in LD in-patient units. There is continuous pressure on bed occupancy, through the number of admissions and the number of patients whose discharge has been delayed due to difficulty in finding appropriate community placements. It is also recognised that the acuity and dependency of patients in in-patient units is increasing, and that patients being cared for in inappropriate environment due to lengthy delays in their discharge can contribute to a deterioration in their presentation and increased levels of behaviours of concern. This may lead to higher levels of behaviours of concern, which are often managed via one to one, or two to one observation. There is no cap on the number of special or enhanced observations that each unit can manage at any given point in time.

The range of staffing is to allow for flexibility in managing patients on special observations – from no patients on observations, at one end of the spectrum to 6 patients at the other end of the spectrum.

In order to manage this from a staffing perspective, it may be necessary to consider each unit in terms of Low Medium and High Dependency patients, predicated on their profile of need. Scoring each patient's dependency level on a scale of low to high would assist in determining the number of staff required for that unit. These units would also facilitate a community in reach model, with nurses from the community providing in reach in order to move patients to the community more rapidly. The Psychiatric Intensive Care Unit and the Forensic Unit would always be considered as having patients with High Dependency thus necessitating a richer skill mix.

Monitoring

Compliance in delivering on agreed key performance indicators requires a sufficient Nursing workforce to deliver safe and effective care. On occasions when Nurse

staffing may be outside the policy range, the Executive Director of Nursing must provide assurance about the capacity of the workforce to provide quality nursing care to patients, and efficient use of resources through internal and external professional and other assurance frameworks.

The testing of new models for Learning Disability Nursing service provision and reform into the future should incorporate a triangulation approach allowing for professional judgement.

As with the Delivering Care approach, the final staffing ranges for Learning Disability Nursing in HSC Trusts will be agreed with reference to the recommended ranges set out in Phase 9A, following a discussion with the Trust Workforce Lead, the Trust Learning Disability Nursing Lead and the Chair of the Working Group/ Steering Group. This may require a phased approach to implementation.

Review

This Phase will be reviewed in 2023/24.

APPENDIX 1

Case Studies

Holly's story

Holly is an example of an admission to an assessment & treatment ward. Holly is 52 years old with a diagnosis of a moderate learning disability and a history of recurrent depression. Holly also has epilepsy with poor seizure control. Holy's epilepsy can impact greatly on her mood and behaviour. When Holly's mental health deteriorates, she presents with a risk of self-harm and suicidal ideation. Holly will attempt to use ligatures. Holly, when presenting with low mood will stop eating and refuse her medication, both are critical to the management of her long-term physical health condition. Holly finds it difficult to use her coping strategies as part of her safety plan during these episodes. Holly lives in supported living, where health has been managed by her support staff, key worker, CNLD, psychiatrist, behaviour support team and psychology input. Holly also has a congenital cardiac defect and type 2 diabetes, managed by medication and diet. Enhanced monitoring is required during these episodes of depression.

Holly is admitted to the specialist LD hospital for a period of assessment and treatment. She was detained under the Mental Health (Northern Ireland) Order 1986 following a self-harm attempt and presentation at ED. A comprehensive biopsychosocial assessment is undertaken and formulation developed. A risk-screening tool is completed followed by a comprehensive risk assessment and risk management plan . A ligature risk assessment is completed as part of the safety plan and staffing levels are prescribed as 1:1 observation. RNLDs will undertake further assessment and develop comprehensive plans of care to monitor Holly's physical and mental health with specific focus on her needs as someone with epilepsy, diabetes and a congenital heart defect. Holly's epilepsy and diabetes while in hospital. Holly's sleep and mood is monitored and recorded. Referrals to other specialists' are considered and made as required. Holly's Pharmacological and non-pharmacological interventions will continue while in hospital. All interventions are reviewed and monitored alongside any blood tests and investigations as required. Staff will support Holly to engage in activities and schedule time to spend time talking and listening to Holly and support her to express her thoughts and feelings and use coping strategies to preserve safety. The RNLD will undertake health promotion advice and diabetes management planning.

Discharge planning commences on admission, with ongoing MDT input and engagement with the family and community staff to ensure continuity of the treatment plan on discharge.

Tom's story

Tom's is admitted to a specialist learning disability assessment & treatment ward. Tom has a diagnosis of a moderate learning disability, autism and ADHD, with associated distressed behaviours and anxiety, which can be exhibited through physical aggression towards others, self-injurious behaviours and destruction of property. Tom is 23 years of age and lives at home with his parents and two younger siblings. Tom's distressed behaviours have escalated in recent weeks; his day-care placement is at risk due to the significant behaviours displayed. There are currently no bespoke short break facilities to enable the family to have a break. His parents are at breaking point and are concerned about the impact on his younger siblings, who are studying at school.

Tom is admitted to hospital for a period of assessment and treatment. The RNLD completes a comprehensive biopsychosocial assessment; an assessment of physical health is undertaken to rule out pain or underlying physical health conditions. Care plans are formulated from identified needs on assessment with outcome measures recorded. Tom has few words; a referral is made to the SALT team for a communication assessment. A referral to OT is made to assess how Tom copes with sensory information. A referral is made to the behavioural team for a functional analysis of behaviours. A comprehensive MDT risk assessment is undertaken, likely triggers for a crisis are detailed, the response to a crisis developed, and a risk management plan developed. The social and physical environmental factors are assessed. Interventions and care plans are formulated following assessment and any pharmacological interventions monitored. Tom requires a number of reasonable adjustments during his admission. A visual schedule is introduced to promote meaningful engagement in activities and improve understanding. Tom is supported in a low stimuli environment to promote sensory regulation. Tom is prescribed a 2:1 staffing level as part of the risk management plan. All restrictive interventions in his best interest are agreed as part of MDT and with the family during admission and documented.

Discharge planning commences on admission, with ongoing MDT input and engagement with the family and community staff to ensure continuity of the treatment plan on discharge.

APPENDIX 2

Influencing Factors for Phase 9 Learning Disability Workforce

Term Used	What does this mean?	How does this impact on a Staffing Range?
Rostering and Shift Patterns	• Rosters are structured process matching staff skills to workload variations. • Shifts plus sequence of contracted working days per staff member = available numbers of staff to manage workload demand.	• Optimal rostering of staff **=** effective management manpower to deliver on workload demand. • Imbalance in the numbers available to meet demand can increase risk to patient safety. • Appropriate shift pattern key factor in delivering safe effective care and maintaining staff morale.
Planned and Unplanned Absence Allowance (PUAA)	• Periods of absence from work - expected or unexpected - factored into workforce planning. • (A) Sickness both short and long term, (long term = 20 days or over/up to six months). • (B) Study leave (as a minimum for mandatory training). • (C) Non-clinical working, e.g. management time.	• PUAA acknowledges staff have particular requirements and rights that render them unavailable to be rostered. • Allowance needs to be agreed and funded to ensure effective workforce planning and efficient deployment of staffing resources.
Department Sister's/ Charge Nurse's /team leader time	• Agreed allocation of 100% of ward manager's (WM) time to fulfil their leadership responsibilities. • Supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures. • Be a role model for good professional practice and behaviours; oversee the environment and assume high visibility as nurse leader.	• Absence of an agreed allowance of time for ward managers can result in essential responsibilities being neglected and failure to provide leadership at department level. • Currently WM's co-ordinate a significant staffing complement with associated appraisal, supervision, regulatory, HR responsibilities and budgetary management including salaries and wages and goods and services.

Term Used	What does this mean?	How does this impact on a Staffing Range?
Skill mix	• Percentage ratio of registered to unregistered nursing staff working within an individual care setting. • Blend of multidisciplinary registered staff including Nurse Therapists that support the Learning Disability workforce. • Clinical Leadership should be reflected in the skill mix of the nursing workforce	• Inappropriate skill mix can result in a mismatch of duties and responsibilities to roles, including clinical leadership/senior cover. • Can present greater clinical risks to patients or, conversely, inefficient deployment of expensive staffing resources. • Appropriate delegation of care to unregistered staff promotes good professional Governance. • Determination of % of nurses required to constitute a Community Learning Disability Team.
Management of Recruitment	• HR policies and procedures take weeks to recruit staff. • Notwithstanding this process, it is essential that nursing vacancies are filled promptly (to ensure staffing levels for safe and effective, person-centred care). • Employers must ensure that a risk-assessed approach is adopted to manage recruitment.	• Vacancy rates should continue to be carefully managed to avoid destabilising a department or team and increasing the risk to patient care through inappropriate staffing levels and skills. • Recruitment and retention strategies need to be put in place to support and sustain the nursing workforce. • Absence rates should be monitored and managed accordingly at HSC Trust level. • Maintenance of staffing levels (which support delivery of safe and effective person-centred care) should be reported on at HSC Trust level. • Avoidance of overuse of temporary staff, eg bank and agency staff. • Matching of staff skill and experience and band mix to patient acuity and dependency within approved guidelines. • Timely and ongoing review of risk assessments linked to service reconfigurations. • Annual review of uptake of LD nursing students.

Term Used	What does this mean?	How does this impact on a Staffing Range?
		• Lack of forward planning will result in inadequate succession plans for post registration LD nursing.
Management of absenteeism/ sickness	• The management process through which periods of sickness/absence are managed for all employees, with the aim of maintaining the lowest level achievable (5% target).	• Effective approaches to the management of periods of staff absence to support the continuity of services, provision of safe and effective person-centred care, patient safety and good staff morale.
Competence skill set to work flexibly	• The level to which the workforce has developed a knowledge base and transferable skill set to enable practice within a particular care setting and be capable of addressing a broad range of patient needs.	• The absence of a core set of transferable skills can limit the capacity of Learning Disability nursing staff to meet a broad range of patient needs in a given care environment. • To ensure that the essential clinical professional nursing skills are developed within a Learning Disability team demands careful identification of learning needs and development opportunities and identified roles for all staff including senior nurses, nurse therapists and unregistered nursing staff.

ACTIVITY

Term Used	What does this mean?	Impact?
Planned ward Attendances	• Persons who attend a clinical setting for a planned visit to seek advice, review or treatment.	• Planned attendances must be captured as a workload indicator at all times. • Incremental growth in these attendances can place increasing demands on nursing teams, without appropriate increases in staffing levels. • Could potentially become an unfunded service development if not appropriately managed.
% Bed occupancy	• A measurement of the percentage of time that beds are occupied measured at midnight. • Day attenders are excluded from this number. • Unplanned review attendances and planned review attendances.	• Capturing bed occupancy at 12 midnight can only result in substantial activity and workload being omitted. • Collection at other times of the day can assist with this measure. • The 24-hour, 7-day service needs to be factored into workforce requirements across Learning Disability care environments where appropriate.
Patient Dependency/ Acuity	• An assessment of the care demands of each patient, incorporating physical and psychosocial needs, using a validated and credible tool.	• Appropriate workload measurement tools can inform the utilisation of appropriate staffing levels for departments and localities, thus supporting safe and effective direct and indirect care.
Demand, need and throughput	• Length of stay; • Caseload analysis; • Trends in increase in complex behaviours and mental illness requiring assessment 24/7. • Referral rates • Delayed discharges • Readmission rates	• Trend in H&SC services towards reducing the time spent in Inpatient units. • Increase in demand on services requires a capacity modelling tool (eg. CAPA). • Increased complex discharge processes, (ongoing treatment and care in community setting).

Term Used	What does this mean?	Impact?
		• Increase in the throughput of patients and results in an increase in the workload demands for staff.
Specialties/ Case Mix	• Range and variation of patients' health conditions managed in a particular clinical setting/care environment, including the demand for psychological and behavioural therapies, with intensive support needs.	• A broader range of specialties and case mix being managed in a care setting presents a greater demand on the Learning Disability nursing team in terms of knowledge, skills and complexity.
Number of spaces for diagnosis and treatment	• There are a number of appropriate treatment areas within Inpatient units that can be used for assessment and management of patients' conditions. • Environmentally robust areas are needed to ensure the care needs of patients are met appropriately	• The number of spaces for diagnosis and treatment and design of a care environment can have an impact on the efficiency of the department, e.g. ECT suites and group therapeutic interventions and low stimulus areas to manage complex and challenging behaviours
Assessment of Risk	• Nurses must assess and manage risk within a clinical environment to ensure the delivery of safe and effective, person-centred care. This includes risk to people in their care, members of staff and other members of the public.	• By adopting an anticipatory approach nurses can proactively support the minimisation of risk and provide a quality service that meets patient/client needs. • Opportunities to act on lessons learned and drive improvements in the quality and safety of services ensure that practice is informed and improved. • Time is required from the nursing team for this activity to carry out ongoing risk assessments for patients within their care environments.
Incremental Service Improvements/	• This is activity concerned with testing new ideas and ways of working, sustaining and sharing best practice to make a tangible difference in outcomes and experience for staff and service users.	• Incremental service improvements are designed to implement improvements in patient care and/or outcomes. • Can result in improved working conditions for staff.

Term Used	What does this mean?	Impact?
Development and Reform		• Alternatively, unrelenting service improvements can also have a disruptive impact on individuals and contribute to low staff morale if not supported with appropriate workforce requirements. • Staff requirements should be factored into elements of reform agendas where appropriate.

ENVIRONMENT AND SUPPORT

Term Used	What does this mean?	Impact?
Technological and Equipment Support	• Support provided within a clinical area by Information Technology and other mechanised systems e.g. ECR. • Sufficient equipment maintained and stored appropriately (which may assist nursing teams in caring for patients).	• Access to available software which links to a range of data systems (can enable efficient transfer of information which assists at many stages of the patient care pathway). • Efficient systems may reduce workload requirement. • Inefficient systems may add to the workload, eg staff spending time sourcing equipment.
Geographical Layout/ Room Structure	• Arrangement and layout of the physical clinical environment, including use of single rooms and low stimulus areas. • Impact of physical arrangement of clinical setting on workforce planning (may require more staff where there are areas of poor visibility or require staff to work in discrete teams).	• A well designed/engineered layout for a clinical environment, with optimal employment of relevant technologies, can support enhanced observation of patients and consequently decrease risks to patients/clients, thus reduce the impact upon staffing requirements. • Where single rooms restrict visibility and therefore compromise clinical observations, this will have an impact on staffing levels in care environments.
Population profile for MH services	• Demographic profile for the population of NI and the significance of incidence of learning disabilities. • Includes relationship to deprivation/ incidence of Mental Health risk factors.	• The demographic profile of any geographical area may determine the service profile and priorities for nurse staffing models required to meet the demand on Learning Disability services, also population workforce profiles and community and voluntary sector support will need to reflect this.
Number of beds	• Number and type of beds will determine the range or ratio for staff in each care environment across Learning Disability inpatient facilities.	• Additional beds to meet demands and acuity of patients may impact on the capacity of staff to provide person-centred care.

Term Used	What does this mean?	Impact?
Departmental Adjacencies Escorting Patients	• Where there may be a number of patients requiring nurse escort, workforce planning impact needs to be considered re staffing levels to support safe, effective person-centred care.	• Nursing staff may be required to escort or transfer patients to other units, including day care thus removing the member of staff from the core team.
Supportive Staff Infrastructure	• The support provided within a care environment by other members of staff, who are not registrants or within the family of nursing, e.g. 'patient trackers', administration or housekeeping staff.	• There are a range of tasks which can be completed by individuals who are not identified as working specifically within the family of nursing, e.g. administrative staff, housekeeping staff. • The support provided by these staff members has an impact on the Learning Disability nursing team to be able to deliver the care required. • Conversely, the absence of such members of staff should be highlighted where there is an indication that this support would be helpful to the nursing team to facilitate effective care delivery. • Additional nurse therapists and nurse specialists facilitate the delivery of patient centred care and can provide enhanced therapeutic interventions and positive behaviour support in a range of care environments. • These posts are **in addition** to the core requirements for inpatient workforce requirements but have a significant supportive role in Learning Disability service provision.

PROFESSIONAL REGULATORY ACTIVITY

Term Used	What does this mean?	Impact?
Indirect care	• Activity linked with nursing care delivery but not a direct element of the process of care delivery, e.g. multi-professional case meetings, referrals to other agencies/services, resetting/restocking environments following use.	• Level of this activity and requirements for delivery of such can impact on the workload of nursing teams. • This requires definition as to what elements are present within the nursing workload and how much time is expended on them for their specific role.
Revalidation	• NMC introduced revalidation for Nurses and Midwives in October 2015. All nurses are required to revalidate to maintain their registration. • The allowance in the planned and unplanned allowance incorporates training.	• Nurses will have to be supported to revalidate every three years to demonstrate that they practice in accordance with the NMC code in their nursing role.
Compliance with professional regulatory standards	• Activity concerned with ensuring that professional standards issued by the NMC are embedded and maintained within a care environment, e.g. revalidation, preceptorship or learning and assessment and practice/mentorship. This may include ongoing monitoring of these standards.	• High activity levels without adequate staffing can negatively impact upon the ability of nurses to comply with regulatory standards. This is of particular importance with the introduction of revalidation.
Supervision	• Process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service user protection, quality and safety.	• An element of the time required to develop nurses and those within the family of nursing, including the time requirement for supervision processes, is included in the Planned and Unplanned Absence Allowance of 24% as endorsed in the Delivering Care policy framework (2014).

Term Used	What does this mean?	Impact?

Accountability and governance requirements	• The impact of nurse staffing levels on the quality and safety of patient care is well documented. The Executive Director of Nursing is accountable for ensuring that nurse staffing levels are sufficient to deliver safe, effective, high standards of nursing care to all who use services.
	• Governance has been defined as 'systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community and partner organisations (DoH Integrated Governance Handbook 2006). Accountability embodies key attributes:
	  • Recognisably high standards of care;
	  • Transparent responsibility and accountability for those standards;
	  • A constant dynamic of improvement.
		• In order to provide safe, effective, person-centred care, appropriate staffing levels are required to impact positively upon the profession's ability to deliver effectively to governance requirements indicated through good performance in Key Performance Indicators agreed regionally.
		• This type of activity can include collecting information about the standard of practice and care through, for example, audit, complaint review, user engagement and benchmarking practice against an evidence base. Following such activity, action plans are required to enable development of nursing practice or service improvement work to ensure the ongoing delivery of safe, effective, person-centred care. All of this activity requires time for the Learning Disability nurse to engage effectively and facilitate ongoing accountability, governance reporting arrangements and improvement of care in all settings

APPENDIX 3

Key Themes Highlighted in PHA Literature Review Learning Disability Workforce Planning (2019)

- *"Learning Disability Services span the lifetime of a service user"*
- *"There is increasing evidence of complexity of need with LD patients"*
- *"A higher proportion of service users are ambulatory rather than bed-based"*
- *"There are increasing numbers of people with a learning disability with this population living longer"*
- *"There is more complex care provision required in the community due to increasing co-morbidities, challenging behaviour and physical needs"*

The **key themes** that emerged from the literature review were as follows:

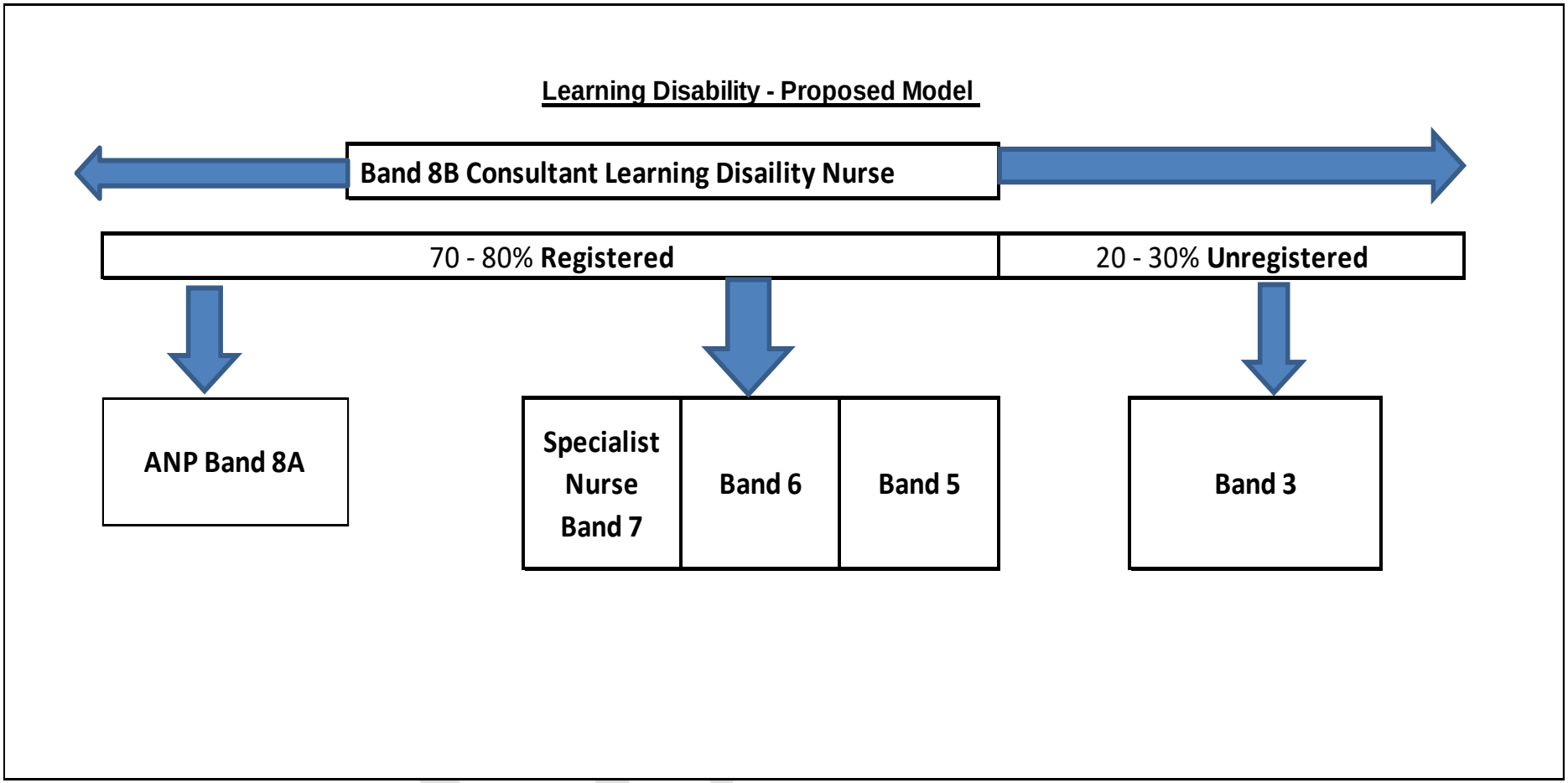
- The increase in incidence of Learning Disabilities in Northern Ireland;
- The need for services to react accordingly;
- The significance of the role of the Learning Disability nursing workforce and the requirement to meet the demands appropriately;
- The strength of the nursing role within this context, with nurses forming the largest group of staff within the NHS and with respect to the unique role and function of the Learning Disability nurse;
- The requirement to shift from a paternalistic approach to a more inclusive approach to health care in order to support people to take control of their own lives (Making Life Better, 2012-2023);
- The challenge of supporting more people in the community;
- Significant challenges for sustaining and managing the numbers of nurses who will leave the service in the next 3 years due to Mental Health Officer status.

In addition, the Royal College of Psychiatrists (RCPsych), in an occasional paper [20]created standards for Standards for adult inpatient learning disability services (refer to footnote below). Within a hospital ward, a professional blend of nursing staff provides care for a set number of patients. In 2006 the Royal College of Nursing in its policy document 15/2006 specified that the ratio of registered to non-registered nursing staff should not fall below 65:35 in general wards in mainland UK. It is accepted by the Royal College of Nursing that the ratio in acute LD wards in Northern Ireland should be 70:30.[21]

[20] Royal College of Psychiatrists (QNLD), Standards for adult inpatient learning disability services(July 2016)

[21] RCN Policy Unit, Policy Guidance (15/2006) Setting Appropriate Ward Nurse Staffing Levels in NHS Acute Trust. Royal College of Nursing.

APPENDIX 4


Learning Disability - Proposed Model
Band 8B Consultant Learning Disaility Nurse
70 - 80% Registered
20 - 30% Unregistered
ANP Band 8A
Specialist Nurse Band 7
Band 6
Band 5
Band 3

References and Helpful Resources:

Chief Nursing Officer for Northern Ireland (2007). *Standards for Supervision for Nursing*. Belfast, DHSSPS.

Department of Health Social Services and Public Safety. (2011). *Framework Document*. Available for download at: http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf

Department of Health (2006). *Integrated Governance Handbook: A handbook for executives and non-executives in healthcare organisations.* Available for download at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4129615.pdf

Northern Ireland Practice and Education Council (2007). *The Review of Clinical Supervision for Nursing in the HPSS 2006 on behalf of the DHSSPS*. Belfast, NIPEC.

http://www.nmc-uk.org/Publications/Standards/

Revalidation:

http://www.nmc.org.uk/standards/revalidation/?_t_id=1B2M2Y8AsgTpgAmY7PhCfg%3d%3d&_t_q=revalidation&_t_tags=language%3aen%2csiteid%3ad6891695-0234-463b-bf74-1bfb02644b38&_t_ip=81.145.165.209&_t_hit.id=NMC_Web_Models_Pages_HubPage/_aad6f732-2620-4c6a-bd07-ac5600a3333a_en-GB&_t_hit.pos=1

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

Guidance on Restraint and Seclusion in Health and Personal Social Services

AUGUST 2005

CONTENTS

WHO SHOULD READ THIS GUIDANCE?

This guidance is intended to be used by:

- service commissioners in health and social care;
- managers of health and social care services;
- staff/professionals working with children and adults who may require to use restraint and/or seclusion;
- internal monitors of services and/or facilities;
- persons responsible for the operation of independent sector services or homes;
- Registration and Inspection staff;
- trainers and training providers.

The information in this guidance may also be helpful to:

- parents and those with parental responsibilities;
- Health and Social Services Councils;
- the Mental Health Review Tribunal;
- the Mental Health Commission;
- independent advocates;
- service users.

1. INTRODUCTION

Background to this guidance

1.1 This guidance on the use of restraint and seclusion is issued by the Department of Health and Social Services (DHSSPS) to inform practice across the Health and Personal Social Services (HPSS) bodies and their agents. It is the result of work undertaken by a HPSS Working Group, initiated by the DHSSPS Human Rights Liaison Group to assist in promoting human rights in these key areas.

1.2 The Liaison Group recognised that restraint and seclusion was an issue of common concern across HPSS and best tackled collaboratively. The Working Group which compiled the guidance was multi-professional and comprised of members from both the voluntary and statutory sectors. The outline terms of reference of the group are provided at **Annex A** and the membership at **Annex B**. Aspects of this guidance relating to the legislative context were taken forward through a sub-group and **Annex C** provides details of those involved.

Purpose of this guidance

1.3 The guidance is intended to be of an overarching nature, to be used to inform at provider level, the development of policies and procedures, training and practice across the relevant client groups in both hospital and other residential settings. The starting point for establishing good practice in the use of restraint and seclusion is the development of organisational policies, which reflect current legislation and case law as well as Departmental guidance, professional Codes of Practice and local circumstances, including the characteristics of the children or adults cared for within particular services. Every agency included within the remit of this guidance is expected to have a policy on the use of restraint and/or seclusion. The definitions of restraint and seclusion for the purpose of this guidance are examined at Section 2. The amount of detail needed will depend upon local circumstances but it should cover the areas set out in **Annex D** (example of HSS Trust Management of Aggression Policy), **Annex E** (example of HSS Trust Protocol on the Use of Physical Restraint and **Annex F** (example of HSS Trust Policy on Seclusion), as appropriate.

1.4 This guidance is issued to help ensure that staff working in various health and social care settings adopt consistent practices in the use of restrictive physical interventions and seclusion based upon common sets of principles. This will provide the most effective support for individual service users and reduce the possibility of confusion or disagreements between staff employed by different agencies.

1.5 This guidance will help staff in health and social services and elsewhere to address important outcomes for children and other service users, such as protecting and promoting their rights, providing appropriate choices, promoting independence and encouraging their social inclusion.

1.6 This guidance, by providing a clear framework to inform staff's practice in these complex areas of work, seeks to facilitate service standards which are consistent with best practice in relation to safeguarding service users and the Human Rights Act and that also reduce the risk to staff of litigation. **HSS Trusts should use the guidance to inform the production of policies and procedures on the use of restraint and/or seclusion.**

Legislative context

1.7 This guidance has been prepared in the context of The Human Rights Act (1998) and The United Nations Convention on the Rights of the Child (ratified 1991). It is based on the presumption that every adult and child is entitled to:

- respect for his/her private and family life;
- the right not to be subjected to inhumane or degrading treatment;
- the right to liberty and security; and
- the right not to be discriminated against in his/her enjoyment of those rights.

1.8 People are also protected under domestic legislation in terms both of the protection of their rights and the potential for redress through the criminal and civil law for assaults against the person.

1.9 Underlying this guidance is the principle that actions must both comply with the letter of the law and incorporate the spirit of respect for human rights.

Legislative position

1.10 The issues of restraint and seclusion are not usually dealt with in primary legislation. Generally, these procedures are informed by guidance and regulations. There is, therefore, little uniformity of approach across both client groups and service areas. There is an increasing focus on the legitimacy of restricting the liberty of an individual, arising from increased awareness of the potential for challenge as a breach of an individual's rights. In addition, increased awareness of individual's rights to seek redress through resort to the criminal and civil courts has raised both staff's and employers' interest in ensuring these processes are used as a last resort, in a safe and therapeutic manner and in a way which protects both staff and the service user.

1.11 Section 4 (Legislative Context) and paragraph 5.2 of this guidance provide detailed consideration of some of the key legislative considerations which need to be considered when using either restraint or seclusion.

When may restraint or seclusion be appropriate?

1.12 Restraint and seclusion should be used only for controlling violent behaviour or to protect the service user or other persons. In exceptional circumstances, physical intervention may be necessary to give essential medical treatment. The decision to use either is extremely serious and restraint and seclusion should only be used as follows:

- as intervention of **last resort;**
- where other, less restrictive, strategies have been unsuccessful, although an emergency situation may now allow time to try those other strategies;
- **never** for punishment;
- in reaching the decision, consideration should also be given to the individual needs of each service user in deciding the best method of control or restraint to be employed.

1.13 Decisions to use either restraint or seclusion have serious civil liberties implications as these interventions limit or restrict the freedom of movement of an individual. Section 4 on the Legislative Context covers these issues in more detail.

Risk assessment

1.14 Risk assessment is an essential element in the care and treatment of all patients and clients and should underpin the guidance which service providers make available to staff. It could be argued that it is one of the most fundamental interventions in the recognition, prevention and therapeutic management of violence and aggression. The use of other interventions such as observation, psychosocial interventions or restraint should be part of a management plan based on an assessment of risk. While it is acknowledged that the occurrence of aggressive or violent incidents are not always predictable, assessment of risk, followed by a properly developed management plan is essential to the prevention and management of aggression and violence. Being able to predict who is more likely to engage in a violent act may enable staff to reduce the risk.

Current position - questionnaire

1.15 To examine the current available guidance across Northern Ireland, the working group issued a questionnaire to all statutory agencies and a selection of independent providers. A copy of the questionnaire and the summary findings are at **Annex G.**

Existing professional or practice guidance

1.16 Guidance on the use of restraint for adults is available in the book *Physical Interventions: A Policy Framework* (BILD 1996), which provides advice and information on the use of physical interventions in different service settings.

Equality Impact Assessment: equality screening

1.17 This paper has been screened for equality implications and the findings are given in **Annex H**.

2. DEFINITIONS AND CONCEPTS

Definition of "service user"

2.1 In this guidance, the term 'service user' is used to refer to adults and children who receive services from HPSS organisations and their agents in care establishments, hospitals or any other health settings and within their own homes.

Definition of "restraint"

2.2 **Different forms of physical intervention are summarised in the table below.** The table demonstrates the difference between restrictive forms of intervention, which are designed to prevent movement or mobility or to disengage from dangerous or harmful physical contact, and non-restrictive methods. Restrictive physical interventions involve the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the person's environment. The use of force is associated with increased risks regarding the safety of service users and staff and inevitably affects personal freedom and choice. For these reasons, this guidance is specifically concerned with the use of restrictive physical interventions. For the purpose of this guidance the terms "restraint" and "physical restraint" mean "restrictive physical interventions".

Examples of non-restrictive and restrictive physical interventions

	Bodily contact	**Mechanical**	**Environmental change**
Non restrictive	Manual guidance to assist a person walking	Use of a protective helmet to prevent self injury	Removal of the cause of distress, for example, adjusting temperature, light or background noise
Restrictive	Holding a person's hands to prevent them hitting someone	Use of arm cuffs or splints to prevent self injury	Forcible seclusion or the use of locked doors

2.3 Physical restraint can, therefore be summarised as:

The use of any part of one's body, or mechanical method, to prevent, restrict or subdue movement of any part of another person's body. It can be employed to achieve a number of different outcomes:

- to break away or disengage from dangerous or harmful physical contact initiated by a service user;

- to separate the person from a 'trigger', for example, removing one service user who has responded to another with physical aggression;

- to protect a service user from a dangerous situation – for example, the hazards of a busy road.

2.4 It is helpful to distinguish between:

- *planned intervention*, in which staff employ, where necessary, pre-arranged strategies and methods which are based upon a risk assessment and recorded in care plans; and

- *emergency or unplanned* use of force which occurs in response to unforeseen events.

2.5 In common law anyone who has the duty to care for another person is expected not to interfere unduly with the personal freedom and autonomy of the person in his/her care. Nevertheless, if restraint is necessary for the safety of that person or others it may be justified as long as it is the **absolute minimum necessary for the minimum time possible**. As this raises the questions of what constitutes necessity and what is the absolute minimum of restraint in a given situation, it is useful to identify general principles. The section on Principles Involved (including Statement of Principles at paragraph 5.19) addresses this in more detail.

Definition of "proportionate"

2.6 The scale and nature of any physical intervention must be **proportionate** to both the behaviour of the individual to be controlled, and the nature of the harm likely to be caused. These judgements have to be made at the time, taking due account of all the circumstances, the unpredictable nature of the work and including any known history of other events involving the individual to be controlled. The minimum necessary force should be used, and the techniques employed should be those with which the staff involved are familiar and able to use safely and are described in the service user's support plan. Where possible, there should be careful planning of responses to individual service users who are known to be at risk of self-harm, or of harming others.

2.7 The use of force is likely to be legally defensible when it is required to prevent:

- self-harming or potentially self-harming behaviours;

- injury to self, other service-users, or staff ;

- serious damage to property;

- an offence being committed.

2.8 The use of force to restrict movement or mobility or to break away from dangerous or harmful physical contact initiated by a service user will involve different levels of risk. Good practice must always be concerned with assessing and minimising risk to service users, staff and others and pre-planning responses, where possible. (See paragraph 1.14 on "Risk assessment".)

Definition of "seclusion"

2.9 Seclusion is the **supervised confinement** of a service user alone in a room, the essence being the involuntary isolation of the individual. In the Mental Health (Northern Ireland) Order 1986 Code of Practice, the Mental Health Commission define seclusion as 'the forcible denial of the company of other people by constraint within a closed environment". The service user is usually confined alone in a room, the door of which cannot be opened from the inside and from which there is no other means of exit available to the service user. This situation would also arise where the door is not locked from outside but the service user is unable to open the door, due to, for example, the height of the door handles or the person's physical disability. The breadth of the definition is important because the practice of seclusion is subject to very stringent control and recording in comparison to other procedures.

2.10 The issue of seclusion is particularly complex. Seclusion is an emergency procedure, only to be resorted to when there is an immediate risk of significant physical harm. There is general agreement that it should not be considered as a form of treatment; the aim should be simply that of safe containment. Seclusion is usually unpleasant, and difficult for a service user to view other than as punishment, and not a therapeutic experience. In 1996, the Royal Colleges of Psychiatry and Nursing published a joint review into strategies for managing disturbed violent patients ("*Strategies for the Management of Disturbed and Violent Patients in Psychiatric Units").* The reason for the review stemmed from the well-founded and widespread concern about the potential for the misuse of seclusion. Concerns had focused on its use for prolonged periods of time (Department of Health and Social Security, 1980; Department of Health and Social Security, 1985 – full references to these reports and those below in this paragraph are given at section 6 of this guidance) as well as on the indications for, and frequency of, its use. Matters came to a head with the occurrence of several deaths, notably those of Sean Walton at Moss Side Hospital in 1988 and of three patients at Broadmoor Hospital (Department of Health, 1993). In 1992 the Committee of Inquiry into complaints at Ashworth Hospital strongly recommended the abolition of seclusion within that hospital as well as a wider, statutory prohibition (Department of Health, 1992). Since the Ashworth Inquiry the Special Hospitals have made it their stated policy to limit the use of seclusion to exceptional circumstances and to promote alternative approaches for the

management of violence. **This approach is endorsed by this Working Group which recommends its adoption.**

2.11 In considering seclusion there is a need to draw a distinction between:

- *seclusion* where a service user is forced to spend time alone against his/her will;

- *time out* which involves restricting the service user's access to all positive reinforcements as part of a behavioural programme (this is explored in more detail in paragraph 2.13); and

- *withdrawal* which involves removing the person from a situation which causes anxiety or distress, to a location where he/she can be continuously observed and supported until ready to resume usual activities.

2.12 The 1996 review (see paragraph 2.10 above) noted that:

> "Any credible review of the use of seclusion must consider other, more routine and therapeutic approaches to aggression that might forestall or replace the practice."

Definition of "time out"

2.13 Time out is a procedure whereby the service user is separated temporarily from the current environment as part of a planned and recorded therapeutic programme to modify his/her behaviour. The breadth of its definition is open to misuse to encompass what is, in fact, seclusion. Although a distinction is made between it and seclusion, in practice it is less readily separable. This potential for confusion is open to abuse. The widespread use of time out, particularly with certain service user groups, such as children or those with a learning disability, makes it difficult to regulate to the same extent as seclusion. It has been recommended that the term 'time-out' be avoided in preference to a clear description of the procedure that is actually proposed. Such an approach inevitably raises the issue of consent, which should underwrite all therapeutic processes. **The term 'time out', or another comparable term, must state explicitly exactly what this entails within the practice of the unit and procedures regarding consent etc for its use. Policies should also provide for ensuring that the understanding of service users is clearly recorded and the action monitored and reported to a senior staff member as soon as possible: in the case of children, parents or those with parental responsibility should also be informed at the earliest possible opportunity.**

Nature and types of physical interventions

2.14 There are three broad categories of physical interventions as described by Harris et al (1996):

- **direct physical contact** between a member of staff and services user;
- **the use of barriers** to limit freedom of movement;
- **materials or equipment which restrict or prevent movement.**

2.15 **Physical intervention skills** are described by McDougall (1996) as a set of techniques that are designed and taught to momentarily prevent or curtail a behaviour which is deemed to be dangerous to that individual or others.

2.16 No physical intervention, whether planned or emergency, should ever intend or knowingly be allowed to cause pain.

Planned physical interventions

2.17 The planned use of physical interventions involves the use of an agreed strategy which includes the possible use of physical intervention to intervene in a sequence of behaviours with the aim of avoiding or reducing injury/injuries.

2.18 Planned physical interventions, including restraint for the purposes of medical interventions, should be part of a broader therapeutic strategy. It is envisaged that there may be rare occasions when restraint might be necessary, in someone's best interests, to facilitate urgent medical treatment. Where medication may be used to facilitate restraint in the management of disturbed or violent behaviour, reference should be made to the recent NICE guidance "The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments".

2.19 Planned physical interventions are normally used as a last resort. Strategies designed to manage aggressive/violent behaviours should include:

i. ecological strategies and the environment of the service user;
ii. early intervention and de-escalation;
iii. emergency use of physical intervention.

(i) Ecological strategies and the environment of the service user (primary prevention)

2.20 Ecological Strategies involve providing environments likely to reduce the likelihood of aggressive or violent behaviours occurring. It involves changing aspects of an individual's personal environment to minimise situations arising that are known precursors to the service user displaying behaviours which have implications for the safety of him/herself or others.

2.21 It is the context in which violence occurs that is of most importance when considering measures to limit the use of restraint and/or seclusion. Violence may reflect the expectations of the staff, low levels of staffing or changing staffing. The emphasis is moving from the control of violence to its prevention

by measures such as an improved environment and staffing, both in levels and skills. Crucial to this are staff attitudes, training, good communications and supervision.

2.22 Children are particularly responsive to their surroundings. Special attention needs to be paid to creating a safe environment for disturbed and violent children. A designated safe area or safe room may be helpful, but this should reflect normal domestic living space as far as possible. Children and adults with certain disabilities, such as autism, benefit from routine, regularity and predictability in their lives which in turn makes disturbed and violent behaviour less likely to occur. People of all ages are less likely to show such behaviour if they are provided with choices or are kept active with relevant challenges.

2.23 In a designated safe area, it is necessary to minimize the risk of self injury or of serious damage to property. In achieving this aim, it is important to balance the service user's need to be cared for in an environment which reflects normal living space (in terms of decoration and furnishings, where appropriate) with the need to ensure his/her safety.

2.24 Trusts and other providers in constructing operational guidance for the use of seclusion and/or restraint need to consider how they can manage the service users' environment or care setting to limit the potential for violent and/or aggressive behaviour. Environment, in this context, includes both the physical environment and the level and qualification of staff. A comprehensive understanding of how setting, staff and service users can interact is necessary to ensure preventative as well as reactive strategies are in place to deal with service users with complex and at times challenging needs.

(ii) Early intervention and de-escalation (secondary prevention)

2.25 Plans for early intervention and de-escalation are instigated after it becomes clear that an aggressive episode of behaviour is likely to occur. They seek to prevent the escalation of such behaviours and in all cases they should be individualised to the service user concerned. These approaches focus on communication, negotiation, use of staff body language, personal space etc. with the overall aim of maintaining safety.

2.26 The use of physical interventions generally raises a number of serious issues for service users, staff and service providers alike. The following are some issues which should be considered more fully, with each organisation regularly providing clear guidelines and advice to staff.

- Consent of service users issues as covered in DHSSPS Guidance "Good Practice in Consent", particularly where there are issues relating to children and the competence of other service users to provide valid consent.

- Assessment for benefit and risks associated with the procedure.

- Legal, ethical and professional issues.
- Physical health status of the service user.
- Impact on individual of intervention.
- Least restrictive physical intervention.
- Particular vulnerability of service users taken into account.
- Staff requirements.
- Method of recording, reporting and reviewing.

(iii) Emergency use of physical interventions

2.27 Emergency physical interventions may be required in response to unexpected episodes of aggressive or violent behaviours. Physical interventions can be justified to maintain the safety of the service user or others. However, the amount of force used must be proportionate to the level of threat presented by the service user - staff should use the minimum amount of force for the least amount of time required with the aim of maximising the safety of everyone involved.

2.28 Following the use of emergency physical interventions, procedures should be followed which entail recording/reporting the incident and the updating of the service user's individual care plan to include assessment of risk, preventative strategies and a programme of planned responses to any such future behaviour. (See paragraphs 3.9-3.18 on Post-Incident Management Monitoring).

3. QUALITY ASSURANCES, COMPLAINTS AND ADVOCACY ARRANGEMENTS AND POST INCIDENT MANAGEMENT AND MONITORING

Quality assurances

3.1 All services should be designed to promote independence, choice and inclusion and to establish an environment that enables service users, regardless of age or need, maximum opportunity for personal growth and emotional wellbeing.

3.2 In care settings, good practice in the use of restraint and seclusion described in this guidance will be monitored as part of HSS Trusts' compliance with the Duty of Quality requirements established by the HPSS Order 2003, which commenced in April 2003. The establishment of the HPSS Regulatory and Improvement Authority (HPSSRIA), which is scheduled to become operational in 2005, will also ensure that standards of practice and levels of compliance in these areas will be regulated on an independent basis across the statutory and independent sectors. It is also expected that local policies and procedures explain how service users, their families (and in the case of children, those with parental responsibility) and advocates participate in planning, monitoring and reviewing the use of restraint and/or seclusion.

3.3 Under health and safety legislation, employers are responsible for the health safety and welfare of their employees and the health and safety of persons not in employment, including service users and visitors. This requires employers to assess risks to both employees and service users arising from work activities, including the use of restraint and seclusion. Employers should establish and monitor safe systems of work and ensure that employees are adequately trained. Employers should also ensure that all employees, including agency staff, have access to appropriate information about service users with whom they are working.

- Leadbetter and Trewartha (Leadbetter, D and Trewartha, R (1995) A question of restraint, *Care Weekly*, 18 May, 10-11) noted that employers have to give equal priority to the safety of staff and service users. Under Health and Safety legislation (Health and Safety at Work Act 1974), they must ensure their staff's welfare against foreseeable risks and provide adequate training to ensure a safe working environment. This obligation has been reinforced by civil cases successfully brought by employees against their employers. Leadbetter and Trewartha cite the case of Walker v. Northumberland County Council (1994) where the judgement hinged on the council's failure in their duty of care in that they had not taken action to avoid or mitigate 'reasonably foreseeable' risks to their employee's health.

- Lindsay and Hosie (Lindsay, M and Hosie, A (2000) *The Edinburgh Inquiry - Recommendation 55. The Independent Evaluation Report.*

University of Strathclyde and the former Centre for Residential Child Care) state that in the case of litigation employers would have to demonstrate that the method of restraint they chose best suited the needs and circumstances of their clients and, on the basis of the best available advice, was likely to address the demands of day to day practice. The problem is that there is a striking absence of evidence about the respective merits of the various techniques.

3.4 Commissioning authorities will need to ensure that provider agencies' policies and procedures follow this guidance where restraint and/or seclusion is used. Registration and Inspection staff will also monitor the implementation of the resulting policies and procedures in the course of their work across the statutory and independent sectors.

Complaints and advocacy arrangements

3.5 Complaints arrangements should follow policies developed for Trusts in response to the "Guidance on Handling HPSS Complaints: Hospital and Community Health and Social Services (April 2000)" and Children Order (Article 45(3)) requirements in respect of complaints and representations made in relation to children's social services.

3.6 Trust staff should ensure that complainants are easily able to make a complaint, that this process is simple and aimed at satisfying the complainants' concerns. Where necessary staff should provide information on the Advocacy Service available. Responses to complainants should be timely and emphasise early resolution. Staff should be informed of the existence of a complaint and appropriate staff involved in the investigatory process. Staff should also be informed of the outcome of any complaints made in respect of them.

3.7 Discussions should take place on the investigatory process and feedback from complaints should inform any review of complaints at team meetings.

3.8 Training and awareness building should usually be managed within the organisation, with lessons emerging from complaint case studies used to promote the development of good practice. To this end, Trusts and other providers should annually monitor complaints received in relation to the use of restraint and seclusion. This annual review should be used to inform, where necessary, the revisions of policies and procedures and the design of staff training and support processes.

Post-Incident Management and Monitoring

General

3.9 It is recognised that Post- Incident Management and Monitoring (PIM&M) is critical where restraint or seclusion are used. Some Trusts may regularly audit the use of these processes as this is considered good practice. Auditing and

monitoring should be carried out on a multi-disciplinary basis, where appropriate.

3.10 The PIM&M procedure will have the following elements clearly itemised within it:

- feedback to those with parental responsibility/carers that does not infringe on the service user's right to confidentiality;
- debriefing the service user after the incident;
- providing information on how to make a complaint;
- service users who are injured will always be examined by a doctor following the incident;
- Trust accident/incident form will be completed as soon as possible after the incident, stating exactly what happened – **no assumptions: facts only** (examples of incident forms are given at Annex I (a) - Restraint Report Form - and Annex I (b) (Seclusion Report Form – organisations will develop their own format to cover their particular circumstances);
- details of all/incidents are recorded in service users' files. In some instances, this record is required even where a separate monitoring form is in use.
- Reports to outside agencies (Mental Health Commission, HPSSRIA etc).

3.11 If staff are injured – a statement must be completed to include as a minimum the following information:

- place where injury happened;
- number of staff on duty and their location at the time of the incident;
- number of service users in the area.

Staff

3.12 Where staff are injured the following actions are required:

- refer staff to Occupational Health Department or Accident and Emergency Department if injured. If they decline, advise them to contact their own GP and record this advice;

- accident report form to be completed according to Trust policy requirements.

3.13 It is important that staff are made aware of the potential emotional shock that may follow on from an assault or injury. Managers/peers need to be supportive, recognising that even minor incidents, such as verbal abuse/comments, can be traumatic. Staff should be given the opportunity to talk and express how they feel. A de-briefing discussion after an incident can assist those involved. Relevant areas for discussion include:

- identification of cause/trigger factors to incident;
- ascertaining what exactly occurred;
- identifying staff's role in the incident;
- ascertaining the feelings of staff involved;
- what learning experiences and/or training needs can be identified from incident.

Staff Support

3.14 Employers have responsibilities to support all staff. To this end, individual members of staff involved in an incident must be given an opportunity to discuss their feelings. This will include:

- individual/group discussion with the line manager;
- access to confidential counselling from Occupational Health Department through self-referral or line management referral;
- awareness of professional body or Trade Union role/support;
- multidisciplinary review/debriefing discussion of incident with colleagues/peers to allow staff to review, reflect and talk about their views following the occurrence;
- access to confidential staff care or support system.

Monitoring Arrangements

3.15 Effective monitoring procedures are essential and must be comprehensive and timely. Monitoring includes:

- the risk of violence being regularly assessed by appropriate senior staff which will vary according to the setting;

- assessing the effectiveness of the implementation of existing policies and procedures, identifying any gaps or need for updating;

- reassessing the effectiveness of countermeasures introduced and disseminating good practice examples;

- discussions at staff meetings, senior staff meetings etc. to raise issues arising with a view to improving safeguards for both service users and staff. This should include ensuring staff are aware of whistle blowing policy and feel confident in using it;

- recording and analysis of complaints made, ensuring that reports are regularly brought to the attention of the Trust's Chief Executive under Clinical and Social Care Governance arrangements.

Audit

3.16 Audit mechanisms should focus on a number of factors which can give managers a baseline assessment on the effective implementation of policy, such as:

- number of incidents of physical injuries sustained by service users as a result of a violent episode;

- number of incidents of physical injuries sustained by staff as a result of a violent episode;

- number of incidents of verbal/threatening behaviour to staff/service users;

- number of occasions that physical restraint, "time out" or equivalent was carried out in a setting, identifying any possible explanation for peaks and troughs in its usage over time.

3.17 It can be helpful to use audit information to compare levels of violence, restraint or seclusion across similar service areas to ascertain if there are any environmental factors (see paragraphs 2.20-2.24) which are either serving to reduce or increase levels in any setting.

Where service users are injured

3.18 If a service user is injured as a consequence of the use of restraint, the following action is required:

- ensure the service user receives appropriate and timely medical assistance;

- notify carer, parent or those with parental responsibility immediately of the injury and the steps taken to deal with the injury, securing appropriate consent for treatment where necessary;

- make a detailed record of the event and the consequences in the service user's case file;

- complete an accident report form and inform the Trusts Risk Management Unit which will make any other necessary notifications;

- complete a Physical Intervention Monitoring/Restraint Report Form (example attached at **Annex I(a) – organisations will develop their own forms to cover their particular circumstances**);

- senior managers review incident on discussion with staff and ascertain if there are any training, support or supervisory matters which require to be addressed;

- inform service user, carer, parent or those with parental responsibility of the Trust's complaints arrangements and how to access them.

4. LEGISLATIVE CONTEXT

General

4.1 Generally, primary legislation makes little explicit reference to the use of restraint and seclusion, with the issue being dealt with in most areas by Guidance and Regulation. The exception to this is the education sector where the use of restraint in schools by authorized persons is regulated by primary legislation and by detailed guidance. There is, however, no uniformity of approach across different sectors and no standard threshold indicating when restraint or seclusion can be used legally. Legislatively and in terms of best practice, restraint and seclusion in relation to the care of service users should only be used in exceptional circumstances and it must be ensured that all techniques used are approved, safe and in compliance with international rights standards. The DHSSPS has issued guidance on consent (Good Practice in Consent) with which staff should acquaint themselves.

4.2 The remainder of this section considers **the European Convention on Human Rights (ECHR)** and **the United Nations Convention on the Rights of the Child (UNCRC)** before outlining some case decisions to assist with identifying situations where the use of restraint or seclusion is potentially open to challenge under these international conventions. It concludes with comment on the legislative context for specific groups of service users who are identified as particularly vulnerable.

The European Convention on Human Rights (ECHR) as incorporated by the Human Rights Act 1998

4.3 Many of the following paragraphs use children's cases for illustrative purposes. This reflects the expertise of the legal issues sub-group whose remit was to specifically address the issue in respect of children. The messages emerging have, however, wider application and the working group has edited the sub-group's contribution and extended parts of the material to the wider field.

4.4 The Human Rights Act 1998, which came fully into force in October 2000, enables most of the rights enshrined in the ECHR to be pursued in the domestic courts rather than through the European Court of Human Rights (ECtHR). All public authorities are obliged to discharge their functions in accordance with the rights sets out in the ECHR and the courts must take Convention rights into account when deciding cases. These rights apply to both children and adults.

4.5 In the context of the use of restraint and seclusion the following articles of the ECHR should be taken into consideration.

Article 3 ECHR

4.6 No one shall be subjected to torture or inhuman and degrading treatment or punishment.

Article 5 ECHR

4.7 Everyone has the right to liberty and security of the person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(a) the lawful detention of a person after conviction by a competent court;

(b) the lawful arrest or detention of a person for non compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;

(c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority;

(d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purposes of bringing him before the competent legal authority;

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, and of drug addicts or vagrants;

(f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

Article 8 ECHR

4.8 1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The United Nations Convention on the Rights of the Child (UNCRC)

4.9 The UNCRC is an international treaty on children's rights, which all countries have signed with the exception of U.S.A. and Somalia. The key relevant provisions of the UNCRC are set out below.

Article 1 UNCRC

4.10 For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2 UNCRC

4.11 States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

4.12 States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians or family members.

Article 3 UNCRC

4.13 In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

4.14 States Parties undertake to ensure the child such protection and care as is necessary for his or her well being, taking into account the rights and duties of his/her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end shall take all appropriate legislative and administrative measures.

4.15 States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health in the number and suitability of their staff as well as competent supervision.

Article 12 UNCRC

4.16 States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Article 19 UNCRC

4.17 States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parents, legal guardians or any other person who has the care of the child.

Article 25 UNCRC

4.18 States Parties recognise the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 37 UNCRC

4.19 States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner, which take account of the needs of a person of his/her age. In particular every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.

(d) Every child deprived of his/her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 39 UNCRC

4.20 States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse, torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self respect and dignity of the child.

The United Nations Committee on the Rights of the Child

4.21 The implementation of the UNCRC is monitored by the United Nations Committee on the Rights of the Child. In the "Concluding Observations of the United Nations Committee on the Rights of the Child, United Kingdom of Great Britain & Northern Ireland", October 2002[1] the Committee expressed concern about figures indicating that children had sustained injuries as a result of the use of restraints and control in prison. In addition, the Committee expressed concern about the frequent use of physical restraint in residential institutions and in custody as well as the placement of children in solitary confinement in prisons.

4.22 The Committee recommended the review of the use of restraint and solitary confinement in relation to children and young people in custody, education, health and welfare institutions to ensure compliance with the UNCRC in particular articles 25 and 37 UNCRC (paragraphs 4.18 and 4.19 respectively of this Guidance).

4.23 The Committee also expressed concern that the principle of primary consideration for the best interests of the child is not consistently reflected in legislation and policies affecting children and recommended that the principle of the best interests of the child as a paramount consideration should be enshrined in all legislation and policy affecting children.

Restraint and seclusion: human rights issues and the key caselaw

4.24 Seclusion is described in the Department of Health (England and Wales) Code of Practice (1999) as:

[1] The Concluding Observations of the UN Committee on the Rights of the Child published on 9 October 2002 and available online at www.unhchr.ch/tbs/doc.nsf

> "*the supervised confinement of a patient in a room, which may be locked for the protection of others from significant harm."*

4.25 In practice, seclusion is a form of solitary confinement which can be used for therapeutic, containing or punitive purposes. The purpose of restraint has been described by the Department of Health as the use of physical force against a patient to minimise unacceptable behaviour. Both seclusion and restraint in relation to the care of service users raise potential human rights issues. A number of these issues have been raised in the domestic courts and further guidance can be obtained from the case law of the European Court of Human Rights (ECtHR).

4.26 The leading domestic authority on the use of restraint in the mental health context remains the House of Lords decision in *Pountney* v *Griffiths* [1976] AC 314 where it was held that hospital staff had "powers of control over mentally disordered patients, whether admitted voluntarily or compulsorily, though the nature and duration of the control varies with the category of patient to which the patient belongs." The ECtHR decision in *Herczegfalfy* v *Austria* [1992] has placed the concept of medical necessity at the core of any intervention of this type. The ECtHR stated that:

> "the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with…..The established principles of medicine are admittedly decisive in such cases; **as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading**. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist." (Highlighting added.)

4.27 The question of the burden of proof in relation to whether a medical necessity has been "convincingly shown" was examined in *R* v *Dr M and others* ex parte *N* [2003] 1 WLR 562 where the Court of Appeal held that while the requirement was not equivalent to a criminal burden of proof it still required a high standard of proof. The decision in this case is an important one in that the Court of Appeal reviewed the common law authorities on consent to treatment. Simon Brown LJ found that the "therapeutic necessity" test applied both to patients with and without capacity. This decision would appear to indicate that where treatment of questionable therapeutic benefit is administered to a patient who strongly opposes it, and which will, if administered, involve the use of physical force with possible detrimental effects to the patient's health, that this will constitute a violation of Article 3 of the Convention. This approach should, therefore, apply to the use of restraint and seclusion of all service users who have capacity and to those whose capacity may be questioned as a consequence of their age or other impairment.

4.28 In order to breach the terms of Article 3 of the Convention the treatment in question must reach a particular threshold of severity. (See *S* v *Airedale NHS*

Trust [2002] EWHC 1780). Brief periods of seclusion and proportionate instances of restraint are, therefore, unlikely to reach the requisite threshold to constitute a breach of a Convention Right.

4.29 There is the possibility that restraint and seclusion could be argued as a breach of Article 5 of the ECHR. In the context of adult mental health the developing jurisprudence has held that Article 5 protections are restricted to the determination of whether detention is lawful or not. (See *R* v *Governor of Parkhurst Prison* ex parte *Hague* [1992] 1 AC 58.) Where detention of a child or adult takes place on a non-statutory basis then the possibility of an Article 5 breach arising from the use of either seclusion or restraint is a real one.

4.30 Similarly, treatment that falls short of medical necessity may constitute a breach of Article 8 of the ECHR. However, the broad justifications available in Article 8(2) are likely to render many interventions with service users to be in accordance with the ECHR.

4.31 The decision in *Herczegfalfy* found that there was no breach of Article 8 where the individual was restrained and force fed in circumstances where he was "entirely incapable of taking decisions for himself." It remains to be determined whether differential treatment of service users deemed to lack capacity because of age or intellectual impairment will fall foul of the anti-discrimination provisions of Article 14 of the Convention. It should be noted that a mere assertion of differential treatment is not enough to ground an Article 14 point. (See Carswell LCJ's discussion in *Re Jean McBride* [2003]).

Impact of legislation for specific service users

Professional guidance relating to medical settings

4.32 The British Medical Association in a recent publication set out a number of considerations in relation to the use of restraint in respect of the care of children in medical settings:[2]

1. Restraint should only be used where it is necessary to give essential treatment or to prevent a child from significantly injuring him/herself or others.

2. Restraint is an act of care and control, not punishment.

3. Unless life prolonging or other crucial treatment is immediately necessary, the approval of a court should be sought where treatment involves restraint or detention to override the views of a competent

[2] British Medical Association, *Consent, Rights and Choices in Health Care for Children and Young People,* BMJ Books, 2001.

young person, even if the law allows doctors to proceed on the grounds of parental consent.

4. All steps should be taken to anticipate the need for restraint and to prepare children, their families and staff for its use.

5. Wherever possible, the members of the health care team involved should have an established relationship with the child and should explain what is being done and why.

6. Treatment plans should include safeguards to ensure that restraint is the minimum necessary to achieve the clinical therapeutic aim, and that both the child and parents have been informed what will happen and why the use of restraint is considered necessary.

7. Restraint should only be used in the presence of other staff, who can act as assistants and witnesses, unless there is no other means of protecting the service user or others.

8. Any use of restraint or detention should be recorded in the medical case records. These issues are appropriate subject for clinical and social care audit.

4.33 The Royal College of Nursing has issued Guidance on the use of restraining and preventing children from leaving a medical setting.[3]

Children's residential care services

4.34 The relevant provisions on children's residential care services are to be found in the Children (Northern Ireland) Order 1995, regulations made under the Order and in Volume 4 (Residential Care) of the associated series of volumes of "Guidance and Regulations". There is no reference at all in the 1995 Order to the use of restraint or isolation. The Children's Homes Regulations (Northern Ireland) 1996, made under the Children Order, make provision at regulation 8 in relation to control and discipline. Regulation 8 (2) sets out measures which should not be used on children in a children's home; and regulation 8 (3) gives measures which the regulations do not prohibit, including "the taking of any action immediately necessary to prevent injury to any person or serious damage to property".

4.35 These provisions are considered under 'Good Order and Discipline' in Chapter 4 of Volume 4 of the Guidance and Regulations. In particular, the following areas are set out and dealt with:

- Disciplinary Measures – general (Paragraph 4.14)

[3] The Royal College of Nursing. *Restraining, Holding Still and Containing Children: Guidance for Good Practice.* London: RCN, 1999.

- Permitted disciplinary measures (Paragraphs 4.15 – 4.19)

- Prohibited measures (paragraph 4.20)
  Corporal punishment
  Deprivation of food and drink
  Restriction or refusal of visits/communications
  Requiring a child to wear distinctive or inappropriate clothing
  The use or withholding of medication or medical or dental treatment
  The use of accommodation to physically restrict the liberty of any child
  Intentional deprivation of sleep
  Imposition of fines
  Intimate physical searches

- General principles governing interventions to maintain control (Paragraph 4.21)

- Methods of care and control of children which fall short of physical restraint or the restriction of liberty (Paragraph 4.42)

- Use of physical presence of staff (Paragraphs 4.43 – 4.24)

- Holding (Paragraphs 4.2.5 – 4.25)

- Touching (Paragraphs 4.27 – 4.28)

- Physical restraint (Paragraphs 4.29 – 4.34)

- Restriction of liberty (Paragraphs 4.35 – 4.39)

- Monitoring (Paragraph 4.40)

4.36 The Children Order guidance provides specific guidance on the use of restraint and the restriction of liberty. Paragraph 4.13 specifically prohibits the locking of children in their bedroom at night "whatever their age and competence". The Guidance outlines permissible forms of care and control and establishes a comprehensive list of general principles governing interventions to maintain control.

Foster care

4.37 The Foster Placement (Children) Regulations (NI) 1996 provide for the approval of Foster Parents (Regulation 3), the Review and Termination of Approval (Regulation 4), Placements (Regulation 5) and Termination of Placements (Regulations 7).

4.38 Regulations 3(6)(b) provides that an authority shall not place a child with an approved foster parent unless he enters into a written agreement with it covering the matters specified in Schedule 2 (Matters and obligations to be covered in foster care arrangements). Pursuant to Paragraph 5 of the Schedule each foster carer must specifically agree "Not to administer corporal punishment to any child placed with him".

4.39 Under the Guidance issues in respect of the Children (NI) Order 1995 (Volume 3 Family Placements and Private Fostering) at paragraph 4.31 (Assessment and approval of foster carers) there is a duty placed on the social worker to 'ascertain the applicant's views on discipline with particular regard to the issue of corporal punishment which is not regarded as an appropriate means of correcting children'. The term "corporal punishment" is then defined to cover 'any intentional application of force as a form of punishment, including slapping, pinching, squeezing, shaking, throwing objects and rough handling. It would also include punching or pushing in the heat of the moment in response to violence from young people. It does not prevent a person taking necessary physical action where any other course of action would be unlikely to avert immediate danger of physical injury to the child or to another person, or to avoid immediate danger to property. Verbal abuse, derogatory remarks and pointed jokes can cause psychological harm to a child and should be avoided'.

4.40 In relation to children who are privately fostered, the Trust does not approve or register private foster parents but must satisfy itself that the arrangements are satisfactory that the private foster parents are suitable. The responsibility for safeguarding and promoting the welfare of the privately fostered child rests with the parents. Regulation 2(2)(j) of The Children (Private Arrangements for Fostering) Regulations 1996 places a duty on the Trust to satisfy itself that the private foster parent is being given any necessary advice. Pursuant to Chapter 15 (Suitability of the foster parent) of the Guidance Volume 3 there is reference to discipline with particular regard to the issue of corporal punishment (paragraphs 15.13-15.14). The definition of corporal punishment is provided and there is requirement that a child should not be refused meals or drink as punishment nor restricted from visiting or being visited by family and friends as a means of punishment. The UK National Standards for Foster Care requires policies to be in place on corporal punishment to ensure that each child in foster care is protected from all forms of corporal punishment (smacking, slapping shaking) and all other humiliating forms of treatment or punishment.[4]

There is no legislative provision in relation to the use of restraint and isolation for the child who is in foster care – either under the Children (NI) Order 1995 itself or any regulations issued thereafter. There is similarly, no specific guidance in relation to restraint and isolation. However the Trust is under a duty to assess foster carers (and give advice to private foster carers) and in this context these issues may be addressed by the individual Trusts. Guidelines are

[4] Published by the National Foster Care Association on behalf of the UK Joint Working Party on Foster Care.

issued by the National Foster Care Association on the Care and Control of Children in Foster Homes.

Secure accommodation

4.41 Article 44 of the Children (NI) Order 1995 sets out the criteria by which a child can be placed or kept in secure accommodation. The associated regulations are the Children (Secure Accommodation) Regulations 1996. This statutory provision permits the restriction of liberty of children but also ensures that any such decisions taken by the Trust or others are scrutinised and endorsed by the Court. A child cannot be placed or kept in secure accommodation unless it appears that

(a) (i) he has a history of absconding and is likely to abscond from any other description of accommodation; and

(ii) if he absconds, he is likely to suffer significant harm; or

(b) that if he is kept in any other description of accommodation he is likely to injure himself or other persons." (Article 44)

4.42 The criteria must apply and once it no longer applies then the child must not continue to have his liberty restricted (even if there is a court order authorising the restriction currently in existence). The definition of "restriction of liberty" is a matter which is to be determined by the Court and may include any practice or measure which prevents a child from leaving a room or building of his own free will. This is a measure of last resort and will only be permitted when it is evidenced that there is no appropriate alternative. The onus is therefore on the Applicant to show that everything else has been comprehensively considered and rejected. The secure placement should only be for as long as is absolutely necessary (and not for the duration of the Court Order itself). The Trust have a duty to take reasonable steps to avoid the need for children to be placed in secure accommodation (The Children (NI) Order 1995; Schedule 2 paragraph 8(c)).

4.43 There is one unit in Northern Ireland which provides secure accommodation for children at Lakewood in Bangor.

Services provided under the mental health legislation

4.44 The use of restraint and seclusion in respect of service users is not referenced in the primary legislation, the Mental Health (NI) Order 1986. The Code of Practice, which accompanies the Mental Health (NI) Order 1986, does, however, provide limited guidance on the use of restraint and seclusion generally.[5] Section 5.33 requires every Unit of Management (i.e HSS Trust) to have a policy on the use of all forms of physical restraint (physical restraint in

[5] 1992, Belfast, HMSO

the context of this guidance includes locked ward doors, time out and seclusion). Sections 5.32 – 5.53 of the Code of Practice gives guidance on restraint, locked doors on open wards, time out and seclusion. Within this Guidance there is, however, no specific reference to children and young people.[6]

4.45 In the case of *S* v *Airedale NHS Trust* a young person who was a mental health in-patient challenged his detention in seclusion by the NHS Trust while they sought a more suitable placement to meet his needs. S was being held in a locked room at night because a bed was not yet available for him at a secure unit. He argued that the NHS Trust was obliged to follow the Mental Health Code of Practice (1999) and that there had been a breach of Article 3 ECHR in relation to the conditions he was held under and a breach of Article 8 ECHR. The High Court rejected the application stating that the conditions he was held under were not poor enough to constitute a breach of Article 3 ECHR. It was concluded that the NHS Trust had acted lawfully, but S appealed to the Court of Appeal, which considered his case alongside the case of Colonel Munjaz who was challenging the policy at Ashworth Hospital not to follow the Mental Health Code of Practice when patients were secluded for more than three days.[7]

4.46 Seclusion is defined in paragraph 19.16 of the 1999 Code of Practice as the supervised confinement of a patient in a room, which might be locked to protect others from significant harm. The Code states that seclusion should be used as a last resort and for the shortest period of time; that a decision to seclude should be taken by a doctor or nurse in charge and that the continued need for seclusion should be reviewed every two hours by a nurse and every four hours by a doctor. The question before the Court of Appeal was whether seclusion was capable of infringing Articles 3, 5 and 8 of the ECHR as incorporated by the Human Rights Act 1998. It was no longer argued that in these particular cases a breach of Article 3 had occurred.

4.47 The Court of Appeal accepted that there was an implied power for the authorities to seclude a person who was compulsorily detained under the Mental Health Act within a hospital setting as a "necessary ingredient flowing from the power of detention for treatment". In addition, seclusion could amount to medical treatment. The Court was of the view that there was no doubt that seclusion could potentially amount to inhuman and degrading treatment or punishment prohibited under Article 3 ECHR, but segregation from other detained patients did not itself constitute such treatment. Seclusion also infringed Article 8 (2) ECHR unless it could be justified under Article 8(2) ECHR. However, the further seclusion of a detained patient did not amount to a deprivation of liberty for the purposes of Article 5 ECHR which was concerned

[6] See also the Mental Health Act 1983, Revised Code of Practice (1999) which applies in England and provides more detailed guidance on restraint, seclusion, locked wards and also contains a detailed section on children and young people.

[7] The Court of Appeal gave judgment in both cases in R (*Munjaz) v Mersey Care NHS Trust and R(S)v Airedale National Health Service Trust and others* [2003] EWCA Civ 1036 (16 July 2003)

with the lawfulness not the conditions of detention, although there would be a breach of Article 5 (1) ECHR if a person was detained in a type of institution which was inappropriate to meet the purpose of his detention.

4.48 Where issues relating to a patient's human rights were engaged, the Code of Practice should be followed by all hospitals unless there was good reason to depart from it in individual cases. In the Munjaz case, the Court held that the wholesale departure from the Code of Practice in certain groups of cases based on the length of time spent in seclusion was unlawful. In the case of S, on the facts the Court found his seclusion (which was in breach of the Code of Practice and used on the basis that there was no other more suitable placement available for him) to be unjustified.

Other areas of interest

4.49 Although not directly related to the HPSS sector, the following examples of interpretation of the law in other sectors are of interest and knowledge of them may assist staff working in settings which interface with either the education or youth justice sectors.

Education sector

4.50 Article 4 of the Education (NI) Order 1998 came into force on 21 August 1998 and authorises teachers to use such force as is reasonable in the circumstances to prevent a pupil from:

- committing an offence;
- causing personal injury to, or damage to the property of, any person (including the pupil himself); or
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils whether during a teaching session or otherwise.

4.51 Non teaching staff are also authorised to use reasonable force in these circumstances provided they have been authorised by the Principal to have lawful control or charge of pupils.

4.52 Detailed guidance for schools is contained in "Guidance on the Use of Reasonable Force to Restrain or Control Pupils", DE Circular 1999/9 and is included in "Pastoral Care in Schools; Child Protection". A copy of this guidance is attached at **Annex J** for reference.

Youth justice

4.53 The use of restraint and seclusion of children in a custodial youth justice setting is regulated by the Juvenile Justice Centre Rules (NI) 1999. Regulation 29 allows for the use of "forms of control" approved by the Secretary of State in

dealing with "unruly children".[9] Regulation 30 allows for the use of temporary confinement of a child for up to 24 hours. These Rules must be interpreted in light of the ECHR as incorporated by the Human Rights Act 1998.

4.54 In a recent case taken by the Howard League for Penal Reform in England[10] an 18 year old applicant (who was 17 at the time complained of) argued that his segregation on two periods for five and four days respectively in a segregation unit in a young offenders centre and the conditions under which he was detained there amounted to a breach of the Young Offender Institution Rules 2000 ("the Rules") and a breach of his rights under Article 3 and Article 8 of the European Convention On Human Rights. The judge held that there had been a breach of the Rules, but on the facts no breaches of Articles 3 and 8 of the Convention. It is of note, however, that the judge stated that, although he was not making a finding under Article 3 in this particular case, he was prepared to accept that solitary confinement of a child (in other words, someone under 18) could amount to a breach of Article 3 in circumstances where it would not in relation to an adult. In respect of Article 8 he stated:

> " *I hope I may be permitted merely to utter this warning: there are clear dangers in placing young people in segregation units in relation to their rights enshrined in Article 8".*

Conclusion

4.55 The legal issues relating to the use of restraint and seclusion are complex. The discussion above has, therefore, sought to highlight issues which staff and their employers need to take into account in using these procedures with any service user. The use of restraint and seclusion are measures of last resort. Staff in making use of either procedure should have a clear understanding of the rights of service users and when it is appropriate for them to employ either restraint or seclusion and the safeguards that should be in place to ensure they are not subject to legal challenge. Employers have a duty to provide key staff with training on human rights considerations under ECHR and other relevant international instruments, and that their policies and procedures ensure that work in these difficult areas is of a high professional standard. There is, therefore, a clear link between this section of the guidance and those relating to policy, training, complaints and management and monitoring arrangements.

[9] This is the wording of Regulation 29

[10] *The Queen on the Application of BP v The Secretary of State for the Home Department* [2003] EWHC 1963 Admin

5. PRINCIPLES INVOLVED

General

5.1 This section discusses some of the key principles relating to the use of restraint and/or seclusion and ends with a statement of principles which should underpin the use of these interventions.

5.2 Important principles regarding the protection of individuals from abuse by State organisations or the staff working within them are set out in the Human Rights Act 1998. In addition, it is a criminal offence to use physical force, or to threaten to use force, unless the circumstances give rise to a 'lawful excuse' or justification for the use of force. Similarly, it is an offence to lock a service user in a room without a court order (even if they are not aware that they locked in) or the consent of the service user, except in an emergency when for example the use of a locked room as a temporary measure while seeking assistance would provide legal justification. For children, rules are specified in the regulation 6 of the Children (Secure Accommodation) Regulations (NI) 1996 ("the 72 hours rule"). Use of physical intervention may also give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned.

5.3 The use of restraint and seclusion should always be designed to achieve outcomes that reflect the best interests of the individual service user whose behaviour is of immediate concern and others immediately affected by the behaviour.

5.4 The decision to use restraint or seclusion must take account of the circumstances and be based upon an assessment of the risks associated with the intervention compared with the risks of not employing either restraint or seclusion as a method of intervention.

5.5 Efforts to minimise the use restraint or seclusion should be in place. This may require the adoption of primary and secondary preventative strategies.

5.6 Primary prevention is achieved by:

- ensuring that the number of staff deployed and their level of competence corresponds to the needs of service users and the likelihood that physical interventions will be needed. Staff should not be placed in vulnerable positions;

- helping service users to avoid situations which are known to provoke violent or aggressive behaviour, for example, settings where there are few options for individualised activities;

- developing care plans, which are responsive to individual needs and include current information on risk assessment;

- creating opportunities for service users to engage in meaningful activities which include opportunities for choice and a sense of achievement;

- developing staff expertise in working with service users who present challenging behaviours;

- talking to service users, their families and advocates about the way in which they prefer to be managed when they pose a significant risk to themselves or others. Some service users prefer withdrawal to a quiet area to an intervention which involves bodily contact.

5.7 Secondary prevention involves recognising the early stages of a behavioural sequence that is likely to develop into violence or aggression and employing 'defusion' techniques to avert any further escalation. Where there is clear documented evidence that particular sequences of behaviour rapidly escalate into serious violence, the use of interventions at an early stage in the sequence may, potentially, be justified if it is clear that:

- primary prevention has not been effective, and

- the risks associated with *not* acting are greater than the risks of using restraint or seclusion; and

- other appropriate methods, which do not involve restraint or seclusion, have been tried without success.

5.8 All prevention strategies should be carefully selected and reviewed to ensure that they do not, except through necessity, either constrain opportunities or have an adverse effect on the welfare or the quality of life of service users (including those in close proximity to the incident) . In some situations it may be necessary to make a judgement about the relative risks and potential benefits arising from activities, which might provoke challenging behaviours compared with the impact on the person's overall quality of life if such activities are proscribed. This is likely to require a detailed risk assessment.

5.9 Particular regard should be had to service users' attitudes towards physical contact, physical stature, age, gender and previous life experiences when restraint is being used. Restraint and seclusion should be used as measures of a last resort and in a way that is sensitive to, and respects the cultural expectations of service users. Any physical intervention used in restraint should avoid contact that might be misinterpreted as sexual.

5.10 Where restraint is employed staff must ensure that they only employ a reasonable amount of force, that is, the minimum force needed to avert injury or serious damage to property, applied for the shortest possible period of time.

Planned physical interventions should only be used as part of a holistic strategy where the risks of employing an intervention are judged to be lower than the risks of not doing so.

Proactive use of restrictive physical interventions

5.11 In most circumstances, restraint or seclusion will be used reactively. Occasionally, it may be considered in the best interests of the service user to accept the possible use of an intervention as part of a therapeutic or educational strategy that could not be introduced without accepting that reasonable force might be required. For example, the best way of helping a child to tolerate other children without becoming aggressive might be for an adult to 'shadow' the child and to adjust the level of any physical intervention needed according to the child's behaviour. Similarly, staff might be sanctioned to use restraint, if necessary, as part of an agreed strategy to help a person who is gradually learning to control his/her aggressive behaviour in public places. In both examples, the physical intervention is part of a broader educational or therapeutic strategy.

5.12 Where this approach is employed it is important to establish in writing a clear rationale for the anticipated use of intervention and to have this endorsed by a multidisciplinary meeting which includes, wherever possible, family members (or those with parental responsibility) and an independent advocate.

Emergency use of restrictive physical interventions

5.13 Emergency use of restrictive physical interventions may be required when service users behave in ways that have not been foreseen by a risk assessment. Research evidence shows that injuries to staff and to service users are more likely to occur when restraint is used to manage unforeseen events and for this reason great care should be taken to avoid situations where unplanned physical interventions is used.

5.14 An effective risk assessment procedure together with well planned preventative strategies will help to keep emergency use of restraint to an absolute minimum. However, staff should be aware that, in an emergency, the use of force can be justified if it is reasonable to use it to prevent injury or serious damage to property.

5.15 Even in an emergency situation, any force used must be reasonable. It should be commensurate with the desired outcome and the specific circumstances in terms of intensity and duration. Before using restraint in an emergency, the person concerned should be confident that the possible adverse outcomes associated with the intervention (for example, injury or distress) will be less severe than the adverse consequences, which might have occurred without the use of a physical intervention.

5.16 There must be a written protocol, which includes:

- a description of behaviour sequences and settings which may require the use of restraint or seclusion;
- the results of any assessment which has determined any contra-indications for the use of physical interventions;
- a risk assessment which balances the risk of using physical intervention against the risk of not using a physical intervention;
- a record of the views of the service user or those with parental responsibility in the case of children, and family members in the case of adults not deemed competent to make informed choices;
- a system of recording behaviours and the use of restrictive physical interventions using an incident book with numbered and dated pages;
- a record of previous methods which have been tried without success;
- a description of the specific physical intervention techniques which are sanctioned, and the dates on which they will be reviewed;
- details of staff who are judged competent to use these methods with this person;
- the ways in which this approach will be reviewed, the frequency of review meetings and members of the review team.

5.17 An up-to-date copy of this protocol must be included in the service user's individual care plan.

5.18 The use of a restraint or seclusion should always be recorded as quickly as practicable (and in any event within 24 hours of the incident) by the person(s) involved in the incident in a book with numbered pages. See paragraphs on Post-Incident Management and Monitoring (paragraphs 3.9-3.18).

STATEMENT OF PRINCIPLES

5.19 **The following principles should underpin the use of restraint and seclusion with service users across the range of client groups**.

- **The philosophy of care is the least restrictive and controlling possible for the individual service user.**

- **Prevention strategies are in place to minimise the need to use either of these interventions.**

- **Institutions or settings employing either restraint and/or seclusion have clearly defined policies for the management of violent service users.**

- **Restraint and seclusion are interventions of last resort, used for the minimum time necessary to protect life, to safeguard from harm or to prevent serious damage to property.**

- **The management of disturbed and violent behaviour requires a multidisciplinary approach to planning for the care and treatment of the service user.**

- **The principles for the management of disturbed and violent behaviour which poses a risk to the individual or other service users are the same whatever the institution or setting.**

- **Planned use of these interventions is based on a risk assessment and is part of the care plan for the individual service user, of which they are informed.**

- **The risk assessment specifies if there are reasons why a specific intervention should not be employed with an individual service user.**

- **The age, gender, personal characteristics of the service user and setting specific factors are all drawn together to inform the use of any approach designed to manage or control behaviours.**

- **The use of these interventions is recorded in a standardised manner as soon as possible after the incident.**

- **Post incident monitoring is carried out at a senior level within the service to:**

  - **ensure compliance with human rights requirements;**

  - **ensure compliance with the *last resort* principle;**

- **ensure that the minimum amount of force was used for the shortest possible period of time;**

- **compliance with the policies and procedures;**

- **that staff involved were appropriately trained; and**

- **determine what lessons can be extracted to inform future practice, training or staff support.**

- **Staff employing these interventions are appropriately trained to ensure they use the procedures to promote the well being and best interests of service users and in a manner consistent with the Human Rights Act and the European Convention on Human Rights.**

- **Staff working with children ensure that their practice is consistent with the United Nations Convention on the Rights of the Child and that complaint procedures are available in a child friendly format.**

- **Staff and service users have opportunities for de-briefing after the use of these interventions.**

- **Management strategies for disturbed and violent behaviour should be regularly monitored and audited.**

- **Service users and their families are aware of how to complain if they are dissatisfied about the way they were managed prior to, during and after the incident.**

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ANNEX A

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

OUTLINE TERMS OF REFERENCE

Restraint and seclusion can be used in a variety of health and social care settings eg. residential/nursing homes, children's homes, hospitals and facilities accommodating people with a learning disability and mental health problems. There are possible implications for Articles 3, 5 and 8 of the ECHR. The purpose of this piece of work is to develop guidelines for staff to ensure that any restraint or seclusion is reasonable, proportionate and justifiable in the circumstances and that appropriate documentation is completed.

Methodology

- Examine current policies and procedures.
- Examine current practices, including local audits, work in progress, research reports - is there evidence of best practice anywhere?
- Examine current documentation and recording mechanisms.
- Examine complaints in this area to identify weaknesses and areas for action.
- Examine existing case law to identify issues and guiding principles.

Product

User-friendly, practical guidelines which:

(a) are human rights compliant and which have been validated by the appropriate professions, legal advisors, the NIHRC, the Equality Commission;

(b) have been quality assured; and

(c) are capable of incorporation into training for new and existing staff, where relevant.

Accountability

Boards, Trusts etc. will be asked to report on progress on implementation of the guidelines within the framework of Priorities for Action and the Health and Well-being Investment Plans. It is not envisage that this piece of work will be issued as a Departmental circular as the objective is to support and encourage staff to develop a human rights culture within their organisations and their own policies and procedures to implement the guidance. This approach recognises that different organisations will be at different stages of applying practice and have varying needs depending on their client group and whether they are residential or community based services.

ANNEX B

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

MEMBERSHIP

Mrs Marion Reynolds (Chair)	Social Services Inspectorate, DHSSPS
Ms Tara Caul	Children's Law Centre
Mr Arthur Dick	Down Lisburn HSS Trust
Ms Heather Ellis	Human Rights Liaison Group
Mrs Roisin Gallanagh	School of Nursing, University of Ulster
Mr Gene Gillease	Western Equality & Human Rights Forum
Dr Joan McGuinness	Armagh & Dungannon HSS Trust
Mr Clinton Stewart	North & West Belfast HSS Trust
Ms Alison Wilson	Secure Units, Lakewood
Ms Linda Wilson	Barnados
Mr Cecil Worthington	Ulster Community and Hospitals HSS Trust
Mr Niall Young	Homefirst HSS Trust
Mr Stewart Love	Human Rights Unit, DHSSPS

ANNEX C

MEMBERSHIP OF SUB-GROUP ON LEGISLATIVE CONTEXT

Tara Caul

Prof Tony McGleenan

Henry Tower QC

Carol Sholdis BL

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ANNEX D

EXAMPLE OF HSS TRUST

MANAGEMENT OF

AGGRESSION POLICY

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1.0 POLICY STATEMENT AND TRUST'S PRINCIPLES

It is the policy of this Trust to promote an organisational culture and develop associated structures that prevent aggression in the workplace. The Trust seeks to equip all staff with the appropriate attitudes, knowledge and skills to work with service users in those situations which critically challenge how they are supported. This will enable management of aggression to be achieved in a caring manner by the implementation of training and policy initiatives that promote best practice.

This approach must fit with the wider quality issues of clinical and social care governance and controls assurance. Each service should develop, where appropriate, local procedures reflecting the ethos of this policy.

The existing law requires that individuals do not interfere with the rights of others, eg the use of physical intervention techniques. Such action can, however, be defended if it is intended to prevent harm to the service user or others. Members of Trust staff must be able to demonstrate clearly that they act at all times in the best interests of the individual.

The following are the Trust's principles underpinning the policy.

- Service users and carers should be treated with respect at all times and their dignity maintained.

- Person centred approaches, sensitive to the needs of the individual and promoting effective communication between service users and staff, should be practised to help reduce the likelihood of aggressive incidents.

- Prevention of aggression is preferable to intervention at a later stage.

- The use of physical intervention techniques, may on occasions be necessary to fulfil a duty of care. However, these should be kept to an absolute minimum and carried out within local service guidelines. Physical intervention techniques when used will take full account of the service user's need for respect, privacy and dignity as well as social and cultural considerations.

- The personal safety of staff, service users, carers, students on placement and other persons carrying out authorised tasks on behalf of the Trust is of paramount importance to this Trust. Personal safety takes priority over damage to property.

- The Trust recognises its legal and moral responsibility to reduce risk to staff, service users, carers, students on placement and others to the lowest level practicable.

- Trust staff have individual and collective responsibility for ensuring that aggressive incidents are kept to a minimum and effective risk management procedures are in place to secure this aim. The safety of service users is everyone's responsibility.

- The training and support provided to Trust staff will recognise these principles and will provide staff with a tool-kit of skills that will enable them to manage difficult situations in a person-centred manner.

2.0 DEFINITION OF AGGRESSION

The Trust defines aggression as behaviour resulting in damaging or harmful effects (physical or psychological) on another person or persons. This includes:

- verbal abuse
- non verbal abuse (eg stalking)
- threats of physical abuse
- physical abuse
- threats of sexual abuse
- sexual abuse
- damage to property

The above definition includes behaviour directed at staff, service users, carers, students on placement and other persons carrying out authorised work on behalf of the Trust.

3.0 RESPONSIBILITIES

[Describe the relevant responsibilities within the Trust]

The Trust Board has the responsibility for overseeing the health, safety and welfare of all service users, staff and others affected by the activities of the Trust. The Chief Executive in conjunction with his colleagues on the operational Management Team is charged with meeting these responsibilities. The Operational Management Team, which includes the Heads of Service in the Trust, directs all Trust initiatives to reduce the risks of aggression whilst providing person-centred services to service users. The Operational Management Team is accountable through the Chief Executive to the Trust Board.

3.1 Staff Responsibilities

All staff have a responsibility to ensure that their behaviour towards service users and their carers reflect a person-centred approach. Staff should be aware of the impact of their own behaviour and how this could precipitate or increase the severity of an incident of aggression. All staff who work directly with service users should endeavour to be aware of the risk factors for aggressive

behaviour. Trust training will reinforce the value of appropriate communication skills. Staff are obliged to adhere to this policy and associated training at all times.

While it is the legal responsibility of the Trust to provide safe systems of work, individuals have a personal responsibility to follow safe working practices.

3.2 Management Responsibilities

Chief Executive

The Chief Executive carries overall responsibility for the health, safety and welfare of all service users, staff and others affected by the activities of the Trust. He is responsible to:

- ensure that appropriate arrangements are in place within the Trust to manage aggression;
- ensure that those systems that are in place are in line with clinical and social care governance;
- ensure that effective monitoring systems are in place to quality assure these arrangements

Heads of Service

- Ensure that their staff are aware of the policy and that its relevance to their work is recognised
- Ensure any additional local procedures in a particular service area fits with the Trust-wide approach.
- Allocate resources (time, people and financial outlay) according to areas of highest risk.
- Ensure staff are adequately trained.
- Provide High level monitoring of the level and effectiveness of training.
- High level monitoring of incident patterns.
- Develop systems which will support staff and service users following an aggressive incident.
- Communicate, where appropriate information, information about significant known risks to ensure remedial action is taken to address these.

Service Managers

- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.
- Implement Trust recruitment and selection procedures to ensure that applicants are fully aware of the roles and inherent risks associated with

the job. This should facilitate the selection of an appropriate person for the post.

- Ensure staff are adequately trained.
- If necessary draw up service specific local procedures to support and underpin the Trust-wide policy and approach.
- Ensure that appropriate risk assessments of aggressive behaviour associated with use of Trust's services have been carried out in conjunction with staff, service users and carers and using a multi-disciplinary approach. This should occur within the annual service-planning cycle.
- Fully implement the Trust's incident reporting policy
- Ensure that any risks identified are managed appropriately through an action-plan approach. These risks should be reviewed within an agreed timescale
- Ensure arrangements to support and supervise staff are implemented and monitor their effectiveness.
- Ensure that managers have a system for investigating any aggressive incidents in their area.
- Monitor and implement lessons learned from incidents and provide feedback and information to staff and the Risk Management Unit.
- Inform their Service Head of areas of significant risk to ensure appropriate action is taken.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

First Line Managers

- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.
- Provide Induction Training for new staff.
- Implement Trust recruitment and selection procedures to ensure that persons applying are fully aware of the roles and inherent risks associated with the job. This should facilitate the selection of an appropriate person for the post
- Ensure appropriate management of aggression and the provision of learning and skills development. This should include, as appropriate, training in a multi-disciplinary and at times multi-agency fashion.
- Ensure all training given to their staff is formally recorded and staff's training is kept up to date.
- Ensure that appropriate risk assessments are carried out and remain up to date.
- Involve other disciplines, as appropriate, in the management and assessment of risk of aggressive incidents.

- Ensure all incidents are reported promptly to the Trust's Incident Reporting Centre.
- Carry out investigation of any incidents occurring, supported by their Service Manager and the Risk Management Unit for significant incidents.
- Arrange for appropriate and comprehensive support for employees following an incident.
- Promote team-working.
- Monitor practice (formally and informally) and ensure the best standard by ongoing supervision.
- Use manpower planning skills to release staff for training.
- Keep Service Manager informed of any significant risks or implementation problems and ensure appropriate action is taken.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

Supervisory Management

- Promote best practice by example and on the job training for staff.
- Assist in implementing risk assessment procedures.
- Ensure that all incidents are reported promptly.
- Inform first-line manager of significant risks or problems and the arrangements required to reduce risk.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

3.3 Special Responsibilities

Consultants and Lead Clinicians/Social Care Professionals

- Responsible to ensure adequate and appropriate assessment of the service user presenting a risk because of aggressive behaviour. Although this process may initially start with one discipline it will in many cases involve a multi-disciplinary approach and may also require involvement from other Trusts and agencies as appropriate.
- Following assessment, development of management/care/treatment plans.
- Monitor, review and adjust these plans following re-assessment of the service user.
- Ensure that known risks are communicated where appropriate to staff and others to ensure other decisions are properly informed.
- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.

- Ensure that their staff receive appropriate induction and updated training, and support and supervision.
- Implement the Trust's Incident Reporting Policy.
- Ensure that their staff are aware of arrangements for post-incident staff support and that these are readily available when required.
- Lessons learned from incidents should be effective in changing practice in the workplace. Any information from this process should be passed on to the relevant staff and the Risk Management Unit.
- Promote team-working.

Head of Operational Support

- Chairs the Health and Safety Committee
- Provides quarterly reports to the Operational Management Team about aggressive incidents including learning points.
- Senior manager responsible for risk management advice, as member of the strategic Operational Support Team.
- Manages the Service Manager responsible for the Risk Management Unit.
- Responsible for alerting other senior managers to significant risk issues to ensure timely, appropriate responses.

Risk Manager

- Service manager responsible for managing the Risk Management Unit.
- Provides professional advice on Trust-wide management of risk.
- Devises, develops and reviews policies and procedures to reduce risk.
- Devises and manages risk assessment processes.
- Manages the process of reporting and monitoring incidents ensuring that managers are kept informed about incidents reported in their area and any significant implications for work practices.
- Responsible for analysing trends and providing managers with quarterly information about lessons to be learnt.
- Manages the training function for the reduction of risk.
- Advises managers at every level on targeting high risk areas.
- Provides assistance to managers to find risk solutions, leading to action plans.
- Ensures that the Trust minimises the risk of civil and criminal liability and that there is appropriate legal defence where cases are filed against the Trust.

Head of Human Resources

- Senior manager responsible for Occupational Health Services, learning and development and all other human resource issues.

- Sets high-level recruitment and selection procedures.
- Responsibility for redeployment and disciplinary issues.
- Provides high-level specialist advice to the Trust in the above areas.
- Establishes processes and protocols and makes arrangements for post-incident staff support and monitors its effectiveness.

Occupational Health Sister

- Manages the process of pre-employment health assessments.
- Provides a service for pre-employment risk assessment.
- Provides specialist advice to managers on employee's health.
- Advises managers and employees on return to work following an incident.
- Provides approved courses for Trust is First-Aiders.
- Organises appropriate health surveillance.
- Provides a work-place assessment service for managers

Human Resources Managers

- Provide advice on managing the processes of recruitment and selection.
- Advise managers on performance management issues.
- Assist and advice managers in implementing disciplinary procedures etc..

Trade Union Health and Safety Representatives

- May investigate hazards and dangerous occurrences in the workplace.
- May investigate complaints relating to health, safety and welfare at work by the staff they represent.
- May make appropriate representations to Trust Management in respect of the above issues.
- May carry out inspections in respect of the above issues.
- May represent appropriate staff in consultations with Trust Management, or inspectors of any enforcing agency.
- May attend meetings of safety committees, as appropriate, in connection with the above functions.

4.0 ARRANGEMENTS FOR MANAGING AGGRESSION

4.1 Organisational Risk Assessment

Information from the individual assessments of service users and risk factors regarding the working environment must feed into a process. This will help inform the broader assessment of risk of a ward, Trust facility/department or caseload. It is important that a collective view of risk is formed, as this is the way risk can best be managed and high-risk areas can be appropriately targeted.

The process is as follows:

- first-line managers of the ward/department/Trust facility have responsibility to initiate the process;
- risk issues from individual risk assessments are drawn together and patterns of risk are identified;
- consideration of any factors which may increase or decrease risk in any place where staff are at work;
- assessments should result in the production of action plans to prioritise and manage high risk and significant risk issues;
- information from this assessment should be used to inform their line manager so that a picture of risk emerges. This will enable the Service Manager to make plans to manage risk through the annual service-planning cycle and also on a day-to-day basis;
- finally, this process should inform the Heads of Service and the Operational Management Team about significant Trust-wide risks.

The organisational assessment of the risk of aggression will include:

- the actual number of incidents;
- the service user groups involved;
- the perceived risks associated with the work situation and procedures;
- staff perceptions of risk;
- the use of preventative strategies;
- the appropriateness of support and supervision arrangements provided by the Trust;

4.2 Individual Risk Assessment

Appropriate professionals should routinely carry out suitable and sufficient risk assessments in conjunction with staff, service users and carers. These assessments must be completed and reviewed at appropriate regular intervals and should include consideration of the risk of aggressive behaviour associated with the use and provision of Trust services.

The individual service user's risk assessment must address the following areas:

- harm to self or others;
- past history of aggression, its pattern, frequency and seriousness;
- likelihood of any possible incident;
- individuals who may potentially be at risk;
- precautions that already exist;
- any further actions that need to be taken to reduce risk.

Following risk assessment a reasoned judgement must be reached and recorded regarding the assessed degree of risk. Appropriate action and communication must then be taken on the basis of that judgement. The initial risk assessment will be reviewed and may change to reflect the ongoing management of the service user's care. Where there is disagreement between professionals regarding the proposed strategy of managing risk, decisions should be taken to a more senior level.

4.3 Communication of Risk Information

Managers and staff must consider their responsibility to provide information about significant risks which may affect other departments/services within the Trust. This should include sharing information about measures in place to address the risks. Information should be exchanged with all people who may be at risk in a timely and easily understood manner. Care must be taken to preserve the confidentiality of service user's information. Serious and imminent danger to others will however on rare occasions form a reasoned basis for the sharing of confidential information.

In addition, all managers have a legal responsibility (under Health and Safety legislation) to inform other persons not employed by the Trust who may be at risk due to the actions, or failure to act, of the Trust.

4.4 Recruitment and Selection

Recruitment and selection documentation should be explicit about the nature of the work, and any foreseeable risks in handling challenging behaviours. Profiles of facilities should be used and reviewed regularly. Recruitment panels, where appropriate, may assess staff's ability, (or potential ability) to deal with situations where aggressive behaviours may occur. At recruitment the pre-employment risk assessment process developed by Occupational Health should be followed.

4.5 Staff Learning and Development

4.5.1 Induction

Managers must ensure that all new staff attend the organisational induction programme. They must agree a personal development plan for the next twelve months for all new staff. New staff will be required to read and understand their responsibilities within the Management of Aggression policy. Line managers should discuss any questions and clarify issues so that new staff have a clear idea of what to expect and how best to manage the different situations.

Training courses should be available, if possible before service commences, or as soon as possible thereafter.

4.5.2 Monitoring and Supervision

People responsible for staff must assist staff with their professional development. They are also responsible for assisting with the development of a competent staff team by identifying training needs.

Ongoing monitoring of compliance with the requirements of the Management of Aggression policy and staff performance will be included in the supervision process.

4.5.3 Training and Development

All staff will have the opportunity to develop their knowledge and skills in a person-centred approach to managing aggression. Appropriate learning and development initiatives currently within the Trust will facilitate this process. The need for staff development will be identified as part of the process of risk assessment. Learning and development will be targeted to address assessment of actual risks and will include the use of information from previous incidents or potential incidents.

The experience and knowledge of service users and carers will be incorporated when staff development resources are being produced and implemented.

Overseeing learning and skills development will be the responsibility of the first line manager and should, where appropriate, include training in a multi-disciplinary and at times multi-agency fashion.

Management of Aggression learning and development objectives will be evaluated in terms of how effectively the knowledge and skills learned have been applied to the workplace by staff. This training should be service specific.

4.5.4 Performance Management and Redeployment

Managers have a responsibility to constantly monitor the performance of staff in managing aggression. If managers or staff are aware of any performance issues this should be addressed using some or all of the following options:

- counselling;
- further training;
- job advice;
- redeployment options;
- disciplinary action.

Where staff have experienced a particularly traumatic incident/s the manager has special responsibility to consider how best to support staff in the working environment.

4.6 Managing an Incident

4.6.1 Reporting, Investigating and Monitoring

Information is essential to assist in the reduction and prevention of incidents, the need for staff development and evaluation of the efficacy of training or other interventions.

The Trust's Incident Reporting Procedure must be implemented throughout Divisions as follows:

- all incidents of aggression must be reported as soon as possible to the person in charge of the relevant area/department by the person(s) directly involved;
- all staff must use the Trust's Incident Report Form to report all significant incidents of aggression (as defined in this policy) and forward immediately to the Incident Reporting Centre at Trust Headquarters;
- major incidents must be reported to the Incident Reporting Centre within 24 hours or as soon as possible. This is a legal requirement under the Reporting of Injuries Diseases and Dangerous Occurrences, (Northern Ireland), Regulations 1997. The responsibility for reporting under these regulations lies with the Risk Management Unit. Managers and staff discharge their responsibility once they have reported to the Incident Reporting Centre.

Line managers must investigate every incident that occurs within their business areas. However, serious or highly significant incidents must involve the Risk Management Unit.

These reporting and investigatory arrangements do not detract from the legal responsibilities placed upon the Trust to formally investigate and report on individual incidents where injury has occurred.

The significance of aggressive incidents will vary within the differing service areas in the Trust. It is the responsibility of the Service Manager to define which incidents are significant for their particular area.

The importance of reporting incidents should be promoted more positively by demonstrating how effective information collection and analysis can contribute to the implementation of appropriate change measures eg training initiatives, resource strategies etc..

Managers should monitor the frequency and severity of incidents in their business areas. The Risk Management Unit will produce reports at agreed intervals for managers to assist them in this task. Areas most at risk need to be clearly identified and remedial measures put in place.

4.6.2 Post Incident Support

The Trust wishes to promote a culture of support that permeates the total organisation. Each service should demonstrate a commitment to providing support to staff, service users and carers involved in an incident.

Service managers are responsible for ensuring that the individual receives the appropriate form of support.

The form of support should be responsive to individual need and the following options should be offered:

- support immediately after the incident within the department/unit (Group or individual);
- opportunity to go off duty;
- contact relative, friend or Trade Union representative;
- taxi Home/Transport arrangements;
- assistance and accompaniment to hospital;
- ongoing managerial contact with individual in a considerate/supportive manner;
- long-term support eg staff care, occupational health.

Managers should be aware of the potential long-term effects of an incident and the incremental effects of a series of incidents on their staff's well-being and performance.

If a member of staff feels it is necessary to pursue legal action against an aggressor in the context of their work the Trust will, where appropriate, offer emotional support to staff through the resulting legal process.

4.6.3 Post Incident Review

Each service should have an Incident Review Procedure. Service managers must demonstrate that their service reviews individual incidents within a prescribed time period from the incident occurrence, (ideally 4-7 days post incident).
It is the manager's responsibility to investigate all incidents of significance within their area of responsibility.

The process of incident review should involve consultation with those involved; ie staff, service user, carer or any other person involved in the incident. Each incident should be examined in terms of:

- antecedents – actions, stressors, behaviour etc that may have contributed to the incident;
- nature of incident;
- how it was handled – identify positive and negative staff interactions and strategies adopted that influenced the effectiveness with which the incident was handled.

4.6.4 Learning from Incidents

Incident Review should be regarded as an opportunity:

- to learn from experience;
- to obtain information to prevent/reduce the risk of further incidents;
- to improve services/resources where necessary;
- to promote a learning culture.

It is important that lessons are learned and conclusions drawn from each and every experience. Managers should promote learning from experience and team working throughout their business areas. Opportunities to share learning across the Trust should be maximised to prevent the reoccurrence of similar incidents in other Trust facilities/departments. These may include: management of aggression training sessions, team meetings, and manager's meeting.

4.6.5 Arrangements to Assist Staff Returning to Work Following an Incident

Every effort will be made to provide support to staff in returning to work following an incident. This will include:

- advice from Occupational Health;

- advice from Personnel Services;
- supportive return to work interview with the line manager;
- implementation as soon as possible, of any organisational learning from the incident;
- provision of any required training in management of aggression.

It is primarily the line-manager's responsibility to provide all possible positive support in re-integrating the member of staff back into the workplace.

4.6.6 Contact with External Organisations

Health and Safety Executive (Northern Ireland)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997, require that certain incidents of aggression must be reported to the Health and Safety Executive. In certain circumstances these reports must be made within 24 hours of the incident occurring. This is a legal requirement and failure to meet this requirement constitutes a criminal offence. The Risk Management Unit is responsible for making these reports and it is the responsibility of persons reporting incidents to report them promptly to the Incident Reporting Centre, Trust Headquarters. In cases of death or serious injury these reports should be made by telephone with the form sent on by post, as soon as possible.

Mental Health Commission

It is the responsibility of the Trust to immediately notify the Commission of the following:

- the death of any service user not resulting from natural causes in both the hospital and community settings;
- suspected suicides in both settings;
- sexual assaults in both settings;
- actual or alleged physical assaults by members of staff in both settings.

Where any of the above incidents have occurred within the community, the Commission would not normally require a report on service users who have not received care or treatment for a mental disorder for more than two years.

Written reports of incidents must be submitted to the Mental Health Commission within six weeks of the incident occurring and must include the following information:

- a brief account of the circumstances of the incident;
- information on the mental state of the service user, particularly at the time of the incident;
- information regarding any other person involved in the incident indicating whether staff, other service user or member of the public;
- a copy of the minutes of the multi-disciplinary review meeting.

Where there was no multi-disciplinary involvement with the service user the Commission expects to receive information on the Trust's own investigation of the incident including any proposed action taken as a result of the investigation.

The Commission expects that the Trust will record, monitor and review all incidents and will inspect records and review management's policies and procedures regarding all untoward events.

Registration and Inspection Unit (R&I Unit)

The same reporting requirements for the Mental Health Commission apply for this external agency. The R&I Unit only requires reports with regard to Trust's residential facilities.

Office of Care and Protection

Where any person suffering from a mental disorder has been referred to the Office of Care and Protection, and has been the victim of mishaps or accidents and suffered injury/loss/damage to property which might entitle him/her to compensation, then the Office of Care and Protection needs to be notified. This is to ensure the rights of such persons are protected.

Police Involvement

The Trust recognises the legal right of employees and others to be protected by the police. The Trust may in exceptional cases instigate legal proceedings for those situations in the interests of Trust staff and the community. This may be against the wishes of individuals who have suffered the consequences of aggression but it may be necessary for the protection of others.

The Trust's training programme and service specific procedures should include guidance for staff on the recognition of those situations when it would be appropriate to call for the assistance of the police.

APPENDIX 1 Committees and Groups with Management of Aggression Responsibilities

APPENDIX 2 OTHER RELEVANT TRUST DOCUMENTS

For example:

Health and Safety Policy

Untoward Incident Reporting Policy

Managing Diversity Policy

Confidentiality Policy

Managing Attendance Policy

Special Observation Policy

APPENDIX 3 RELEVANT LEGISLATION

Mental Health (Northern Ireland) Order 1986, ***ISBN 0-11-066595***

Children (Northern Ireland) Order 1995, ***ISBN 0-337-92257-8***

The Northern Ireland Health and Personal Social Services Order 1991

Health and Safety at Work Order (Northern Ireland) 1978 ***ISBN 0-11-084039-9***

Management of Health and Safety (Northern Ireland) Regulations (1992) ***ISBN 0-337-90359-X***

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (1997) ***ISBN 0-337-93043-0***

APPENDIX 4 SOURCES OF FURTHER INFORMATION

B.I.L.D, Physical Interventions, a policy framework, 1996, *ISBN 1-873791-86-0*

Dealing with Violence against Nursing Staff, an RCN Guide for Nurses and Managers, 1998, order code 000837

Violence at Work, UNISON

The Management of Aggression and Violence in Places of Care. An RCN position statement, 1997, order code 000 713

Mental Health (Northern Ireland) Order 1986, Code of Practice, 1992, *ISBN 0-337-077142*

Violence and Aggression to Staff in the Health Services. Guidance on Assessment and Management. Health and Safety Commission, Health Services Advisory Committee, 1997, *ISBN 0-7176-1466-2*

Management of Imminent Violence, clinical practice guidelines to support mental health services. Occasional paper, 1998, Royal College of Psychiatrists Research Unit.

Trainers in the Management of Actual or Potential Aggression. Code of Professional Conduct and Minimum Training Standards RCN Institute 1997

Practitioner-Client relationships and the Prevention of Abuse, UKCC, 1999

Code of Professional Conduct, UKCC, June 1992

Protecting the Public, UKCC, July 1997

Guidelines for Mental Health and Learning Disabilities Nursing, UKCC, April 1998

Guidelines for Records and Record-keeping, UKCC, October 1998.

ANNEX E

EXAMPLE OF HSS TRUST

Protocol on the Use of Physical Restraint

Mental Health Hospital Services and Adolescent Psychiatric Inpatient Services

TABLE OF CONTENTS

1.0 Introduction

This policy underpins the Trust's *"Management of Aggression Policy"* and should be read in conjunction with it. It is specifically written for Mental health Hospital Services and Adolescent Psychiatric Inpatient Services, it is not applicable to any other business area of the Trust.

The law requires that individuals do not unnecessarily/arbitrarily interfere with the rights of others, e.g. the use of physical intervention techniques. However, such action may be defended *if it is intended to prevent harm to the service user or others.* Trust staff must be able to demonstrate that they have acted at all times with regards to the best interest of the individual. All physical restraint must be carried out in accordance with the principles and ethos taught in the Management of Aggression training provided by the Trust.

Since staff have a responsibility for the health and safety of themselves and others, they must give assistance in managing aggression where and when necessary. This does not mean that all staff will become involved directly with the physical restraint of a service user, but that they may be able to provide other supporting assistance in meeting the needs of the situation.

In compliance with Section 75 of the Northern Ireland Act 1998, this policy/protocol has been drawn up, with the underlying principle, that this course of action should not adversely impact any of the 9 equality groups set out in Section 75 of the above Act.

2.0 When should physical restraint be used?

Physical restraint is designed to take control of a dangerous situation, limiting the person's freedom for no longer than necessary to end or reduce the potential harm to self or others.

Staff should attempt to remain calm and use de-escalation techniques before, and during, the use of physical restraint. Physical restraint should only be used when all other approaches at de-escalation have failed and/or physical aggression is actual or imminent.

The degree of restraint must be reasonable in the circumstances and the force used deemed the minimum required to deal with the potential harm. All physical restraint should be applied in a manner that attempts to defuse, rather than provoke, further aggression.

Physical restraint should only be employed as a proportionate response to aggression likely to harm the service user or others. Damage to property does not usually warrant the use of restraint, unless the act in itself is going to cause danger to others or the service users themselves.

The number of staff required to safely employ physical restraint will depend on the situation. If alone and faced with real or potential violence staff should attempt to escape from the situation, then summon assistance by the most appropriate means e.g. use of alarm systems, shout for help etc..

3.0 Training

[Provide information on any training available to staff.]

4.0 Best Practice in the use of Physical Restraint

There are basic principles that should be borne in mind when using physical restraint. These principles and practical guidance for their implementation are contained within the Trust's Management of Aggression training courses. Staff attending these courses will be provided with this knowledge and skill.

- Service users should be treated with respect at all times and their dignity maintained.

- De-escalation must be attempted at all times, continuous explanation and reassurance is required in restraint situations, the aim being to encourage the service users' co-operation and a return to voluntary control as soon as is safely possible.

- Well-briefed, trained and a co-ordinated staff response will be the most effective means of dealing with restraint situations.

- The aim is to restrain the service user safely in a low stimulus environment. This may mean moving the service user or asking others to leave.

- Preferably staff taking the lead in restraint situations should be those who have received training within the Trust as they will be able to provide advice and guidance to others.

5.0 Weapons

For the purpose of this document a weapon is defined as:

"Any object that is made, adapted or intended to be used to cause physical injury to a person"

A concise dictionary of Law (1192) pp 282
Oxford University Press, Oxford

Staff are not expected to disarm a person of a weapon that may be used to inflict harm on others, the Trust does not provide training on weapons disarmament. Judgements must be made using professional knowledge and

experience, risk assessment and management of aggression training. Reasonable efforts should be made to isolate the person with the weapon and to summon appropriate assistance to the situation, this may mean contacting the police.

6.0 Involvement of Police Service of Northern Ireland

There may be times when the level of threat posed or the nature of the attack means that staff are not appropriately, or safely, equipped to manage the situation and police involvement will be required. At these times it will be the responsibility of the nurse in charge of the unit to action appropriate assistance. The use of the police for assistance will trigger the completion of an untoward incident review.

7.0 Management of physical restraint

1. One person should take the lead in the restraint and nominate others to assist him/her.

2. In a team restraint situation the person taking care of the head should co-ordinate the restraint. The rest of the team should take their instruction from the co-ordinator.

3. The service users' co-operation should be sought and encouraged at all times.

4. Communication with the service user is imperative throughout and he/she should be kept informed of what is happening to encourage his/her co-operation.

5. All persons not involved in the restraint should be asked to leave however, other staff should be available to provide additional assistance if required.

6. The doctor should be called to see the service user as soon as possible after commencement of restraint in the adult wards. Young People's Centre staff should refer to the procedure for restraint of an individual in their unit.

7. A full account of the incident must be documented clearly and concisely in the service user's notes and on the incident form and a physical intervention monitoring form must be completed (see Appendix 1).

8. If physical restraint is employed for more than half an hour a review must be carried out by the nurse manager/duty nurse manager at that time, and every half-hour thereafter to ensure that only intermittent restraint is used. This review must be fully documented in the service user's notes.

9. Following restraint the nursing team must review their interventions. The multi-disciplinary team must review the interventions as soon as possible.

Appendix 1
Physical Intervention Monitoring Form - Sample

Trust
PHYSICAL INTERVENTION MONITORING FORM

Service User's Name	Service User's Number	Unit/Ward	Date of Incident

Exact time commenced and exact location am/pm	Exact time discontinued and exact location am/pm

Staff action(s) immediately PRIOR to using physical intervention (please tick

1. None-insufficient time		4. Administration of PRN medication	
2. Told the service user to stop		5. Counselling	
3. Attempts to de-escalate the situation (specific in comments section)		6. Other (specify in comments section)	

Why did you first intervene? ***(tick one box only)***
Aggressive behaviour in progress

1. Towards others	
2. To self	
3. Other (specify)	

Details of all people involved

Name	Job title	Role/Responsibility	Method used*

*Key
1. Looking after the head
2. Immobilisation of the legs
3. Immobilisation of an outstretched arm
4. Immobilisation of a bent arm
5. Immobilisation of the hand
6. Taking over from a colleague

Breakaway (please indicate point of contact eg wristgrab, method used to breakaway and subsequent actions.)

Service User's position during the restraint

Column 1 – Please indicate all positions that the service user was held in during the restraint process. Number from 1 accordingly.
1st position – 1,
2nd position – 2 etc
Column 2 – Please indicate the SINGLE position that was maintained the most throughout the restraint process

1. Sitting on a chair/sofa		
2. Sitting on a bed		
3. Sitting on the floor		
4. Kneeling on the floor		
5. Lying on a bed – face up		
6. Lying on a bed – face down		
7. Lying on the floor – face up		
8. Lying on the floor – facedown		
9. Walking to another area		
10. Standing		

Use of protective clothing or other equipment by staff

Not used		Plastic apron	
Latex gloves		Cut-resistant gloves	
Ligature cutters		Eye wear	

Injuries occurring during the intervention process

Service User	*Injury*	*Staff*
	No visible injury	
	Reddening/bruising	
	Swelling	
	Lacerations/Cuts	
	Scratches	
	Friction burns	
	Thermal burns/Scalds	
	Other – Please specify In the 'comments' box	

Subsequent Action
'As required' medication given

No Further Action Required ☐ **Orally** ☐ **Injection** ☐ **Time administered** ☐

Comments: Further details of actual behaviour preceding restraint, and attempts made to prevent the situation escalating any injuries sustained, use of protective clothing or equipment and any other relevant points.		
Date of Completion	Name of person leading	Signature
For administration use only Incident form no……	Copies to: Incident Report Centre	

TO BE COMPLETED BY THE PERSON IN CHARGE AT THE TIME OF THE PHYSICAL INTERVENTION TAKING PLACE

ANNEX F

EXAMPLE OF HSS TRUST

POLICY ON SECLUSION

Definition for Seclusion

The forcible denial of the company of other people by constraint within an enclosed environment.

(Code of practice Mental Health NI Order 1986)

The objective of seclusion is the short term safe containment of patients who are displaying severely disturbed behaviours which are likely to cause harm to themselves or others. It is an emergency management procedure, used only when all other reasonable steps/measures have been exhausted.

Seclusion facilities

Seclusion should be in a safe, secure and clearly identified room which offers maximum opportunity for observation. The room should have adequate heating, lighting and ventilation. Patients should be asked regularly if they require to use the toilet and be escorted to and from the toilet. Staff must make a careful judgement as to what the patient is permitted to take into the room. The patient must always be clothed when placed in seclusion but all belts, ties and shoe laces that could cause harm must be removed. Safety must always be a priority.

The decision to authorise any visit to a patient in seclusion rests with the patients consultant or a medical officer acting on the consultants behalf.

Courtyards should not be sued for seclusion. Where patients wish to access a Courtyard the door must remain unlocked, permitting the patient to re-enter the unit.

Procedure for the use of seclusion

The initial decision to place a patient in seclusion can be taken by:

The Medical Officer
The Nurse-In-Charge of the unit
The Nurse Duty Officer

Where the decision is taken by someone other than a doctor the medical officer should be contacted immediately. The patient should be constantly observed by a designated nurse until the authorisation is obtained from the medical officer.

If not involved in the decision to seclude a patient the nurse duty officer should be informed as soon as possible.

Where seclusion is required frequently or for extended periods, the patient must be referred to the multi-disciplinary team for consideration of their legal status, if not subject to detention.

A nurse should be present and observe the patient from outside the seclusion room door when:

A. the patient has been sedated prior to being secluded.

B. The patient is on constant supervision.

The purpose of seclusion should be explained to the patient, where possible.

Observation

The objective of observation is to assess the condition of the patient, ensure his/her well-being and to determine whether seclusion can be terminated.

The patient should be directly observed at least every 15 minutes and more frequently if individual circumstances demand. A documented report must be made every 15 minutes. This should include information on the patients mood, behaviour, appearance and any request made by the patient. In the case of continued seclusion a review should take place every two hours by the nurse in charge and every four hours by a doctor.

If seclusion continues for more than eight hours consecutively or 12 hours in total over a period of 48 hours, the responsible consultant should be informed by the nurse in charge, to ascertain if a review is necessary.

Record keeping

Detailed records should be maintained in the patients care plan of any use of seclusion, this will include:-

The reasons for its use
Time commenced
Medical staff involved and time of notification
Nurse Duty Officer and time of notification
Nurse in charge of unit
Staff to patient ratio
Staff allocated for observation
Reports on observation and reviews
Time terminated

In addition to recording in the patient care plan, the information will also be forwarded via the day/night report to Nursing Administration for central recording/audit purposes.

Patient requested "Seclusion"

Seclusion is not regarded as a treatment technique. However there may be times when a quiet period in a room may help to reduce agitation or alleviate distress. Individual patients may request time separated from the presence of others. This is not regarded as seclusion unless the door is locked.

Occasionally the patient may request/insist that the door be locked. Where the patient can open the door from inside the room this is not defined as seclusion, however where a patient request time alone in a locked room and cannot open the door from inside this should in all circumstances be regarded as seclusion. The patient should be observed every 15 minutes as per policy and asked if they wish to leave the seclusion room. Seclusion must be terminated immediately on request by the patient.

Use of unlocked seclusion room

There may be occasions where the seclusion room is accessed by a patient with the door unlocked, this does not meet the definition of seclusion. In all cases it should be authorised by the Nurse-In-Charge, discussed with the multi-disciplinary team and recorded in the patients care plan and day/night report.

ANNEX G

QUESTIONNAIRE AND SUMMARY OF FINDINGS

1. To assist in establishing the current position, a questionnaire was issued in June 2003 to all HSS Trusts and to a range of other service providers.

2. The questionnaire issued to providers is attached as an Appendix to this annex.

3. A total of 81 responses were received, greater than the number of organisations approached as in some cases corporate responses were received from units within organisations while others gave a single response. 54 responses were received from HSS Trusts, including Hospital HSS Trusts and Community HSS Trusts, and 27 from voluntary or private organisations and both adult and children's services were covered.

4. The questionnaires asked about restraint and seclusion policies and practices under four main headings:

   Policies and Procedures
   Monitoring Arrangements
   Training
   Complaints Procedure

Policies and Procedures

5. Most of the organisations responding indicated that some policies and procedures on restraint and seclusion were in place: for restraint of adults – 46; restraint of children – 13; seclusion of adults – 6; and seclusion of children – 5. There were 17 organisations which said they did not have or did not need these policies or procedures – however, some of these were in the process of developing a policy. Of those with policies and practices, a number were high level policies, and others were by reference to standards and guidance of professional organisations, eg Royal College of Nursing. Some were detailed documents for the particular organisation and others were relatively brief guidelines. In some instances, although lacking a policy on restraint or seclusion, training was provided on management of violence and aggression.

6. A few organisations (9 in total) said they had facilities for seclusion.

Monitoring Arrangements

7. 15 organisations indicated they had conducted a local audit of practice in relation to restraint and 5 in relation to seclusion.

8. Proformas were available in 32 organisations for recording restraint and in 9 organisations for seclusion.

9. Arrangements were in place to review each client group in the use of restraint in 42 organisations and on the use of seclusion in 8 organisations.

Training

10. For restraint, 53 organisations provided information to their staff of policies and procedures and 39 provided training to staff. For seclusion, 9 organisations indicated that they provided information and 5 training.

11. On the inclusion of human rights implications in training, 33 organisations indicated that it was included for restraint and 7 for seclusion.

Complaints

12. The response to the questionnaire indicated that 45 organisations had mechanisms in place to scrutinise complaints on restraint and 7 had mechanisms in place for seclusion.

Outcome

13. The responses to the questionnaires and the accompanying papers provides very useful background to the working group in establishing the current positions and considering the extent and content of the guidance required.

Annex G, Appendix

HSS TRUST/OTHER SERVICE PROVIDER

QUESTIONNAIRE ON RESTRAINT & SECLUSION

(Please return completed Questionnaires by 27 June 2003)

Name of Trust/Other service provider: …….

Name of Member of staff
responsible for completing
this questionnaire: ……..…….

Position in Organisation: ……

Business area/programme of care ……

Contact telephone number:…..……...

E-mail address: ……

Policies & Procedures

1. Do you have policies and procedures, which inform, across all client groups, the use of:

- restraint of adults Yes ☐ No ☐
- restraint of children Yes ☐ No ☐
- seclusion of adults Yes ☐ No ☐ N/A ☐
- seclusion of children Yes ☐ No ☐ N/A ☐

If you have answered **Yes** to any of the above please forward copies of the policies and procedures when returning the completed questionnaire.

If you have answered **No** please outline below what arrangements are in place to regulate the use of **both** restraint and seclusion.

2. Do you have a definition of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please forward a copy of these with the completed questionnaire.

3. Do you have facilities for seclusion: Yes ☐ No ☐

If **Yes** please provide details on the facility and any other information which you feel would be helpful to us in understanding your provision.

Monitoring Arrangements

4. Has your organisation conducted a local audit of practice in relation to:

- the use of restraint with any client group Yes ☐ No ☐
- the use of seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please forward a copy of the audit report with the completed questionnaire.

5. Do you have pro forma for each client group to record use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please forward a copy of the pro forma with the completed questionnaire.

6. Do you have arrangements in place to review each client group the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please provide copies of any pro formas used **or** outline below these arrangements.

Training

7. Do you have arrangements in place to inform staff across all professional groups and programmes of care of your policies and procedures regarding the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please outline the arrangements below

8. Do you provide training to staff on the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please attach a sheet detailing the **range** of training provided, the **frequency** at which it is provided and the **number** of staff trained each year. If you have a written training programme on restraint and/or seclusion, please enclose it with the completed questionnaire.

9. Please name the type of training provided, indicating, where appropriate, the accrediting body.

10. Does your training include consideration of the human rights implications of using:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If you have answered **Yes** please outline the issues covered.

Complaints Procedures

11. Do you have mechanisms in place to scrutinize complaints to identify weaknesses and areas for action in respect of the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If you have answered **Yes** please provide details below, including how you have specifically addressed restraint and seclusion issues in this process.

12. If you have any other comments, which you feel would assist us in this area please outline these.

Completed Questionnaires should be returned **by 27 June 2003 to:**

Mrs Heather Humphries
Room C4.22
Castle Buildings, Stormont
BELFAST BT4 3SQ
Email [redacted]

Many thanks for your assistance

ANNEX H

DRAFT GUIDANCE ON RESTRAINT AND SECLUSION IN HEALTH AND PERSONAL SOCIAL SERVICES

EQUALITY IMPACT ASSESSMENT: EQUALITY SCREENING

1. BACKGROUND

1.1 Section 75 of the Northern Ireland Act 1998 requires all public authorities in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity -

- **between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;**
- **between men and women generally;**
- **between persons with a disability and persons without; and**
- **between persons with dependants and persons without.**

1.2 In addition, without prejudice to the above obligation, public authorities must also, in carrying out their functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

1.3 Schedule 9 of the Act requires public authorities to prepare Equality Schemes, which should state, among other things, the authorities' arrangements for assessing the likely impact of policies adopted, or proposed to be adopted, by the authority on the promotion of equality of opportunity. Schedule 9 also requires a public authority, in publishing the results of an assessment, to give details of any consideration given to measures which might mitigate any adverse impact of the policy on the promotion of equality of opportunity and alternative policies which might better achieve the promotion of equality of opportunity.

1.4 Equality Schemes are in place for the Department of Health, Social Services and Public Safety and all Health and Social Services Boards and Trusts. The Department and its associated bodies are committed to promoting equality of opportunity.

2. PROPOSALS

2.1 The proposed guidance on Restraint and Seclusion in Health and Personal Social Services (HPSS) is intended to assist HPSS bodies in developing and implementing policies on restraint and seclusion. The purpose is to protect and promote the human rights of anyone in their care who may be subject to such procedures. It is designed to help ensure compliance with, and respect for, the provisions of the Human Rights Act, which gives effect to the European Convention on Human Rights, and other human rights conventions.

2.2 Restraint and seclusion issues, as defined in the guidance, may arise in a range of care settings, such as residential homes for the elderly, children or disabled people, in hospitals, in day-care centres, health centres and where people are being cared for in their own homes.

3. EQUALITY IMPACT ASSESSMENT SCREENING

3.1 Specific areas of concern in relation to the issues of restraint and seclusion may arise for young people, older people and persons with a disability who are in a position of being cared for, whether in a residential setting or otherwise. It is therefore possible that these proposals could differentially impact on **persons of different age** and **persons with or without a disability**. However, no quantifiable evidence is available on the groups subject to restraint and seclusion procedures in HPSS.

3.2 There is no indication of any differential impact in terms of the other seven Section 75 distinctions:

- **between men and women generally;**
- **persons of different marital status;**
- **persons of different religious belief;**
- **persons with/without dependants;**
- **persons of different political opinion;**
- **persons of different racial group;**
- **persons of different sexual orientation.**

3.2 These proposals are intended to inform the development of policies by Health and Social Services Trusts, Boards and other agencies. All public authorities designated as such for the purposes of Section 75 will in any event have to screen these policies as they are developed, to determine whether a full Equality Impact Assessment is desirable. This fact affords a double safeguard regarding equality of opportunity.

4. CONCLUSION

4.1 The proposals are intended to be entirely beneficial in protecting and preserving the human rights of the people affected. There is no adverse impact on other people. Accordingly, it is considered that the proposals do not have an adverse impact in terms of any of the Section 75 distinctions.

4.2 It is also considered that these proposals will have no effect on good relations between persons of different religious belief, political opinion or racial group.

ANNEX I(a)

HSS TRUST

RESTRAINT REPORT FORM

This form should be completed if physical restraint is used in the management of any incident or accident.

Physical restraint refers to any method of responding to aggressive or violent behaviour which involves some degree of direct physical force to limit or restrict movement or mobility, ie the actions of one person which restricts the movements of another person. Physical restraint implies the restriction of a person's movement which is maintained against resistance. It is therefore qualitatively different form other forms of physical contact such as manual prompting, physical support or guidance.

Physical Restraint may involve:

1. **Direct physical contact between a member of staff and a client** eg holding a client's hand to prevent him hitting etc.
2. **The use of barriers, such as locked doors, to limit freedom of movement,** eg placing someone in a chair with a table in front so that he/she can cannot easily stand up or move away, locking doors, etc.
3. **Materials or equipment which restrict or prevent movement,** eg strapping someone into a wheelchair, having a person wear a helmet to reduce the effects of head banging, placing splints on a person's arms to restrict movement, etc.

(A) Form Reference Number ☐

(B) Type of Restraint used: Physical Contact ☐ Barriers ☐ Equipment ☐

(C) Outline the reasons why restraint was used

(D) Outline details of the method of restraint used (who was involved in the restraint procedure; what procedure was used; who carried out different elements of the procedure; what areas of eth body were in contact etc).

(E) Time restraint started: (24 hr clock) ☐ Time restraint stopped: (24 hr clock) ☐

(F) Outline the individual's response to the restraint procedure being applied.

(G) Was a body check of the individual completed following the restraint procedure?

Check completed	Check refused	Delayed as may have caused Further aggression
☐	☐	☐

Outline details of any injury noted

(H) Outline the tasks completed in recording and reporting this incident (eg IRI form completed; reported incident to carer, manager etc)

(I) Outline any issues arising from this incident which may influence future contact with this individual.

Name of person Completing form _____ Signature _____

Date _____

Please return to _____ by _____

ANNEX I(b)

HSS TRUST

SECLUSION REPORT FORM

Ward No. Date:

Patient's Name _____ Status and Reg No. _____

Description of Incident _____

Alternative Measures Tried Prior to Seclusion _____

Patient checked for harmful objects/clothing | Yes/No |

Nurses present _____

Authorisation for seclusion given by _____

Ward Doctor/Duty Doctor informed _____ At _____

Visited by Doctor _____ At (time) _____

Senior Nurse Manager _____ Notified at (time) _____

Duration of Seclusion: From _____ To _____

Monitor Chart Completed | Yes/No

2 Hourly Review by Nurses _____

4 Hourly Review by Doctor _____

Signed: _____
(Nurse in Charge)

CLINICAL SERVICES MANAGER'S REPORT

Signed: _____

ANNEX J

DENI CIRCULAR NUMBER 1999/9 –

PASTORAL CARE: GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

Subject:

Pastoral Care: Guidance on the Use of Reasonable Force to Restrain or Control Pupils

Circular Number:
1999/9

Date of Issue:
8 March 1999

Audience:

- Principals and Boards of Governors of all grant-aided schools;
- Education and Library Boards;
- Council for Catholic Maintained Schools;
- Association of Governing Bodies of Voluntary Grammar Schools;
- Northern Ireland Council for Integrated Education; and
- Teachers' Unions.

Summary of Contents:

This Circular provides clarification and guidance on the use of reasonable force, by teachers and other authorised staff, to restrain or control pupils in certain circumstances. It gives guidance about who can use reasonable force, when it is appropriate to use it, and the procedures for recording incidents where reasonable force was used. It also advises that schools should have a written policy about the use of reasonable force which should be made known to parents.

Enquiries:

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

Mr Jackie Simpson (Tel: 01247-279247)
Pupil Support Branch
Department of Education
Rathgael House
Balloo Road
BANGOR
BT19 7PR

Status of Contents:
Advice
Information for schools

Related Documents:
Circular 1999/10
(Pastoral Care in Schools: Child Protection)

Superseded Documents:
None

Expiry Date:
Not applicable

DENI Website:
This Circular is also available on http://www.deni.gov.uk

PASTORAL CARE: GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

1. All schools have a pastoral responsibility towards the pupils in their charge and should therefore take all reasonable steps to ensure that the welfare of pupils is safeguarded and that their safety is preserved. The Board of Governors and the Principal of each school also have a duty to promote and secure good behaviour and discipline on the part of pupils at the school.

2. Article 4 of the Education (Northern Ireland) Order 1998, which came into force on 21 August 1998, clarifies powers which already exist under common law. It enables a member of staff of a grant-aided school to use, in relation to any pupil at the school, such force as is reasonable in the circumstances to prevent a pupil from:

a. committing an offence;

b. causing personal injury to, or damage to the property of, any person (including the pupil himself); or

c. engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils, whether during a teaching session or otherwise.

3. The right of a member of staff to use such force as is reasonable to restrain or control a pupil applies:

- where the member of staff is on the premises of the school; or
- elsewhere at a time when he/she has lawful control or charge of the pupil concerned;
- to teachers at the school, **and** to any other member of staff who with the authority of the principal has lawful control or charge of pupils.

4. **The need to use reasonable force to restrain or control a pupil should be rare.** This Circular and the attached Appendix provide clarification and guidance on a number of issues relating to the use of "reasonable force" by teachers and others to restrain or control pupils. **However, it is emphasised that corporal punishment remains unlawful, and that neither Article 4 nor this Circular, in any way, authorise teachers or others to use any degree of physical contact which is deliberately intended to cause pain or injury or humiliation.** The application of reasonable force to restrain or control a pupil is to be used as a last resort, only when other behaviour management strategies have failed, and when the pupil, other pupils, members of staff, or property are at risk, or the pupil is seriously compromising good order and discipline.

Article 4 does not however prevent any person from exercising his/her right under common law to defend themselves against an attack provided he/she does not use a disproportionate degree of force to do so. The purpose of Article 4 is to make it clear that teachers, and authorised staff, are also entitled to intervene in other, less extreme, situations.

Need for Schools to Have a Written Policy

5. The use of reasonable force is only one of the strategies available to schools and teachers to secure pupils' safety and well being and also to maintain good order and discipline. All those who may have to use reasonable force with pupils must clearly understand the options and strategies open to them, and they must know what is regarded as acceptable action on their part and what is not. It is important, therefore, that schools have a clear written policy about the use of reasonable force to restrain or control pupils. This should be understood by teachers, authorised staff, pupils and parents and should form part of the school's policy on discipline and child protection within its overall pastoral care policy.

6. In drawing up a written statement of the school's disciplinary policy, as required in Article 3 of the 1998 Order, it is recommended that the Board of Governors, in consultation with the Principal, should:

- include a statement setting out the school's policy and its guidelines on the use of reasonable force to restrain or control pupils;
- discuss these with staff who may have to apply them; and
- issue or make them known to parents and pupils.

Boards of Governors should also have regard to any advice issued by Education and Library Boards and, where appropriate, the Council for Catholic Maintained Schools.

7. The Department has asked a Working Group, comprising representatives from the Education and Library Boards, CCMS and schools, who are already drafting best practice guidelines for schools on a wide range of disciplinary matters, to draft a model policy for schools on the use of reasonable force based on the guidance in this Circular. This will be available later this year. Schools may wish to draw up their own policies in the meantime in order to provide guidance to staff and others on the use of reasonable force and its place in the school's strategies for maintaining good behaviour and discipline.

8. A statement of the school's policy on the use of reasonable force to restrain or control pupils should be included with the information the school gives parents about its overall policy on discipline and standards of behaviour.

9. The Department considers that it would also be useful if schools designated an experienced senior member of staff (the Principal or a senior teacher, or perhaps the designated teacher for child protection) as having special responsibility for providing guidance to other staff on the use of reasonable force. This teacher should also assume responsibility for notifying parents about incidents where reasonable force has had to be used and for dealing with any complaints which may emerge. This will help to ensure a consistent approach within the school to the use of reasonable force and the reporting arrangements.

C JENDOUBI (MRS)
School Effectiveness Division

Appendix

GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

Who may use reasonable force?

Teachers

1. Article 4 of the 1998 Order authorises teachers to use such force as is reasonable in the circumstances to prevent a pupil from:

- committing an offence;
- causing personal injury to, or damage to the property of, any person (including the pupil himself); or
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils whether during a teaching session or otherwise.

Non-teaching staff

2. Other members of staff at the school are also authorised to use reasonable force in the circumstances described at 1. above, provided they have been authorised by the Principal to have lawful control or charge of pupils. This might, for example, include classroom assistants, midday supervisors, and escorts. In addition the authorisation could extend to education welfare officers and educational psychologists.

3. In determining which non-teaching staff to authorise, Principals will wish to have regard to the roles and responsibilities of the staff concerned. In particular they should consider whether the staff have a responsibility to supervise pupils as part of their normal duties or whether, from time to time, they may have to take on that responsibility when a teacher is not present.

Volunteers

4. Suitably vetted volunteers normally work only under the direction and supervision of a teacher or other member of staff and should not be expected to assume sole responsibility for the safety and well-being of pupils. Where a situation arises, therefore, where the use of reasonable force may need to be exercised, the volunteer should alert the member of staff in charge and defer to his/her judgement as to the appropriate means of handling the situation.

There may, however, be circumstances in which the Principal may need to authorise a volunteer to use reasonable force in exceptional circumstances. These might include school visits, holidays and residential activities where some degree of delegated responsibility may have to be given to the volunteers in the organisation of activities; where a member of school staff may not be readily available to deal with an incident; and where it is possible that significant harm will occur if action

is not taken immediately. Where volunteers are so authorised, it is essential that they receive appropriate training and guidance.

5. **The key issue is that all non-teaching staff and volunteers must be identified and specifically authorised by the Principal to be in control of or in charge of pupils.** The Principal should clearly inform all persons concerned and ensure that they are aware of and understand what the authorisation entails. Principals may find it helpful to arrange for training or guidance to be provided by a senior member of the teaching staff who has been designated as having special responsibility for this matter and who has already received suitable training on the use of reasonable force. Principals should also keep an up to date list of authorised non-teaching staff and others who are so authorised and ensure that teachers know who they are, for example, by placing a list on the staff room notice board.

Where can reasonable force be used?

6. The right of a teacher or other person to use reasonable force applies where the pupil concerned is on the school premises **and** when he/she has been authorised to have lawful control or charge of the pupil concerned elsewhere e.g. supervision of pupils in bus queues, on a field trip, or other authorised out of school activity such as a sporting event or educational visit.

What is meant by reasonable force?

7. There is no precise legal definition of "reasonable force" so it is not possible to state, in fully comprehensive terms, when it is appropriate to use physical force to restrain or control pupils or the degree of force that may reasonably be used. It will always depend on the circumstances of each case. However, there are three relevant considerations to be borne in mind:

- the **use of force** can be regarded as reasonable **only** if the circumstances of the particular incident warrant it. The use of any degree of force is unlawful if the particular circumstances do not warrant the use of physical force. Therefore physical force could not be justified to prevent a pupil from committing a trivial misdemeanour, or in a situation that clearly could be resolved without force;

- the **degree of force** employed must be in proportion to the circumstances of the incident and the seriousness of the behaviour or the consequences it is intended to prevent. Any force used should always be the minimum needed to achieve the desired result;

- whether it is reasonable to use force, and the degree of force that could reasonably be employed, might also depend on the age, level of understanding and sex of the pupil, and any physical disability he/she may have.

Is it appropriate to use reasonable force in every situation?

8. **Reasonable force should not be used automatically in every situation nor should it be used as a form of discipline. In a non-urgent situation, reasonable force should only be used when other behaviour management strategies have failed.** That consideration is particularly appropriate in situations where the aim is to maintain good order and discipline, and there is no

direct risk to people or property. Any action which could exacerbate the situation needs to be avoided, and the possible consequences of intervening physically, including the risk of increasing the disruption or actually provoking an attack, need to be carefully evaluated. The age and level of understanding of the pupil is also very relevant in those circumstances - physical intervention to enforce compliance with staff instructions is likely to be increasingly inappropriate with older pupils and **should never be used as a substitute for good behaviour management.**

9. Staff may not always have the time to weigh up the possible courses of action and it would be prudent therefore for them to have considered in advance the circumstances when they should and should not use reasonable force. Staff should, whilst taking due account of their duty of care to pupils, always try to deal with a situation through other strategies before using reasonable force. All teachers need to be aware of strategies and techniques for dealing with difficult pupils and situations which they can use to defuse and calm a situation. Best practice guidelines on successful discipline policies are currently being drawn up by a Working Group comprising representatives from schools, the Education and Library Boards and CCMS. These will be circulated to all schools shortly.

When might it be appropriate to use reasonable force?

10. In a situation where other behaviour management strategies have failed to resolve the problem, or are inappropriate (eg in an emergency), there are a wide variety of circumstances in which reasonable force might be appropriate, or necessary, to restrain or control a pupil. They will fall into three broad categories:

a. where action is necessary in self-defence or because there is an imminent risk of injury;

b. where there is a developing risk of injury, or significant damage to property;

c. where a pupil is behaving in a way that is compromising good order and discipline.

11. Examples of situations that fall into one of the first two categories are

- a pupil attacks a member of staff, or another pupil;
- pupils are fighting;
- a pupil is causing, or at risk of causing, injury or damage by accident, by rough play, or by misuse of dangerous materials, substances or objects;
- a pupil is running in a corridor or on a stairway in a way in which he/she might have or cause an accident likely to injure him- or herself or others;
- a pupil absconds from a class or tries to leave school (**NB this will only apply if a pupil could be at risk if not kept in the classroom or at school**).

12. Examples of situations that fall into the third category are:

- a pupil persistently refuses to obey an order to leave a classroom;
- a pupil is behaving in a way that is seriously disrupting a lesson.

13. However, some practical considerations also need to be taken into account:

- Before intervening physically a member of staff should seek to deploy other behaviour strategies. Where these have failed, the member of staff should, wherever practicable, tell the pupil who is misbehaving to stop, and what will happen if he/she does not. The member of staff should continue attempting to communicate with the pupil throughout the incident, and should make it clear that physical contact or restraint will stop as soon as it ceases to be necessary. A calm and measured approach to a situation is needed and staff should never give the impression that they have lost their temper, or are acting out of anger or frustration, or to punish the pupil.

- Sometimes a member of staff should not intervene in an incident without help (unless it is an emergency), for example, when dealing with an older pupil, or a physically large pupil, or more than one pupil, or if the teacher believes he/she may be at risk of injury. In those circumstances the member of staff should remove other pupils who might be at risk, and summon assistance from a colleague or colleagues, or where necessary telephone the Police. The member of staff should inform the pupil(s) that he/she has sent for help. Until assistance arrives the member of staff should continue to attempt to defuse the situation orally, and try to prevent the incident from escalating.

- Situations where a pupil refuses to obey an order to leave a classroom need to be handled carefully as they can be a prelude to a major confrontation, especially if reasonable force is used to eject older pupils. Where a pupil persistently refuses to leave a classroom and the teacher believes that the use of reasonable force will endanger the teacher or other pupils, the school should have an emergency response procedure whereby assistance can be summoned quickly, for example a trusted pupil is sent for help.

- If a school is aware that a pupil is likely to behave in a disruptive way that may require the use of reasonable force, it will be sensible to plan how to respond if the situation arises. Such planning needs to address:

  - managing the pupil (eg reactive strategies to de-escalate a conflict, holds to be used if necessary);
  - involving the parents to ensure that they are clear about the specific action the school might need to take;
  - briefing staff to ensure they know exactly what action they should be taking (this may identify a need for training or guidance);

- ensuring that additional support can be summoned if appropriate.

What might be regarded as constituting reasonable force?

14. Physical intervention can take a number of forms. It might involve staff:

- physically interposing between pupils;
- blocking a pupil's path;
- holding;
- pushing;
- pulling;
- leading a pupil by the arm;
- shepherding a pupil away by placing a hand in the centre of the back; or
- (in extreme circumstances) using more restrictive holds.

15. In exceptional circumstances, where there is an immediate risk of injury, a member of staff may need to take any necessary action that is consistent with the concept of "reasonable force", for example, to prevent a young pupil running off a pavement onto a busy road, or to prevent a pupil hitting someone, or throwing something. **However, staff should never act in a way that might reasonably be expected to cause injury, for example by:**

- holding a pupil round the neck, or by the collar, or in any other way that might restrict the pupil's ability to breathe;
- slapping, punching, kicking or using any implement on a pupil;
- throwing any object at a pupil;
- twisting or forcing limbs against a joint;
- tripping up a pupil;
- holding or pulling a pupil by the hair or ear;
- holding a pupil face down on the ground.

16. Staff should also avoid touching or holding a pupil in any way that might be considered indecent.

What action can be taken in self-defence or in an emergency situation?

17. Neither Article 4 nor the guidance contained in this Circular can cover every possible situation in which it might be reasonable for someone to use a degree of force. For example, everyone has the right to defend themselves against an attack provided they do not use a disproportionate degree of force to do so. Similarly, in an emergency, for example if a pupil is at immediate risk of injury or on the point of inflicting injury on someone else, **any** member of staff would be entitled to intervene whether or not specifically authorised by the Principal to do so. The purpose of Article 4 and this Circular is to make it clear that teachers, and authorised staff, are also entitled to intervene in other, less extreme, situations.

Is physical contact with pupils appropriate in other circumstances?

18. The Code of Conduct for staff which has been issued to all schools makes it clear that, although physical contact with pupils should generally be avoided, there can be occasions when physical contact with a pupil may be proper or necessary other than those situations covered by Article 4. For example, some physical contact may be necessary to demonstrate exercises or techniques during PE lessons, sports coaching, music or technology and design, or if a member of staff has to give first aid. Young children and children with special educational needs may also need staff to provide physical prompts or help. Touching may also be appropriate where a pupil is in distress and needs comforting. Teachers should use their own professional judgement when they feel a pupil needs this kind of support. Guidance on these issues can be found in the Code of Conduct, and also in paragraphs 73 and 74 of the booklet accompanying Circular 1999/10 (Pastoral Care in Schools: Child Protection).

19. There may be some children for whom touching is particularly unwelcome, because, for example, they have been abused. Physical contact with pupils becomes increasingly open to question as pupils reach and go through adolescence, and staff should also bear in mind that even innocent and well-intentioned actions can sometimes be misconstrued.

Should incidents where reasonable force is used be recorded?

20. It is extremely important that there is a detailed, contemporaneous, written report of any occasion (except minor or trivial incidents) where reasonable force is used. This may help prevent any misunderstanding or misrepresentation of the incident, and it will be helpful should there be a complaint. Schools should keep an up-to-date record of all such incidents, in an incident book. Immediately following any such incident the member of staff concerned should tell the Principal or a senior member of staff and provide a short written factual report as soon as possible afterwards. That report should include:

- the name(s) of the pupil(s) involved, and when and where the incident took place;
- the names of any other staff or pupils who witnessed the incident;
- the reason that force was necessary (eg to prevent injury to the pupil, another pupil or a member of staff);

- briefly, how the incident began and progressed, including details of the pupil's behaviour, what was said by each of the parties, the steps taken to defuse or calm the situation, the degree of force used, how that was applied, and for how long;
- the pupil's response, and the outcome of the incident;
- details of any obvious or apparent injury suffered by the pupil, or any other person, and of any damage to property.

At least annually, the Chairman of the Board of Governors and the Principal should review the entries in the incident book. Records of incidents should be kept for 5 years after the date they occurred.

21. Staff may find it helpful to seek advice from a senior colleague (eg the Principal or senior member of staff who has been designated to provide training and guidance on the use of reasonable force), or a representative of their professional association when compiling a report. They should also keep a copy of the report.

22. Incidents involving the use of force can cause the parents of the pupil involved great concern. It is always advisable to inform parents of an incident involving their child (other than a trivial incident), and give them an opportunity to discuss it. The Principal, or a member of staff to whom the incident is reported, will need to consider whether that should be done straight away or at the end of the school day, and whether parents should be told orally or in writing.

Are complaints about the use of reasonable force likely to occur?

23. Involving parents when an incident occurs with their child, and having a clear policy about the use of reasonable force that staff adhere to, should help to avoid complaints from parents. It will not, however, prevent all complaints, and any complaint from a parent about the use of reasonable force on his/her child should be dealt with in accordance with the procedures set out in the booklet accompanying Circular 1999/10 (Pastoral Care in Schools: Child Protection).

24. The possibility that a complaint might result in a disciplinary hearing, or a criminal prosecution, or in a civil action brought by a pupil or parent, cannot be ruled out. In these circumstances it would be for the disciplinary panel or the court to decide whether the use and degree of force was reasonable in all the circumstances. In doing so, the disciplinary panel or court would have regard to the provisions of Article 4. It would also be likely to take account of the school's policy on the use of reasonable force, whether that had been followed, and the need to prevent injury, damage, or disruption, in considering all the circumstances of the case.

Will suitable training and supporting advice on the use of reasonable force be provided for teachers and other authorised staff?

25. Education and Library Boards are being asked to arrange suitable training courses for a senior teacher in each school who will then be responsible for providing "cascade" training and advice to other staff in the school. Boards are being asked to place an emphasis on and cover behaviour management strategies which seek to avoid the need to use reasonable force to restrain or control pupils. Such training will be in the context of schools' behaviour and child protection

policies. Arrangements are also being made for suitable training to be included as part of INSET and initial teacher training courses.

26. The Education and Library Boards are also establishing multi-disciplinary Behaviour Support Teams, to offer professional advice and practical support to schools on a range of behavioural and disciplinary matters, including the use of reasonable force.

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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Department of Health
Mental Health Action Plan

MAHI - STM - 127 - 306

Ministerial foreword

As a population we are only too aware that mental health, and mental ill health, is a huge challenge for our society. Too many people are struggling to access appropriate mental health services when they need them and suicide is robbing our communities of too many young lives.

When I became Health Minister I set out very clearly that mental health would be one of my top priorities. I am therefore very pleased to publish this Mental Health Action Plan, which will deliver key improvements to services in the short term, while preparing the ground for future strategic change. Three actions stand out. Firstly, in this Action Plan I am confirming the commitment to co-produce a Mental Health Strategy. Secondly, I am confirming my announcement of 27 April to create a Mental Health Champion to champion and enhance mental health in all aspects of public life. Thirdly, I am including an action to develop perinatal mental health services. By providing a bespoke, specialist service to those with perinatal mental health needs, this vulnerable group can get the specialist services they need.

During these particularly difficult times, I am committed to ensuring that those who's psychological wellbeing and mental health sufferers as a result of the COVID-19 pandemic will receive the support they need. I am therefore including a COVID-19 Mental Health Response Plan as an annex to the Mental Health Action Plan. The Response Plan outlines key areas of intervention during the pandemic to help and support the population as a whole.

Much work has been done in recent years to improve mental health services, and I am grateful for the focus and energy of staff who work in this important field and who recognise the need for change. This Action Plan provides the impetus to drive this work forward as a matter of urgency.

Yet the publication of this Action Plan is only the first in a series of steps I will take to ensure those suffering from mental ill health will be able to access the services they need, when they need them. It will put the foundations in place for the longer term, strategic improvements which will be set out in the new Mental Health Strategy. However, it is worth remembering the difficult context in which we operate and that any investment in mental health services will have to be balanced against other service priorities and in the context of the Department's financial settlement.

I would like to thank all those stakeholders who played a part in developing this Action Plan. Your voice, your experiences and your expertise were invaluable in creating an Action Plan that will kick-start real improvement in mental health services, and I look forward to working together with you as we move forward.

Robin Swann MLA
Minister of Health

Introduction

Since the early 2000s, mental health services in Northern Ireland have seen great improvements. An ever increasing strategic focus has been placed on improving the quality of life for service users by adopting a person centred recovery approach to care and effecting cultural change in the mental health system through the promotion of parity of esteem. Stories captured from people with lived experience evidence improving services and better experiences.

At the centre of this shift was the Bamford Review, and the impact of the publication of its reports[1] between 2005 and 2007 should not be underestimated. They have been the foundation upon which the Department of Health has built its strategic direction in the last decade and have produced significant improvements in mental health and learning disability services in Northern Ireland. Services are now largely mainstreamed into the wider service provision and the evidence suggests that many patients have had significantly better outcomes and experiences than they would have prior to the Review.

It is only right to recognise the excellent work from people across health and social care in making Bamford a success, whether employed by statutory Health and Social Care organisations, independent contractors or the voluntary and community sector. However, the time has also come to build upon their efforts with a new strategic direction.

It is clear that a new way forward is required for mental health, a view endorsed by the Northern Ireland Affairs Committee in its report on health funding published in November 2019.[2] The Department of Health is therefore putting the pieces in place to develop a new mental health strategy. In the interim this co-produced action plan is designed to create a common direction and focus for mental health services in Northern Ireland, in

[1] https://www.health-ni.gov.uk/articles/bamford-review-mental-health-and-learning-disability

[2] https://publications.parliament.uk/pa/cm201920/cmselect/cmniaf/300/30008.htm

preparation for the new mental health strategy, while also delivering key and essential improvements to service delivery in the short and medium term. It has been shaped by recurring themes from a number of post Bamford reports and studies which have highlighted how the services should be developed.

The first of these is the draft Bamford Evaluation report which is a review of the second Bamford action plan (2012-2015) carried out by the Department in 2016. Focused primarily on outcomes that matter to service users and their families, the evaluation also considered the effectiveness of the current Bamford structures and whether or not Bamford's aims have been mainstreamed within the ordinary course of business. The general conclusion was that the Bamford Review and subsequent Action Plans have been a catalyst for the development of improved mental health and learning disability services in Northern Ireland but that there are still needs and gaps within both services.

"Building on Progress: Achieving Parity for Mental Health in Northern Ireland", commonly known as The Lord Crisp Report, was produced by the Commission on Acute Adult Psychiatric Care and published on 17 June 2016. Its recommendations concentrated on parity of esteem for mental health, service structure, improved functioning of the system, support for patients and carers, investment, reform of commissioning and the need for improved data.

''Health and Wellbeing 2026 - Delivering Together''[3] was approved by Health Minister Michelle O'Neill in October 2016 and sets out the 10 year vision for the Department of Health. It promotes person-centred care, and is focussed on prevention, early intervention, supporting independence and wellbeing. Specifically it states there should be better specialist mental health services in Northern Ireland, expansion of services in the community, services to deal with the trauma of the past and a commitment to parity of esteem between mental health and physical health.

[3] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf

The Department, as part of Confidence and Supply Transformation Funding, commissioned an independent review of the acute inpatient pathway which was produced in 2019 and made 12 recommendations all of which are reflected in this Action Plan. Other documents of influence include the NICS Outcomes Delivery Plan[4] (specifically outcomes 4 and 8) and Protect Life 2.[5]

The evidence provided by these reports has been presented to a wide range of stakeholders for collaborative policy development and a number of key themes have emerged which this document addresses. Patient experience, access to services, workforce issues and governance structures are areas that have been identified for improvement and many of the actions included involve completing work that has already started, or that has been agreed but not yet initiated. Specific objectives have been set for each theme and progress towards achieving targets will be monitored by a lead organisation, which will usually be the Department, the Health and Social Care Board or the Public Health Agency.

All actions, even those that are not directly relating to improvements for persons with mental ill health, are aimed to improve the person centred care approach, with an underpinning trauma focussed methodology. The outspoken aim within the Action Plan is to improve the person's experience of mental health services and to help the health and social care system work better to be able to improve the person's experience.

The actions in this Mental Health Action Plan fall into three broad categories; immediate service developments, longer term strategic objectives and preparatory work for future strategic decisions. The first category aims to provide fixes to immediate problems and immediate service developments where there has been an identified immediate need. This includes, for example, consideration of alternative methods of

[4] https://www.executiveoffice-ni.gov.uk/sites/default/files/publications/execoffice/outcomes-delivery-plan-2018-19.pdf

[5] https://www.health-ni.gov.uk/sites/default/files/publications/health/pl-strategy.PDF

working for the mental health workforce to respond to the immediate, and significant, workforce pressures. The longer term strategic objectives aim to fulfil future strategic needs and includes, for example, a workforce review to consider how the mental health workforce should be structured. The third category relates to preparatory work for future strategic directions. This includes, for example, development of an action plan for the use of technology and creating better governance structures.

It should be noted that the Mental Health Action Plan includes specific actions which are in addition to normal service development. Not every development work or ongoing issue is noted in the plan and normal business planning for mental health services continue alongside the plan. This includes, for example, the work to ensure discharge from hospital is not delayed through working with Supporting People colleagues in other Departments, and work relating to Protect Life 2. The absence of such actions from the Action Plan is not due to lack of importance, rather an indication that the work is already ongoing through normal business channels. Similarly actions as a direct consequence to the COVID-19 pandemic are not included in the main Action Plan. Instead a separate COVID-19 Mental Health Response Plan has been developed and included as an annex to the main Action Plan. However, going forward much learning must be taken from the actions to respond to the psychological wellbeing and mental health COVID-19 challenges. This will allow continuation of new practices such as use of technology, where found effective and appropriate.

Strategic Linkages

COVID-19 Mental Health Response Plan

The COVID-19 pandemic has created very specific challenges to the psychological wellbeing and mental health of the whole population. Measures, such as complete societal lock down, social isolation and financial hardship, normally not seen outside a war zone has become the norm. This will undoubtedly lead to new challenges to mental health and require appropriate responses. In addition normal services have not been able to function in the same way as they normally do, with meeting being held remotely and using new technology.

These challenges will create problems, but also offer opportunities. Linkages must be had with new initiatives and with the work underway to help and support those who are suffering as a result of the pandemic. A dedicated COVID-19 Mental Health Response Action Plan has been created to outline the actions to respond to the challenges. Going forward, the implementation of the Mental Health Action Plan must be with the pandemic response in mind.

Mental Health Strategy

The development of a new 10 year strategy has been accepted by all key stakeholders as a key priority. It will be co-produced with multi-disciplinary and multi-sectoral participation in its development, be evidence based, take a whole life approach, focus on population need, be trauma informed and place the need and experiences of the persons using the system at its centre. This will be a significant undertaking given the wide variety of stakeholders, the complexity of the issues to address, and the need to develop a funding plan. Due to this it is anticipated that it will take a number of months to complete. *New Decade, New Approach* set a target date for the publication of the Strategy to the end of 2020. Due to the pandemic co-production has not been possible as expected, meaning that there will be delays in publication of the new Mental Health Strategy. Nevertheless, the delays will be kept to a minimum; whilst quick publication of the Strategy is important, getting it right is more important.

The Strategy will be broad in its scope, and will consider the mental health needs of the population at all stages in life, from childhood to old age. Prevention and early intervention will be a key consideration, and the Strategy will seek to bring together work being taken forward across government.

The Strategy will also consider the future configuration of specialist mental health services, including psychological therapies, personality disorder services, support for people with eating disorders, and perinatal mental health support. The new Strategy will seek to provide a strategic basis for the further development of the Regional Mental Trauma Network, as featured in the Stormont House Agreement. The Strategy will also provide a clear mapping of funding and structures.

Interdepartmental Action Plan in response to Still Waiting

An Interdepartmental cross-sectoral action plan has been developed in response to the NICCY "Still Waiting" report, a rights based review of mental health services and support for children and young people in Northern Ireland. The Interdepartmental Action Plan was published in draft in October 2019 and sets out a range of actions to address the agreed recommendations of the 'Still Waiting' report and improve child and adolescent mental health services (CAMHS), such as full implementation of the CAMHS care pathway, development of regional guidelines on transitions between CAMHS and Adult Mental Health Services and more mental health support in schools.

While the Interdepartmental Action Plan in response to 'Still Waiting' maintains focus on mental health services and support for children and young people, many of its actions overlap with those in the Mental Health Action Plan, such as implementation of a Managed Care Network for CAMHS, fund mapping and improved transition planning from CAMHS to adult services.

The two Action Plans remain separate, but closely linked. Implementation of one will complement and drive progress on the other; and both work together towards the overall goal of improving mental health across the lifespan.

Protect Life 2

Protect Life 2 2019-24 is a long-term strategy for reducing suicides and the incidence of self-harm with action delivered

across a range of Government departments, agencies, and sectors. It recognises that no single organisation or service is able to influence all the complex interacting factors that lead someone to harming themselves or, ultimately, to taking their own life.

There are a number of close linkages between Protect Life 2 and the Mental Health Action Plan with several actions which are complementary. In particular the focus on crisis intervention and crisis services requires close work between officials and services going forward. Protect Life 2 highlights the importance of the Early Liaison Service, and design of crisis de-escalation services. The evaluation of the Multi Agency Triage Team initiative and Belfast Crisis De-escalation Service pilot in BHSCT will inform future service delivery. Protect Life 2 also contains a number of actions in relation to the new Mental Health Liaison Service.

Protect Life 2 also has a focus on upstream intervention to improve emotional health and wellbeing and several initiatives are commissioned and planned to support this.

Improving Health Within Criminal Justice Strategy

The Improving Health Within Criminal Justice Strategy, and associated Action Plan, was published in June 2019. It was developed jointly between Departments of Health and Justice and outlines a substantial work programme to ensure that children, young people and adults in contact with the criminal justice system have the highest attainable standard of health and well-being.

The strategy recognises that many members of the community who come into contact with the Criminal Justice System have unmet health needs, with mental ill health often prominently featuring within these needs.

The strategy outlines a commitment to better align resources, to enhance access to relevant health services, and to improve the continuity of care delivered to the criminal justice population. It aims to improve the health and well-being of our criminal justice population and in doing so also contribute to safer detention and a reduced risk of reoffending.

Implementation of the strategy ongoing, with 11 of the 45 action measures in the action plan explicitly referencing mental health.

Regional Trauma Network

Implementation of the Regional Trauma Network (RTN) is included in the draft PfG Outcome 4 and Outcome 8. As part of the Stormont House Agreement in 2014, the Northern Ireland Executive made a commitment to establish a comprehensive Mental Health Trauma Service (the RTN). Once implemented, this network will deliver a comprehensive regional trauma service drawing and building on existing resources and expertise in the statutory and community and voluntary sector with particular focus on trauma and PTSD.

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Work to develop and implement the RTN is ongoing. The HSCB recently undertook a public consultation: 'Regional Trauma Network: Service Delivery Model and Equality Impact Assessment' which closed in October 2019 and the responses are currently being considered and will inform service development considerations prior to the launch of the new service.

We will also work to support the commitments to veterans in *New Decade, New Approach*

The Action Plan

The Action Plan contains a number of commitments to review and develop services, and to put measures in places to ready the system for the long term strategic change that will be brought about by the development and implementation of the 10 year Mental Health Strategy. A major strategic driver is the commitment announced on 27 April 2020 to create a Mental Health Champion.

Service developments

The Action Plan contains a number of service developments. The primary development is the determination and creation of a specialist community perinatal mental health service. It is likely that creating this service will take some time, to ensure that the right people are in post to deliver the service.

Other service developments include the creation of dedicated managed care networks for CAMHS and forensic mental health and the consideration if the forensic services should be regionalised into one regional service. There is also a proposal for an innovation fund which would provide earmarked funding for local initiatives. This could be to help in-patients or community services.

Reviews

There are a number of reviews in the Action Plan. These will pave the way for more efficient services in the future and underpin the mental health strategy work. There is a review to consider the response to homicide and suicide, the use of restraint and seclusion, transitions between CAMHS and adult service and adult services and old age psychiatry, outcomes data collection and future inclusion of community and voluntary sector's role in core mental health services.

Co-production

Whilst co-production is underpinned in all actions across the whole Action Plan, and has been one of the key principles in the development of the Plan, a number of actions specifically address the importance of co-production. This includes greater inclusion of persons with lived experience and staff in local decision making.

Governance

A number of actions seek to improve the governance structures of mental health services. With more streamlined and efficient governance, better decisions can be made, and more quickly. By improving the governance structure in preparation for a new mental health strategy, the organisations will be ready for future action plans stemming from the strategy.

Workforce

The mental health workforce are facing significant challenges. The Action Plan recognises this by including actions for new ways of working for staff and an increase in the mental health workforce.

A work plan for the actions can be found in **Annex A**.

Much work has been done in recent years to improve mental health services. This Action Plan provides the impetus to drive this work forward as a matter of urgency. Most of the actions in the Mental Health Action Plan are either resource neutral or are implementing decisions already taken regarding services which are currently already funded. It does not provide resources for the actions that require additional funding, but will prepare the way for informed decisions regarding future funding requirements. There are some specific costs in the Action Plan for year 1 after publication which can be categorised as below:

- Mental Health Strategy – up to £100k.
- Work associated with a Mental Health Strategy – up to £295k.
- Mental Health Champion – up to £75k.
- Service improvements, including a new perinatal mental health service – up to £1,521k.
- Reviews, including homicide and suicide, restraint and seclusion, transitions and specialists services – up to £420k.
- Governance, including new structures – up to £35k.
- Innovation fund – up to £500k.

The total cost of the Mental Health Action Plan in in the first year is up to £2.8m. The recurrent cost in future years is higher with the cost for perinatal mental health is expected to be up to £3.6m per year and the Mental Health Champion up to £500k per year.

Until the new 10 year mental health strategy is published, this Action Plan will ensure that momentum is not lost in terms of mental health service improvement. It will provide the drive to continue to improve and develop services to better support our population. The Action Plan has been drafted in line with the Department's commitment to co-production and has had input from those with lived experience, carers, community and voluntary organisations, academics, health professionals and their representative bodies, Health and Social Care organisations, politicians and governmental Departments. It has been scrutinised and approved by a Project Board consisting of representatives from these stakeholder groups, and a number of engagement methods have been employed to encourage stakeholder interaction. This included a series of workshops to identify key priorities, analyse them, and refine drafts of the document, some of which were managed in partnership with Inspire, Action Mental Health and the Patient Client Council.

Mental Health Action Plan

Mental Health Strategy							
Objective	**No**	**Action**	**Measures**	**Outcome**	**Lead**	**Resource implications**	**Time frame for completion**
Mental Health Strategy	1	Coproduce a sustainable mental health strategy based on the identified needs of people, created through cross Departmental, cross sectoral and multidisciplinary co-production.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	1.1	Create a 10 year mental health strategy.	Approval by July 2020. Project Board established September 2020. Consultation in March to June 2020. Mental health strategy published by July 2021.	A clear mental health strategy for the next 10 years.	DoH	Requires funding of up to £100k.	July 2021.
	1.2	Prepare for a Mental Health Strategy	Publish final Bamford Evaluation Report by September 2020. Evaluate and close the psychological therapies strategy by February 2021. Evaluate and close the personality disorder strategy by February 2021	Closure of Bamford as the policy direction for mental health. Closure of the psychological therapies strategy. Closure of the personality disorder strategy.	DoH	None for publication of the final Bamford Evaluation Report. Up to £35k for psychological therapies strategy.	February 2021.

						Up to £35k for personality disorder strategy.	
	1.3	Implement the inter-departmental Action Plan in response to NICCY's Still Waiting report	Implement the inter-departmental action plan by June 2021.	Better outcomes for children and young people.	DoH	Funding requirements as per the inter-departmental action plan.	June 2021.
10 year funding plan	2	Evaluate funding patterns and create a clear funding plan					
	2.1	Create a 10 year funding plan for mental health	Published with strategy by July 2021. Fund map mental health services, adults and CAMHS by September 2021.	A clear funding plan which will help improve decision making and commissioning.	DoH	Up to £100k for fund mapping.	September 2021.
Mental Health Champion	3	Create a Mental Health Champion					
	3.1	Create a Mental Health Champion	Executive approval by May 2020. Start appointment process by June 2020. Appoint a Champion in September 2020 to be in post by February 2021.	An independent voice who will support work on mental health and champion mental health across all sectors of life.	DoH	Up to £75k in 2020/21. Up to £500k per year after 2020/21.	February 2021.
People / Experience							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Better understanding of the system	4	Create a service map of the system to help and guide					

		understanding of what services are available	[redacted]				
	4.1	Create a map of the services available throughout the system.	Scope the extent of service mapping available by connecting to Directorate of Services work. Services map based on the stepped care pathways completed.	Better understanding of the system by both users and professionals.	DoH	Requires funding of up to £25k	July 2021.
Enhanced user involvement	5	Enhance the involvement of people with lived experience, including service users and carers in service delivery and service planning.	[redacted]				
	5.1	Embed co-production in all service improvement processes.	Regional agreed policy directions in the Trusts for service improvement processes by March 2021. Regional agreed policy direction in the Trusts for inclusion of carers in co-production. New for a for patient / staff involvement including peer support workers by March 2021.	Increased involvement of service user and people with lived experience (including carers) and therefore better user experience.	Trusts	None	March 2021.
	5.2	Create a regional service user and carer structure and ensure that processes are in place to support this by restructuring the Bamford Monitoring Group.	Consider the role of Patient Client Council and the Bamford Monitoring Group. A new terms of reference, membership criteria and name for Bamford Monitoring Group.	Better system for supporting service user consultants and a regional approach to service user involvement.	DoH HSCB Trusts PCC	Up to £30k	December 2020.

			New regional structures to support service user involvement.				
Enhanced pathways and structures	6	Improve mental health service pathways and structures.	[redacted]				
	6.1	Repeal the Mental Health Order for over 16's and commence Mental Capacity Act	Mental Capacity Act fully commenced for over 16's.	Reduced stigma for mental health patients.	DoH	None	Timings to be confirmed after Ministerial approval.
	6.2	Create managed care networks	Fund and implement the CAMHS managed care network by April 2021. Fund and implement the forensic mental health managed care network and consider a regional forensic service by April 2021.	Better outcomes for CAMHS patients. Regional consistency of approach and standardisation where appropriate. Greater local evidence based developed to inform commissioning of forensic mental health services.	DoH HSCB	Up to £200k for CAMHS MCN Up to £350k for forensic MCN	April 2021.
	6.3	Full implementation of mental health care pathways. Fully implement the "You in Mind" mental health care pathway.	Fully implemented You in Mind mental health pathway. Fully implemented CAMHS pathway. Ensure compliance with NICE guidelines. Implement the You in Mind forensic service model pathway	Under development.	HSCB PHA Trusts	None	April 2021.
	6.4	Review the process for dealing with suicide and homicide and deaths by mental health patients or a	Robust review to ensure that all is done to avoid, gather learning and engage appropriately with those affected by suicide, homicide and death of persons	Better response to suicide and homicide. Safer practice and implementation of	DoH HSCB PHA	Up to £60k	Review completed by July 2021.

		person known (within the last 12 months) to mental health services subject to funding .	known to mental health services. The review should benchmark outcomes against other jurisdictions. Implementation of good practice to reduce likelihood of suicide and homicide, drawing on the recommendations from the National Confidential Inquiry into Suicide and Homicide, Towards Zero Suicide and quality improvement initiatives.	learning from suicide and homicide SAI reviews.			Implementation dependent on outcome of review.
	6.5	Review restraint and seclusion.	Review of restraint and seclusion. Final report to contain regional policy on restrictive practices and seclusion and regional operating procedures for seclusion. Review to be completed by December 2020. Outcomes to be implemented by April 2021.	Better patient care and safe practice.	DoH	Up to £30k	Review completed by December 2020. Implementation by April 2021.
Improved transitions	7	Improve transitions between different aspects of mental health services.					
	7.1	Improve transitions in mental health services	Consider a new model for CAMHS to smooth transitions when a child turns 18 subject to funding. Multi-disciplinary project team set up to review and consider options to reduce difficult transitions by September 2020. Review completed by March 2021.	Less complex and traumatic transitions.	DoH HSCB PHA	Up to £100k in year 1 and up to £50k in year 2. New model may require funding.	Reviews completed by March 2021. Review of transitions into old age services completed by March 2022.

			Review and consider transitions between adult and old age mental health services and create transition pathways subject to funding by March 2022. Review and consider interfaces between services, including between different mental health specialisms, physical health, dual diagnosis, learning disability, autism, looked after children and criminal justice system by March 2021				
	7.2	Introduce availability of Mental Health Passports for all service users to assist with transition between services subject to funding.	All patients who wish to have a mental health passport should have one. Consider inclusion in the patient portal work.	Service users have a smoother transition between services	HSCB PHA Trusts	Costs to be scoped Initial allocation of up to £30k	March 2021
Improved care and treatment in an emergency	8	Consider and enhance the experience when a person is experiencing a mental health crisis, in particular in relation to emergency care.	[redacted]				
	8.1	Consider the outcome of the RQIA Review of Emergency Mental Health Service Provisions across Northern Ireland.	Consider the review and provide responses by December 2020. Support the work of review of emergency and urgent care.	RQIA recommendations taken into consideration	DoH	None	December 2020
	8.2	Reconfigure mental health crisis services	Evaluate alternative to ED for people in mental health crisis.	Reduction in people attending ED in a MH crisis.	DoH	£50k	December 2020

			Evaluation and rollout of Multi Agency Triage Team. Consider interactions between different crisis responses such as MATT, Home Crisis Teams, ED, 999, police, primary care MDT and similar. Further development of liaison mental health services across all trusts.	Better MH crisis response.			
Access to services							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Improved specialists services	9	Review and develop specialist services across the mental health system.	[redacted]				
	9.1	Decide on perinatal mental health services.	Consideration of business case for perinatal mental health services – April 2020. Agreement on new service model for specialist perinatal mental health services by September 2020.	Better services for those suffering from perinatal mental health needs which will also improve the child's health and development.	DoH	Up to £3.6m recurrent £900k in 2020/21	September 2020
	9.2	Review specialist mental health services.	Consideration of options paper for eating disorder services by March 2021. Review eating disorder services to provide a new service model for specialist eating disorder mental health services by July 2021.	Better services for those people diagnosed with eating disorders.	DoH	Up to £100k	July 2021.

			Review of current personality disorder services to evaluate effectiveness, identify gaps and make recommendations for future service developments by July 2021.				
	9.3	Consider model for both low secure and rehabilitation services and develop concrete proposals subject to funding.	Proposals for way forward by December 2020, subject to any revised NICE guidelines.	Better care for those with specialist needs.	DoH HSCB	Costs to be scoped	December 2020 (subject to any revised NICE guidelines).
	9.4	Implement the first phase of the Regional Trauma Network.	Implement the first phase of the Regional Trauma Network by April 2021.	Better care for those who have suffered trauma.	DoH HSCB	Existing funds	April 2021
Better mental health care and treatment in primary care	10	Enhance mental health in primary care					
	10.1	Create opportunities for training of GPs on general and specialist mental health and CAMHS, including dual diagnosis and those patients with a learning disability or autism that also have a mental illness subject to funding.	New / improved training programme for GPs for adult mental health. New / improved training programme for GPs for CAMHS.	Improved knowledge of mental health conditions, mental health brief interventions and mental health services among GPs.	DoH HSCB PHA	Costs to be scoped	July 2021.
	10.2	Roll out of mental health workers in primary care MDTs.	Support agreed further roll out of mental health workers in primary care MDTs – ongoing.	Improved access to mental health intervention services in primary care.	DoH	Funding provided through transformation and primary care programme of care.	ongoing
	10.3	Consolidate and expand the availability	Increase uptake on counselling provisions in primary care.	Improved access to services in primary	DoH HSCB	Costs to be scoped.	Significantly advanced by

		of talking therapies and other community based support through mental health hubs, and expand the geographical coverage of mental health hubs. Subject to funding	Increase availability of evidence based and professionally accredited counselling. Significantly advance integration of primary care hubs / talking therapy hubs into primary care within 24 months of approval. Improve regional consistency in delivery of hubs within 24 months of approval. Clear strategy for inclusion of community and voluntary sector in regional consistency.	care for those who do not need specialist secondary care services.	C&V		December 2021.
	10.4	Create an integrated model for primary care hubs / talking therapy hubs where primary care is responsible for service delivery. Consider the transfer of mental health hubs to GPs and GP Federations, linked to the Primary Care MDT model	Scope model for primary care / talking therapy hubs. Create model where the hubs are driven through primary care.	Improved access to services in primary care for those who do not need specialist secondary care services.	DoH HSCB C&V	Costs to be scoped.	Work commenced by September 2021.
Staff / workforce							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Help all staff to work more effectively	11	Create systems and procedures that reduces bureaucracy and helps staff deliver effective services.					

	11.1	Review documentation that is currently used and consider how it is used subject to funding.	Review of use of non-essential documentation with clear recommendations by July 2021. Consider outcome of review of documentation and take appropriate action	More effective use of staff time.	HSCB PHA	Up to £30k	July 2021
Encourage local initiatives and improve staff morale	12	Create a system that encourages local initiatives and improves staff morale and helps them feel more resilient, supported and respected	[redacted]				
	12.1	Create clear systems where all front-line staff are included in co-production and a leadership environment that encourages staff involvement	Consider current systems and ensure there is sufficient front-line staff included in decision making on a system wide level by December 2020.	Improved morale among staff and improved local services.	Trusts	None	December 2020.
	12.2	Create regional and local fora that encourages staff innovation and local initiatives subject to funding.	Each trust to create a local fora to consider local initiatives by October 2020. The HSCB and PHA to create a regional fora to support local forums by October 2020. Create a fund earmarked for local initiatives for the fora to distribute.		Trusts HSCB PHA	Up to £500k (circa) Funding may require Ministerial approval.	Immediate
Stronger mental health workforce	13	Create a stronger and more resilient mental health workforce	[redacted]				
	13.1	Initiate a workforce review of the mental	Review to be initiated by DoH Workforce Directorate.	A better understanding of the current mental health workforce and	DoH	Costs to be scoped	Timeline for review to be scoped.

		health workforce subject to funding.		the pressures and the requirements for the future.			
	13.2	Review and create a regional protocol for peer support workers including clear governance structure and role subject to funding.	New protocol for peer support workers including clear definition of the role and the governance structures.	Better understanding among peer support workers and others of the role of peer support workers.	Trusts	Up to £30k	December 2020.
	13.3	Consider the mental health workforce. Consider new ways to use the mental health workforce subject to funding.	Consideration of alternative methods of working and alternative workforce. Implement new methods as soon as possible thereafter. Increase the mental health workforce subject to funding.	More resilient workforce. Better services	DoH HSCB Trusts C&V	Costs to be scoped	Immediate
Structures, evidence and commissioning							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Enhance governance structures	14	Enhance the governance structures in the mental health system					
	14.1	Carry out a review of governance structures for policy making and policy accountability of the mental health system to create clear lines of accountability.	Review completed by September 2020. Implement review by December 2020. Create a process map of structures by December 2020.	Greater accountability in mental health governance structures to ensure that decisions are taken at the right level by the right people.	DoH	£5k	December 2020.
Better evidence and better use of evidence	15	Increased use of evidence and using the right evidence.					
	15.1	Create an outcomes framework for mental	Create a multi-disciplinary task and finish group established by	Greater understanding of what works and	DoH HSCB	Up to £50k (circa)	September 2021.

		health services to measure outcomes data subject to funding and ensure consistence in data collection.	October 2020 to consider an outcomes framework and how to develop based on mental health service framework and integration with Encompass. Final product developed by March 2021. Implemented by September 2021. Ensure all Trusts are enrolled in NHS benchmarking by September 2020	evidence to help in bidding for funding and commissioning. Implement practice based outcomes for capturing effective therapeutic interventions in all mental health services.			
	15.2	Conduct a prevalence study for adult mental health subject to be scoped	Prevalence study for Adult mental health complete	Better understanding of the prevalence of mental health which may indicate unmet need and may redirect investment and will help investment based on evidence.	HSCB PHA	Costs to be scoped	24 months after approval
Improved commissioning	16	Ensure regional commissioning					
	16.1	Create structures for more regional consistency in commissioning within the commissioning framework.	Introduce a regional structure for commissioning based on other working practices within existing commissioning framework.	Better commissioning with more regionally consistent services which will ultimately have a better outcome for the person who is suffering from mental illness.	HSCB	None	December 2020.
	16.2	Create a regional approach to bed management to ensure consistency in admission and discharge	Regional consistency in bed stay (with explained local variations).	Better commissioning with more regionally consistent services which will ultimately have a better outcome for the person who is suffering from mental illness.	DoH HSCB PHA	None	December 2020.

New ways of working and technology	17	Consider new innovative ways of working					
	17.1	Understand where the pressures on the system are and how the community and voluntary sector can help relieve such pressures	Create task and finish group to consider community and voluntary involvement in mental health services by October 2020. Report on improvements by March 2021.	Better and increased use of the community and voluntary sector where it is relevant to do so.	DoH HSCB PHA	None for task and finish group work.	March 2021.
	17.2	Enhance the use of technology subject to funding.	Monitor trial of body worn cameras in Southern Trust and consider feasibility for regional roll out. Consideration in line with timelines for trial. Monitor trial of advanced cameras in seclusion rooms in Southern Trust and on completion of trial consider regional roll out and how it should be implemented. Monitor C&V sector trial of chat bots and consider how it can be developed across HSC systems and how Trusts can link with C&V sector. Create an action plan to develop the use of technology in mental health services subject to funding by March 2021. Support the introduction of Encompass in mental health services.	Enhanced services for patients. Better safety for patients and staff. Better use of staff resources.	DoH HSCB PHA Trusts C&V	Costs to be scoped	Ongoing.

It is important to note the timescales and costs outlined in this plan are indicative and will require further prioritisation, workforce mapping and planning to ensure realistic delivery. The investment required is in addition to existing expenditure in mental health services and is dependent on the release of resources either through service efficiencies and reconfiguration or new year on year investment. Any investment in mental health services will have to be balanced against other service priorities and in the context of the Department's financial settlements and this will determine the pace of change.

Annex A – Workplan for actions

Mental Health Action Plan - workplan

Action	2020 July	Aug	Sep	Oct	Nov	Dec	2021 Jan	Feb	Mar	April	May	June	July	Aug	Sep
1.1 Mental Health Strategy															
1.2 Prepare for Strategy															
1.3 Implement NICCY action plan															
2.1 10 year funding plan															
3.1 Mental Health Champion															
4.1 Service map															
5.1 Embed co-production															
5.2 Regional SU structures															
6.1 Mental Capacity Act															
6.2 Create Managed Care Networks															
6.3 Implement pathways															
6.4 Review of suicide, homicide and deaths															
6.5 Review of restraint and seclusion															
7.1 Improve transitions															
7.2 Introduce mental health passports															
8.1 Urgent and emergency care															
8.2 Review crisis services															
9.1 Perinatal mental health															
9.2 Review specialist services															
9.3 Review low secure and rehab facilities															
9.4 Implement Regional Trauma Network															
10.1 Training in primary care															
10.2 Support primary care MDT															
10.3 Expand availability of hubs															
10.4 Integrate hubs and primary care															
11.1 Review documentation															
12.1 Integrate co-production															
12.2 Innovation fund															
13.1 Workforce review															
13.2 Peer support review															
13.3 New ways of working for the workforce															
14.1 Review governance structures															
15.1 Outcomes framework															
15.2 Prevelance study															
16.1 Structures for regional commissioning															
16.2 Structures for bed management															
17.1 Review involvement of C&V sector															
17.2 Improved use of technology															

Strategic work
Co-production
Reviews
Service developments
Governance
Workforce

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Annex B
Department of Health
COVID-19 Mental Health Response Plan

May 2020

Introduction

This document is the Department of Health COVID-19 Mental Health Response Plan.

This is a living document and will be updated regularly in response to the rapidly changing environment.

This response plan focusses on seven strategic themes that have been identified to respond to the impact of the pandemic on the population in Northern Ireland. The overarching outcome of the plan is to increase the psychological wellbeing and good mental health for the population as a whole.

The COVID-19 Mental Health Response Plan outlines the high level actions of the Department, and how support is provided to the Health and Social Care system, independent sector and others.

The response plan is in addition to the existing work, in particular the inter-Departmental Resilience and Mental Health Working Group in response to COVID-19, implementation of a Mental Health Action Plan and Strategy and regular mental health service improvements and strategic work by the Department of Health. The COVID-19 Mental Health Response Plan does not replace existing strategic directions, such as Protect Life 2, but builds on existing work.

Strategic linkages with existing and future work are vital to ensure improvements post-COVID-19. Key linkages are provided at the end of the plan.

The document has been developed by the Department of Health.

Background

Mental health services in Northern Ireland are provided in line with the stepped care model used in mental health services across the region.[6] This approach remains during COVID-19. Mental health services have not stopped, and all who need care and treatment will be provided with services that are clinically appropriate.

The responses in this response plan are to ensure that the stepped care model is still deliverable during the pandemic and provide COVID-19 specific actions to mitigate the psychological and mental health impact.

[6] The picture represents the adult stepped care mode set out in the You in Mind Regional Mental Health Care Pathway.

Background

There are a number of COVID-19 specific factors which will likely have an impact upon the mental wellbeing of our population during this pandemic. These include:

social distancing and isolation

bereavement

unemployment

financial hardship

inability to access services

stress

There is significant evidence of the impact of these on psychological wellbeing and mental health.[7]

[7] Rapid review - Mental Health Impact of the Covid-19 Pandemic in Northern Ireland; Greenberg et al Managing mental health challenges faced by healthcare workers during COVID-19 pandemic, 2020; Rhodes et al, The impact of hurricane Katrina on the mental and physical health of low-income parents in New Orleans, 2010; Department of Health; World Health Organisation; Mental Health Foundation; Centre for Mental Health; articles in the British Medical Journal and the Lancet

MAHI - STM - 127 - 339

Prior to the pandemic Northern Ireland is estimated to have higher levels of mental ill health than any other region in the UK with 1 in 5 adults (185,000 people) having a mental health problem at any one time.

The impact of large scale trauma could mean an increase in higher levels of mental health diagnosis (including depression, acute stress disorder, adjustment disorder, post-traumatic stress disorder, prolonged grief disorder, psychotic illness and other anxiety disorders) and substance use.

Health and social care staff are at specific risk of negative outcomes, with challenges such as moral dilemmas relating to inadequate resources, fears about lack of knowledge or experience and the traumatic experiences faced.

Social isolation is associated with suicidal ideation, where those who frequently experienced loneliness were at 21% increased risk of having suicidal thoughts (as against 2.5% of those who were not as frequently lonely) and had a 8.4% chance of attempting suicide as against 0.7% for those who were less frequently lonely.

Infection with the virus will directly impact on the mental well-being of some people, through the experience of being in an intensive care environment which is known to cause PTSD for some.

It is known that unemployment is a factor of mental ill health and it is estimated that the likelihood of developing a mental health disorder is doubled if unemployed. That means for every 1% increase in unemployment an estimated 9,000 people are twice as likely to develop mental health disorders.

Financial loss may lead to anger or anxiety with those on a lower income more likely to be affected. Stigma, due to a perception of risk of infection, may be a factor particularly for healthcare workers perpetuating the trauma and distress already experienced.

Strategic Themes

Considering the evidence of the psychological and mental health impact of the pandemic we have identified a number of problems and have structured a response across seven broad themes. The themes broadly covers the work to respond to, and mitigate, the effects of the pandemic on psychological distress and mental ill health.

Mental health and resilience response to COVID-19	Public health messaging	Provision of advice, information and support	Evidence based support and interventions	CAMHS specific issues	Existing mental health services contingency	Service realignment
• To ensure a coherent and joint up response to the pandemic we are committed to creating structures to respond to the psychological and mental health needs.	• To help and support the whole population to have clear, accurate and up to date information we will provide coordinated public health messaging to promote psychological wellbeing and good mental health.	• As help and support desperately needed during difficult times are not available using normal channels, we will provide advice, information and support using both digital and traditional methods.	• Many people will need help and support to cope during the pandemic, and some will require specialist help and support. It is vital to be able to provide quick and accurate information without pathologising people. We are therefore committed to provide evidence based support and interventions.	• Children and young people are faced with particular challenges during the pandemic. Normal activities have stopped and the peer support normally enjoyed is not as easily accessible. We will ensure that children and young people are considered in the strategic response to COVID-19 and that any children and young people specific issues are resolved.	• Mental health services in Northern Ireland faced significant challenges prior to COVID-19. This, in combination with COVID-19 specific pressures, means there are challenges in providing the care and treatment required. We are committed to supporting services, and to provide a framework to ensure those who need mental health services can avail of them.	• It is expected that the pressures on mental health services post-COVID-19 will continue to increase, potentially significantly. This will mean that service recovery and realignment will be key going forward. We are committed to working closely with delivery partners to create clear recovery plans.

1. COORDINATED MENTAL HEALTH AND RESILIENCE RESPONSE TO COVID-19

Action 1.1

Create a mental health and resilience work stream to ensure a coherent, cross-departmental and cross-sectoral strategic approach

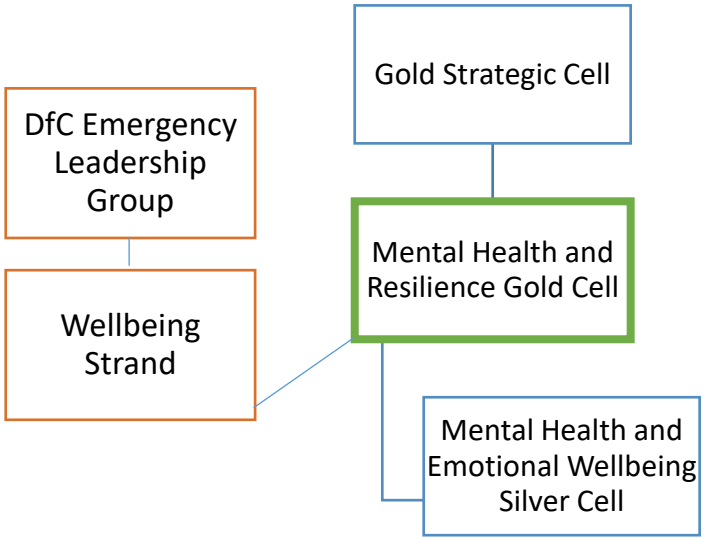
Theme 1 – Coordinated mental health and resilience response to the pandemic

COVID-19 affects all areas of life and all aspects of mental health and wellbeing. It is expected that the pandemic will have significant impact on the wellbeing of the population across Northern Ireland.

Health and social care services are provided by a broad range of bodies including statutory sector, community and voluntary sector and the independent sector providers. When delivering actions it is vital that all parts of the system must be considered and must be supported to enable us to deliver the response that is required at this time.

The strategic response must be coordinated and have clear outcomes. This will help in ensuring consistency in messaging and linking in to the Executive COVID-19 Strategy.

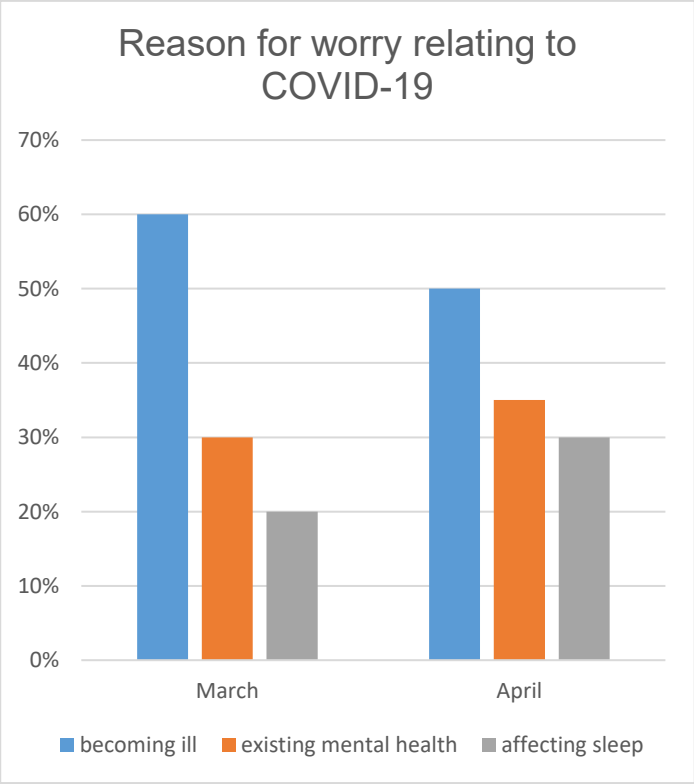
To ensure that this is captured in the response to the pandemic a mental health and resilience work stream has been created to ensure coherent, cross-departmental and cross-sectoral strategic approach to psychological wellbeing and good mental health during COVID-19.



2.
PUBLIC HEALTH MESSAGING

Theme 2 - Public health messaging to promote mental wellbeing

There are clear early indications that people are worried about the pandemic and that anxiety levels are increasing.



Preventative steps are essential to mitigate this and will include a clear and widely proliferated message setting out how to address mental wellbeing and support good mental health.

It is therefore important to provide clear and consistent messages and advice across media outlets, to avoid over-crowding, conflicting messages and subsequent lack of understanding and confusion.

We will work in partnership with the Health and Social Care system and across government to ensure consistency in public messaging specifically relating to maintaining mental wellbeing while at home and improving good mental health

2. PUBLIC HEALTH MESSAGING

Action 2.1
Create public health messaging to promote mental wellbeing

Action 2.1 – Create public health messaging to promote mental wellbeing

The Department of Health, the Public Health Agency, the Health and Social Care Board, the Health and Social Care Trusts, community and voluntary and independent sector have a responsibility to give clear, coherent evidence based information and consistent advice and information to the population.

The Public Health Agency's Take 5 Steps to Wellbeing is a useful framework to support both the physical and mental health of our population during the pandemic and provides accessible and familiar messaging for the wider population.

The Department is committed to ensure consistent public health messaging supporting the Take 5 Steps to Wellbeing and ensuring that this is the main message made public.

The Department will also support and promote Minding Your Head (www.mindingyourhead.info) as a useful platform for information for help and support for mental health. A wide range of information will continue to be made available through the Family Support NI website (www.familysupportni.gov.uk).

2. PUBLIC HEALTH MESSAGING

Action 2.2
Support the development on a regional HSC owned communications plan

Action 2.2 – Support the development on a regional HSC owned communications plan

The primary driver for public health messaging rests with the Public Health Agency.

During the pandemic it is important that the messaging provided is consistent and continuous. The Department is supporting the development of a regional HSC owned communications plan, outlining key areas of communication and methods to reach everyone who needs information.

The objectives of the communication plan are to:

- acknowledge the natural emotional distress as result of the pandemic;
- acknowledge and provide support to those who are grieving the loss of loved ones and colleagues in these very difficult times and circumstances;
- provide clear facts and dispel myths about mental health and wellbeing; and
- acknowledge and provide support to those who are grieving the loss of loved ones, colleagues and those in their care.

The communications plan includes specific actions during Mental Health Awareness Week, 18 to 24 May, to help and promote psychological wellbeing and good mental health both as a result of the pandemic and relating to mental health in general.

3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Theme 3 – Provision of advice, information and support

During periods of social distancing and isolation, alternative means of providing information, advice and support are needed as the ability to meet in person is limited. In particular, online and digital tools can provide an excellent way for people to stay in touch, to access therapy or other support services and to get up to date, factual information.

It is also important to consider the needs of those for whom the internet or other digital tools are not available or inaccessible. We will work with partners across government to ensure such groups are identified, their needs assessed, and support is put in place.

3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Action 3.1
Provide online classes for stress control

Action 3.1 – Provide online classes for stress control

It is widely accepted that people feel stressed as a result of the pandemic. In a recent UK wide survey the Mental Health Foundation found that:

57% of all asked are worried about COVID-19	**17%** of all asked are panicked about COVID-19	**26%** of unemployed asked felt hopeless

When normal methods cannot be used to help people control stress, we must work to deliver alternative channels. Stress Control are available free of charge online through a collaboration across the UK nations and Ireland. The classes are made by Dr Jim White, Consultant Clinical Psychologist.

The class is six sessions long over three weeks and are viewable on YouTube with supporting material on Stress Control's website. The first class started on 13 April and the second class started on 11 May. Further information on classes and supporting material can be found at www.stresscontrol.org.

The classes have been successful to date:

- The 1st session had 10,548 views and further sessions had an average of 6,207.
- Most people who watched more than the first session finished the course.
- 75% of users were women.
- 87% of users were between the ages of 25 and 65.

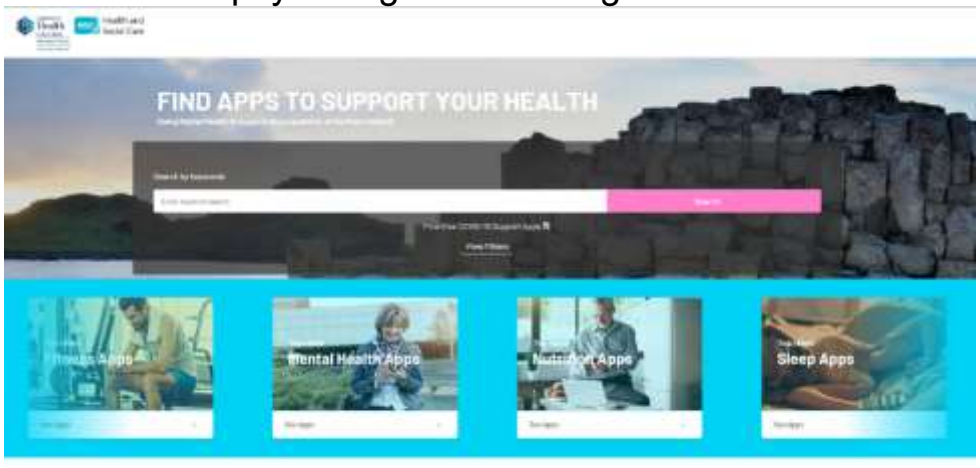
3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Action 3.2
Create an apps library for HSC safe apps for mental resilience and wellbeing

Action 3.2 – Create an apps library for HSC safe apps for mental resilience and wellbeing

Due to social isolation and the reduction in personal contacts, alternative methods to provide help and support are needed, without pathologising the population. One method to do this is to provide safe and approved online resources. The HSC has therefore partnered with ORCHA (The Organisation for the Review of Care and Health Apps), to create a library of health and wellbeing apps that have been reviewed and rated as helpful, safe and secure.

The library is being launched in phases and will support the population through the pandemic and beyond. The first phase launched on 5 May by the PHA using existing ORCHA libraries relevant to psychological wellbeing.



The apps library can be accessed at: https://apps4healthcareni.hscni.net

3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Action 3.3
Provide support for health and social care workers

Action 3.3 – Provide support for health and social care workers

Those working in health and social care, both in the HSC workforce, independent sector and volunteers, are particularly at risk of negative impact on their mental health because of the extreme pressures during the pandemic.[8] Centre for Mental Health notes in their 15 May COVID-19 Briefing:

Health and care workers and other frontline workers are at greater risk of developing mental health problems as a result of Covid-19.

50% increase in significant stress for those who have worked with SARS-CoV patients	Psychological impact on staff from SARS-CoV between **29-93%**	**40%** of staff showed significant mental health symptoms 3 years after SARS-CoV	**44%** of doctors in UK are self reporting mental health problem due to COVID-19

Three specific support mechanisms have been created:

- A framework for supporting staff developed by clinical psychology with input from others such as Trade Unions, occupational health services and HSC organisations was published on 16 April.
- Seven days a week phone line to help and support all health and social care workers. Phone numbers can be found on PHA's website.
- Handbook for new staff who have qualified earlier than expected.

[8] Centre for Mental Health Covid Mental Health Forecasting 15 May 2020; Douglas et al, Preparing for Pandemic Influenza and its Aftermath, 2009; Wu et al, The Psychological Impact of the SARS Epidemic on Hospital Employees in China, 2009; BMA, Stress and burnout warning over COVID-19, 2020

4.
EVIDENCE BASED SUPPORT AND INTERVENTIONS

Theme 4 – Evidence based support and interventions

It is essential that appropriate evidence based support is available throughout this time for those who need it.

In many instances this may be provided digitally using online tools and apps, and we will work to provide access to appropriate, safe and clinically recommended digital solutions. However, it is also important to ensure individuals have access to more traditional support options if required.

This is particularly important for staff working on the front line across the statutory, independent and community and voluntary sectors, where psychological first aid is one of the globally recommended responses.

4.
EVIDENCE BASED SUPPORT AND INTERVENTIONS

Action 4.1
Review / research into impact

Action 4.2
Enable access to psychological first aid

Action 4.3
Enable prescription of specific apps within the apps library

Action 4.1

To fully understand the impact of the pandemic on people, services and strategy evidence is required.

We will continue to work with research partners inside and outside the HSC, including Universities, external research agencies and those with appropriate expertise who are willing to provide guidance and evidence.

We will draw on the experiences from past pandemics, and evidence from COVID-19 specific research and incorporate the findings in decision making going forward.

Action 4.2

The World Health Organisation, War Trauma Foundation and World Vision International have developed psychological first aid, which involves humane, supportive and practical help, to help others who are suffering a serious crisis event.

We will support the HSC to develop and make psychological first aid available across Northern Ireland.

The HSC has in collaboration with the Red Cross and NHS Education Scotland made available interim guidelines and a short E-Learning module on Psychological First Aid.

Action 4.3

As noted above, an apps library has been developed in cooperation with ORCHA to provide advice, information and support.

Further phases of the apps library will allow clinicians and wider professionals to “prescribe” and allocate apps to clients as appropriate.

We are working with the HSC to create licences and to support Trust implementation.

This also involves research and evaluation to quality improve and assess the impact of the website and apps library.

Theme 5 – Child and Adolescent Mental Health Services specific issues

5.
CAMHS SPECIFIC ISSUES

The pandemic has brought with it a myriad of unprecedented challenges for children and young people. Closure of schools, academic uncertainty, restricted contact with support networks and increased exposure to social media and 24/7 news outlets are all likely to have an adverse effect on the mental health of children and young people both now and in the future.[9]

The expectation from Child and Adolescent Mental Health Services (CAMHS) professionals is that a surge in referrals will be seen, due to the negative impacts of the pandemic on children and young people. It is important that children and young people know how, where and when to get help and that CAMHS continues to operate efficiently and effectively to provide care and treatment for those children and young people that need it.[10]

Children and young people are considered in all aspects of mental health services and feature in all strategic areas. However, particular actions have been developed for this group.

[9] Education Policy Institute Social media and children's mental health: a review of evidence, 2017; Volkin, S. The Impact of the COVID-19 Pandemic on Adolescents, John Hopkins University, 2020; The Children's Sociaty Young people's mental health and well-being during COVID-19, https://www.childrenssociety.org.uk/news-and-blogs/our-blog/young-peoples-mental-health-and-well-being-during-covid-19 accessed 14 May 2020.

[10] UN Policy Brief: The Impact of COVID-19 on Children 15 April 2020; Waite et al, Report 02: COVID19 worries, parent/carer stress and support needs, by child special educational needs and parent / carer work status 3 May 2020.

5.
CAMHS SPECIFIC ISSUES

Action 5.1
Create a sub cell with focus on CAMHS

Action 5.2
Suspend transitions from CAMHS to AMHS

Action 5.3
Promote the use of electronic platforms

Action 5.4
Promote and signpost

Action 5.1	Action 5.2	Action 5.3	Action 5.4
Creation of a sub cell to the Mental Health and Emotional Wellbeing Silver Cell in the command and control structures to focus on the mental health needs of children and young people during and after the pandemic, to support recovery and to quickly raise any issues with the Department for resolution. This will ensure that children and young people specific issues are not forgotten and are dealt with quickly.	Transitions from CAMHS to adult mental health services for 18 year olds have been temporarily suspended. This will help to facilitate continuity of care for patients and families, to enable risks to be safely managed and ease pressures on mental health beds. The suspension is reviewed every 4 weeks.	Promote the use of electronic platforms in appointments and communications with young people. This will ensure that services are provided in line with social distancing guidelines.	Promote and signpost to: Helplines: – Lifeline – Childline – Samaritans – NSPCC Online resources: – Annafreud.org – PHA website – Family Support NI website Continued use of Family Support Hubs. This will ensure awareness of the support and services available to them.

6.
EXISTING MENTAL HEALTH SERVICES CONTINGENCIES

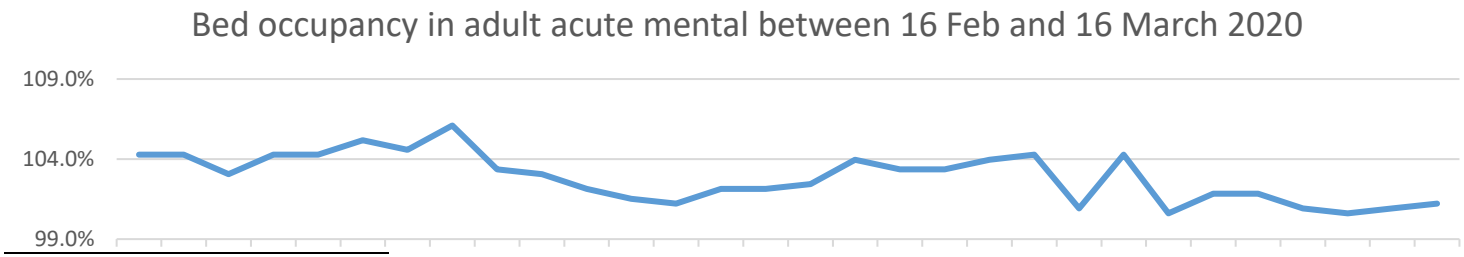
Theme 6 – Existing mental health services contingencies

In our planning for the impacts of COVID-19 a significant number of staff were expected to be unavailable for work, either through illness, isolation or shielding.

These pressures on mental health services come at a time when services across all five HSC Trusts have been experiencing significant pressures. Vacancy levels pre-COVID-19 among mental health nurses were up to 25%, bed occupancy levels in mental health in-patients were regularly over 100% and growing breaches of CAMHS waiting list targets.

Combining existing pressures with new pressures on mental health services, both during and after COVID-19 will provide significant challenges. Northern Ireland experiences higher levels of mental ill health than in other parts of the UK and Ireland. UK wide predictions estimates a significant level of increase of general mental ill health and increases in serious mental ill health.

At least half a million more people in UK may experience mental ill health as a result of Covid-19, says first forecast from Centre for Mental Health.[11]



[11] Centre for Mental Health https://www.centreformentalhealth.org.uk/news/least-half-million-more-people-uk-may-experience-mental-ill-health-result-covid-19-says-first-forecast-centre-mental-health

6.
EXISTING MENTAL HEALTH SERVICES CONTINGENCIES

Action 6.1
Establish coordination between HSC Trusts, Board and the Department

Action 6.2
Surge plans for mental health services

Action 6.3
Emergency statutory provisions and guidance

At all times mental health services have to be provided to ensure that those who need services can access services that meet the need they have. Any restriction in access to services, or alteration to normal provisions is a balance between safely caring for people, and ensuring that there is a functioning mental health service even with a reduced staffing complement or an outbreak of COVID-19 in mental health services.

A crisis situation requires clarity between providers of care, commissioners and the Department on key decisions. A clear governance, reporting and communication structure, with monitoring was therefore set up through a series of actions. Included in this were surge plans which included pre-planned actions for specific pressures.

Further it was identified that the safe care and treatment of mental health patients would not be possible without legislative change.

Action 6.1	Action 6.2	Action 6.3
Twice weekly conference calls between the Department/Board/Trusts/ PHA have been established to ensure quick communication channels and to deal with emerging issues.	The HSC Trusts have developed surge plans for mental health services, and the surge plans have been provided to the Department to help and support the practical work to ensure continued availability of mental health services.	The Coronavirus Act 2020 makes amendments to the Mental Health (NI) Order 1986 to ensure continued ability of HSC Trusts to provide safe and effective mental heath services even during extreme workforce pressures due to COVID-19.

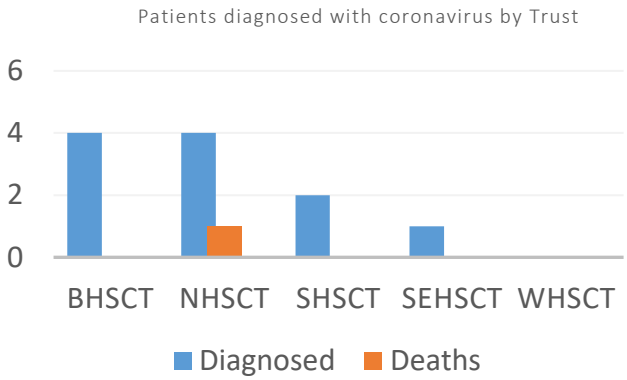
6. EXISTING MENTAL HEALTH SERVICES CONTINGENCIES

Action 6.4
Monitor infection rates and bed occupancy to quickly identify mitigating actions

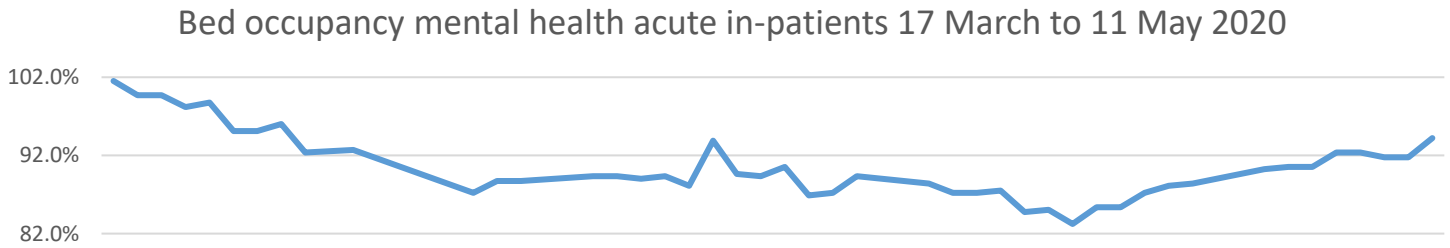
Action 6.5
Respond to pressures and approve temporary practices

Action 6.4

Daily statistics on inpatient bed pressures are captured to monitor change in need and all admissions to inpatient facilities are swabbed. At 11th May 11 patients had been diagnosed with Coronavirus with one death recorded.



Bed occupancy levels dropped from over 100% to below 85% at the end of April. Since then the levels have been steadily rising.



Action 6.5

We are committed to using both statistics and evidence from professionals to identify where temporary practices are necessary.

Temporary modification have been made:

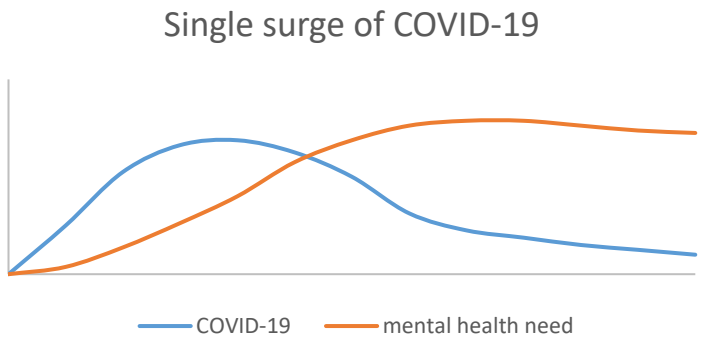
- The regional bed management protocol;
- The process for medical examinations for detention for assessment;
- The Promoting Quality Care protocol; and
- Approved Social Worker procedures.

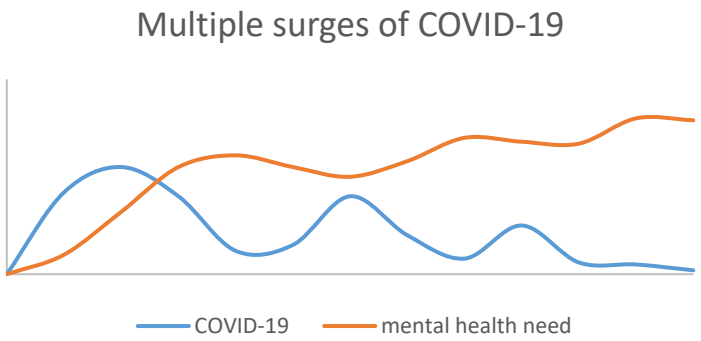
7. SERVICE REALIGNMENT AND BUSINESS POST-PANDEMIC

Theme 7 – Service realignment and business post-pandemic

The number of people who will need mental health services support post-COVID-19 is expected to be significant, together with the built up need among those who normally use mental health services, but who may have felt unable to do so during COVID-19.

The expected impact on mental health is linked to the impact of COVID-19. A single surge of COVID-19 will create pressures that will ease out, with the peak coming after the COVID-19 peak. If there are multiple surges of COVID-19, it is expected that the mental health pressures will be cumulative, with little resetting between surges, as outlined below.





Mental health services therefore need to consider, as part of their business continuity planning, existing and emerging evidence to plan for service realignment, which will include consideration of future needs and service delivery models. We will work with the HSC Board and HSC Trusts to do this as part of their normal business planning approaches. This work will also be taken forward in liaison with the Silver Cell on Mental Health and Emotional Wellbeing.

7.
SERVICE REALIGNMENT AND BUSINESS POST-PANDEMIC

Action 7.1
Develop recovery plans

Action 7.1 – Develop recovery plans

We will work with the HSC Board and HSC Trusts to develop sustainable recovery plans. The plans will be based on a clear decision making framework, with key indicators and will account for pressures in the mental health system. This will allow robust action plans with regional consistency on key areas, such as service levels, staff redeployment, isolation, visiting and physical health of patients.

	Status	Green	Amber	Red	Black
	Pressure	Low			High
	C-19 +ve Patients / Residents in 24 hour care settings with C	Up to **4** patients / resident	Up to **10** patients / resident	**10>** patients / resident	**50%** of ward/Unit
	C-19 +ve Staff in 24 hour care settings	Up to 10% Staff	10-25% Staff	25-50% Staff	>50%
	PPE & Equipment required for management of COVID-19	Adequate PPE & equipment for one month	Adequate PPE & equipment for one week	Not adequate PPE or equipment currently to meet service needs	
	Surge in referrals to Statutory Mental Health	**5%** Increase in referrals received against same period 2019 Baseline Community = Baseline Inpatient =	**Up to 10%** Increase in referrals received against same period 2019 Baseline Community = Baseline Inpatient =	**Up to 20%** Increase in referrals received against same period 2019 Baseline Community = Baseline Inpatient =	**20%+** increase in referrals received Baseline Community = Baseline Inpatient =
	Maintenance & prioritisation of Mental Health & Emotional Well Being	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders

7.
SERVICE REALIGNMENT AND BUSINESS POST-PANDEMIC

Action 7.2
Incorporate new ways of working

Action 7.2 – Incorporate new ways of working

The pandemic and social isolation has required new working practices, such as remote access, use of technology and new innovative practices. Post-pandemic work is required to analyse what has happened, the effectiveness and how to incorporate new ways of working in normal mental health services. We are committed to using the difficult experiences during the pandemic to our advantage post-COVID-19.

In **CAMHS** the use of technology should be evaluated to consider if new ways of using technology had a positive impact and what effect it had on efficiency. The continued use of technology post-pandemic may help in reducing pre-pandemic waiting lists and provide quicker access to quality services for children and young people.

For **adult services**, the use of remote delivery has enabled ongoing contact and treatment of people with mental ill health. On line resources for prevention, early intervention, and treatment of mild to moderate mental illness has been particularly developed and increased. The outcomes of remote delivery will be evaluated and adopted longer term if found to be efficient and effective.

For **adult in-patient services**, an initial reduction in bed occupancy of over 15% and reduction in admissions of over 20% was noted, taking the bed occupancy levels to its lowest in a number of years. This may be because of differences in risk management, but it may be as result of working with patients in different ways. If the alternative use of in-patient services is as effective, this may help post-pandemic pressures on in-patient services.

POST COVID-19 PRIORITY WORK STREAMS

Post COVID-19 priority work streams

Mental health development work does not stop with the pandemic, and must incorporate the response to the pandemic. The good work on psychological wellbeing and improving mental health during COVID-19 feeds into a number of existing mental health priority policy work streams.

Work stream 1	Work stream 2	Work stream 3	Work stream 4
Creation of a **Mental Health Champion.** The purpose of the Mental Health Champion is to further the mental health agenda to promote emotional health and wellbeing, access to evidence based support and services and promote recovery.	Incorporation of COVID-19 specific work in **existing service developments**, including the action plan in response to the NICCY 'Still Waiting' report and work on immediate mental health pressures, in particular pressures on adult in-patient services.	Implement the **Mental Health Action Plan** and develop a **Mental Health Strategy**. This will also link with the development of a new strategy to address substance misuse.	Continued consideration of **legislative changes**, including the Coronavirus Act, the Mental Health Order and the Mental Capacity Act.

COVID-19 Mental Health Response Plan strategic themes and post-COVID-19 work streams

Work stream 1
Mental Health Champion

The Mental Health Champion is a joint initiative across the NI Executive, and is fully supported by all Executive Ministers.

The development of a Champion was announced on 27 April 2020.

What will the Champion do?
The purpose of the Mental Health Champion is to further the mental health agenda across all platforms and fora to promote emotional health and wellbeing, access to evidence based support and services and promote recovery.

The Champion will be a public advocate, consensus builder, network hub and challenger of decisions.

Co-production
The Mental Health Champion will have to work closely with people with lived experience. It is important that the Mental Health Champion will work to promote wellbeing and share a positive message, both in terms of public messaging and in the policy work the Champion is involved in.

The Champion must also focus on recovery, as a key element in the journey of those suffering from mental ill health.

Work stream 2
Existing service developments

Mental health services pre-pandemic was experiencing significant pressures and were undergoing change.

This will link to the cross-Departmental action plan in response to NICCY's Still Waiting. It will also link to mental health service in general, and in-patient services in particular. The pandemic has changed the approach to in-patient care, and the use of community and voluntary sector. This learning must be incorporated in the ongoing work on these service pressures.

COVID-19 Mental Health Response Plan strategic themes and post-COVID-19 work streams

Work stream 3
Mental Health Strategy

The pandemic, and the effect of COVID-19, is likely to have a long term impact on people's mental health and on mental health services.

As part of the New Decade, New Approach a commitment was made to create a new long term Mental Health Strategy. The Strategy will be person centred, with a whole life approach and a whole system focus and the aim is to ensure long term good outcomes for people's mental health.

The Strategy will have to consider the pandemic, and the effect on peoples mental health and mental health services.

This response plan will feed directly into this work and the strategic work will also drive the work on legislative challenges and address existing service developments.

The Mental Health Champion will have an integral part in ensuring that the Strategy will provide the best outcomes possible for the whole population.

This will also link with the development of a new strategy to address substance misuse.

Work stream 4
Legislative challenges

The Coronavirus Act 2020 made amendments to the Mental Health Order and the Mental Capacity Act. These must be reviewed, and considerations must be had on long term changes as a result, including the options of remote working and using technology in statutory functions.

The pandemic has also highlighted the importance of ethical decision making and person centred approach. Both are key components of the Mental Capacity Act and learning from the pandemic must shape the implementation planning going forward

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Regional Policy on the use of Restrictive Practices in Health and Social Care Settings

And regional operational procedure for the use of Seclusion

Northern Ireland

March 2023

TABLE OF CONTENTS

1. Introduction

Purpose of this Guidance

1.1. Restrictive Practice is an umbrella term that refers to the entire range of interventions that are considered restrictive and which infringe a person's rights.

1.2. This policy provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland, with the emphasis on, ideally, elimination of their use, but certainly a minimisation of their use. It is applicable across the lifespan - children, young people[i], adults and older people, to all health and social care staff and within all health and social care services.

1.3. The policy draws upon the views of people who use health and social care services, those who have experience of restrictive practices, restraint and seclusion, and best practice from other jurisdictions. It aims to ensure that when restrictive practices are used, they are managed in a proportionate and well-governed system. This will assist in protecting people, reducing the risk of misuse and potential over-reliance on restrictive practices.

1.4. The use of restrictive interventions, restraint or seclusion may be necessary on occasion, as one element of managing a high-risk situation. Best practice highlights that restrictive interventions, restraint and seclusion should only be used as last resort when all other interventions have been exhausted and there is a presenting risk to the person or to others.[ii] [iii] [iv] Nevertheless, some of those who have been involved with or subject to seclusion, restraint or restrictive interventions recall traumatic experiences which can hinder recovery and relationship building. Reports from across the UK and Ireland have highlighted the need for change regarding the use of restrictive interventions, restraint and seclusion.[v] [vi] [vii] [viii] [ix]

1.5. The use of restraint and seclusion across health and social care settings and services in Northern Ireland is difficult to quantify, with challenges in capturing and articulating data on a regional basis. Whilst many organisations will have their own governance systems relating to monitoring the use of seclusion, there will be clear benefits to an agreed regional approach to this.

What will this Policy do?

1.6. This regional policy sets out the expectations for minimising use of restrictive interventions, restraint and seclusion. It also provides requirements for decision making, reporting and governance arrangements for the use of any restrictive practice. The policy provides this through seven standards.

1.7. The standards are underpinned by the principle of early intervention measures to minimise and eliminate their occurrence and promote the principle of least restriction possible. The standards set out in this policy must be applied to the

management of behaviours of concern and distressed reactions, even if they are unforeseen, or in contexts where they cannot be anticipated and/or responses pre-planned.

1.8. This policy sets accountability for the minimisation strategy at the top level of each organisation, emanating from the drive for a rights-based approach to practice, culture, and policy from the centre of organisational decision-making. Organisations must establish a baseline of the use of all restrictive interventions to enable organisational minimisation strategies.

1.9. This policy requires the development of a standardised, regional approach to recognition, implementation, recording, monitoring, learning and quality improvement. This will improve the understanding of what constitutes restraint, seclusion and interventions that fall under the umbrella term of restrictive practices and will drive minimisation strategies, embedded in a rights-based approach.

Who is this Policy for?

1.10. This policy is intended for use by people who work in health and social care across all health and social care services in both statutory (which refers to all six Health and Social Care Trusts) and non-statutory sectors (which refers to all other services providing health and social care). Health and social care staff working in non-health settings, and the employing organisation, should also consider the requirements of this policy document in conjunction with other legislation, policy and procedure relevant to the particular work setting, using it to inform their decision-making and practices.

Status of this Policy

1.11. This policy is issued by the Department of Health with the clear expectation that all Health and Social Care organisations understand their individual and collective roles and that they implement the guidance in full.

1.12. This policy is issued with strong recommendation for implementation in full by non-statutory health and social care providers.

1.13. HSC organisations commissioning services from non-statutory health and social care providers will include compliance with this policy within contracting arrangements.

1.14. Anyone working in a health and social care setting must follow all relevant legislation. There are a number of legal requirements relating to restrictive practices. At all times people working in the health and social care system must be mindful of the requirements under human rights obligations and must always act with the best interests of the patient/person in mind.

1.15. In Northern Ireland care homes are by law required to only use restraint when it is in the welfare of the patient. Each instance of restraint must be recorded in respect of each resident[x] [xi]. This policy does not remove or change this requirement.

1.16. When commenced in full, the Mental Capacity Act (Northern Ireland) 2016 will provide requirements relating to restraint when a person over 16 lacks capacity to consent to the action[xii]. This policy is compatible with that Act.

1.17. If restraint becomes a deprivation of liberty, a legal authority must be in place for the deprivation of liberty to be lawful. This can be the Mental Health (Northern Ireland) Order 1986[xiii], the Mental Capacity Act (Northern Ireland) 2016, an Order from a Court or another statute. Only in emergency situations can the common law defence of necessity be relied upon.

1.18. Seclusion is always a deprivation of liberty and must therefore have a legal authority prior to being carried out. Secluding a person without a legal authority is unlawful.

2. The Standards

1. **All organisations must use the standard definitions to identify all interventions which are potentially restrictive.**

2. **All local policies and practices must embed use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of restrictive interventions.**

3. **Effective and person-centred communication must be central to care and treatment planning.**

4. **Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans.**

5. **Organisational strategies and related policies for minimising the use of restrictive interventions must follow a shared and consistent content.**

6. **Roles and responsibilities are defined in terms of monitoring, reporting and governance.**

7. **Any use of seclusion as a last resort intervention must follow the regional operating procedures.**

3. Key Principles

3.1. Restrictive Practice is an umbrella term that refers to the entire range of interventions that are considered restrictive and which infringe a person's rights.

3.2. Evidence of therapeutic benefits for use of restraint and seclusion is limited.

3.3. Organisations must have robust monitoring arrangements in place that provide assurances that restrictive practices are used only as a last resort, and that any restrictive practice used provides a therapeutic benefit to the person.

3.4. Minimisation strategies, culture change and practice improvement will only be successful with robust monitoring, oversight and assurance, led by identified individuals in each organisation.

Rights Based Approach

3.5. The value of each and every person receiving services is recognised through service delivery founded on a rights-based approach which empowers and involves the individual in decision making.

3.6. The lived experience is a critical contribution for all aspects of minimisation strategies.

3.7. Rights based approaches, evidenced based interventions, robust monitoring and governance, and a drive to "always do better" for people receiving services and staff delivering care, treatment and support will be the foundations of any and all policy and practice. The routine use of *Three Steps to Positive Practice*[xiv] will contribute to ensuring that any use of any restrictive practice, restraint or seclusion has been considered as the least restrictive, most therapeutic intervention available to meet a person's needs.

3.8. The routine use of *Three Steps to Positive Practice* will drive any culture change necessary to realise the organisation's minimisation strategy at both practice and strategic levels.

3.9. Transparency is key in building relationships, authentic communication, developing person-centred, rights based and evidence-based care. Transparency must therefore be part of treatment and support plans, reviewing and debriefing incidents, and improving service delivery.

4. Key Actions

Leadership and Accountability throughout Health and Social Care Statutory and Non-Statutory Organisations

Action 1. Health and Social Care organisations, where restrictive interventions are used, must develop minimisation strategies centred on rights based and evidence based positive and preventative approaches.

Action 2. HSC organisations must embed the use of the *Three Steps to Positive Practice Framework* ensuring that any restrictive practice has been considered through a "least restrictive" lens.

Action 3. Non-statutory health and social care organisations, where restrictive interventions are used, should develop minimisation strategies centred on rights based and evidence based positive and preventative approaches.

Action 4. Non-statutory organisations should embed the use of the *Three Steps to Positive Practice Framework* ensuring that any restrictive practice has been considered through a "least restrictive" lens.

Action 5. Identified senior staff are responsible and accountable for leading the restrictive practice minimisation strategy for their own organisation, as well as contributing to a regional vision of eliminating unnecessary restrictive interventions, restraint and seclusion.

Action 6. Leadership will be modelled in practice by organisations adopting/developing "Positive Practice" champions/teams.

Monitoring, Oversight and Assurance

Action 7. Each individual organisation is responsible for ensuring the requirements of this policy are implemented, providing evidence of monitoring, oversight and action to address deviation from the policy.

Action 8. Identified individuals in each organisation will lead the minimisation strategy, driving culture change and practice improvement underpinned by robust monitoring, oversight and assurance.

Action 9. The DoH Strategic Performance and Planning Group (SPPG) will be tasked with overall monitoring of organisations' implementation of restrictive practice minimisation strategies and plans and providing assurances. SPPG will work with all organisations involved to set the systems and structures in place to facilitate this.

Action 10. This will include establishing systems and processes for standardising terminology across the region to allow data collection, mandatory reporting etc., leading to a baseline position to inform minimisation strategies. This will also involve developing regional quality improvement programmes, aiming to

support organisations and staff in safely and effectively implementing the minimisation strategy.

Action 11. The Public Health Agency (PHA) through its safety and quality functions, will support analysis of incident reporting for the purposes of learning and service improvement and develop regional quality improvement initiatives informed by that data analysis and learning.

Action 12. The Regulation and Quality Improvement Authority (RQIA) will have a monitoring and assurance role consistent with their role and function set out in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, Mental Health (Northern Ireland) Order 1986, Mental Capacity Act (Northern Ireland) 2016, service specific regulations and inspection key themes. This will include reviewing the implementation of rights-based approaches for individuals and achievement of organisational restrictive practice minimisation measures.

5. Standard 1 – All organisations must use the standard definitions to identify all interventions which are potentially restrictive.

Restrictive Practices

Restrictive practices are those that limit a person's movement, day to day activity or function.

Restrictive Interventions

Environmental restrictions

The use of obstacles, barriers or locks to prevent a person from moving around freely. This could also include the use of electronic monitoring.

Psychological restrictions

Depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do.

Coercion

The practice of persuading someone to do something by using force or threats.

Observation

A restrictive intervention of varying intensity in which a member of healthcare staff observes and maintains contact with a person to ensure the person's safety and the safety of others.

Restraint

Physical Restraint

Any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body, of another person.

Mechanical Restraint

The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

Chemical Restraint

The use of medication, which is prescribed and administered for the purposes of controlling or subduing acute behavioural disturbance, or for the management of on-going behavioural disturbance.

Seclusion

The confinement of a person in a room or area from which free exit is prevented.

5.1. The use of restrictive interventions can be traumatic for all those involved. They have the potential to have a long-term negative impact on people subject to the intervention and the staff involved, with damage to any therapeutic relationship. There must be a focus on person centred practice and promotion of positive relationships, to support recognition of any potentially restrictive intervention is recognised as aiming to minimise/eliminate such interventions.

General principles for any use of restrictive practices

These principles apply across the lifespan, but specific techniques may need adjusted to suit individuals, for example, children, young people, older people, condition specific considerations, etc.

Decisions to use restrictive practices must be supported by robust justification.

Children and young people should never be subject to seclusion.

Restrictive interventions, restraint and seclusion should not be used for reasons related to disability.

Any use of restrictive practices must only be considered as a last resort.

Initial attempts of restraint should as far as possible be non-physical.

There must be a real possibility of imminent harm to the person or to staff, the public or others if no action is undertaken.

Any use of restrictive practice must be most effective and therapeutic intervention possible with regards to reducing behaviours associated with risk and/or their impact.

The nature of the technique used must be proportionate to the risk of harm and the seriousness of that harm and be the least restrictive option that will meet the need.

Any restriction should be imposed for no longer than absolutely necessary.

Restrictive interventions, restraint or seclusion must never be used as discipline, to inflict pain or humiliation, or a substitute for the provision of proper, person-centred care.

Use of restraint or seclusion must be considered in the context of the legal authority for its use, and fully compliant with a rights-based approach.

5.2. There is significant value in all health and social care organisations using the same language and descriptors to identify all interventions which are potentially restrictive[xv]. Therefore, all organisations must use the standard definitions to identify all interventions which are potentially restrictive, including restraint measures and seclusion, across all health and social care settings, statutory and non-statutory. This will support staff in identifying which practices are restrictive and contribute to considered decision making about their use.

5.3. "Restrictive practice" is an umbrella term that refers to the entire range of interventions that are considered restrictive – from a person's walking aid, controlling their access to kitchen cupboards, covert administration of medication, or continuous observations, through to various methods of restraint and on to seclusion at the far end of restrictive measures that infringe a person's rights.

5.4. This definition encompasses all restrictive practices and is wide enough to invoke a considered thought process around any and all interventions that may be potentially restrictive. Even though an intervention may be considered to be in an individual's best interest or to ensure safety, it may still potentially be restrictive and should be considered as such.

Restrictive Practices

5.5. In its broadest sense, the regional definition incorporates any and all restrictive practices; those which are obvious, for example, hands on physical restraint or the use of seclusion, as well as those which are less obvious, including coercion and psychological measures like controlling how often and for how long someone watches television.

5.6. Organisations must identify and include all potentially restrictive interventions, including those that are not always obvious. With effective definitions it will be possible to monitor the use of restrictive practices or put in place mechanisms to minimise their use; actions which protect both people who use health and social care services and staff implementing the measures.

5.7. Recognising and acknowledging the use of restrictive interventions in the context of the regional definition will enable organisations and individual staff to understand the extent to which restrictive practices are used in the everyday care, treatment and support they deliver, realising the ethical and legal implications.

5.8. Every use of restrictive practice must be described in a care/support/treatment plan that meets the requirements of the *Three Steps to Positive Practice Framework,* ensuring that it is the least restrictive, most effective and therapeutic intervention that will be used for the shortest period of time possible, with a defined review period specified. Using the *Three Steps to Positive Practice Framework* will ensure that the intervention is supported by best evidence for its use and is human rights compliant and lawful.

Environmental Restrictions

5.9. Environmental restrictions include the use of obstacles, barriers or locks to prevent a person from moving around freely. It could also include the use of electronic monitoring in the form of 'wandering' technology such as 'tag' monitors or alarm mats. If the restrictive intervention prevents a person from leaving, the intervention constitutes a deprivation of that person's liberty and a breach of the international Human Rights law (European Convention of Human Rightsxvi Article 5, or the United Nations Convention on the Rights of the Childxvii, Article 37), and is unlawful unless undertaken within a legislative framework.

5.10. The Mental Health (Northern Ireland) Order, 1986, The Mental Capacity Act (Northern Ireland) 2016, The Children (Northern Ireland) Order, 1995, and in some cases individual Court Orders provide authorisations for lawful health and social care related deprivations of liberty. Whilst the common law Doctrine of Necessity will allow a temporary deprivation of liberty, to keep a person safe from immediate danger, any sustained or planned deprivation of liberty is only lawful when used with the most appropriate legislation. This includes any use of seclusion.

5.11. Organisations have a responsibility to ensure that staff are aware of and fully understand the relevant legislation and apply that legislation comprehensively and correctly. At an individual practitioner level, the values, competencies and professional registration requirements of health and social care staff dictate understanding and practice compliant with current legislation.

Psychological/Psychosocial Restrictions

5.12. Psychological/psychosocial restriction refers to depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do. This could include "punishment" interventions for children such as potentially removing contact with parents or carers[xviii] or access to social interaction/digital access, withholding nutrition or fluids, or corporal punishment, to force compliance.

5.13. All staff must be aware that the use of body language, non-verbal and paraverbal communication, in an attempt to apply control or force compliance are equally restrictive interventions, and possibly constitute coercion.

5.14. Health and social care staff have a responsibility to keep people safe and healthy. For those who cannot understand the consequences of making positive and negative choices/do not have the capacity to understand such consequences, due to neurodevelopmental and/or cognitive difficulties and challenges, there will sometimes be a necessity to "control" choices to keep people safe, for example limiting access to unhealthy food choices.

5.15. There are times when strategies to increase motivation to complete less preferred, but essential or important tasks required to build skills and independence, could be considered as making "someone do something they don't want to do". However, health and social care professionals must understand how this can relate to the imbalance of power between those who provide a service - staff - and those who

use the service. Power imbalance can lead to the use of coercion, abuse and degrading treatment[xix].

Coercion

5.16. Coercion is defined as the practice of persuading someone to do something by using force or threats. However, in reality, coercion may not be obvious "force or threats", but much subtler. Coercive atmospheres create tension and conflict, with the potential to generate increasingly restrictive staff interventions and environments. Coercive language and behaviour will harm relationships and damage therapeutic milieus and is something of which staff must always be conscious. Coercion should never be used in any of its forms.

> ***"If you take all your medicines, I will be able to tell the doctor and you won't have to go back to hospital"***
>
> ***"If you don't have any fizzy drinks this week, you will be able to see your mummy at the weekend"***
>
> *Some examples of more subtle coercive practice*

Observation

5.17. Observations are "*restrictive interventions of varying intensity in which a member of the healthcare staff observes and maintains contact with a person to ensure the person's safety and the safety of others*". While it is clear that the intention is to provide a therapeutic component or opportunity, observation as an intervention is restrictive and often limits a person's movement, day to day activity or function[xx] [xxi].

Restraint

5.18. Restraint must only be used as an emergency last resort when all other non-restrictive measures have been exhausted and only when the specific risks to self or others posed by the individual's behaviour cannot be managed by other reasonable means. The use of restraint should always be viewed as a temporary solution to any behaviour causing concern and should only be used following assessment and decision making measuring the likelihood and severity of the outcome.

5.19. Any restraint should represent the least restrictive intervention, for the least amount of time possible, and a reasonable, and proportionate response to the prevailing risks[xxii].

5.20. The application of restraint for any reason is an imposition on an individual's rights and dignity, by its nature restricts a person's liberty, and in some cases may subject the person to an increased risk of physical and/or psychological harm[xxiii].

5.21. The use of restraint must also be considered in the context of the legal authority for its use. All use of restraint must be monitored and recorded. Monitoring must be proportionate to the level of restriction. Regulated services registered with the Regulation and Quality Improvement Authority[xxiv] must ensure alignment with any relevant standards applicable to the setting. For the statutory sector, this means ensuring that the same level of recording takes place, regardless of setting.

Physical Restraint

> *"Physical restraint can be humiliating, terrifying and even life-threatening. It should only be used as the last resort, when there is no other way of de-escalating a situation where someone may harm themselves or others."*

5.22. Physical restraint is defined as any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body, of another person. The use of any physical restraint is not without risks, despite any legal and professional justifications. Staff must be aware of the potential risks involved when applying any physical restraint technique to minimise the potential impacts that are associated with the use of physical restraint[xxv]

5.23. Health and social care staff must also be aware that certain groups are more vulnerable to risks and adverse outcomes associated with restraint – either intrinsically, or because they are more likely to be restrained. These groups are those people with serious mental health illness, intellectual disabilities or cognitive impairment, people from ethnic minority groups, individuals with high BMI, men aged 30-40, children and young people below the age of 20[xxvi].

5.24. Prone restraint must not be used by health and social care staff unless in exceptional circumstances[xxvii xxviii xxix].

5.25. Any other uses of physical restraint must not be prolonged (exceeding 10 minutes) unless in exceptional circumstances and must follow best practice standards. Alternative non-physical interventions must be considered before and during the restraint episode. If restraint is required for longer than 10 minutes alternative non-physical interventions such as rapid tranquillisation or seclusion should be considered.

5.26. For these reasons and in line with NICE guidelines any use of physical restraint reaching or exceeding the threshold of "prolonged" must be subject to a formal incident review, in line with organisational policy.

5.27. A person who suddenly stops resisting a physical restraint intervention may be experiencing cardio-respiratory de-compensation which is a medical emergency.

5.28. In the circumstance where physical restraint may be required:

- Staff must be appropriately trained by an accredited training organisation;

- Deliberate pain or the threat of use of pain must not be used by staff in an attempt to force compliance;

- People must not be restrained in a way that impacts their airway, breathing or circulation - pallor, cyanosis or complaining of not being able to breathe are clear indicators of respiratory arrest or positional asphyxia;

- The mouth and/or nose must never be covered, and techniques should not incur pressure on the neck region, ribcage and/or abdomen;

- There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor;

- One member of staff involved must take overall responsibility for monitoring the person's airway and physical condition throughout the restraint event. If the person's physical condition and/or their expressions of distress give rise to concern, the restraint should cease immediately;

- Avoid "taking the person to the floor". If this is unavoidable, any movement towards the floor is dictated by the person as they descend; staff involved should support the safety of the descent. Where possible a supine position must be used instead of a prone position. However, **if** there are exceptional circumstances where prone restraint is unavoidable, it should be for the shortest amount of time possible[xxx] [xxxi].

- Clinical observations including pulse, respiratory rate, temperature, blood pressure and observation of the person's colour should be undertaken during the event and for a period of time after the event to be determined by the lead clinician.

5.29. In the exceptional circumstances where physical restraint is considered for use for a child or young person[xxxii], staff must have the appropriate training to ensure that they undertake any interventions in line with NICE guidelines[xxxiii]. NICE advise that restraint[xxxiv] techniques are adjusted according to the child or young person's height, weight and physical strength. Staff must also be trained in the use of resuscitation equipment on children and young people.

5.30. If possible, staff members who are the same sex as the child or young person should undertake the physical restraint intervention. There may be times when physical restraint is required to safely support a person with essential personal care needs, specialist care and treatment or in an emergency for essential medical treatment, in the circumstances where the person cannot provide/lacks the capacity to provide informed consent[xxxv] [xxxvi]for the intervention.

5.31. The use of restraint for clinical treatment, essential treatment in an emergency or for essential care tasks has been differentiated from that of physical restraint in regard to the rationale and intention of using holding skills.[xxxvii] However, health and social care staff must be aware that these techniques are considered physical restraint and they must be trained in their use.[xxxviii] [xxxix]

5.32. Physical restraint for clinical treatment, essential treatment in an emergency or for essential care tasks cannot proceed where a person has the capacity to provide informed consent but chooses to withhold that consent.

5.33. In circumstances where a person requires physical restraint to meet their needs as result of lack of capacity and inability to consent to an intervention, then this should be agreed within the context of best interests and by a multi-disciplinary team, using the *Three Steps to Positive Practice Framework*. As with all restrictive practices, physical restraint in these circumstances must only be used in the context of a last resort, least restrictive and most effective intervention. A detailed care plan is required where physical restraint might be used for essential clinical treatment, essential treatment in an emergency or for essential care tasks.

5.34. Any and every use of physical restraint, including when used for clinical treatment, essential treatment in an emergency or for essential care tasks, should be subject to a review of the restraint event and the person's care and treatment plans amended where required and appropriate, to mitigate against continued need for the use of restraint.

5.35. The review should include:

- the type of restraint technique employed;
- the date and the duration of the intervention;
- the names of the staff and people involved;
- reasons for using the restraint technique employed (rather than an alternative less restrictive approach);
- whether the person or anyone else experienced injury or distress;
- the person's views of the incident (if appropriate, through family, caregiver or advocate);
- what follow-up action was taken, including the need for any formal emotional support.

Mechanical Restraint

5.36. Mechanical restraint is the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control[xl].

5.37. Mechanical restraint can involve the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part(s) of a person's body. This type of intrusive mechanical restraint should not be used outside of a designated secure setting[xli]. It must only be used in limited and exceptional circumstances for management of extreme violence directed towards others, or to limit self-injurious behaviour of extremely high frequency or intensity.

5.38. Nice guidelines[xlii] advise against use of this type of restraint for children and young people.

5.39. Organisations must have policies for the use of this type of restraint, detailing what would constitute the limited and exceptional circumstance of extreme violence/self-injurious behaviour that would warrant use of such equipment, in which designated facility and the robust governance arrangements that authorises, monitors, and reviews their use.

5.40. The use of mechanical restraint should be avoided where possible. However, there may be exceptional circumstances where mechanical restraints (other than those for exceptional use within secure settings only (5.31 above)) are required to limit self-injurious behaviour of high frequency or intensity, for example, use of arm splints, use of cushioned helmets etc.

5.41. Mechanical restraint may also, for example, be the use of "safe space" equipment, lap straps, bed rails and harnesses for the purposes of preventing harm to the person or endangering others, and by their nature restrict liberty. The use of the *Three Steps to Positive Practice Framework* will assist in the assessment, planning and review of these measures in these exceptional circumstances and provide assurances regarding the application of a proportionate and least restrictive use of mechanical restraint.

5.42. Mechanical restraint in these cases must be:

- robustly assessed as the least restrictive measure possible that will maintain the safety, well-being and dignity of the person;
- part of a support/care plan that includes actions and interventions that aims to bring about the circumstances where continued use of mechanical restraint will no longer be required (where possible);
- reviewed at pre-determined intervals, according to the individual's unique situation, to include:
    - the type of mechanical restraint used;
    - the date and the duration of the intervention;
    - reasons for using the type of mechanical restraint (rather than an alternative less restrictive approach);
    - whether the person or anyone else experienced injury or distress;
    - the person's views on the use of mechanical restraint (if appropriate, through family, caregiver or advocate);
    - any amendments to care/support plans or follow up action, including the need for any formal emotional support.

5.43. Mechanical restraint should not be used:

- as a substitute for other less restrictive interventions;
- as a form of discipline or punishment;

- as a substitute for inadequate staffing levels;
- as a substitute for staff training in crisis prevention and intervention to manage aggressive, harmful behaviours; or
- when seclusion is being used simultaneously.

Chemical Restraint

5.44. Chemical restraint refers to the use of medication to control or subdue acute behavioural disturbance, or the management of on-going behavioural disturbance. It is important to recognise that it can bring therapeutic benefit to a person experiencing particularly distressing symptoms, such as hallucinations.

5.45. Acute Behavioural Disturbance is an acute mental state associated with an underlying mental or physical disorder[xliii]. The symptoms associated with acute behavioural disturbance range from agitation, distress and actual or potential aggression and violence, that causes the person to harm themselves or cause harm to another person, or where a person causes damage to property, with the intent to use objects to harm self or others.

5.46. Responses to and management of acute behavioural disturbance will require combined evidence based and therapeutic strategies, including management and treatment of physical ill health, de-escalation, and other non-pharmacological approaches[xliv], to be used in advance of a pharmacological approach, and/or along with a pharmacological approach.

5.47. In these cases, the purpose of the use of medication is to “control or subdue” behaviours which may potentially result in harm to the person or to others. This use of medication is considered chemical restraint.

5.48. Potentially sedating medications might be used over months or even years in the management of on-going behavioural disturbance. This captures a wide range of practice from high dose sedating medications over a period of weeks (when an individual might be experiencing a very acute disorder) through to occasional use of low dose medications which may cause a degree of sedation in individuals with long term conditions. The use of these medications aims to bring relief from behavioural or psychological symptoms associated with long term neurodevelopmental or neuropsychiatric conditions (e.g. autism, dementia etc) and will therefore be therapeutic

5.49. Staff should assess whether the person will accept oral medication as part of a de-escalation technique where non-pharmacological de-escalation techniques were not adequate to diffuse anger or avert aggression, and there is not an immediate risk of violence or aggression. This is sometimes known as “pre-rapid tranquillisation. NICE[xlv] guidelines advise that oral Pro Re Nata (PRN) medication on its own is not de-escalation.

5.50. If the pharmacological response is rapid tranquillisation – medication by the parenteral route (which means by methods other than taken orally, usually intramuscular injection or exceptionally, intravenously, if oral medication is not possible or appropriate and urgent sedation with medication is needed) – a formal incident review is required for each episode of administration.

5.51. Health and social care staff who are involved in the management of Acute Behavioural Disturbance using pharmacological responses must follow the requirements set out in local policy and procedure, relevant best practice guidance and/or regional protocols.

5.52. There are situations where the use of medication to undertake a specific procedure – for example general anaesthesia for dental extraction - *is* intended to subdue, control or restrict the individual, to allow the intervention to proceed. The use of pharmacology in this circumstance is not in response to acute behavioural disturbance but is nonetheless considered chemical restraint. Staff should recognise the intervention as chemical restraint and use the *Three Steps to Positive Practice Framework,* to determine that the proposed pharmacological response is the least restrictive, most proportionate intervention available at that time.

5.53. There are situations where the use of medication in the treatment of a particular illness, condition or presentation is not intended to subdue, control or restrict that individual, but potentially has restrictive side effects. In these cases, the intent behind the medication must be considered.

5.54. In all cases where potentially sedating medications are being used for management of behavioural symptoms, irrespective of the nature or degree of 'restriction' these might cause, the *Three Steps to Positive Practice* will provide a useful framework for decision-making and interdisciplinary review of the use of potentially sedating medications in line with NICE guidance.

Frequency of review of the use of restrictive practices

5.55. The regional procedures for use of seclusion (Standard 7) dictate a specific timeline for review of its use. However, it is not appropriate to define a "minimum/maximum" timeframe for review of other restrictive practices within this policy document.

5.56. The frequency for review of the use of restrictive practices will be agreed on an individualised basis and in the context of changing presentation, assessed risk of harm to the person or others, changing circumstances and/or any fluctuation in capacity to consent to interventions.

5.57. For example:

- the presentation of a person with delirium who is subject to restrictive practices, such as close observation or deprivation of liberty, may change day to day, meaning that any restrictive practice should be reviewed on a daily basis;

- a person with advanced dementia who requires to be deprived of liberty is unlikely to present significantly differently day to day, meaning that the intervals between review periods will likely be longer;
- the requirement for the use of arm splints to manage the risk of a person causing harm to themselves will be assessed and reviewed at every use, possibly multiple times per day, with the shortest interval possible between review to allow the mechanical restraint intervention to end;
- the use of PRN medication and Rapid Tranquillisation will be reviewed after every use as part of an incident review with the intention of mitigating against recurring use;
- The use of physical restraint will be reviewed after the restraint event with the intention of mitigating against recurring use.

5.58. The Three Steps to Positive Practice requires an agreed timeframe for review of any restrictive practice, before the intervention is initiated.

Seclusion

5.59. Seclusion is the confinement of a person in a room or area from which the person is not free to leave.

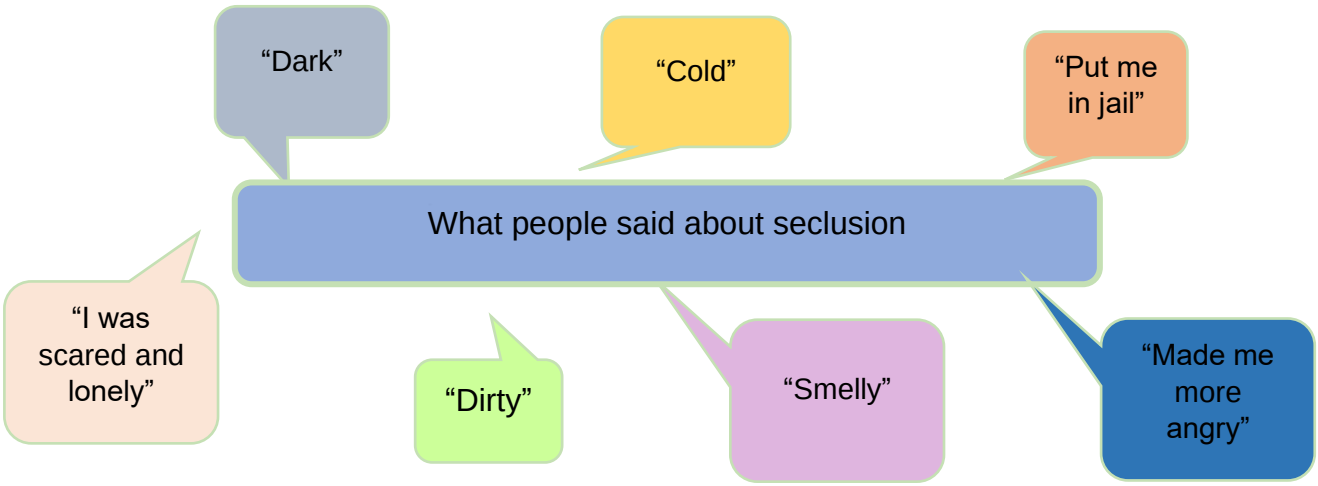
5.60. Children and young people should not be subject to seclusion.

5.61. Not being free to leave does not require a locked door. It can be staff locking the door but can also be the person believing that the door is locked, staff holding the door handle, blocking exit, refusing exit, coercing the person and so on. The key point being that the person being secluded can only leave the confinement area when permitted to do so.

5.62. If seclusion is required, it must only be used:

- As a last resort intervention in an emergency where there is an unmanageable risk to others and other less restrictive methods are deemed insufficient to manage that immediate risk;
- When a person is, or is liable to be, detained in accordance with an appropriate legal framework;
- In a hospital setting in a room or suite specifically designated for this purpose;
- In accordance with the regional operating procedures (see Standard 7).

5.63. Worldwide evidence provides no definitive conclusion that the use of seclusion has a therapeutic benefit[xlvi]. It can be seen as punitive and can cause psychological harm.[xlvii] [xlviii] The use of seclusion can often be a traumatic experience for those involved and can cause potential damage to therapeutic relationships compromising recovery and well-being.



5.64. In every circumstance where a person is confined in a room, or an area, and the person is not free to leave, no matter the name given to the intervention, the person is subject to deprivation of liberty, which may also amount to seclusion.[xlix] Seclusion used outside of the circumstances set out at 5.62 is not acceptable. Seclusion used outside of a legal framework breaches human rights and is unlawful. This applies to both adults and children. A health and social care professional using seclusion outside of a lawful process may be subject to prosecution for false imprisonment or unlawful detention of the person.

5.65. There is no such thing as “consenting” to deprivation of liberty and therefore no one can consent to seclusion, even if the situation is believed to be one where the person has “requested” seclusion and/or can “ask” to be released. Health and social care staff must consider the practice in question in the context of the definition and the circumstances in which it is considered for use. Plans should be put in place to replace the seclusion intervention as soon as is possible with an intervention that has an evidence based therapeutic intent, with the aim of eliminating any use of seclusion for that individual.

5.66. Some individuals may express a preference for seclusion rather than physical restraint, for example, in circumstances that they exhibit behaviours that present an immediate and unmanageable risk of serious harm to others when acutely mentally unwell. This is not to be confused with a person “consenting” to seclusion but can be an important aspect of care planning. Advance statements – a written statement which primarily informs all staff of the person’s wishes, feelings, beliefs, values and preferences regarding their future treatment – is recommended.

5.67. All those who are capable and wishing to do so should be encouraged to make an advance statement with regards to the use of any restrictive intervention. An advance statement does not provide legal authority but must be taken into account by all health and social care professionals when making decisions about the management of a person where their behaviour is presenting as a risk towards themselves or others.

5.68. There may be circumstances where a person is confined to an area supported by staff, promoting the use of a lesser stimulating environment to support emotional

regulation. Decision making around an intervention such as this must provide therapeutic benefits and outcomes for the person, which must be clearly set out in care/support plans.

5.69. All staff must be aware that their actions, if preventing free exit, amount to a deprivation of liberty. All staff must consider if, in implementing the intervention, their action amounts to secluding the person, that is – are they acting in an emergency, confining a person in response to an unmanageable risk of harm to others where other responses have been deemed insufficient?

5.70. Where the intervention amounts to deprivation of liberty, there must be a regular review process that reflects the least restrictive approach for the least amount of time possible. The person's care and treatment plan must be reviewed to consider other proactive and positive approaches to prevent re-occurrence.

5.71. Where the intervention amounts to seclusion, there must be an urgent, in-depth review of the person's care and treatment plan, with the aim of eliminating any use of seclusion for that individual with an intervention that has an evidence based therapeutic intent.

5.72. All staff need to ensure that they are acting within the requirements of this regional policy, and relevant legislative frameworks.

5.73. Seclusion must not happen outside of the hospital environment. NICE guidelines[l] advise against the use of seclusion in the emergency department.

5.74. If an emergency situation occurs outside of the hospital setting where a person requires to be deprived of their liberty in circumstances that amount to seclusion, urgent and in-depth review of the incident and the person's care and treatment plans is required, and appropriate therapeutic actions taken to avoid recurrence. However, seclusion outside hospital cannot be part of the person's care plan and must only ever be in response to an emergency.

Long term segregation

5.75. People can be subjected to a range of restrictions that fall short of seclusion but may result in an extreme restriction of social contact over a prolonged period of time. It is different from seclusion.

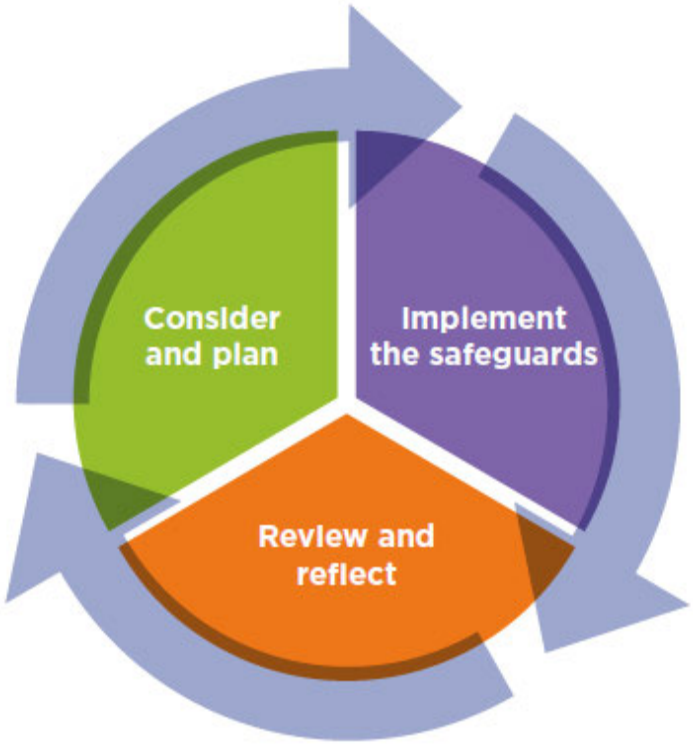
5.76. While formal 'long term segregation' is not a recognised form of care in Northern Ireland, people can spend very long periods of time with minimal or no contact with their peers and without having any time out of the health and social care facility, be that a hospital, a care home, or their own home. This is comparable to long term segregation. It is key that policies and procedures provide safeguards for people who may be subject to this type of arrangement. Segregation from others is a form of restrictive intervention.

5.77. Staff must be alert to this practice, recognise it as restrictive and use the *Three Steps to Positive Practice Framework* to ensure there is a clear plan to minimise and eliminate the use of segregation as quickly as possible.

5.78. Organisational policies must include mechanisms and safeguards that prevent any person being cared for, supported, or treated in a situation that amounts to long-term segregation.

6 Standard 2 – All local policies and practices must embed the use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of restrictive interventions

6.1. All local policies and practices must embed the use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of any restrictive intervention, from locking cupboard doors right through to use of seclusion.[i] [iii]

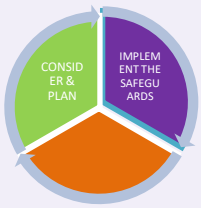
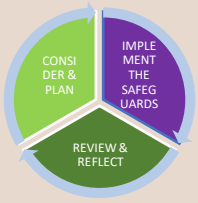


6.2. There are occasions when the use of restrictive practice is unavoidable in order to keep a person or others safe from harm. Not all restrictive interventions are inherently wrong, harmful or illegal; they are sometimes necessary and could form part of health and social care delivery. In this context it is essential that any use of restrictive practice is therapeutic, ethical and lawful.

6.3. *The Three Steps to Positive Practice* is a collaborative Royal College framework designed and endorsed by the Royal College of Nursing, Royal College of Psychiatrists, the British Association of Social Workers, and the Royal College of Occupational Therapists. This framework assists health and social care professionals to think about culture and practices and to guide professional, ethical and legal decision making when considering the use of potentially restrictive practices document, supporting legal, ethical and professional decision making around the use of restrictive interventions, every time a decision is made, or an action is taken.

6.4. *The Three Steps to Positive Practice* is a continuous and cyclical process which requires a health and social care professional to routinely adhere to all three steps of the framework. This framework has been designed to be applied at points of assessment, implementation, evaluation and review, and in situations where the use of restrictive interventions has been in place for some time or associated with a particular environment.

STEP 1 Consider and plan 	Has a multi-disciplinary discussion around how to keep the person (or others) safe resulted in recommending a potentially restrictive practice? Does the proposed intervention or the way in which care is being delivered: • limit the person's movement, daily activity or function; • result in the loss of objects or activities that the person values; or, • require the person to engage in a behaviour that he/she would not engage in given freedom of choice? If you answer yes to any of these questions, then the proposed intervention is potentially restrictive.	You must ensure that a multi-disciplinary discussion has taken place before you proceed. The plan must be discussed with the person and/or their representative, including advocates. Decisions must be clearly documented and communicated to all parties. Remember that some decisions may require a legal opinion.
	What other less restrictive options have been considered?	You must ensure that other, less restrictive options, starting from the point of no restriction or least restriction have been discussed. A clear rationale must be documented to evidence why they are not appropriate at this time.
	How will the proposed intervention reduce risk, and build or retain the person's skills and the opportunities available to them?	You must ensure that the proposed intervention is the best and only approach to reducing an identified risk and achieving therapeutic benefit. You must ensure that the proposed intervention is a positive and evidence based therapeutic approach which clearly articulates how the intervention will reduce the identified risk. The intervention must also support the person's ability to develop and retain skills and learn through experiences.

Implement the safeguards 	Is this proposed intervention considered to be in the person's best interests?	You must consider the areas of capacity and consent when deciding if the proposed intervention is in the person's best interests. You must ask questions if you are not satisfied that the evidence confirms that the implementation of the proposed intervention will be in the person's best interests. Documentation must clearly record the formal discussions and processes involved in reaching a multi-disciplinary agreement.
	How do I ensure that I am using a rights-based approach?	You must ensure that the plan is fully considerate of human rights and the FREDA principles and can be implemented under an appropriate legal framework. You must support the person and their representatives to understand their rights and provide information on how they can raise any objections or complaints.
	What professional accountability frameworks must be considered?	You must ensure that the decisions you make are ethical and fully considerate of your individual professional responsibilities, and your organisation's accountability and governance structures.
STEP 3 **Review and reflect** 	Has a regular and timely review of the intervention been planned?	You must ensure that a pre-determined timeframe for review of the intervention has been agreed before the intervention is implemented.
	Is there a plan to ensure that the intervention will be for the shortest length of time possible?	You must ensure that there is a positive therapeutic care plan that includes a planned reduction of the restrictive practice. The review must re-consider steps 1 and 2.
	Are there mechanisms available to you as an individual and to your team to enable reflection about the impact of using restrictive interventions?	You must recognise that the use of restrictive interventions, especially restraint, can have a negative emotional impact. It is important that opportunities for supportive discussion and reflection are made available to you and your colleagues.

6.5. The Three Steps to Positive Practice Framework seeks to build a culture of practice embedded in a rights-based approach as the “norm”. The truest articulation of a rights-based approach that meets the needs and circumstances of the individual is based on person-centred culture and practice, which will be realised with embedding the rights-based approach of this framework in policy. A professional using the framework is directed towards the use of a rights-based approach, thereby ensuring the minimisation of such interventions. As the agreed regional framework, every member health and social care staff must follow the Three Steps to Positive Practice Framework when considering the use of any restrictive practice. Where the process is not being implemented and staff are aware of the use of restrictive practices, it should be recognised as a potential safeguarding issue. Staff must escalate their concerns using organisational reporting processes highlighting the requirements of this regional policy.

Rights Based Approach

6.6. A rights-based approach to health and social care means two things – ensuring that the rights of individuals enshrined in law, known as “Human Rights”[liii] [liv] [lv] are upheld and influence decision making about health and social care delivery; and practice that is shaped by the core principles and values that put the person receiving the service at the centre of decision making about that service, the FREDA principles. A rights-based approach means that all restrictive practices must be subject to appropriate procedural safeguards. In particular, a fair balance must be struck between the severity and consequences of interfering with the rights of the person restricted, the main purpose of which is to ensure the safety of the individual and others.

6.7. A rights-based approach puts the person at the centre of decision making supporting an individualised plan to meet their individual needs. The person subject to the restrictive practice and/or their representatives must be actively involved in all consultation, decision-making and monitoring processes regarding the use and minimisation of restrictive practices. This is an essential aspect of the partnership working that is required in developing proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people**.**

Human Rights

6.8. The application of Human Rights is particularly relevant to a rights-based health and social care provision. These rights are realised through European Convention on Human Rights (ECHR), The United Nations Convention on the Rights of the Child (UNCRC) & the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). There are additional internationally accepted human rights standards, which may have relevance for how health and social care staff and organisations shape rights-based practice[lvi] [lvii]

6.9. These legal frameworks set out how both individual practitioners and organisations must provide and deliver health and social care services. They recognise and protect the dignity of all human beings, and impose legal duties on authorities, both local and national, to respect the human rights set out in the Conventions in their

decisions and actions. Importantly, ECHR, UNCRC and UNCRPD are vital in providing a rights-based approach to health and social care delivery, protecting the key human rights set out in the table below:

	Specific Article		
	ECHR	**UNCRC**	**UNCPD**
Right to life The right to life is protected by law.	2	6	10
Prohibition of Torture The right not to be tortured or treated in an inhumane or degrading way.	3	37	15
Right to Liberty and Security The right not to be deprived of liberty "arrested or detained" – except where there is proper legal basis.	5	37	14
Right to Respect for Private and Family Life The right to family, relationships, well-being, privacy, correspondence and home, including seeing family and being heard.	8	16	22 23
Prohibition of Discrimination The right not to be treated differently because of race, religion, sex, political views or any other personal status, unless this can be justified objectively.	14	2	5

6.10. Every health and social care professional must understand the rights enshrined in human rights law and how this must influence their practice and be alert to the potential for breaches of human rights in everyday practice[lviii].

6.11. These laws are not mutually exclusive. The ECHR applies to every human being, adult and child, with the UNCRC and UNCRPD providing more explicit detail of

human rights law and rights specifically for children and persons with disabilities respectfully. The additional internationally accepted human rights standards contribute to full recognition and application of human rights.

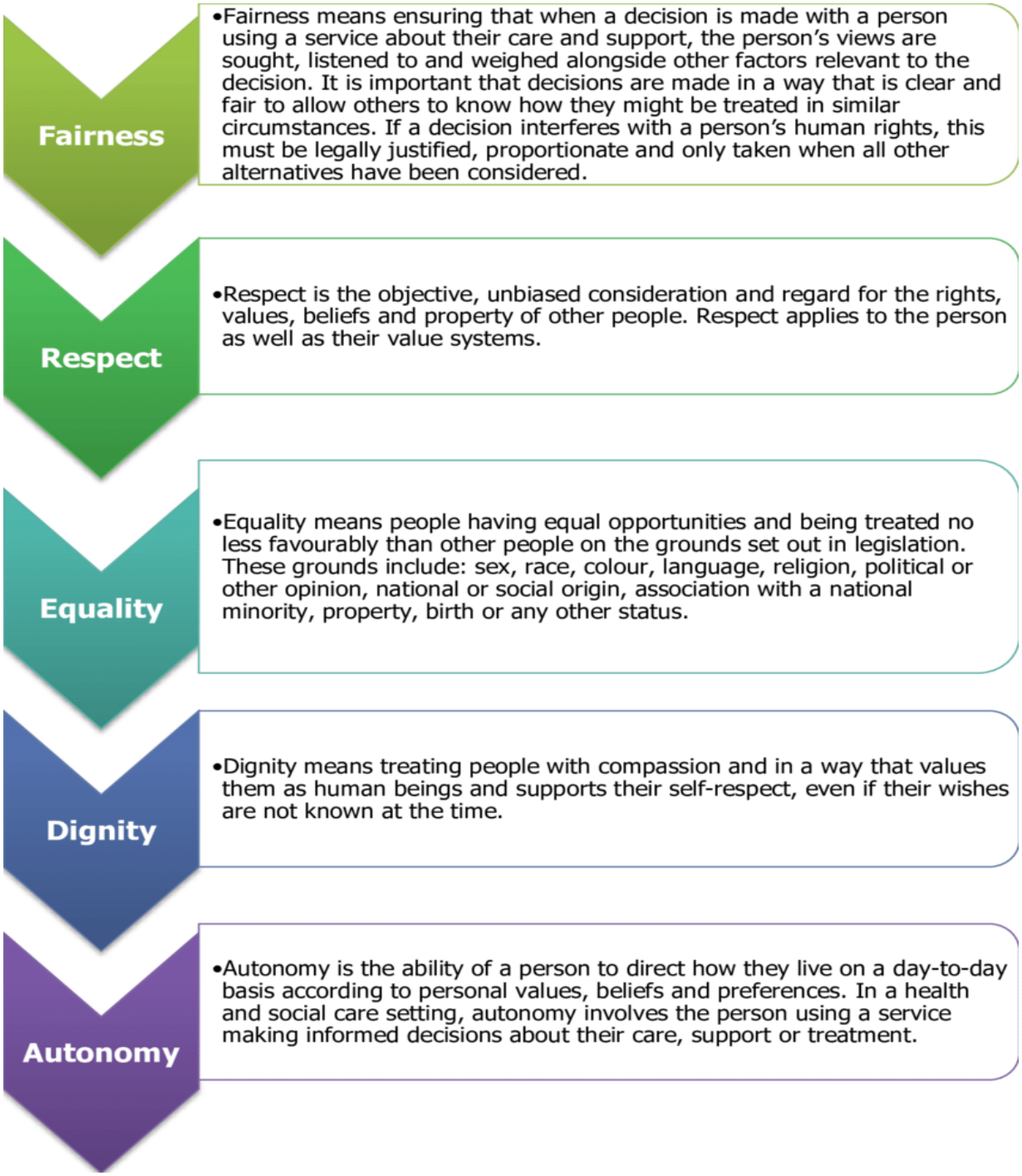
6.12. Health and social care organisations are corporately responsible for creating the circumstances which ensure that staff understand and apply human rights laws and for ensuring that the human rights of everyone who uses their services are upheld. All organisations should ensure that all policy and practice are compatible with the relevant human rights instruments[lix].

FREDA Principles

6.13. A rights-based approach can be achieved by applying the FREDA Principles, the core values that shape practice and which underpin the articles in the human rights frameworks.

6.14. The FREDA Principles are the basis of good health and social care which should be used mutually and individually to inform decision making, supported by inclusive communication strategies. They are a useful guide for health and social care staff to ensure that everyone for whom they are providing care, treatment, support and/or services is:

- Treated with dignity and respect;
- Provided with care which best suits their individual needs;
- Able to live free from abuse, neglect or discrimination;
- Able to participate in the choices and decisions made about their lives;



6.15. Whilst the principal components of a rights-based approach are modelling the core values in the FREDA principles to support the fulfilment of an individual's human rights, there are other elements that are essential in the realisation of a rights-based approach.

Working within a Legislative Framework

6.16. Restrictive interventions must only be used within a relevant legislative framework. All health and social care professionals must be familiar with the laws which are

relevant, to them, their area of practice and their organisation. This protects the individual, staff and the organisation.

6.17. The use of legislative frameworks allows staff to make reasonable and proportionate decisions regarding the use of restrictive interventions. It is important that the justification process is reflective and inclusive of legal, professional and ethical considerations. Organisations must provide the necessary mechanisms, supports and environments to ensure employees can operate within all relevant legislative requirements.

6.18. This includes understanding that every starting point in decision making regarding care, support and treatment is presuming that every adult can make that decision independently (given the correct support to do so where needed), and that the person can provide or withhold consent to that care, support or treatment. This is a foundation step in a rights-based approach to service delivery, putting the person at the centre of the decision-making process.

6.19. Continuing with a restrictive intervention in the situation where a capacitous person withholds consent can only happen in circumstances permitted by the Mental Health (Northern Ireland) Order, 1986, a High Court Declaratory Order or in response to an immediate risk of harm to a person or others around them using the common law Doctrine of Necessity.

6.20. In the situation where a person aged over 16 years has been assessed as lacking the capacity to independently make decisions regarding care, support or treatment, (and if detention for care and treatment in a hospital in accordance with the Mental Health Order does not apply) the Mental Capacity Act (Northern Ireland) 2016 sets out the requirements in terms of lawful deprivation of liberty with all other decisions requiring collective “best interests’” discussions and agreements.

6.21. An adult with parental responsibility can provide consent for a child. In addition to the legislation above, The Children (Northern Ireland) Order 1995, The Children (Secure Accommodation) Regulations (Northern Ireland) 1996, The Age of Majority Act (Northern Ireland) 1995 as well as Gillick Competence principles must be considered relating to decisions involving children.

6.22. As noted at 5.64, there is no such thing as consenting to deprivation of liberty. For a young person aged 16-17, where legislation permits a parent or the State with parental responsibility to provide consent for care and treatment, health and social care staff and organisations must be aware that this does not extend to consenting to deprivation of liberty[lx].

6.23. The situation is less clear for those under 16 years of age. However, in the absence of any definitive Court ruling, where a legal process exists, for example, the Mental Health Order or The Children Order, it is advisable to use the legal process to ensure the child or young person has access to the safeguards within the processes that protect their rights.

6.24. In all circumstances, adherence to a rights-based approach to minimising the use of restrictive interventions will be achieved through the routine use of the *Three Steps to Positive Practice Framework*.

6.25. A list of relevant legislation is provided at Appendix 9. Whilst this is a wide-ranging list, it may not be exhaustive. Health and social care staff may be aware of other legislation that may be applicable to their practice and/or where they deliver their service.

6.26. It is vital that organisations and individual staff work to the legislative framework applicable to their service delivery and practices at any particular time and be aware of and responsive to changes in relevant legislation.

Staff Support

6.27. Even when a decision to implement a restrictive intervention is the last resort, lawful, ethical and in a person's best interests, staff involved can find the implementation of restrictive practices morally and emotionally challenging. Witnessing or being directly involved in a restrictive practice could contribute to work-related stress.

6.28. The Three Steps to Positive Practice includes "reflection" as a supportive mechanism for staff within the Framework and must be considered as important and essential as every other part of the process. There are various evidence-based methodologies to guide this type of activity, for example, structured de-briefing. Structured de-briefing (which has been included as a requirement within the operational procedure for use of seclusion) provides emotional and educational support immediately following incidences of behaviours that challenge and can contribute to the reduced use of restrictive practices. However, those involved should be mindful that the process of discussing incidences in which restrictive practices have been used may be traumatic for both person subject to the intervention and the staff involved or witnessing the event. Organisations must ensure that opportunities for supportive discussions and reflection for individuals and teams are provided as standard, with other pastoral type support available where an individual member of staff might require additional support.

Advocacy

6.29. Advocacy in all its forms seeks to ensure that people can have their voice heard. Organisations should involve an independent advocate in all "best interests" decision-making processes, particularly where a restrictive practice is proposed, if there is an advocate available. For those unable to articulate their views about their care, support and treatment for whatever reason advocacy can be an important method by which a person can be considered and protected in what might be quite complex decision making about how they live their lives and how their care is provided. This is an essential element of a rights-based approach.

Provision of Appropriate Training

6.30. Organisations providing services where people's behaviours can present as a risk, have at times a challenging job that requires a specialised skill set to balance risk, welfare and safety. Training that includes any form of restrictive intervention has potential risks associated and is distressing for everyone involved.

6.31. For this reason, organisations must ensure that the training delivered to staff in the management of such behaviours is accredited and provided by a certified training body. The content must provide training models which are strong on proactive and preventative strategies, human rights-based interventions, and embrace the monitoring, oversight and assurance required in relation to restrictive practices. This approach minimises the use of restrictive practices and creates and maintains a positive and enabling service delivery culture beyond the application of physical restraint or other restrictive interventions.

6.32. Organisations and line managers are responsible for continual assessment of staff competence.

6.33. Education providers are expected to incorporate the principles in this policy into all pre-registration courses preparing future health and social care practitioners.

Co-Production

6.34. Working in partnership is about realising value through people; identifying and using their different skills, experience, and expertise and working supportively and collaboratively to deliver improved outcomes and experiences of health and social care by being part of designing, planning and delivering those improvements.[lxi]

6.35. Crucially, it is also about providing a direct link to the co-design, co-production and co-delivery of services, at strategic level, so those improvements can be embedded and cascaded to benefit everyone in Northern Ireland.

6.36. By connecting those providing health and social care, those with lived experience of care, their families and carers, staff, policy makers and local communities in the planning, delivery and evaluation of healthcare services, people will truly be at the heart of making decisions and choices about services. Doing so supports people to receive the service they want and need with better outcomes and enables service providers to deliver better quality, more targeted health and social care provision.

7 Standard 3 – Effective and person-centred communication must be central to care and treatment planning.

7.1 Inclusive, effective and person-centred communication must be central to care and treatment planning. Inclusive or total communication means sharing information in a way that everybody can understand.[lxii] A person centred approach to communication is a commitment to include a person in all aspects of their care, to gain an understanding of who they are and how to support them best,[lxiii] promoting proactive and ethical methods of reactive and ethical restrictive interventions.[lxiv]

7.2. The Royal College of Speech and Language Therapists has developed a set of practice standards[lxv] that describe what "good communication" looks like, with supporting references and resources. Whilst these were developed in the first instance to support inclusive and effective communication for people with learning disability and autism, they are equally applicable and supportive for anyone who experiences speech, language or communication challenges. Organisations should use the standards to shape their communication policies and practice.

Standard 1 There is a detailed description of how best to communicate with individuals.	In order to communicate effectively it is essential that everyone understands and values an individual's speech, language and communication needs. Individuals should be supported and involved, together with the people who know them best, to develop a rich description of the best ways to interact together. This description needs to be agreed, active, regularly updated and readily available. The description is sometimes referred to as a communication passport, guideline or profile. It includes the best ways of supporting their understanding and expression, the best methods of promoting interaction and involvement and describes 'how to be with someone'
Standard 2 Services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.	Individuals with speech, language and communication needs are often either excluded from patient experience feedback processes or included in a tokenistic way. There is a risk that their needs and opinions are assumed, misinterpreted or ignored. All communication needs to be inclusive. For service providers, this means making sure they recognise that people understand and express themselves in different ways. For individuals this means getting information and expressing themselves in ways that meet their needs[lxvi]. Inclusive Communication is an approach that seeks to 'create a supportive and effective communication environment, using every available means of communication to understand and be understood'.[lxvii] For services to demonstrate inclusion and involvement innovative and creative solutions to understanding the views of individuals are often required due to the nature of communication needs.
Standard 3	Staff working in specialist hospital and residential services must recognise communication difficulties. They must

Staff value and competently use the best approaches to communication with each individual they support.	understand that they need to change their communication style to support the service user and have the knowledge and skills to adapt their communication levels, styles and methods. Staff are aware of factors that impact on communication, especially hearing, sight and sensory integration. They understand that what they say and how they say it matters and can impact positively or negatively on the individual. Staff also understand how good communication underpins informed consent and capacity. They are able to promote the individual's understanding and expression and create opportunities for positive communication.
Standard 4 Services create opportunities, relationships and environments that make individuals want to communicate.	An understanding, welcoming and socially rich environment is fundamental to relationships for all individuals, and particularly people with communication needs. Relationships are central to wellbeing. Getting the communication environment right will contribute to enabling people to live valued and meaningful lives. Individuals need to have the opportunity to communicate about all the things that all people talk about in everyday life such as dreams, hopes, fears, choices as well as everyday wants and needs. Good communication needs to be considered broadly. It is about social interactions – greetings, sharing stories and fun. It is the quality of interaction that contributes to overall emotional and mental wellbeing; providing a sense of belonging, involvement and inclusion. Interaction may not necessarily involve speech. For someone without formal language, interactive approaches are a way of 'being' with another person, making meaningful contact with those who are hard to reach or easy to ignore. It may be about very basic early developmental interaction and communication and relationship building.
Standard 5 Individuals are supported to understand and express their needs in relation to their health and wellbeing.	It is essential to consider communication needs in order to support individuals with their health. Arriving at a diagnosis can prove difficult if a person cannot describe signs and symptoms easily, or their behaviour is misunderstood and misconstrued. Staff need to be aware of how individuals communicate about their health and how they show that they are in pain. This includes considering ill health as a cause for changes in behaviour. Knowing how much a person can understand is also essential in making a decision about their capacity to have a health treatment. It is also required to meet the principles of nursing practice that everyone can expect[lxviii]. This includes treating individuals with compassion and dignity and providing person-centred care.

Key Themes underpinning inclusive, effective and person-centred communication

7.3. Inclusive and effective communication is a key element within an organisational restrictive practice minimisation strategy, centred on collaborative relationships.

7.4. Transparent and trusting relationships support the foundation for effective communication sharing and being able to support a person and their families to be part of their care and treatment. Use of independent advocacy will be an important support for a person in articulating their views for planning their care and treatment. Relationships based on transparency and openness can address the power imbalance so often felt by people dependent on service provision.

7.5. This is especially important in terms of sharing of information[lxix]. Sharing of information between the members of the interdisciplinary team and the person's wider support system is to be expected in pursuit of positive outcomes for the person. However, a balance required with respect to what information can or should be shared with others regarding the person's care and treatment – balancing confidentiality and right to privacy in any communication seeking to develop care and treatment plans with those who know the person best.

7.6. Professionals must also remember that their professional registrations and “Codes of Conduct” require a professional duty of candour, regardless of any potential future statutory requirement.

7.7. A Partnership approach to care and wellbeing is vital. It underpins a rights-based approach, further developing the positive relationships required to ensure that people feel protected, treated fairly, listened to and respected. The organisational ethos must be one of leading from the top and by example where policies, procedures and management of practice sets out a co-production approach as an organisational value.

7.8. How communication happens is important. Those with speech, language or communication needs (SLCN) require services and processes to be inclusive and accessible to enable full participation in all decision making. People with SLCN may need support to make decisions. Their needs must be considered in terms of how they communicate/understand and what support is required to promote involvement and empowerment. This will include those who know the person best – possibly a family member, or someone who works closely with them, as well as the possible need for specialist professional staff for example, nursing staff, speech and language therapy staff, psychology staff and other allied health professional staff. It is a potential breach of a person’s human rights if staff are unable to communicate in a way that the person understands.

7.9. Staff must be appropriately trained in a range of communication methods and inclusive communication strategies to ensure that the people that they care for are understood. For some individuals, the fluctuating nature of communication must be acknowledged and recognised, supporting flexibility whereby staff can adapt to meet the needs of the person. Effective communication skills and identifying a person’s needs are vital in supporting them and preventing situations escalating to the point where restrictive interventions, restraint or seclusion is required.

7.10. This may include identifying barriers to effective and inclusive communications, such as sensory impairment or the need for translation.

7.11. This also includes proverbial communication training (voice, tone, pace) which supports a trauma informed approach to care delivery and the use of de-escalation techniques which consist of a variety of psychosocial techniques, aiming to reduce disruptive and/or behaviours of concern and risk using verbal and non-verbal communication skills.

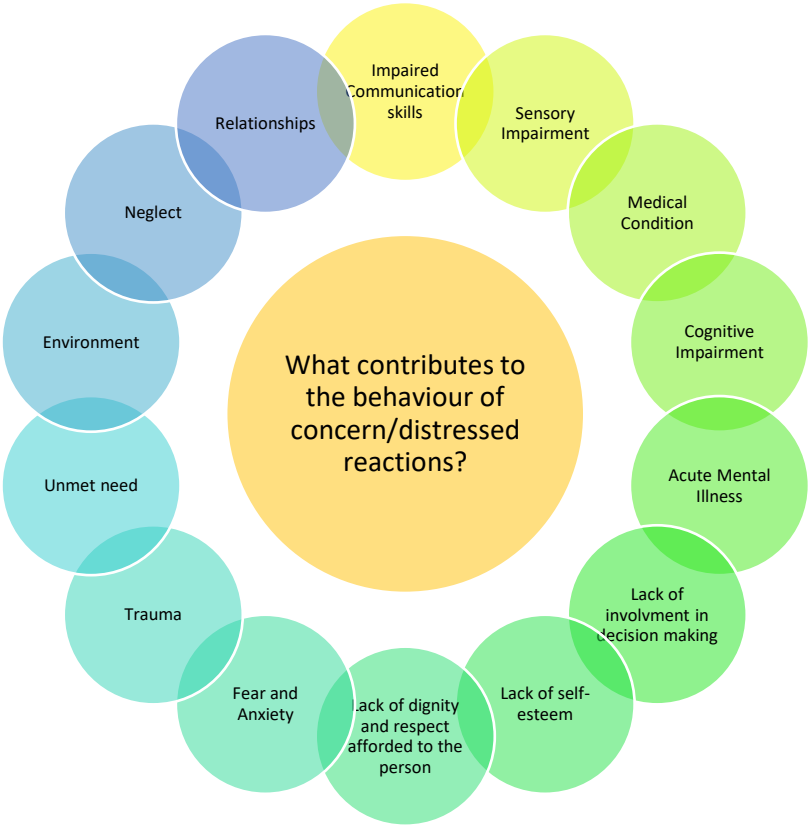
7.12. Organisations should recognise when additional staff training is required, with access to and use of appropriate communication support tools which assist staff to facilitate effective communication. Behaviours of concern and distressed reactions are communicating something; therefore, it is essential that people are helped to communicate in a way that is supportive and as safe as possible– physically and psychologically.

8 Standard 4 – Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans

8.1. Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans. All organisations must adopt positive approaches in the delivery of care, support and treatment plans that deliver proactive and preventative strategies, to better support the people using services and improve outcomes that support a better quality of life.

8.2. Using positive, proactive and preventative evidence-based strategies will support working towards reducing reliance on reactive and restrictive interventions[lxx]. This is a crucial component of a rights based, person centred approach, steering the organisational drive to minimise the use of restrictive interventions, restraint and seclusion, and must be reflected in organisational policy through to individual practice.[lxxi lxxii lxxiii lxxiv]

8.3. The key to establishing positive and proactive approaches is the need for health and social care staff to understand the reason and meaning behind behaviour. This will include areas such as environment, understanding history, and understanding family support and family dynamics, which could be influencing or contributing to how or why an individual behaves in a particular way.



8.4. Positive and proactive interventions assist the development of a therapeutic relationship between health and social care staff and those that they care for. The establishment of a therapeutic relationship aids communication, promotes recovery and supports the development of skills building to allow people to express themselves appropriately, therefore reducing the likelihood of behaviours of concern.

8.5. Underpinning positive, proactive and preventative approaches requires:

8.6. Proactive strategies may include:

- Incorporated meaningful activities.
- Promoting mental health and well-being.
- Promoting outdoor activity to support good mental and physical well-being.
- Promoting engagement using structured daily activities and routine.
- The removal of precipitating factors such as changes within the environment.

- Promoting the use of an environment and strategies to support the person to develop alternative behaviour patterns to support their needs.

- Use of communication aids to support identification and understanding of the person's needs[lxxv].

- Respecting culture and ethnicity.

- Working in partnership, ensuring that people (where capable) are involved in decision making around their care and treatment.

8.7. Creating a therapeutic culture and environment is key in supporting a person who may display a behaviour of concern and/or a distressed reaction which presents as a risk towards themselves and/or others. Staff must consider the physical environment, in addition to other external environmental factors, when thinking about proactive and preventative strategies to support the person.[lxxvi]

8.8. Preventative strategies may include:

- Use of relaxation.

- Individual personalised therapeutic activities/routines to promote wellbeing and behaviours and reduce avoid the need for a restrictive practice.

- Offering opportunity to discuss thoughts/feelings.

- Supportive approach – communicating in a way that suits the individual person and their needs.

- Environmental cues, optimal use of lighting, colour, contrast, signage, noise reduction, or stimulation as preferred by the individual, temperature, space and the ability to walk and explore freely but safely, other people.

- Timely access to specialist assessment and comprehensive, evidence-based treatment.

8.9. Providing person centred care is essential to the development of care and treatment plans. In order to provide good quality care and support to a person, it is important that all professionals are able to work together in partnership with the person, and their families and/or carers identified as partners in care, to ensure respect and dignity is afforded to everyone involved.

8.10. Cognisance of preventative and proactive measures in care and support provision are critical to the application of a rights-based approach in all health and social care settings. In order to ensure this is threaded throughout all policy and practice proactive measures must be considered in advance of any decision making regarding the planning and implementation of care, treatment and support plans. This requires staff, teams and services to define proactive measures several steps

back in any organisational and service delivery planning or decision-making processes.

8.11. Staff must be aware of the accumulative impact of a number of separate restrictive interventions, the potential for physical and psychological risks to the person, as well as unintended consequences of any restrictive practice.

8.12. When health and care needs are appropriately assessed and met, crises are rare. Analysing behaviours to identify antecedents and anticipating an individual's needs, including any current or potential behaviours of concern or risk assessments, should initiate discussion around proactive steps in care, treatment and support that are likely to reduce or prevent any need for consideration or use of restrictive practices. Where required, for those with SLCN challenges, specialist assessment and support by speech and language therapy services may be necessary.

9 Standard 5 – Organisational strategies and related policies for minimising the use of restrictive interventions must follow a shared and consistent content

9.1 All organisations must follow a minimum policy content format in relevant policy documents that includes details of the organisational strategy for minimising the use of restrictive interventions. Language used must be free from jargon and accessible to all age groups and abilities. Terminology must be regionally standardised.

9.2 People using health and social care services have a legitimate expectation of consistent treatment and application of approaches, particularly those who might move between different settings. Scope for differing interpretation is unfair and potentially detrimental. Therefore, a consistent approach in all aspects of application of this policy and, in particular, setting the context for practice, implementation and oversight in local and organisational policy, is important in articulating the wider principles and values that people should expect and indeed be in receipt of, from health and social care provision.

9.3 All organisations must have clear vision, values and philosophy that demonstrate how they aim to eliminate, where possible, or minimise the use of restrictive interventions within services. Any restrictive practice elimination/minimisation programme should address leadership, the use of data to inform practice, specific reduction tools, development of the workforce, and use of models for post incident review

9.4 It is important there are mechanisms by which organisations can produce evidence demonstrating the steps have been taken within the service to eliminate or minimise restrictive interventions.

9.5 Local and organisational policy frameworks should be co-produced and must include as a minimum:

- the organisational values that underpin the approach to minimising restrictive interventions;
- the detail of the organisational vision and strategy for minimising restrictive interventions;
- details of job roles within the organisation with specific restrictive practice minimisation responsibility and accountability;
- communication requirements and strategies;
- standard definitions;
- clear professional/clinical guidance;
- reference to working within current legislative frameworks and professional registration requirements;

- an emphasis on positive, proactive, preventative and evidence-based interventions and strategies;

- how the Three Steps to Positive Practice Framework as the organisational methodology for considering and reviewing the use of restrictive interventions is embedded and operationalised;

- details of accredited training required, including training required for specific interventions;

- details of interfaces with other regional and local policies, agreed protocols and any associated requirements;

- reference to clear recording, reporting, monitoring and governance arrangements (including how data will be used in the minimisation strategy, ensuring alignment with the UK Data Protection Act 2018 (DPA18) & the General Data Protection Regulations (UK GDPR));

- support mechanisms for those who are subject to restrictive interventions; and

- support mechanisms for staff who restrict, restrain and/or seclude those in their care.

10 Standard 6 – Roles and responsibilities are defined in terms of monitoring, reporting and governance

10.1 Each organisation must define roles and responsibilities within their restrictive practice minimisation strategies in terms of monitoring, reporting and governance.

10.2 A total organisational approach is required in the minimisation of restrictive interventions at the organisational level[lxxvii]. A regional approach is also required to understand behaviours and responses, the impact of those responses with analysis of that understanding underpinning actions required to minimise use of restrictive interventions.

Roles and Responsibilities

Department of Health (DoH)

10.3 The Department of Health (DoH) is responsible for setting regional policy and holding overall accountability for regional minimisation of restrictive practices, restraint and seclusion.

Strategic Performance and Planning Group (SPPG)

10.4 The Strategic Performance and Planning Group (SPPG) in DoH is responsible for monitoring the effectiveness of Health and Social Care Trust (HSCT) strategies in minimising the use of restrictive practices, restraint and seclusion.

10.5 SPPG must appoint a relevant Director who is responsible for:

- Agreeing the structures for reporting data and supporting narrative with Trusts and non-statutory provider organisations to ensure that the requirements of this regional policy can be produced in the format that facilitates both organisational and regional information across all relevant services;
- Agreeing the detail of data to be collected and format for reporting (in line with the Information Commissioner's Office guidance for data sharing)[lxxviii] , ensuring consistency across statutory and non-statutory provider organisations, with particular reference to agreeing terminology;
- Providing assurances regarding robust incident specific review and analysis of use of prolonged physical restraint, rapid tranquillisation and seclusion (and any incidents that amount to seclusion); and
- Providing a monitoring and assurance report on behalf of the Department of Health on an annual basis regarding the effectiveness of Trust strategies in minimising the use of restrictive practices, restraint and seclusion.

Provider Organisations – Health and Social Care Trusts (HSCTs)

10.6 Each Health and Social Care Trust is responsible for approving their evidence-based and co-produced restrictive practices minimisation strategy.

10.7 Each HSCT must appoint an identified Director who is responsible and accountable for realising the organisational minimisation of restrictive practices, restraint and seclusion.

10.8 The Director is responsible for:

- Articulating the organisational vision and strategy to minimise the use of restrictive practices across all services;
- Developing the required policy and embedding the processes required to implement the restrictive practice minimisation strategy ensuring adherence to the regional policy;
- Obtaining the baseline information and data and achieving the subsequent restrictive intervention minimisation set out within organisational strategy;
- Oversight of the organisational use of restrictive practices, restraint and seclusion, to include specific issues escalated via restrictive practice analysis and reporting;
- Oversight of the review of incident-by-incident use of prolonged physical restraint, rapid tranquillisation, and seclusion (or incident that amounts to seclusion) and the agreed plan to mitigate against any recurrence;
- Oversight of assurances provided by non-statutory services regarding minimisation of the use of restrictive practices; and
- Preparation and submission of six-monthly assurance reports with monitoring data to SPPG.

Provider Organisations – Non-Statutory Provider Organisations

10.9 This policy cannot make requirements on non-statutory organisations. However, this policy provides non-statutory best practice recommendations:

- Non statutory provider organisations should appoint an identified health and social care Director /Senior Manager who is responsible and accountable for realising the organisational minimisation of restrictive practices, restraint and seclusion.
- The identified Director /Senior Manager is responsible for:
    - Articulating the organisational vision and strategy to minimise the use of restrictive practices across all services;

- Developing the required policy and embed the processes required to implement the restrictive practice minimisation strategy ensuring adherence to the regional policy;
- Obtaining the baseline information and data and achieving the subsequent restrictive intervention minimisation set out within organisational strategy;
- Oversight of the organisational use of restrictive practices, restraint and seclusion, to include specific issues escalated via restrictive practice analysis and reporting;
- Oversight of the review of incident-by-incident use of prolonged physical restraint, rapid tranquillisation, and seclusion (or incident that amounts to seclusion) and the agreed plan to avoid any recurrence; and
- Providing reports where required to commissioning HSCTs and RQIA.

Regulation and Quality Improvement Authority (RQIA)

10.10 RQIA will have a monitoring and assurance role consistent with their role and function set out in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order, 2003, Mental Health (Northern Ireland) Order, 1986, Mental Capacity Act (Northern Ireland) 2016, service specific regulations and inspection key themes. This includes reviewing the implementation of rights-based approaches for individuals and achievement of organisational restrictive practice minimisation measures.

Monitoring

Incident by Incident Review

10.11 Management of incidents that carry significant risk must be subject to incident-by-incident review (which should not be confused with de-briefing) no longer than 72[lxxix] hours after the incident to establish learning and promotion of preventative strategies in the work towards minimisation of restrictive interventions.

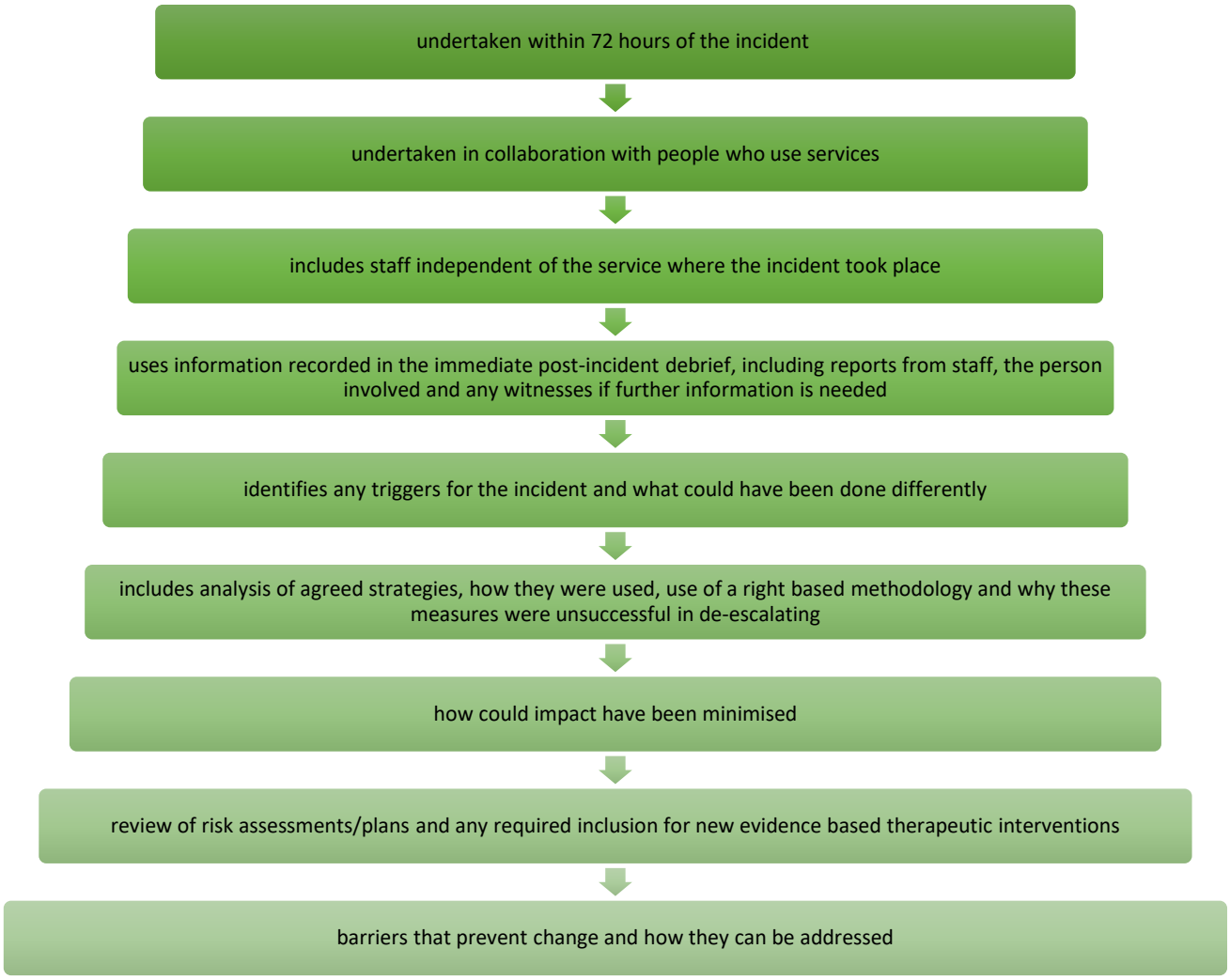
10.12 This includes incidents of: [lxxx]

- prolonged physical restraint;
- rapid tranquillisation;
- seclusion; and
- any incident that amounts to seclusion.

10.13 The use of a formal incident-by-incident review process is important in identifying the causes of the incident and the impact on all those involved. Doing so will create

learning for prevention of further incidents, improvements in an individual's care plan and safety improvements for all.

10.14 Incident by incident review considerations:



Restrictive Practice Register

10.15 All organisations must retain restrictive practice registers at local service level, maintained and reviewed by the local service manager.

10.16 The register must provide a current overview of the number and type of restrictive interventions in use within a service, supporting the link from local minimisation actions to the overall organisational strategy.

Leading Positive Practice

10.17 Organisations may wish to consider adopting a “Positive Practice Champion” role (smaller organisations), or “Positive Practice Teams” (larger organisations).

10.18 The Champion or Team is key in supporting the organisation’s minimisation strategy at service delivery level to produce better outcomes for people. This may include:

- assisting and contributing to the detail of minimisation strategy and implementation plans;
- supporting the implementation of minimisation plans, monitoring effectiveness and value to the individual, the service and the organisation;
- undertaking audit of practice in line with minimisation strategy and plans;
- advising on policy content, communication strategies, terminology and language;
- advising and supporting quality improvement initiatives for minimisation of restrictive interventions;
- supporting de-brief and review processes;
- undertaking training needs analysis;
- contributing to data analysis; and
- producing data reports, quality assessment reports, quality improvement recommendations.

Learning for Improvement

10.19 Learning for improvement in safety and quality is essential – for individuals, for services and for the system as a whole. The Public Health Agency through its safety and quality functions, is responsible for supporting analysis of incident reporting for purposes of learning and service improvement and developing regional quality improvement initiatives informed by that data analysis and learning.

11 Standard 7 – Any use of seclusion as a last resort intervention must follow the regional operating procedures

11.1 Seclusion is the confinement of a person in a room or area from which free exit is prevented.

Purpose

11.2 The operating procedure set out below provides the requirements for all health and social care organisations for the use of seclusion. HSC Trusts must follow this procedure.

Scope

11.3 Seclusion is an intervention of **last resort**. Seclusion must only be used in hospitals in a room or area that has been specifically designed for that purpose.

11.4 The designated room or area that has been specifically designed for the use of seclusion must not be used for any other purpose.

11.5 Seclusion can only be used where a person is (or liable to be) detained in hospital within an appropriate legal framework.

11.6 Seclusion can never be voluntary or consented to. Some individuals may express a preference for seclusion rather than physical restraint, for example, in circumstances where they exhibit behaviours that present an immediate and unmanageable risk of serious harm to others when acutely mentally unwell. This is not to be confused with a person “consenting” to seclusion and does not provide legal protection for seclusion. Expressed preferences may be part of care planning and may form part of an advance statement. This does not provide legal authority but should be considered by all health and social care professionals when making decisions about the management of a person where their behaviour is presenting as a risk towards themselves or others.

Responsibilities, Accountabilities, Duties

Chief Executive

11.7 The Chief Executive of each organisation is responsible for:

- Ensuring that there is a policy in place that governs the safe use of seclusion, which all staff have access to.
- Ensuring the ethos of *last resort* and *least restrictive* is embedded within organisational culture to work towards the minimisation of restrictive interventions.

Directors

11.8 The Directors of relevant areas are responsible for:

- Ensuring that all staff are aware and compliant in the delivery of the seclusion operating procedures.
- Ensuring that any local level procedures are reflective of the ethos outlined within the regional seclusion operating procedures.
- Ensuring that all episodes of seclusion are documented and recorded appropriately.
- Ensuring that all staff are appropriately equipped with knowledge and skills required in understanding and managing incidents of crisis behaviour/acute behavioural disturbance that may require seclusion.
- Ensuring that all incidents of seclusion are appropriately governed/audited in line with individual organisational procedures.

Service Specific Lead Nurse/Social Worker

11.9 Service Specific Lead Nurses/Social Workers are responsible for:

- Completion of a training needs analysis and overseeing training for seclusion awareness and any other relevant training needs (including Deprivation of Liberty Safeguards, Mental Health (NI) Order 1986, Human Rights etc.), and ensuring training is accessible for all staff.

Service Manager/Assistant Service Manager

11.10 Service Managers/Assistant Service Managers are responsible for:

- Monitoring overall compliance with the policy.
- Ensuring that all staff who require the training have access to it.
- Ensuring that clear systems for reviewing those who require seclusion and recording are in place.

Inter-disciplinary Team (IDT)

11.11 All Inter-Disciplinary Team staff are responsible for:

- Being aware of the policy and being compliant in the delivery of the operating procedures

- Ensuring that an IDT approach is taken in reviewing, developing and updating treatment plans and risk assessments.

- Ensuring that there is clear communication and regular incident reviews as per NICE guidelines.

Line managers

11.12 Line managers are responsible for:

- Ensuring that mechanisms are in place so that all staff are aware of the policy and are compliant in the delivery of operational procedures.

- Ensuring that all staff attend mandatory training which includes seclusion operating procedures.

- Promoting an ethos of human rights-based approach where staff are committed to protecting the rights of those they care for and treating them with dignity and respect.

- Ongoing monitoring and review of working practices regarding seclusion operating procedures.

- Where possible ensuring that the person, families and carers are included in decision making regarding the use of seclusion.

All staff

11.13 All staff are responsible for:

- Complying with the operational procedures.

- Reporting any untoward incidents regarding seclusion in line with organisational safeguarding procedures and incident reporting procedures.

- Ensuring that any episode of seclusion is documented and recorded appropriately.

- Working with people in line with a human rights-based approach.

- Having an understanding of integrated experience – the understanding of the potential impact of their behaviour towards people in their care and how this can affect the behaviour of others, becoming a precipitating factor.

- Where possible, ensuring that the person, families and carers are included in decision making regarding the use of seclusion.

- Ensuring care plans and risk assessments being kept up to date.

- Organisational policies must be referred to and contact should be made (where or if required) with the relevant organisation's training team for support and guidance on the management of a person presenting with unmanageable risk and/or supporting transition of the person to designated seclusion room.

Procedure for Seclusion

Use of seclusion

11.14 There are several factors that need to be considered with regards to the use of seclusion.

11.15 Seclusion can cause psychological harm with no definitive evidence that it has any therapeutic benefit. The use of seclusion can often be seen as negative and a non-therapeutic experience, with potentially harmful physical and psychological effects. The effectiveness and adverse effects of seclusion and restraint seem to be similar, although the evidence base for both is limited.

11.16 Seclusion must only be used in an emergency in response to an unmanageable risk of harm to others where other responses have been deemed insufficient. However, seclusion may form part of a patient's care plan for use in emergency situations.

11.17 In the absence of clinical guidance to review every potential situation that may arise, any interventions regarding the use of seclusion will be based on clinical judgement by the relevant nursing and medical staff who are involved. All interventions regarding the use of seclusion must be a last resort option that is proportionate and justifiable to the presenting risk.

11.18 Seclusion might be used as an alternative to physical restraint or rapid tranquillisation. The factors influencing this will be specific to the individual and situation, and the individual's preference should be determined as soon as possible.

11.19 The use of seclusion for a person not detained in accordance with a relevant legal framework will necessitate a review of their legal status with a view to legal detention. Seclusion, outside of an emergency, is unacceptable, potentially unlawful and in breach of human rights and could be considered as a crime as result of false imprisonment of the person.

11.20 Seclusion should **not** be used:

- Where there is a risk of suicide.
- Where a person is engaging in self-harm or there is evident risk of serious self-harm.
- Due to a lack of resources to manage an incident where the person is displaying risk behaviour.

- As a punitive action.
- As part of a treatment plan – unless the person has completed an advance statement expressing their wishes/preference.
- Where mechanical restraint is also in use.
- Where a person has a pre-existing condition that staff are aware of and where care plan documentation indicates seclusion should not be used.

Seclusion Room

11.21 Seclusion should only occur in a room or area designed specifically for that purpose. lxxxi,lxxxii,lxxxiii

11.22 Seclusion room specifics:

- The construction of the room must be designed to withstand high levels of violence with the potential to damage the physical environment e.g. walls, window, doors and locks.
- There should be no:
    - ligature points;
    - access to electrical fixtures that could pose a risk of harm.
- There must be an anti-barricade door system.
- The room must allow for staff to be able to clearly observe and hear the person within the designated room.
- The designated room should be in an area free from others but not isolated.
- The person in seclusion must be able to have a clear view of the outside environment but those on the outside must not be able to have any view of the person within seclusion.
- The room must be large enough to support the person and team of staff (who may be) required to use physical interventions during transition to seclusion.
- Adequate lighting must be provided, in particular a window in order to provide natural light. Lighting should be able to be controlled both by the person within seclusion and those external.
- The room must be equipped with adequate temperature and ventilation system with heat sensor for effective monitoring.
- The room must be decorated in a calming manner that appears non-threatening to the person.

- The room must be kept clean and fresh.
- The room must have direct access to washing and toilet facilities.
- The room must be safe and secure.
- There must be a visible clock.
- There should be limited furnishings. Any furnishings must be as safe as possible and must not include anything that could potentially cause harm. Furnishing must be comfortable and in good condition.

11.23 To ensure that the designated seclusion room or suite is maintained appropriately, all organisations should ensure the following mechanisms are in place:

- Weekly maintenance check (see Appendix 1).
- Ensure the designated room remains locked at all other times when not in use.
- Is part of routine cleaning schedules (in situations where the room requires deep clean, each organisation should follow individual IPC procedures and set out interim guidance for management of the person should seclusion require early termination to facilitate deep cleaning).
- Ensure that only appropriate equipment i.e. soft furnishings are kept within the designated room/suite.

11.24 If at any stage there is requirement for maintenance work to be carried out, then each organisation should ensure that there is interim plan in place for management of a person in an emergency situation where there is deemed unmanageable risk and ensure that all staff are aware of the interim arrangements.

Commencement of Seclusion

Decision to seclude

11.25 Seclusion should only ever be used as an emergency intervention.

11.26 The use of seclusion must always be a reasonable and proportionate response to the level of risk shown and where decision making clearly shows that there has been consideration to the use of other restrictive interventions. Decision making might reflect the use of seclusion as a safer alternative than prolonged restraint or the use of medication.

11.27 The decision to seclude a person is based on clinical professional judgement regarding knowledge of the patient and potential unmanageable risk towards others.

11.28 The person making the decision to seclude should be:

- The nurse in charge of the team providing the person's care at the time of seclusion;

OR

- A doctor with responsibility for the care of the person or the duty doctor on call.

11.29 The person making the decision to seclude should ensure that:

- There is an appropriate legal framework in place;
- They have seen the person immediately before seclusion commences;
- They have consulted with the team providing the person's care at the time of seclusion;
- They are familiar with relevant aspects of the person's healthcare records (e.g. risk assessment) as far as possible;
- They are aware of the person's advance wishes in relation to what should happen in an emergency, as far as possible;
- The intervention is necessary, appropriate and can happen safely, and that reasonable alternatives have been considered;
- The necessary observation and review can take place to monitor the person's physical and mental wellbeing; and
- Where required, individual organisation search policies are adhered to, if there are concerns about any items that a person may have.

Review Process

11.30 There are a number of review processes which should be commenced as soon as a period of seclusion is initiated.

11.31 All reviews should be considered as an opportunity to determine whether the seclusion period can be terminated or if it requires continuation.

Roles and Responsibilities

Medical staff

11.32 Medical reviews must be carried out in person and must include the following:

- Assess and review the need for seclusion period to continue;
- Review mental and physical health;
- Review level of risk towards others;
- Review level of observations;
- Review potential risk to self; and
- Review prescribed medication and consider/assess any potential adverse effects of medication.

11.33 If a doctor was involved in the decision to seclude then their assessment at the time seclusion was commenced will be considered as the first medical review and they will not be required to complete a separate first medical review.

11.34 If a doctor was not involved in the decision to seclude then they must be notified to attend immediately to undertake the first medical review. The first review should take priority over routine tasks or any of those which are anticipated to cause further delay. Any potential delay should be discussed with the Consultant Psychiatrist on call, to ensure that any delays are considered reasonable and justifiable.

11.35 Where the seclusion period is so short that the doctor does not visit before termination then this must be recorded on the seclusion care plan and within the person's care record.

11.36 Medical reviews must take place every four hours - one of which should be undertaken by the person's Consultant Psychiatrist within 24 hours unless stipulated during the first internal IDT review.

11.37 A medical review should be undertaken by the Consultant Psychiatrist at least once in every 24-hour period.

11.38 Medical staff must complete an individualised seclusion care plan in partnership with nursing staff and provide input following the review process.

11.39 The outcome of the medical review must be documented in the person's care record.

Senior Management

11.40 Senior management staff will be contacted by nursing staff to inform them of the commencement of a period of seclusion.

11.41 The senior manager in receipt of the call should arrange to attend the ward to receive a report on the decision to seclude – the senior manager should sign records acknowledging receipt of the report and any other information or advice provided. If the senior manager does not attend in person, the nurse in charge must document the detail of conversation and decisions agreed as per telephone

conversation. The senior manager should email confirmed details of the conversation and agreement reached to the nurse in charge as soon as possible

11.42 The senior manager should provide support and guidance to support the person within seclusion and staff involved in managing the period of seclusion.

11.43 The Senior Manager should discuss presentation, risks and agreed management plan with nurse in charge.

Nursing Staff

11.44 Nursing staff will contact and inform the multi-disciplinary team (who have caring responsibility for the person) of the commencement of a period of seclusion period as soon as possible, making a contemporaneous entry in the person's records. They will also contact the senior manager to inform them of the commencement of the period of seclusion.

11.45 The nurse in charge will complete a formal review of the on-going seclusion every one hour during the seclusion period to ascertain if there is an opportunity for seclusion to be terminated. If it is not yet safe to terminate seclusion, the nurse in charge will review the implementation of the seclusion care plan actions to ensure that everything that can be done to end the period of seclusion is being done.

11.46 Every two hours, the nurse in charge will be accompanied by a registered nurse to ascertain if there is an opportunity for seclusion to be terminated. Ideally the second nurse should not be directly involved in the incident that led to a decision to seclude. If it is not yet safe to terminate seclusion, both nurses will review the implementation of the seclusion care plan actions to ensure that everything that can be done to end the period of seclusion is being done.

11.47 Outcomes for the nursing reviews should be recorded contemporaneously in the person's care records.

11.48 Where a doctor fails to attend immediately, as requested, to complete the first medical review (where they were not a part of the initial decision to seclude) an incident form should be completed by the nurse in charge, for review by senior management.

11.49 The next of kin/significant others should be informed in a timely manner of the necessity for seclusion but in a considerate manner taking into account the time of day/night. Consent for sharing information should be clarified[lxxxiv].

Reviews of seclusion

Internal multi-disciplinary team review

11.50 An internal multi-disciplinary team review must include the patient, their doctor, nurse in charge, and other professionals who may usually be involved with the person. An initial review must be carried out as soon as practicable once the seclusion period commences.

11.51 An internal review must also take place once in every 24-hour period of continuous seclusion.

Independent multi-disciplinary team review

11.52 If a patient is secluded for more than 8 hours repeatedly or 12 hours over a period of 48 hours, there must be an independent review undertaken by professionals who were not involved in the incident that led to the period of seclusion or where part of the decision to commence the seclusion period. The review must include the patient, with a review team comprising of a doctor, nurse and other professionals, and an independent advocate.

11.53 Even if the seclusion period has since ended, once a trigger point has been reached, the review must be held. If the seclusion period is ongoing, then the independent review can make additional recommendations as appropriate to the seclusion care plan.

Recording and Documentation

11.54 Seclusion records must include as a minimum:

- Personal details of the person in seclusion;
- Date and time the seclusion commences;
- Decision to seclude the person, preceding incident(s) and other unsuccessful measures used to manage the situation (including use of physical intervention where required to support transition to seclusion room);
- If search procedure was required;
- Nurse in charge details;
- Details of doctor contacted;
- Details of senior manager (or others) contacted;
- Legal status of person – and any actions taken to review legal status;
- Date and time of termination of seclusion;

- Consent for information sharing with next of kin and / or family; and
- The Seclusion care plan.

11.55 A seclusion care plan must be completed as soon as the seclusion period commences. It must reflect the person-centred care needs of the person and record the actions that should be taken to end the period of seclusion in the shortest time possible.

11.56 A seclusion care plan must include as a minimum:

- Personal details;
- Known clinical needs (including mental and physical considerations);
- How de-escalation strategies will continue to be used;
- Outline actions towards termination of seclusion;
- Recognising signs where behaviour is no longer considered an unmanageable risk towards others, e.g. evidence of tension reduction, improved communication etc;
- How potential risks may be managed;
- Reference to individual care plans, support plans, behaviour support plans, sensory regulation strategies etc;
- Meeting of food/fluid needs;
- Meeting of needs in regard to personal hygiene/dressing;
- Meeting of elimination needs (with specific reference to how privacy and dignity will be managed);
- Medication reviews (in consultation with a doctor or other as delegated);
- Monitoring of physical observations;
- Person’s views in regards to the seclusion process; and
- Information about informing next of kin and/or families as stated within individual support plans or as previously discussed in advance statements regarding emergency situations.

11.57 A template for a seclusion care plan is included in Annex B.

Observations

11.58 A registered nurse must observe and monitor the person and their action's whilst in the seclusion room and determine whether seclusion can be terminated.

11.59 The registered nurse may be outside the person's room (or in an adjacent room with a connecting window), provided that the person can fully see the registered nurse and can continuously observe and hear the person.

11.60 CCTV must not be used to replace continuous staff presence. CCTV does not replace the usual observation process but can be used to enhance observation and to increase safety and security of the person within the seclusion room. The observing nurse should remain in the immediate vicinity (directly outside the seclusion room door) and be available to provide immediate (including discrete) observation and assessment at any stage during the seclusion period. Immediately after the commencement of the seclusion period, the person must be placed on 1:1 observation. **A registered nurse** must be delegated to undertake 1:1 observation of the person within the seclusion room, for the period of seclusion. The registered nurse must be exempt from undertaking other duties for the period of seclusion.

11.61 Observation of a person subject to seclusion involves a range of other professional and intricate competencies, including assessment, using clinical judgement, making clinical decisions, risk management, and, very importantly, the delivery of person centred and human rights-based care. Therefore 1:1 observation of a person in seclusion should be only undertaken by a registered nurse.

11.62 Consideration must be given to the registered nurse chosen to support the person in seclusion, and any potential impact on the person. This must be considered on an individual basis.

11.63 An observation record must be documented at a minimum of every 15 minutes; this can be reviewed based on clinical presentation and risk assessment.

11.64 The registered nurse completing the observations must monitor the following:

- Physical appearance and documenting any evidence of physical ill health such as shortness of breath, unusual facial pallor or potential cyanosis;
- Mental state presentation;
- What the person is doing or saying whilst in seclusion;
- Level of communication; and
- Level of alertness/awareness (particularly following administration of medication).

11.65 If medication has been administered prior to the person entering seclusion, with intent to subdue acute behavioural disturbance, individual organisational policies

(developed in line with regional guidelines) should be followed and the person should be observed in accordance with same.

11.66 It may be difficult at this time to complete full clinical monitoring and NEWS chart. As a minimum the registered nurse observing, should record:

- Person's respiration rate;
- Person's response to verbal or tactile stimulation;
- Person's level of movement;
- Person's level of awareness; and
- Any attempts to complete physical monitoring, whether successful or not, must be recorded.

11.67 Observing staff must have access to a personal alarm or call system should they need to seek urgent assistance in an emergency.

11.68 Handover between staff observing must be documented. Observing staff should be able to respond to a situation where patient safety becomes compromised i.e. self-injurious behaviour.

Care of the Person in Seclusion

11.69 During a period of seclusion, staff must ensure that a good level of care is maintained and delivered, ensuring that the person's privacy and dignity is maintained. The health, safety and wellbeing of the person is paramount.

Personal care/elimination/dressing needs

11.70 Seclusion rooms must have toilet and shower facilities.

11.71 Staff must be able to supply the person with toilet paper, hand soap, towels and other hygiene products as and when required.

11.72 If a person is in seclusion for a period prolonging 24 hours, they should be encouraged and, where required, assisted to meet their personal hygiene needs.

11.73 A persons' privacy and dignity must be maintained at all times throughout seclusion. Items of clothing must only be removed where there is potential for the person to use the items of clothing as ligatures and cause serious risk of harm to self.

11.74 Each individual organisation must consider the use of tear proof clothing should it be required.

Provision of food/fluids

11.75 The provision of food must not be denied to the person within seclusion. All meals and drinks must be provided as normal.

11.76 Crockery and utensil items that are considered safe to use i.e. plastic and non-metallic must be used.

11.77 All offers, acceptance and refusal of food and fluid items must be documented within the seclusion observation form and within the person's records.

Accessing seclusion room in planned or unplanned scenarios

11.78 Staff may at times be required to enter the seclusion room in planned/unplanned scenarios. Planned scenarios may include (but are not exhaustive to) facilitating reviews, supporting access to toilet/showering facilities, providing food/fluids or administering medication.

11.79 Unplanned scenarios may include (but are not exhaustive to) when the person's health, safety and wellbeing is compromised, deterioration in clinical presentation or engaging in risk behaviour where there is imminent risk to the person.

Administration of Rapid Tranquillisation whilst the person is in seclusion

11.80 There may be occasions where the person in seclusion may require the administration of medication via rapid tranquillisation. If required, staff should refer to the guidance within local policy and procedure, relevant best practice guidance and/or regional protocols.

11.81 Staff must be aware of potential side effects and be prepared to address any complications that may arise.

11.82 A registered nurse must observe the person within sight. A doctor and nurse in charge must review the seclusion care plan and associated risks and consider the termination of seclusion once rapid tranquillisation has had the desired effect.

11.83 If there is an identified risk to the person at any time, then the seclusion room must be entered at the earliest and safest opportunity.

11.84 In a scenario where staff are unable to clearly see the person within seclusion due to covering of the head or face, the observing staff member should encourage the person to remove the covering to maintain observations and also assess the person's clinical and physical presentation. If the person is non-communicative the observing staff member should seek immediate assistance and assess the need to enter the seclusion room. This will be a decision based on clinical judgement and the need to maintain safety of the person whilst in the seclusion room.

11.85 Any need for staff entry or exit of the seclusion room (outside of a response to an emergency) must be informed by careful application of specific skills learnt in training for managing situations where an individual presents with behaviour of concern/distressed behaviour.

Termination of Seclusion

11.86 Seclusion must be terminated at the earliest opportunity when it is assessed to no longer be required.

11.87 The seclusion care plan must detail safe management and support of the person on the ending of seclusion, and during reintegration of the person to the general ward setting within the hospital.

11.88 If the person is sleeping, then the risk is no longer immediate and unmanageable, and seclusion must be terminated. The continuation of observation if the person is sleeping will be based on clinical judgement of the situation at the time.

11.89 Opening of the seclusion room door in order to facilitate reviews, support access to toilet or showering facilities, provide food/fluids, administer medication does not constitute an end to seclusion.

Post Seclusion

11.90 Nursing staff will complete the documentation required for the seclusion period. The end of seclusion must be recorded in the observation record by the nurse in charge.

11.91 When seclusion is ended, a body chart must be completed. The next of kin must be informed of the termination of seclusion (taking into account consent from the person and appropriateness of the time of day/night to provide update).

11.92 Following seclusion, the nurse in charge must make arrangements for the room to be reviewed, maintenance checks to be complete and cleaning procedures in line with IPC guidance.

Incident review

11.93 The purpose of a post incident review is to provide opportunity for learning and provide support to the person and staff. A post incident review must take place as soon as possible, but no later than 72 hours[lxxxv] following termination of seclusion.

11.94 There must be a designated person to lead the incident review, and where possible they should not have been involved in the seclusion incident.

11.95 The review process must include discussing the incident with the person secluded to ascertain their thoughts and views.

11.96 The review will consider the following key points:

- What happened during the incident?
- Why did it happen? (Possible triggers, precipitating factors or early warning signs/Any noticeable patterns)
- How can a recurrence be avoided?
- What might be done differently the next time?
- What has been learned?
- Any changes to care plan or risk assessments?
- Any additional emotional support required for the person who has been secluded and any staff involved in the seclusion?

Use of CCTV in a Period of Seclusion

11.97 The use of CCTV for a period of seclusion within a hospital setting is to enhance the safety of all involved. The use of CCTV must not replace staff presence[lxxxvi]. Where organisations use CCTV, staff must refer to individual organisational policies for guidance. Data protection requirements[lxxxvii] related to the use of CCTV must be incorporated in organisational policies for use of CCTV and guide decision-making for each individual use of CCTV for monitoring a period of seclusion. This will include a Data Protection Impact Assessment[lxxxviii] that outlines the necessity, fairness and proportionality of the decision to use CCTV to monitor a period of seclusion. In addition to the above, each organisation that uses CCTV to monitor a period of seclusion should consider and outline how the proposed processing meets the seven key principles under the UK GDPR.

11.98 CCTV does not replace the usual observation process but can be used to enhance observation and to increase safety and security of the person within the seclusion room.

11.99 The privacy and dignity of the person must be protected at all times.

Emergency scenarios

Fire Alarm

11.100 If the fire alarm was to sound whilst a person is in seclusion, the observing staff member must immediately seek direction from the nurse in charge and take direction in line with evacuation procedures.

11.101 Where there is a potential immediate risk to life, then seclusion must be terminated, and the person escorted out of the building in line with evacuation procedures to the nearest fire assembly point.

11.102 There must be an appropriate level of staffing in order to enter seclusion and evacuate the person.

Medical emergency

11.103 All staff involved must have the appropriate training and associated skills in order to manage a medical emergency.[lxxxix] [xc]

Monitoring and Governance

11.104 Organisations must develop their policies in support of the regional seclusion operating procedures in regard to the monitoring and governance arrangements for the use of seclusion.

11.105 The Seclusion Audit tool (see Appendix 6) provides an opportunity for the Nurse with overall responsibility of the hospital ward, in which seclusion occurred, to review key procedures and processes.

12 Appendices

Appendix 1 – Seclusion Maintenance Record

Seclusion Maintenance Record

DATE		TIME	

SIGNED	
PRINT NAME	
IS THE ROOM FIT FOR USE/SATISFACTORY/WORKING ORDER: **ALL STAFF SHOULD ASSESS THE ROOM AND ENSURE ADEQUATE STANDARDS**	

	YES/NO	COMMENTS/ACTION (IF REQUIRED)
Safe (free from harm/weapons)		
Clean		
Lighting		
Heating		
Clock		
Locks		
Appropriate furnishings		
Doors/Door Frames		
Vision Panels		
Flooring		
Windows		
Skirting/Window Frames		
CCTV		
Ventilation		
Safety alarms in area		

ANY OTHER COMMENTS/ACTIONS REQUIRED FROM MAINTENANCE CHECK:

Appendix 2 – Record of Seclusion

Record of Seclusion

Person	**D.O.B** **Hospital Number** **Paris Number**
Ward	**Date of completion**
Date seclusion commenced	**Time seclusion commenced**
Name of those involved in decision to seclude:	**Name of professional initiating seclusion (doctor, nurse):** **Print Name:** **Signature:** **Designation:**
Medical Staff **Name of Doctor/Duty doctor informed of seclusion period:** **Time informed:** **Signature of Doctor who attended:** **Time attended seclusion:** **Were there problems in contacting doctor?** **If yes, please state what/why:** **Did Doctor attend to review immediately?** **If no, please state why?**	**Senior Management or Other (outside of usual working hours)** **Name of Senior Management/Other informed of seclusion period:** **Time informed:** **Signature of Senior Management/Other who attended:** **Time attended seclusion:** **Were there problems in contacting senior management?** **If yes, please state what/why:**

If no, complete incident form, reference no:	

Decision to seclude (Events leading to initiation of seclusion)

_____
_____
_____
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_____

Alternative measures utilised prior to decision that seclusion was required as last resort option

_____
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_____

Where Search procedures required due to potential risk of harms:

Yes ☐

No ☐

Items on the person within the seclusion room, if any items were removed for potential to cause harm (i.e. ligatures) Please detail below:

Not applicable ☐

Tear proof clothing required ☐

Consent to share information with NOK/family ☐

Consent to share information

Consent provided through advance statements ☐

Detail below where consent may not have been sought to information share/provide update (i.e. lack capacity)

_____

_____

_____

Were Physical intervention techniques required? Yes ☐ No ☐

Was 'as required' / 'rapid tranquillisation' medication administered? Yes ☐ No ☐

Incident Form Complete: Yes ☐ No ☐

Datix number:

Termination of Seclusion

Date seclusion terminated	**Time seclusion terminated**

Duration of seclusion (total):

Name of those involved in decision to terminate seclusion:

Name of professional terminating seclusion:
Print Name:

Signature:

Designation:

Post Seclusion

Clinical observations complete ☐

Debriefing with person ☐

Debriefing with staff ☐

Incident review ☐

Appendix 3 - Seclusion Care Plan

Seclusion Care Plan

Person	**D.O.B** **Hospital Number** **Paris Number**
Ward	**Date of completion**
Date seclusion commenced	**Time seclusion commenced**

Clinical needs of the person/Physical and Mental state considerations/Potential risks
Management of any potential risks as outlined above
De-escalation strategies and outline of actions that will continue to be used to support termination of seclusion at earliest opportunity
How to recognise signs of tension reduction in person
Meeting person's needs and how this is planned for during seclusion period (food/fluid/elimination/personal hygiene/clothing)

Person’s views regarding seclusion process
Process of information sharing as in main care plan

Appendix 4 – Seclusion Observation Record

Seclusion Observation Record

A documented report **must** be made at least **every 15 minutes** or more frequently if required (including during reviews etc.).

Things to observe: person's physical and mental state presentation, person's behaviour, communication, personal hygiene, therapeutic interventions, food and fluid intake.

		Person **DOB**	**Hospital No:** **Paris No:**	
		Name of professional who initiated seclusion:	**Hospital setting:**	
Date	**Time**	**Comments**	**Print and Sign Name** **Signature/Designation**	
	Hourly review by Nurse in Charge	**Comments**	**Outcome**	**NIC signature**
	Hourly review by Nurse in Charge	**Comments**	**Outcome**	**NIC Signature**

Appendix 5 – Seclusion Review Record

Seclusion Review Record

There are a number of review processes which should be commenced once a seclusion period is commenced.
All reviews should be considered as an opportunity to determine whether the seclusion period can be terminated or if it requires continuation.

Medical Staff Review

Initial Assessment by Doctor/Duty Doctor *(Required immediately if the Doctor is not the professional implementing period of seclusion):* **Discussion:** **Outcomes:**
Name and Designation Print_____ Signature_____

Hour Review by Doctor/Duty Doctor: **Discussion:** **Outcomes:**
Name and Designation Print_____ Signature_____

Nursing Staff Reviews

2 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge
Discussion: **Outcomes:**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

_____ Hour Review by 2 Registered Nurses, one who is the Nurse In Charge
Discussion: **Outcomes:**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

Internal IDT Review

Names of those participating in Internal IDT review: **Discussion:** **Outcomes and Actions**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

Independent IDT Review

Names of those participating in Independent IDT review: **Discussion:** **Outcomes and Actions:**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

Appendix 6 – Seclusion Audit Form

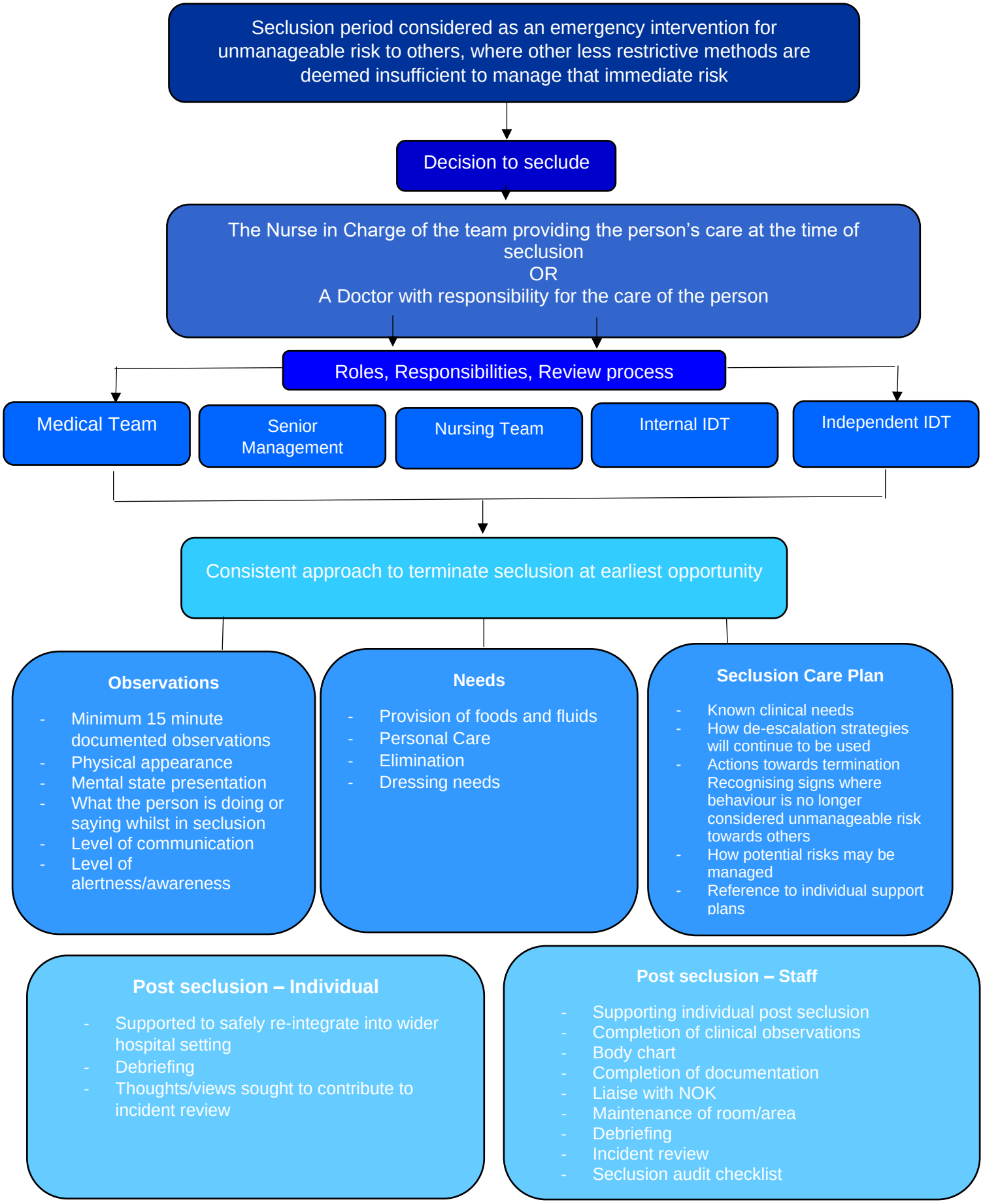
Seclusion Audit Form

		Yes	No	N/A	Comments
1.	Is there evidence that other alternative interventions were considered prior to the use of seclusion				
2.	Has the following documentation been completed as required:				
	• Record of Seclusion				
	• Seclusion Care plan				
	• Seclusion Observation record				
	• Seclusion Review record				
	• Seclusion maintenance record				
	• Incident form				
	• NEWS Chart (or equivalent)				
3.	Is there evidence that seclusion process was explained to the person If additional resources are required to support/aid understanding, is it evidenced that they were utilised				
4.	If a doctor was not the professional authorising seclusion, did they attend for review immediately If not, was an incident form complete				
5.	Is there evidence of completion/attempts to complete clinical observations during seclusion period				
6.	Is there evidence that following administration of medication before/during seclusion period that the following was monitored:				
	• Respiration Rate				
	• Response to verbal or tactile stimulation				
	• Level of movement				
	• Level of awareness				
	If no, is it evidenced as to why staff were unable to monitor and record				
7.	Was the person searched prior to entering seclusion				
	• Is this evidenced				
	• Is it evidence that this was discussed with the person and rationale explained				
8.	Is it evidenced that the NIC completed an hourly review				

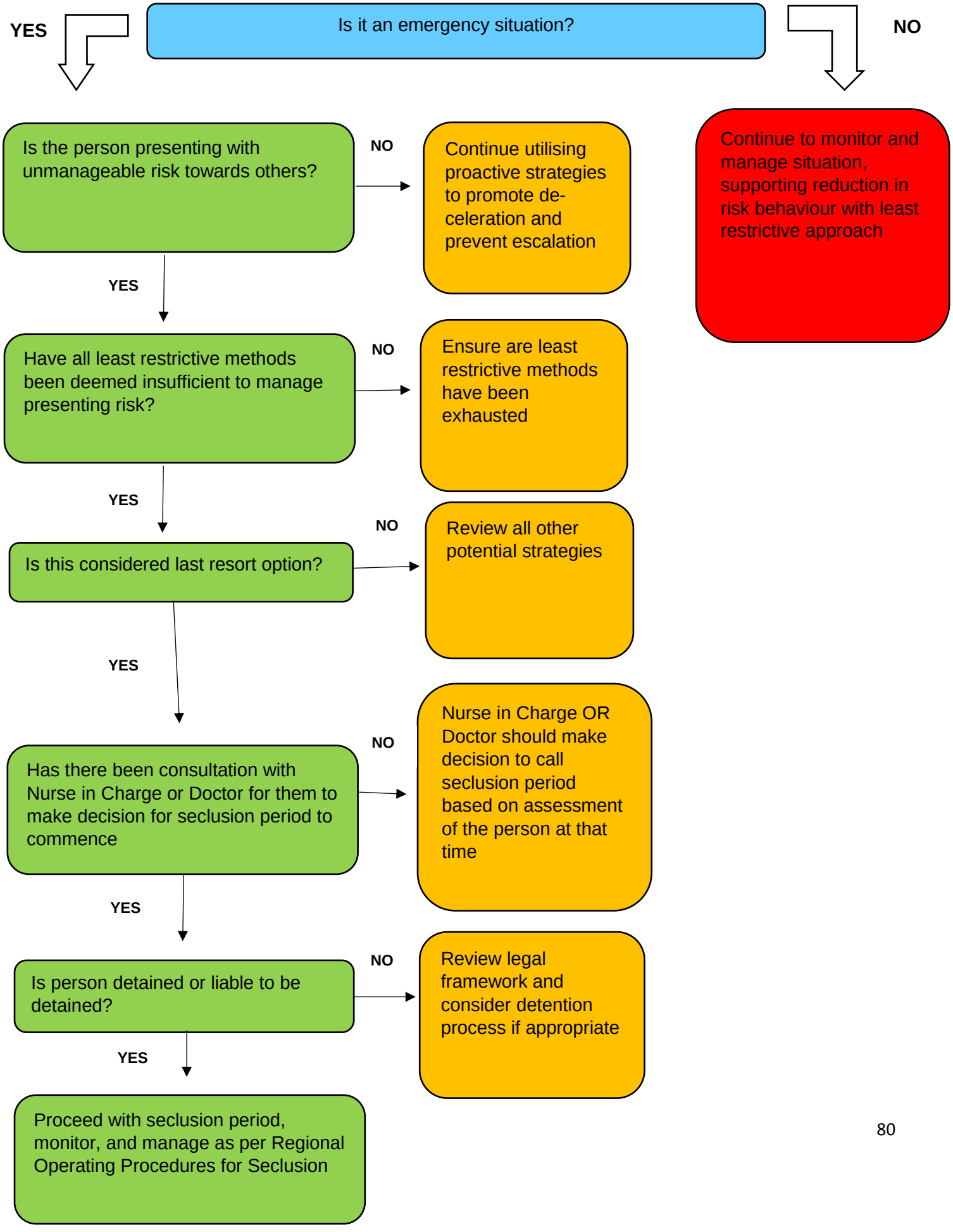
9.	It is evidenced that medical staff completed 4 hourly reviews after initial review				
10.	Is it evidenced that Nursing staff completed 2 hourly reviews x 2, one whom being the NIC				
11.	Is it evidenced that seclusion met the trigger for internal IDT review Did an internal review take place Are the outcomes of this evidenced and actions agreed				
12.	Is it evidenced that seclusion met the trigger for an independent IDT review Did an independent review take place Are the outcomes of this evidenced and actions agreed				
13.	Is it evidenced that consent has been given to share information with NOK/family. If not, are reasons explained as to why				
14.	Is there evidence that the person was offered food/fluids				
15.	Is there evidence of incident review by IDT following period of seclusion Is there key learning identified Are there actions set out to prevent incident from re-occurring Has this been reflected in the person's care record and where required care record and risk assessments updated				
16.	Is there evidence of post incident debrief • For the person who required seclusion • For staff involved				

Appendix 7 – Seclusion Flowcharts

Quick Reference Chart – Procedure for Seclusion



Quick Reference Flowchart – Decision to Seclude



Quick reference flowchart – Roles and Review process

Medical Team

- Assess and review need for seclusion period to continue
- Review mental and physical health
- Review level of risk to others
- Review level of observations
- Potential risk to self
- Review medication and potential adverse effects

- If the doctor was not involved in the decision to seclude the person, then they must attend immediately to complete review
- Medical review complete every 4 hours
- Medical reviews must take place every four hours - one of which should be undertaken by the person's Consultant Psychiatrist within 24 hours unless stipulated during the first internal IDT review
- Document review within review record and care plan
- Complete seclusion care plan with nursing staff and make amendments as required following review

Senior Management

- Provide support and guidance to person in seclusion and staff supporting
- Discuss presentation, potential risks and agreed management plan with NIC
- Assure appropriate resources in place until termination

- Senior management staff will be contacted by nursing staff to inform them of commencement of a period of seclusion
- The senior manager in receipt of the call should arrange to attend the ward to receive a report on the decision to seclude – the senior manager should sign records acknowledging receipt of report and any other information or advice provided. If the senior manager does not attend in person, the NIC must document the detail of conversation and decisions agreed as per telephone conversation.

Nursing Team

- Monitor physical and mental state presentation of person via observations
- Inform and update professionals and NOK
- Complete and review seclusion care plan
- Completion of documentation

- Commence 1:1 observations at commencement of seclusion
- Registered nurse must monitor and observe the person in seclusion
- An observation record must be documented at a minimum of every 15 minutes
- NIC must complete formal hourly review
- NIC and further RN (ideally one not involved in decision to seclude) will undertake formal 2 hourly review

Internal IDT

- Review seclusion period and incident that led to seclusion
- Review care plan and ensure appropriate actions in place to terminate seclusion at earliest opportunity
- Document any actions required

- An initial internal IDT review of the need for seclusion will be carried out as soon as practicable once the seclusion period commences.
- An internal IDT review will include the person's doctor, nurse in charge, and other IDT professionals who may usually be involved with the person
- An internal IDT review should take place once in every 24 hour period of continuous seclusion

Independent IDT

- Independent professionals **not** involved in initial incident or that led to decision to seclude
- Review seclusion period and incident that led to seclusion
- Review care plan and ensure appropriate actions in place to terminate seclusion at earliest opportunity
- Document any actions required

- An independent IDT review should take place where a person has been secluded for 8 hours consistently or 12 hours intermittingly during a 48 hour period
- Even if the seclusion period has since ended, once a trigger point has been reached, the review must be held. If the seclusion period is ongoing then the independent IDT review should make recommendations as appropriate to the seclusion care plan

Quick reference guide– Care of the person in seclusion

During a period of seclusion, staff must ensure that a good level of care is maintained and delivered, ensuring that their privacy and dignity is maintained. The health, safety and wellbeing of the person is paramount.

Clothing

-If there are any concerns regarding use of clothing as potential ligatures or concealing of unsafe items

- Follow local organisational policy Search procedures
- Document if anything found during search that is deemed unsafe
- If any items or clothing deemed unsafe and require removal due to potential to compromise safety then they must be removed by staff who have received appropriate training and are competent
- Privacy and dignity should be maintained at all times
- If tear proof clothing is required then this must be provided

Personal Care/Elimination

- Encouragement and prompting for individual to meet personal care needs
- Support for individual where required
- Access to appropriate items/resources

- Privacy and Dignity should be maintained at all times
- Providing of resources i.e. hygiene products to support person to meet their needs
- Support individual as required to meet personal care and elimination needs

Food/Fluids

-All meals and drinks must be provided as normal

- All offers/acceptance and refusal of food and fluid items should be documented within the seclusion observation form and within the person's records
- Consider use of fluid chart to monitor and document fluid intake and promote adequate fluid intake as required
- Safe to use crockery and utensil items provided

Safety

- Any potential risk to the person
- Deterioration in clinical presentation

- If there is an identified risk to the person at any time then the seclusion room must be entered at the earliest and safest opportunity (Staff must have complete required training and be deemed competent)
- This will be a decision based on clinical judgement and need to maintain safety of the person whilst in the seclusion room.

Quick reference flowchart – Termination of Seclusion

Seclusion must be terminated at the earliest opportunity when it is no longer assessed as required. Seclusion can be terminated by one of the following:

- Nurse in Charge
- Doctor
- Medical Review
- Internal IDT Review
- Independent Review

Seclusion terminated

Yes

No

Identify management plan to safely support person following termination of seclusion and reintegration into general ward setting. Including offering/planning to support person in preferred activities, having meals with others and engaging in therapeutic activities with staff

Nursing team to complete relevant documentation:

- NIC must document termination on observation record
- Complete documentation in person's care plan
- Body chart
- Incident form
- Clinical Observations on NEWS Chart
- Inform NOK (as appropriate)

The seclusion room/area must be reviewed, maintenance record complete and cleaning complete in line with IPC procedures

Ensure debriefing process is completed with both the person and staff involved. All efforts to promote and encourage completion of debriefing but where person has not engaged should be documented

Incident review must be complete post seclusion period.

- Within 72 hours
- Person's thoughts/views included
- Identified learning

Completion of seclusion audit tool.

Quality assurance against regional operating procedures

Continue with review process and continue to monitor person, follow seclusion care plan and utilisation of de-escalation strategies and outline of actions that will continue to support termination of seclusion at earliest opportunity.

Appendix 8 - References

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Appendix 9 – Relevant Legislation

Legislative Context

Relevant legislation and Guidance should always be adhered to and staff should ensure that they are up to date with the most up to date Legal framework relating to use of Seclusion.

Criminal Law Act (1967)
Data Protection Act (2018)
Disability Discrimination Act (1995)
European Convention on Human Rights
Mental Capacity Act (Northern Ireland) 2016
Mental Capacity Act (Northern Ireland) 2016 – Deprivation of Liberty Safeguards – Code of Practice
Mental Health (Northern Ireland) Order 1986 and Code of Practice
Northern Ireland Act 1998
Northern Ireland Children's Order (1995)
Race Relations (Northern Ireland) Order (1997)
Section 75 of the Northern Ireland Act (1998)
Special Educational Needs and Disability Act (Northern Ireland) 2016
The Age of Majority Act (Northern Ireland) 1969
The Children (Northern Ireland) Order 1995
The Children (Secure Accommodation) Regulations (Northern Ireland) 1996
The Criminal Justice (Children) Northern Ireland Order 1998
The Day Centre Setting Regulations (Northern Ireland) 2007
The Equality Act 2010
The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
The Health and Safety at Work Act 1974
The Human Rights Act (1998)
The Protection of Children and Vulnerable Adults Order (Northern Ireland) 2004
The Public Order (Northern Ireland) Order 1987
The United Nations Convention on the Rights of the Persons with Disabilities, 2006
United Nations Convention on the Rights of the Child 1989
United Nations Convention on the Rights of the Child- UNICEF UK - 1992

Appendix 10 - Acknowledgements

Rosaline Kelly	Author and Project Lead
Amanda Scott	Author and Project Manager
Claire Henry	Project Officer

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Focus Group involvement from:

ArcNI	Bryson House	VOYPIC
Cause	Mencap	

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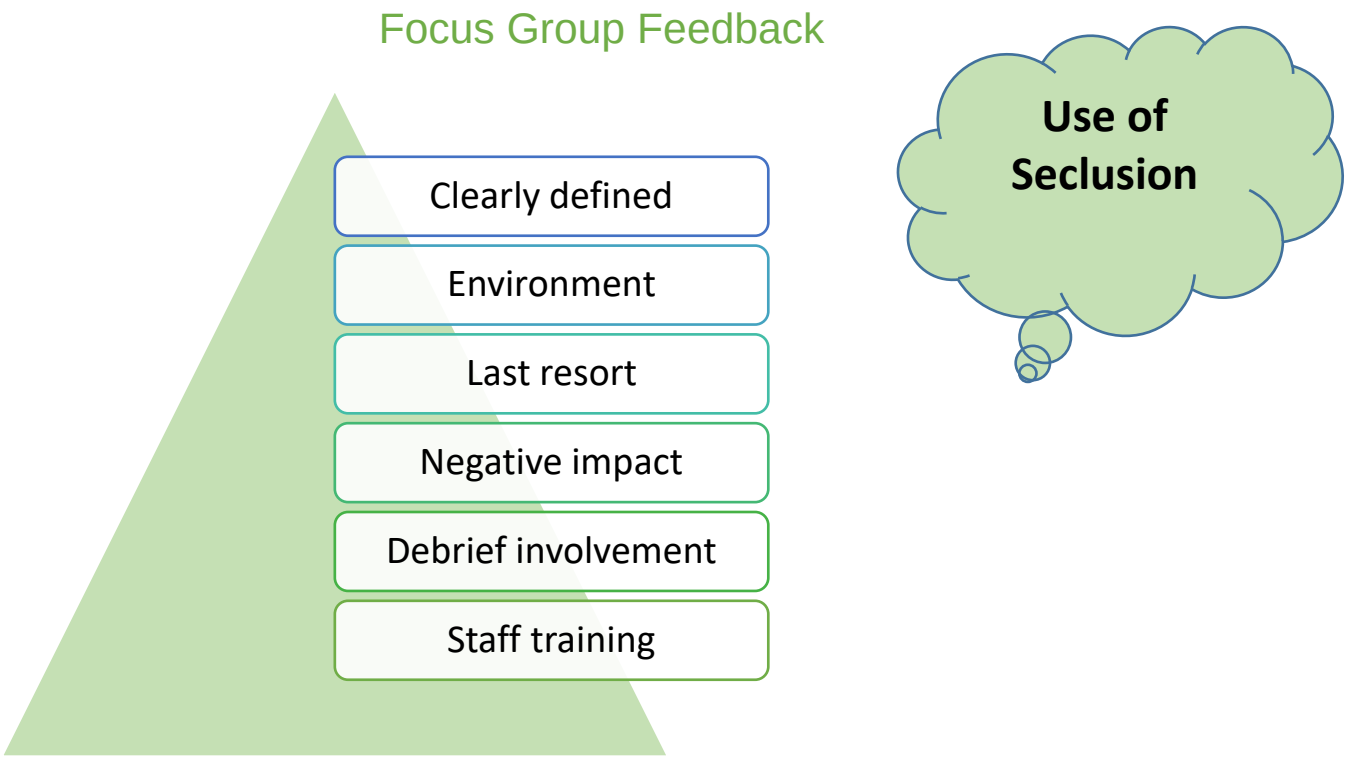
Appendix 11 – Themes and Feedback



All focus groups agreed that seclusion should only be used as a last resort once all other methods had been exhausted.

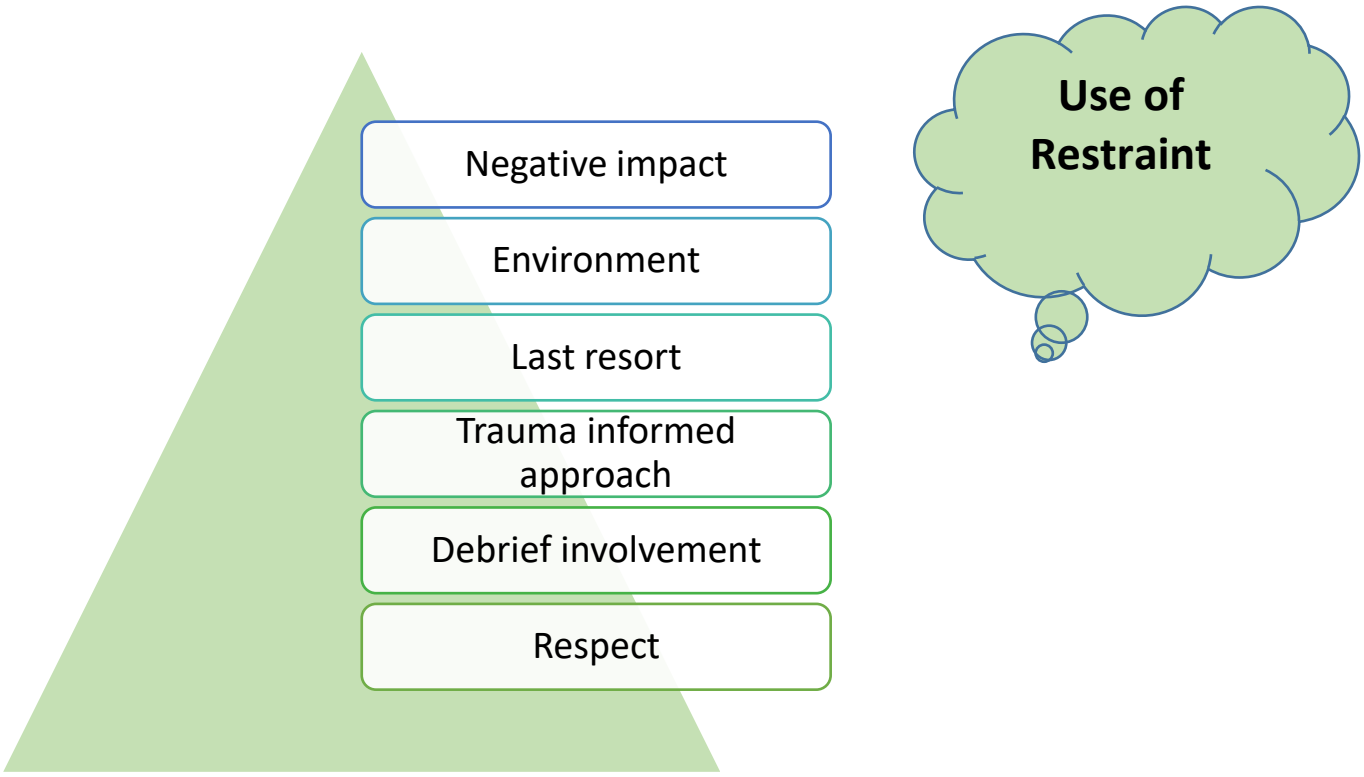
Focus groups agreed that reasons for using seclusion should clearly be defined and communicated to the person, their families and carers.

Focus groups fed back that seclusion had a negative impact on their health and wellbeing and in some cases made them feel worse.

Seclusion rooms have been described as “cold, dark, lonely, disgusting, like a jail”. A low stimulus room would be nice. Comfortable, safe, calming, with drinking water available. Possibly slow, quiet, calming music in the background.

Staff should know their patients and their specific needs; this would help to avoid incidents arising as staff would be able to recognise triggers. Staff should try to deescalate in the first instance. Focus groups members did recognise that sometimes staff are at risk too but felt that staff need more training.

Feedback suggested that staff should have conversations and a debriefing process should be completed, with the person and their families/carers, whenever an incident occurrs.



All focus groups agreed that restraint should only be used as a last resort, however members agreed that sometimes there is a need for restraint, especially if someone may hurt themselves or others.

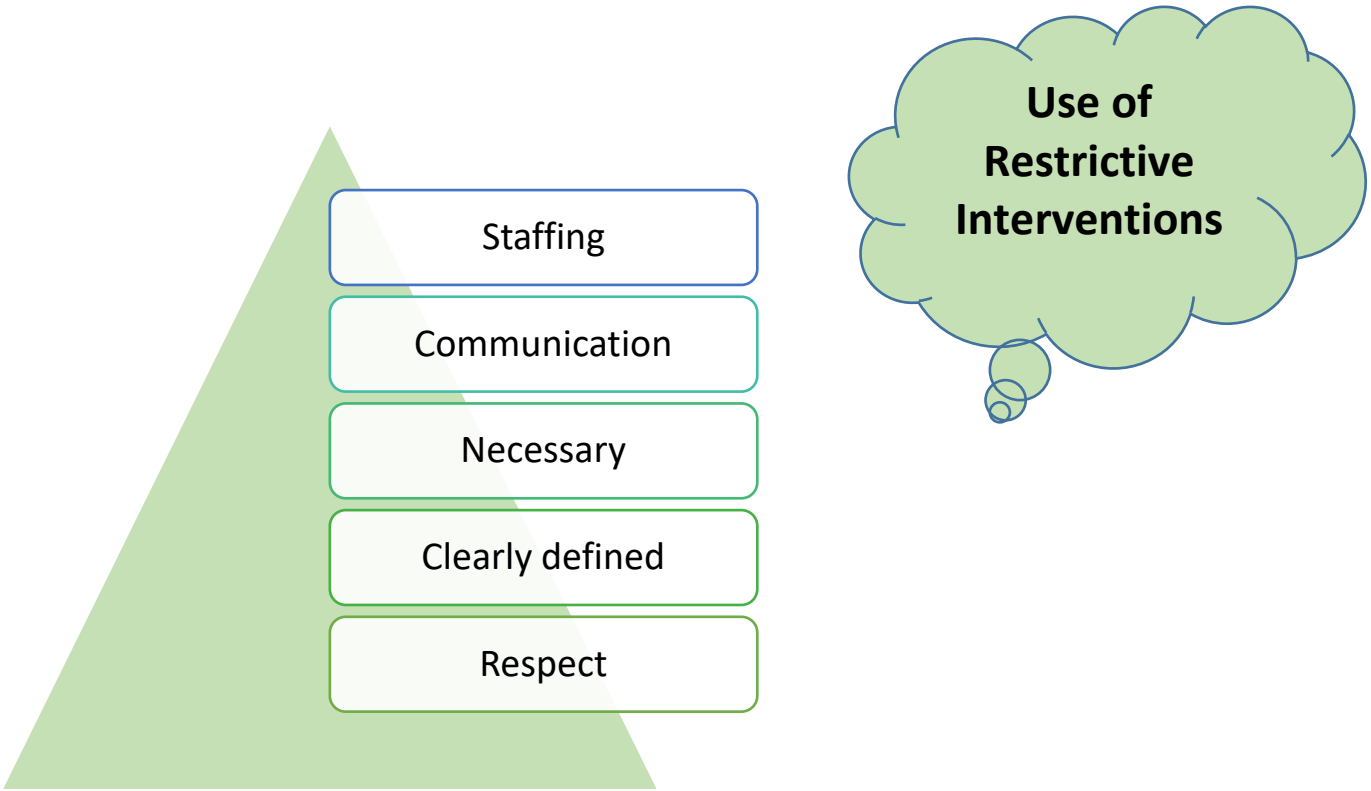
Accommodation or the environment in which a person is living should be spacious to help de-escalate emotion and reduce any potential for physical or chemical restraint.

All focus groups agreed that being restrained was negative to a person's health and wellbeing.

Group participants called for a trauma-informed care approach in order to help identify triggers and encourage sensitivity in approach.

Families should be informed about any use of restraint to discuss what and why, in order to create better understanding.

Focus groups said they realised staff were at risk of being hurt, but they want to be respected and listened to.



Feedback suggested that staff don't always have enough time and felt that staff shortages should not affect them being able to live their life or restrict their movements.

Focus group participants acknowledged that sometimes restrictive interventions are needed in order to keep individuals well, like sleep hygiene, but suggested restrictive interventions should be reviewed every fortnight/month.

Participants suggested there should be better communication between staff and patients. They thought staff should be explaining why they are taking things away or locking doors.

Feedback asked for clearer definitions of restrictive interventions and suggested that any restrictions should be agreed to through dialogue and not just enforced.

Feedback suggested that staff should be respectful of age and patient needs for example accommodating for later bedtimes, allowing freedoms like accessing beverage making facilities or items that are self-soothing.

Focus group feedback included suggestions regarding the use of developing technology in accommodations, such as use of keypads, water taps being on a timer, showers on a timer and better monitoring devices.

Staff Engagement Day

Feedback from breakout room discussions

It's important to identify and explore options around practises, while balancing risk and safeguarding patients.

We need to ensure all interventions are captured consistently.

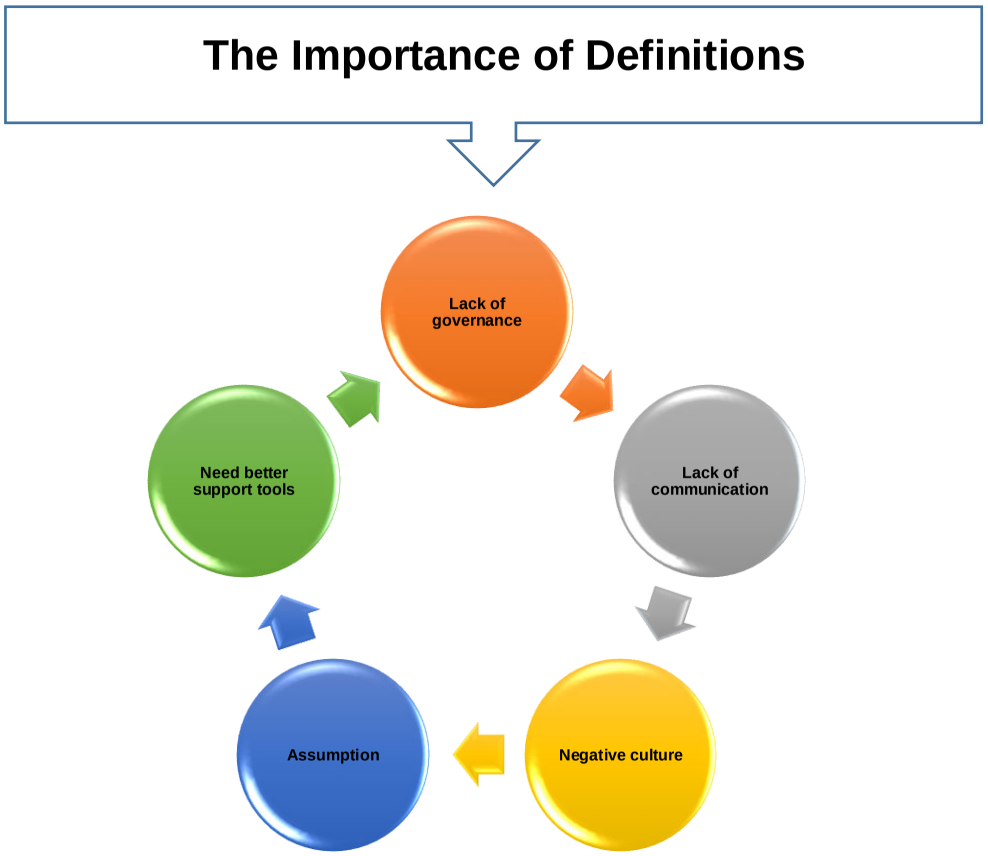
Human rights for patients starts on ground floor.

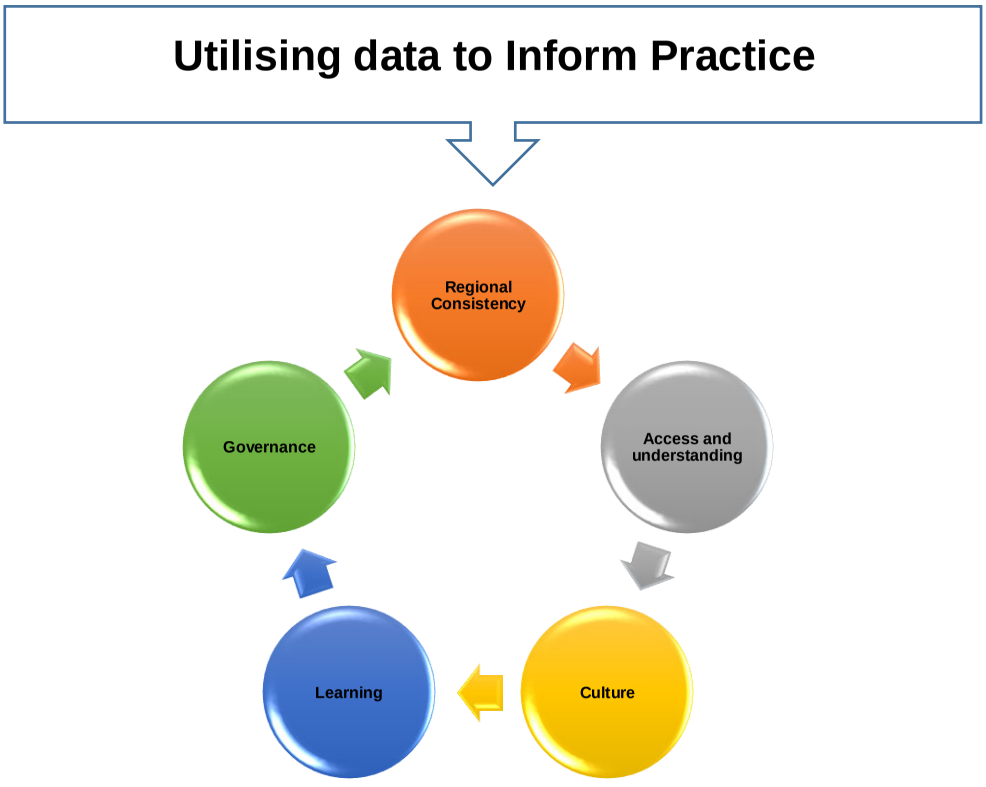
Better leadership to help staff to feel valued.

It's important to view the person as human.

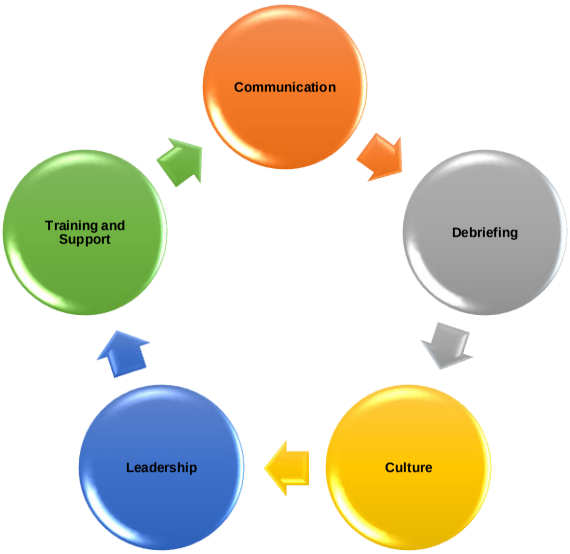
There should be clearer evidence of how you're actually supporting people.

Emerging Themes

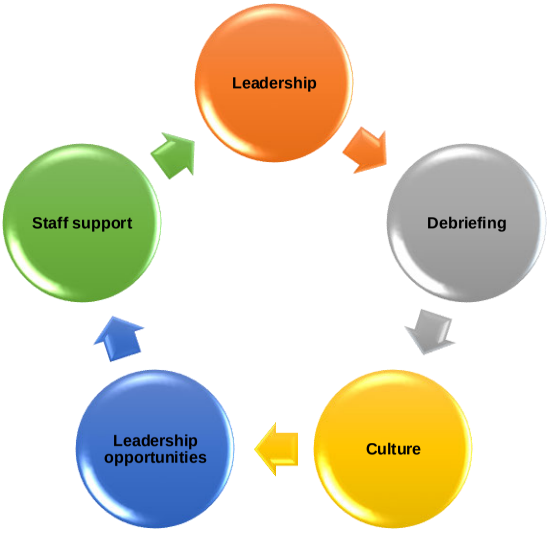




How human rights affects those that we care for



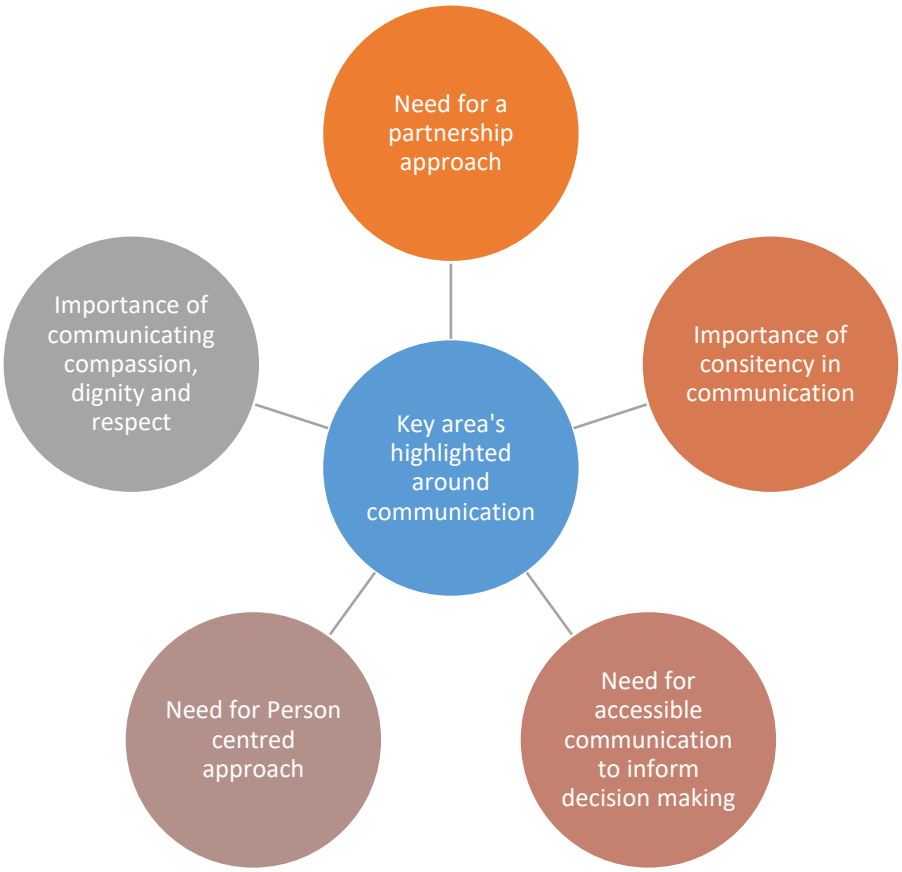
Supporting Cultural Change



Communication Sub-Group Feedback

Throughout engagement with those who helped develop this policy, communication was a repeated theme. Reports of poor communication impacting on the quality-of-care delivery could be rectified by a partnership approach and regular, authentic communication that will assist informed decision-making, allowing for more person-centred, more therapeutic and less restrictive alternative strategies to be agreed.

This is considered critical to minimising restrictive interventions.



Whilst not everyone expressed a negative experience, it was agreed that this did not suggest that improvements in effective communication would not be important.

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Northern Ireland Practice and Education Council for Nursing and Midwifery

SAFEGUARDING ADULTS

CORE COMPETENCY FRAMEWORK

for Nurses and Midwives

CONTENTS

Foreword:

Safeguarding adults is everybody's business. All nurses who work with vulnerable adults have the responsibility to safeguard their wellbeing and safety in different ways. Safeguarding forms part of core business by ensuring health and patient safety, promoting independence and wellbeing and protecting people from harm. However, it also refers to a very specific area of work- the reactive inter-agency response to protect vulnerable adults who are at risk of significant harm.

I am delighted to endorse my support of this framework which sets out the knowledge, skills and attitudes that nursing staff across the public and private sectors will require in order to interact and respond effectively to the needs of people presenting with safeguarding needs. Training of nurses is needed to ensure those working with vulnerable adults have the right knowledge and skills to do their job well, to be able to protect, identify and take the appropriate action to sure people in their care are kept safe from harm.

It is the culmination of considerable efforts by staff working within adult protection services, academics and regulators and I am delighted that this document complements the work already undertaken through the NI Adult Safeguarding Partnership (NIASP) in the development of a multi-disciplinary training strategy.

It will allow individual nursing staff and their managers to assess their training needs and those of their staff team and will enable educationalists to design and deliver targeted training programmes.

Ultimately this framework will enhance the quality of life, improve care and treatment for vulnerable adults and higher standards of service will be delivered by a competent and professional nursing workforce.

Professor Charlotte McArdle
DOH Chief Nursing Officer

SECTION 1

1.1 Introduction

Safeguarding in its simplest terms is identifying harm or the risk of harm and acting in such a way as to prevent or reduce that risk. Safety, along with respect, dignity and choice, is a basic human right and something most of us take for granted. At times we will all be vulnerable, whether through accident or injury, physical or mental illness, disability or the ageing process. Our ability to remain in control of our own lives may be challenged and our own level of dependence on others to meet these needs will vary. This makes the process of adult safeguarding complex and challenging.

The Policy (DHSSPSNI & DoJNI, 2015) Adult Safeguarding; Prevention and Protection in Partnership highlights the importance of prevention in relation to the safeguarding continuum. It would be the intention of this framework, that by bringing safeguarding competency to the fore, potential abuse may be identified in a timely manner, and preventative steps taken, to prevent the protection threshold being reached; whilst equipping registrants with the essential skills to effectively deal with this should it occur.

While adult safeguarding is everybody's business and should be a core aspect of all professional practice, the Northern Ireland Adult Safeguarding Partnership (NIASP) recognises that no single person or professional group can possibly address these complex situations in isolation. NIASP continues to promote the importance of positive partnership working across professional boundaries, with service users, patients and their families/carers to achieve the best possible outcomes for the victims/potential victims of adult abuse, neglect or exploitation. It is therefore the responsibility of all staff within health and social care, irrespective of background, department or sector to be aware of their roles and responsibilities in relation to adult safeguarding and, as stated by the Nursing and Midwifery Council (NMC, 2015), it should be part of everyday practice for all nurses and midwives.

The aim of this competency framework is to ensure staff gain and maintain the correct level of skills and knowledge in relation to adult safeguarding practice. It is intended that this will provide nurses and midwives with the confidence and skills to recognise and effectively

manage those situations which may arise where there is suspicion of abuse, neglect or harm to an individual. This framework clearly identifies the skills, knowledge and attributes each registered nurse and midwife should have in relation to their own role. It emphasises an understanding of the processes within each Trust area, the need to know who the safeguarding team are and how to access them. The competency framework aims to enable nurses and midwives to identify their learning and development needs in relation to Adult Safeguarding ensuring the provision of safe, effective person centred services. It is an important addition to a range of tools for best practice which include *The Code* (NMC, 2015), *Enabling Professionalism* (NMC, 2017), *Adult Safeguarding; Prevention and Protection in Partnership* **(**DHSSPSNI & DoJNI, 2015).

1.2 Development of the Competency Framework

This Competency framework has been developed through;

- A review of the literature and existing competency frameworks to ensure identification and prioritisation of the key areas to be included in the competency framework
- Consideration of available training on adult safeguarding.
- Consultation with Nurses and midwives working throughout Northern Ireland in both the independent and statutory sectors.
- Advice from the Expert Reference group and Steering group members (Appendix 2)

1.3 What is a competency framework?

A competency framework defines the knowledge, skills and attitudes needed in order to perform effectively in a given job, role or situation. The main goal of a competency framework is to clearly identify and communicate the knowledge, skills and attitudes an employee needs to thrive in a job; it can increase clarity around performance expectations.
This competency framework has been designed to help you prepare for:

- Supervision meetings
- KSF development review or annual appraisal meetings
- Job interviews
- Revalidation

1.4 Who is this competency framework for?

- This competency framework is aimed at all registered nurses and midwives regardless of practice area or speciality. The framework has been developed taking cognisance of the NIASP Training and Development Framework which succinctly outlines the levels of training for everyone who is involved in the lives of adults at risk in Northern Ireland. The table below will assist you to identify which level of competence you require for your role. Each level builds on the competencies identified in the preceding level.
- Those staff not registered with the NMC should discuss their training needs with their line manager and refer to the NIASP Training and Development Framework for guidance as to the level of training they require to fulfil their role.

1.5 Using the Competence Assessment Tool

The *Assessment Tool* has been devised to be used alongside a range of general competency frameworks (that focus on core skills and competencies for all qualified nurses and midwives). The Competence Assessment Tool can help you think about the knowledge and skills required for your current role. You may use the Tool to prepare for supervision meetings or to gather evidence that you can bring to your annual development review and/or appraisal meetings.

Your assessment results and any related reflections can be entered into your professional portfolio, online or in hard copy. This means you can demonstrate your learning and development and meet Revalidation requirements.

To assess your personal competence identify which competency level is relevant to your current role. You should use the following rating scale to assess your learning and development needs against each of the attribute statements within your level:

- **LD** - You need a **lot of development**.
- **SD** - You need **some development**.
- **WD** - You feel you are **well developed**.

It generally takes about 15 minutes to assess yourself against the competence statements. Place a ✓ to rate the statement which is applicable to your individual learning and

development. When you have finished, review the number of LDs,
SDs, and WDs. You can then plan, with your line manager, the learning and development activities which are relevant to your role.

Practice Tips

Before starting your assessment, you may find it helpful to discuss the statements with one of your peers. You can also test your self-assessment with your line manager. Be honest with yourself when thinking about your role and your learning and development needs and rate them realistically.

Adult Safeguarding Competency Framework

Level 1 – General Awareness (See NIASP Training and Development Framework)
Target Audience All staff and volunteers in the organisation
Level 2 – Awareness Raising, Recognising & Responding
Target Audience All Nurses & Midwives who have direct contact with adults at risk of harm or in need of protection
Level 3 – Managers Training
Target Audience All front line Managers / nominated Managers/and Safeguarding Champions
Level 4 – Investigating Officer and Specialist Nurse[1]
Target Audience 4a – All Trust Nurses & Midwives who are nominated for the Investigating Officer role 4b – All Adult Safeguarding Nurse Specialists who are nominated for Investigating Officer role and should be read in conjunction with the *'Career Framework for Specialist Nursing Roles'(2018* pending publication*).*

The core specific competency areas have also been mapped to the relevant themes of the NMC's Code – Professional standards of practice and behaviour for nurses and midwives (2015)[2] and specific dimensions of the Knowledge and Skills Framework (KSF), (Department of Health, 2004)[3]

[1] Only those Nurses with a Specialist Practice Qualification should use the title Specialist (*Career Framework for Specialist Practice Nursing roles* (DoH 2018 pending publication)

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SECTION 2

LEVEL 2	LD	SD	WD
Knowledge • Recognise those contributory factors which increase an individual's vulnerability, risk of harm or need of protection. • Understand the impact of social media in relation to adult safeguarding. • Have an understanding of adult safeguarding legislation including Human Rights Legislation. • Understand the importance of, and the local process for, escalating adult safeguarding concerns. • Understand local and regional Adult Safeguarding Policies and Procedures and Regional Guidance. • Understand the interface between adult and child safeguarding. **Skills** • Use nursing assessment skills to recognise an adult who is potentially at risk of harm or in need of protection. • Take immediate action within your level of expertise, to safeguard an individual whilst maintaining personal safety and the safety of others. • Report and record accurately details of issues of concern according to local and regional policies/procedures. • Record factual, succinct, person centred and contemporaneous records being mindful of the need for confidentiality and issues regarding data protection when sharing information. • Preserve potential evidence as part of any possible Health and Social Care (HSC) Trust or Police Service of Northern Ireland (PSNI) investigation, seeking advice and guidance in relation to what needs to be preserved.			

LEVEL 2	LD	SD	WD
• Communicate clearly with the multi professional team in a timely way. • Contribute to the development and implementation of a protection plan, contributing to the evaluation of its effectiveness. • Participate in learning by reflecting on outcomes, applying what has been learnt, and sharing any learning to improve practice and service delivery. • Participate in preventative strategies, to minimise risk before it occurs, and minimise the impact of harm where it is unavoidable. • Support others to report concerns. • Advocate for the rights of individuals, their families and carers within the care environment recognising influences such as power, control and conflict. • Communicate openly with clients and their families. **Attitude** • Be alert to, identify, and act upon Safeguarding concerns. • Accept responsibility to proactively respond to concerns/signs of risk. • Recognise your own role, and respect the role of the multiagency team, to ensure effective adult safeguarding. • Engage in and encourage a continuous learning culture. • Work within an ethos which ensures service users/carers are supported to understand the safeguarding process in a person centred and sensitive manner, being mindful of the effects of abuse and the ensuing safeguarding processes may have on the individual and their carer(s). • Show respect for and foster effective relationships with all stakeholders.			

LEVEL 3	LD	SD	WD
Knowledge • Demonstrate an in-depth knowledge of the application of policies and procedures including Human Resource (HR) processes. • Demonstrate a clear understanding of the thresholds and pathways for investigating/responding to a safeguarding alert and/or referral. • Demonstrate a clear understanding of the roles and responsibilities of all agencies involved in adult safeguarding. • Have knowledge of support services for carers and staff and be able to signpost to these for support. • Have a knowledge of child safeguarding Policy and Procedures and the interface between adult and child safeguarding. • Have a knowledge of conflict resolution and mediation strategies**.** **Skills** • Consider the capacity to consent of the person at risk of harm / in need of protection throughout the investigation process and using a person centred approach effectively communicate with the person and relevant stakeholders including carers. • Compile and analyse appropriate records providing clear rationale for decisions taken. • Adhere to and support robust record keeping practices. • Understand the process of referral to a Designated Adult Protection Officer (DAPO). • Contribute to multi professional and interagency communication and collaboration related to adult safeguarding concerns in a timely way. • Adhere to and evaluate agreed protection plans.			

LEVEL 3	LD	SD	WD
• Support the workforce to have the required knowledge and skills to contribute fully to adult safeguarding by ensuring that effective training is in place. • Facilitate an effective learning environment to support the dissemination of learning and the professional development of staff. • Challenge circumstances that may lead to poor practice in adult safeguarding. • Manage conflicts, disputes and difficult situations. • Provide support and supervision to staff involved in adult safeguarding cases. **Attitudes/Behaviours** • Promote a person centred approach throughout safeguarding practice. • Promote open and transparent working cultures that encourage good practice. • Be aware of own limitations and knowledge in relation to the remit of adult safeguarding. • Display professional accountability to ensure safe and effective practice that meets the needs of patients/clients, their families and carers.			

LEVEL 4A	LD	SD	WD
Knowledge • Know how to apply the principles of the safeguarding policy and procedures to the investigative process. • Know the roles and responsibility of partner agencies involved in investigations. • Understand data protection requirements during the recording, transfer and filing of all data. • Knowledge of legislation, processes, standards and organisational procedures such as issues around Human Rights, Deprivation of Liberty & Capacity and Consent. **Skills** • Establish a collaborative working relationship with the DAPO to set out clear guidelines in relation to the investigation process. • Recognise the capacity to consent of the person at risk of harm / in need of protection throughout the investigation process, and if required, seek a formal assessment of capacity in relation to the matter. • Work in collaboration with the DAPO to ensure that recommendations outlined in the investigation reports are implemented by the relevant stakeholders. • Maintain appropriate records in line with Adult Safeguarding Policies, including protection planning and risk assessment. • Contribute to the protection plan and ensure it is robust and balances human rights, deprivation of liberty and wider safeguarding considerations. • Monitor implementation of the protection plan. • Communicate the content of any protection plan to key stakeholders. • Contribute to the improvement of the service by influencing			

LEVEL 4A	LD	SD	WD
change through the use of Evidence Based Practice. • Deliver expert nursing advice/education and training concerning adult safeguarding to multiagency teams/stakeholders, and foster a culture of shared learning within the team. • Contribute to any SAI or case review, as requested, where adult safeguarding is an issue. **Attitudes and behaviours** • Investigate allegations of abuse/neglect in a non-judgemental, sensitive and respectful manner, utilising expert nursing knowledge and experience, within the guidance of the associated policy and procedures. • Promote effective working relationships, and communication strategies, with multiagency partners and stakeholders. • Challenge barriers to effective Adult safeguarding.			

LEVEL 4B - should be read in conjunction with the *'Career Framework for Specialist Nursing Roles' (2017).*	**LD**	**SD**	**WD**
Knowledge • Comprehensive knowledge of professional standards such as Nursing and Midwifery Council (NMC), Northern Ireland Social Care Council (NISCC), Health and Care Professions Council (HCPC). • Advanced knowledge of organisational/regional strategic objectives for Adult safeguarding services. **Skills** • Demonstrate strategic and professional nursing leadership in relation to adult safeguarding. • Lead innovation and change to improve safeguarding across all adult services. • Provide expert nursing advice, support and consultancy to other nurses and health and social care professionals within the Trust and external organisations. • Contribute to the development of effective inter disciplinary and inter agency relationships to improve outcomes for adults at risk of harm and in need of protection. • Identify complex and multifaceted issues that require the expertise of an adult safeguarding specialist nurse. • Participate in the implementation of the work plan developed by the Local Adult Safeguarding Partnership (LASP). • Demonstrate the ability to challenge internal and external agencies to ensure wider safeguarding risks are identified and acted on appropriately. • Contribute to / engage in adult safeguarding research activities and evaluate the effectiveness of evidence based practice. • Analyse findings from national reports, local reports and case reviews considering the implications for service delivery/learning.			

LEVEL 4B - should be read in conjunction with the *'Career Framework for Specialist Nursing Roles' (2017).*	**LD**	**SD**	**WD**
• Use lessons learnt from audits, feedback and current research to identify/ highlight areas for service improvement and promote creative solutions with a focus on a person centred approach. • Participate in the development of local and regional policies and strategic guidance. **Attitudes and behaviours** • Act as an expert role model for nursing in the field of adult safeguarding. • Engage with staff teams, employing an attitude of enthusiasm towards adult safeguarding, motivating others to improve the service and outcomes for individuals.			

APPENDIX 1

The framework is informed by the following documents:

DHSSPSNI, DoJNI (2015) **Adult Safeguarding; Prevention and Protection in Partnership**. Belfast; DHSSPSNI & DoJNI

Northern Ireland Adult Safeguarding Partnership (2016) **Training Strategy and Framework 2013** (Revised 2016). Belfast; HSCNI. Available from: http://www.hscboard.hscni.net/download/PUBLICATIONS/safeguard-vulnerable-adults/niasp-publications/Adult-Safeguarding-Operational-Procedures.pdf

Nursing and Midwifery Council (2015) **The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives**. London; NMC

Nursing and Midwifery Council (2017**) Enabling Professionalism in Nursing and Midwifery Practice**. London; NMC

Royal College of Nursing (2015) **Safeguarding Adults – everyone's responsibility**. RCN guidance for nursing staff. London; RCN

The Regulation and Quality Improvement Authority (2018) **Guidance for Regulated Service Providers**. Belfast; RQIA Available from https://www.rqia.org.uk/guidance/guidance-for-service-providers/guidance-for-regulated-service-providers/ (accessed 07/06/18)

APPENDIX 2

Membership of the Steering Group

Name	Designation	Organisation
Geraldine Brown	Assistant Director of Nursing for Secondary Care (Chair)	WHSCT
Eleanor Ross	Assistant Director of Nursing	PHA
Joel McFetridge	Safeguarding Nurse	BHSCT
Raymond Mc Cafferty Norma McIntyre	Safeguarding Nurse	NHSCT
Louise Magee	Safeguarding Nurse	SEHSCT
Louise Hall	Mental Health Nursing	SHSCT
Megan Miller	Safeguarding Nurse	WHSCT
Sibymol Joseph	Safeguarding Nurse	SHSCT
Joyce McKee	Regional Adult Safeguarding Officer	NIASP
Janet Montgomery	Director	IHCP
Lorraine Thompson	Regional Manager	FSHC
Melanie McClements	Assistant Director of Older Peoples Services	SHSCT
Joanne Blair	Lecturer	QUB
Seana Duggan	Lecturer	UU
Eilish Boyle	Senior manager	CEC
Martina Doolan	Team Leader NHSCT	RCM
Rosaline Kelly	Senior Professional Development Officer	RCN
Jane Greene	Consultant Nurse	SHSCT
Valerie McConnell	Social Care Commissioning Lead MH & LD	HSCB
Karen Murray	Senior Professional Officer (Project lead)	NIPEC

Expert Reference Group

Name	Designation	Organisation
Eleanor Ross	Assistant Director of Nursing	PHA
Karen Murray	Senior Professional Officer (Project lead)	NIPEC
Joel McFetridge	Safeguarding Nurse	BHSCT
Raymond Mc Cafferty Norma McIntyre	Safeguarding Nurse	NHSCT
Louise Magee	Safeguarding Nurse	SEHSCT
Megan Miller	Safeguarding Nurse	WHSCT
Sibymol Joseph	Safeguarding Nurse	SHSCT
Joanne Blair	Lecturer	QUB
Seana Duggan	Lecturer	UU
Eilish Boyle	Senior Manager	CEC
Jane Greene	Consultant Nurse	SHSCT
Ann Marie Fox Anne Marie Lyons	Manager Adult Safeguarding	BHSCT
Jenny Fitzsimmons	Safeguarding Lead	SEHSCT

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This document can be downloaded from the NIPEC website
www.nipec.hscni.net

2018

MAHI - STM - 127 - 487

Medication Without Harm

WHO Global Patient Safety Challenge

World Health Organization

WHO/HIS/SDS/2017.6

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Foreword

More than 10 years ago, with colleagues in the World Health Organization (WHO), I was involved in establishing the foundation programme of a global patient safety initiative that was the first of its kind. It was wide-ranging and led to the launching of two Global Patient Safety Challenges. It also created a programme led by patients and families who had suffered avoidable harm from health care, and it set a clear agenda for research and development, among many other areas of work aimed at improving safety globally.

In the last decade, the WHO Patient Safety Programme has raised awareness across the world of the key concepts and strategies in patient safety. It has inspired passion for the universal cause of making health care safer. It has secured commitment at the highest level among health ministers and health leaders in Member States of WHO. It has provided standards, evidence-based guidance and practical tools to support those involved in the design of patient safety programmes within countries' health care systems. It has championed the use of the stories of patients and families who have been the victims of unsafe care.

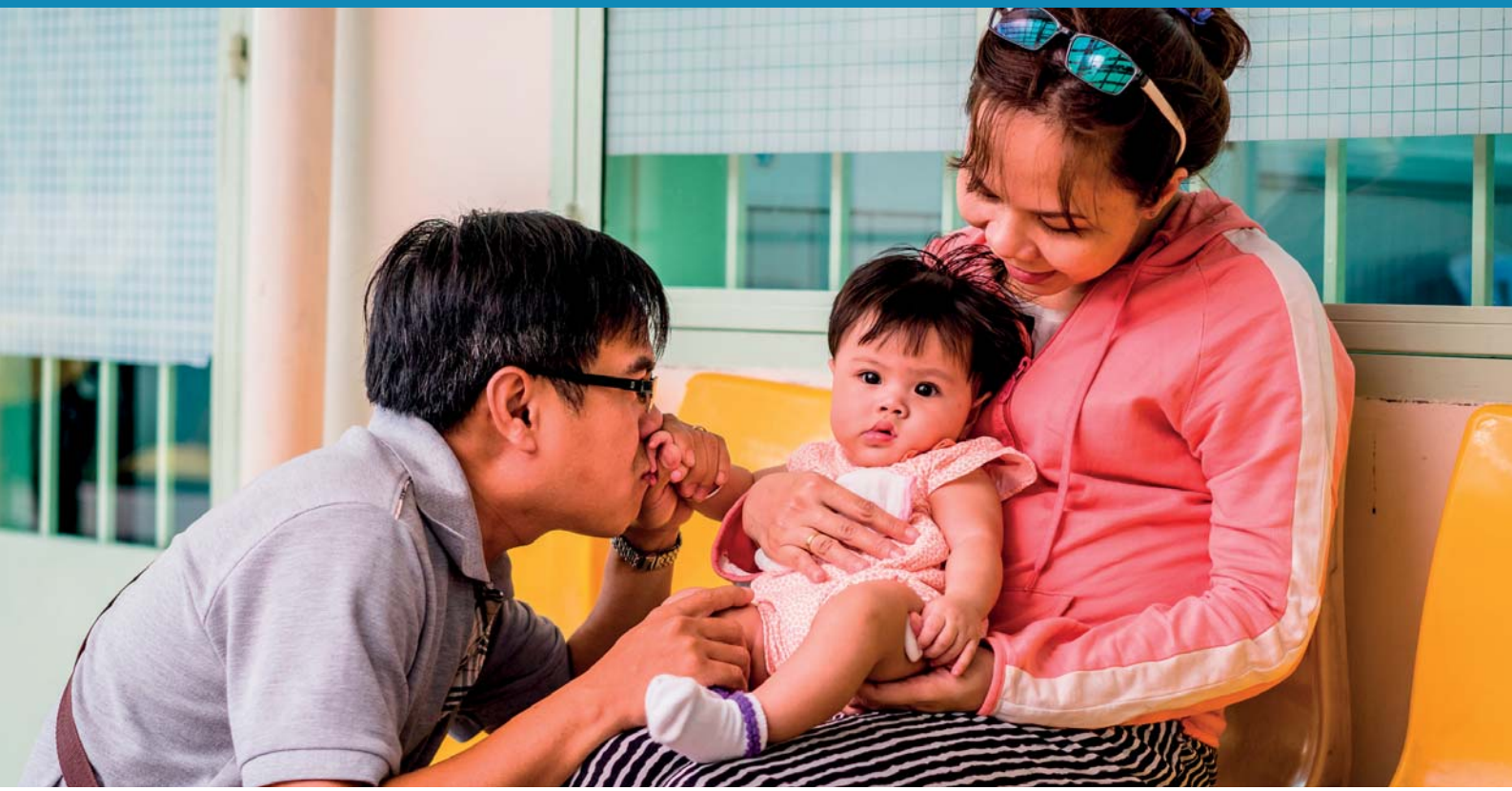
Significant portions of the Programme's initial work have been delivered and a new direction and new priorities are now required for the next phase in this programme. Moreover, the global context of patient safety as a science has evolved considerably since the creation of the Programme. At the time, there were few, if any, national agencies with a recognized mandate to work on patient safety and virtually no training and education programmes in patient safety globally. Currently, many Member States have active safety and quality programmes, campaigns and agencies, although some still ask the World Health Organization to provide implementation assistance.

The WHO Patient Safety Team has received strong feedback from major stakeholders and

experts that a third global patient safety challenge should be the first of these new priorities and would be greatly welcomed. The Global Patient Safety Challenge is essentially a programme of change aimed at improvement and risk reduction. The programme blends evidence-based interventions with multi-modal implementation strategies. They seek to achieve widespread engagement and commitment. They span the needs of all countries. They are most impressive when they develop the features of a social movement, as the first and second challenges managed to do.

I was delighted and honoured, two years ago, when Assistant Director-General, Dr Marie-Paule Kieny, asked me to advise on the design of a third Global Patient Safety Challenge on medication safety. Dr Kieny and WHO's Director-General, Dr Margaret Chan have given me, as well as the world's patient safety community, unfailing support in continuing to pursue the goal of safer care as a core component of universal health coverage. In the hard work of bringing this historic Challenge to life, the WHO Secretariat and leading world experts and stakeholders have given invaluable advice and support. In participating in the work to create this third Global Patient Safety Challenge, I have been driven and inspired by three things. Firstly, an awareness of studies in the 1960s that identified sources of medication error that can, and do, kill and harm patients in hospitals around the world today, nearly sixty years on. Secondly, that there are many individuals and groups in the fields of pharmacy, medicine, nursing, and other professions, who have been fighting for decades to see the day when medication safety would become a global priority; their passion has always been to save lives from this long-standing intractable type of avoidable harm. Thirdly, over the years, I have spoken to many people who have lost loved ones to medication-related harm; their stories, their quiet dignity and their acceptance of situations that should never have arisen have moved me deeply. It is to the memories of all those who have died due to incidents of unsafe care that this Challenge should be dedicated.

Sir Liam Donaldson
WHO Envoy for Patient Safety



Global Patient Safety Challenges

Global Patient Safety Challenges identify a patient safety burden that poses a significant risk to health, then develop frontline interventions and partner with countries to disseminate and implement the interventions. Each Challenge focuses on a topic that poses a major and significant risk to patient health and safety. WHO provides leadership and guidance in collaboration with Member States, stakeholders and experts, to develop and implement interventions and tools to reduce risk, improve safety and facilitate beneficial change.

Previous Global Patient Safety Challenges

Beginning in 2004, the World Health Organization (WHO) working in partnership with the (then) World Alliance for Patient Safety, initiated the two previous Global Patient Safety Challenges: *Clean Care is Safer Care*, followed a few years later by *Safe Surgery Saves Lives*. Both aimed to gain worldwide commitment and spark action to reduce health care infection and risk associated with surgery, respectively.

The scale and speed of implementation of these Challenges remains unprecedented. They secured strong and rapid commitment from health ministers, professional bodies, regulators, health system leaders, civil society and health care practitioners. Their success resulted from the following solid basis and achievements:

- an evidence-based analysis of the key problems and proposed solutions;
- an invitation to Member States and other relevant parties to pledge, or sign up, to address the aims of the Challenge;
- high-profile actions to generate passion and enthusiasm;
- facilitation of implementation by the WHO Secretariat and associated experts and advisers;
- strong leadership and extensive internal and external communication.

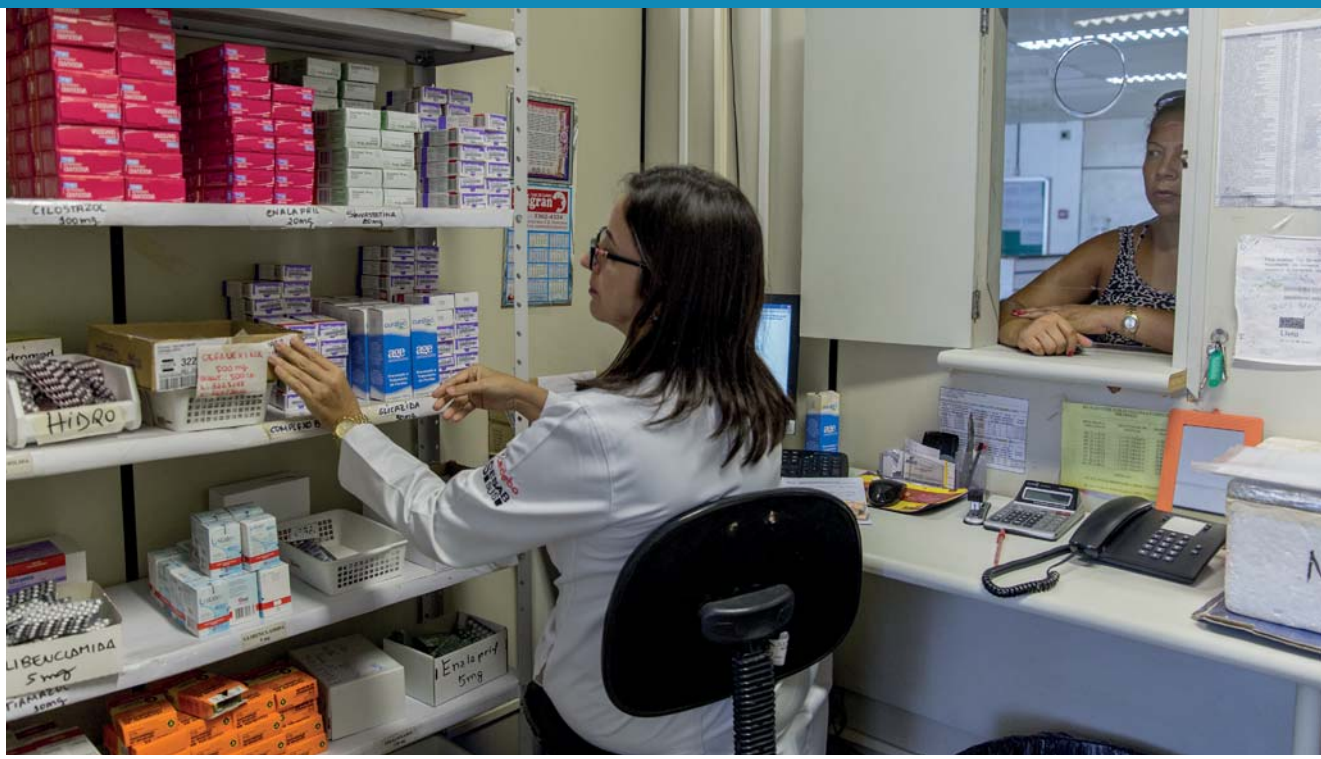
The third Global Patient Safety Challenge

Medication Without Harm

WHO is initiating the third Global Patient Safety Challenge with the theme of medication safety. It is set within the philosophy of patient safety previously developed by WHO, namely that errors are inevitable and provoked in large part by weak health systems, and so the challenge is to reduce their frequency and impact. The Challenge was launched in March 2017, at the Global Ministerial Summit on Patient Safety in Bonn, Germany. By seeking the commitment of high-level delegates, ministers of health and experts, the launch created an opportunity for leaders to drive change and work together to make real difference to the lives of patients, families and health workers at the frontline. This Challenge will draw on the experience accumulated during the previous Challenges and will drive a process of change to reduce patient harm generated by unsafe medication practices and medication errors.

Every person around the world will, at some point in their life, take medicines to prevent or treat illness. Medicine has forever altered our ability to live with disease and generally increased the duration of our lives. However, medicines do sometimes cause serious harm if taken incorrectly, monitored insufficiently or as the result of an error, accident or communication problem.

Experience from other high-risk industries, and WHO's longstanding work with experts in health care safety, demonstrate that human beings make mistakes rarely through neglect, but instead because the systems, processes and procedures that they work with are often flawed or dysfunctional. This inevitably gives rise to errors and medication harm is no exception to this rule. All medication errors are potentially avoidable. They can thus be greatly reduced or even prevented by



improving the systems and practices of medication, including ordering, prescription, preparation, dispensing, administration and monitoring. Given that the subject is so vast, the approach of this third Challenge aims to save lives and reduce the medication-related harm caused by unsafe practices and errors, by specifically addressing the weaknesses of service delivery and developing more effective health care systems.

Severity of the problem

- Unsafe medication practices and medication errors are a leading cause of avoidable harm in health care systems across the world.
- The scale and nature of this harm differs between low-, middle- and high-income countries. Globally, the cost associated with medication errors has been estimated at US$ 42 billion annually.
- Patients living in low-income countries experience twice as many disability-adjusted life years lost due to medication-related harm than those in high-income countries.
- Medication errors occur when weak medication systems and/or human factors such as fatigue, poor environmental conditions or staff shortages affect prescribing, transcribing, dispensing, administration and monitoring practices, which can then result in severe harm, disability and even death.
- Errors occur most frequently during administration, however there are risks at different stages of the medication process.

Overall goal

The Global Patient Safety Challenge on Medication Safety focuses on improving medication safety by strengthening the systems for reducing medication errors and avoidable medication-related harm.

Reduce the level of severe, avoidable harm related to medications by 50% over 5 years, globally

The goal of the third Global Patient Safety Challenge on Medication Safety is to gain worldwide commitment and action to reduce severe, avoidable medication-related harm by 50% in the next five years, specifically by addressing harm resulting from errors or unsafe practices due to weaknesses in health systems. The Challenge aims to make improvements at each stage of the medication process, including prescribing, dispensing, administering, monitoring and use.

Objectives of the Global Challenge on Medication Safety

The Global Patient Safety Challenge on Medication Safety will facilitate a strengthening of systems and practices that can initiate corrective action within countries to improve patient safety and decrease avoidable harm related to medications.

In order to achieve this, the Challenge will adopt five specific objectives.

1. ASSESS the scope and nature of avoidable harm and strengthen the monitoring systems to detect and track this harm.

2. CREATE a framework for action aimed at patients, health professionals and Member States, to facilitate improvements in ordering, prescribing, preparation, dispensing, administration and monitoring practices, which can be adopted and adapted by Member States.

3. DEVELOP guidance, materials, technologies and tools to support the setting up of safer medication use systems for reducing medication errors.

4. ENGAGE key stakeholders, partners and industry to raise awareness of the problem and actively pursue efforts to improve medication safety.

5. EMPOWER patients, families and their carers to become actively involved and engaged in treatment or care decisions, ask questions, spot errors and effectively manage their medications.

Shaping the Challenge – the Strategic Framework

The lessons for success drawn from earlier Global Patient Safety Challenges include high visibility, political and professional commitment, multileveled 'spearheading' interventions and WHO's ability to lead and mobilize the global community to reach the proposed goals. The Strategic Framework for this Challenge should galvanize commitment to reduce medication errors and medication-related harm and strengthen measurement and safety monitoring systems.

Four fundamental problems lay the ground for the strategic framework:

- **Patients and the public** are not always medication-wise. They are too often made to be passive recipients of medicines and not informed and empowered to play their part in making the process of medication safer.

- **Medicines** are sometimes complex and can be puzzling in their names, or packaging and sometimes lack sufficient or clear information. Confusing 'look-alike sound-alike' medicines names and/or labelling and packaging are frequent sources of error and medication-related harm that can be addressed.

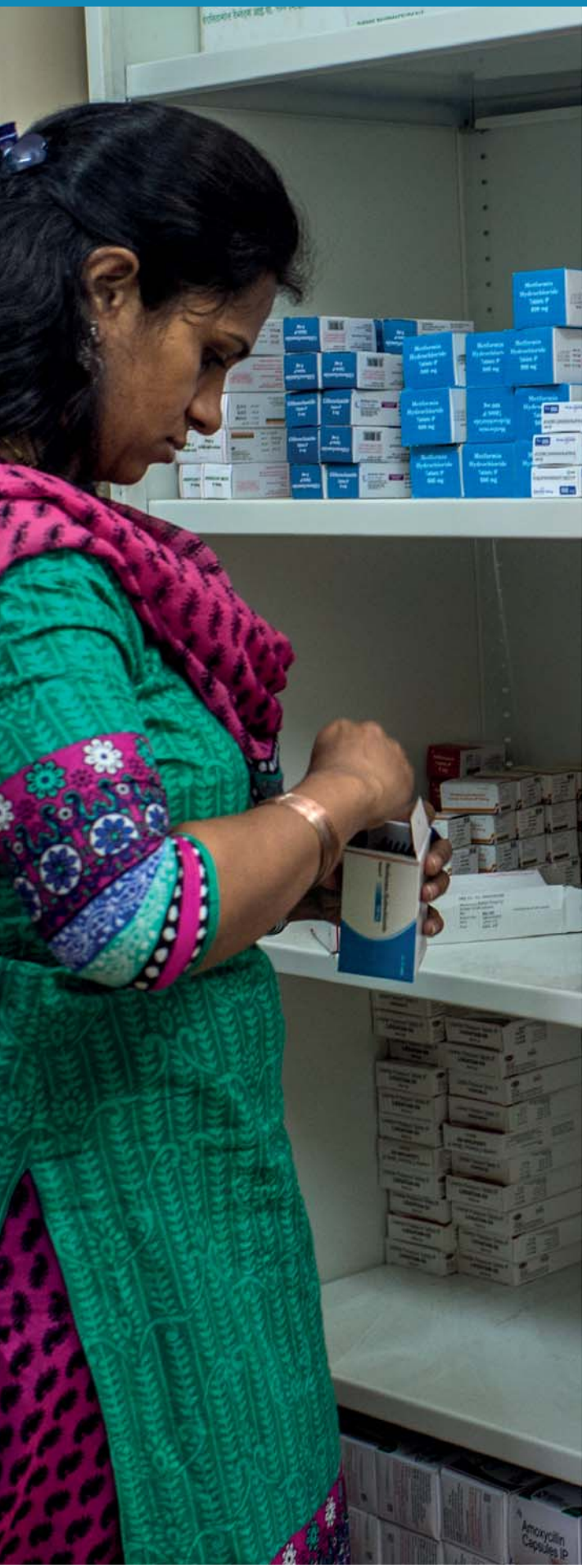
- **Health care professionals** sometimes prescribe and administer medicines in ways and circumstances that increase the risk of harm to patients.

- **Systems and practices of medication** are complex and often dysfunctional, and can be made more resilient to risk and harm if they are well understood and designed.

The actions planned in this Challenge are based on four domains of work, one for each fundamental problem identified. These are:

- patients and the public
- medicines
- health care professionals
- systems and practices of medication.

In each of these domains, there are many ways in which using medications can cause avoidable harm. There are many ways, too, in which care could be made safer.



Key action areas

The actions embraced by the Challenge fall into three categories:

Early priority actions. Ask countries and key stakeholders to make strong commitments, prioritize and take early action, and effectively manage three key areas to protect patients from harm, namely:

- high-risk situations
- polypharmacy
- transitions of care

Developmental programmes. Ask countries to convene experts, health care professionals and leaders, key stakeholders and patient representatives to design targeted programmes of change and take action to improve safety in each of the four domains of the Challenge framework: 1) patients and the public; 2) medicines; 3) health care professionals; and 4) systems and practices of medication.

Global action. WHO aims:

a) to provide guidance and develop strategies, plans and tools to ensure that the medication process has the safety of patients at its core, in all health care settings;

b) to strengthen human resource capacity through leadership development and skill-building;

c) to strengthen the quality of monitoring data;

d) to promote and support research in this area as part of the overall agenda of patient safety research;

e) to continue engaging with regulatory agencies and international actors and continuously improve medication safety through improved packaging and labelling; and

f) to develop mechanisms for the engagement and empowerment of patients to safely manage their own medications.

A mother's call for medication without harm

My oldest daughter, Martha went to study nursing with a strong desire of caring for the sick. But she had some health concerns of her own. She had chronic hypokalemia or low potassium that required supplementation from time to time and her EKG's were always abnormal. Even when further cardiac tests were done, the abnormal results were seen as normal for her and the results were simply filed away, and Martha and I remained unaware of her heart condition. Later, she developed mood swings that were seen as symptoms of bipolar affective disorder and she was prescribed lithium which helped to regulate her moods. We read the information sheet together and looked up the drug online, but we were not aware of a warning in her medical file specifically advising against prescribing lithium and we were not told of severe adverse reactions to look for. Even though her heart began to race at times, the lithium dosage was increased. Then 13 days later, her father went to wake her up one morning, and found Martha on her bedroom floor where she had died. She had not been able to get to the door to call for help. At just twenty-two years old, our daughter had suffered a fatal cardiac arrhythmia.

Although a tragic series of medical errors and the adverse medication reaction took Martha's life, no reporting took place and her death was simply identified as 'natural'. It took six years of great effort, extensive media coverage, and two further death reviews to finalize Martha's death investigation and create meaningful changes to help prevent similar fatalities. So as patients and families, what can we do to help avoid medication-related harm? There are two things that stand out: 1) We can encourage reporting and can even report an adverse medication event ourselves; and 2) We can take an active role in the patient's own medical care and medication management.

Let's honour those like Martha who have been harmed, not by covering up what happened, but by demanding transparency and centralized reporting so these tragic events can lead to improved medication safety for everyone.

High-risk situations

The impact of medication errors is greater in certain clinical circumstances, such as with inpatients in hospital, rather than in ambulatory care. This may be related to the more acute or serious clinical situations in these settings and the use of more complex medication regimes. Young children and the elderly are more susceptible to adverse outcomes, as well as those with concomitant kidney or liver disease. Medication errors in these circumstances often involve the administration of the wrong dose, use of the wrong route, and a failure to follow treatment regimens.

Understanding the situations where the evidence shows there is higher risk of harm from particular medicines, is key to this Challenge. Tools and technologies may help health care professionals using high-alert medications (those that are associated with a high risk of severe harm if used improperly), and also enhance patient knowledge and understanding of these medications.

Polypharmacy

Polypharmacy is the routine use of four or more over-the-counter, prescription and/or traditional medications at the same time by a patient. Polypharmacy has increased dramatically with greater life expectancy and as older people live with several chronic diseases. Polypharmacy increases the likelihood of side effects, as well as the risk of interactions between medications, and may make adherence more difficult. If a patient requires many medicines, they must be utilized in an optimal manner, so that the medicines are appropriately prescribed and administered, to ensure that they produce direct and measurable benefits with minimal side effects. The standardization of policies, procedures and protocols is critical to polypharmacy. This applies from initial prescribing practices, to regular medication reviews.

Patients can play a vital part if provided with the right information, tools and resources to make informed decisions about their medicines. Technology can also serve as a useful aid.

Transitions of care

Transitions of care occur when a patient moves between facilities, sectors and staff members; for example: a transfer from the emergency room to the intensive care unit, from a nursing home to a hospital, from a primary care doctor to a specialist, or from one nurse to another during a shift change. Transitions of care increase the possibility of communication errors, which can lead to serious medication errors. Patients are at increased risk during transitions of care and so serious mistakes can and do occur at these times, in particular.

Good communication is vital, including a formal comparison of medicines pre- and post-care, so-called medication reconciliation. Patients can be valuable and active participants in this process by maintaining a current medicine list that is updated when any medicine changes occur.

Political leadership, commitment and support

The third Global Patient Safety Challenge on Medication Safety invites WHO Member States to prioritize medication safety at the national level. Demonstrable commitment and leadership are needed to significantly reduce the level of severe, avoidable harm related to medications in their countries over a period of five years. The emphasis is on countries working out their own priorities and action programmes using the Challenge framework to support their work.

A five-point plan has been developed to facilitate adoption:

1. Take early action to protect patients from harm arising from: high-risk situations; polypharmacy; and transitions of care.
2. Convene national experts, health system leaders and practitioners to produce guidance and action plans for each of the targeted domains.
3. Put mechanisms in place, including the use of tools and technologies, to enhance patient awareness and knowledge about medicines and medication use process, and patients' role in managing their own medications safely.
4. Designate a national coordinator to spearhead the Global Patient Safety Challenge on Medication Safety.
5. Assess progress regularly.

The success of the Challenge will depend on the high prioritization of medication safety within health care systems, achieving widespread buy-in by stakeholders, a shift to the mainstream of care provision activities and taking concrete action to prevent harm.

WHO action

In driving forward the Global Patient Safety Challenge on Medication Safety, WHO will provide support in 10 key areas:

1. Lead the process of change and take global action to make progress on the domains of the Challenge framework.
2. Facilitate the development and implementation of country programmes.
3. Commission expert reports to provide a starting point for in-country work to develop guidance and action plans in each of the domains of the Challenge.
4. Develop strategies, guidelines, plans and tools to ensure safety of medication practices.
5. Publish a strategy setting out research priorities and mobilize resources for an international research study on hospital admissions due to medication effects.
6. Hold regional launch events in each WHO region following on from the global launch.
7. Create and implement a communications and advocacy strategy and a global campaign, and produce promotional and educational materials.
8. As part of the WHO Patients for Patient Safety programme, ensure that patients and families are closely involved in all aspects of the Challenge and develop a tool to help patients protect themselves from harm.
9. Monitor and evaluate impact of the Challenge.
10. Mobilize resources to enable full and successful implementation of the Challenge.

Throughout the implementation process, WHO will also seek to develop a much greater understanding of the special problems of medication-related harm in low- and middle-income countries and to reshape the Challenge to meet needs in diverse settings.

Collaboration and partnerships

Working with international experts, partners and interested stakeholders, WHO will develop the guidelines, tools, technologies and materials needed, and work in close collaboration with countries to implement the Challenge.

Who should act as a catalyst for change?

Ministries of health and health system leaders
Educational and research institutions
Regulatory authorities
Health care professional societies
Patient advocacy groups
Donors and development partners
Pharmaceutical industry

In addressing the overall goal and action areas of the Challenge, WHO will work with a wide range of stakeholders including: ministries of health, national coordinators or programme managers for medication safety, health system leaders, experts, educational institutions, researchers, safe medication practice centres, regulatory agencies, patient representative bodies and professional societies and industry.

World Health Organization

For more information, please contact the following departments:

Service Delivery and Safety
World Health Organization
Avenue Appia 20
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Email: patientsafety@who.int
www.who.int/patientsafety

Essential Medicines and Health Products
World Health Organization
Avenue Appia 20
CH-1211 Geneva 27 Switzerland
Email: empinfo@who.int
www.who.int/medicines

Health and Social Care Board

Public Health Agency

Sent by email only

12-22 Linenhall Street
BELFAST BT2 8BS
Tel : 0300 555 0115
Web Site : www.hscboard.hscni.net

To: Trust Chief Executives

Copy to: Trust First point of contacts for SQAs

Our Ref: SQR-SAI-2021-075 (All PoCs)

22 October 2021

Dear Colleagues,

Urgent 3rd Line Assurance required – Risk of serious harm or death from choking on foods – SQR-SAI-2021-075 (All PoCs)

You will be aware of the attached Safety and Quality Reminder of Best Practice Guidance letter entitled 'Risk of serious harm or death from choking on foods' (SQR-SAI-2021-075 (All PoCs), that the HSCB/PHA issued on 3 February 2021 and reissued on 9 June 2021, following the reporting of five Serious Adverse Incidents (SAIs) related to adults with eating, drinking and swallowing difficulties and the failure to recognise and support their needs.

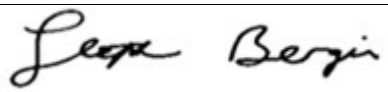
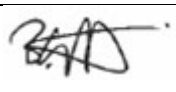
This Safety and Quality Alert (SQA) was marked closed on the HSCB Datix Alerts module on 30 July 2021, as all Trusts had confirmed through the completion of a 2nd Line of Assurance template, that the necessary audit processes were in place to monitor compliance of the SQA.

Despite the assurances received from Trusts informing the HSCB/PHA that necessary audit processes are in place to monitor compliance of this SQA, further choking related SAIs have been notified, which has sadly resulted in patient/client deaths.

In light of these recent SAI notifications, we are requesting that Trusts now provide an urgent **3rd Line of Assurance** to HSCB/PHA to ensure actions as detailed within the SQA have been taken forward to prevent and mitigate the risk of this type of incident recurring.

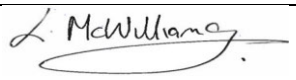
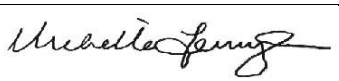
Please provide assurance by 19 November 2021 to the alerts mailbox at Alerts.HSCB@hscni.net by completing the attached 3rd line assurance template.

Yours sincerely

Signed:		
Issued by	Dr Stephen Bergin Director of Public Health and Medical Director (Interim)	Mr Brendan Whittle Director of Social Care and Children Services

Health and Social Care Board

Public Health Agency

Signed:		
Issued by	Mrs Lisa McWilliams Director of Strategic Performance	Mrs Michelle Tennyson Acting Director of Nursing, AHPs, PPI & PCE.

Enc.

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SAFETY AND QUALITY
REMINDER OF BEST PRACTICE GUIDANCE

Subject	Risk of serious harm or death from choking on foods
HSCB reference number	SQR-SAI-2021-075 (All PoC) **Revised – Supersedes letter of 3 February 2021**
Programme of care	**All Programmes of Care (PoC)**
Assurances required	**2nd Line Assurance**

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

SUMMARY OF EVENT

Incident 1

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

Incident 2

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

Incident 3

An inpatient with eating, drinking and swallowing difficulties, recommended a texture

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

Incident 4

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

Incident 5

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

REQUIREMENTS UNDER CURRENT GUIDANCE

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

Current guidance relevant to these incidents is noted below:

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

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

The reasons why people choke are complex and can have numerous contributing

factors. Recognition of patients' difficulties, implementation of SLT Eating, Drinking and Swallowing Recommendations into a care plan, alongside coordinated multidisciplinary team efforts reduces the risk of serious harm or death.

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

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

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

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

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

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

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

Resources:

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

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ACTION REQUIRED

Note – this letter has been amended to include <u>all Programmes of Care</u> (letter of 3 February stated the regional learning was only applicable to Older Peoples Services / Mental Health Services / Acute Services).

HSC Trusts should:

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

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

3. Provide assurance by **23 June 2021** to the alerts mailbox at Alerts.HSCB@hscni.net by completion of the attached 2nd line assurance template confirming the additional PoCs not included in the original letter have been added to the Trusts safety and quality assurance work-plan for actions 1 – 2 above (for implementation) and monitoring processes, so as to ensure compliance.

NIMDTA should:

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

RQIA should:

1. Disseminate this letter to relevant Independent Sector Providers.

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

HSCB should:

1. Disseminate this letter to GP Practices, GP Out-of-hours services, Dispensing GPs, and Community Pharmacists for information to raise awareness of those with dysphagia.

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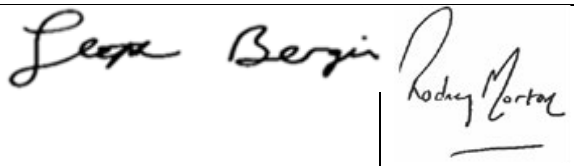
Date issued	9 June 2021		
Signed:			
Issued by	Dr Stephen Bergin Director of Public Health and Medical Director (Interim)	Mr Rodney Morton Director of Nursing, Midwifery and Allied Health Professions	Mr Brendan Whittle Director of Social Care and Children Services

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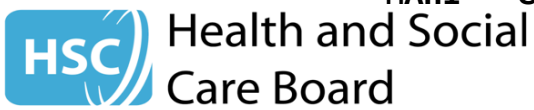
RE: Reissued - SQR-SAI-2021-075 (all PoCs) - Risk of serious harm or death from choking on foods – Distribution List

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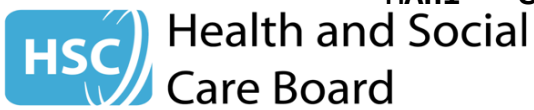
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Summary Paper

Report of Choking Serious Adverse Incidents and Adverse Incidents in Northern Ireland (2016 – 2021) and Regional Learning from the work of Dysphagia NI and service user and carer experience

June 2021

Health and Social Care Board

Public Health Agency

Contents

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Executive Summary

This 'Report of Choking Serious Adverse Incidents and Adverse Incidents in Northern Ireland (2016 – 2021) and Regional Learning from the work of Dysphagia NI and service user and carer experience' has identified a number of improvements required to further reduce the likelihood of avoidable choking incidents. The focus of the recommendations is to set out targeted action required. Going forward the recommendations will be focussed on the following key areas:

- Progress targeted work in identified Care Environments with increased risk of choking incidents
- Put in place robust choking surveillance data/incident monitoring systems
- Deliver more standardised care

A detailed Choking Improvement Plan summarising the further regional interventions required is outlined in Appendix 7 in the Supporting Paper. Whilst much work has been undertaken and demonstrable improvements have been made, the SAIs and deaths as a result of choking remain unacceptably high.

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Purpose

Choking remains a prevalent Public Health issue in Northern Ireland, with 18 choking-related Serious Adverse Incidents and 1383 choking-relating Adverse Incidents reported from 2016-2021.

This summary paper presents a PHA and HSCB assessment of additional regional interventions required to further reduce the risk of choking, and should be read in conjunction with the Supporting Paper – Report of Choking Serious Adverse Incidents and Adverse Incidents in Northern Ireland (2016-2021) and Regional Learning from the work of Dysphagia NI and service user and carer experience. All Appendices referenced herein can be found in the Supporting Paper.
This paper is informed by 3 key programmes of work:

- Choking and Learning review of Serious Adverse Incidents (SAIs) and Adverse Incidents (AIs) related to choking (data 2016-2021)
- Dysphagia NI work to meet the 7 actions set out in the Regional Choking Review Analysis – thematic review (2018)[1] (Appendix 1 and Appendix 2), and
- 10,000 More Voices, Your Experience of Living with a Swallowing Difficulty (2020) report

1. Background

In 2018 the PHA and HSCB produced a 'Report on the Regional Choking Review Analysis – thematic review' which reinforced the need for co-ordinated efforts to facilitate learning and inform future quality improvement work with the aim of preventing or reducing the risk of choking in future.

Since 2018 a significant programme of regional work has been undertaken, primarily by Dysphagia NI, to reduce the risks associated with choking and to understand the experiences of those living (or caring for people) with Dysphagia.

[1] Report on the Regional Choking Review Analysis – thematic review (2018)

On 3rd February 2021, the HSCB/PHA released a Safety and Quality Reminder of Best Practice Guidance – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075)[2]. In response the Chief Medical Officer (CMO) wrote to the HSCB and PHA outlining extreme concern at the preventable deaths which 'appear to continue despite previous interventions and guidance issued'. The CMO stipulated that such omissions in care must be considered as 'never events' and requested the HSCB/PHA bring forward an assessment of further regional interventions deemed necessary. The PHA and HSCB undertook a rapid review of SAIs and AIs related to choking from 2016 – 2021 as the key driver for the identification of further regional interventions.

2. Choking and Learning Review of Serious Adverse Incidents (SAIs) and Adverse Incidents (AIs) related to choking occurring between 2016 – 2021

Analysis was carried out on 18 SAIs and 1383 AIs, the methodology for which is outlined in Appendix 3. This focussed on a root cause analysis of 18 SAIs identifying the causes of choking, cases where different care may have made a difference to the outcome. High level information from HSC Trusts was analysed in terms of AI findings and the extent of learning since the report on the Regional Choking Review Analysis – thematic review (2018).

3. SAI Review Key Findings

- This Choking and Learning Review (data 2016-2021) considered 18 SAIs, 17 of which (94%) tragically resulted in death.
- The age profile of SAIs has changed with most now occurring in the over-70 age group (n=11, or 61%)
- SAIs continue to occur most frequently occur in Nursing Homes (n=10, or 56%)

[2] Safety and Quality Reminder of Best Practice Guidance – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075)

- The profile of high risk Programmes of Care has changed. Reduced numbers of SAIs have occurred in Mental Health (from 41% to 17%, n=7 in a 6-year period to n=3 in a 5-year period) and Learning Disability (from 35% to 17%, or n=6 to n=3). The highest number of SAIs 2016-2021 occurred in the Elderly Programme of Care (n=10, or 55%).
- People with a confirmed diagnosis of EDS under the care of Speech and Language Therapy remain at the highest risk of choking (n=13, or 72%).
- Clear root causes have been identified and themed accordingly. While not directly comparable, the root causes of SAIs identified in this Choking and Learning Review (2021) are largely consistent with the themes identified in the previous Thematic Review (2018).

4. AI Review Key Findings

Whilst it is challenging to draw comparisons between AI data in this Choking and Learning Review (2021) and the previous Thematic Review (2018) due to variation, the lack of consistency of coding and collating of AI Datix information, nonetheless there is value in reflecting on the findings of both reviews.

- In this Choking and Learning Review (2021), 1383 Adverse Incidents relating to Choking were recorded, with on average 276 AIs reported per year.
- Since the last Thematic Review (data 2010-2016) there has been an exponential growth (73%) in AIs reported.
- The profile of AIs has changed since the Thematic Review (2010-2016). AIs in Day Care settings have reduced from 46% to 24% (n=367 to n=277[3]), and AIs in Hospitals have reduced from 28% to 17% (n=222 to n=196). Nursing and Residential AIs in 2010 - 2016 accounted for 15%, and AIs in Supported Living settings accounted for 7% (22% in total or n=173 incidents). In the 2016-2021 Choking and Learning Review, Nursing, Residential and Supported Living settings collectively account for 42% (or n=485 incidents that data is available for).

[3] Of the 1155 Adverse Incidents that data relating to settings is available for

- Key themes remain consistent between both reviews, however this Choking and Learning Review (data 2016-2021) has facilitated the identification of key AI themes in ranked order of frequency. The top three are:
    - Interpretation, understanding & documentation
    - Training – food preparation, Dysphagia, CPR & First Aid
    - Recommendations not adhered to

Appendix 4 contains a table summarising all of the key figures from the Regional Choking Review Analysis – thematic review (2018), and the present Choking and Learning Review of Serious Adverse Incidents (SAIs) and Adverse Incidents (AIs) related to choking (2021).

The findings above provide updated analysis regarding SAIs and AIs reported in the period 2016-2021 to inform the current position. Since the publication of the previous Report on the Regional Choking Analysis - Thematic Review (2018) there has been a significant focus across Northern Ireland on reducing the risks associated with choking. This work, including the seven actions set out in the Thematic Review (2018), has been primarily driven by Dysphagia NI, which is a whole system, Public Health partnership approach to Eating, Drinking and Swallowing (EDS) difficulties established in 2018.

5. Dysphagia NI work to meet 7 actions of the Regional Choking Review Analysis – thematic review (2018)

Since its establishment in 2018, Dysphagia NI has undertaken significant safeguarding actions to: improve professional and public awareness, develop standardised approaches to identifying and managing people with EDS, improve access to specialist intervention and coproducing with service users and families. Of particular note are the following actions:

- Implementation of the International Dysphagia Diet Standardisation Initiative (IDDSI) across NI which introduced a standardised common language for

describing texture modified foods and thickened fluids for people with Dysphagia.

- SQR-SAI-2021-075 (OPS/MH/AS) was published (03.02.2021). This set out actions to improve and standardise practice, policy and audit to support safe eating and drinking across care settings targeting six key areas.
- Raised potential safety issue relating to PEG laxatives and starch-based thickeners. The Medicines and Healthcare Products Regulatory Agency issued a National Alert[4].

Appendix 5 describes in full the 7 actions of the Thematic Review (2018), the specific work of Dysphagia NI to address these actions, and related regional outcomes/impacts.

Integral to effective whole-system EDS transformation is the engagement of service users and carers. The 10,000 More Voices report examining the experiences of 82 people living with Eating, Drinking and Swallowing difficulties has provided very important insights.

6. Key Messages from 10,000 More Voices, Your Experience of Living with Eating, Drinking and Swallowing Difficulties

People shared details of their high levels of anxiety living with the risk of choking (85%), outlined their confidence in the services provided to support them (70%) and reflected quite positively on their meaningful involvement in care planning (62%). 59% shared positive experiences relating to the nature and timeliness of information. Significantly 38% accessed help in secondary care settings, which suggests reduced and delayed identification and access to specialist care, and 18% waited up to 12 months plus before seeking help.

The 10,000 More Voices report also outlined a range of areas requiring regional reflection and learning. These related to the provision of information, training for carers, system-wide awareness including strategies engaging the hospitality sector,

[4] Drug Safety Update - Polyethylene glycol (PEG) laxatives and starch-based thickeners: potential interactive effect when mixed, leading to an increased risk of aspiration

individualised management plans, and the need to develop a risk/choice decision-making framework.

Taking into consideration the PHA/HSCB Choking and Learning Review (2021), the work of Dysphagia NI and the 10,000 More Voices Report, the PHA and HSCB present the following assessment of additional regional interventions required.

7. PHA and HSCB assessment of additional regional interventions required

This Choking and Learning Review (2021) considered 18 SAIs, 17 deaths and 1383 AIs or near-misses. Work to reduce the risk of death by choking and safeguard people with eating, drinking and swallowing difficulties continues to be a priority for Health and Social Care. A summary table of the key safeguarding actions taken to reduce the risk of choking across Northern Ireland since the publication of the Report on the Regional Choking Review Analysis – thematic review in February 2018 can be found in Appendix 6. The establishment of Dysphagia NI in 2018 is the first attempt in the UK to improve and standardise care for people with eating, drinking and swallowing difficulties across a whole system.

SAIs have continued to occur most frequently in Nursing and Residential care settings since the previous Thematic Review (2018). This Choking and Learning Review (2021) further showed that the majority of AIs are now also taking place in Nursing, Residential and Supported Living settings, rather than in Day Care settings as had previously been identified, thus highlighting these as long-standing high-risk environments and indicating the need to target and support these settings in ongoing programmes of work with focussed safeguarding attention and action.

The profile of both SAIs and AIs has changed since the previous Thematic Review (2018) in a number of ways. The age profile of SAIs has changed with most now occurring in the over-70s age group, and this observation aligns with the data indicating that most SAIs are now taking place in Elderly Programmes of Care, with numbers in Mental Health and Learning Disability Programmes of Care having reduced.

This Choking and Learning Review (2021) has established the root causes of SAIs and themed them accordingly to inform and focus regional learning. While not directly comparable, the root causes of SAIs identified in this review (2021) are

largely consistent with the themes identified in the previous Thematic Review (2018). Trust-reported key AI themes again remain relatively consistent and there are clear similarities between the Trust-reported key themes of AIs and the root causes of SAIs. This confirms that there are still fundamental issues that require further definitive action.

The number of SAIs where the person concerned was known to SLT has also remained consistent. This supports the need for timely access to SLT services. Given that the root causes of the majority of SAIs relate to people being given, or having access to, food that they should not, it also highlights the need for clear understanding of the full range of SLT recommendations for people with EDS difficulties, the communication and availability of the recommendations, and the application of all recommendations.

While it is challenging to demonstrate that changes observed since the Thematic Review (data 2016-2021) are directly related to the work of Dysphagia NI alone, the dramatic increase of 73% in the number of AIs reported suggests that this has been influenced to a significant degree by Dysphagia NI's substantial work since 2018. The peak of AI reporting coincides with Dysphagia NI-led IDDSI implementation (figure 4). Dysphagia NI has focussed on raising awareness both with clinical staff and the general public, and improving clinical knowledge and reporting processes through the development of regional resources, training programmes, and clinical (including AI reporting) guidance. It is possible that this work may also be contributing towards addressing the potential 'blame culture' surrounding such incidents. Taking into account the shorter reporting period of the second review, it can be estimated that the number of AIs reported over the equivalent 6-year period will have more than doubled.

It is vital that patterns and trends identified through enhanced reporting are routinely monitored and analysed to then inform and target the planning and development of future work in order to build on the foundation work completed to date for long-term sustainable improvement. The identification of key themes and, now, root causes will continue to inform *what* needs to be done, and analysis of the numbers and the profile of settings and programmes of care where incidents are taking place will inform *where* it should be done and *with whom*.

In response to SQR-SAI-2021-075, the Chief Medical Officer (CMO) stipulated that omissions in care must be considered as 'never events' and requested that the PHA/HSCB bring forward an assessment of further regional interventions deemed necessary. Never Events are defined by NHS England[5] as "*serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers*".

Based on this Choking and Learning Review (2021), the PHA and HSCB have established that up to 75% of SAIs for which regional learning was available were preventable.

Recommendations

Taking the learning into account, to consolidate and build upon the foundation work carried out to this point, this paper recommends further strengthening of the regional systemic protective barriers. This work will align with the categorisation of relevant SAIs as 'Never Events'. To support this, the PHA and HSCB will:

- Progress targeted work in identified Care Environments with increased risk of choking incidents
    - Establish an ECHO platform for EDS with Dysphagia NI and all relevant HSC staff across sectors.
    - Develop awareness and capacity-building programmes and information packs for service users, carers, staff, and families with EDS
    - Develop a checklist to support understanding of EDS processes at meal and snack times, including contributing factors such as behaviour, posture and environmental factors
- Put in place robust choking surveillance data/incident monitoring systems
    - Establish a Dashboard to bring together adverse incident and serious adverse incident information, monitor and take preventative action
    - Establish monitoring arrangements for implementation of standardised Dysphagia Care Framework (standards) for use in all care settings, including e.g.
        - implementation and availability of SLT EDS recommendations sheet

[5] NHS England Revised Never Events Policy and Framework (2018)

        - implementation of safe EDS at mealtimes tool
        - implementation of regional guidance for safety pauses
    - Establish systems to monitor uptake of mandatory training
    - Establish systems to monitor waiting times for access to SLT services
- Deliver more standardised care
    - Develop a standardised Dysphagia Care Framework (standards) for use in all care settings
    - Identify actions required to support complex decision-making relating to patient safety vs patient choice and address, to help balance risk and personal choice. Further work is required to fully understand what this would entail.
    - Development of Dysphagia training framework which includes mandatory Awareness Training for all Health and Social Care staff to prevent choking and respond to choking incidents
    - Designate Dysphagia NI a Managed Clinical Network with formal reporting arrangements and establish the role of QI Lead
    - Review Trust staffing infrastructure to support Dysphagia management, identify and address gaps
    - Implement SQR-SAI-2021-075 (OPS/MHS/AS) recommendations and update in light of new evidence and learning
    - Issue a special edition of Learning Matters – Risk of Serious Harm of Death from Choking on Foods
    - Implement regional improvement initiatives which have been shown to deliver improvements and reduce risk as identified, e.g. Tele EDS and Dysphagia-Friendly Foods
    - For all patient clients identified at risk of choking and having an SLT care plan in place, and who experience an adverse outcome, these should be investigated as **Never Events**

A detailed Choking Improvement Plan summarising the further regional interventions required is outlined in Appendix 7.

How Will We Know There is Reduced Risk?

For a period of time AIs are likely to increase, illustrating greater awareness and reporting of incidents. The numbers of SAIs, including deaths, should stabilise and then reduce. Dysphagia NI will evidence specifically how interventions reduce risk.

8. Conclusion

Choking and choking near-misses are distressing for people with Dysphagia, families, carers and healthcare professionals. People with Dysphagia report high levels of anxiety and embarrassment around their condition.

On 3rd February 2021, the HSCB and PHA released a Safety and Quality Reminder of Best Practice Guidance – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075) and the Chief Medical Officer in turn wrote to the HSCB and PHA outlining extreme concern at the preventable deaths outlined which 'appear to continue despite previous interventions and guidance issued'. The CMO stipulated that such omissions in care must be considered as 'never events' and requested the HSCB and PHA bring forward an assessment of further regional interventions deemed necessary.

This Choking and Learning Review (2021) considered 18 SAIs, 17 deaths and 1383 AIs, and examined the work Dysphagia NI has undertaken to meet 7 actions set out in the Regional Choking Review Analysis – thematic review (2018) and the experiences of service users and carers in the 10,000 More Voices, Your Experience of Living with a Swallowing Difficulty (2020) report.

Whilst much work has been undertaken and demonstrable improvements have been made, the SAIs and deaths as a result of choking remain unacceptably high. The report brings forward an assessment of further regional interventions deemed necessary to reduce the risks of choking.

Appendix 7 – Choking Improvement Plan

Recommendations	Tasks	Expected Outcome	Who	Timescale
Target identified Care Environments with increased risk of choking incidents	1. Establish an ECHO platform for EDS with Dysphagia NI and all relevant HSC staff across sectors.	1. Increased communication between all dysphagia stakeholders, good practice consistently and rapidly shared and implemented	HSCB	December 2021
	2. Develop awareness and capacity-building programmes and information packs for service users, carers, staff, and families with EDS.	2. Increased awareness and capacity in all relevant groups	PHA CEC	March 2022
	3. Develop a checklist to support understanding of EDS processes at meal and snack times, including contributing factors such as behaviour, posture and environmental factors.	3. Checklist developed and implemented regionally	PHA	November 2021
Put in place robust choking surveillance data/incident monitoring systems.	1. Establish a Dashboard to bring together adverse incident and serious adverse incident information, monitor and take preventative action.	1. Dashboard created, information monitored and preventative actions taken	HSCB	February 2022
	2. Establish monitoring arrangements for implementation of standardised Dysphagia Care Framework (standards) for use in all care settings, including e.g. a. implementation and availability of SLT EDS recommendations sheet	2. Implementation monitored and reported	RQIA PHA Trusts	February 2022

	b. implementation of safe EDS at mealtimes tool c. implementation of regional guidance for safety pauses			
	3. Establish systems to monitor uptake of mandatory training	3. Systems in place, uptake monitored and actions identified	RQIA PHA Trusts HSCB	February 2022
	4. Establish systems to monitor waiting times for access to SLT services	4. Systems in place, waiting times monitored and actions identified	HSCB PHA	April 2022
Deliver more standardised care	1. Develop a standardised Dysphagia Care Framework (standards) for use in all care settings	1. Development of Care Framework	PHA	December 2021
	2. Identify actions required to support complex decision-making relating to patient safety vs patient choice and address	2. Mapping of current practice, gaps identified and actions taken	PHA Trusts BSO	March 2022
	3. Development of Dysphagia training framework which includes mandatory Awareness Training for all Health and Social Care staff to prevent choking and respond to choking incidents.	3. All HSC staff have access to mandatory training	HSCB PHA CEC	May 2022
	4. Designate Dysphagia NI a Managed Clinical Network with formal reporting arrangements and establish the role of QI lead	4. Managed Clinical Network, reporting arrangements, and quality improvement lead in place	HSCB PHA	December 2021
	5. Review Trust staffing infrastructure to	5. Capacity and demand analysis complete	HSCB	May 2022

	support Dysphagia management, identify and address gaps.		Trusts PHA	
	6. Implement SQR-SAI-2021-075[1] recommendations and update in light of new evidence and learning	6. Each Trust has an action plan for implementation in place and recommendations implemented	Trusts PHA HSCB	July 2021
	7. A special edition of Learning Matters will be issued – Risk of Serious Harm of Death from Choking on Foods	7. Learning Matters issued	PHA	August 2021
	8. Implement regional improvement initiatives as identified e.g. Tele EDS and Dysphagia-Friendly Foods	8. Initiatives identified and implemented	Trusts	June 2022
	9. For all patient clients identified at risk of choking and having an SLT care plan in place, and who experience an adverse outcome these should be investigated as **Never Events**	9. Develop choking Never Event Criteria and publish guidance for all Health and Social Care Providers	PHA	July 2021

[1] Safety and Quality – Reminder of Best Practice Guidance (hscni.net)

From the Chief Medical Officer
Professor Sir Michael McBride

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An Roinn Sláinte
Männystrie O Poustie
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Tel: [redacted]
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Date: 14 October 2021

For Action by:

Chief Executive, HSCB and PHA
Chief Executives, HSC Trusts for cascade to:
Medical Directors
Directors of Acute Hospital Services
Directors of Nursing
Governance Leads
Chief Executive, NIMDTA
Chief Executive, RQIA

For Information to: see over

Dear colleagues

NCEPOD REPORT: HARD TO SWALLOW?

On the 12th August 2021 NCEPOD published its report; "Hard to swallow? A review of the quality of dysphagia care provided to patients with Parkinson's disease aged over 16 years who were admitted to hospital when acutely unwell". This study was conceived with the main intention of examining the quality of care for patients with dysphagia.

Background

The study in this report was undertaken to examine the pathway of care for patients with Parkinson's disease (PD) who were admitted to hospital when unwell, and to explore multidisciplinary care and organisational factors in the process of identifying, screening, assessing, treating and monitoring of their ability to swallow.

A summary of the key recommendations contained within the report is set out in Annex 1.

Action

- HSC Trusts, the Public Health Agency (PHA) and Health and Social Care Board should consider the key findings and recommendations of this report, bring these to the attention of relevant staff and take appropriate action.

- The HSC Board and PHA will report progress on implementation of the findings set out in this report through the existing arrangements for 6-monthly updates on Clinical Outcome Review Programme (CORP) Reports.

The full report can be accessed at:
https://www.ncepod.org.uk/2021dysphagia/Dysphagia%20in%20people%20with%20PD_Hard%20to%20Swallow_Full%20report.pdf

Yours sincerely

PROFESSOR SIR MICHAEL McBRIDE
Chief Medical Officer

For Information to:

Executive Medical Director/Director of Public Health, Public Health Agency
Director of Nursing and AHPs, Public Health Agency
Director of Performance Management, HSCB
Assistant Director of Performance Management, HSCB
Alerts Office, HSCB
Director, HSC Safety Forum
Post Graduate Dean, NIMDTA
Prof Donna Fitzsimmons, Head of Nursing and Midwifery, QUB
Dr Neil Kennedy, Acting Director of Centre for Medical Education, QUB
Prof McKeown, Director of Centre for Medical Education, QUB
Sonja McIlfatrick, Head of School of Nursing, UU
Staff Tutor of Nursing, Open University
Clinical Education Centre
NI Royal College of Nursing

Annex 1

Key Recommendations

The key **recommendations** of the report are:

1. Document the swallow status of all patients with Parkinson's disease at the point of referral to hospital.
   Target audiences: Primary care and community Parkinson's disease teams

2. Notify the specialist Parkinson's disease service (hospital and/or community) when a patient with Parkinson's disease is admitted, if there is any indication from the notes or following discussion with the patient or their relatives/carers, that there has been a deterioration or progression of their clinical state.
   Target audiences: Healthcare professionals who see patients at admission, clinical and medical directors

3. Screen patients with Parkinson's disease for swallowing difficulties at admission, irrespective of the reason for admission. This should include:

   - Ability to swallow food, fluids and medication
   - Control of saliva
   - A history of pneumonia

   Target audiences: Healthcare professionals who see patients at admission and clinical directors

4. Refer patients with Parkinson's disease who have swallowing difficulties* (or who have problems with communication) to speech and language therapy.
   Target audiences: Healthcare professionals who see patients throughout their admission and clinical directors.
   *See Figure 4.3 in the report for a list of indicators of swallowing difficulties

5. Ensure patients are able to take the medication they have been prescribed at, and throughout, their admission. If there are concerns about whether or not the patient can swallow safely consider other formulations of medication (e.g. liquid rather than a tablet) or ways of administering them.

   Target audiences: Healthcare professionals who see patients at, and throughout, their admission, pharmacists, and clinical directors
   NB: Levodopa should be administered within 30 minutes of the prescribed administration time. This is in line with NICE Quality Standard 164. See also the Parkinson's UK medication optimisation consensus statement

6. Ensure there is a hospital policy for the different ways of administering medication and the review of medications at the point of patient discharge. This includes the use of rotigotine patches.

   Target audiences: Clinical directors, medical directors, hospital pharmacists, specialist Parkinson's disease teams and quality improvement leads

7. Screen the nutritional status of patients admitted to hospital with Parkinson's disease and act on the findings.

   Target audiences: Clinical directors, dietitians, nutrition team members and healthcare professionals who see patients at, and throughout, their admission NB: All patients admitted to hospital should undergo a nutritional screen using a validated screening tool such as the BAPEN Malnutrition Universal Screening Tool ('MUST') this in line with NICE Quality Standard 24

8. Involve speech and language therapists, pharmacists, dietitians and nutrition team members in any multidisciplinary (MDT) discussion of patients with Parkinson's disease and swallowing difficulties.

   Target audiences: Clinical directors, speech and language therapists, pharmacists, dietitians and nutrition team members

9. Formalise pathways for the provision of modified texture diet and fluids to include input from:

   - Speech and language therapists
   - Pharmacists
   - Dietitians or other nutrition team members
   - Hospital housekeeping and catering services
   - Community care

   This is in line with the International Dysphagia Diet Standardisation Initiative (IDDSI).

   Target audiences: Medical directors, clinical directors, clinical teams caring for patients with dysphagia. This includes speech and language therapists, pharmacists, dietitians, hospital housekeeping and catering services, community Parkinson's disease teams and quality improvement leads

10. Ensure there is a hospital policy for 'risk feeding' which includes the assessment or re-assessment (if already undertaken at admission) of mental capacity regarding this decision. The policy should state that discussion should involve:

    - Patients
    - Family members and/or carers
    - Speech and language therapists
    - Dietitians/nutrition team members
    - Pharmacists

    Target audiences: Clinical directors, medical directors, speech and language therapists, pharmacists, dietitians and nutrition team members and quality improvement leads

11. Provide written information at discharge on how to manage swallowing difficulties, including:
12.

- Swallow status
- Ability to take oral medication
- Changes to medication including any new ways of administering them
- Nutrition screening tool score and care plan including any texture modifications to food and/or fluids
- Positioning
- Level of dysphagia risk in the community

To:

- The patient
- Family members and/or carers
- Community healthcare professionals (e.g. GP, community Parkinson's disease team, community pharmacist, care home staff)

A proforma could be used for this discharge summary.
Target audiences: Clinical directors, healthcare professionals who see patients throughout their admission, quality improvement leads

TEN THOUSAND MORE VOICES

Your experience of Living with a Swallowing Difficulty

- The lived experience of people with swallowing difficulties living in Northern Ireland, their relatives & carers

March 2020

Share your story, shape our service

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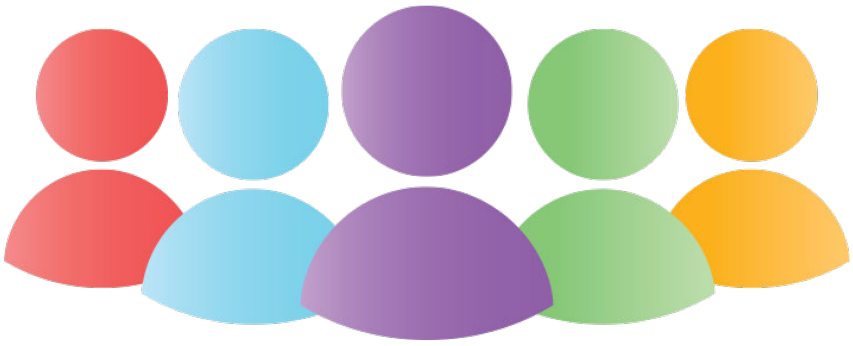
ACKNOWLEDGEMENTS

The 10,000 More Voices team would like to express their heartfelt thanks to the patients, clients, relatives and carers who shared openly their experiences of living with a swallowing difficulty. It is recognised many patients, relatives and carers gave of their time to share the stories to support the development of services and have openly shared their experiences. The engagement of people using services is essential for health and social care services in Northern Ireland to recognise what is working and also where changes are required.

The Public Health Agency and Patient Client Experience leads would also like to sincerely thank the people who co-designed the survey – Quality Improvement lead, Jocelyn Harpur and a group of 15 service users who supported the team to identify the core concepts. Our thanks and appreciation to the many staff who supported this survey – in particular the Dysphagia NI partnership, HSCB, PHA, Speech and Language Therapy managers and speech and language therapy staff. It is important to acknowledge the work of the Trust Patient Client Experience Facilitators, their energy and support enabled the collection of this experience in the short timeframe available (Appendix 1).

" I really worry about the choking. I had an experience of it myself, it was horrible, it frightened the life out of me. I'm sure when it happens it scares her too..."



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CONTEXT

Data collection commenced in 1st February 2020 and ended 31st March 2020.
In total **82** stories were collected across the region.

Trust (n=82)

- **18** from Belfast Health and Social Care Trust
- **34** from Northern Health and Social Care Trust
- **16** from South Eastern Health and Social Care Trust
- **4** from Southern Health and Social Care Trust
- **9** from Western Health and Social Care Trust
- **1** Other

How Long Before You Sought Help? (n=82)

- **4** - Managed from birth
- **38** - Immediately
- **14** - After 1 month
- **11** - After 6 months
- **2** - After 1 year
- **13** - After more than 1 year

Age Represented (n=82)

- **4** - 0-18 yrs
- **5** - 19-29 yrs
- **6** - 30-39 yrs
- **4** -40-49 yrs
- **8** - 50-59 yrs
- **19** - 60-69 yrs
- **16** - 70-79 yrs
- **18** -80+ yrs
- **2** - No comment

Who Responded (n=82)

- **7** x I am a carer
- **52** x I am a person who has a swallowing difficulty
- **21** x I am a relative
- **2** x Other

Rating (n=82)

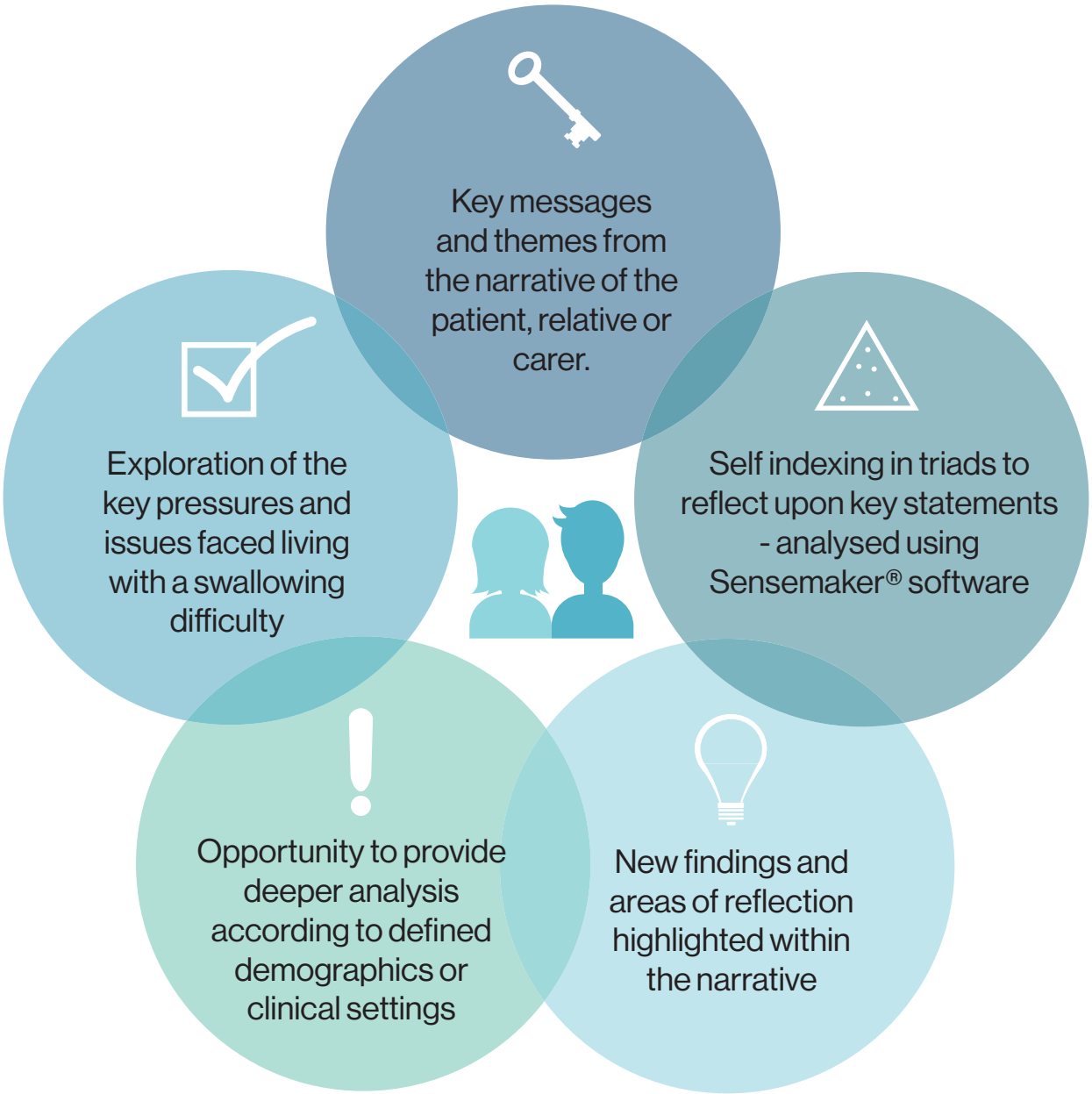
- **31** x Very positive
- **31** x Positive
- **15** x Neutral
- **4** x Negative
- **1** x Very negative

Where Did You Seek Help From? (n=82)

- **32** - Hospital/Specialist services
- **22** - GP
- **8** - Day Centre
- **6** - Self referral to Speech & Language Therapy
- **5** - Nursing/Residential Care Home
- **3** - Community Nursing Team
- **2** - Social Worker
- **1** - Dietitian
- **1** - Occupational Therapy
- **2** - Can't remember/no answer

ANALYSIS OF SURVEYS

Key messages and areas for reflection highlighted in this report have been identified using a range of analysis tools, these provide rich insight and understanding into the experience of the children, parents and guardians engaging with services.



RESULTS

Summary of the main findings in relation to the key concepts analysed through Sensemaker®.

1 PCE Standards

76% reflected that they were treated with privacy, respect and compassion.

2 Engagement

62% reflected positively on meaningful engagement as they had the opportunity to ask questions, to be part of decisions around care and were believed and listened to.

3 Information

59% of responses indicating the information received was timely, easily understood and answered questions related to swallowing difficulties.

4 Service or care received

70% felt confidence in the service provided, and that they received individualised treatment where professionals had worked in collaboration.

5 Enjoyment of food

Swallow assessment had a minor impact on the emotional experience of respondents relating to eating food: 68% before assessment; 62% after assessment reflected they enjoyed their food.

6 I followed my management plan

59% of respondents indicated they almost always followed the management plan.

7 Eating with friends & family

52% felt it was easy to eat with friends and family at home; however 29% noted they found eating with friends and family difficult.

8 Eating in public

44% stated they found it extremely difficult to eat in public.

9 Participating in sport activity

Further study required to gain insight into this area. 12 respondents reflected a negative tone in relation to how their swallowing difficulty affected participation in sports.

10 Anxiety around choking

85% of responses indicated anxiety in varying degrees towards choking.

11 Embarrassment

43% had felt varying degrees of embarrassment due to their swallowing difficulty.

12 Concern regarding my weight

28% indicated some concern about weight management within their experience.

13 Experience of people staring

Over 50% responded with a high concern related to people staring in public.

KEY MESSAGES

The following is a summary of the findings from the regional data. Each Trust can also review local Trust data to inform further service improvement.

- The provision of clear, concise information regarding a person's management plan is crucial to support them, their carers and others to implement the plan. This includes communicating and consulting with families and carers regarding assessments and changes to the plan.
- To support confidence in the delivery of the management plan it is recognised that training and support is required for informal and formal carers. Such training should support them to develop a practical knowledge base and to deliver safe and compassionate care.
- Awareness training on swallowing difficulties is essential across the whole system as many patients or clients have complex needs with a wide range of healthcare professional engagements.
- Increased awareness in our communities is essential to support the health & wellbeing of someone with swallowing difficulties. Strategies engaging with restaurants and caterers support someone to socialise safely and easily.
- Management plans need to be individualised in partnership with the person and their carer- it should explore the whole person, including personal preference and tackling wider issues such as concerns regarding choking, impact on weight and socialising.
- Management plans need to be readily available for all healthcare professionals as management of a swallowing difficulty extends beyond Speech and Language therapy and often requires input from others such as dentists, physiotherapists, dietitians.
- There is a need to develop a framework or risk assessment to support the complex debate between patient safety versus patient choice in the case of a person who does not comply with the management plan. This is particularly important for carers such as domiciliary care and care home assistants.

Next steps:

The Dysphagia NI partnership will include this insight from the voices of patients, relatives & carers to influence the current strategic work.

1.0 INTRODUCTION

The 10,000 More Voices Initiative has been commissioned and funded by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) to provide a person centred approach to improving and influencing experience of health and social care services. Embracing the principles of Co-Production, Patient Client Experience (PCE) is both a driving force for service improvement and also a quality indicator for service improvement. The methodology for 10,000 More Voices engages service users at the point of survey design, and on completion of the project presents the findings to service users to validate or challenge the findings. Projects are undertaken in partnership with HSC Trust nominated service leads and the Trust PCE facilitators for 10,000 More Voices (detailed in Appendix 1).

The project entitled "The Experience of Living with a Swallowing Difficulty" was part of the work plan 2019/2020, reflecting the strategic developments in relation to dysphagia being identified as a public health issue in Northern Ireland. In 2018 an interprofessional review team undertook the Regional Choking Review, exploring the themes from Serious Adverse Incidents across the region. Eight key themes were identified:

1. Factors causing high risk of choking
2. Behaviours increasing risk of choking
3. Signs & Symptoms of a Swallowing Difficulty
4. Communication & Understanding of recommendations
5. Individual Care Plans
6. Physical Environment & impact of changes
7. Meal time & snacks
8. Dysphagia training & Awareness

The Regional Dysphagia NI partnership, a transformation project was formed in 2018 to address the issues outlined in the Regional Choking Review (2018). The aim of the regional group is to develop collaborative whole systems solutions to support outcomes for adults with dysphagia to include:

1. Improve awareness of dysphagia
2. Standardise identification & management of people with learning disabilities
3. Improve access to specialist interventions
4. Adopt a co-production approach across all action

This report has been co-produced alongside Dysphagia NI and the findings will inform the future direction of the regional learning. These elements inform the analysis, reflection and learning identified in the 10,000 More Voices Project.

2.0 PROJECT OUTLINE

2.1 Aim

The aim of the study was to explore the experience of living with a swallowing difficulty, to identify key features of positive experiences and to learn where further developments are required.

2.2 Objectives

1. To capture and learn from the narrative of people who live with swallowing difficulties through a bespoke survey and support them to engage with a platform to share freely their experience.
2. To explore the experience of engaging with services to support living with swallowing difficulties.
3. To consider areas for reflection and improvement and to inform new ways of working to support people living with swallowing difficulties.

2.3 Target Group

This project embraced the experience of anyone living with a swallowing difficulty, including those under 18 years old, with the exception of people who were acutely unwell and with a new diagnosis of a problem with their swallow, for example, following a stroke. Relatives and carers could also share the experience from their perspective.

3.0 METHODOLOGY

3.1 Survey Design

In keeping with the core principles of 10,000 More Voices the survey was co-designed and piloted with people who have experience of swallowing difficulties. Stories shared, as part of face to face interviews, identified the core concepts to be explored using Sensemaker® Analyst software. This software gathers the experiences of real people and supports the visualisation of patterns in the narrative, as explained in Section 3.3.

3.2 Engagement

The project was launched in February 2020 with a focus to share learning on Swallow Awareness day, however due to the COVID-19 pandemic the collection of stories was discontinued in March 2020. In total 82 stories were collected prior to the project ceasing. Surveys were completed in collaboration with the Trust PCE facilitators. Additional support was required for the completion of some surveys to support communication by the patient/carer. In this context surveys were completed as part of semi-structured interviews and the responses recorded on the survey by the PCE facilitator.

3.3 Data Analysis - Using Sensemaker®

When completing the survey respondents were first asked to describe the experience of engaging with services regarding their swallowing difficulty. The second section contained a number of statements to support the respondent to "self-index" or analyse their experience.

Section 4.0 of this report displays a series of triangles (known as triads) which contain clusters of response to the statements. In relation to triads, respondents were asked to mark in each triangle the position which best describes their experience in relation to three pre-specified responses (known as signifiers). If none of the responses applied the respondent could tick "this does not apply to me". The closer the marker is to any one statement, the stronger this relates to the experience. Each dot within the triad represents an individual experience of a patient, client or stakeholder. A high concentration of dots in a specific area identifies an emerging pattern in relation to the signifier. This illustrated in Figure 1. The same principles apply for dyads, which demonstrate two extreme responses to a statement/question, moving from negative emotional tone to a positive emotional tone, as illustrated in Figure 2.

Figure 1. Example of a Triad

Responses to statement: In my experience I was treated with...

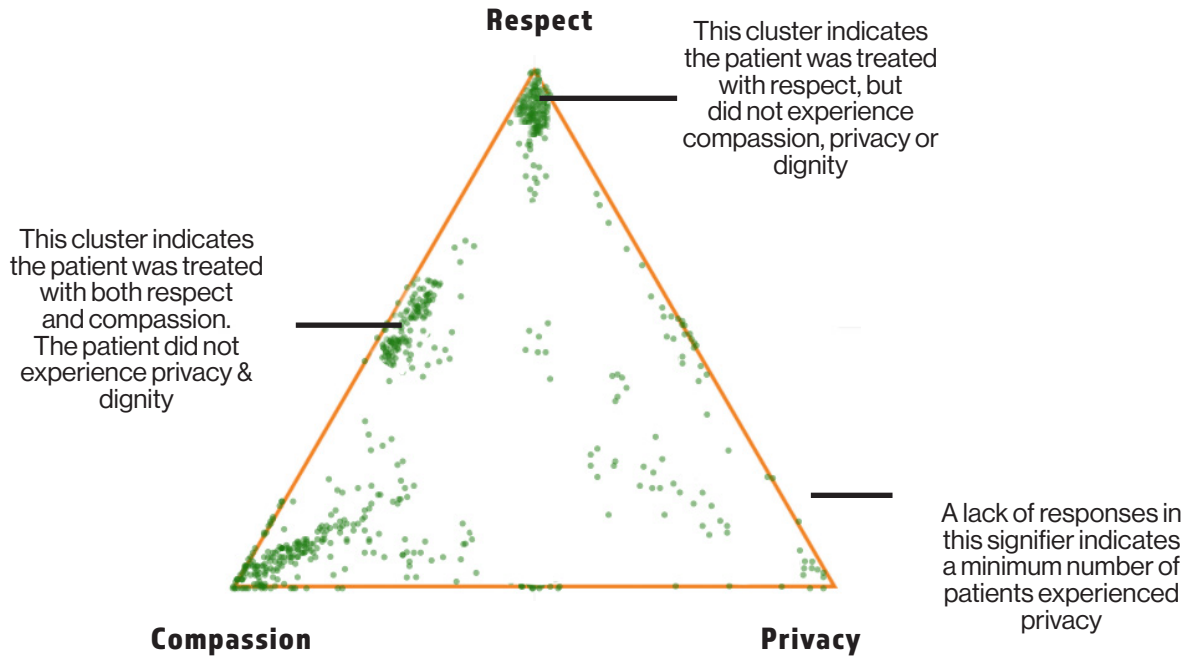


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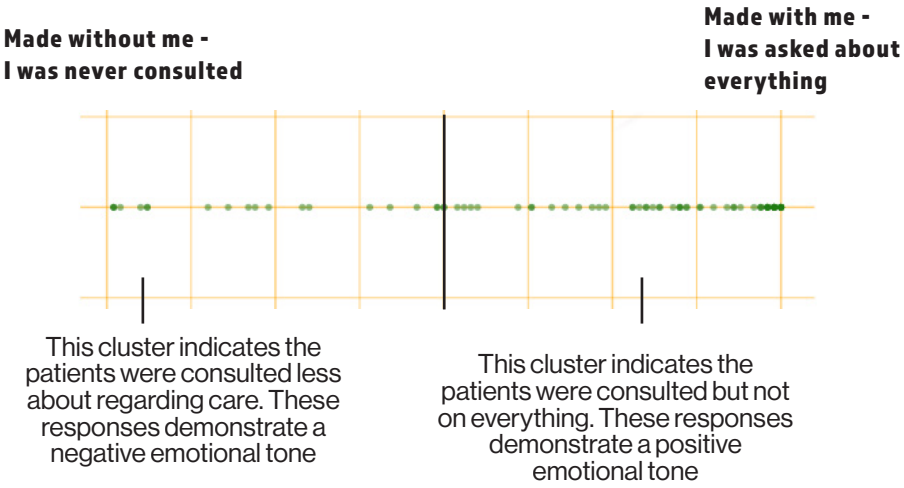
Figure 2. An example of a Dyad.

Responses to statement: Decisions regarding my care were...



3.5 Limitations

- Project was only promoted for 4 weeks and closed early in response to the pandemic. It is recognised the opportunity to complete the surveys were limited and a wider reach would have supported additional benefits for robust analysis.

- An easy read version of the survey was requested but not developed within the timescale therefore reducing the opportunity for people with cognitive impairment who did not have access to a PCE facilitator.

- The survey focused upon people with experience of swallowing difficulties. It did not support collection of the experience of people newly diagnosed with a swallowing difficulty.

The following section presents the regional findings from the stories (inclusive of the pilot) and informs the areas for learning and reflection (Section 5.0). Appendix 2 includes an overview of the context questions included in the survey. Further briefing papers can be explored under each of the context questions for example - trust specific briefing reports.

4.0 FINDINGS & ANALYSIS

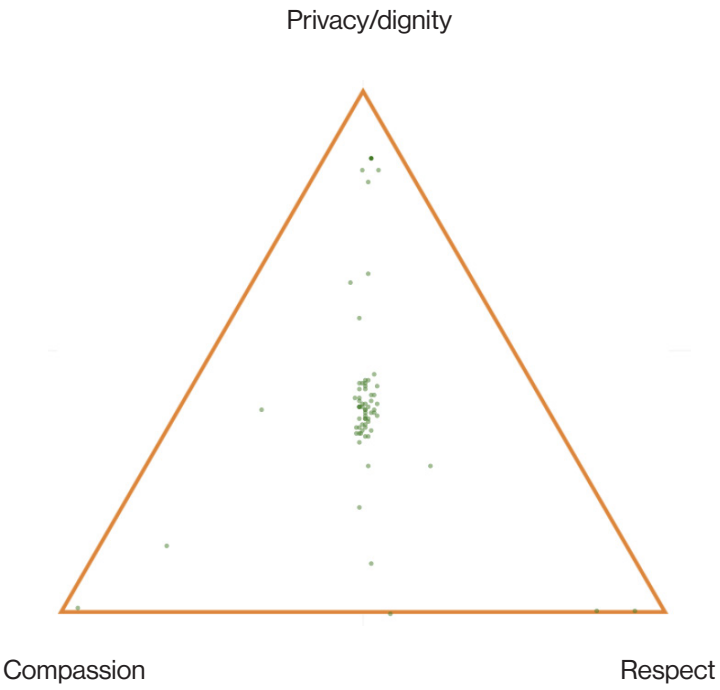
Presenting the voice of the service user

The following section presents the responses in relation to 9 statements/core concepts, presented as Triads and Dyads. The main messages are highlighted as clusters and indicate the majority of responses however it is also important to take cognisance of the smaller patterns emerging which can indicate areas for further reflection and development. Each pattern formation is analysed using the narrative shared and the results further demonstrated using some of the anonymised quotes from the database. The first 4 statements reflect upon the services relating to a swallowing difficulty and are presented as Triads. **The narrative includes stories of people having deviated from their professional Speech and Language Therapy Eating, Drinking, and Swallowing Recommendations, at their own risk. Health and social care professionals strongly advise that people with eating, drinking and swallowing difficulties and their carers adhere to Speech and Language Therapy Eating, Drinking and Swallowing Recommendations**

4.1 Patient Client Standards

Statement 1 addresses the key elements in the Patient Client Experience Standards. These standards present that health and social care staff should at all times treat patients/carers with respect; have a positive and compassionate attitude; have professional and considerate behaviour; be sensitive in their communication manner; and uphold privacy & dignity. Responses are shown below in Figure 3.

Figure 3. (n=67) Statement 1: In telling your story were you treated with ….



The central cluster of 76% (n=62) reflects upon being treated with privacy, respect and compassion. Within the narrative patients and carers reflect upon being listened to about preferences and being engaged during assessment or care. This extends outside of HSC services to others such as staff in restaurants or private carers. In relation to the standards respondents highlighted the importance of respecting personal choice and empowerment through education and information.

"....The Speech Therapist is a good girl she knows what I like, she let me have a piece of bread and jam. It has to be cut up but I enjoy it.... If we go out we take thickener with us for the tea. We would ask the staff to cut the sandwiches up small and cut the crusts off. They do it no problem..."

"...We had education sessions with SLT to show us how to feed my daughter. They were very attentive and provided us with written information..."

"....The Speech Therapist has been amazing, she is so caring when she speaks to him she shows him respect. I have been given a lot of information and places to contact for advice and information..."

Outlying minor pattern formations still reflect upon a positive experience, however in a small number of stories where respect was not included respondents reflected upon the lack of choice in relation to their plan of care.

".... I didn't know I had a problem and all of a sudden I am told I cannot eat the things I love. I do not like it – they tell me I must thicken my coffee, but this is not how I like my coffee..."

The key messages in this concept were the importance of understanding the perspective of the patient or client and exploring choice in relation to a plan of care.

4.2. Meaningful Engagement

Statement 2 explores elements of meaningful engagement – the opportunity to ask questions, to be part of decisions around care and to be believed and listened to. This is illustrated in Figure 4.

Figure 4. (n=69) Statement 2: In your experience were you....

Central cluster of 62% (n=51) reflects positively on meaningful engagement. Again in the narrative respondents shared on the importance of exploring their choice and preference and responding to questions. Also included is the complex debate on how to ensure patient safety versus offering patient choice.

"... She [Day Care Support] always talks to me and lets me ask questions... I know to eat slowly and not talk. I am told to cut up food. I get a personal place mat PPM with my picture on it and it has all the instructions about my diet on it. It shows food I can eat, the level of supervision and all good information..."

"...They just give you advice (SLT) about what you should and shouldn't be doing for eating and drinking. It was up to me; 'my discretion to make the decision- as long as you understand what might happen. It was helpful to make my own decision..."

There are a number of responses which are varied across the triad, which although do not form a pattern, they do focus on the bottom half of the triad reflecting upon the experience of being believed & listened to and being involved in decisions. Partnership working with the patient or carer is an important element of meaningful engagement - to support understanding of the risks and empower the patient or carer to follow an agreed plan. This is further discussed in Section 4.4.

4.3 Effectiveness of Information given

Statement 3 focuses about important elements for information sharing – that the information is easily understood, timely and answered the respondents questions. This is demonstrated in Figure 5.

Figure 5. (n=70)Statement 3: The information given was...

Central cluster represents 59% (n=48) of responses indicating the information received was timely, easily understood and answered questions related to swallowing difficulties. In particular carers reflected upon the importance of the information shared.

"...She [daughter] was put on a thickened fluids and soft diet so she could adapt and her care plan was clearly set out and this was explained to us a family in a way that we could understand...."

10% (n=8) of respondents did not feel this was part of their experience. In these cases there was a lack of information shared or the information was not accessible at the right time. Examples include lack of information on how to use thickener, conflicting information between health professionals and lack of engagement with carers, in particular in the case of a resident in a Care Home.

"...I got different pieces of information from staff in hospital and what the therapist told me. This can be confusing..."

"...I have been prescribed thickener for my drink, left with little information, how long to take, how to order any follow up.."

"... they changed all his [brother] regime. I didn't know until I arrived at the home and found something stuck on his wardrobe door – when I asked staff they weren't sure and said it was something to do with guidelines; I am still his next of kin... I love him... I need to know when things change..."

The key message relating to the provision of information is the importance of information which is consistent across the region. It is also important to ensure key people who support care such as next of kin and carers are aware of changes and this information is shared in a timely manner.

4.4. Outcome of Engaging Services

Statement 4 considers the outcome of engaging services – considering elements of confidence in the service provided, individualised treatment and collaborative working with others. Figure 6 demonstrates a central cluster of 70% (n=57) whereby all these elements were part of the experience. The narrative within the central cluster reflects upon examples of collaborative working between Speech and Language therapy and carers or other allied health professionals, supporting confidence and well planned treatment.

"....If I have any problems I would link with the senior carer who would contact the speech therapist. She is very very good/ fantastic. They keep close connections with her community nurse and speech therapist..."

"...If I have an issue or if they notice something that doesn't seem right they will contact me. We discuss it and the Speech Therapist is contacted straight away and followed up..."

"...I have a neck brace that helps to support my head up for eating, the Speech Therapist spoke to the Occupational Therapist and they got me this..."

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Figure 6. (n=68) Statement 4: The service or care you received provided…

There is a diverse range of responses to the bottom third of the triad, reflecting how the experience did not instil confidence. Identified in the narrative is a lack of confidence in the knowledge base of other healthcare professionals - two contributing factors were a lack of skill in managing a swallowing difficulty and lack of knowledge on the individuals care due to agency work/lack of consistency in domiciliary care. The challenge is to identify the training needs to support someone with a swallowing difficulty and also how to communicate an individual's care needs for consistency in care. This is a key theme identified in the Regional Choking Review (2018) which identified the need for consistent, accessible training. This need extends beyond HSC workforce and into the independent sector – care homes, agency workers and domiciliary care.

"…My mother is in a care home. The awareness of swallowing difficulties is very poor and the management even worse – My mother had a near miss choking episode…"

"…Agency night staff have often given her solid meds with a real risk if her choking or spitting them out and not getting them…"

"…I look after him [brother] every day; I know him and I know his needs but twice a week someone comes to let me get out and have a breather. I don't really blame them for not knowing him as we would be lucky if it is the same girl each week. I wish we could get someone regular – someone who wants to know my brother and learn what he wants. Most of the girls don't really care – they come, they go … he might have eaten nothing but they sign the book and leave. There is only one I have faith in…"

There are also external stakeholders which make a significant impact upon someone living with a swallowing difficulty. One of the stories entitled "Everyone needs to know the right information" outline concerns in relation to unscheduled care (often in a crisis or period of acute illness) and lack of knowledge and support from the staff or service.

"...There have been times when in A&E they don't have any of the powder for thickening fluids and I have to bring down some from home. Another thing is that he has had a stroke 2 years ago and did not always get the assistance he needed do ended up spilling food over himself. He can manage when he has a feeder cup but sometimes they are not available either. I feel when he moves departments information isn't shared properly and the patient gets lost in the middle. Sometimes I feel guilty when I can't get down to feed him. On occasions he has been given the wrong diet. Once when I challenged this, the doctor told me to go to the shop and buy a couple of yoghurts..."

Another key professional is dentistry. Dental care significantly impacts upon the ability to eat.

"...I went to get my dentures tightened up but they said there was nothing they could do but I know my dentures are not right. I wish they would listen to me..."

Other reflections which demonstrate a lack of confidence in the system are delays in communication or management. A story entitled "Lost in the system" expresses concern their condition is serious but the system is not responding in a timely manner causing anxiety.

"...Consultant felt my problem was quite serious and wondered how I had managed with my symptoms. I was given a copy of my test that day. He wished for me to have a barium swallow test they were very nice doing the test and I got an appointment very quickly-however I was a little baffled when they said I would get my results when I see my Consultant next .I advised I do not have another appointment that I am aware of to the best of my knowledge they have not arranged another appointment neither have the offered to send me my results? I questioned this as I do not want lost in the system..."

The key messages highlight the importance of collaborative working when supporting someone who lives with swallowing difficulties. The support required extends beyond Speech and Language therapy with a multidisciplinary approach required. The main challenges is ensuring there is effective communication for continuity of care between the various disciplines; also where necessary a joint eating, drinking and swallowing management plan to support the individual as a whole. There is also a challenge to ensure the wider understanding of how to support someone with a swallowing difficulty across the system, in particular within nursing profession.

The following statements consider the personal reflections of a respondent living with a swallowing difficulty – the deeper emotional responses and challenges faced on a daily basis by the person or their carer.

4.5 Relationship with food

Statement 5 is divided into the relationship with food before and after the specialist dysphagia swallow assessment performed by Speech and Language Therapists. It considers the impact on enjoying food. These are demonstrated as dyads in Figure 7 and 8.

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Figure 7. (n= 71) Statement 5a – ENJOYMENT OF FOOD: Before assessment

I hated to eat – I had no enjoyment of food

I loved eating - it was the highlight of my day

Figure 8. (n= 69) Statement 5b – ENJOYMENT OF FOOD: After assessment

I hated to eat – I had no enjoyment of food

I loved eating - it was the highlight of my day

Before assessment the majority of responses (68%/n=56) had a positive emotional experience relating to eating food. There is also minimal change in the impact of the assessment with 62% (n=51) of respondents reflecting they enjoyed food. Therefore the process of Specialist Dysphagia Assessment for the majority of respondents does not impact significantly on the enjoyment of eating. In the narrative individuals did reflect upon how the assessment made them feel safer and more in control.

"...I'm not coughing or choking I'm much happier about this now. Although I do not enjoy coffee the way I used to, it's not the same with thickener..."

"...The speech therapist told me to eat slowly and to make sure my food is moist. Before I began liquidising my food at home I had an awful fear it would stick in my throat..."

"...I love my food but my food doesn't love me Sometimes I have a mouthful of saliva, I just can't swallow or control it and it just lets go and I have to spit it out..."

"...now a pureed diet which he has tolerated without complaining. He was allowed jaffa cakes but he is not allowed anymore, he misses this. We try and subsidise this with trifles. As a learning disability he is not in a position to disagree but we act as advocates to him. He is so compliant. What helps our patients is when the food looks appealing.."

A small number highlighted the use of pureed meals was less appealing to them and impacted upon their enjoyment of food. Dissatisfaction with the taste, consistency and lack of visual presentation of pureed textured meals was highlighted.

"...I never thought I had any problems, it came out of the blue. I loved my food and ate everything. Now I have to eat thick meals, they are rotten, I don't think much of them. There's a lump of stuff on the plate you wouldn't know what it was. I can eat the puree peas and carrots. There is no taste to them. The custard and yogurt are alright. I asked for a boiled egg, a salad and a piece of bread but they wouldn't give it to me. I can't really understand it but I have to abide by it..."

"...At the beginning I found the change in meals hard to adapt to. I would love to just have normal meals but I know if it keeps me safe that is the most important thing..."

"...I have to put in 2 spoonfuls in all of my drinks, except tea. It's unpleasant in tea although it is tasteless, it's like wall paper paste.."

"...When I was in hospital I had to eat the pureed meals they were awful, it sickens me now even thinking about them. When I came to XXXXX [name removed] I got potatoes and mince mashed up and it was lovely. When I started to liquidise my own food at home, I felt more comfortable eating not as afraid of choking, but I always like to have a glass of water beside me just in case..."

The final statement regarding the relationship with food was to explore how closely individuals follow the management plan. As demonstrated in Figure 7 59% (n=48) of respondents indicated they almost always followed the management plan. **The narrative includes stories of people having deviated from their professional Speech and Language Therapy Eating, Drinking, and Swallowing Recommendations, at their own risk. Health and social care professionals strongly advise that people with eating, drinking and swallowing difficulties and their carers adhere to Speech and Language Therapy Eating, Drinking and Swallowing Recommendations.**

Figure 9. (n=66) Statement 5c – I followed my management plan...

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In the narrative where respondents indicated they did not always follow the management plan a number factors were identified.

1. Individual's favourite foods were not part of the management plan
2. Challenge to modify behaviours
3. Carers decision to change the recommendations as influenced by the individual with swallowing difficulties
4. Conflict by carer in adhering to recommendations and pleasing the individual with swallowing difficulties
5. Accessing the correct resources (for example recommended thickener)

"...Although she sticks to her diet here [day centre] I cook normal meals for her at home and I cut her food up into small pieces. I understand the Centre's position they have to do what is right as it is a big responsibility to feed her. I am responsible for what I do at home and I am happy for her to have cut up meals.."

"...He loves his food and when we go out he likes to get chips. Although the chips aren't recommended we cut hem up into small pieces and feed him slowly..."

"...When I am at the Day Centre I think I could eat normal food but I don't get a choice, I have to eat pureed meals. I feel like they don't listen to me. At home or if I go out to a restaurant I can eat what I want. I enjoy normal food much more. My wife is very alert to it she would cut up my food into small pieces. She keeps me right – It's a hard job I normally eat quite quickly and swallow quickly..."

"...I asked for a boiled egg, a salad and a piece of bread but they wouldn't give it to me. I can't really understand it but I have to abide by it..."

"...The food didn't look like ordinary food at all as it put on plate it looked a lot which put my mother off eating. She didn't like the thickener in the fluids. I myself was quite concerned of how I was going to cope when she came home from hospital. I would have been more afraid and more aware of what could happen more so than my mother. It does change the life of a family eating together because of my mother looking to have the same food as you..."

"...My son has severe swallowing difficulties with fluids but he is OK with mashed foods. He takes nutilis clear and i think this can cause extra secretions. I really don't like giving it to him but it is the only safe way i can give him fluids. Before i had thick n easy which i believed caused stomach problems. I believe thickener can add to my son having more problems. The SLT team located a thickener that suited my son but we can't access it..."

"...Sometimes temptation rears its ugly head and I eat certain foods which are not blended - but generally I am sticking to the plan..."

The narrative also demonstrates a challenge for day care centres/care homes/domiciliary workers whereby they seek to keep the person safe by adhering to the management plan, but in some cases against the person's choice. This conflict of interest is a challenge for all healthcare professionals when seeking a balance between patient choice and patient safety.

"...Need a more detailed risk assessment to protect staff and allow them to take calculated risks to go outside of level 4 diet occasionally so that more treats would be possible..."

"...You really need to know her when your feeding her, she sometimes turns her head away, like she is refusing her food but she's not it's just what she does. I go to the other side and feed her if she turns her head away, but the staff think she is refusing the food and stop trying as they don't want to force her. She really needs to eat..."

It is evident from the narrative that the relationship with food is complex, in particular when seeking a balance between the safety of the individual versus their desires and choice around food. These decisions should be made in partnership with the individual and/or their carer and in the case of a Care Home or Day Centre the relevant staff need to be involved to ensure informed decision making.

4.6 Challenges living with a Swallowing difficulty

The following dyads demonstrate responses to possible scenarios whereby living with a swallowing difficulty may be a challenge. These challenges were identified by the service users who supported the design of the survey.

4.6.1 Eating with others

Figure 10 explores the concept of eating with friends and family – often those closest to us. There is a diverse spread of responses - main cluster of 52% (n=43) find it easy to eat with friends and family at home; however a cluster of 29% (n=24) in negative emotional tone indicated they found eating with friends and family difficult. Contributing factors are the length of time taken to eat a meal and adding to family worries/concerns.

Figure 10. (n= 65) Statement 6: Eating with friends & family

Extremely difficult Extremely easy

"...I don't like to go out or eat in front of people I just like to eat on my own".

"...I have to eat slowly and by the time I come to the end of my dinner my food is usually cold. I'm always way behind the family a lot slower than they are..."

"...It does change the life of a family eating together because of my mother looking to have the same food as us..."

"...At the start I couldn't understand I found it strange but now it's a part of life. It effects the whole family and their lives..."

The next statement, illustrated in Figure 11 explores the experience of eating in public. The dyad shows a shift in responses with more stating it was extremely difficult to eat in public (44%/n=36).

Figure 11. (n= 59) Statement 7: Eating in Public

Extremely difficult Extremely easy

Main cluster of 44% (n=36) found eating in public (for example at work or in a restaurant) to be difficult. On balance 41% (n=34) responded with a positive emotional tone indicating they did not find eating in public a challenge. A contributing factor for this positive shift is access to a restaurant which facilitates modified meals.

"If we are going out for something to eat, I would phone the restaurant before we go and ask to speak to the chef. If they can accommodate a meal for my son then we go and if not we go somewhere else. On most occasions people are very accommodating. We have been on holiday to XXXXX [country name removed] with my son, even in XXXXX [name removed] I ask to speak to the Chef. It is a courtesy to the Chef to ask and most places accommodate."

"...frightening how much it can change your life can change so much even though it's a silly thing or seems to be a silly thing. - I don't go out for meals anymore.-I have my tea before I go out for a meal.-It's inconvenient to say one thing. More embarrassing on the other hand..."

"...If I'm going out for something to eat I am conscious about what I order, it has to be moist and easy to eat. I always feel conscious that I am a lot slower at eating than my family. Not that it makes any difference to them but I'm still conscious of it..."

"...If we go out we take thickener with us for the tea. We would ask the staff to cut the sandwiches up small and cut the crusts off. They do it no problem..."

"...If we are going out for something to eat, I would phone the restaurant before we go and ask to speak to the chef. If they can accommodate a meal for my son then we go and if not we go somewhere else..."

The key messages reflect upon the importance of understanding the needs of the individual when eating in front of friends & family and in public. Factors which support the individual include meals which can be adapted to meet their needs, ability to ask for support and an understanding of the time required to eat safely. This applies to eating in front of anyone however there is a challenge in restaurants, coffee shops etc. to help them understand their role in supporting someone who lives with a swallowing difficulty.

4.6.2 Engaging with sports

This question refers to any sporting activity which may be affected by a swallowing difficulty. As part of the pilot a respondent shared her fear of swimming – a sport which she used to undertake daily. This impacted upon her health & wellbeing as she couldn't overcome the fear she might drown when swimming. The following two dyads explore how people engage with sports.

Figure 12 demonstrated that only 10% of respondents (n=8) regularly participated in sports. The sports regularly engaged with are walking, swimming, jogging, day-care activities and circuit training.

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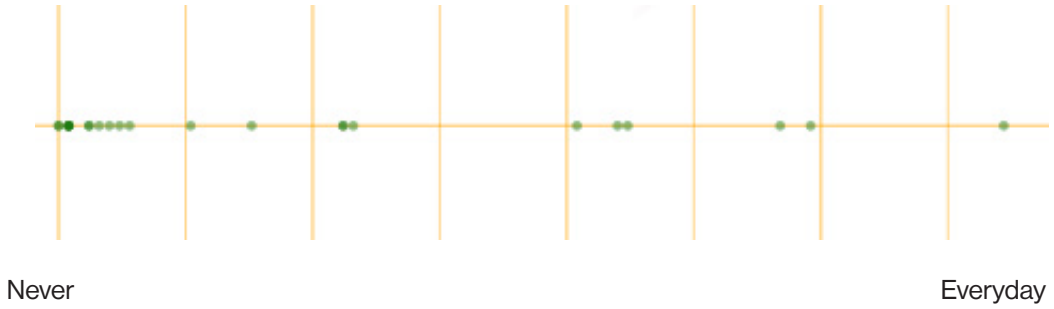
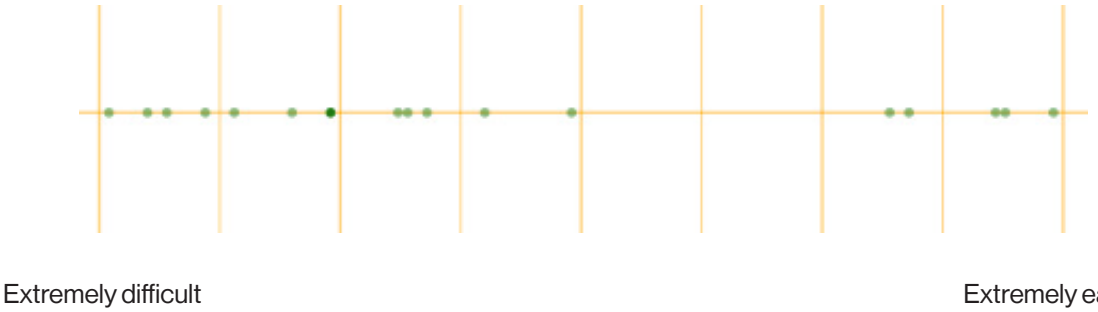
Figure 12. (n= 23) Statement 8a: I participate in sports activities...



Only 17 respondents completed Statement 8b exploring if a swallowing difficulty impacted upon sports as illustrated in Figure 13. Although no one expanded upon this in the narrative it is important to note that 12 responses had a negative emotional tone stating the swallowing difficulty impacted negatively on the sports.

Figure 13. (n= 17) Statement 8b: I find my swallowing difficulty means sports is...



This reinforces, as part of the swallow assessment, the importance of looking at the person as a whole and where appropriate include detail around sporting activity. Due to the lack of narrative on this matter in the project it is proposed that this area requires a further deep dive into the experience.

4.6.3 Choking

The next statement explored anxiety around choking, as demonstrated in Figure 14. 85% (n=70) of responses indicated anxiety in varying degrees towards choking. A number of elements contributed to this fear, as demonstrated in the narrative.

1. Previous episode of choking
2. Lack of confidence in others to assist
3. Embarrassment in relation to choking

Figure 14. (n= 82) Statement 9a: Anxiety around choking

I am never anxious about choking

I am always anxious on a daily basis about choking

"...One time I did choke I felt like someone was putting their hands around my throat and wouldn't let go, it scared the life out of me..."

"...My fear that my experiences from significant choking events make me believe that when a 'major' choking event occurs my family will be unable to respond effectively to help and save me as they have not been trained in choking response and do not have access to choking release equipment..."

"...I nearly choked on carrots a year ago, my son had to save me, and it scared me. I didn't eat for days after..."

A key message in the responses is the recognition of the trauma caused by a choking episode – for the individual or the carer involved. There is a need to provide training and information to empower key people to respond appropriately. Also, in a case where someone has choked, it is important to support the person as whole – not only considering the cause of the incident, but recognising an emotional response which can challenge their confidence and general wellbeing.

4.6.4 Embarrassment

Embarrassment was an element highlighted in the event of choking, however the experience of embarrassment was also linked to requiring a modified meal, excessive secretions or people staring. Figure 15 demonstrates a diverse range of responses regarding embarrassment. 29% (n=24) stated they did not experience embarrassment due to their swallowing difficulty; however 43% (n=35) stated varying degrees of embarrassment in their experience.

Figure 15. (n= 82) Statement 9b: Embarrassment

I am never embarrassed about my swallowing difficulty

I am always embarrassed about my swallowing difficulty

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"... I don't take him out often. I know it sounds awful – he doesn't know to be embarrassed but I feel it especially as he drools and requires a bib. He's a grown man..."

"....I kind of knew I wasn't well I had a choking episode on holiday last year it was frightening I choked on a bit of steak. It was my birthday few weeks ago and I wouldn't go out for dinner with the wife and sons in case I choked. I also have stopped going out as often with my mates for a pint. It's the fear and embarrassment of choking in public...."

The responses in this dyad reinforce some of the difficulties faced by someone living with a swallowing difficulty. It is important in the assessment and management plan that these factors are recognised and included to provide a holistic approach to care.

4.6.5 Weight management

The responses in this dyad reinforce some of the difficulties faced by someone living with a swallowing difficulty. It is important in the assessment and management plan that these factors are recognised and included to provide a holistic approach to care.

"... he is finally starting to gain weight now we have his swallow sorted..."

"...before all this he lost so much weight it scared me..."

However a diverse range of answers towards high levels of concern – a cluster of 28% (n=23) in the middle indicates they experience some concern about weight management.

Figure 16. (n= 82) Statement 9c: Concern regarding my weight

I am never concerned about my weight

I am always very concerned about my weight

A small number of responses indicated high levels of concern regarding weight. In the narrative of these stories the concern related to weight loss referenced the importance of the role of the dietitian and use of supplements.

"...She had a swallowing assessment done, they started her on liquidised meals and her fluids were thickened with thick and easy. I became unwell myself and she had to go into respite care, she was there for 7 weeks then for 4 weeks... They let me out to visit her one day and I noticed that she had lost a lot of weight, I saw it in her arms, and her watch was spinning round her wrist. When she went in she was 6and a half stone when she came out she was 4 stone... we are dealing with it... she is now on supplements"

"...I am now having meals blended or pureed which I find agrees with me more. I am also on high protein drinks and a powder in a sachet to help with absorption of food. I have made some adjustments to my diet & eating habits with the help of Speech & Language Therapists& Dietitians. Sometimes it can be difficult socially to lead a normal life but slowly I am gaining weight and remain positive that all will be well..."

"...I miss my proper food and am losing weight but the food they make me is nice..."

It is evident in the responses of this dyad that weight management is an indicator for the patient or the carer of how effective the management plan is. Input is required from a various disciplines such as Speech & Language Therapy, Dietetics and Nursing – once again reinforcing the importance of a multidisciplinary approach to supporting someone living with a swallowing difficulty.

4.6.6 Staring

The final statement explored the possibility of being stared at because of their swallowing difficulty. Figure 17 demonstrated 39% (n=32) experienced little or no concern in relation to people staring.

Figure 17. (n= 82) Statement 9d. Experience of people staring

I am never concerned about people staring

I am very concerned about people staring

Over 50% of the responses were plotted towards high concern relating to people staring. The narrative reflects upon people staring in public. This highlights the importance of improving awareness around dysphagia and increasing public understanding to support people with swallowing difficulties to engage socially.

"...I don't go out very often but when I do I notice that people stare, it makes me feel embarrassed..."

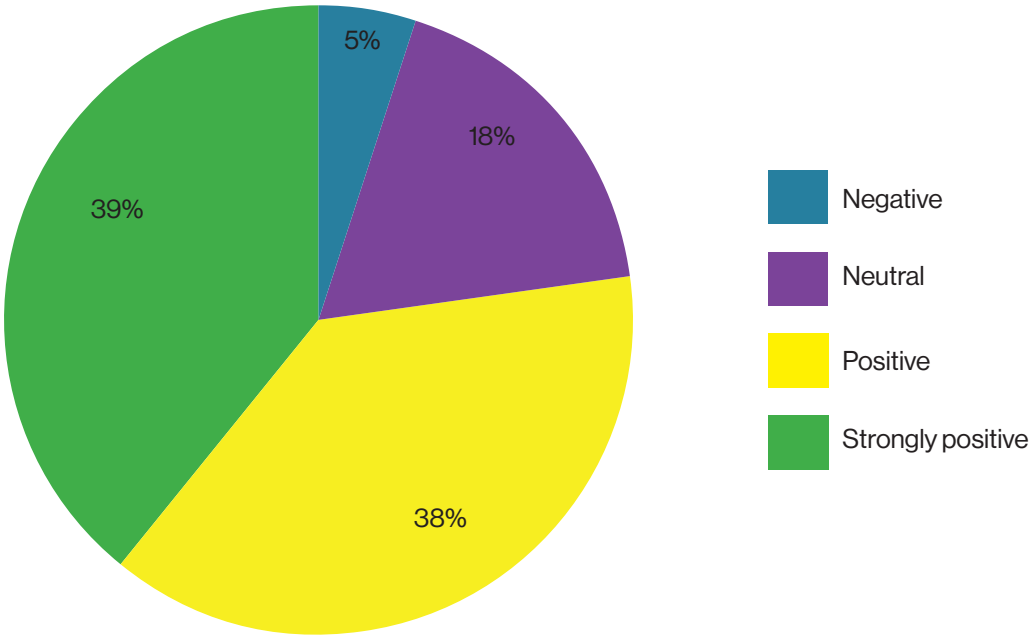
"...Sometimes I feel embarrassed when people stare, it doesn't feel nice. I don't like to give out about it but my friend would tell them..."

Through exploring the day to day concerns when living with a swallowing difficulty (choking, embarrassment, weight change, sports and eating with others) it is important these concerns inform the assessment and individualised management plan. Through addressing concerns and anxieties in these areas the person can be supported in their daily lives. Individual Care planning is a key theme identified in the Regional Choking Review (2018).

4.7 Overall Experience

Respondents were asked to rate their overall experience of managing their swallowing difficulty. It is largely positive with a smaller number rating neutral or negative; there were no stories rated strongly negative. This is illustrated in Figure 18.

Figure 18. (n= 82) How would you rate your overall experience?



It is encouraging to learn from the positive experience of respondents, who reflect upon the importance of effective information, partnership working, individualised care and meaningful engagement. It is also important to learn from the issues raised in the neutral and negative stories. All these elements and the key messages in Section 4.0 are summarised in the following Section 5.0 Areas for Reflection & Learning.

5.0 AREAS FOR REFLECTION AND LEARNING

5.1 Key Messages

The following summarises the key messages outlined in Section 4.0, embracing the voices of patients, clients, relative and carers into areas of learning and to influence future work in these experiences.

- The provision of clear, concise information regarding a person's management plan is crucial to support them, their carers and others to implement the plan. This includes communicating and consulting with families and carers regarding assessments and changes to the plan.

- To support confidence in the delivery of the management plan it is recognised that training and support is required for informal and formal carers. Such training should support them to develop a practical knowledge base and to deliver safe and compassionate care.

- Awareness training on swallowing difficulties is essential across the whole system as many patients or clients have complex needs with a wide range of healthcare professional engagements.

- Increased awareness in our communities is essential to support the health & wellbeing of someone with swallowing difficulties. Strategies engaging with restaurants and caterers support someone to socialise safely and easily.

- Management plans need to be individualised in partnership with the person and their carer- it should explore the whole person, including personal preference and tackling wider issues such as concerns regarding choking, impact on weight and socialising.

- Management plans need to be readily available for all healthcare professionals as management of a swallowing difficulty extends beyond Speech and Language therapy and often requires input from others such as dentists, physiotherapists, dietitians.

- There is a need to develop a framework or risk assessment to support the complex debate between patient safety versus patient choice in the case of a person who does not comply with the management plan. This is particularly important for carers such as domiciliary care and care home assistants.

5.2 Next Steps

This project is supported by the Dysphagia NI partnership to champion the voices of patients, relatives & carers to influence the current strategic work. In particular, consideration should be given to the areas of reflection and learning and defined actions to ensure the messages have been heard. This includes identifying the key messages in work undertaken since the project closed.

It is recognised this report presents the wider regional learning; however the database remains open and available for further briefing papers through Trust PCE facilitators (Appendix 1). This would support learning at a local level. It is also important to identify other lenses through which the narrative can be analysed, for example, according to age or services engaged.

Moving forward it is important this report supports our continuous conversation across related forums to ensure the voice of the patient, relatives and carers is central to the work by HSCNI to support people living with swallowing difficulties.

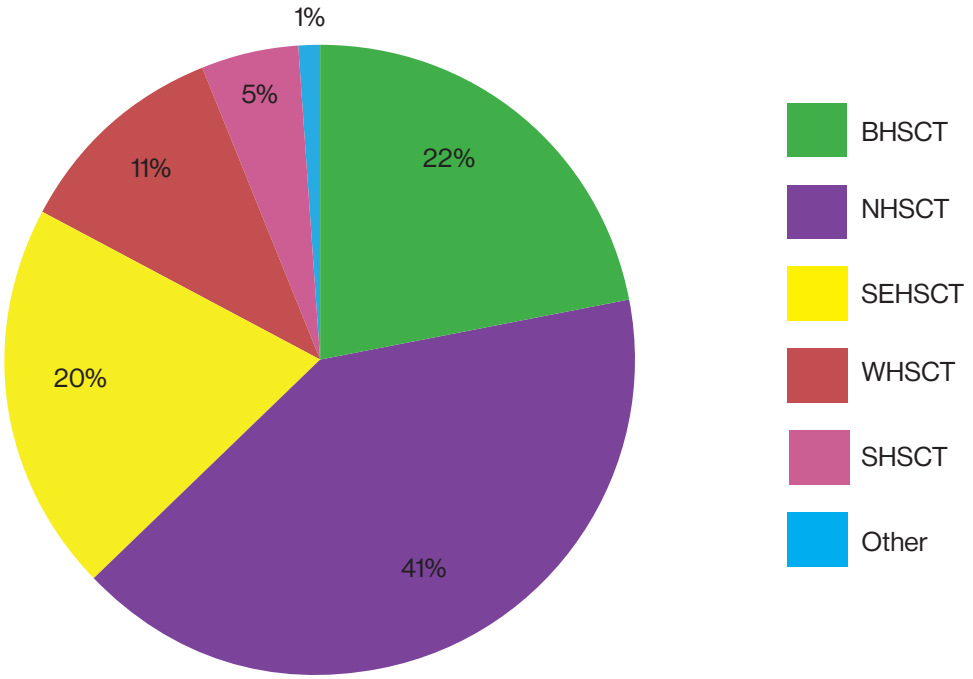
6.0 APPENDICES

Appendix 1 – 10,000 More Voices Team

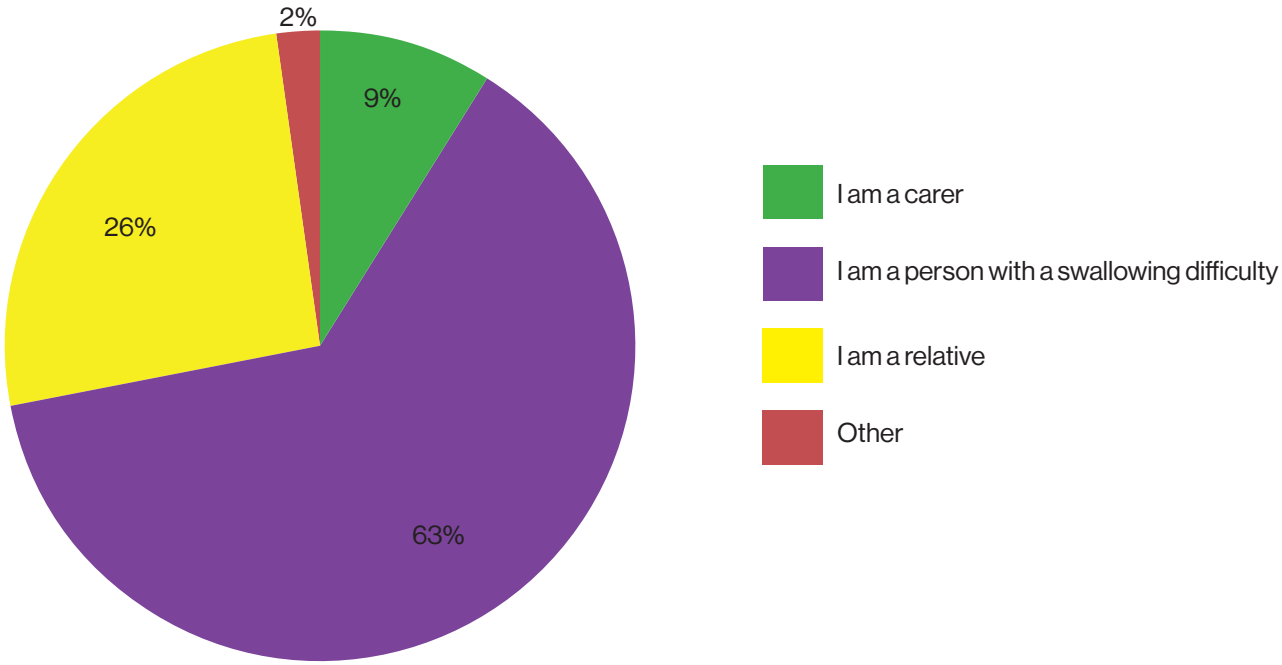
Organisation	Patient Client Experience Representative	Role	Contact Details
PHA	Michelle Tennyson	AD for AHP/PPI/PCE	[redacted]
	Linda Craig	Regional Lead for PCE	[redacted]
	Dalrene Masson	PCE Facilitator	[redacted]
	David Todd	Project Support	[redacted]
BHSCT	Barry Murtagh	PCE Facilitator	[redacted]
NHSCT	Sarah Arthur	PCE Facilitator	[redacted]
SEHSCT	Emma Campbell	PCE Facilitator	[redacted]
SHSCT	Mairead Casey	PCE Facilitator	[redacted]
WHSCT	Vi Gray	PCE Facilitator	[redacted]

6.2 Appendix 2. Context of returns

(a) Trust Returns (n=82)



(b) Who responded? (n=82)



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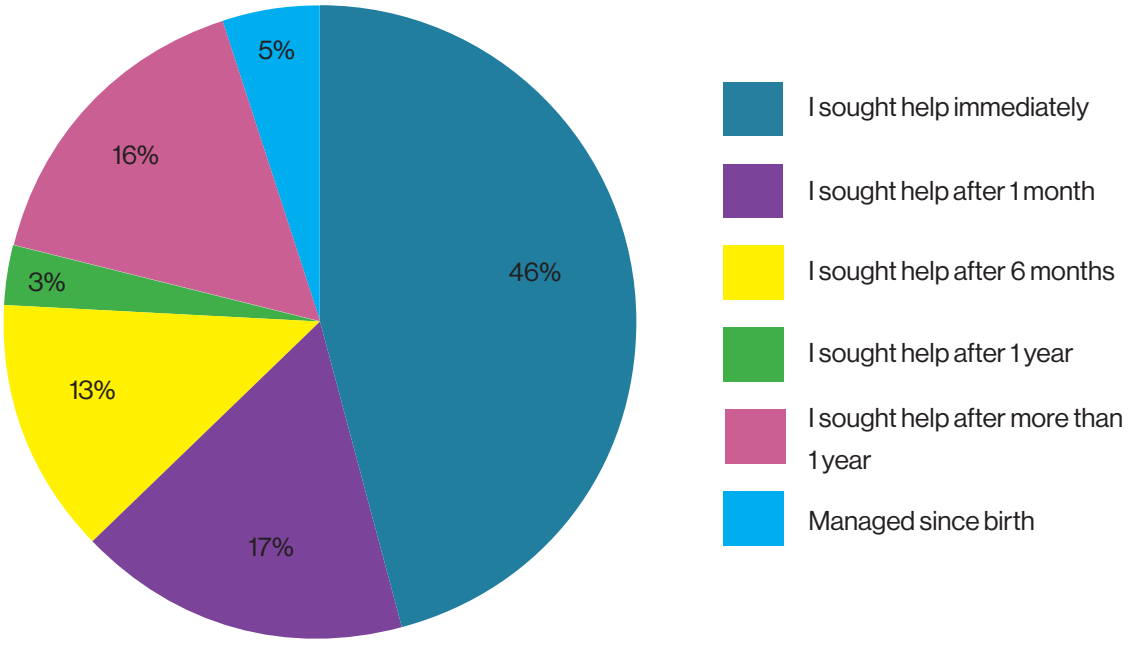
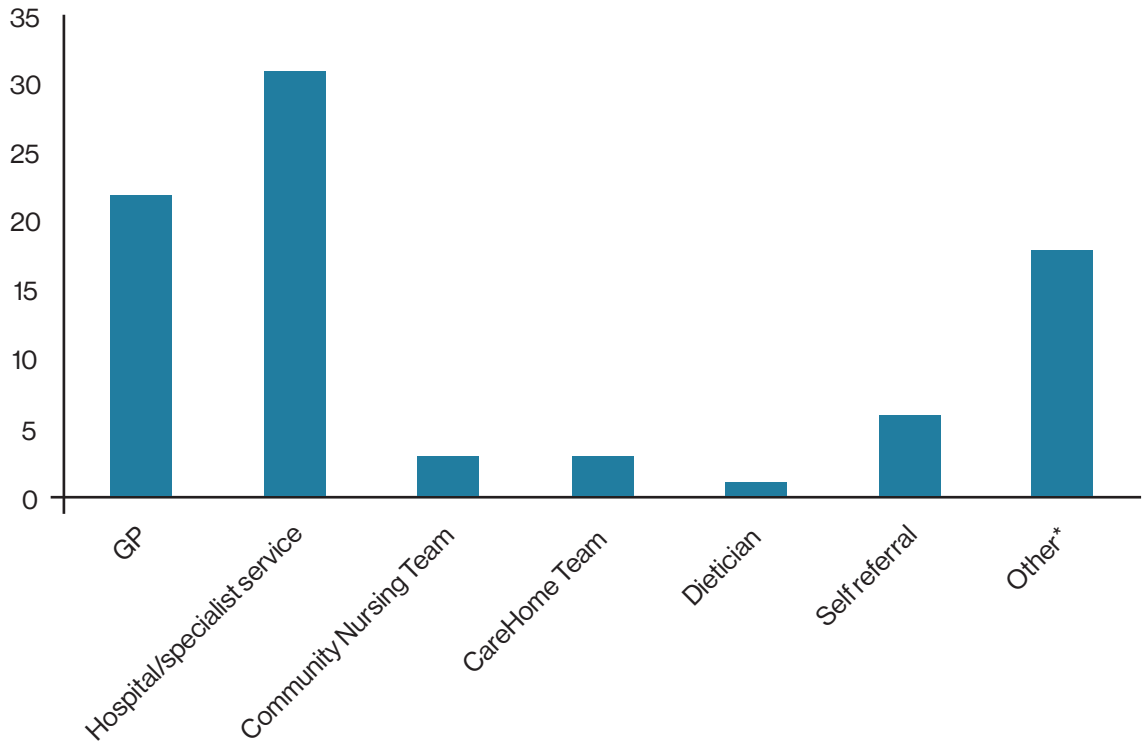
(c) When did the person seek help for their swallowing difficulty? (n=82)



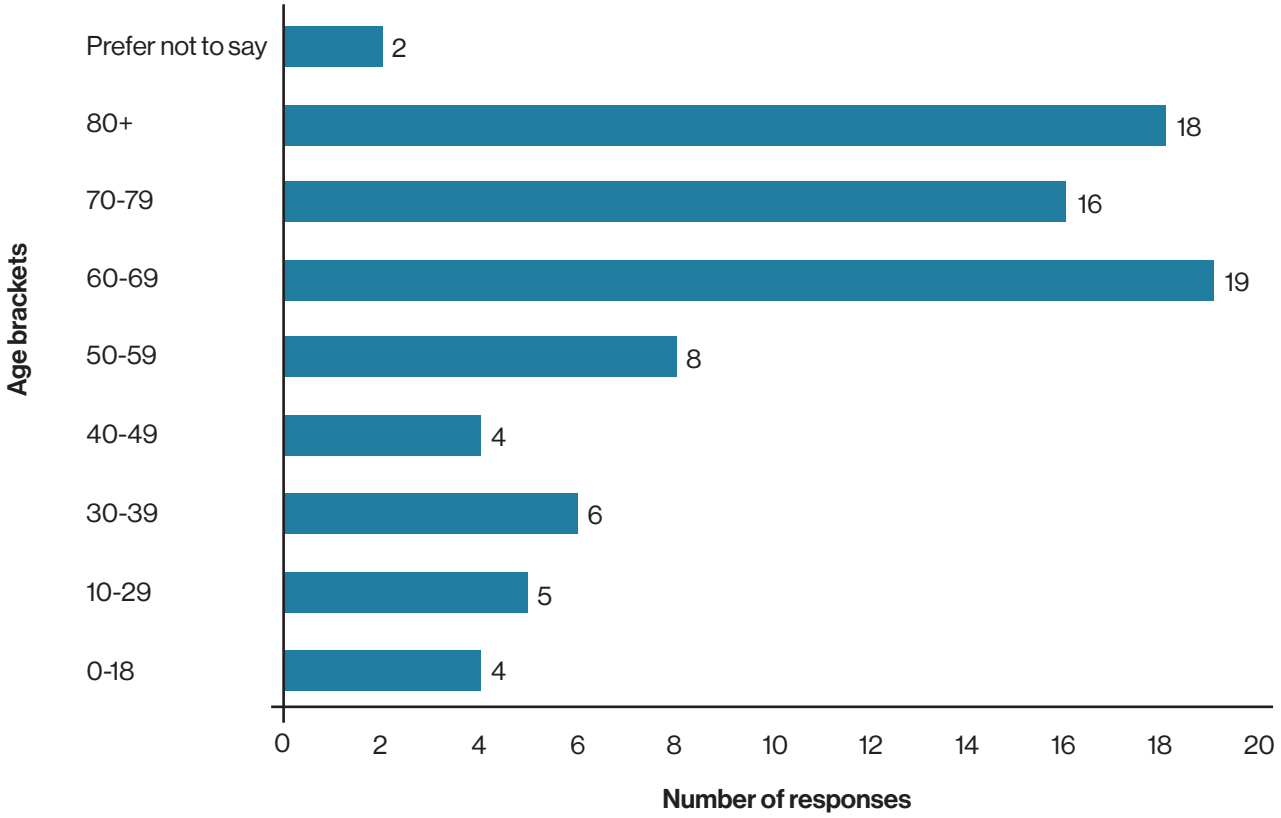
(d) Where did you first seek help? (n=82)



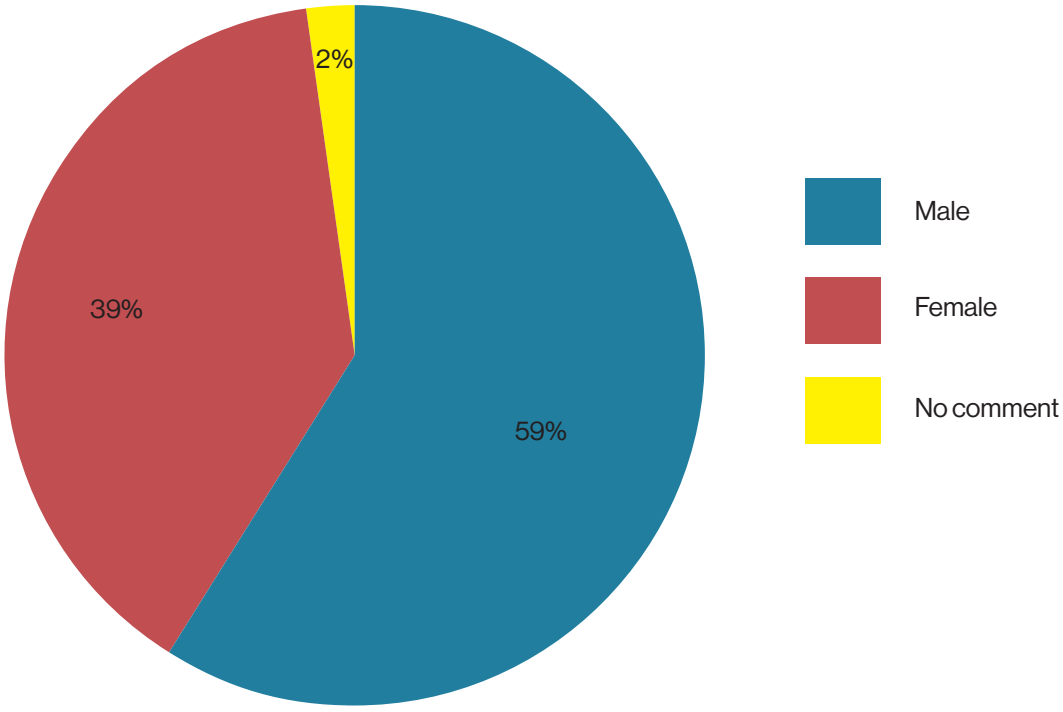
(*other includes Occupational Therapy, Day Care Centre, Social Work)

Appendix 3. Demographics

(a) Age of person with swallowing difficulties (n=82)



(b) Gender (n=82)



(c) Country of Birth (n=82)

Northern Ireland	75
England	5
Republic of Ireland	1
Elsewhere	1

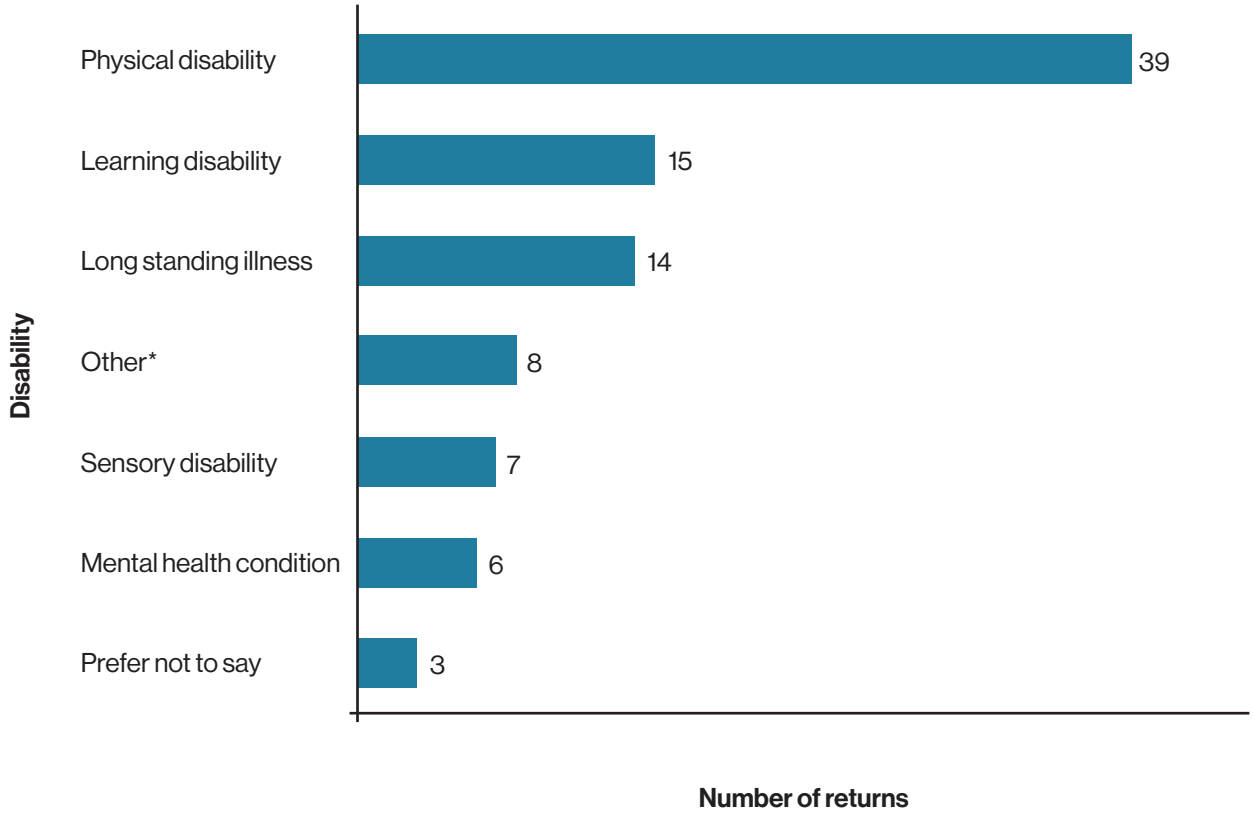
(d) Sexuality (n=82)

Heterosexual	75
Homosexual	0
Other	1
No comment	6

(e) Do you have a disability according to the stated definition (n=82)

Yes	55
No	21
Prefer not to say	6

(f) Which of the following do you identify with? (respondents can select more than one)



*heart attack, kidney failure, Motor Neurone Disease, Stroke, Neurological, Dementia

Swallow Aware

The Regional Team for 10,000 More Voices can be contacted by:

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HSC Public Health Agency

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03/21

LEARNING MATTERS

ISSUE 18
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Welcome to this Special Edition (issue 18) of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

HSC Health and Social Care

QUALITY 2020

Special Edition Learning Matters: Risk of serious harm or death from choking on foods

Background

Welcome to this Special Edition Learning Matters Newsletter on risk of serious harm or death from choking on foods. This edition will focus on the serious patient safety issue of choking, which unfortunately remains a prevalent public health concern for the Northern Ireland adult population. From 2016 to the present day, there have been **23** choking related Serious Adverse Incidents (SAIs) reported across Health and Social Care (HSC) and the private and independent sector. Of these 23 SAI's, 21 have tragically resulted in death due to choking. Five of these SAIs have occured since February 2021.

In addition, there have been approximately **1383** choking related Adverse incidents (AI's) reported across Northern Ireland HSC Trusts (2016-Feb 2021).

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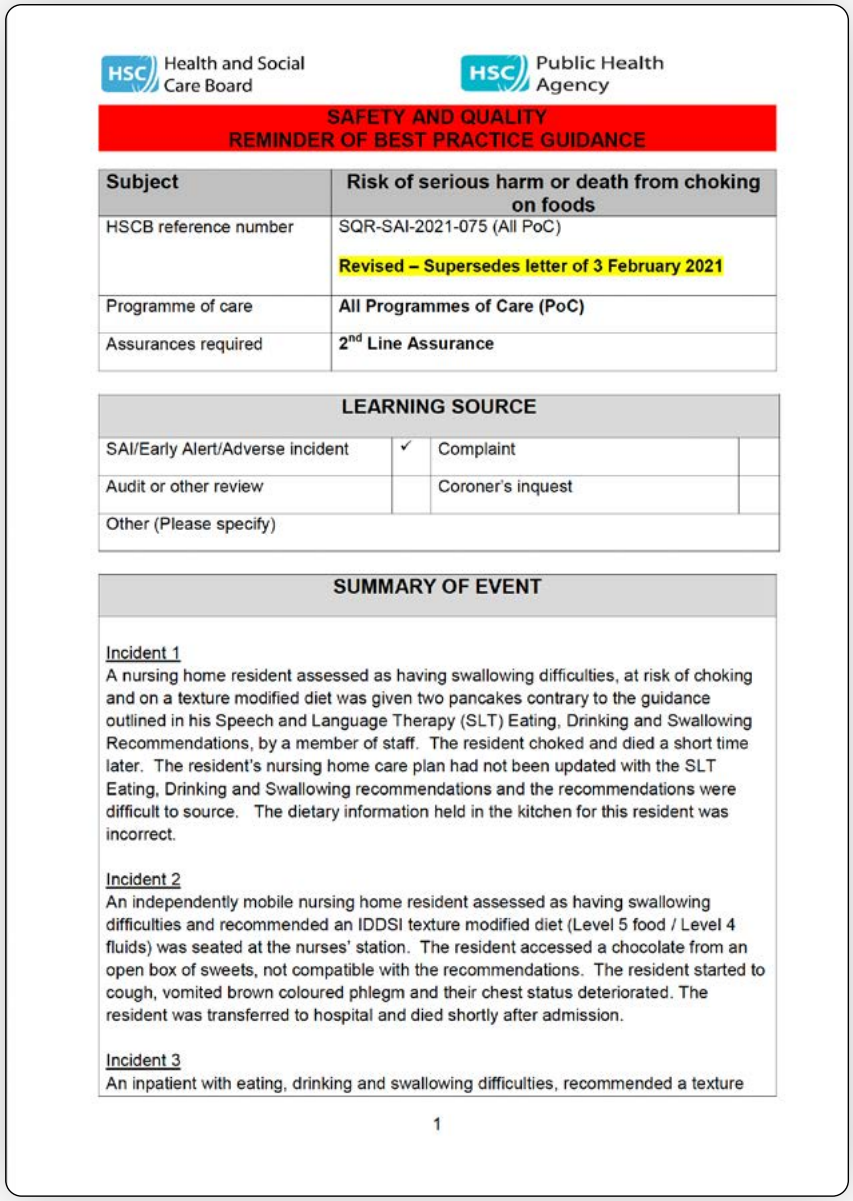
Recent regional learning issued in relation to harm from Choking

On 3rd February 2021, the HSCB / PHA issued a Safety and Quality Reminder of Best Practice Guidance Letter – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075)[1]

The letter outlined five choking serious adverse incidents attributed to a failure to recognise and support the needs of people with eating, drinking and swallowing difficulties and at risk of choking. **Six key learning points/recommendations** for all health and social care staff involved with supporting the care of adults and children who present at risk of eating, drinking and swallowing (EDS) difficulties were highlighted. This letter was reissued in June 2021 to include all Programmes of Care.

Whilst much regional work has been undertaken to maximise the safety of people with EDS difficulties, the ongoing deaths as a result of choking remain unacceptably high. In response to the Safety and Quality Reminder of Best Practice Guidance letter, the Chief Medical Officer (CMO) wrote to the HSCB and PHA outlining extreme concern at the preventable deaths which continue, despite previous interventions and guidance issued.

This Special Edition Learning Matters is part of this work and aims to keep the spotlight on this serious patient safety concern. Health and Social Care staff must be aware of the **6 recommendations** for all staff involved with supporting the care of adults and children who present at risk of choking.



HSC Health and Social Care Board
HSC Public Health Agency

SAFETY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE

Subject	Risk of serious harm or death from choking on foods
HSCB reference number	SQR-SAI-2021-075 (All PoC) **Revised – Supersedes letter of 3 February 2021**
Programme of care	**All Programmes of Care (PoC)**
Assurances required	**2nd Line Assurance**

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

SUMMARY OF EVENT

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

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

Incident 3
An inpatient with eating, drinking and swallowing difficulties, recommended a texture

1

1 Safety and Quality Reminder of Best Practice Guidance – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075)

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SAFEY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE LETTER: RISK OF SERIOUS HARM OR DEATH FROM CHOKING ON FOODS - KEY LEARNING

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

- SAFETY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE Letter 'Risk of serious harm or death from choking on foods' (SQR-SAI-2021-075) outlines **six recommendations** for all staff involved with supporting the care of adults and children who present at risk of eating, drinking and swallowing difficulties. They are:

1. When a person has identified eating, drinking and swallowing difficulties this should be centered on an **up to date** Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet, within individual care plans.
2. Clear mechanisms for the **communication** of swallowing recommendations to those who are providing food or caring directly for individuals with swallowing difficulties should be in situ within the care setting, including when transferring between locations, include all staff (domestic and catering staff) and where appropriate families and visitors. Nil By Mouth signs should be clearly visible to all staff.
3. The needs of individuals with swallowing difficulties should be **communicated at pivotal times**; handover, meal and snack times, if people move facilities, attend day centres or go out in the care of others.
4. The development of a process for a **safety pause** before any meals and snacks should be considered e.g. "what patient safety issues for meal and snack times do we need to be aware of today?"
5. Ensure foods or fluids that pose a risk to individuals with eating, drinking and swallowing difficulties are stored securely.
6. The **training** and **development** needs of staff providing care for individuals with eating, drinking and swallowing difficulties should be identified and arrangements put in place to meet them.

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Serious Adverse Incidents reported since February 2021

Since issuing the Safety and Quality Reminder of Best Practice Guidance Letter in February 2021, six further SAIs have been reported to the HSCB/PHA. An overview of those with regional learning are provided below:

- A resident in a Private Nursing Home was passing a tea trolley in the corridor which had a plate of buns on it. The resident ate one of the buns. Five minutes later they were found choking by a member of staff in the corridor. An ambulance was called and the resident was transferred to hospital. The resident had a Speech and Language Therapy (SALT) care plan which recommended their food as IDDSI Level 6 (soft, "Food should be cut into small pieces (no bigger than 1.5cm)". The resident required supervision at meal times as they were identified as being at risk of choking. The resident's capacity regarding their dietary needs had not been assessed. Sadly the resident was pronounced dead a short time later.

- A hospital inpatient was not provided IDDSI Level 1 (Slightly Thick Fluids) from admission and 5 days later they experienced a choking episode. They were commenced on antibiotics for pneumonia/aspiration. The patient's family advised that they should have been on IDDSI Level 1 from the outset. The patient deteriorated and sadly passed away.

- A patient with a history of aspiration and diagnosis of dysphagia was transferred between sites within a hospital. Nursing handover noted a requirement for modified diet and fluids. Speech and Language Therapy Eating Drinking and Swallowing Recommendations could not be located. The patient aspirated on food which did not meet the Speech and Language Therapy recommendations. The patient's condition deteriorated and they were transferred for medical management.

- An inpatient in an acute mental health care setting was discovered unresponsive and sitting on the bed in a lent over position by nursing staff. Food was observed on the person's shoulder. CPR was commenced and the patient was transferred to the Intensive Care Unit. The patient died eight days later and the cause of death was recorded as cerebral hypoxia secondary to cardiac arrest which resulted following choking on food. The patient had been recommended an IDDSI Level 7 diet at the time of the incident and food intake was to be supervised.

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

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Current Guidance

Current guidance relevant to these Serious Adverse Incidents which all Health and Social Care workers must be aware of is:

1. International Dysphagia Diet Standardization Initiative
2. In 2018 NHS Improvement issued Patient Safety Alert NHS/PSA/RE/2018/004 “Resources to support safer modification of food and drink” detailed at
   HSC (SQSD) 16 18 - Resources to support safer modification of food and drink (hscni.net)

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Fundamentals of Care – Identifying and supporting the needs of people with Eating Drinking and Swallowing (EDS) difficulties

The following measures will support identification of EDS difficulties and the complex needs of people at risk of choking. In adult inpatient care settings all registered nursing staff must ensure that every patient has a robust Person-centred Nursing Assessment and Plan of Care completed on admission. The section on Eating and Drinking (see below) must be accurately completed to ensure early identification of any eating, drinking and swallowing difficulties, support referral to Speech and Language Therapy for further assessment and /or support identification of any existing SLT recommendations.

Eating and drinking

Person – All About Me	Assessment
Able to eat and drink: ☐ Independently ☐ Help required ☐ Full assistance	Nil by mouth ☐ Yes ☐ No Last ate: _____ Last drank: _____
Difficulty swallowing: ☐ Yes ☐ No	
Appetite: ☐ Good ☐ Fair ☐ Poor	Enteral feeding: ☐ Yes ☐ No
Appetite change: ☐ Yes ☐ No	Type of feed:
Dietary Requirements/Modifications including preferences:	Regime:
	Route/ Device type:
Food intolerances:	Size:
	Frequency of change:
Do you wear dentures: ☐ Yes ☐ No	Date next change due:
Top present: ☐ Yes ☐ No	Are you taking oral steroids: ☐ Yes ☐ No
Bottom present: ☐ Yes ☐ No	Do you wish to be involved in your insulin administration: ☐ Yes ☐ No ☐ NA
Secure fitting: ☐ Yes ☐ No	If Yes, Person able and agrees to administer insulin under supervision: ☐ Yes
Diabetes: ☐ Type1 ☐ Type 2 ☐ None	
Controlled by: ☐ Diet ☐ Tablet ☐ Hormone ☐ Insulin	
Other: _____	

Figure one: Person-centred Nursing Assessment and Plan of Care

All other healthcare settings

For all other health care settings that do not use the inpatient Person-centred Nursing Assessment and Plan of Care document, such as nursing and residential settings, the same principles must apply and the regional Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet (REDS) must be central to safe management of the person's needs.

Interface between primary and secondary care

All relevant healthcare staff must ensure effective communication between the primary and secondary care interface, regarding any patients/clients who have identified eating, drinking and swallowing difficulties. An up to date Speech and Language Therapy Eating, Drinking and Swallowing Care Plan specific to their needs, must be in place.

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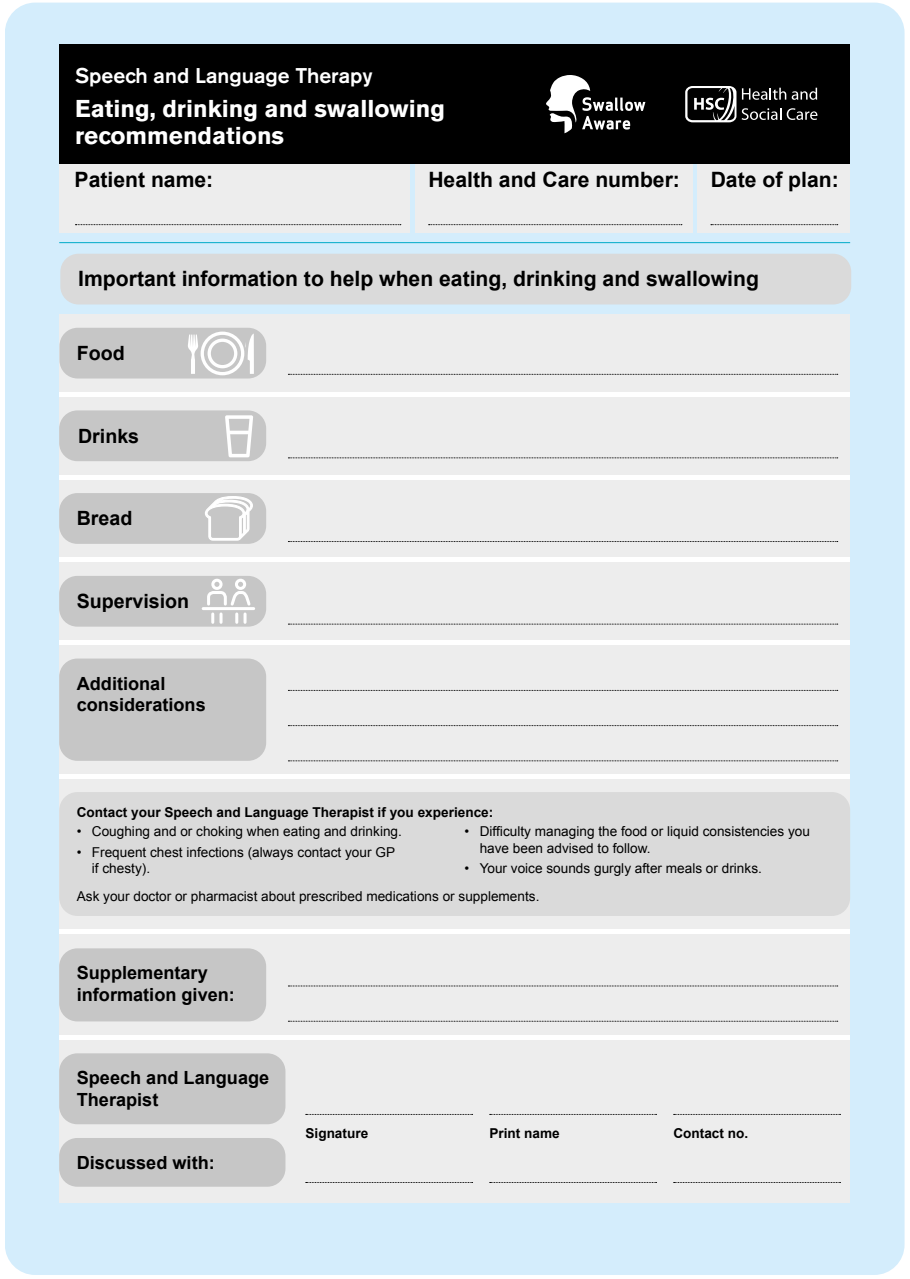
The Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet

FOR ALL STAFF: When a person has identified eating, drinking and swallowing difficulties this MUST be centred on an up to date Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet. This document is central to supporting the needs of people with dysphagia. Robust communication and meal time systems must be in place to support its implementation and communicated widely with all staff.

For adults, the Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet (REDS) was launched in October 2021, to help maximize the safety of people with EDS difficulties.

This document must be kept in its **original format** and **not translated or modified!**



Speech and Language Therapy
Eating, drinking and swallowing recommendations

Swallow Aware

HSC Health and Social Care

Patient name:	Health and Care number:	Date of plan:

Important information to help when eating, drinking and swallowing

Food	
Drinks	
Bread	
Supervision	
Additional considerations	

Contact your Speech and Language Therapist if you experience:

- Coughing and or choking when eating and drinking.
- Frequent chest infections (always contact your GP if chesty).
- Difficulty managing the food or liquid consistencies you have been advised to follow.
- Your voice sounds gurgly after meals or drinks.

Ask your doctor or pharmacist about prescribed medications or supplements.

Supplementary information given:			
Speech and Language Therapist	Signature	Print name	Contact no.
Discussed with:			

Figure two: Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet

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Staff roles and responsibilities in supporting people with EDS difficulties.

Dysphagia NI has developed guidance on the roles and responsibilities of Health and Social Care staff in supporting the safety of people with eating, drinking and swallowing difficulties. The regional document can be accessed at the following link: 'Are you caring for someone with Eating, Drinking and Swallowing difficulties?'

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Other Key Patient Safety Alerts

1. Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder

In 2015, NHS England issued a Patient Safety Alert on Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder (health-ni.gov.uk). This alert was issued following an incident where a care home resident died following the **accidental ingestion** of the thickening powder that had been left within their reach. Thickening powder formed a solid mass which caused fatal airway obstruction.

Whilst it is important that thickening products remain accessible, all relevant staff must be aware of **potential risks to patient safety**. **Appropriate storage and administration** of thickening powder needs to be embedded within the wider context of protocols, bedside documentation, training programmes and access to expert advice required to safely manage all aspects of the care of individuals with dysphagia.

2. Polyethylene glycol (PEG) laxatives and starch-based thickeners: potential interactive effect when mixed, leading to an increased risk of aspiration

In April 2021 the Medicines and Healthcare Products Regulatory Agency (MHRA) issued their Drug Safety Update volume 14, issue 9: April 2021: 1. Of note:

- There have been reports of a possible **potential harmful interaction** between **polyethylene glycol (PEG) laxatives and starch-based thickeners** when they are mixed together.
- Combining the two compounds can counteract the thickening action and result in a thin watery liquid — patients with swallowing difficulties (dysphagia) are potentially at **greater risk of aspiration** of the thinner liquid.
- **Avoid directly mixing together PEG laxatives and starch-based thickeners**, especially in patients with dysphagia who are considered at risk of aspiration, such as elderly people and people with disabilities that affect swallowing.
- Report suspected adverse drug reactions (ADRs) to the Yellow Card Scheme

3. Risk to patient safety: prescribing and dispensing thickeners and thickened oral nutrition supplements

HSCB has received reports of adverse incidents where people with dysphagia received thickeners or thickened oral nutritional supplements that were not suitable for them. Reasons for this include:

1. Parallel imported products were dispensed from community pharmacies that could cause confusion and increased risk to patient safety; these include thickening products that are not IDDSI compliant and thickened oral nutritional supplements in packs using older “Stage” terminology rather than the new “Level” description.

2. GPs prescribe these products on the recommendation of a SLT or dietitian. Non-specific product descriptions e.g. “Thickening product” may result in an inappropriate product being prescribed. Product details should be clearly described in letters of recommendation to avoid any confusion.

People with dysphagia must receive IDDSI compliant food and fluid consistencies and IDDSI compliant products to reduce the risk of complications such as choking and aspiration. See letter issued from HSCB ‘Risk to patient safety: Parallel imports of thickeners and thickened oral nutritional supplements’

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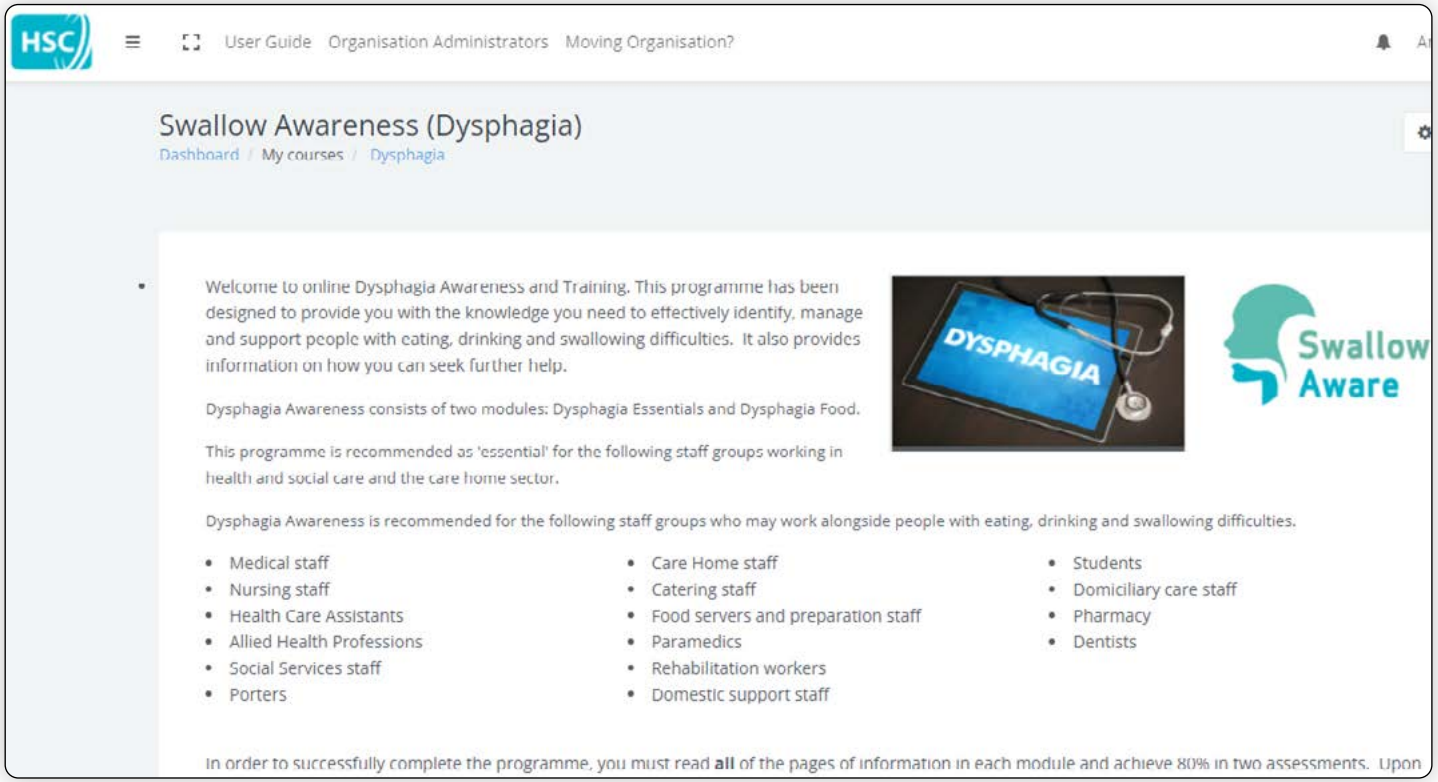
REGIONALLY ENDORSED E-DYSPHAGIA AWARENESS TRAINING TO SUPPORT STAFF:

One of the 6 recommendations of the Safety and Quality Reminder of Best Practice Guidance letter is to ensure the training and development needs of staff providing care for individuals with eating, drinking and swallowing difficulties are identified and arrangements put in place to meet them. To support this recommendation, it is advised that staff access regionally endorsed e-Dysphagia Awareness training via the HSC Learning Centre. This training has been designed to help all staff identify, support and manage the needs of people at risk of choking and / or eating, drinking and swallowing difficulties. This e-learning programme is available at: Dysphagia (hsclearning.com)



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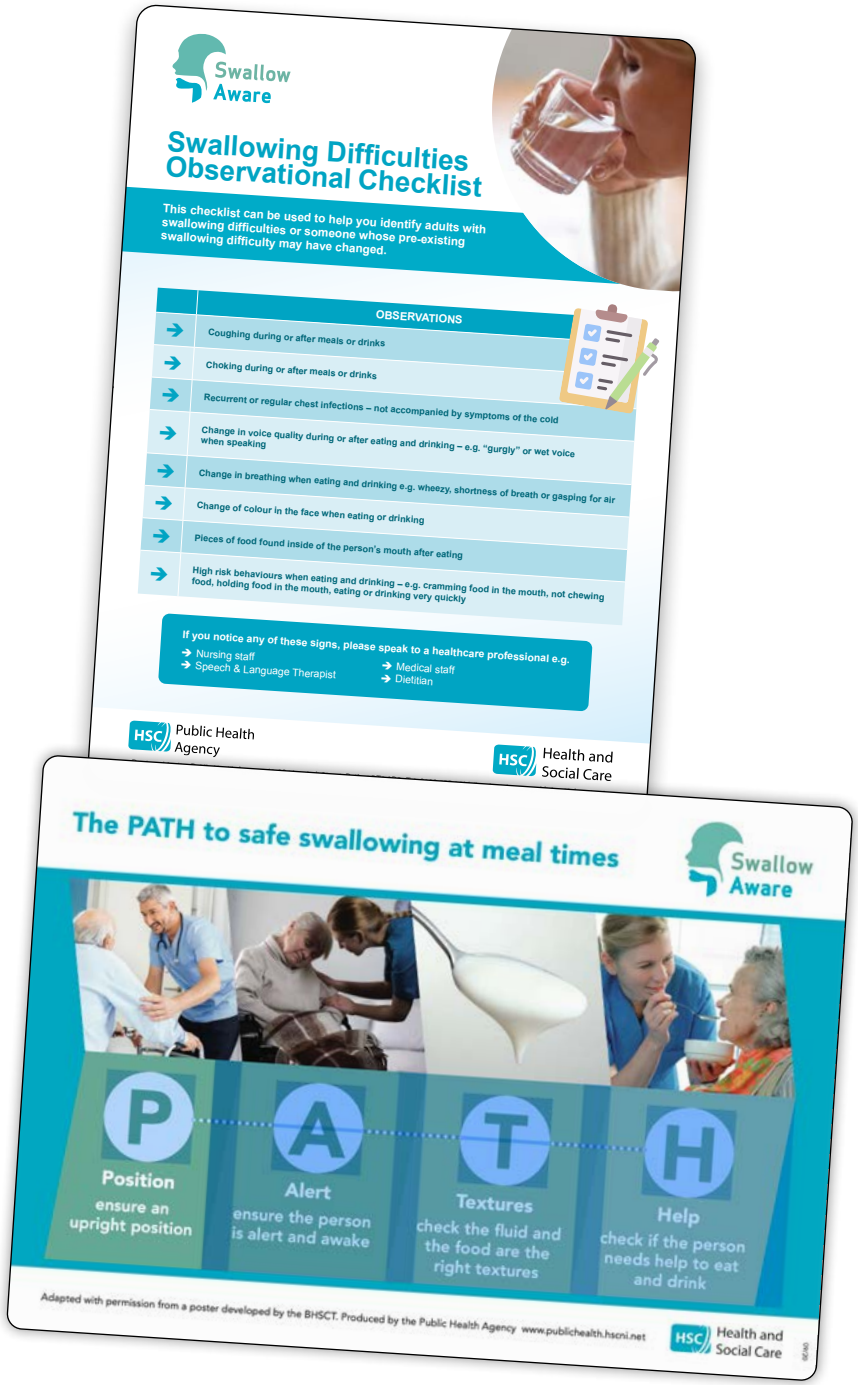
Practical resources to support staff:

- International Dysphagia Diet Standardization Initiative IDDSI - Home
- Resuscitation Council UK (2021), Choking Guidance; available at: Adult Choking Algorithm 2021.pdf (resus.org.uk)
- Resuscitation Council UK (2021), Paediatric Choking Guidance; available at: Paediatric Choking Algorithm 2021.pdf (resus.org.uk)
- Dysphagia Northern Ireland, Public Health Agency, practical resources to support staff available here: Dysphagia | HSC Public Health Agency (hscni.net)
- Staff Roles and Responsibilities supporting people with EDS
- **Swallowing Difficulties Observational Checklist** – a checklist to help staff identify adults with swallowing difficulties or someone whose pre-existing swallowing difficulty may have changed
- **PATH Resource** – Position, Alert, Textures, Help – feeding support for carers and staff to support safe swallowing at mealtimes



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Practical resources to support staff:

- How to Help People with Swallowing Difficulties Keep Their Mouths Clean – guidance for carers and staff to support oral hygiene for people with swallowing difficulties
- Dysphagia Adverse Incident Trigger List – Information for staff on reporting swallowing related incidents or "near misses" using local risk management systems
- NI Formulary Website Poster – Medication information for adults with swallowing difficulties – everything at just one click for healthcare professionals, patients and carers

If you have any comments or questions related to this Special Edition of Learning Matters please get in contact by email at learningmatters@hscni.net

All previous editions of the Learning Matters Newsletter can be accessed here:
Learning Matters Newsletters | HSC Public Health Agency (hscni.net)

Health and Social Care

YOU IN MIND

A Guide to Mental Health Psychological Therapies

Equality Statement

In line with Section 75 of the Northern Ireland Act 1998, Psychological Therapies Services will be provided and available to all irrespective of gender, ethnicity, political opinion, religious belief, disability, age, sexual orientation, and dependant, marital status. The services are designed to diagnose, treat and improve the well-being of all those people requiring mental health care.

Psychological Therapies Services have a duty to each and every individual that they serve and must respect and protect their human rights. At the same time, Psychological Therapies Services also have a wide social duty to promote equality through the care it provides and in the way it provides care. This includes addressing the needs of those groups or sections of society who may-be experiencing inequalities in health and well-being outcomes.

This Guide can be provided in alternative formats including: written information in the preferred language and/or an accessible format and interpretative services can also be provided by Trusts.

March 2015

Contents

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Rodney Morton	Health and Social Care Board

1.0 Purpose and Context

The case for improving access to Psychological Therapies is well evidenced and researched. The Bamford Strategies, the Department of Health, Social Service and Public Safety (DHSSPS) Psychological Therapies Strategy, the revised Mental Health Services Framework and Mental Health National Institute for Health and Care Excellence (NICE) Guidance all make a compelling argument for delivering evidence based psychological therapies.

This message is further reinforced in Transforming Your Care (2011). Transforming Your Care aims to shift investment into care that works, and which delivers a better outcome. Central to this objective is the emphasis on prevention and early intervention. Improving access to psychological therapies is a fundamental component of recovery and is critical to the successful implementation of the Stepped Care Model for people with mental health problems.

In June 2010, the Department of Health, Social Services and Public Safety (DHSSPS) launched its strategy for the development of Psychological Therapy Services. The strategy recommends the development of psychological therapies "as a core component of mental health and learning disability services" (DHSSPS, 2010). The strategy requires Health and Social Care (HSC) Trusts to:-

1. Improve access to evidenced based psychological therapies by embedding these therapies into all mental health care pathways.
2. Standardise service models and integrate the delivery of psychological therapy services across primary care and secondary mental health care services.
3. Provide information on the all those therapies as recommended by NICE Clinical Guidelines.
4. Match a person's need with the right level of intervention.
5. Provide accredited training in line with NICE approved psychological therapies.
6. Provide supervision and support practitioners to undertake session by session measurement and routinely capture outcomes by using validated outcomes tool.

It is within this context that this guidance has been developed and is designed to strengthen and embed psychological therapies into practice across all Mental Health Services.

2.0 How to read this document

This Guide should be read in conjunction with the new You in Mind Regional Mental Health Care Pathway. http://www.hscboard.hscni.net/mentalhealth/

It is also important that practitioners also read the relevant National Institute for Health and Care Excellence (NICE) Clinical Guidelines in the development of Personal Well-being Plans.

This document provides a model for understanding the provision of psychological therapies at all levels of need and severity with respect to psychological well-being. The model is predicated on a whole systems approach to mental health and encompasses Primary Care, Specialist Mental Health Services and Community/ Voluntary provision. It is based on matching an individual needs to specific steps of care and therapies as outlined in Section 4.0.

The document also includes a condition specific mental health psychological therapist matrix, which guides practice and referrals from primary care to specialist services.

It is important to note that for more specialist conditions many of the therapies documented in this guide will apply. Specialist treatment however, will be detailed in separate treatment/ condition-specific care pathways.

HSC Trusts will be required to embed this guidance across Mental Health Services including all services commissioned and provided by community, voluntary and independent sectors.

3.0 Guiding Principles and Improving Outcomes

3.1 Guiding Principles

The development and implementation of this guide is based on four core principles:-

1. Person Centred Approach - any psychological intervention needs to be personalised and reflect a persons preferences. People who need psychological therapies should have the opportunity to make informed decisions about their care and the types of intervention available. At the heart of person centred care is an understanding that decisions about care options should be co-produced. Co-production is a fundamental partnership principle.

2. Recovery Strengths Based Approach - “Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are on-going or recurring symptoms or problems”. (Shepherd, Boardman and Slade 2008)

3. Goals Oriented Approach - which focuses on delivering outcomes in line with best evidence, and personal expectations and which enable long term sustainable recovery.

4. Improving Experience and Outcome Based Approach - at the core of this guide is the drive to improve the experience of care and outcomes for individuals with mental health needs. The following key outcomes are sought:-

- Improved access to information about all those therapies which can help recovery;
- Involvement of the person and/or their families, and/or friends or nominated carer in all stages of the care process, from consultation, through to the formulation of needs and development of the Personal Well-being Plan;
- Positive impact on psychological social social/educational/ occupational settings.
- Improved experience of therapy, support arrangements and of community life;
- Individual goals are met;
- Higher levels of individual and family satisfaction;
- More personal control;
- Improved quality of life;
- Included as a valued and respected member of society.

4.0 Definitions, Thresholds and the Stepped Care Model

4.1 Definitions

The term Psychological Therapies is an umbrella term for a range of approaches, while therapies differ, all psychological therapies will require the person to talk with a therapist who has specialised training.

The focus of psychological therapy will often be on a particular issue that causes distress or difficulties in daily functioning, with the aim that treatment helps with symptoms, increases a person's understanding of their issues and/or enhances a persons overall well-being.

The following table outlines the range of therapies which are available across primary and/or secondary care mental health services. The choice of therapy will depend on the individuals presenting needs and the evidence of effectiveness in responding to the specific needs.

4.2 Overview of Key Psychological Therapies

Therapy Type	Therapy Description	Therapy Can Help
Bibliotherapy and Computerised Cognitive Behavioural Therapy (Self-directed Self- Help Based Approaches)	**Computerised Cognitive Behavioural Therapy (CBBT)** is designed the help resolve unhealthy thinking, behaviour and emotional responses to life events. Computerised CBT is provided through a website, CD or DVD. **Bibliotherapies** are self-help resources such as books, audio tapes, pamphlets, play scripts, journals, poems, songs, and stories adapted from cinema and television. These resources are educational in nature, and help create personal insights, facilitate understanding, support healthy lifestyle and assist in the restructuring of thinking, therefore enabling self-discovery and personal growth. These therapies can be offered on their own or alongside other psychological treatments and interventions.	NICE recommend these types of therapy for the treatment of mild anxiety, mild depression, mild obsessive compulsive disorders, relationship problems, managing emotional response to health care problems, dealing with difficult adverse life events, stress and in addressing unhealthy life style habits which contribute to poor emotional health.

Therapy Type	Therapy Description	Therapy Can Help
Humanistic – Person Centred Counselling	**Humanistic therapies** are an umbrella term for several therapies that focus on human development and personal growth. Often used to refer to person-centred counselling, it can also refer to Gestalt Therapy, Existential Therapy and Transactional Analysis. These types of therapy recognise the variety of human needs and tend to focus on the person rather than the problem. Humanistic therapy adopts the position that the person often holds the key to solving their own particular problems. Person-centred counselling tends not to follow an agenda or involve set tasks, but instead involves active listening from the therapist creating space to speak about their feelings and their problems and to reflect. For this type of therapy individual experience is the main focus and helps person to increase their personal understanding and resolve difficulties.	Humanistic Therapies/Person Centred Counselling can be used to treat a range of personal problems such as depression, bereavement, anxiety and substance misuse.
Cognitive Behavioural Therapies (CBT)	**Cognitive Behavioural Therapy (CBT)** is one of the best researched therapies and views problems as arising from beliefs and patterns of behaviour which are learnt across the course of a person's life. This type of therapy looks at unhelpful thoughts, emotions and behaviours, and aims to overcome any problems that arise from these. CBT focuses on the here and now by exploring the cycles and patterns of behaviour that keep a problem going. CBT can help the person overcome difficulties by restructuring thinking, behaviour and emotional responses.	NICE recommend this type of therapy for treating a range of problems including depression, anxiety, panic disorders, phobias, obsessive compulsive disorder, addictions, grief and managing long-term illnesses. There is also evidence for the effectiveness of adapted CBT-based programmes in the treatment of complex disorders such as Psychosis, Schizophrenia, Bi Polar Disorders, Post-Traumatic Stress Disorder and Bulimia Nervosa.

Therapy Type	Therapy Description	Therapy Can Help
Psychodynamic / Psychotherapy	**Psychodynamic Psychotherapies** refer to a set of approaches that see problems as a result of the link between the present and past. It looks to help understand intense unmanageable feelings that people may not even be aware of. This type of therapy can explore early childhood experiences and sees how these have influenced a person's development. This model works towards understanding the underlying cause of a particular problem. Psychodynamic therapy involves helping the person to understand of the interactions between a person's thought patterns, behaviours and emotions and improves personal awareness of what is happening consciously and unconsciously. It can also involve investigating patterns of conflict, blocks to personal growth or unresolved difficulties that may cause distress. Treatment is generally conducted over a longer period (over a year) and is less likely to be structured. This type of therapy can also focus more on the feelings and what is happening within the therapy room (i.e. the process) and will involve provision of interpretations or critical insights that a person maybe overlooking.	NICE recommends psychodynamic therapy for people experiencing depression and other deep seated complex mental health problems. There is evidence for it being effective in treating a range of other problems especially when other structured therapies have not worked in the past.

Therapy Type	Therapy Description	Therapy Can Help
Dialectic Behaviour Therapy (DBT)	**Dialectic Behaviour Therapy (DBT)** is a version of CBT combined with meditation techniques developed for disorders where people suffer from extreme mood swings, intense feelings interpersonal conflict and experience impulsive behaviours. This approach follows CBT's goal of tackling unhelpful ways of thinking and behaving, but also includes techniques about being able to tolerate intense distress and working towards self-acceptance. DBT also uses mindfulness and meditation techniques to enable the person to learn to focus their attention on what is happening in the current moment and learning strategies to deal with difficult emotions, developing self-care skills, as well as learning to be able to interact better with other people.	NICE recommends DBT for persistent binge Eating Disorder and for people with Personality Disorders and for those who are suicidal and self-harm.

Therapy Type	Therapy Description	Therapy Can Help
Interpersonal Therapy (IPT)	**Interpersonal Therapy** explores interconnection between a person's thoughts and feelings and how they relate to other people. IPT focuses on issues that develop between people in a social context. It is particularly suited for people who have repeated difficulties with social interactions or relationships. In particular, IPT is tailored towards exploring changes in life (e.g. retirement, changes in health), bereavement and loss, conflicts with other people, and how people maintain relationships. The focus of the therapist will be in the present, and therapy usually involves exploring communication style, practicing skills using role plays or learning problem solving strategies.	NICE recommends this for people with Eating Disorders various forms of depression, anxiety grief reactions, as well as those who experience interpersonal and communication difficulties.
Mindfulness Based Therapies	**Mindfulness Based Therapies** combine psychological therapies with meditation. The approach enables greater psychological and personal self-awareness, and helps the person to better manage negative thoughts and feelings so that they have much less impact and influence over behaviour. Other versions of this treatment include mindfulness based stress reduction and mindfulness-based cognitive therapy.	NICE recommends this treatment in prevention of recurring depression and when used in conjunction with other therapies aid mental health recovery.

Therapy Type	Therapy Description	Therapy Can Help
Eye movement Desensitisation and Reprocessing (EMDR)	**Eye Movement Desensitisation and Reprocessing (EMDR)** is a therapy which involves stimulating the brain through eye movements and evidence shows that this makes distressing memories feel less intense.	NICE recommends this treatment for Post-Traumatic Stress Disorder. It is used for a range of traumas, including past sexual, physical or emotional abuse, adverse life events, accidents and injuries, phobias, addictions and fear of performing in public.

Therapy Type	Therapy Description	Therapy Can Help
Systemic Therapies - Family and Couples Therapies	**Systemic therapy** (sometimes known as couples therapy or family therapy) looks at how people interact with each other, in family or relationship. Unlike other forms of therapy that usually only work with an individual, systemic therapy works with couples or entire families. Systemic therapy looks at the various perspectives of the people involved in the family/relationships and explore those interpersonal dynamics which contributing to personal problems. The therapy helps to build a shared understanding of complicated relationships, and use these to work towards finding solutions. This kind of therapy can be helpful in resolving deep seated interpersonal conflicts through identifying and understanding thinking and behavioural patterns which give rise to unhealthy emotional responses.	NICE recommends family therapy for Anorexia Nervosa, Depression, families of people with Addictions, Schizophrenia, Bi-Polar Disorders. NICE recommends 'couples therapy' if partners have tried individual therapy and this has not helped. Research also suggests that systemic therapies are effective in dealing with family based problems around disruptive behaviour such as conduct disorder, drug abuse and marital distress and for addressing the intergenerational impact of trauma.
Motivational Interviewing	**Motivational Interviewing (MI)** is a way of talking about things you may be sensitive about that doesn't feel threatening. The therapy focuses on your hopes and ambitions and problems that could stop you reaching your goals.	NICE recommends this for people with a mental health problem who have problems with alcohol or substance misuse.

Therapy Type	Therapy Description	Therapy Can Help
Cognitive Analytic Therapy (CAT)	**Cognitive Analytic Therapy (CAT)** integrates aspects of CBT and psychodynamic therapies to provide a problem focussed approach. The therapy explores early life experiences and persons relational style. The therapy analysis the reciprocal roles, behaviours and feeling when people have adopted conflicting positions. CAT adopts a collaborative framework with the persons and helps identify and create understanding of patterns of unhelpful behaviours, as well as how sequences of events or thoughts can lead to the development of problems. Once these have been recognised, the person is facilitated to learn new, more helpful methods of coping.	The evidence base for CAT is not as wide as other therapies, but there is emerging support for its effectiveness in treating anxiety, eating disorders, mood swings and interpersonal difficulties, and other conditions where interpersonal interactions may play a role.

Therapy Type	Therapy Description	Therapy Can Help
Solution Focused Brief Therapy (SFBT)	**Solution Focused Brief Therapy (SFBT)** is about focusing on solutions, rather than on problems. Solution-Focused Therapy, is future-focused, goal-directed, and enables the person to build on personal strengths to overcome problems. The therapy helps the person to formulate new life goals and contends that people are equipped with the skills to create change in their lives and that people already know, on some level, what change is needed in their lives. The therapy helps the persons explore times in their life when the present problem(s) were less detrimental or more manageable, and identify those factors which were different and using these factors enable the person to create the necessary circumstances for personal and psychological recovery. The therapy using a series of coping style questions and through incremental goals setting, measurement, positive reinforcement, affirmation and validation. The person is **encouraged to** do more of what is working and less of what is not working.	This therapy can help with a wide range of common mental health problems and can be used in combination with a range of other psychological therapies.
Creative Therapies	**Creative Therapies** are for some people who find the words to talk about their problems difficult. Creative therapies such as art, music, drama and creative writing can be used to help a person to unlock their thoughts and feelings, create personal understanding, and enables discussion and resolution of problems.	These therapies can help with a wide range of common mental health problems and can be used in combination with a range of other psychological therapies for the treatment of more complex mental health problems.

Therapy Type	Therapy Description	Therapy Can Help
Group Therapies	**Group Therapies** can be provided to treat a range of issues from lifestyle choices to very specific issues such as substance misuse, depression, anger or loss. For the most part group therapy is provided to people with similar needs with the objective that they will learn, find solutions together and help each other to recover. Group therapy has a number of objectives; instil hope by helping participants to see that they are not alone and that recovery is possible; promotes interpersonal relationships, social cohesion/ responsibility; and enables the development of healthy choices through education and expert learning and development as a group.	NICE recommends group therapy for people with Obsessive Compulsive Disorder and can help people with depression, panic disorder, social anxiety, substance abuse. More generally on improving social skills, helping people deal with a range of lifestyle issues and behaviours. This type of therapy is can also be offered in conjunction with other psychological therapies.

Therapy Type	Therapy Description	Therapy Can Help
Life Style Coaching and Mentoring Therapies	**Life Style Coaching and Mentoring Therapies** focus on identifying personal strengths, goals, ambitions and explores how a person's current health and mental health choices maybe contributing to their problems. The therapy uses motivational and solution focused approaches to help the person make changes. The coaching process involves reviewing lifestyle patterns, habits, physical health, personal goals, occupational ambitions, and personal successes, and relationships transitions, economic and social circumstances. By examining the interplay of these factors the person develops an insight into the behaviours and issues which are contributing to their problems The Life Coach helps the person to refocus their life's goal and facilitates personal growth through using a range of psychosocial education and behavioural activation strategies in order to help the person to make real and lasting change.	These therapies can help with a wide range of common mental health problems and can be used in combination with a range of other psychological therapies for the treatment of more complex mental health problems.

Therapy Type	Therapy Description	Therapy Can Help
Acceptance and Commitment Therapy (ACT)	**Acceptance and Commitment Therapy (ACT)** focuses on helping the person to accept what is out of their personal control, and commit to reasonable action that improves the quality of their lives. The therapy helps the person develop psychological flexibility by being mindful of the present and realigning reaction, action and behaviours with healthy values. The therapy helps the person learn new thinking patterns to rectify interacting thoughts, images, emotions, and memories and enables the person to manage thoughts without having to struggle with them.	These therapies can help with a wide range of common mental health problems and can be used in combination with a range of other psychological therapies for the treatment of more complex mental health problems.

4.3 Levels of Need and Intensity along the Stepped Care Model

A stepped care approach enables care to be tailored in accordance with a persons needs.

The Stepped Care Model therefore supports the coherent reorganisation of services into steps which enables the effective management of care across primary, secondary and specialist psychological services.

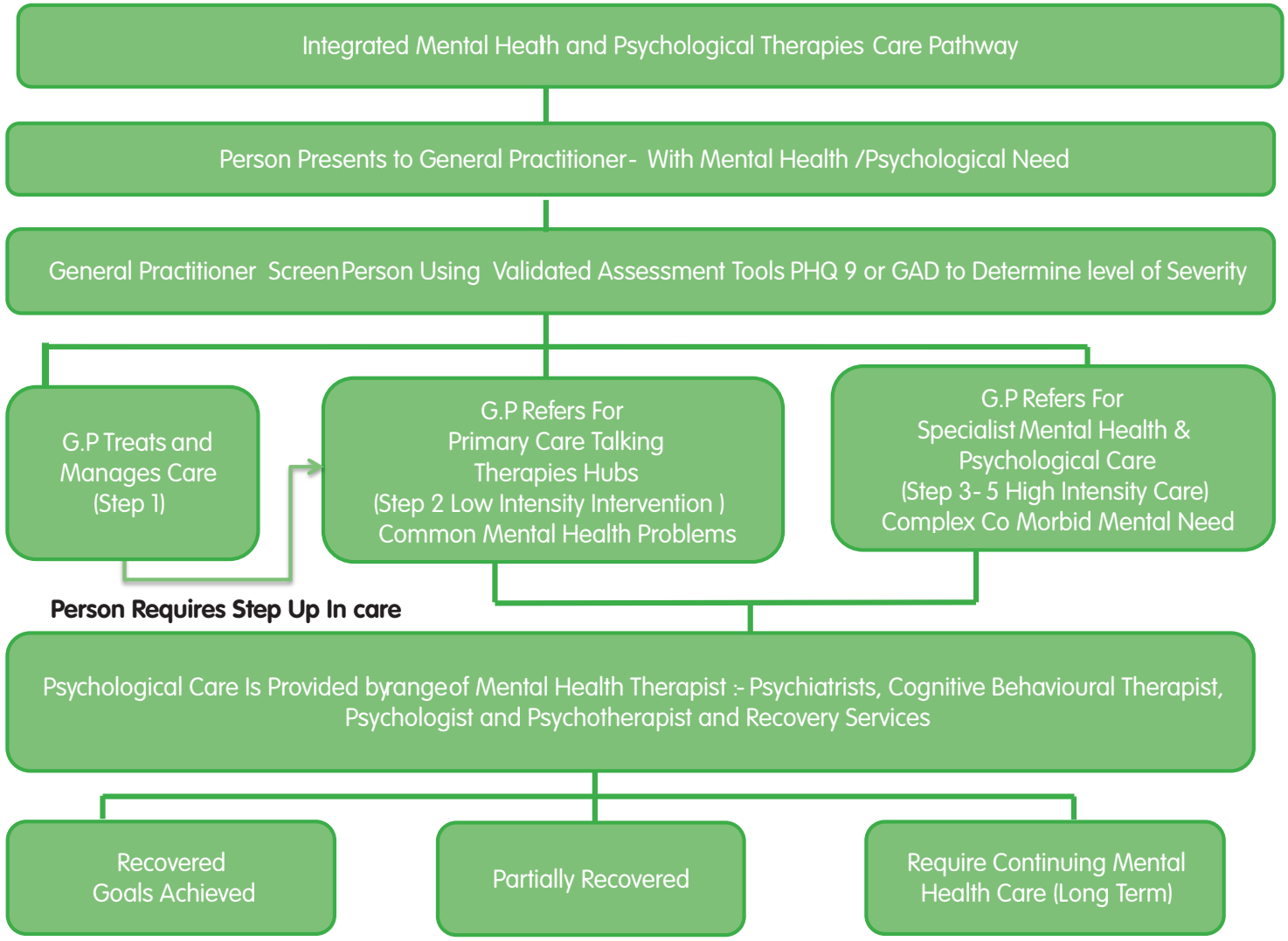
The guidance has been designed using a stepped care approach which enables the matching of therapies with a persons level of need/complexity.

The stepped care needs model supports the development of systems of care which promotes earlier intervention, streamline access points, enables consultancy and co-working across mental health services and effective case management.

Levels of Need, Interventions and Supports

Step	Level/Category of Need	Level of Intervention	Type of Support
Steps 1 and 2	**Low** A Low/moderate impact on personal functioning. Occasional distress in one or two activities in one or more areas of functioning.	**Low Intensity Interventions** Addressing mild/moderate mental health difficulties which have a limited impact on functioning. Interventions can involve between 1-8 sessions of care	• Self Directed Support • Community Support • Lifestyle Adjustment • General Practitioner • Low Intensity Psychological Therapies
Steps 3 and 4	**Medium** B Moderate/high impact on personal functioning. Unable to carry out several activities in one or more vital areas of functioning.	**High Intensity Interventions** Require a comprehensive assessment of mental health needs. Interventions can involve between 8-20 sessions of care.	• Specialist Mental Health and Psychological Therapy Services
Steps 4 and 5	**High** C D High/severe impact on personal functioning. Severely distressed unable to carry out majority of activities. Severe levels of need.	**Highly Specialised Interventions** For complex and co-morbid mental health needs. Interventions can involve more than 20 sessions of care and may last for more than 1 year.	• Highly Specialist Mental Health and Psychological Therapies.

5.0 Psychological Therapies Care Pathway



6.0 Condition Specific Psychological Therapies Matrix (NI)

Section 6.0 sets out the Condition Specific Psychological Therapies Matrix detailing the levels of psychological need, the intervention within the stepped care model, clinical examples and therapeutic providers, with respect to separate clinical conditions.

(N.B - Level of need and urgency should be adjusted for women in pregnancy or the postnatal period. Thresholds for non-drug treatments, particularly psychological treatments are likely to be lower, and prompt and timely access to treatments should be ensured).

Glossary

AN:	Anorexia Nervosa
ASD:	Autism Spectrum Disorder
BA:	Behavioural Activation
BCT:	Behavioural Couples Therapy
BDD:	Body Dysmorphic Disorder
BED:	Binge-Eating Disorder
BMI:	Body Mass Index
BN:	Bulimia Nervosa
BPD:	Borderline Personality Disorder
CAT:	Cognitive Analytic Therapy
CBT:	Cognitive Behavioural Therapy
CCBT:	Computerised Cognitive Behavioural Therapy
DBT:	Dialectical Behaviour Therapy
DSM-IV:	Diagnostic and Statistical Manual of Mental Disorders 4th Edition
EMDR:	Eye Movement Desensitisation and Reprocessing
ERP:	Exposure and Response Prevention
FFT:	Family Focused Therapy
FI(s):	Family Intervention(s)
GAD:	Generalised Anxiety Disorder
GP:	General Practitioner
ICD-10:	International Classification of Diseases - Version 10
IPSRT:	Interpersonal and Social Rhythm Therapy
IPT:	Interpersonal Psychotherapy
MBCT:	Mindfulness-Based Cognitive Therapy
MBT:	Mentalisation-Based treatment
MET:	Motivational Enhancement Therapy
MH:	Mental Health as in Mental Health Services
NICE:	National Institute for Health and Clinical Excellence Guidelines
OCD:	Obsessive Compulsive Disorder
PD:	Panic Disorder
PTSD:	Post-Traumatic Stress Disorder
SFT:	Schema-Focused Therapy
SIGN:	Scottish Intercollegiate Guidelines Network
STEPPS:	Systems Training for Emotional Predictability and Problem Solving (CBT-based)
TFP:	Transference-Focused Psychotherapy

Stepped Care Needs Matrix

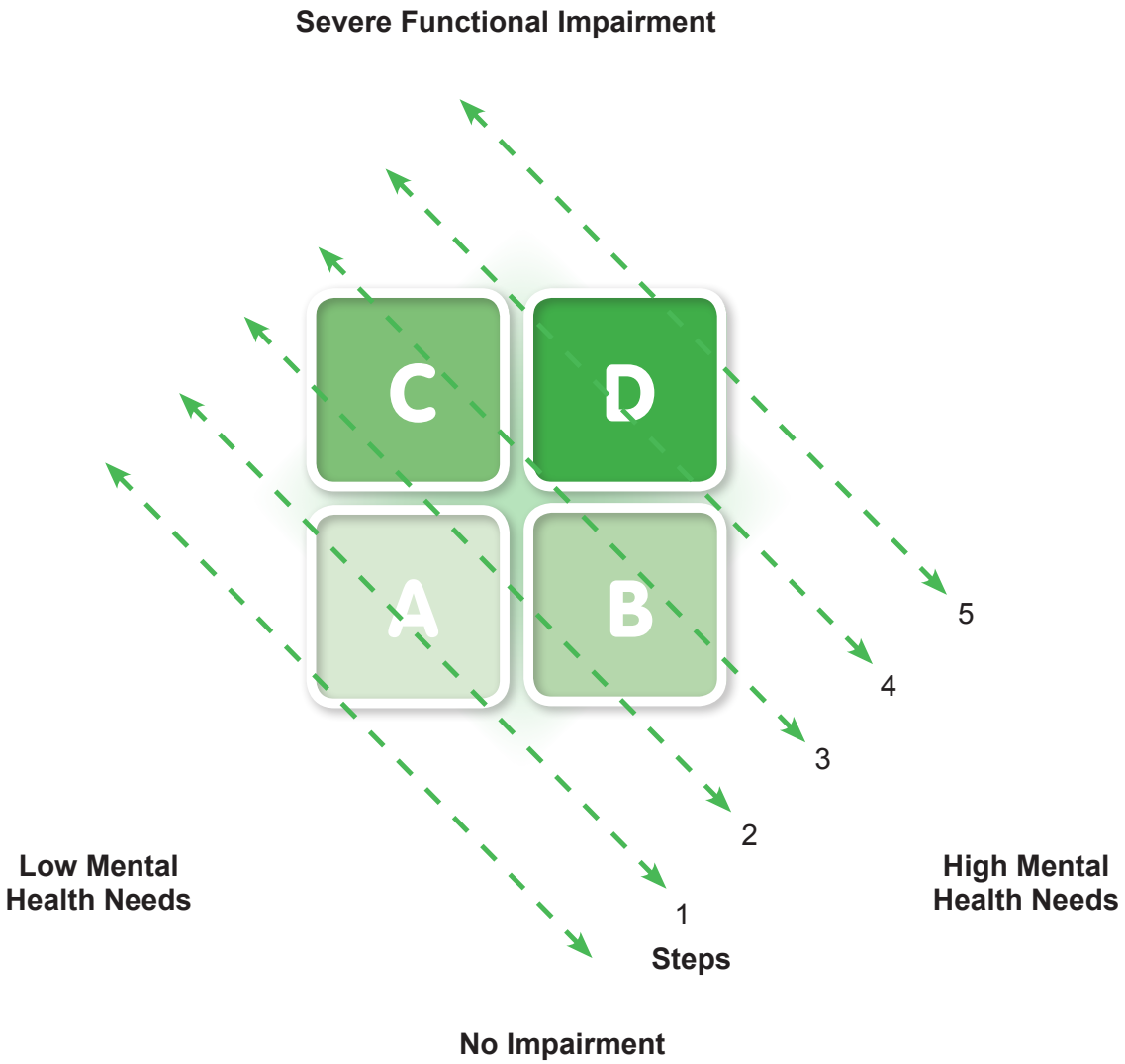


Figure 1:

The Stepped Care Model (diagonal arrow): relationship with mental health needs (horizontal axis) and level of impairment (vertical axis). The levels/steps range from 1-5 as individual needs increase commensurate with severity of difficulties.

This model provides a framework for organising mental health care by adopting a whole systems approach in matching presenting need with the least necessary intervention to achieve patient centred outcome. Category Descriptors for Levels of Need can be found in **Appendix 1.**

Category Descriptors for Levels of Need

Category A (Low Mental Health Needs/Low Impairment) – for example, discrete difficulties, short duration. In statistical terms Category A will constitute the largest number of individuals requiring psychological services. This category remains the prerogative of primary care and/or community services. Focus on psycho-education, self-help and skill acquisition. (Step 1and 2).

Care pathways will need to accommodate the likelihood that people will move between Categories B, C and D depending on their stage of recovery. In other words, this is a dynamic process within the mental health system and service delivery may occur through different steps in any one episode of mental health difficulties.

Category B (High Mental Health Needs/Low Impairment) – for example, increased level of distress and degree of risk; acute presentation; individuals requiring early intervention services. Intervention needs to be timely to reduce potential for long term/ enduring mental illness/impairment. (Transient Step 4 and 5).

Category C (Low Mental Health Needs/High Impairment) – for example, long term stable presentation. Individuals who may require intermittent secondary care services (and at times require specialist expertise). Intervention has focus on enhancing functional capacity and maintaining self-reliance. Focus on community resources for support to reduce crises. Management of long term condition for example, Expert Patient Model. (Step 3 and 4).

Category D (High Mental Health Needs/High Level of Impairment) – for example, SMI/enduring difficulties/disabling symptoms such as mood disorders. Level of risk. May also include acute mental illness where level of functioning is temporarily impaired but will improve. Likely to require an infrastructure of support and intervention from specialist services. (Step 4 and 5).

Stepped Care Model Explained

Step 1:

Low impact on Personal Functioning

Self Directed Help - Health and Well-being Advice and Support for Mild Emotional Problems.

Support involves self-directed therapies such as CCBT, Education, Bibliotherapy, Making lifstyle adjustments.

Step 2:

Low – Moderate Impact on Personal Functioning

Primary Care Talking Therapies

Support at this level usually involves responding to common mental health problems such as anxiety, stress and depression.

Talking Therapies will include a combination of Counselling, Low Intensity CBT, Interpersonal Therapy, Mindfulness, Solution Focused, Brief Therapy, Life Coaching and Creative Therapies.

Step 3:

Moderate High Impact on Personal Functioning

Specialist Psychological Therapies

Support at this level usually involves responding to mental health problems which are disrupting daily functioning. Talking therapies will be delivered by Psychologists, Family Therapist, CBT Therapist and other specially trained practitioners.

Talking Therapies will include High Intensity CBT, Family/ Couples Therapy, EMDR DBT, Cognitive Analytic Therapy and Acceptance and Commitment Therapy, and include all those therapies delivered at Step 2.

Step 4:

High Impact on Personal Functioning

Condition Specific Psychological Therapies

Support at this level usually involves providing care in response to complex comorbid mental health needs.

High intensity Talking Therapies are delivered as in Step 3 and may include access to Psychotherapies and highly specialist/ specific programmes of recovery delivered by a combination of Highly Metal Health Specialists.

Step 5:

Server Impact on Personal Fuctioning

Highly Specialist Therapies

Support at this level usually provided in response to highly complex mental health needs. Therapies involves highly specialist Psychological and Psychiatric Care. Compbination of High Intensity Talking Therapies are provided to address personal and social risks.

6.1 Panic Disorder

Panic Disorder (PD) is characterised by recurring, unforeseen panic attacks followed by at least 1 month of persistent worry about having another attack and concern about its consequences, or a significant change in behaviour related to panic attacks. Panic Disorder can be diagnosed with or without agoraphobia. Panic Disorder varies in severity and complexity and can follow a chronic or remitting course. Where possible, the goal of intervention should be complete relief of symptoms (remission) with associated improvements in functioning and a lower likelihood of relapse.

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
A **Step 1**	Limited impact on personal and social functioning.	Self Help Materials Psycho Education Groups Life Style.	NICE CG 113 All other relevant NICE Guidelines	• Self Help Third Sector.
A B **Step 2**	Negatively impacts some aspect of the individual's social and personal functioning.	In addition Step 1offer CBT (up to 8 sessions).		• Primary Care Therapy Hubs.
B C **Step 3**	Limited impact on personal and social functioning.	In addition to steps 1-2 offer CBT (16-20 sessions). Short Pharmacological interventions, as per NICE guidance Recovery College Support.		• Specialist Mental Health Services. • Recovery College.
C D **Step 4-5**	Severely impacts all aspect of personal, social, psychological and occupational functioning which significantly compromises the individual's wellbeing and personal safety. Individual presents with other complex co- occurring mental health needs.	May requires High intensity MDT Input CBT (20+ sessions). Other therapies for example. Psychotherapy, Pharmacological Intervention and Safety Planning.		

6.2 Anxiety (Generalised Anxiety Disorder)

Anxiety (Generalised Anxiety Disorder) is a common disorder, a central feature of which is excessive worry about a number of different events associated with heightened tension. Typically the worries are widespread, involve everyday issues and have a shifting focus of concern. The affected person finds the worries difficult to control, and this can result in decreased occupational and social functioning. GAD can exist in isolation but more commonly occurs with other anxiety and depressive disorders.

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
A **Step 1**	Limited impact on personal and social functioning.	• Self Help Materials • Psycho Education Groups • Life Style.	NICE CG 113 All other relevant NICE Guidelines	• Self Help Third Sector. • Primary Care Therapy Hubs.
A B **Step 2**	Symptoms of distress remain after Step 1 interventions have been completed.	In addition Step 1offer CBT (up to 8 sessions).		• Primary Care Therapy Hubs. • Self Help Third Sector.
B C **Step 3**	Significantly disrupts the Individual's daily functioning, preoccupied and intrusive thoughts. Moderate level of emotional distress which may compromise personal wellbeing and safety.	• In addition to steps 1 & 2 offer CBT (16-20 sessions). • Short Pharmacological Support as per NICE guidance. • Recovery College Support.		• Specialist Mental Health Services. • Recovery College.
C D **Step 4-5**	Severely impacts all aspect of personal, social, psychological and occupational functioning which significantly compromises the individual's wellbeing and personal safety. Individual presents with other complex co- occurring mental health needs.	May requires High intensity MDT Input CBT (20+ sessions). Other therapies for example. Psychotherapy, Pharmacological Intervention and Safety Planning.		

6.3 Obsessive Compulsive Disorder/Body Dysmorphic Disorder

Obsessive Compulsive Disorder (OCD) is characterised by the presence of either obsessions or compulsions, but commonly both. The symptoms can cause significant functional impairment and/or distress.

Body Dysmorphic Disorder (BDD) is characterised by a preoccupation with an imagined defect in one's appearance, or in the case of a slight physical anomaly, the person's concern is markedly excessive.

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
A **Step 1**	Recent onset of obsessional thinking and/or compulsive behaviours. Limited impact on personal and social functioning.	Low intensity interventions: Brief individual or CBT (including ERP) using structured self-help materials. Brief individual CBT (including ERP) by telephone. Group CBT (including ERP) (note, the patient may be receiving more than 10 hours of therapy in this format).	NICE CG 31 All other relevant NICE Guidelines	• Self Help Third Sector. • Primary Care Therapy Hubs.
A B **Step 2**	Symptoms of distress remain after Step 1 interventions have been completed.	In addition Step 1 offer individual or group CBT (up to 6- 8 sessions). Recovery College Support.		• Primary Care Therapy Hubs. • Self Help Third Sector. • Recovery College.
B C **Step 3**	Significant impact on individual's daily functioning, preoccupied and high levels of emotional distress which may compromise personal wellbeing and safety.	In addition to steps 1 and 2 offer CBT (10+ sessions). Pharmacological interventions in line with NICE guidelines. Recovery College Support.		• Specialist Mental Health Services.
B C **Step 4-5**	Severely impacts all aspect of personal, social, psychological and occupational functioning which significantly compromises the individual's wellbeing and personal safety. Individual presents with other complex co-occurring mental health needs.	May requires High intensity MDT Input CBT (20+ sessions). Other therapies for example. Psychotherapy, Pharmacological Intervention and Safety Planning.		

6.4 Schizophrenia

Schizophrenia is a major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perception, thoughts, affect, and behaviour. Typically there is a prodromal period often characterised by some deterioration in personal functioning. The prodromal period is usually followed by an acute episode marked by ha llucinations, delusions, and behavioural disturbances. Following resolution of the acute episode, usually after pharmacological, psychological and other interventions, symptoms diminish and often disappear for many people, although sometimes a number of negative symptoms may remain. This phase, which can last for many years, may be interrupted by recurrent acute episodes, which may need additional intervention.

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
D **Step 1-2 Recognition**	For those at ultra-high risk for developing psychosis.	• Brief individual or group CBT including Exposure and Response Prevention (ERP – up to 10 hours). • Self-help materials.	NICE CG 82, 178 All other relevant NICE Guidelines	• Primary Care Therapy Hubs.
C D **Step 3-4**	Moderate or high impact associated with persistent residual symptoms.	• CBT (16+ sessions for 6 months). • Family Interventions (minimum 10 planned sessions). • Supported Employment		• Specialist Mental Health Services.
B C D **Step 5**	Severe impact on individual's daily functioning, likely to be of concern to others. Individual may be treatment resistant	• CBT (16+ sessions for 6 months). • Family Interventions (minimum 10 planned sessions). • Consider art therapies. • Keep psychological therapies under review.		

6.5 Bipolar Disorder

Need Category Description	Impact	Recommended Intervention	Guideline Reference	Provider
D **Step 1-2 Recognition**	Symptoms of overactive disinhibited behaviour. Refer urgently individuals without a diagnosis with mania or severe depression who are at risk to self or others. Refer urgently an individual with bipolar disorder with acute symptoms of mania or depression.	• Assessment required. • Structured exercise, goal-directed activities, social support. • Safety planning for patients at risk.	NICE CG 38 All other relevant NICE Guidelines	• Primary Care Therapy Hubs. • Referral to Specialist Mental Health Services
B C **Step 3-4**	Significant impact on individual's daily functioning, preoccupied and high levels of emotional distress which may compromise personal wellbeing and safety.	• Structured exercise, goal-directed activities, social support. • Safety planning for patients at risk. • If symptoms persist, follow advice for moderate/severe depression. • CBT (16-20 sessions) • Family focused therapy (FFT). • Group Psychoeducation. • Interpersonal and Social Rhythm Therapy (IPSRT). • Befriending/social support.		• Specialist Mental Health Services
D **Step 4-5**	Severely or chronically impacts all aspect of personal, social, psychological and occupational functioning which significantly compromises the individual's wellbeing and personal. Individual may be treatment resistant.	• Individuals with severe depression without psychotic symptoms follow Steps 3 and 4. • Individuals with acute mixed symptoms should be monitored weekly, particularly for suicide risk.		• Specialist Mental Health Services.

6.6 Depression

Depression is a broad and heterogeneous diagnosis, characterised by depressed mood and/or loss of pleasure or interest in most activities. Severity of the disorder is determined by both the number and severity of symptoms and the degree of functional impairment. In addition to depressed mood and loss of enjoyment/interest, there are other cognitive, emotional and somatic changes. Cognitive symptoms can include hopeless thoughts and suicidal ideas as well as concentration difficulties and indecision. Additional emotional symptoms include feelings of guilt or worthlessness. Anxiety is another emotional symptom that often co-occurs with depression although is not a diagnostic criterion. For a diagnosis symptoms need to be present for at least 2 weeks (although often persist for months) and cause disruptions to the person's ability to care for themselves and cope at work, school/college or in their relationships.

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
A **Step 1**	Limited impact on personal and social functioning. Less than 5 depressive symptoms. Risk is low.	• Self-help materials. • Computerised CBT. • Structured exercise. • Recovery College Support.	NICE CG 90,91,28	• Self Help Third Sector. • Primary Care Therapy Hubs. • Recovery College.
A B **Step 2**	Moderate impact on personal and social functioning.	• Self-help materials. • Computerised CBT. • Structured exercise. • Recovery College Support.		• Primary Care Therapy Hubs.
B C **Step 3**	Significant impact on individual's daily functioning, preoccupied and high levels of emotional distress which may compromise personal wellbeing and safety.	• CBT, IPT or BA with supplementary written materials (8-16 sessions). • Keep under review • Pharmacological interventions in line with NICE guidelines. • Relapse prevention – consider Mindfulness (8 2hourly weekly groups).		• Specialist Mental Health Services. • Recovery College.

6.6 Depression

Need Category Description	Impact	Recommended Intervention	Guideline Reference	Provider
B C **Step 4**	Severely impacts on all aspect of personal, social, physical, psychological and occupational functioning which significantly compromises the individual's well-being and personal safety. Individual may present with other complex co- occurring mental health needs. Individual may be treatment resistant.	• CBT, IPT, BA or BCT with supplementary written materials (up to 20 sessions). • Keep under review • Pharmacological interventions in line with NICE guidelines. • If individual declines antidepressant medication, consider counselling (6-10 sessions) or psychodynamic therapy (16-20 sessions).	All other relevant NICE Guidelines	• Specialist Mental Health Services.
D **Step 5**	Severely impacts on all aspect of personal, social, physical, psychological and occupational functioning which significantly compromises the individual's wellbeing and personal safety. Individual may present with other complex co- occurring mental health needs. Individual may be treatment resistant.	• May requires high intensity MDT Input, including healthcare • CBT, IPT, BA or BC (20+ sessions) . • Pharmacological interventions in line with NICE guidelines. • Safety Planning. • Integrative approaches to address multiple needs.		• Specialist Mental Health Services.

6.7 Borderline Personality Disorder

Borderline personality disorder (BPD) is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are particularly at risk of suicide. (NICE CG78 January 2009).

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
A B **Step 1 Recognition**	Symptoms of persistent risk-taking behaviour including self-harm, emotional instability.	• Refer to Mental Health Services for assessment.	NICE CG78 All other relevant NICE Guidelines	• Primary Care Therapy Hubs.
B C **Step 2-3 Crisis Mngt**	For an individual with an existing diagnosis who presents to primary care in crisis.	• Offer follow up appointment. • Refer to Mental Health Services.		• Mental Health Services. • Specialist Mental Health Services.
B D **Step 4**	Significant impact on individual's daily functioning, preoccupied and high levels of emotional distress which may compromise personal wellbeing and safety. Individual may present with other complex co-occurring mental health needs.	• In addition to steps • 1 & 2 offer CBT (30+ sessions over 1 year). • SFT (twice weekly over 3 years). • DBT (twice weekly for 1 year). • Do not use brief Interventions (less than 3 months). • Consider pharmacological interventions only in treatment of co-occurring conditions and in line with NICE guidelines.		• Specialist Mental Health Services.
D **Step 5**	Severely or chronically impacts all aspect of personal, social, psychological and occupational functioning which significantly compromises the individual's well-being and personal safety. Individual presents with other complex co- occurring mental health needs. Individual may be treatment resistant.	• MBT (2/3 times weekly over 18 months) • Consider pharmacological interventions only in treatment of co-occurring conditions and in line with NICE guidelines. • Follow NICE Self Harm CG 16 to manage episodes of self-harm or attempted suicide.		

6.8 Alcohol Problems

Acute alcohol withdrawal: the physical and psychological symptoms that some people can experience when they suddenly reduce the amount of alcohol they consume when they have previously been drinking excessively over a prolonged period of time.

Alcohol dependence: A cluster of behavioral, cognitive and physiological factors that typically include alcohol cravings, a high tolerance and preoccupation with alcohol. It is also associated with an increased rate of significant mental and physical disorders.

Alcohol-use disorders: These cover a wide range of mental health problems as recognized within DSM-IV and ICD-10, including hazardous and harmful drinking and alcohol dependence.

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
A B **Step 1-2**	Limited impact on personal and social functioning.	• Brief interventions (10 – 45 minute sessions). • Written materials. • Structured CBT.	NICE CG 100, 115 All other Relevant NICE Guidelines	• Self Help Third Sector. • Primary Care Therapy Hubs. • Community Addiction Services.
B C **Step 3**	Significant impact on individual's daily functioning. Regular pattern developing with increased frequency of episodes. Avoidance behaviours.	• As per Step 1.		• Community Addiction Services.
B D **Step 4**	Severe impact on individual's daily functioning, preoccupied and high levels of emotional distress which will compromise personal well-being and safety.	• CBT/Family Therapy/Coping Skills/Social Behaviour Network Therapy/Positive Reinforcement Approaches. • Signpost to AA attendance.		
D **Step 5**	Severely or chronically impacts all aspect of personal, social, psychological and occupational functioning which significantly compromises the individual's well-being and personal safety. Individual may be treatment resistant.	• As per Step 4.		

6.9 Substance Misuse

Substance/Drug Misuse: here relates to opioids, stimulants and cannabis. The patterns of use vary for these drugs, with cannabis the most likely to be used in the UK. Cocaine is the next most commonly used drug in the UK, followed by other stimulants such as amphetamine. Opioids, although presenting the most significant health problem, are used less commonly. A large proportion of people who misuse drugs are polydrug users and do not limit their use to one particular drug. Opioid misuse is often characterised as a long-term, chronic condition with periods of remission and relapse. Although abstinence may be one of the long-term goals of treatment, it is not always achieved.

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
A D **Step 1**	Limited impact on personal and social functioning.	• Motivational based brief intervention. • Self-help materials. • Recovery College Support.	NICE CG 51,52 All other relevant NICE Guidelines	• Self Help Third Sector. • Primary Care Therapy Hubs. • Recovery College.
B C **Step 2**	Use of cannabis with co-occurring anxiety and/or depression. Use of stimulants with co-occurring anxiety. Use of benzodiazepines with co-occurring panic disorder.	• Individual and/or Group CBT (up to 10 sessions).		• Primary Care Therapy Hubs. • Self Help Third Sector. • Community Addiction Services.
B D **Step 3**	Significant impact on individual's daily functioning. Regular pattern developing with increased frequency of episodes. Avoidance behaviours present. High levels of emotional distress.	• Contingency management. • Behavioural Couples Therapy.		• Primary Care Therapy Hubs. • Community Addiction Services.

6.9 Substance Misuse

Need Category Description	Impact	Recommended Intervention	Guideline Reference	Provider
B D **Step 4**	Significantly impacts on a lot of personal, social, psychological and occupational functioning which may compromise the individual's well-being and personal safety.	• CBT.		• Primary Care Therapy Hubs. • Community Addiction Services.
C D **Step 4**	Significantly impacts on a lot of personal, social, psychological and occupational functioning which may compromise the individual's well-being and personal safety and safety of others. Individual may be treatment resistant.	• CBT/Family Therapy/Coping Skills/Social Behaviour Network Therapy/Positive Reinforcement Approaches • Signpost to AA attendance		

6.10 Eating Disorders

Eating disorders include anorexia nervosa, bulimia nervosa, or other related (or 'atypical) eating disorders (mainly binge eating disorder).

Anorexia Nervosa (AN) is a syndrome in which the individual maintains a low weight as a result of a pre-occupation with body weight, construed either as a fear of fatness or pursuit of thinness. In younger people, the diagnosis may be made in those who fail to gain weight during the expected growth spurt of puberty, as they can become underweight without weight loss.

Bulimia Nervosa (BN) is characterised by recurrent episodes of binge eating and secondly by compensatory behaviour (vomiting, purging, fasting or exercising or a combination of these) in order to prevent weight gain. Binge eating is accompanied by a subjective feeling of loss of control over eating. Self-induced vomiting and excessive exercise, as well as the misuse of laxatives, diuretics, thyroxine, amphetamine or other medication, may occur.

Binge Eating Disorder (BED) is characterized by episodes of binge eating, but individuals do not try to control their weight by purging. BED may have an effect on the individual's social life and relationships.

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
A **Step 1**	Limited impact on personal and social functioning. Occasional distress in one or two specific situations	• Self-help materials and primary care advice • Recovery College support	NICE CG 9 All other relevant NICE Guidelines	• Self Help Third Sector • Primary Care Therapy Hubs • Recovery College
A B **Step 2**	Symptoms of distress remain after Step 1 interventions have been completed.	• In addition Step 1 follow evidenced-based self-help programme for BN and BED		• Primary Care Therapy Hubs • Self Help Third Sector
B C **Step 3,4 & 5**	Significant impact on individual's daily functioning, Regular pattern developing with increased frequency of episodes. Avoidance behaviours present. High levels of emotional distress.	• For AN –CBT/IPT/CAT/MET/ • FIs adapted for EDs • For BN – CBT (16-20 sessions) • For BED - CBT		• Specialist Mental Health Services.

6.10 Eating Disorders

Need Category Description	Impact	Recommended Intervention	Guideline Reference	Provider
B D **Step 4**	Significant impact on individual's daily functioning, Regular pattern developing with increased frequency of episodes and preoccupation. Significant impact on the individual's wellbeing and personal safety. Individual may be treatment resistant.	• Follow Step 3 for Psychological Interventions and will involve Combined Therapies (CBT/IPT/CAT/FI). Acute medical or inpatient mental health interventions may also be required.	NICE CG 9 All other relevant NICE Guidelines	
D **Step 4**	Chronic impact on individual's daily functioning wellbeing and personal safety. Regular pattern developing with increased frequency of episodes and preoccupation. Individual may be treatment resistant.			

6.11 Autism: recognition, referral, diagnosis and management of adults on the autism spectrum

The term **Autism Spectrum Disorder (ASD)** is used to cover conditions termed autism, atypical autism and Asperger's Syndrome. These are complex developmental disorders, behaviourally defined, that include a range of possible developmental impairments in reciprocal social interaction and communication, and also a stereotyped, repetitive or limited, behavioural repertoire. ASD may occur in association with any level of general intellectual/ learning ability and manifestations range from subtle problems of understanding and impaired social function to severe disabilities.

ICD-10 and DSM-IV have similar symptom criteria for diagnosis, based on a triad of impairments, with the behaviours being discrepant relative to the individual's mental age. The diagnostic criteria for ASD continue to develop, and they are likely to change with future revisions. Currently, for a diagnosis of Asperger's Syndrome, there has to be no clinically significant general delay in language (speech or words and phrases by specified times) and no clinically significant general delay in cognitive development. There is not consistent evidence that the separation of Autism and Asperger Syndrome is meaningful in terms of outlook, and it should be noted that clinical usage may not always reflect the definitions in classification systems. For example, the name Asperger's Syndrome may be used as a clinical diagnosis for some individuals who speak well later, but did in fact have early language delay.

Signs that an adult might have an ASD include: social isolation, anxiety or depression; lifelong difficulties, particularly in relation to the social aspects of life and employment; unusual conversational style, tone, content and eye contact; rigidity of thought and behaviour; strong special interests and, unusual sensory responses.

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
A **Step 1-2**	Limited impairment and impact on an individual's safety.	• Referral to ASD service for assessment, as per NICE CG.	NICE CG 142 All other relevant NICE Guidelines	• ASD Adult Services

6.11 Autism: recognition, referral, diagnosis and management of adults on the autism spectrum

Need Category Description	Impact	Recommended Intervention	Guideline Reference	Provider
C **Step 3**	Significant impairment in functioning. Individual is preoccupied by their difficulties. May experience anxiety or depression.	• Referral to ASD service for assessment, as per NICE CG. • Co-occurring mental health conditions addressed as per NICE CG		• ASD Adult Services
B C **Step 4**	Significant impact on individual's daily functioning, preoccupied and high levels of emotional distress which may compromise personal wellbeing and safety.	• Provide individualised care to support daily functioning, for example, structured learning, leisure and supported employment programmes. • Co-occurring mental health conditions addressed as per NICE CG.		• ASD Adult Services. • Specialist Mental Health Services.
C D **Step 5**	Severely or chronically impacts all aspect of personal, social, psychological and occupational functioning which significantly compromises the individual's well-being and personal safety, and that of others. Individual may present with other complex co- occurring mental health needs. Individual may be treatment resistant.	• Consider anger management programmes, psycho-social interventions for challenging behaviour, based on functional analysis. • Co-occurring mental health conditions addressed as per NICE CG.		• Primary Care Therapy Hubs. • Community Addiction Services.

6.12 Post Traumatic Stress Disorder (PTSD)/Dissociative Disorders

Post-Traumatic Stress Disorder (PTSD) can develop in people of any age following a stressful event or situation of an exceptionally threatening or catastrophic nature. PTSD does not usually develop following generally upsetting situations such as divorce, loss of job or failing an exam. Effective treatment of PTSD can only take place if the disorder is recognised. PTSD is treatable even when problems present many years after the traumatic event. Symptoms typically associated with PTSD are re-experiencing, avoidance, hyper-arousal and emotional numbing. Persistent re-experiencing of the traumatic event may occur through flashbacks, nightmares, repetitive and distressing intrusive images or sensory impressions. In children, these symptoms may include: re-enacting the experience, repetitive play or frightening dreams without recognisable content. Persistent avoidance of stimuli associated with the trauma can be indicated by avoidance of people, situations or circumstances resembling or associated with the event as well as thoughts feelings and conversations associated with the trauma.

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
A **Step 1-2**	Limited impact on personal and social functioning in one or two areas and on personal safety.	• Watchful waiting for 1 month. Follow up contact recommended after this time.	NICE CG26 All other relevant NICE Guidelines	• Primary Care Therapy Hubs.
B D **Step 3**	Significant impact on individual's daily functioning as increase in frequency of episodes. Individual is preoccupied and experiences high levels of emotional distress which may compromise personal wellbeing and safety.	• Trauma-focused CBT.		• Primary Care Therapy Hubs. • Self Help Third Sector. • Mental Health Services.
B C **Step 4**	Highly significant impact on individual's daily functioning as increase in frequency of episodes. Individual is preoccupied and experiences high levels of emotional distress which may compromise personal well-being and safety.	• CBT (8-12 sessions). • Eye Movement. Desensitisation and Reprocessing (EMD).		
C **Step 5**	Severe and enduring impact on all aspect of an individual's personal, social, psychological and occupational functioning which significantly compromises their well-being and personal safety. Individual may present with other complex co-occurring mental health needs. Individual may be treatment resistant.	• May requires high intensity MDT input. • Pharmacological interventions in line with NICE guidelines. • Integrative approaches to address multiple needs.		

6.13 Self Harm

Self Harm is 'self-poisoning or self-injury, irrespective of the apparent purpose of the act'. Many acts of self-harm are not directly connected to suicidal intent. They may be an attempt to communicate with others, to influence or to secure help or care from others or a way of obtaining relief from a difficult and otherwise overwhelming situation or emotional state. The methods of self-harm can be divided into two broad groups: self-poisoning and self-injury. Self-harm can occur at any age but is most common in adolescence and young adulthood. Overall, women are more likely to self-harm than men. Certain psychological characteristics are more common among the group of people who self-harm, including impulsivity, poor problem-solving and hopelessness. Also, people who self-harm more often have interpersonal difficulties.

Need Category Description	*Impact*	*Recommended Intervention*	*Guideline Reference*	*Provider*
A **Step 1**	Occasional distress in one or two specific situations or places with limited impact on personal safety.	• Self-help materials. • Comprehensive assessment of need should be carried out. • Recovery College Support.	NICE CGs 16, 133 All other relevant NICE Guidelines	• Primary Care Therapy Hubs.
A B **Step 2**	Moderate impact on individual's daily functioning as increase in frequency of episodes. Individual is preoccupied and experiences some level of emotional distress.	• Self-help materials/self-help groups. • Consider CBT/Psychodynamic/ Problem-solving therapy. • DBT.		• Primary Care Therapy Hubs. • Self Help Third Sector. • Mental Health Services.
B C **Step 3,4 & 5**	Significant impact on individual's daily functioning as increase in frequency of episodes. Individual has difficulty tolerating anxiety and displays avoidance behaviours. Individual is preoccupied and experiences levels of emotional distress.	• CBT (6 sessions). • Treat associated mental health conditions in line with NICE guidelines • DBT.		• Specialist Mental Health Services.

7.0 References

This guidance has been developed taking account of best practice strategies and guidance.

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Health and Social Care

YOU IN MIND

A Guide to Mental Health Psychological Therapies

http://www.hscboard.hscni.net/our-work/social-care-and-children/mental-health/

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SUMMARY OF
"A REVIEW OF SAFEGUARDING AT MUCKAMORE ABBEY HOSPITAL – A WAY TO GO"

February 2019

Summary of "A Review of Safeguarding at Muckamore Abbey Hospital - A Way to Go"

Introduction

In late 2017, the Belfast Health and Social Care Trust commissioned an independent Review Team[1] to look at safeguarding practices at the Hospital between 2012 and 2017. They began their work in January 2018.

The reason for this was that there were allegations of abuse of patients by staff, which were raised in August 2017. There were also delays in the reporting of these incidents.

CCTV information gathered at the Hospital revealed staff behaviours, which resulted in harm to patients. This led to 19 precautionary staff suspensions and a large police investigation which is continuing.[2] Separately, a team of staff was commissioned to view over 5,000 hours of CCTV images.

This summary is based on the Independent Review Team's report which was submitted to the Belfast Trust during November 2018 and shared with the families whose relatives are known to have been harmed.

What the Review Team did

There were five sets of activities. The Team;

1) Read the Hospital's safeguarding files, the Regulation and Quality Improvement Authority's (RQIA) reports and the Health and Social Care Board's information about safeguarding in Northern Ireland
2) Met the Hospital's managers and staff, patients, relatives, advocates, a Director and Inspectors from the RQIA
3) Discussed findings, emergent lessons and ways of setting these out in a report
4) Wrote and shared summaries about: the quality of care across settings; an updated history of the Hospital; the Hospital's safeguarding allegations and their outcomes; the Hospital's workforce; the themes within 61 RQIA reports; and the health needs of people with learning disabilities across the lifespan. These feature in the report's appendices with the RQIA's comments about the themes abstracted from inspection reports;

[1] Margaret Flynn (from Wales), Mary Bell (NI), Michael Brown (NI), Bryce McMurray (NI) and Ashok Roy (from England)

[2] At the time of writing, 23 January 2019

5) Facilitated multi-agency events during September 2018 to present the findings and build on the Team's recommendations.

What the Review Team found

- It is important to think about safeguarding "in context." The role of the Muckamore Abbey Hospital in improving the lives of people with learning disabilities and autism in NI and the limited availability of community based support and services characterised all meetings. The absence of adequate home-treatment, supported living and provider expertise is associated with people's crisis admissions to Muckamore Abbey Hospital. Delayed discharges mean that people become stuck in the hospital – which also means that the hospital's "assessment and treatment" main function is compromised.

- The RQIA reports do not provide a single overview of the Hospital since they focus on individual wards and produced hundreds of recommendations.

- Over a two-year period, the Hospital recorded 4,385 "adverse incidents." However, it is important to ask questions about these numbers because a single person may be associated with lots of incidents for example.

    - People's lives at the hospital are characterised by inactivity and boredom.
    - Hospital patients are significantly likely to be harmed by their peers.
    - A typical response to allegations of abuse made by patients about staff is 2:1 "observations." These create a demand for additional staff amounting to paying 50 more members of staff every week (50 whole time equivalents).

- Nurse staffing shortages feature in the hospital's Risk Register and there is a case that nurse staffing at the Hospital is insufficient to meet people's needs. However, a low ratio of registered staff was not a factor in the areas of the hospital where CCTV evidence show patients being harmed.

- People's families are hurt, distressed and angry that nobody intervened to halt the harm experienced by their relatives.

- It is possible that a policy requiring the involvement of the Police Service of NI (which has since been set aside) has skewed understanding of what proportionate responses to safeguarding allegations should look like.

- The extensive paperwork associated with safeguarding investigations and inspections did not uncover the abuses captured on CCTV.

- In parts of Muckamore Abbey Hospital, work practices were harmful and disproportionate, for example, the unmonitored use of seclusion. Its intensive

use by a small number of patients is anti-therapeutic. In contrast, families want it to be known that there are some staff who conscientiously provide compassionate care.

- It is not clear how closely Muckamore Abbey Hospital's safeguarding practice, as revealed in its files, align with the regional Safeguarding Operational Procedures.

- The credibility of patients' allegations is compromised by statements concerning their "history of making allegations", consultant's decision-making concerning their mental capacity as well as relative's views. .

- It is unclear how the Hospital dovetail safeguarding practice, RQIA inspections, professional regulation, police investigations, complaints, clinical governance and internal disciplinary processes.

- Advocacy is typically absent from considerations of safeguarding.

Important Considerations Highlighted by the Review Team

- Since Muckamore Abbey Hospital is not being used for rapid and short-term admissions, a network of leaders inside and outside the Hospital is required to address the over-reliance on Muckamore Abbey.

- Any coalition for progress must begin with the experiences of people with learning disabilities and their families.

- All services must demonstrate their readiness to plan for the care, support and treatment of infants and children with extensive medical and health support needs. Early intervention services are vital to the health and well-being of the adults with learning disability in the future.

The Review Team Identified the Following Lessons

a) The process of safeguarding should not be compromised by questions about a person's history, their mental capacity, the permission of their family or "thresholds"
b) The Muckamore Abbey Hospital's senior managers and clinicians must evidence the support they provide to staff who report harmful events and practices

c) Learning from people's families is invaluable. They must be treated as equal partners and heard on a continuous basis
d) Muckamore Abbey Hospital is part of the wider system located in the Belfast Trust, within the totality of Trusts, the Department of Health and the Legislative Assembly. Change needs to happen in all parts of the system simultaneously to ensure maximum benefit for patients and families. The case for major change is incontrovertible
e) Since it is not clear what the Hospital is achieving, it is highly unlikely that the families of infants and children with learning disabilities and complex neuro-developmental disabilities envisage Muckamore Abbey Hospital as part of their waiting future.

The Review Team's Recommendations

- Provide evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports

- An updated strategic framework for Northern Ireland's citizens with learning disability and neuro-developmental challenges is co-produced with people and their families. The transition to community-based services requires the contraction and closure of the Hospital…a life course vision of "age independent pathways," participative planning and training for service development remain to be described.

Patients' families recommended that:

- Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners
- Families and advocates should be allowed open access to wards and living areas
- There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use of seclusion at the Hospital
- The use of seclusion ceases
- The perception that people with learning disabilities are unreliable witnesses has to change
- People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives
- The Hospital's CCTV recordings are retained for at least 12 months

- Families are advised of lawful practices Muckamore Abbey Hospital may undertake with (i) voluntary patients and (ii) sectioned patients[3]
- Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives
- Families receive regular progress updates about what happening as a result of the review.

Hospital staff recommended that:

- An enhanced role for specialist nursing staff is set developed.
- Responses to safeguarding incidents and allegations are proportionate and timely
- Safeguarding documentation is substantially revised.

Senior managers from the Health and Social Care Trusts and the RQIA recommended that:

- A shared narrative is developed about the future of services
- Commissioners specify what "collective commissioning" means
- The transformation required in learning disability services must be values driven and well led
- The purpose of all of our services is clear
- All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing
- The default "Friday afternoon and weekend admissions" to Muckamore Abbey Hospital have to stop[4]
- Time limited and timely Assessment and Treatment become the norm
- Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families
- Trusts and Commissioners should set out the steps required in the Department of Health's post Bamford plan: in the short and medium term.[5]

[3] A family was advised by a clinician seeking to section their relative that "It doesn't sit easy using seclusion on a voluntary patient"

[4] At the time of the feedback events (September 2018), the Hospital was addressing its low threshold for admissions

[5] For example, it may be helpful to distinguish the recommendations and points made in the review which may be addressed in the short term and in the medium term. For example, in the short term:

1. The three main stakeholders – people with learning disabilities, their families and advocates; the Learning Disability service providers in NI and commissioners should work as equal partners so that the service can be transformed - perhaps as an accountable group
2. The flow of admissions - especially readmissions - into the hospital should be restricted to halt the "revolving door" phenomenon. The hospital is being used inappropriately to respond to a wide range of situations which would need to be managed locally if community services are to begin designing services around individuals
3. Existing patients need to spend time in and be visible in the community
4. Families and advocates should be allowed open access to wards and living areas

5. Monitoring and reporting of all restrictive practice - the use prn medication, physical restraint and seclusion must be strengthened

In the medium term:

1. Trusts should begin to build “all age care pathways” which bring together children’s and adult services, hospital and community services and health and social care and education services
2. Out of hours’ services should be enhanced using strengthened community learning disability and mental health teams as well as the hospital team to support families and service providers for all age groups
3. The professional development of all front line staff must be prioritised using educational approaches based on providing better care rather than on formal course based approaches
4. New approaches to enhance housing capacity need to be accelerated to deal with ever increasing deman

PUBLIC HEALTH AGENCY

STANDARDS AND GUIDELINES FOR HANDLING AND MONITORING OF COMPLAINTS

1. Introduction

1.1 This document sets out the procedure for staff on how complaints relating to the Public Health Agency, its actions and decisions are to be managed and monitored. These procedures reflect the new arrangements for dealing with complaints which became effective from 1 April 2009 and should be read in conjunction with "Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning" (thereafter the HSC Complaints Procedure) and “Directions to the Regional Agency for Public Health and Social Wellbeing on procedures for dealing with Health and Social Care Complaints” (The Directions).

1.2 The proper handling of complaints, suggestions or queries is a fundamental responsibility of the Public Health Agency. 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.

1.3 The HSC Complaints Procedure is designed to address patient and client complaints, not staff grievances, which will continue to be handled separately.

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 and 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

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.

4.2 Complainant:

Complainants will be existing or former users of the Public Health Agency's services and facilities. People may complain on behalf of existing or former patients/clients provided they have their consent. If the patient/client is unable to act then consent is needed from their next of kin.

4.3 Complaints Excluded from this policy

The following complaints are excluded from the scope of this policy:

- Complaint made by an employee of the PHA about any matter relating to their contract of employment, including any complaints relating to disciplinary proceedings.
- Complaint made by an Independent provider about any matter relating to arrangements made by the PHA with that provider
- Complaints relating to Data Protection
- Where a complainant has stared that they intend to take legal action.

- Complaints relating to activation of vulnerable adults policy /procedures or is subject to Child Protection enquiry or activates the Children Order
- A complaint which has raised an Independent inquiry and or criminal investigation and those which have resulted in a referral to a professional regulatory body.

Full details can be found in paragraph 7 of the Directions

5. Complaints about Commissioning Decisions by the Public Health Agency

5.1 The Public Health Agency is required to have 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 Public Health Agency may be made by, or on behalf of, any individual personally affected by a commissioning decision taken. The HSC Complaints Procedure may not deal with complaints about the merits of a decision where the Public Health Agency 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 Agency and they should receive a full explanation of the Agency's policy. These are not, however, issues for the HSC Complaints Procedure.

6. Local Resolution of Complaints

6.1 The Public Health Agency's complaint officer is: -

Mary Hinds, Director of Nursing & Allied Health Professions

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 All complaints, whether oral or written, 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 offering an apology and explanation as appropriate, referring to any remedial action that is to follow.

6.5 In the context of local resolution for the Agency, for example, a member of staff from a relevant Directorate may respond directly to a complainant. The Agency's Complaints Office should, however, be made aware of the nature of the complaint and response.

6.6 The HSC Complaints Procedure (para 3.41) states that 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.

6.7 Where complaints have been raised electronically the Agency must obtain a postal address for the purposes of the response to maintain appropriate levels of confidentiality. Responses should not be made electronically (para 3.39).

7. Receipt of Complaints

7.1 Complaints received orally should be dealt with by staff promptly, sympathetically and constructively. Such complaints should be dealt with according to the principles of local resolution and should be resolved immediately or within two days of receipt. Staff should complete the Complaints Form Appendix A and copy to the Complaints Officer.

7.2 Oral complaints which cannot be resolved to the complainant's satisfaction should be referred to the Agency's Complaints Officer.

7.3 Complaints received through the Private Office of the DHSSPS will be forwarded to the Agency'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).

7.4 Complaints addressed directly to the Agency's 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 7.5 with the exception that the response should be signed by the Chairman.

7.5 Complaints received from members of the public and others not specified above, generally written complaints or all unresolved informal complaints, will be forwarded to the Agency's Complaints Office who will arrange for an acknowledgement and the preparation of a response from the Chief Executive (or designated senior person).

7.6 In all cases complaints will receive an acknowledgement within 2 working days, and a full investigation and resolution sought within 20 working days.

7.7 Written responses to complaints will be under the signature of the Chief Executive or a designated senior person.

7.8 Complainants will be advised of what action they can take should they remain dissatisfied following consideration of the response.

7.9 Where a complaint is received by the Agency in error, the Complaints Office should ensure that it is passed immediately to the correct body, after consulting with the complainant and provided that the complainant wishes this to be done. The complainant and the body concerned should both then be advised in writing.

8.0 Time Limits

8.1 The period for making a complaint is:

a) 6 months from the date on which the matter which is the subject of the complaint occurred; or
b) Where the complainant was not aware that there was cause of complaint, within
   i) Six months from the date on which the matter which is the subject of the complaint comes to the complainant's notice.
   ii) Twelve months from the date on which the matter which is the subject of the complaint occurred whichever is sooner.

8.2 Where a complaint is received which was not made during the period specified in paragraph 8.1 above it shall be referred to the complaints officer, who will make a judgement on the appropriate action guided by Paragraph 11 of the Directions.

9.0 NI Commissioner for Complaints (Ombudsman)

9.1 All papers relating to the local resolution investigation will be made available to the Commissioner where such a case has been referred by the complainant to the Commissioner 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; performance management and dissemination of learning.

10.2 The operation and effectiveness of the HSC Complaints Procedure will be monitored continuously. A Regional Complaints Group (HSC Board and Agency) has been established and will meet quarterly to consider analysis of information pertaining to HSC Board complaints, Family Practitioner complaints, HSC Trust complaints and Agency complaints. The Group will look at the number and subject of complaints received, their outcomes and what learning can be determined and disseminated from these throughout the service.

10.3 The operation and effectiveness of the PHA Complaints Policy and Procedure will be monitored by the PHA Governance and Audit Committee. The Director with responsibility for complaints will report on a regular basis (normally twice a year) about the number and subject of complaints received, their outcomes and what learning can be determined and disseminated.

10.4 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.

11 Annual Reports

11.1 The PHA will include within its Annual Report a report on the management of complaints. The Annual report, in its circulation, will include:

a) The Department of Health Social services and Public Safety
b) The Patient Client Council.

12. 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.

Appendix A

Complaints Record Form	
Date:	Time:
Details taken by:	
Complainant	
Name	
Address	
Contact telephone number	
If the complaint is about services to a person other than the complainant please advise the complainant that consent may be required.	
Details of the Complaint	
Action taken:	
Is the complaint resolved?	Yes ❑ No ❑
Please forward a copy of the complaint form to the complaints officer	
To be completed by the Complaints Officer	
Further Action Required	Yes ❑ No ❑ (If yes detail below)
Date complaint closed	Signed

Public Health Agency

WHISTLEBLOWING (Raising Concerns) POLICY

2020

Version	**2.0** **(Replaces PHA Whistleblowing Policy 2018)**
Approved by AMT	**26 April 2018**
Approved by GAC	**6 June 2018**
Approved by PHA Board	**11 June 2018**
Review Date	**May 2023**

(Based on DoH 'Your Right to Raise a Concern' HSC Framework and Model Policy)

CONTENTS:

1. Introduction

All of us at one time or another may have concerns about what is happening at work. The Public Health Agency (PHA) wants you to feel able to raise your concerns about any issue troubling you with your managers at any time. It expects its managers to listen to those concerns, take them seriously and take action to resolve the concern, either through providing information which gives assurance or taking action to resolve the concern. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues, or *the PHA itself*, it can be difficult to know what to do.

The PHA recognises that many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. This policy and procedure is aimed at those issues and concerns which are **not resolved, require help to get resolved or are about serious underlying concerns.**

Whistleblowing refers to staff reporting suspected wrongdoing at work, for example, concerns about patient safety, health and safety at work, environmental damage or a criminal offence, such as, fraud.

You may be worried about raising such issues and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may also feel that raising the matter would be disloyal to colleagues, to managers or to the organisation. It may also be the case that you have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

Rather than wait for proof, raise the matter when it is still a concern. If something is troubling you, which you think we should know about or look into, please let us know. The PHA has implemented these whistleblowing arrangements for you to raise any concern where the interests of others or the organisation itself are at risk.

2. Aims and Objectives

The PHA is committed to running the organisation in the best way possible. The aim of the policy is to promote a culture of openness, transparency and dialogue which at the same time:

- reassures you that it is safe and acceptable to speak up;
- upholds patient confidentiality;
- contributes towards improving services provided by the PHA;
- assists in the prevention of fraud and mismanagement;
- demonstrates to all staff and the public that the PHA is ensuring its affairs are carried out ethically, honestly and to high standards;
- provides an effective and confidential process by which you can raise genuine concerns so that patients, clients and the public can be safeguarded.

The PHA roles and responsibilities in the implementation of this policy are set out at Appendix A**.**

3. Scope

The PHA recognises that existing policies and procedures which deal with conduct and behaviour at work (Disciplinary, Grievance, Working Well Together, Harassment and Bullying, the Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate to extremely sensitive issues which may need to be handled in a different way.

This policy provides a procedure for all staff of the PHA, including permanent, temporary and bank staff, staff in training working within the PHA, independent contractors engaged to provide services, volunteers and agency staff who have concerns where the interests of others or of the organisation itself are at risk. **If in doubt - raise it!**

Examples may include:

- malpractice or ill treatment of a patient or client by a member of staff;
- where a potential criminal offence has been committed, is being committed or is likely to be committed;
- suspected fraud;
- breach of Standing Financial Instructions;
- disregard for legislation, particularly in relation to Health and Safety at Work;
- the environment has been, or is likely to be, damaged;
- a miscarriage of justice has occurred, is occurring, or is likely to occur;
- showing undue favour over a contractual matter or to a job applicant;
- research misconduct; or
- information on any of the above has been, is being, or is likely to be concealed.

This list is not intended to be exhaustive or restrictive

If you feel that something is of concern, and that it is something which you think the PHA should know about or look into, you should use this procedure. If, however, you wish to make a complaint about your employment or how you have been treated, you should follow the PHA grievance procedure or policy for making a complaint about Bullying and/or Harassment which can be obtained from your manager. This policy complements professional and ethical rules, guidelines and codes of conduct and freedom of speech. It is not intended to replace professional codes and mechanisms which allow questions about professional competence to be raised. (However such issues can be raised under this process if no other more appropriate avenue is apparent).

4. Suspected Fraud

If your concern is about possible fraud or bribery the PHA has a number of avenues available to report your concern. These are included in more detail in the PHA Fraud Policy, Fraud Response Plan and Bribery Policy and are summarised below.

Suspicions of fraud or bribery should initially be raised with the appropriate line manager but where you do not feel this is not appropriate the following officers may be contacted:

- Senior Manager
- Head of Department
- Directors
- Fraud Liaison Officer (FLO)

Employees can also contact the regional HSC fraud reporting hotline on **0800 096 33 96** or report their suspicions online to www.reporthealthfraud.hscni.net These avenues are managed by Counter fraud and Probity Services (CFPS) on behalf of the HSC and reports can be made on a confidential basis.

The Fraud Response Plan will be instigated immediately on receipt of any reports of a suspicion of fraud or bribery.

The prevention, detection and reporting of fraud and bribery and other forms of corruption are the responsibility of all those working for the PHA or under its control. The PHA expects all staff and third parties to perform their duties impartially, honestly, and with the highest integrity.

5 The PHA commitment to you

5.1 Your safety

The PHA, the Chief Executive, managers and the trade unions/professional organisations are committed to this policy. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any detriment (such as a reprisal or victimisation). The PHA will not tolerate the harassment or victimisation of anyone who raises a genuine concern.

The PHA expects you to raise concerns about malpractices. If any action is taken that deters anyone from raising a genuine concern or victimises them, this will be viewed as a disciplinary matter.

It does not matter if you are mistaken or if there is an innocent explanation for your concerns, you will be protected under the law. However, it is not uncommon for some staff to maliciously raise a matter they know to be untrue. In cases where staff maliciously raise a matter they know to be untrue, protection under the law cannot be guaranteed and the PHA reserves the right to take disciplinary action if appropriate.

5.2 Confidentiality

With these assurances, the PHA hopes that you will raise concerns openly. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If this is the case, you should say so at the outset to a member of staff in the Governance Team.

The PHA is committed to maintaining confidentiality for everyone involved in a concern. This includes the person raising the concern and the person(s) whom the concern is about. Confidentiality will be maintained throughout the process and after the issue has been resolved.

If you ask for your identity not to be disclosed, we will not do so without your consent unless required by law.

You should however understand that there may be times when we will be unable to resolve a concern without revealing your identity, for example, where personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

5.3 Anonymity

Remember that if you do not disclose your identity, it will be much more difficult for us to look into the matter. It will also not be possible to protect your position or give you feedback. So, while we will consider anonymous reports in the exact same manner as those which are not anonymised, these arrangements are not best suited to deal with concerns raised anonymously.

If you are unsure about raising a concern you can get independent advice from Protect – Speak up, stop harm (see contact details under Independent Advice).

6. Raising a concern

If you are unsure about raising a concern, you can get independent advice at any stage from your trade union/professional organisation, or from one of the organisations listed in Section 7. You should also remember that you do not need to have firm evidence before raising a concern. However, you should explain as fully as possible the information or circumstances that gave rise to the concern.

6.1 Who should I raise a concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it with your line manager. But where you do not think it is appropriate to do this, you can use any of the options set out below.

If raising it with your line manager does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people:

- Your Director
  - ➢ Director of Operations
  - ➢ Director of Nursing and Allied Health Professions (AHP)
  - ➢ Director of Public Health
  - ➢ Director of Health and Social Care Quality Improvement (HSCQI)
- The designated advisor (Assistant Director, Planning & Operational Services)

If you still remain concerned after this, you can contact:

- Chief Executive
  or
- Designated Non-Executive Director

All these people have been trained in receiving concerns and will give you information about where you can go for more support. Advice for managers responding to a concern is outlined in Appendix B.

If, for any reason, you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (see section 7 below).

If, exceptionally, the concern is about the Chief Executive, then it should be made (in the first instance) to the Chair, who will decide on how the investigation will proceed.

6.2 Independent advice

If you are unsure whether to use this policy, or if you require confidential advice at any stage, you may contact your trade union/professional organisation.

Advice is also available through the independent charity Protect – Speak up, stop harm, 7-14 Great Dover Street, London, SE1 4YR (tel: [redacted] website: www.protect-advice.org.uk.

6.3 How should I raise my concern?

You can raise your concerns with any of the people listed above, in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concerns.

7. Raising a concern externally

The PHA hopes this policy reassures you of its commitment to have concerns raised under it taken seriously and fully investigated, and to protect an individual who brings such concerns to light.

Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the PSNI, the PHA would hope that the robust implementation of this policy will reassure staff that they can raise such concerns internally in the first instance.

However, the PHA recognises that there may be circumstances where you can raise a concern with an outside body including those listed below:

- Department of Health
- A prescribed person, such as:
  - General Chiropractic Council, General Dental Council, General Medical Council, General Osteopathic Council, Health & Care Professional Council, Northern Ireland Social Care Council, Nursing and Midwifery Council, Pharmaceutical Society Northern Ireland, General Optical Council;
  - The Regulation and Quality Improvement Authority;
  - The Health and Safety Executive;
  - Serious Fraud Office;
  - Her Majesty's Revenue and Customs,
  - Comptroller and Auditor General;
  - Information Commissioner;
  - Northern Ireland Commissioner for Children and Young People;
  - Northern Ireland Human Rights Commission

Disclosure to these organisations/persons will be protected provided you honestly and reasonably believe the information and associated allegations are substantially true.

We would wish you to raise a matter with the external agencies listed above than not at all.

Protect – Speak up, stop harm (or your union) will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely.

8. The Media

You may consider going to the media in respect of your concerns if you feel the PHA has not properly addressed them. You should carefully consider any information you choose to put into the public domain to ensure that patient/client confidentiality is maintained at all times. The PHA reserves the right to take disciplinary action if patient/client confidentiality is breached.

Communications with the media are coordinated by the Communications Department on behalf of the PHA. Staff approached by the media should direct the media to this department in the first instance.

9. Board oversight

The PHA board and the Department of Health will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and want you to feel free to speak up. The Chair has nominated a non-executive director (Ms Deepa Mann-Kler) with responsibility for the oversight of the organisation's culture of raising concerns.

10. Review & reporting

We will review the effectiveness of this policy and local processes at least annually, with the outcome published and changes made as appropriate.

We will provide regular reports to senior management and to our Governance and Audit Committee on our whistleblowing caseload and an annual return to the Department of Health setting out the actions and outcomes.

Instances of whistleblowing should be reported to the Whistleblowing Advisor, to enable the production of the annual report.

11. Conclusion

While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly, impartially and properly. By using these whistleblowing arrangements you will help us to achieve this.

Please note: this document has been developed to meet best practice and comply with the Public Interest Disclosure (NI) Order 1998 (the Order) which provides employment protection for whistleblowing.

The Order gives significant statutory protection to staff who disclose information reasonably in the public interest. To be protected under the law an employee must act with an honest and reasonable belief that a malpractice has occurred, is occurring or is likely to occur. Disclosures may be made to certain prescribed persons or bodies external to the PHA listed in the Order. The Order does not normally protect employees making rash disclosures for example to the media, when the subject could have been raised internally.

12. Equality, Human Rights & DDA

This policy has been screened for equality implications as required by Section 75, Schedule 9 of the Northern Ireland Act (1998). No significant equality implications have been identified, and therefore an Equality Impact Assessment is not required.

13. Alternative Formats

Every effort will be made to provide information in an alternative format if written format is not accessible to a member of staff.

APPENDIX A

Roles and Responsibilities

The Public Health Agency

- To listen to our staff, learn lessons and strive to improve patient care;
- To ensure that this policy enables genuine issues that are raised to be dealt with effectively;
- To promote a culture of openness and honesty and ensure that issues are dealt with responsibly and taken seriously;
- To ensure that employees who raise any issues are not penalised for doing so unless other circumstances come to light which require this, e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue;
- To share learning, as appropriate, via organisations shared learning procedures.

The Non-Executive Director (NED)

- To have responsibility for oversight of the culture of raising concerns within their organization.

Directors

- To take responsibility for ensuring the implementation of the whistleblowing arrangements.

Managers

- To take any concerns reported to them seriously and consider them fully and fairly;
- To recognise that raising a concern can be a difficult experience for some staff and to treat the matter in a sensitive manner if required;
- To seek advice from other professionals within the PHA where appropriate;

- To invoke the formal procedure and ensure the Whistleblowing Advisor or Director of Operations is informed, if the issue is appropriate;
- To ensure feedback/learning at individual, team and organisational level on concerns and how they were resolved.

Whistleblowing Adviser

- To ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through all management levels;
- To intervene if there are any indications that the person who raised a concern is suffering any recriminations;
- To work with managers and HR to address the culture in the organisation and tackle the obstacles to raising concerns as appropriate.

This list is not intended to be exhaustive or restrictive

All Members of Staff

- To recognise that it is your duty to draw to the PHA attention any matter of concern;
- To adhere to the procedures set out in this policy;
- To maintain the duty of confidentiality to patients and the PHA and consequently, where any disclosure of confidential information is to be justified, you should first, where appropriate, seek specialist advice for example from a representative of a regulating organisation such as the Nursing & Midwifery Council or the General Medical / Dental Council.

Role of trade unions and other organisations

All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Nursing & Midwifery Council, the General Medical Council, Health Professional Council and the Social Care Council for Northern Ireland.

APPENDIX B

ADVICE FOR MANAGERS RESPONDING TO A CONCERN

1. Thank the staff member for raising the concern, even if they may appear to be mistaken;
2. Respect and heed legitimate staff concerns about their own position or career;
3. Manage expectations and respect promises of confidentiality;
4. Discuss reasonable timeframes for feedback with the member of staff;
5. Remember there are different perspectives to every story;
6. Determine whether there are grounds for concern and investigate if necessary as soon as possible. Where appropriate alert those identified as the subject of the concern. If the concern is potentially very serious or wide-reaching, consider who should handle the investigation and know when to ask for help. If asked, managers should put their response in writing;
7. Managers should ensure that the investigator is not connected to the concern raised and determine if there is any actual, potential or perceived conflict of interest which exists prior to disclosing full details of the concern. Should a conflict of interest arise during the investigation the investigator must alert the manager. (Note: Any such conflict must be considered, and acted on, by the manager);
8. Managers should bear in mind that they may have to explain how they have handled the concern;
9. Feed back to the whistleblower and those identified as the subject of a concern (where appropriate) any outcome and/or proposed remedial action, but be careful if this could infringe any rights or duties which may be owed to other parties;
10. Consider reporting to the board and/or an appropriate regulator the outcome of any genuine concern where malpractice or a serious safety risk was identified and addressed;
11. Record-keeping - it is prudent to keep a record of any serious concern raised with those designated under the policy, and these records should be anonymous where necessary.

APPENDIX C

PHA PROCEDURE FOR RAISING A CONCERN

Step one (informal)

If you have a genuine concern about what you believe might be malpractice and have an honest and reasonable suspicion that the malpractice has occurred, is occurring, or is likely to occur, then the matter should be raised in the first instance with your Line Manager. This may be done verbally or in writing.

You are entitled to representation from a trade union/fellow worker or companion to assist you in raising your concern.

Step two (informal)

If you feel unable to raise the matter with your Line Manager, for whatever reason, please raise the matter with our designated adviser (Assistant Director Planning & Operational Services).
Or
Director of Operations
Director of Public Health
Director of Nursing/AHP
Director of HSCQI

They will:

- treat your concern confidentially unless otherwise agreed;
- ensure you receive timely support to progress your concerns;
- escalate to the board any indications that you are being subjected to detriment for raising your concern;
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with;
- ensure you have access to personal support since raising your concern may be stressful.

If you want the matter dealt with in confidence, please say so at the outset so that appropriate arrangements can be made.

Step three (formal)

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact:

Chief Executive

or

Designated Non- Executive

Step four (formal)

You can raise your concerns formally with the external bodies listed at section 7:

What will we do?

We are committed to listening to our staff, learning lessons and improving patient care. On receipt, the concern will be recorded and, where possible, you will receive an acknowledgement within three working days.

A central register will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback. While your identity may be included within the allegation or report, the register will not include any information which may identify you, nor should it include any information which may identify an individual or individuals against whom an allegation is made.

Investigation

Where you have been unable to resolve the matter quickly (usually within a few days) with your Line Manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of).

Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process: for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

We will advise you, where possible, and those identified as the subject of a concern, of the process, what will be investigated and what will not, those who will be involved, the roles they will play and the anticipated timescales.

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

Where an Agency worker raises a concern then it is the responsibility of the PHA to take forward the investigation in conjunction with the Agency if appropriate.

For the purposes of recording, if the concern is already, or has previously been, the subject of an investigation under another procedure e.g. grievance procedure it will not be appropriate to categorise it under the PHA Whistleblowing Policy.

Communicating with you

We welcome your concerns and will treat you with respect at all times. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will endeavour to provide a response within 12 weeks of the concern being received. We will provide an update on progress by week 6 and again by week 10 of the investigation. We will share the outcome of the investigation report with you (while respecting the confidentiality of others).

How we will learn from your concerns

The focus of the investigation will be on improving our services. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made and are working effectively. The final outcome and 'lessons learned' will be documented and approved as final by the responsible Director. In addition the relevant professional Executive Director will independently assess the findings and recommendations for assurance that the matter has been robustly considered and appropriately addressed.

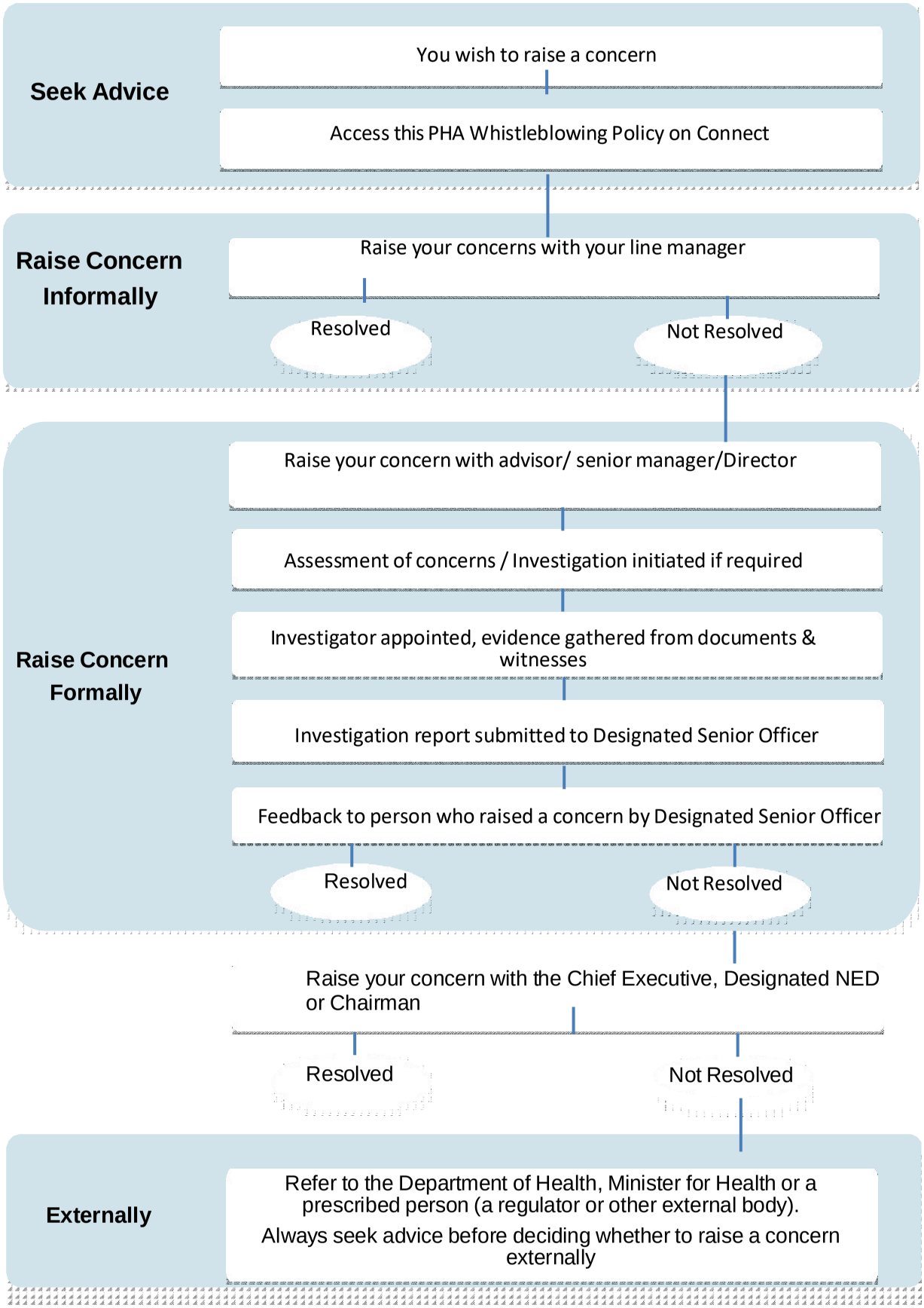
APPENDIX D

PHA CONTACT DETAILS

Title	Name	Email	Phone
Directors:			
Director of Operations			
Director of Nursing and AHP	Mr Rodney Morton	[redacted]	[redacted]
Director of Public Health	Prof. Hugo van Woerden	[redacted]	[redacted]
Designated Advisor:			
Assistant Director Planning and Operational Services	Miss Rosemary Taylor	[redacted]	[redacted]
Chief Executive	Mrs Olive MacLeod	[redacted]	[redacted]
Designated Non-Executive Director	Ms Deepa Mann-Kler	[redacted]	[redacted]
PHA Chair	Mr Andrew Dougal	[redacted]	[redacted]
Governance Team			
Assistant Director Planning and Operational Services	Miss Rosemary Taylor	[redacted]	[redacted]
Senior Operations Manager	Ms Karen Braithwaite	[redacted]	[redacted]

APPENDIX E

Raising Concerns & Whistleblowing Process



THE HEALTH AND SOCIAL CARE (REFORM) ACT (NORTHERN IRELAND) 2009

DIRECTIONS TO THE REGIONAL AGENCY FOR PUBLIC HEALTH AND SOCIAL WELL-BEING ON PROCEDURES FOR DEALING WITH HEALTH AND SOCIAL CARE COMPLAINTS

The Department of Health, Social Services and Public Safety, in exercise of the powers conferred by section 6(1)(b) of the Health and Social Care (Reform) Act (Northern Ireland) 2009(**a**), and having consulted the Regional Agency for Public Health and Social Well-being, hereby directs as follows**:**

ARRANGEMENT OF DIRECTIONS

(**a**) 2009 c.1 (N.I.)

PART I

CITATION, COMMENCEMENT, INTERPRETATION AND APPLICATION

Citation and commencement

1.These Directions, which may be citied as the Directions to the Regional Agency for Public Health and Social Well-Being on procedures for dealing with Health and Social Care complaints, shall come into operation on 26th July 2010.

Interpretation

2. In these Directions —

"the 2009 Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"arrangements" means the arrangements which are required to be made under these Directions;

"complaint" means a complaint by a member of the public about any matter connected with the provision of services by the Public Health Agency, and "complainant" shall be construed accordingly;

"complaints manager" means the person appointed under paragraph 6(1)(b);

"disciplinary proceedings" means —

(a) any procedure for disciplining employees adopted by the Public Health Agency;

(b) any reference of any matter to a representative body having disciplinary powers over members of a profession;

(c) any reference of any matter to the police; and

(d) any inquiry under the Inquiries Act 2005 (**a**);

"HSC body" means a health and social care body as specified in section 1(5) of the 2009 Act;

"independent provider" means a body who is not the Public Health Agency, but with whom the Public Health Agency has made arrangements for the provision of services;

"NI Commissioner for Complaints" means the NI Commissioner for Complaints appointed in accordance with the Commissioner for Complaints (Northern Ireland) Order 1996(**b**);

"Patient and Client Council" means the Patient and Client Council established under section 16 of the 2009 Act;

"patient or client" means a person who is receiving, or has received, services provided by, or on behalf of, the Public Health Agency;

(**a**) 2005 c.12
(b) S.I. 1996/1297 (N.I.7)

"person subject to complaint" means any person or persons against whom a complaint is made or, where the complaint does not identify a named person against whom the complaint is brought, a person who, in the opinion of the complaints manager, is best able to deal with the matters which are the subject of the complaint;

"Public Health Agency" means the Regional Agency for Public Health and Social Well-being established under section 12 of the 2009 Act;

"relevant person" means—

(a) a patient or a client;

(b) any person who has been refused any services;

(c) any person who is receiving, or has received, any services from, or is affected by any action, omission or decision of, the Public Health Agency;

"services" means any service or services: -

(a) provided by the Public Health Agency, or which it is a duty of the Public Health Agency to provide; or

(b) provided by an independent provider.

Application of Directions

3. These Directions apply to any complaint made on or after 26th July 2010 in respect of the Public Health Agency.

PART II

HANDLING AND CONSIDERATION OF COMPLAINTS

Requirement to make arrangements

4.—(1) The Public Health Agency shall make arrangements in accordance with the provisions of these Directions for the handling and consideration of complaints.

(2) The arrangements much be such as to ensure -

(a) that the complaints procedure is accessible;

(b) that complaints are dealt with efficiently;

(c) that complaints are properly investigated;

(d) that complainants are treated with respect and courtesy;

(e) that complainants receive, so far as is reasonably practicable —

(i) assistance to enable them to understand the procedure in relation to complaints; or

(ii) advice on where they might obtain such assistance;

(f) that complainants are, as far as possible, involved in decisions about how their complaint is handled and considered;

(g) that complainants receive a timely and appropriate response;

(h) that complainants are told of the outcome of their complaint; and

(i) that action is taken in light of the outcome of a complaint.

(3) The arrangements shall be in writing and a copy of the arrangements shall be given, free of charge, to any person who makes a request for them.

(4) Where the Public Health Agency makes arrangements for the provision of services with an independent provider, it must ensure that the independent provider has in place arrangements for the handling and consideration of complaints about any matter connected with its provision of services as if these Directions applied to it.

(5) The Public Health Agency shall make arrangements in accordance with Part IV (Monitoring and Publicity) of these Directions for monitoring the effectiveness of and for publicising the arrangements for dealing with complaints.

General duty to co-operate

5. (1) The arrangements under these Directions must be such as to ensure that a full and comprehensive response is given to a complainant and to that end there is all necessary co-operation in the handling and consideration of complaints between —

(a) different HSC bodies; and

(b) the NI Commissioner for Complaints.

(2) The general duty to co-operate required by sub-paragraph (1) includes, in particular, a duty to -

(a) answer questions reasonably put by the body carrying out the investigation;

(b) provide any information relating to the complaint which is reasonably requested by the body carrying out the investigation; and

(c) attend any meeting reasonably required to consider the complaint.

Responsibility for arrangements and complaints manager

6.—(1) The Public Health Agency must appoint —

(a) a senior person within the organisation to take responsibility for ensuring compliance with the arrangements made under these Directions and for ensuring that action is taken in light of the outcome of any investigation; and

(b) a person, in these Directions referred to as a complaints manager -

(i) to perform the functions of the complaints manager under the arrangements;

(ii) to perform such other functions relating to the investigation of complaints as the Public Health Agency may direct; and

(iii) generally to co-ordinate and manage the operation of the procedures for dealing with complaints under the arrangements.

(2) The functions of the senior person appointed under sub-paragraph (1)(a) may be performed personally or by a person authorised by the Public Health Agency to act on his behalf.

(3) The functions of the complaints manager appointed under sub-paragraph (1)(b) may be performed personally or by a person authorised by the Public Health Agency to act on his behalf.

No investigation of complaint

7.—(1) The following complaints are excluded from the scope of the arrangements made under these Directions and shall not be investigated, or shall cease to be investigated —

(a) a complaint made by a HSC body which relates to the exercise of its functions by the Public Health Agency;

(b) a complaint made by an employee of the Public Health Agency about any matter relating to his contract of employment;

(c) a complaint made by an independent provider about any matter relating to arrangements made by the Public Health Agency with that independent provider;

(d) a complaint arising out of the Public Health Agency's alleged failure to comply with a data subject request made under the Data Protection Act 1998(**a**) or a request for information under the Freedom of Information Act 2000(**b**);

(e) a complaint about which the complainant has stated that he intends to take legal proceedings;

(f) a complaint about which the Public Health Agency is taking or is proposing to take disciplinary proceedings in relation to the substance of the complaint against a person subject to the complaint;

(g) a complaint which has lead to the protection of vulnerable adults policy or procedures having been activated;

(h) a complaint which is the subject matter of a Child Protection enquiry;

(i) a complaint which has raised an independent inquiry and/or a criminal investigation;

(j) a complaint which has resulted in a referral to a professional regulatory body;

(k) a complaint which activates the Children Order Representation and Complaints Procedure;

(l) a complaint the subject matter of which has previously been fully investigated under —

(i) these Directions; or

(ii) former Directions.

(m) a complaint which is being or has been investigated by the NI Commissioner for Complaints.

(2) Where the investigation of a matter which is the subject of a complaint is not commenced, or has ceased, in accordance with sub-paragraph (1)(e), investigation shall be commenced, or resumed, where a complainant states in writing that he no longer intends to pursue a remedy by way of legal proceedings.

(3) Where the investigation of a matter which is the subject of a complaint is not commenced, or has ceased, in accordance with sub-paragraph (1)(f), investigation shall be commenced, or resumed in relation to any matter which has not been dealt with by disciplinary proceedings.

(4) Where the investigation of a matter which is the subject of a complaint is not commenced, or has ceased, in accordance with heads (g), (i) or (j) of sub-paragraph (1), investigation shall be commenced, or resumed in relation to any matter which has not been dealt with under the proceedings referred to in those heads.

(5) The Chief Executive of the Public Health Agency shall notify the complainant and any person subject to complaint of any decision not to investigate the complaint or to discontinue an investigation of a complaint under sub-paragraph (1) and of any start, or resumption, of an investigation.

(6) The notification to be given under sub-paragraph (5) shall be in writing and shall state the reason for any decision referred to in that sub-paragraph.

(**a**) 1998 c.29
(**b**) 2000 c.36

PART III

THE INITIAL COMPLAINT

Requirement to deal with the complaint

8.Subject to paragraph 7, a complaint shall be dealt with in accordance with the arrangements if it is made—

(a) by a person specified in paragraph 9;

(b) in the manner specified in paragraph 10;

(c) about any matter connected with the provision of services; and

(d) within the period specified in paragraph 11.

Person who may make a complaint

9.—(1) A complaint may be made by —

(a) a relevant person; or

(b) a person (in these Directions referred to as a representative) acting on behalf of a relevant person in any case where the relevant person —

(i) has died;

(ii) is a child;

(iii) is unable by reason of physical or mental incapacity to make the complaint himself; or

(iv) has requested the person to act on his behalf.

(2) In the case of a relevant person who has died or who is incapable, the representative must be a relative or other person, who, in the opinion of the complaints manager, had or has a sufficient interest in his welfare and is a suitable person to act as representative.

(3) If in any case the complaints manager is of the opinion that a representative does or did not have a sufficient interest in the person's welfare or is unsuitable to act as representative, he must notify that person in writing, stating his reasons. The complaints manager may then either refuse to deal with the complaint or nominate another person to act with respect to the complaint.

(4) In the case of a child, the representative must be either a parent, or in the absence of both parents, guardian or other adult person who has care of the child, or where the child is in the care of an authority or a voluntary organisation, the representative must be a person authorised by the authority or the voluntary organisation.

(5) In these Directions any reference to a complainant includes a reference to his representative.

Making a complaint

10.—(1) Where a person wishes to make a complaint under these Directions, he may make the complaint to the complaints manager or any other member of staff of the Public Health Agency.

(2) Any person other than the complaints manager to whom a complaint is made, whether orally, in writing or electronically, shall refer the complaint to the complaints manager.

(3) A complaint may be made orally or in writing, including electronically, and —

(a) where it is made orally, the complaints manager or other member of staff of the Public Health Agency shall make a written record of the complaint which includes the name of

the complainant, the subject matter of the complaint and the date on which it was made, and provide a copy of the written record to the complainant;

(b) where it is made in writing, the complaints manager shall make a written record of the date on which it was received.

(4) For the purposes of these Directions where the complaint is made in writing it is treated as being made on the date on which it is received by the complaints manager or as the case may be, other member of staff of the Public Health Agency.

Time limits

11.—(1) Subject to sub-paragraph (2), the period for making a complaint is—

(a) six months from the date on which the matter which is the subject of the complaint occurred; or

(b) where the complainant was not aware that there was cause of complaint, within —

(i) six months from the date on which the matter which is the subject of the complaint comes to the complainant's notice; or

(ii) twelve months from the date on which the matter which is the subject of the complaint occurred,

whichever is the sooner.

(2) Where a complaint is received which was not made during the period specified in sub-paragraph (1) it shall be referred to the complaints manager and if he is of the opinion that —

(a) having regard to all the circumstances of the case, it would be unreasonable to have expected the complainant to have made the complaint within that period; and

(b) notwithstanding the time that has elapsed since the date on which the matter which is the subject of the complaint occurred, it is still possible to investigate the complaint properly,

the complaint shall be treated as though it had been received during the period specified in sub-paragraph (1).

Acknowledgement and record of complaint

12.—(1) The complaints manager shall send to the complainant a written acknowledgement of the complaint within 2 working days of the date on which the complaint was made.

(2) Where a complaint was made orally, the acknowledgment shall be accompanied by the written record mentioned in paragraph 10(3)(a) with an invitation to the complainant to sign and return it.

(3) The complaints manager shall send a copy of the complaint and its acknowledgement to any person subject to complaint unless he has reasonable grounds to believe that to do so would be detrimental to that person's health or well-being.

(4) The acknowledgement sent to the complainant under sub-paragraph (1) must include information about the right to assistance from the Patient and Client Council.

Investigation

13.—(1) A complaint must be investigated to the extent necessary and in a manner which appears most appropriate to an efficient and effective resolution.

(2) The complaints manager may, in any case where he thinks it would be appropriate to do so and with the agreement of the complainant, make arrangements for independent expert advice, conciliation or other assistance for the purposes of resolving the complaint.

(3) The complaints manager must take such steps as are reasonably practicable to keep the complainant informed about the progress of the investigation.

Response

14.—(1) The complaints manager must ensure a written response is prepared to the complaint which summarises the nature and substance of the complaint, describes the investigation and summarises its conclusions.

(2) The response must be signed off by the Chief Executive of the Public Health Agency. A copy shall be provided to the complainant and any person subject to complaint.

(3) The Chief Executive of the Public Health Agency can delegate responsibility for responding to a complaint, where in the interests of a prompt reply a designated Executive Director of the Public Health Agency undertakes this task on the Chief Executive's behalf.

(4) The response must be sent to the complainant within 20 working days beginning on the date on which the complaint was made or, where that is not possible, the complainant must be notified of the delay and the full response issued as soon as reasonably practicable.

(5) The response must notify the complainant of his right to refer the complaint to the NI Commissioner for Complaints should he remain dissatisfied with the result of the HSC complaints procedure.

(6) Copies of the response mentioned in sub-paragraph (1) must be sent to any other person to whom the complaint was sent under paragraph 12(3).

(7) Responses should not be made electronically.

PART IV

MONITORING AND PUBLICITY

Monitoring

15.—(1) For the purposes of —

(a) monitoring the arrangements for the handling and consideration of complaints;

(b) considering the nature, volume and outcome of complaints;

(c) taking remedial action following investigation of complaints; and

(d) organisational learning,

the Public Health Agency shall prepare reports at such intervals as it may determine for consideration by its board.

(2) The reports mentioned in sub-paragraph (1) must: —

(a) specify the number of complaints received;

(b) identify the subject matter of those complaints;

(c) summarise how they were handled including the outcome of the investigations;

(d) specify the number of complaints that have been accepted for investigation by the NI Commissioner for Complaints; and

(e) identify any complaints where the recommendations of the NI Commissioner for Complaints were not acted upon, giving the reasons why not.

(3) For the purposes of ensuring the efficient use of resources the Public Health Agency will monitor the effectiveness and usage of independent experts, conciliation and lay person assistance.

Learning

16. The Public Health Agency is responsible for ensuring that arrangements are in place for the purposes of organisational learning.

Annual Reports

17. The Public Health Agency shall include within its annual report a report on its handling and consideration of complaints under these Directions which shall be sent to —

(a) the Department of Health, Social Services and Public Safety; and

(b) the Patient and Client Council.

Publicity

18.—(1) The Public Health Agency shall take such steps as are necessary to ensure that —

(a) the patient or client;

(b) staff working for that body;

(c) the Patient and Client Council;

are fully informed of the arrangements for dealing with complaints and are informed of the name of the complaints manager and the address at which he can be contacted.

(2) The requirement to provide information specified in sub-paragraph (1) includes a requirement to provide information on the services which the Patient and Client Council offers to persons who wish to make complaints.

Training

19. The Public Health Agency must ensure that its staff are informed about and appropriately trained in the operation of the complaints arrangements.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 23rd July 2010.

A senior officer of the
Department of Health, Social Services and Public Safety

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

GUIDANCE IN RELATION TO THE

HEALTH AND SOCIAL CARE COMPLAINTS PROCEDURE

Updated April 2023

REVISIONS TO HSC COMPLAINTS PROCEDURE

Title	Update/Action	Date Effective
Guidance in relation to the Health and Social Care Complaints Procedure	Updated to reflect the closure of the Health and Social Care (HSC) Board and migration of functions to Strategic Planning and Performance Group (SPPG), DoH.	01 April 2022
Guidance in relation to the Health and Social Care Complaints Procedure	Introduced in place of: Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning.	01 April 2019
Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	Introduced in place of: (HPSS) Complaints Procedure 1996.	01 April 2009
Health and Personal Social Services (HPSS) Complaints Procedure 1996	Revoked and replaced with new Guidance.	31 March 2009

AMENDMENTS TO COMPLAINTS DIRECTIONS

Directions	Details	Date Effective
Health and Social Care Complaints Procedure Directions	The Main Directions were amended for the third time at: • Paragraph 2 (Interpretation) of the principal Directions: ▪ omit the definition of "HSC Board". ▪ in the definition of "HSC Body" omit "HSC Board". ▪ in the definition of "Serious Adverse Incident" omit "HSC Board's". (1)	28 October 2022 **2022 No. 4**

(1) Also refers to the 2013 Amendment Directions

Directions	Details	Date Effective
	• Paragraph 7 (No investigation of complaint): ▪ in sub-paragraph (1)(d) for "the Data Protection Act 1988" substitute "the Data Protection Act 2018([2])". ▪ in sub-paragraph (4A) for "Serious Adverse Incident investigation" substitute "Serious Adverse Incident review". • In paragraph 15(4) (Monitoring), for "HSC Board" at each place it occurs, substitute "Department of Health" and for the "Data Protection Act 1998" substitute "Data Protection Act 2018". • In paragraph 16(2) (Learning), for "HSC Board" substitute "Department of Health". • In paragraph 17 (Annual Reports) omit sub-paragraph (2).	
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The Directions to the Health and Social Care Board on Procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers 2009 are revoked.	28 October 2022 **2022 No. 4**

([2]) 2018 c. 12

Directions	Details	Date Effective
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The **PHA Directions** were amended for the second time at: • In paragraph 2 (Interpretation) in the definition of "Serious Adverse Incident" omit "HSC Board's". • In paragraph 7 (No investigation of complaint): ▪ in sub-paragraph (1)(d) for "the Data Protection Act 1998" substitute "the Data Protection Act 2018([3])". ▪ in sub-paragraph (4A) for "Serious Adverse Incident investigation" substitute "Serious Adverse Incident review".	28 October 2022 **2022 No. 5**
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The **BSO Directions** were amended for the second time at: • In paragraph 2 (Interpretation), in the definition of "Serious Adverse Incident" omit "HSC Board's". • In paragraph 7 (No investigation of complaint): ▪ in sub-paragraph (1)(d) for "the Data Protection Act 1998" substitute "the Data Protection Act 2018([4])". ▪ in sub-paragraph (4A) for "Serious Adverse Incident investigation" substitute "Serious	28 October 2022 **2022 No. 3**

([3]) 2018 c. 12
([4]) 2018 c. 12

Directions	Details	Date Effective
	Adverse Incident review".	
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The **BSO Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman. • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	01 April 2019 **2019 No. 4**
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The **PHA Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	01 April 2019 **2019 No. 3**

Directions	Details	Date Effective
	• Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol	
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the third time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b) substitute(b) The HSC Board Complaints Manager acts impartially as “honest	01 April 2019 **2019 No. 2**

Directions	Details	Date Effective
	broker" to the complainant and Practice/Practitioner in the resolution of the complaint.	
Health and Social Care Complaints Procedure Directions	The **Main Directions** were amended for the second time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—update to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b) substitute(b) The HSC Board Complaints Manager acts impartially as "honest broker" to the complainant and Practice/Practitioner in the resolution of the complaint.	01 April 2019 **2019 No. 1**

Directions	Details	Date Effective
	• Paragraph 14 (Response) of the principal Directions omit sub-paragraph (7).	
Complaints about Family Health Services Practitioners and Pilot Scheme Providers **(Amendment)** Directions (Northern Ireland) 2013	The **HSC Board Directions** were amended for the second time in regard to the handling of complaints under paragraph 12(5)(b) at: • Paragraph 18(c) (Response) was amended to include sub-paragraph 18(c)(i) to respond to the complainant within 20 days when the HSC Board has been asked to act as 'honest broker'; and • Sub-paragraph 18(c) (ii) to respond to the complainant within 10 days in all other cases.	02 September 2013 **2013 No. 12**
Health and Social Care Complaints Procedure Directions **(Amendment)** (Northern Ireland) 2009	The **Main Directions** were amended for the first time at: • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	02 September 2013 **2013 No. 11**
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The Directions were introduced. Known as **BSO Directions**	26 July 2010
Directions to the Regional Agency for Public Health	The Directions were introduced. Known as **PHA Directions**	26 July 2010

Directions	Details	Date Effective
and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints		
Amendment Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the first time in respect to monitoring and the requirement by the Family Practitioner Services or pilot scheme provider to obtain consent from the complainant was removed at: Paragraph 21(2)(a) in regards to what the practitioner must send to the HSC Board and the timescale: and Paragraph 21(2) (b) in regards the practitioner sending the HSC Board quarterly complaints.	01 October 2009
Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The Directions were introduced. Known as **HSC Board Directions**	01 April 2009
Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009	The Directions were introduced. Known as **Main Directions**	01 April 2009

BACKGROUND

The HSC Complaints Procedure*, 'Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning'* was developed and published in 2009*.* It replaced the former Health and Personal Social Services (HPSS) Complaints Procedure 1996 and provided a streamlined health and social care (HSC) complaints process that applies equally to all HSC organisations. As such it presented a simple, consistent approach and set out complaints handling procedures with clear standards and guidance for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

The HSC Complaints Procedure (published 2009) was developed in conjunction with HSC organisations and publically consulted on before being finalised and published. It reflected the changing culture across HSC services and demonstrated an increased emphasis regarding the promotion of and need for **safety and quality** in service provision as well as the need to be open and transparent; and to learn from complaints and take action in order to reduce the risk of recurrence.

On the 1st April 2019 revised guidance was introduced and incorporated a number of legislative changes. The document was renamed, '*Guidance in relation to the Health and Social Care Complaints Procedure' or 'HSC Complaints Procedure'* for short.

The HSC Complaints Procedure presents HSC organisations with detailed, yet flexible, complaints handling arrangements designed to:

- provide effective local resolution and learning;
- 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, lay persons and conciliation;
- resolve complaints quickly and efficiently;
- provide flexibility in relation to target response times;

- provide an appropriate and proportionate response within reasonable and agreed timescales;
- provide clear lines of responsibility and accountability;
- improve record keeping, reporting and monitoring; and
- increase opportunities for shared learning across the region.

The standards for complaints handling are designed to assist HSC organisations in monitoring the effectiveness of their complaints handling arrangements locally and build public confidence in the process. The eight specific standards of HSC are:

Standard 1: Accountability
Standard 2: Accessibility
Standard 3: Receiving complaints
Standard 4: Supporting complainants and staff
Standard 5: Investigation of complaints
Standard 6: Responding to complaints
Standard 7: Monitoring
Standard 8: Learning

More details on each of the standards are provided in Annex 1 of this document.

It is recognised that sometimes, and even in despite of the best efforts of all concerned, there will be occasions when local resolution fails. Where this happens the complainant will be advised of their right to refer their complaint to the Ombudsman. The HSC Organisation also reserves the right to refer complaints to the Ombudsman.

Update – 01 April 2022

As a result of the migration of the HSC Board to the Department of Health (DoH) this guidance has been amended to reflect the transfer of the HSC Board functions in respect of HSC Complaints to the Strategic Planning and Performance Group (SPPG) in the Department.

SPPG will on behalf of the Department of Health assume the roles and responsibilities previously undertaken by the HSC Board. This updated guidance is effective from 01 April 2022.

SECTION 1 – INTRODUCTION

Purpose of the HSC Complaints Procedure

1.1 This document is an updated version of the HSC Complaints Procedure which was first published in 2009 and sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services. It replaces any previous or existing guidance with effect from 01 April 2022 and continues to provide a streamlined complaints process which applies equally to all HSC organisations, including the HSC Trusts, Business Services Organisation (BSO), Public Health Agency (PHA), NI Blood Transfusion Service (NIBTS), Family Practitioner Services (FPS), Out of Hours services, pilot schemes and HSC prison healthcare. As such, it presents a simple, consistent approach for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

1.2 The HSC Complaints Procedure continues to promote an organisational culture in health and social care that fosters openness and transparency for the benefit of all who use it or work in it. It is designed to provide ease of access, simplicity and a supportive and open process which results in a speedy, fair and, where possible, local resolution. The HSC Complaints Procedure provides the opportunity to put things right for service users as well as learning from the experience and improving the safety and quality of services. Dealing with those who have made complaints delivers an opportunity to re-establish a positive relationship with the complainant and to develop an understanding of their concerns and needs.

Local resolution

1.3 The purpose of local resolution is to enable the complainant and the organisation to attempt a prompt and fair resolution of the complaint.

1.4 HSC organisations should work closely with service users to find an early resolution to complaints. Every opportunity should be taken to resolve complaints as close to the source as possible, through discussion and negotiation. Where possible, complaints should be dealt with immediately. Where this is not possible, local resolution should be completed within 20 working days of receipt of a complaint (10 working days within FPS settings). The expectations of service users should be

managed by HSC staff and any difficulties identified in being able to resolve a complaint within 20 days by local resolution should be communicated to the service user immediately.

1.5 Local procedures should be easily accessible, open, fair, flexible and conciliatory and should encourage communication on all sides. They should include a well-defined process for investigating and resolving complaints. Complainants must be advised of their right and be signposted to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the HSC Complaints Procedure.

Principles of an effective Complaints Procedure

1.6 The HSC Complaints Procedure has been developed around four key principles:

- **openness and accessibility** – flexible options for pursuing a complaint and effective support for those wishing to do so;
- **responsiveness** – providing an appropriate and proportionate response;
- **fairness and independence** – emphasising early resolution in order to minimise strain and distress for all; and
- **learning and improvement** – ensuring complaints are viewed as a positive opportunity to learn and improve services.

Learning

1.7 Effective complaints handling is an important aspect of clinical and social care governance arrangements. Lessons learned during the complaints resolution process will assist organisations to make changes to improve the quality of their services and safeguard high standards of care and treatment. Increased efforts should be made to promote a more positive culture of not just resolving complaints but also learning from them. Furthermore, by highlighting the potential added value of complaints and subsequent quality and safety improvements made within HSC organisations the process becomes more acceptable and amenable to all.

1.8 Complaints are seen as a significant source of learning within health and social care and provide opportunities to improve:

- outcomes for services users;
- the quality of services; and
- service user experiences.

1.9 How HSC organisations handle complaints is an indicator of how responsive they are to the concerns of service users and/or their representatives. An increase in the number of complaints is not in itself a reason for thinking the service is deteriorating. The important point is to handle complaints well, take appropriate action and use the lessons learned to improve quality and safety.

What the HSC Complaints Procedure covers

1.10 The HSC Complaints Procedure 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, for example:

- HSC Trusts
  - hospital and community services
  - registered establishments and agencies where the care is funded by the HSC
  - HSC funded staff or facilities in private pay beds
  - HSC prison healthcare
- Business services organisation (BSO)
  - services provided relevant to health and social care
- Public Health agency (PHA)
- Northern Ireland Blood Transfusion Service (NIBTS)
- Family practitioner Services (FPS)

1.11 The HSC Complaints Procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased patients under the Access to Health Records (NI) Order 1993[5] as an alternative to making an application to the courts.

[5] Access to Health Records (NI) Order 1993 applies only to records created since 30 May 1994.

What the HSC Complaints Procedure does not cover

1.12 Complaints about private care and treatment or service; which includes private dental care[6] or privately supplied spectacles are not dealt with in this guidance. In addition those services which are not provided or funded by the HSC, for example, provision of private medical reports are also not covered under the HSC Complaints Procedure.

1.13 Complaints may be raised within an HSC organisation which need to be addressed, but the complaint or aspects of it may 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 which can be referred to in order 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 DoH
- requests for information under Freedom of Information or access to records under the UK General Data Protection Regulation (GDPR) and Data Protection Act 2018
- independent inquiries and criminal investigations
- the Children Order Representations and Complaints Procedure
- adult safeguarding
- child protection procedures
- Coroners cases
- legal action
- Serious Adverse Incidents (SAIs)
- Whistleblowing[7]

1.14 Complaints received that appear to indicate the need for referral under any of the processes listed above should be immediately transferred to the Complaints

[6] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/
[7] Public Interest Disclosure (Northern Ireland) Order 1998

Manager for onward transmission to the appropriate department. Where a complaint is referred to any of these other processes it will be the responsibility of the officers involved to ensure that information is given to complainants on the reason for the referral; how the new process operates; their expectations for involvement in the process; anticipated timescales and the named officer/organisation the complainant can contact for ongoing communication. If any aspect of the complaint is not covered by the referral it will continue to be investigated under the HSC Complaints Procedure. In these circumstances, investigation will only be taken forward if it does not, or will not, compromise or prejudice the matter being investigated under any other process.

Staff Grievances

1.15 HSC organisations should have separate procedures for handling staff grievances.

Disciplinary Procedure

1.16 Disciplinary matters are not covered under the HSC Complaints Procedure. Its purpose is to focus on resolving complaints and learning lessons for improving HSC services. It is not for investigating disciplinary matters though these can be investigated by the HSC organisation and may be referred to a Professional Regulatory Body (see paragraph 1.20 below). The purpose of the HSC Complaints Procedure is not to apportion blame, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

1.17 Where a decision is made to embark upon a disciplinary investigation, action under the HSC Complaints Procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint <u>not</u> covered by the disciplinary investigation, they may continue to be dealt with under the HSC Complaints Procedure.

1.18 The Chief Executive (or designated senior person[8]) must advise the complainant in writing that an investigation is being dealt with under appropriate Trust staff procedures. They also need to be informed that they may be asked to take part

[8] A designated Senior Person should be a Director (or Nominee)

in the process and that any aspect of the complaint not covered by the investigation will continue to be investigated under the HSC Complaints Procedure.

1.19 In drafting these letters, the overall consideration must be to ensure that when investigation is required the complainant is not left feeling that their complaint has only been partially dealt with.

Investigation by a Professional Regulatory Body

1.20 A similar approach to that outlined above should be adopted in a case referred to a professional regulatory body (Annex 3). The Chief Executive (or designated senior person) must inform the complainant in writing of the referral. This should include an indication that any information obtained during the complaints investigation may need to be passed to the regulatory body. The letter should also explain how any other aspect of the complaint not covered by the referral to the regulatory body will be investigated under the HSC Complaints Procedure.

Services Commissioned by the DoH

1.21 Correspondence raising an issue on the availability, commissioning and/or the purchasing of services arising as a result of a decision taken by the Department, should be addressed directly to the Department of Health.

Requests for Information/Access to Records

1.22 Although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000[9] and requests for access to health or social care records under the UK General Data Protection Regulation (GDPR)[10] and Data Protection Act 2018.

[9] Freedom of Information Act 2000: http://www.legislation.gov.uk/ukpga/2000/36/contents
[10] General Data Protection Regulation (GDPR): https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

Independent Inquiries and Criminal Investigations

1.23 Where an independent inquiry into a serious incident or a criminal investigation is initiated, the Chief Executive (or designated senior person) should immediately advise the complainant of this in writing. As the HSC Complaints Procedure cannot deal with matters subject to any such investigation, consideration of those parts of the original complaint must cease until the other investigation is concluded.

1.24 When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended may recommence if there are outstanding matters remaining to be considered under the HSC Complaints procedure.

Children Order Representations and Complaints Procedure

1.25 Arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annex 14. The HSC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995[11].

Adult Safeguarding

1.26 Where it is apparent that a complaint relates to abuse, exploitation, or neglect of an adult at risk of harm then the regional '*Adult Safeguarding Operational Procedures*' (September 2016[12]) and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases'* (August 2016[13]) should be activated by contacting the Adult Protection Gateway Service at the relevant HSC Trust[14]. The HSC Complaints Procedure should be suspended pending the outcome of the adult safeguarding investigation and the complainant advised accordingly. However, if there are aspects of the complaint that do not cause the aforementioned Operational Procedures and associated Protocol to be activated, then these should continue to be investigated under the HSC Complaints Procedure. However, only those aspects of the complaint

[11] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[12] Adult Safeguarding Operational Procedures: Adult Safeguarding (hscni.net)
[13] Protocol for Joint Investigation of Adult Safeguarding Cases: DRAFT (hscni.net)
[14] Information about and contact details for HSC Trusts can be accessed at the following link - https://www.nidirect.gov.uk/articles/who-contact-if-you-suspect-abuse-exploitation-or-neglect

not falling within the scope of the safeguarding investigation will continue via the HSC Complaints Procedure.

Child Protection Procedures

1.27 Any complaint about individual agencies should be investigated through that agency's complaints procedure. Appeals which relate to decisions about placing a child's name on the Child Protection Register should be dealt with through the Child Protection Registration Appeals Process. The Safeguarding Board for Northern Ireland (SBNI) Child Protection procedures manual outlines the criteria for appeal under that procedure. These include when the:

- ACPC procedures in respect of the case conference were not followed;
- information presented at the case conference was inaccurate; incomplete or inadequately considered in the decision making process;
- threshold for registration/deregistration was not met;
- category for registration was not correct.

Coroners Cases

1.28 With the agreement of the Coroner's Office, where there are aspects of the complaint not covered by the Coroner's investigation they will continue to be dealt with under the HSC Complaints Procedure. Once the Coroner's investigation has concluded, any issues that are outstanding in relation to the matters considered by the Coroner may then be dealt with under the HSC Complaints Procedure.

Legal Action

1.29 Even if a complainant's initial communication is through a solicitor's letter it should <u>not be</u> inferred that the complainant has decided to take formal legal action.

1.30 If the complainant has either instigated formal legal action, or advised that he or she intends to do so, the complaints process should cease. The Chief Executive (or designated senior person) should advise the complainant and any person/member of staff named in the complaint of this decision in writing. However, those aspects of the complaint not falling within the scope of the legal investigation will continue via the HSC Complaints Procedure.

1.31 It is not the intention of the HSC Complaints Procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides **not to take legal action**. If he/she then wishes to continue with their complaint via the HSC Complaints Procedure and requests this, the investigation of their complaint should commence or resume. However, any matter that has been through the legal process to completion cannot also be investigated under the HSC Complaints Procedure.

Serious Adverse Incidents (SAI)

1.32 Complaints may indicate the need for a Serious Adverse Incident (SAI) review. When this occurs, the Chief Executive (or designated senior person), must advise the complainant and any person/staff member named in the complaint in writing that an SAI review is under way. They must also indicate to all concerned that the HSC Complaints Procedure may still continue during the SAI review. However, only those aspects of the complaint not falling within the scope of the SAI review will continue via the HSC Complaints Procedure.

1.33 The overall consideration must be to ensure that when the review is through the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

Whistleblowing

1.34 The Department of Health has a framework and model policy in place for HSC organisations on Whistleblowing[15]. All HSC organisations should have their own separate procedures in place.

[15] https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-whistleblowing.PDF

SECTION 2 – MAKING A COMPLAINT

What is a complaint?

2.1 A complaint is "**an expression of dissatisfaction that requires a response**". 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 actually complaints and therefore need to be handled as such.

Promoting access

2.2 Standard 2: *Accessibility* provides the criteria by which organisations should operate (Annex 1 refers). Service users should be made aware of their right to complain and given the opportunity to understand all possible options for pursuing a complaint. Complainants must, where appropriate, have the support they need to articulate their concerns and successfully navigate the system. They must also be advised on the types of help available, for example, through front-line staff, the Complaints Manager and the Patient and Client Council (PCC). HSC organisations should promote and encourage more open and flexible access to the HSC Complaints Procedure and other less formal avenues in an effort to address barriers to access.

Who can complain?

2.3 Any person can complain about any matter connected with the provision of HSC services. Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
  - someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

Consent

2.4 Complaints by a third party should be made with the written consent of the individual concerned. There will be situations where it is not possible to obtain consent, such as when the:

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

2.5 Where a person is unable to act for him/herself, his/her consent shall not be required.

2.6 The Complaints Manager, in discussion with the Chief Executive (or designated senior person), will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or designated senior person) must provide them with information in writing outlining the reasons the decision has been taken. More information on consent can be found in the DoH good practice in consent guidance[16].

2.7 Third party complainants who wish to pursue their own concerns can bring these to the HSC organisation without compromising the identity of the patient/client. The HSC organisation must consider the matter then investigate and address the issue and any concerns identified fully. A response will be provided to the third party on any issues which may be addressed without breaching patient/client confidentiality.

[16] https://www.health-ni.gov.uk/articles/consent-examination-treatment-or-care

Confidentiality

2.8 HSC staff should be aware of their legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the UK General Data Protection Regulations (GDPR) and Data Protection Act 2018 which controls how personal information is used by organisations, businesses or the government. Additional requirements are detailed in the Human Rights Act 1998 (HRA) which requires public authorities to act in a way which is compatible with the list in the European Convention on Human Rights (the Convention). The Common Law Duty of Confidentiality 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. More detailed information can be found in the DoH guidance entitled *Code of Practice on Protecting the Confidentiality of Service User Information*[17] published January 2012.

2.9 It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. Even so, it is good practice to explain to the service user that information from his/her health and/or social care records may need to be disclosed to the complaint investigators, but only if they have a demonstrable need to know and for the purposes of investigating. If the service user objects to this, it should be explained to him/her that non-disclosure could compromise the investigation and his/her hopes of a satisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

Third Party Confidence

2.10 The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social care professional. Only information which is relevant to the complaint should be considered for disclosure, and then only to those *within* the HSC who have a demonstrable 'need to know' in

[17] DoH Code of Practice: https://www.health-ni.gov.uk/publications/dhssps-code-practice-protecting-confidentiality-service-user-information

connection with the complaint investigation. Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure.

2.11 Disclosure of information provided by a third party outside the HSC also requires express consent. If the third party objects, then information they provided can only be disclosed where there is an overriding public interest in doing so.

Use of Anonymised Information

2.12 Where anonymised information about a patient/client and/or third parties would suffice for investigation of the complaint, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use certain information, then it can only be used where there is an overriding public interest in doing so.

How can complaints be made?

2.13 Complaints may be made in a variety of formats including verbally, written or electronic. Should a verbal complaint be made the complainant should be asked to formalise their complaint in writing. If the complainant is unable to put their complaint in writing then Trust staff or the Patient Client Council can provide assistance. It is helpful to establish at the outset what the complainant wants to achieve in order to avoid confusion or dissatisfaction and subsequent complaints. HSC organisations should be mindful of technological advances specifically in regard to email communications and must adhere to their relevant Information Technology (IT) policies and procedures. Complaints Managers should also consider local arrangements to ensure there is no breach of patient/client confidentiality in the management of information surrounding complaints.

2.14 Complaints may be made to any member of staff, for example receptionists, clinical or care staff. In many cases complaints are made orally and front-line staff may either resolve the complaint “on the spot” or pass it to the Complaints Manager.

It is important that front-line staff receive the appropriate complaints handling training including refresher training according to extant local procedures. They must also be supported to respond sensitively to the comments and concerns raised and be able to distinguish those issues which would be better referred elsewhere for more detailed investigation. Front line staff should familiarise themselves with Section 75 of the Northern Ireland Act 1998 which changed the practices of government and public authorities so that equality of opportunity and good relations are central to policy making, policy implementation, policy review and service delivery[18]. (See Flowchart page 45)

Options for pursuing a complaint

2.15 Some complainants may prefer to make their initial complaint to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer, to the Chief Executive. All HSC organisations have named Complaints Managers. The following paragraphs outline the options available to complainants who want to raise complaints in relation to:

- Family Practitioner Services;
- Regulated Establishments and Agencies; and
- Independent Sector Providers.

Family Practitioner Services (family doctors, dentists, pharmacists, opticians)

2.16 Family Practitioner Services (FPS) are required to have in place a practice-based complaints procedure which forms part of the local resolution mechanism for settling complaints. A patient may approach any member of staff with a complaint about the service or treatment he/she has received.

2.17 Alternatively, the complainant has the right to lodge his/her complaint with the SPPG Complaints Team[19], if he/she does not feel able to approach immediate staff (see flowchart page 46).

[18] Section 75 of the Northern Ireland Act 1998 https://www.legislation.gov.uk/ukpga/1998/47/section/75
[19] SPPG Complaints Team acting on behalf of the DoH.

2.18 Where requested, the SPPG Complaints Team will act impartially as "honest broker" to the complainant and Practice/Practitioner in either the resolution of a complaint or by assisting all parties in reaching a position of understanding. The objective for the SPPG Complaints Team should be, wherever possible, to restore the trust between the patient and the Practice/Practitioner staff. This will involve an element of mediation on the part of the SPPG Complaints Team or the offer of conciliation services where they are appropriate. The SPPG Complaints Team should seek with the complainant's agreement to involve the FPS Complaints Manager as much as possible in resolving the issues. The SPPG Complaints Team is also available to Practice/Practitioner staff for support and advice.

2.19 The SPPG Complaints Team has a responsibility to record and monitor the outcome of complaints lodged with them.

2.20 The SPPG Complaints Team will provide support and advice to FPS in relation to the resolution of complaints. It will also appoint Independent Experts, Lay Persons or Conciliation Services, where appropriate.

2.21 Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the practice-based complaints procedure.

Regulated Establishments and Agencies

2.22 All regulated establishments and agencies[20] must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards and the HSC Complaints Procedure. This includes:

- Effectively publicising the arrangements for dealing with complaints and ensuring service users, clients and families are aware of such arrangements;
- Ensuring that any complaint made under the complaints procedure is investigated;
- Ensuring that time limits for investigations are adhered to;

[20] Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.

- Advising complainants regarding the outcomes of the investigation; and
- Maintaining a record of learning from complaints that is available for inspection.

2.23 Complainants must also be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the HSC Complaints Procedure. It is for the Ombudsman to determine whether or not a case falls within that office's jurisdiction.

2.24 Complaints may be made by service users or persons acting on their behalf providing they have obtained the service user's consent. Complaints relating to contracted services provided by the registered provider or agency may be received directly by the service provider or by the contracting Trust. Complainants should be encouraged to raise their concerns, at the outset, with the registered provider or agency. The registered provider is required by legislation to ensure the complaint is fully investigated. The general principle in the first instance would be that the registered provider or agency investigates and responds directly to the complainant.

2.25 However, individuals placed in a regulated establishment or who have their service provided by a regulated agency may, if they prefer, raise their concerns through the HSC Trust that commissioned the care on their behalf (see flowchart on page 47) as the commissioning Trust has a continuing duty of care to the service user and should participate in local resolution as necessary.

2.26 Where complaints are raised with the HSC Trust, the Trust must establish the nature of the complaint and consider how best to proceed. For example, the complaint may be about an aspect of the "care plan" and can, therefore, only be fully dealt with by the Trust. The complaint may also trigger the need for an investigation under child protection or protection of vulnerable adults' procedures or indeed, might highlight non-compliance with statutory requirements. It is not the intention to operate parallel complaints procedures, however, if the RQIA is notified of a breach of regulations or associated standards it will review the matter and take whatever appropriate action is required. It is important, therefore, that Trusts work closely with the registered

providers, other professionals and the RQIA to enable appropriate decisions to be made.

2.27 HSC Trusts must assure themselves that regulated establishments and agencies that deliver care on their behalf are effective and responsive in complaints handling. Service users may approach the Ombudsman if they remain dissatisfied. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the registered provider without HSC Trust participation in local resolution will be referred to the HSC Trust by the Ombudsman for action.

2.28 Copies of all correspondence relating to regulated sector complaints should be retained. The RQIA will use this information to monitor all regulated services including those services commissioned by the HSC Trust.

2.29 Voluntary Adoption Agencies became regulated by the RQIA in 2010 and in due course, these arrangements will extend to Fostering Agencies services which will also be regulated by the RQIA.

Independent Sector Providers

2.30 This section of the guidance has been developed for use in complaints against Independent Service Providers (ISP) in contract with HSC Trusts. Complaints against regulated establishments and agencies, such as, residential and nursing homes should be handled in accordance with paragraphs 2.22 to 2.28 above. On occasions HSC organisations contract with ISPs to provide services for patients/clients. An example where this may be the case is in the maintenance of waiting lists for elective forms of treatment.

2.31 Such contracts are agreed and managed by HSC Trusts and procured in accordance with public procurement law. ISPs may have their own premises or may be permitted to use Trust premises, equipment and facilities.

2.32 Trusts must be assured that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints. This should include the appointment of designated

officers of suitable seniority to take responsibility for the management of the in-house complaints handling procedures, the investigation of complaints and the production of leaflets, or other literature (available and accessible to patients/clients) that outline the provider's complaints procedure.

2.33 Complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust. The general principle in the first instance would be that the ISP investigates and responds directly to the complainant. Independent Sector Providers are required to notify Trusts of any complaints received without delay and in any event within 72 hours. Trusts can then determine how they wish the complaints to be investigated (see flowchart on page 48).

2.34 Where complaints are raised directly with the Trust, it must establish the nature of the complaint and consider how best to proceed. The Trust may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where it raises serious concerns or where the Trust deems it in the public interest to do so. This may also be considered preferable should the Trust premises and/or staff have been involved (see flowchart on page 48).

2.35 In all cases, appropriate communication should be made with the complainant to inform them which organisation is leading the investigation into their complaint.

2.36 In complaints investigated by the ISP:

- A written response will be provided by the ISP to the complainant and copied to the Trust;
- Where there is a delay in responding within the target timescales the complainant will be informed and where possible provided with a revised date for conclusion of the investigation; and
- The letter of response must advise the complainant that they may progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and, if so, will confirm who should be responsible for conducting it. The Trust will work closely with the ISP to enable appropriate decisions to be made.

2.37 The complainant must also be informed of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

2.38 It is possible that referrals to the Ombudsman, where complaints are dealt with directly by the ISP without Trust participation in local resolution, will be referred to the Trust by the Ombudsman for action.

2.39 Trusts should have agreed arrangements in place to ensure that ISPs regularly provide information relating to all complaints received and responded to directly by them. This information should be made available to the Trust for monitoring purposes. The ISP must keep a record of complaints, the subsequent investigation and its outcome and any action taken as a result. This record must be submitted to the Trust no longer than 10 working days after the end of each quarter for complaints closed in the period. This should include details of the number, source and type(s) of complaint, action taken and outcome of investigation.

2.40 The ISP should also indicate if the learning from complaints has been disseminated to all relevant staff. The ISP must review their complaints procedure on an annual basis and in this annual review shall include a review of the outcome of any complaints investigations during the preceding year to ensure that where necessary any changes to practice and procedure are implemented. This annual review must be available for inspection by Trust staff on request.

What information should be included in the complaint?

2.41 A complaint need not be long or detailed, but it should include:

- contact details;
- who or what is being complained about, including the names of staff if known;
- where and when the events of the complaint happened; and
- where possible, what remedy is being sought – e.g. an apology or an explanation or changes to services.

Supporting complainants and staff

2.42 Standard 4: *Supporting complainants and staff* provides the criteria by which organisations should operate (Annex 1 refers). Advice and assistance is available to complainants and staff at any stage in the complaints process from the Complaints Manager. Independent advice and support for complainants is available from the PCC (detailed in Section 5 – Roles and responsibilities). Independent advocacy and specialist advocacy services are also available (Annex 7 refers).

What are the timescales for making a complaint?

2.43 A complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. HSC organisations should encourage those who wish to complain to do so as soon as possible after the event. Investigation is likely to be most effective when memories are fresh and the relevant evidence such as records of treatment will be easier to source.

2.44 If a complainant was not aware that there was potential cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is the earlier.

2.45 There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier and where it is still possible to investigate the facts of the case. This discretion should be used with sensitivity and impartiality. The complainant should be advised that with the passage of time the investigation and response will be based largely on a review of records.

2.46 In any case where a Complaints Manager has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant should be advised of the options available to pursue this further.

2.47 The Complaints Manager must consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety

and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

SECTION 3 – HANDLING COMPLAINTS

Accountability

3.1 Standard 1: *Accountability* provides the criteria by which organisations should operate (Annex 1 refers). Accountability for the handling and consideration of complaints rests with the Chief Executive (or Clinical Governance Lead in FPS settings). The HSC organisation must designate a senior person within the organisation:

- to take responsibility for the local complaints procedure;
- to ensure compliance with the regulations; and
- to ensure that action is taken in light of the outcome of any investigation.

In the case of HSC Trusts, a Director (or a Clinical Governance Lead in FPS setting) should be designated. All staff must be aware of, and comply with, the requirements of the complaints procedure. These arrangements will ensure the integration of complaints management into the organisation's governance arrangements.

3.2 Where care or treatment is provided by an independent provider, for example residential or nursing home care, the commissioning body must ensure that the contract includes entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Performance Management

3.3 Complaints provide a rich source of information and learning from complaints should be considered a vital part of the HSC organisation's performance management strategy. HSC organisations need to be able to demonstrate that positive action has been taken as a result of complaints and that learning from complaints is embedded in the organisation's governance and risk management arrangements.

3.4 Complaints should be used to inform and improve the standard of service provision. HSC organisations should aim for continuous change and improvement in their performance as a result of complaints. Where something has gone wrong or fallen below standard the organisation has the opportunity to improve and avoid a

recurrence. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Co-operation

3.5 Local arrangements must ensure that a full and comprehensive response is given to a complainant and that there is the necessary co-operation in the handling and consideration of complaints between:

- HSC organisations;
- Regulatory authorities e.g. professional bodies, DoH, Medicines Regulatory Group (MRG);
- The Ombudsman; and
- The RQIA.

3.6 This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

Complaints Manager

3.7 HSC organisations must appoint:

- A senior person within the organisation to ensure compliance with the relevant Complaints Directions[21] and to ensure that action is taken in light of the outcome of any investigation; and
- A Complaints Manager to co-ordinate the local complaints arrangements and manage the process.

3.8 The Complaints Manager or whoever is designated on their behalf must be readily accessible to both the public and members of staff. The Complaints Manager should:

- deal with complaints referred by front-line staff;
- be easily identifiable to service users;

[21] DoH Complaints Directions: https://www.health-ni.gov.uk/publications/hsc-complaints-directions

- be available to complainants who do not wish to raise their concerns with those directly involved in their care;
- provide advice and support to vulnerable adults;
- consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;
- provide support to staff to respond to complaints;
- be aware of and advise on the role of the Medical Defence Organisations (MDOs)[22] to assist staff requiring professional indemnity[23];
- have access to all relevant records (including personal medical records);
- take account of all evidence available relating to the complaint e.g. witness to a particular event;
- identify training needs associated with the complaints procedure and ensure those needs are met;
- ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;
- compile a summary of complaints received, actions taken and lessons learnt;
- maintain and appropriately store records;
- assist the designated senior person in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement; and
- assist the designated senior person in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

3.9 Complaints Managers should involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options available in seeking complaint resolution. Throughout the process, the Complaints Manager should

[22] There are 3 MDOs, the Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS), and Medical Protection Society (MPS).
[23] Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK.

assess what further action might best resolve the complaint and at each stage keep the complainant informed.

Publicity

3.10 HSC organisations must ensure that the complaints process is well publicised locally. This means that service users should be made aware of:

- their right to complain;
- all possible options for pursuing a complaint, and the types of help available; and
- the support mechanisms that are in place.

3.11 Ready access to information can make a critical difference to the service user's experience of HSC services. Information about services and what to expect, the various stages involved in the complaints process, response targets and independent support and advice should be available. Clear lines of communication are required to ensure complainants know who to communicate with during the lifetime of their complaint. The provision of information will improve attitudes and communication by staff as well as support and advice for complainants.

3.12 Local information should:

- be visible, accessible and easily understood;
- be available in other formats or languages as appropriate;
- be provided free of charge; and
- outline the arrangements for handling complaints, how to contact complaints staff, the availability of support services, and what to do if the complainant remains dissatisfied with the outcome of the complaints process.

Training

3.13 All staff should be trained and empowered to deal with complaints as they occur. Appropriately trained staff will recognise the value of the complaints process and, as a result will welcome complaints as a source of learning. HSC staff have a responsibility to highlight training needs to their line managers. Line managers, in turn, have a responsibility to ensure needs are met to enable the individual to function

effectively in their role and HSC organisations have a responsibility to create an environment where learning can take place. It is essential that staff recognise that their initial response can be crucial in establishing the confidence of the complainant.

Actions on receipt of a complaint

3.14 Standard 3: *Receiving Complaints* provides the criteria by which organisations must operate (Annex 1 refers).

3.15 All complaints received should be treated with equal importance regardless of how they are submitted. Complainants should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they may say will be treated with appropriate confidence and sensitivity. Complainants should be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. The first responsibility of staff is to ensure that the service user's immediate care needs are being met. This may require urgent action before any matters relating to the complaint are addressed.

3.16 The involvement of the complainant throughout the consideration of their complaint will provide for a more flexible approach to the resolution of the complaint. Complaints staff should discuss individual cases with complainants at an early stage and an important aspect of the discussion will be about the time it may take to complete the investigation especially if it is likely to exceed the 20 working day target for any reason. Early provision of information and an explanation of what to expect should be provided to the complainant at the outset to avoid disappointment and subsequent letters of complaint. Each complaint must be taken on its own merit and responded to accordingly. It may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive way.

3.17 Where possible, all complaints should be registered and discussed with the Complaints Manager in order to identify those that can be resolved immediately, those that require formal investigation, or those that should be investigated and managed outside of the HSC Complaints Procedure by other means. Front-line staff will often find the information they gain from complaints useful in improving service quality. This

is particularly so for complaints that have been resolved “on the spot” and have not progressed through the formal HSC Complaints procedure. Mechanisms for achieving this are best agreed at organisational level.

Acknowledgement of Complaint

3.18 A complaint should be acknowledged in writing within **2 working days** of receipt. FPS complaints should be acknowledged within **3 working days** in line with legislative requirements (see Legal Framework at Annex 2). The acknowledgement letter should always thank the complainant for drawing the matter to the attention of the organisation. A copy of the complaint and its acknowledgement should be sent to any person involved in the complaint unless there are reasonable grounds to believe that to do so would be detrimental to that person’s health or well-being.

3.19 There should be a statement expressing sympathy or concern regarding the issue that led to a complaint being made. This is a statement of common courtesy, not an admission of responsibility.

3.20 It is good practice for the acknowledgement letter to be conciliatory, and indicate that a full response will be provided within **20 working days**. FPS acknowledgement should indicate that a full response will be provided within **10 working days**. As soon as the HSC organisation becomes aware that the relevant response timescale is not achievable they must provide the complainant with an explanation. The complainant must be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

3.21 The acknowledgement should:

- seek to confirm the issues raised in the complaint;
- offer opportunities to discuss issues either with a member of the complaints staff or, if appropriate, a senior member of staff; and
- provide information about the availability of independent support and advice.

3.22 Complaints Managers should provide the complainant with further information about the complaints process. This may include locally produced information leaflets or those provided by the Ombudsman's Office or the RQIA. It is also advisable to include information about the disclosure of patient information at this stage.

Joint Complaints

3.23 Where a complaint relates to the actions of more than one HSC organisation the Complaints Manager should notify any other organisations involved. The complainant's consent must be obtained before sharing the details of the complaint across HSC organisations. In cases of this nature there is a need for co-operation and partnership between the relevant organisations in agreeing how best to approach the investigation and resolution of the complaint. It is possible that the various aspects of the complaint can be divided easily with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

Out of Area Complaints

3.24 Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the DoH or HSC Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. HSC contracts must include entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the Departmental or the HSC Complaints Procedure.

Investigation

3.25 Standard 5: *Investigation* provides the criteria by which organisations must operate (Annex 1 refers). HSC organisations should establish a clear system to ensure an appropriate level of investigation. The purpose of investigation is not only "resolution" but also to:

- ascertain what happened or what was perceived to have happened;
- establish the facts;
- learn lessons;

- detect misconduct or poor practice; and
- improve services and performance.

3.26 An investigation into a complaint may be undertaken by a suitable person appointed by the HSC organisation. Investigations should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner. The investigation must uphold the principles of fairness and consistency. The investigation process is best described as listening, learning and improving. Investigators should be able to seek advice from the Complaints Manager/senior person, wherever necessary, about the conduct or findings of the investigation.

3.27 Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of a complaint should be advised of the process, what will and will not be investigated, those who will be involved, the roles they will play and the anticipated timescales. Everyone involved should be kept informed of progress throughout. Staff involved in the investigation process should familiarise themselves with Section 75 of the Northern Ireland Act 1998.

Assessment of the complaint

3.28 It is unrealistic to suggest that all complaints should be investigated to the same degree or at the same level. HSC organisations must ensure that a robust risk assessment process is applied to all complaints to allow serious complaints, such as those involving unsafe practice, to be identified. The use of assessment tools to risk assess and categorise a complaint may be helpful in determining the course of action to take in response. It can help ensure that the process is proportionate to the seriousness of the complaint and the likelihood of recurrence.

Investigation and resolution

3.29 The HSC organisation should use a range of investigating techniques that are appropriate to the nature of the complaint and to the needs of the complainant. Those

responsible for investigation should be empowered to choose the method that they feel is the most appropriate to the circumstances.

3.30 The investigator should establish the facts relating to the complaint and assess the quality of the evidence. Depending on the subject matter and complexity of the investigation the investigator may wish to call upon the services of others. There are a number of options available to assist HSC organisations in the resolution of complaints. These should be considered in line with the assessment of the complaint and also in collaboration with the complainant and include the involvement of:

- senior managers/professionals at an early stage;
- honest broker;
- independent experts;
- lay persons; and
- conciliators.

3.31 It is not intended that HSC organisations utilise all the options outlined above as not all these will be appropriate in the resolution of the complaint. Rather HSC organisations should consider which option would assist in providing the desired outcome. The SPPG Complaints Team on behalf of DoH will provide the necessary support and advice to FPS in relation to access and appointment of these options, where appropriate.

Completion of Investigation

3.32 Once the investigator has reached their conclusion they should prepare the draft report/response. The purpose is to record and explain the conclusions reached after the investigation of the complaint. The Department's *HSC Regional Template and Guidance for Incident Investigation/ Review Reports*[24] will assist HSC organisations in ensuring the completeness and readability of such reports.

3.33 Where the complaint involves clinical/ professional issues, the draft response must be shared with the relevant clinicians/ professionals to ensure the factual

[24] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2034-07_0.pdf

accuracy and to ensure clinicians/ professionals agree with and support the draft response.

3.34 All correspondence and evidence relating to the investigation should be retained. The Complaints Manager should ensure that a complete record is kept of the handling and consideration of each complaint. Complaints records should be kept separate from health or social care records, subject only to the need to record information which is strictly relevant to the service user's on-going health or care needs.

3.35 HSC organisations should regularly review their investigative processes to ensure the effectiveness of these arrangements locally.

Circumstances that might cause delay

3.36 Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement. Delays may also be as a result of the complainant's personal circumstances at a particular time e.g. a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure (as outlined in paragraphs 1.12 to 1.14).

Periods of acute mental illness

3.37 If a service user makes a complaint during an acute phase of mental illness, the Complaints Manager should register the complaint and consideration should be given to delaying the complaint until his/her condition has improved. A delay such as this will need either the agreement of the complainant or someone who is able to act on his/her behalf including, where appropriate, consultation with any advocate. The decision about whether a complainant is well enough to proceed with the complaint should be made by a multi-disciplinary team, and the Complaints Manager should refer regularly to this team to establish when this point has been reached.

Physical Injury

3.38 Where a complainant is alleging physical injury, a physical examination should be arranged without delay and with the consent of the injured person. Medical staff undertaking the physical examination should clearly report their findings. If a person refuses a physical examination, or if his or her mental state (for example, degree of agitation) makes this impossible, this should be clearly documented.

3.39 Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the HSC organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements. The complainant must also be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

Responding to a complaint

3.40 Standard 6: *Responding to complaints* provides the criteria by which organisations must operate (Annex 1 refers). A response must be sent to the complainant within **20 working days of receipt** of the complaint (**10 working days within FPS**) or, where that is not possible, the complainant must be advised of the delay (as per paragraph 3.39 above).

3.41 Where appropriate, HSC organisations must consider alternative methods of responding to complaints whether through an immediate response from front-line staff, a meeting, or direct action by the Chief Executive (or senior person). It may be appropriate to conduct a meeting in complex cases, in cases where there is serious harm/death of a patient, in cases involving those whose first language is not English, or, for example in cases where the complainant has a learning disability or mental illness. Where complaints have been raised electronically the HSC may reply electronically whilst ensuring they adhere to the relevant Information Technology (IT) policies and procedures and maintain appropriate levels of confidentiality according to Trust policies and procedures

3.42 Where a meeting is scheduled it is more likely to be successful if the complainant knows what to expect and can offer some suggestions towards resolution. Complainants have a right to choose from whom they seek support and should be encouraged to bring a relative or friend to meetings. Where meetings do take place they should be recorded and that record shared with the complainant for comment.

3.43 The Chief Executive (or Clinical Governance Lead) may delegate responsibility for responding to a complaint, where, in the interests of a prompt reply, a designated senior person may undertake the task (or the governance lead within FPS settings). In such circumstances, the arrangements for clinical and social care governance must ensure that the Chief Executive (or Clinical Governance Lead) maintains an overview of the issues raised in complaints, the responses given and be assured that appropriate organisational learning has taken place. HSC organisations should ensure that the complainant and anyone who is a subject of the complaint understand the findings of the investigation and the recommendations made.

3.44 The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong;
- report the action taken or proposed to prevent recurrence;
- indicate that a named member of staff is available to clarify any aspect of the letter;
- advise of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure; and
- advise of the availability of the Patient and Client Council to provide assistance in making a submission to the Ombudsman.

Concluding Local Resolution

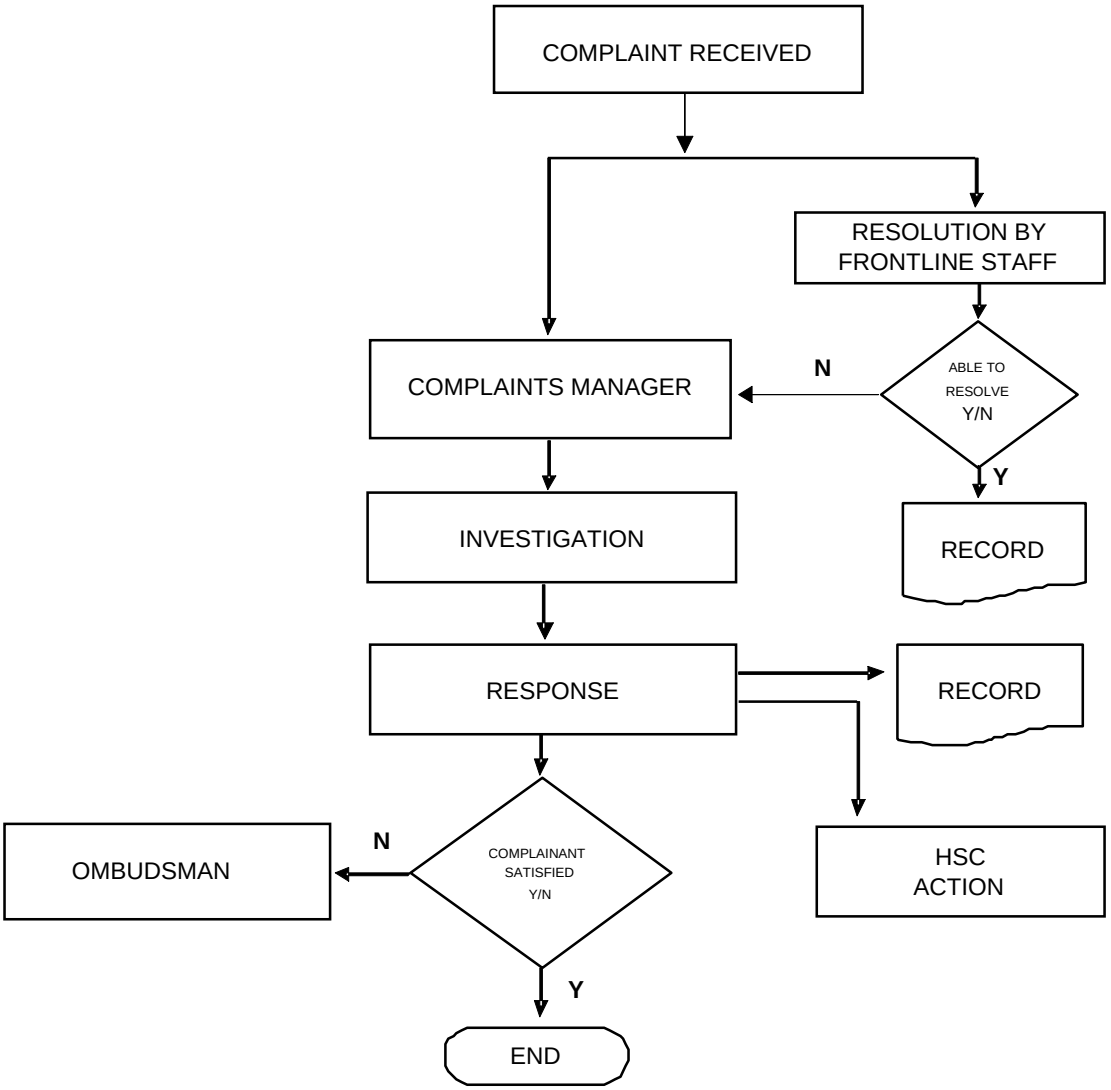
3.45 The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying "closure". Complainants should contact the organisation within one month of the organisation's response if they are dissatisfied with the response or require further clarity[25]. There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

3.46 Once the final response has been signed and issued, the Complaints Manager, on behalf of the Chief Executive/Clinical Governance Lead, should liaise with relevant local managers and staff to ensure that all necessary follow-up action has been taken. Arrangements should be made for any outcomes to be monitored to ensure that they are actioned. Where possible, the complainant and those named in the complaint should be informed of any change in system or practice that has resulted from the investigation into their complaint.

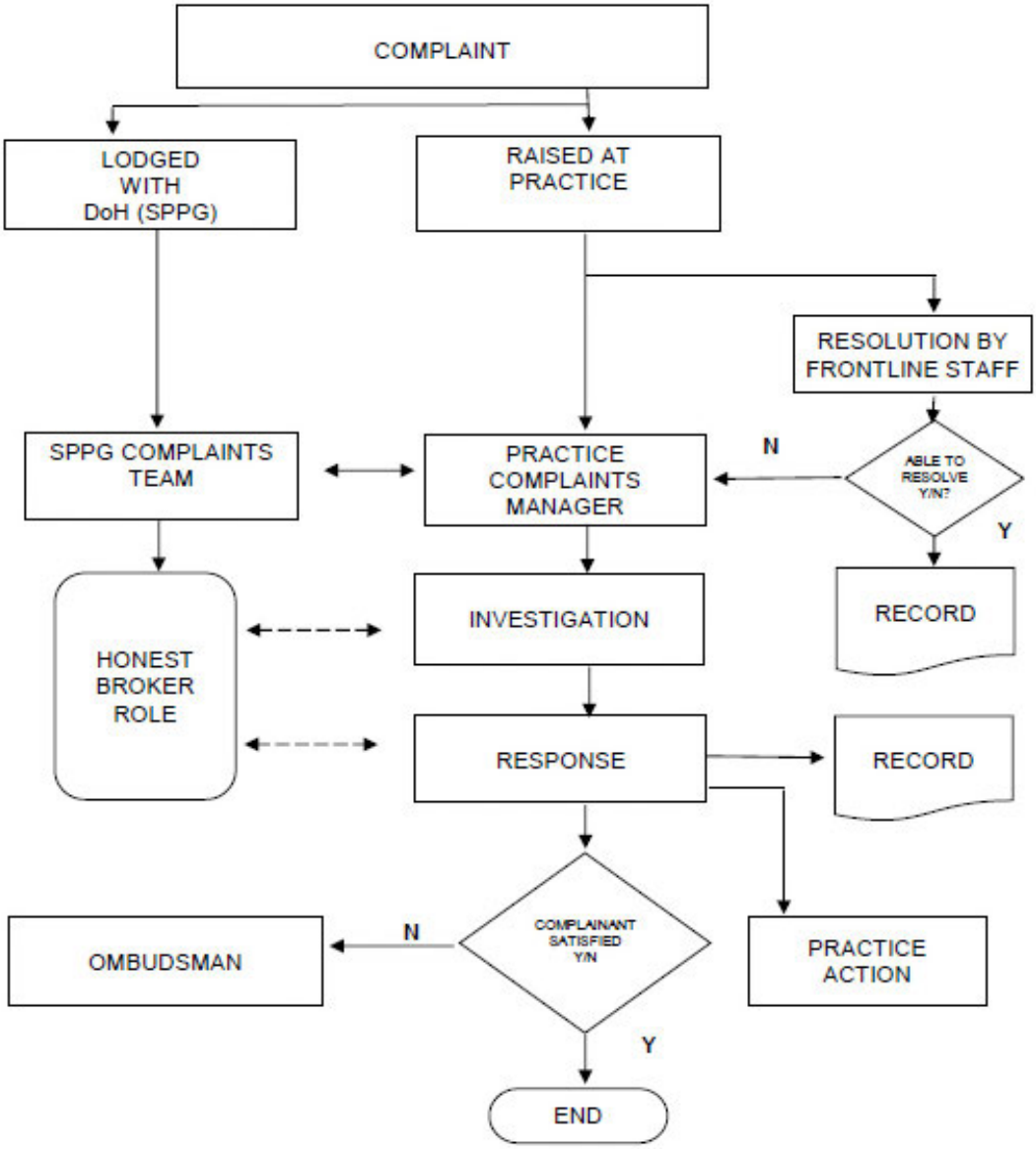
3.47 This completes the HSC Complaints Procedure. There is a statutory obligation on all HSC organisations to signpost to the Ombudsman upon completion of the complaints procedure. Please refer to Annex 5 for details on the requirements for signposting.

[25]Inserted 5th June 2013 per letter from Director of Safety, Quality & Standards Directorate

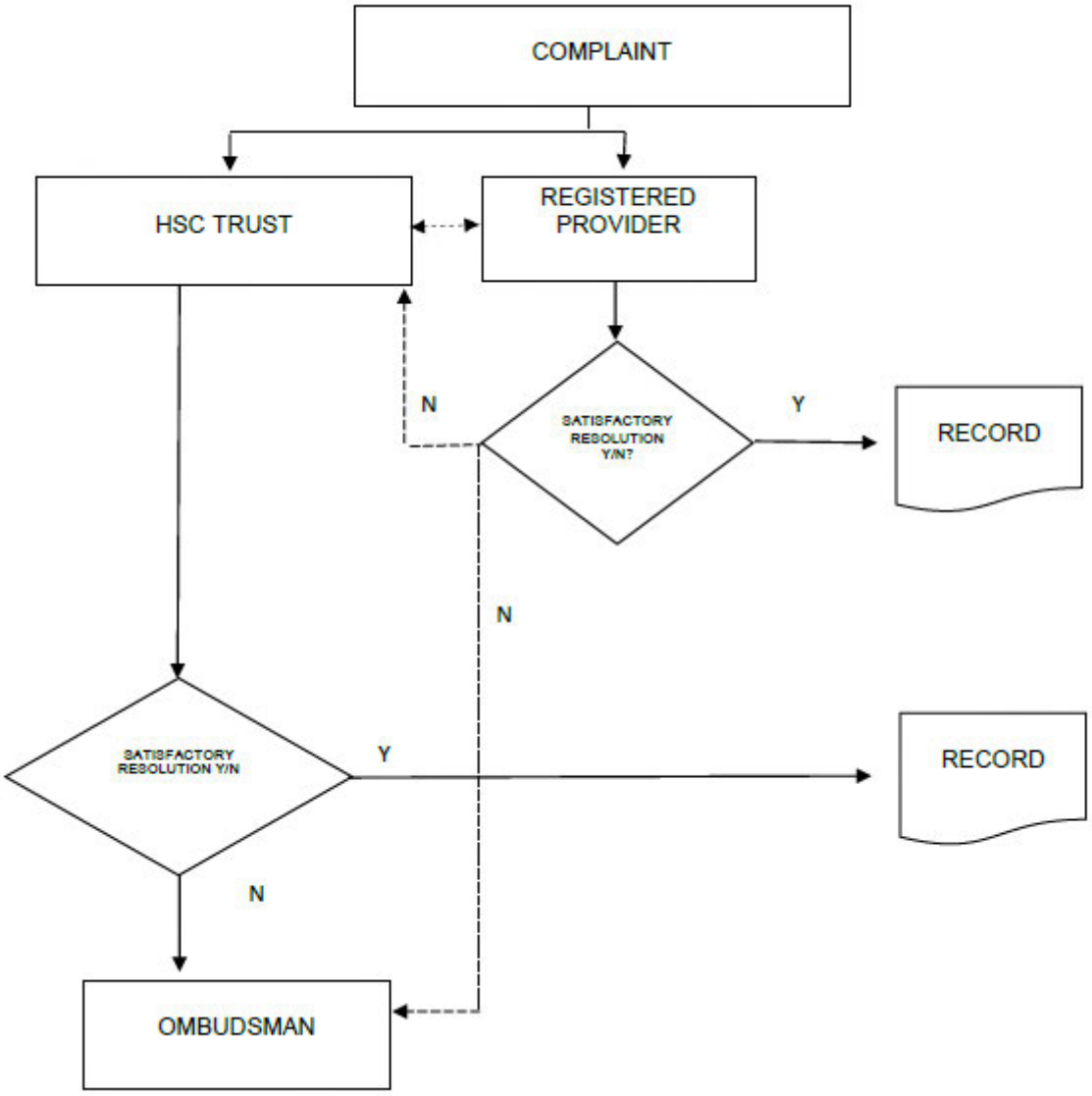
HOSPITAL OR COMMUNITY COMPLAINTS FLOWCHART



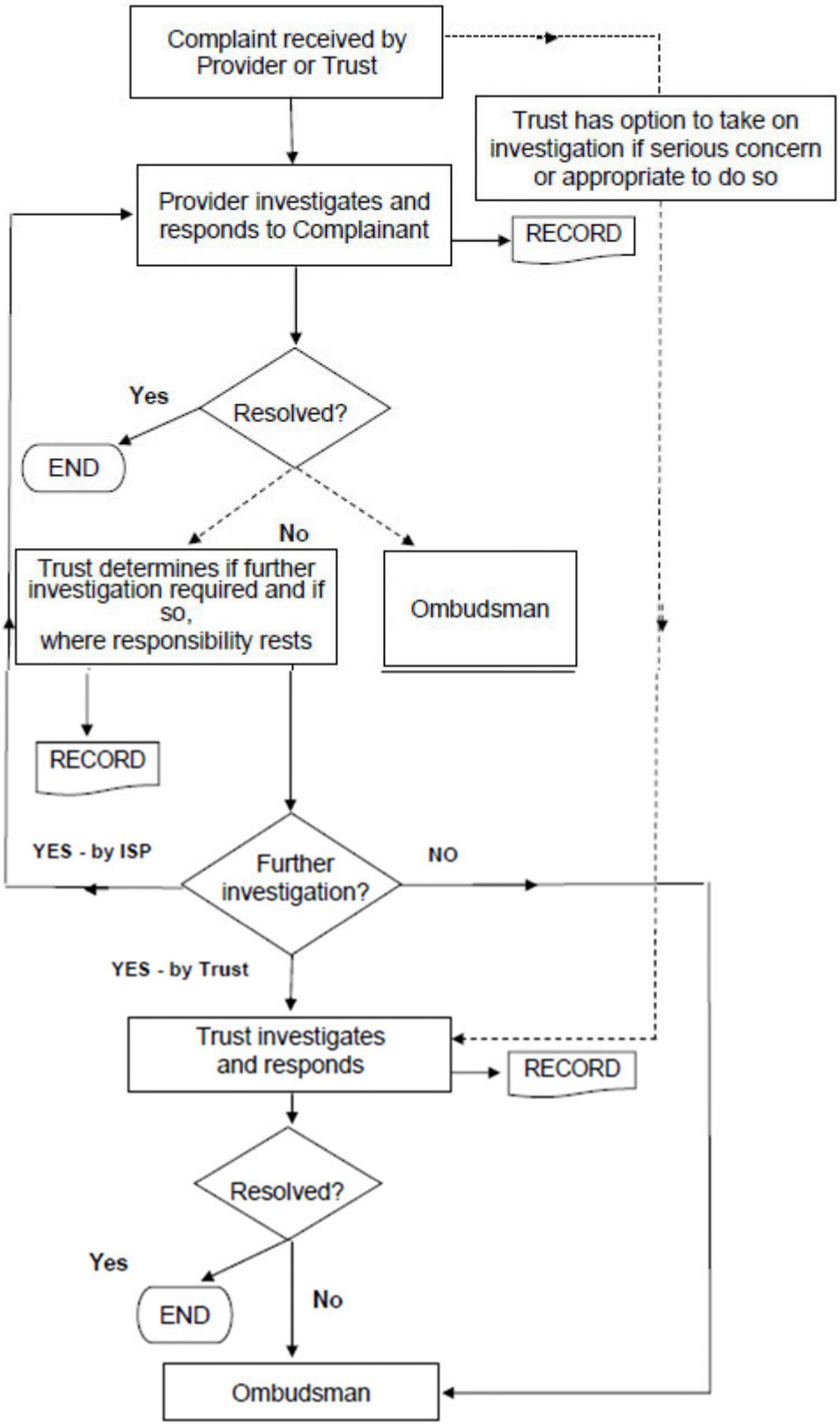
FAMILY PRACTITIONER SERVICE COMPLAINTS FLOWCHART



REGULATED ESTABLISHMENTS & AGENCIES FLOWCHART
(Services commissioned by HSC - Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.)



INDEPENDENT SECTOR PROVIDER (ISP) COMPLAINTS FLOWCHART



SUMMARY OF TARGET TIMESCALES

EVENT	TIMESCALE
Making a complaint	within 6 months of the event, or 6 months after becoming aware of the cause for complaint, but no longer than 12 months from the event
Acknowledgement Family Practitioner Services	within 2 working days* of receipt within 3 working days
Response Family Practitioner Services	within 20 working days within 10 working days (20 working days if lodged with the SPPG Complaints Team)
Should complainant wish to seek clarity in relation to response or express continued dissatisfaction	within 1 months of the organisation's response

*** A working day is any weekday (Monday to Friday) which is not a local or public holiday.**

SECTION 4 – LEARNING FROM COMPLAINTS

Reporting and Monitoring

4.1 Each HSC organisation has a legal duty to operate a complaints procedure and is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with governance arrangements and monitoring the effectiveness of the procedure locally. The HSC organisation must:

- regularly review its policies and procedures to ensure they are effective;
- monitor the nature and volume of complaints;
- seek feedback from service users and staff to improve services and performance; and
- ensure lessons are learnt from complaints and use these to improve services and performance.

4.2 HSC organisations are also required to keep a record of all complaints received, including copies of all correspondence relating to complaints. HSC organisations must have effective processes in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared. HSC organisations must ensure regular and adequate reporting on complaints in line with agreed governance arrangements.

4.3 The *Standards for Complaints Handling* (Annex 1 refers) provide the criteria by which organisations must operate and will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally. HSC organisations should also involve service users and staff to improve the quality of services and effectiveness of complaints handling arrangements locally

4.4 The HSC must ensure they have the necessary technology/information systems to record and monitor all complaints. For the purposes of measuring the effectiveness of the procedures, HSC organisations must maintain systems as described below.

DoH

4.5 The SPPG Complaints Team on behalf of DoH will maintain an oversight of all FPS and HSC Trust complaints received (including HSC prison healthcare) and be prepared to analyse any patterns or trends of concern or clusters of complaints against individuals, practices, or organisations.

4.6 The SPPG Complaints Team will produce an annual report on complaints outlining the number of FPS and, where appropriate, out-of-hours services complaints received, the categories to which the complaints relate and the response times. The annual report should also include the number of FPS complaints in which the SPPG Complaints Team acted as "honest broker". Copies should be sent to the PCC, the RQIA and the Ombudsman. Reports must not breach patient/ client confidentiality.

4.7 The DoH will continue to collect statistics on the number, type and response times of complaints made to HSC organisations. A regional breakdown of complaints statistics will be provided via the Departmental website on an annual basis.

HSC Trusts

4.8 All HSC Trusts must provide the Department with quarterly statistical returns on complaints.

4.9 HSC Trusts must provide their Management Boards and the DoH with quarterly complaints reports outlining the number and types of complaints received, the investigation undertaken and actions as a result including those relating to regulated establishments and agencies, and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare. The reports must summarise the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.10 HSC Trusts must also produce an annual complaints report to include the number of complaints received, the categories to which the complaints relate, the response times and the learning from complaints. Copies should also be made available to the PCC, RQIA, the Ombudsman and the DoH. Reports must not breach patient/ client confidentiality.

Quarterly reports

4.11 The management boards of the HSC Trusts should receive quarterly reports summarising the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.12 HSC Trusts' quarterly reports to their management board should include a breakdown of all complaints received including those received by, or on behalf of, residents in statutory or independent residential care and nursing homes and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare.

Family Practitioner Services

4.13 Family Practitioner Services must provide the SPPG Complaints Team with anonymised copies of all written complaints received and responses provided by the Practice within 3 working days of the response being issued.

4.14 Arrangements should be in place to ensure that the complainant is aware and agrees to his/her complaint being forwarded to the SPPG Complaints Team.

4.15 The SPPG Complaints Team will record and monitor the outcome of all FPS complaints lodged with them.

Other HSC organisations

4.16 All other HSC organisations must publish an annual report on complaints handling. Copies should be sent to the PCC and the DoH. Reports must not breach patient/client confidentiality.

Regulated establishments and agencies

4.17 All regulated establishments and agencies are required if requested to provide the RQIA with a statement containing a summary of complaints made during the preceding 12 months and the action that was taken in response. The RQIA will record and monitor all outcomes and will report on complaints activity within the regulated sector.

Learning

4.18 All HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services. Learning should take place at different levels within the HSC organisation (individual, team and organisational) and the HSC organisation must be able to demonstrate that this is taking place[26].

4.19 Learning is a critical aspect of the HSC Complaints Procedure and provides an opportunity to improve services and contribute to and learn from regional, national and international quality improvement and patient safety initiatives. All HSC organisations, the RQIA and Ombudsman must share the intelligence gained through complaints.

4.20 The SPPG Complaints Team on behalf of the DoH will have in place regional-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints and must ensure they are used to improve service quality. HSC Trusts and FPS should be encouraged to share learning and seek feedback from service users for further improvement.

[26] The Quality Standards for Health and Social Care, Theme 5 (8.3 (k)) - https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/the-quality-standards-for-health-and-social-care.pdf

SECTION 5 - ROLES AND RESPONSIBILITIES

DoH

5.1 The SPPG on behalf of DoH is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This will include monitoring complaints processes, outcomes and service improvements. The S*tandards for Complaints Handling* provides a level against which HSC service performance can be measured (Annex1 refers).

5.2 The SPPG Complaints Team will maintain an oversight of all FPS and HSC Trust complaints received and, where appropriate, out-of-hours services. The SPPG Complaints Team must be prepared to investigate any patterns or trends of concern or clusters of complaints against individual clinicians/ professionals.

5.3 The SPPG Complaints Team on behalf of the DoH will have in place area-wide procedures for collecting and disseminating learning and sharing intelligence.

5.4 The SPPG Complaints Team will provide a vital role in supporting FPS complaints that includes:

- providing support and advice;
- the role of “honest broker” between the complainant and the service provider;
- providing independent experts, lay persons, conciliation services, where appropriate;
- recording and monitoring the outcome of all complaints;
- addressing breaches of contractual arrangements; and
- sharing complaints intelligence with appropriate authorities e.g. the DoH Medicines Regulatory Group (MRG).

HSC Organisations

5.5 HSC organisations must:

- make arrangements for the handling and consideration of complaints and publicise these arrangements locally;
- appoint a Complaints Manager with responsibility for co-ordinating the local complaints arrangements and managing the process;
- appoint a senior person to take responsibility for delivering the organisation's complaints process and ensuring that all necessary organisational learning takes place;
- ensure that all staff who provide services on their behalf are aware of, and trained in, the procedures to be followed when dealing with complaints;
- ensure that complainants and staff are supported and made aware of the availability of support services;
- ensure that there is full co-operation between organisations/bodies in the handling and consideration of complaints;
- integrate complaints management into the organisation's clinical and social care governance and risk management arrangements;
- monitor the effectiveness of local complaints handling arrangements;
- have in place area-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints; and
- where appropriate, publish annually a report on complaints handling.

The Patient and Client Council (PCC)

5.6 The PCC is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public;
- promoting involvement of the public;
- providing assistance to individuals making or intending to make a complaint;
- promoting the provision by HSC bodies of advice and information to the public about the design, commissioning and delivery of health and social care services; and

- undertaking research into best methods and practices for consulting and engaging the public.

5.7 If a person feels unable to deal with a concern alone, the staff of the PCC can offer a wide range of advocacy, assistance and support. This assistance may take the form of:

- information on the complaints procedure and advice on how to take a complaint forward;
- discussing a complaint with the complainant and drafting letters;
- making telephone calls on the complainants behalf;
- helping the complainant prepare for meetings and going with them to meetings;
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services; and
- help in accessing medical/social services records.

5.8 All advice, information and assistance with complaints is provided free of charge and is confidential. Further information can be obtained from: pcc-ni.net or Freephone 0800 917 0222

Where can I get support

If you wish to raise a concern or issue relating to a Health or Social Care service the PCC can provide advocacy to support and assist you.

You can contact the PCC in the following ways

Free phone number 0800 91702222

Or email the PCC on

info@pcc.ni.net

The PCC can support and assist you through our advocacy service to seek a resolution to the concern you have. You can view the PCC website for additional information on the PCC.

www.pcc-ni.net

ANNEX 1: STANDARDS FOR COMPLAINTS HANDLING

Standards for complaints handling

1. The following standards have been developed to address the variations in the standard of complaints handling across HSC organisations. These will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally and will build public confidence in the process by which their complaint will be handled. These are the standards to which HSC organisations are expected to operate for complaints handling:

STANDARD 1: ACCOUNTABILITY

HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.

Rationale:

HSC organisations will demonstrate that they have in place clear accountability structures to ensure the effective and efficient investigation of complaints, to provide a timely response to the complainant and a framework whereby learning from complaints is incorporated into the clinical, social care and organisational governance arrangements.

Criteria:

1. Managerial accountability for complaints within HSC organisations rests with the Chief Executive (or Clinical Governance Lead in FPS settings);
2. HSC organisations must designate a senior person to take responsibility for complaints handling and responsiveness locally;
3. HSC organisations must ensure that complaints are integrated into clinical and social care governance and risk management arrangements;
4. HSC organisations will include complaints handling within its performance management framework and corporate objectives;
5. Each HSC organisation must ensure that the operational Complaints Manager is of appropriate authority and standing and has appropriate support;
6. All staff must be aware of, and comply with, the requirements of the complaints procedure within their area of responsibility;
7. Where applicable, HSC organisations will ensure that independent provider contracts include compliance with the requirements of the HSC Complaints Procedure; and
8. Each HSC organisation is responsible for quality assuring its complaints handling arrangements.

STANDARD 2: ACCESSIBILITY

All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.

Rationale:

Those who wish to complain will be treated impartially, in confidence, with sensitivity, dignity and respect and will not be adversely affected because they have found cause to complain. Where possible, arrangements will be made as necessary for the specific needs of those who wish to complain, including provision of interpreting services; information in a variety of formats and languages; at suitable venues; and at suitable times.

Criteria:

1. Arrangements about how to make a complaint are widely publicised, simple and clear and made available in all areas throughout the service;
2. Arrangements for making a complaint are open, flexible and easily accessible to all service users, no matter what their personal situation or ability;
3. Flexible arrangements are in place in order that individual complainants may be suitably accommodated in an environment where they feel comfortable; and
4. All staff have appropriate training about the needs of service users, including mental health, disability and equality awareness training.

STANDARD 3: RECEIVING COMPLAINTS

All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.

Rationale:

All complaints are welcomed. Effective complaints handling is an important aspect of the HSC clinical and social care governance arrangements. All complaints, however or wherever received, will be recorded, treated confidentially, taken seriously and dealt with in a timely manner.

Criteria:

1. Flexible arrangements are in place so that complaints can be raised in a variety of ways (e.g. verbally or in writing), and in a way in which the complainant feels comfortable;
2. Complaints from a third party must, where possible, have the written consent of the individual concerned;
3. HSC staff are aware of their legal and ethical duty to protect the confidentiality of service user information;
4. Attempts to resolve complaints are as near to the point of contact as possible, and in accordance with the complainant's wishes;
5. Where possible, the complainant should be involved in decisions about how their complaint is handled and considered; and
6. Complaints are appropriately recorded and assessed according to risk in line with agreed governance arrangements.

STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

HSC organisations will support complainants and staff throughout the complaints process.

Rationale:

The HSC will support service users in making complaints and will encourage feedback through a variety of mechanisms. Information on complaints will outline the process as well as the support services available. Staff will be trained and empowered to deal with complaints as they arise.

Criteria:

1. HSC organisations will ensure the provision of readily available advice and information on how to access support services appropriate to the complainant's needs;
2. The HSC organisation's Complaints Manager will offer assistance in the formulating of a complaint;
3. HSC organisations will promote the use of independent advice and advocacy services;
4. HSC organisations will facilitate, where appropriate, the use of conciliation;
5. HSC organisations will adopt a consistent approach in the application of DoH guidance on responding to unreasonable or abusive complainants;
6. HSC organisations will ensure that staff receive training on complaints, appropriate to their needs; and
7. HSC organisations will ensure that mechanisms are in place to support staff throughout the complaints process.

STANDARD 5: INVESTIGATION OF COMPLAINTS

All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.

Rationale:

HSC organisations will establish a clear system to ensure an appropriate level of investigation. Not all complaints need to be investigated to the same degree. A thorough, documented investigation will be undertaken, where appropriate, including a review of what happened, how it happened and why it happened. Where there are concerns, the HSC organisation will act appropriately and, where possible, improve practice and ensure lessons are learned.

Criteria:

1. Investigations are conducted in line with agreed governance arrangements;
2. Investigations are robust and proportionate and the findings are supported by the evidence;
3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant;
4. Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant's consent;
5. People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint;
6. All HSC providers/commissioners and regulatory bodies will co-operate, where necessary, in the investigation of complaints;
7. The HSC organisation will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised; and
8. All correspondence and evidence relating to the investigation will be retained in line with relevant information governance requirements.

STANDARD 6: RESPONDING TO COMPLAINTS

All complaints will be responded to as promptly as possible and all issues raised will be addressed.

Rationale:

All complainants have a right to expect their complaint to be dealt with promptly and in an open and honest manner.

Criteria:

1. The timescales for acknowledging and responding to complaints are in line with statutory requirements;
2. Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress;
3. HSC organisations must consider alternative methods of responding to complaints;
4. Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology;
5. 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 this task (or a clinical governance lead in FPS settings);
6. Complainants should be informed, as appropriate, of any change in system or of practice that has resulted from their complaint; and
7. Where a complainant remains dissatisfied, he/she should be clearly advised of the options that remain open to them.

STANDARD 7: MONITORING

HSC organisations will monitor the effectiveness of complaints handling and responsiveness.

Rationale:

HSC organisations are required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. Monitoring performance is essential in determining any necessary procedural change that may be required. It will also ensure that organisations have taken account of the issues and incorporated improvements where appropriate.

Criteria:

1. HSC organisations should ensure the regular and adequate reporting on complaints in accordance with agreed governance arrangements;
2. HSC organisations must produce and disseminate, where appropriate, an Annual Report on Complaints;
3. HSC organisations must ensure that they have in place the necessary technology/information system to record and monitor all complaints and outcomes;
4. HSC organisations should have a mechanism to routinely request feedback from service users and staff on the operation of the complaints process;
5. HSC organisations must review the arrangements for complaints handling and responsiveness; and
6. HSC organisations must be assured, that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints.

STANDARD 8: LEARNING

HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.

Rationale:

Complaints are viewed as a significant source of learning within HSC organisations and are an integral aspect of its patient/client safety and quality services ethos. Complaints will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. HSC organisations must have effective structures in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared.

Criteria:

1. HSC organisations will monitor the nature and volume of complaints so that trends can be identified and acted upon;
2. HSC organisations will ensure there are provisions made within governance arrangements for the identification of learning from complaints and the sharing of learning locally and regionally;
3. Learning will take place at different levels within the HSC (individual, team and organisational);
4. HSC organisations will ensure that they have adequate mechanisms in place for reporting on progress with the implementation of action plans arising from complaints;
5. HSC organisations will incorporate learning arising from any review of findings of an investigation;
6. HSC organisations will contribute to, and learn from, regional, national and international quality improvement and patient safety initiatives; and
7. HSC organisations will include learning from complaints within its Annual Report on Complaints.

ANNEX 2: LEGAL FRAMEWORK

HPSS Complaints Procedure Regulations:

- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004;
- Health and Personal Social Services General Dental Services (Amendment) Regulations (NI) 2008;
- The General Ophthalmic Services (Amendment) Regulations
- (Northern Ireland) 2014The Pharmaceutical Services Regulations (NI) 1997.

The Children (NI) Order 1995:

- The Representations Procedure (Children) Regulations (NI) 1996.

HSC Complaints Procedure Directions:

- The Health and Social Care Complaints Procedure Directions (NI) 2009;
- Health and Social Care Complaints Procedure Directions (NI) 2009 (Amended 2013);
- Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009) (Honest Broker Timescales) (Amended 2013);
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (2010);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (2010);
- Health and Social Care Complaints Procedure Directions (Amended 2019);
- Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) (Amended 2019);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (Amended 2019);
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (Amended 2019);
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (Amended 2022);

- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (Amended 2022);
- Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) (Revoked 2022);
- Health and Social Care Complaints Procedure Directions (Amended 2022).

The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003:

- The Residential Care Homes Regulations (NI) 2005;
- The Nursing Homes Regulations (NI) 2005;
- The Independent Health Care Regulations (NI) 2005;
- The Nursing Agencies Regulations (NI) 2005;
- The Adult Placement Agencies Regulations (NI)2007;
- The Day Care Settings Regulations (NI) 2007;
- The Residential Family Centres Regulations (NI) 2007;
- The Domiciliary Care Agencies Regulations (NI) 2007.

ANNEX 3: PROFESSIONAL REGULATORY BODIES

General Chiropractic Council (GCC) Chiropractors Phone: [redacted] www.gcc-uk.org	**Nursing and Midwifery Council (NMC)** Nurses, midwives and specialist community public health nurses Phone: [redacted] www.nmc-uk.org
General Dental Council (GDC) Dentists, dental therapists, dental hygienists, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists Phone: [redacted] www.gdc-uk.org	**Royal Pharmaceutical Society of Great Britain (RPSGB)** Pharmacists, pharmacy technicians (on the voluntary register) and pharmacy premises Phone: 08452572570 https://www.rpharms.com
General Medical Council (GMC) Doctors Phone: 01619236602 www.gmc-uk.org	**Pharmaceutical Society of Northern Ireland** Pharmacists and pharmacy premises in Northern Ireland Phone: [redacted] www.psni.org.uk
General Optical Council (GOC) Opticians Phone: [redacted] www.optical.org **General Osteopathic Council (GOsC)** Osteopaths Phone: [redacted] www.osteopathy.org.uk	**Professional Standards Authority for Health and Social Care (the Authority)** aims to protect the public, promote best practice and encourage excellence among the nine regulators of healthcare professionals listed. Phone: [redacted] http://www.professionalstandards.org.uk
Health and Care Professions Council (HCPC) Arts therapists, biomedical scientists, chiropodists, podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists Phone: 03005006184 www.hpc-uk.org	**Northern Ireland Social Care Council (NISCC)** Social care workers, qualified social workers, and social work students on approved degree courses in Northern Ireland Phone: [redacted] www.niscc.info

ANNEX 4: HSC PRISON HEALTHCARE

1. HSC prison healthcare is commissioned by the DoH. The South Eastern HSC Trust has responsibility for providing or securing the provision of health and social care services for prisoners.

2. Complaints raised about care, treatment or issues relating to the provision of prison healthcare will be dealt with under the HSC Complaints Procedure.

ANNEX 5: THE NI PUBLIC SERVICES OMBUDSMAN

1. The Ombudsman[27] can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly, and the organisation or practitioner has not put things right where they could have, the Ombudsman may be able to help. The Ombudsman powers have also been extended to include the power to investigate complaints about social care decisions.

All listed authorities within the Ombudsman's jurisdiction have a statutory obligation to signpost complainants to the Ombudsman's office where the listed authority's complaints handling procedure is exhausted.

Section 25 of the Public Services Ombudsman Act (Northern Ireland) 2016 states:

25. (1) This section applies where a listed authority's complaints handling procedure is exhausted.

(2) The authority must, within 2 weeks of the day on which the complaint handling procedure is exhausted give the person aggrieved a written notice stating –

(a) that the complaints handling procedure is exhausted, and

(b) that the person aggrieved may, if dissatisfied, refer the complaint to the Ombudsman.

(3) A notice under subsection (2) must –

(a) inform the person aggrieved of the time limit for referring the complaint to the Ombudsman; and

(b) provide details of how to contact the Ombudsman.

[27] With effect from 1 April 2016 the statutory office of "NI Commissioner for Complaints" was abolished and the new statutory office of "Northern Ireland Public Services Ombudsman" was created as a result of the Public Services Ombudsman Act (Northern Ireland) 2016 coming into operation.

2. The Ombudsman's contact details are:

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Freepost: Freepost NIPSO
Telephone: [redacted]
Freephone: (0800) 34 34 24
Email: nipso@nipso.org.uk

3. Additional information on the jurisdiction and powers under the Public Services Ombudsman Act (NI) 2016 can be accessed at:
www.nipso.org.uk

ANNEX 6: THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

1. The RQIA is an independent non-departmental public body. The RQIA is charged with overall responsibility for regulating, inspecting and monitoring the standard and quality of health and social care services provided by independent and statutory bodies in Northern Ireland.

2. The RQIA has a duty to assess and report on how the HSC and the regulated sector handle complaints in light of the standards and regulations laid down by the DoH. The RQIA will assess the effectiveness of local procedures and will use information from complaints to identify wider issues for the purposes of raising standards.

3. The RQIA has a duty to encourage improvement in the delivery of services and to keep the DoH informed on matters concerning the provision, availability and quality of services.

4. The RQIA may be contacted at:

James House
2-4 Cromac Avenue
Belfast
BT7 2JA
Tel: [redacted]

http://www.rqia.org.uk

ANNEX 7: ADVOCACY

1. Some people who might wish to complain do not do so because they do not know how, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their views and wishes known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

2. Within the HSC sector, advocacy has been available mainly for vulnerable groups, such as people with mental health problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and be intimidated by professional attitudes.

3. HSC organisations should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

ANNEX 8: CONCILIATION

1. 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 and will aim to prevent the complaint being taken further. He/she 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/ Practitioner/HSC organisation/SPPG on behalf of the DoH and both parties feel it would assist in the resolution of the complaint;
- where it is important, e.g. because of ongoing care issues, to maintain the relationship between the complainant and the Practice/Practitioner/HSC organisation/SPPG on behalf of the DoH; or
- when there are misunderstandings with relatives during the treatment of the patient.

2. All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each other's point of view and ask questions.

3. Where a complainant is considered unreasonable or abusive under the *Unacceptable Action Policy* (Annex 13 refers) then conciliation would NOT be an appropriate option.

4. 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. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve difficulties, for example, if there is a breakdown in the relationship between a doctor or practitioner and their patient.

5. Conciliation may be requested by the complainant, the Practice/Practitioner/HSC organisation/SPPG on behalf of the DoH. In FPS complaints it may be suggested by the SPPG Complaints Team.

FPS arrangements

6. The Practitioner/Practice/Pharmacy Manager (respondent) should approach the SPPG Complaints Team for advice.

7. Where a request for a conciliator is received the SPPG Complaints Team will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that conciliation would aid resolution then the SPPG Complaints Team will advise the FPS Practice/Practitioner. In some cases the SPPG Complaints Team may consider an alternative to conciliation, such as, an honest broker.

Agreement by parties involved

8. The FPS Practice/Practitioner/HSC organisation must contact the complainant and discuss the rationale for involving a conciliator and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. It is important that all parties involved are aware of the confidentiality clause attached to conciliation services. Once agreement is received, the HSC organisation or the SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

9. Where it has been agreed that the intervention of a conciliator is appropriate, the HSC organisation or SPPG Complaints Team (on behalf of FPS) should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand what conciliation involves;
- agreeing the timescales;
- agreeing when conciliation has ended; and
- explaining what happens when conciliation ends.

10. The conciliator must advise the Practice/Practitioner/ HSC organisation when conciliation has ceased and whether a resolution was reached. No further details should be provided. The Practice/Practitioner must then notify the SPPG Complaints Team of the outcome.

11. Using conciliation does not affect the right of a complainant to pursue their complaint further through the HSC organisation or the SPPG Complaints Team (for FPS) if they are not satisfied. Neither does it preclude the complainant from referring their complaint to the Ombudsman should they remain dissatisfied.

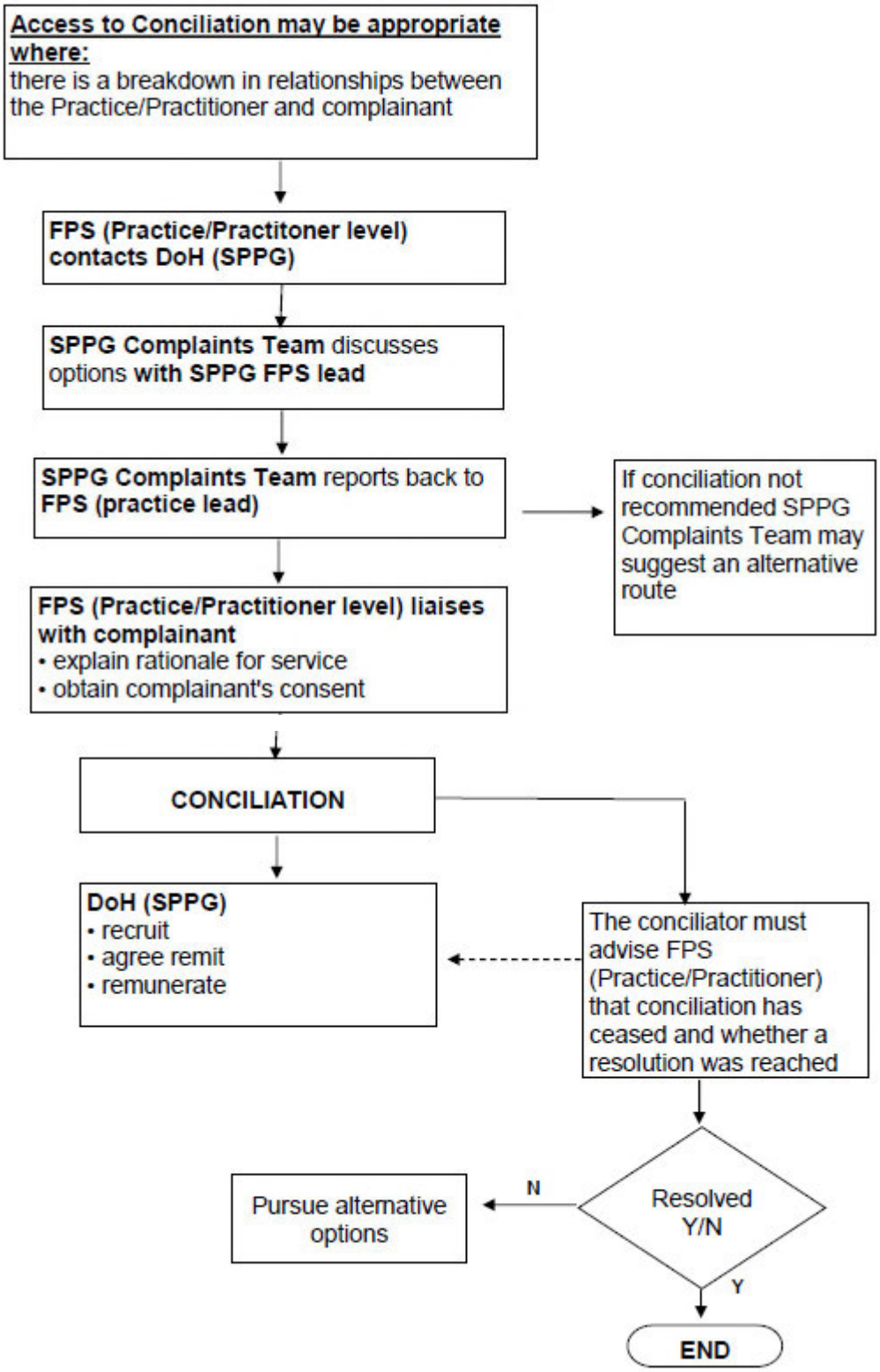
Appointment of conciliators

12. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate conciliation service. In addition it is responsible for all other arrangements, including remuneration.

Monitoring

13. The SPPG Complaints Team will monitor the effectiveness and usage of conciliation arrangements within HSC Trusts and FPS.

Conciliation – FPS



ANNEX 9: INDEPENDENT EXPERTS

1. The use of an Independent Expert in the resolution of a complaint may be requested by the complainant, the Practice/Practitioner/ HSC organisation. In FPS complaints it can also be suggested by the SPPG Complaints Team on behalf of the DoH. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at resolution. Input will not be required in every complaint but it 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; and
- to give an independent perspective on clinical issues.

FPS arrangements

2. The Practice/Practitioner should approach the SPPG Complaints Team for advice.

3. Where a request for an Independent Expert is received the SPPG Complaints Team **may** wish to liaise with the relevant FPS lead to consider the best way forward. Where it is considered that independent expert advice would aid resolution then the SPPG Complaints Team will advise the FPS practice. In some cases the SPPG Complaints Team may consider an alternative to an Independent Expert.

Agreement and consent

4. The FPS Practice/Practitioner/HSC organisation/SPPG Complaints Team must contact the complainant and discuss the rationale for involving an Independent Expert and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once agreement is received, the HSC organisation or the SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

5. The HSC organisation or SPPG Complaints Team may decide to involve an Independent Expert in a complaint without the complainant's consent, outside the complaints procedure, for the purposes of obtaining assurances regarding health and social care practice.

6. Where it has been agreed that an Independent Expert will be involved the Practice/Practitioner/HSC organisation/SPPG Complaints Team should clearly define the remit of the appointment for the purposes of:

- explaining and agreeing the issue(s) to be reviewed;
- ensuring all parties understand the focus of the issue(s);
- agreeing the timescales;
- agreeing to the provision of a final report; and
- explaining what happens when this process is complete.

7. The Independent Expert's findings/report will be forwarded to the Practice/Practitioner/HSC organisation/SPPG Complaints Team (if acting as contact point). A full report of the findings should be made available by the practice/pharmacy/HSC organisation to:

- the complainant; and
- the SPPG Complaints Team (for FPS only).

8. The letter of response to the complainant is the responsibility of the Practice/Practitioner/ HSC organisation.

Appointment of Independent Experts

9. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate Independent Expert. In addition, it is responsible for all other arrangements, including remuneration and indemnity.

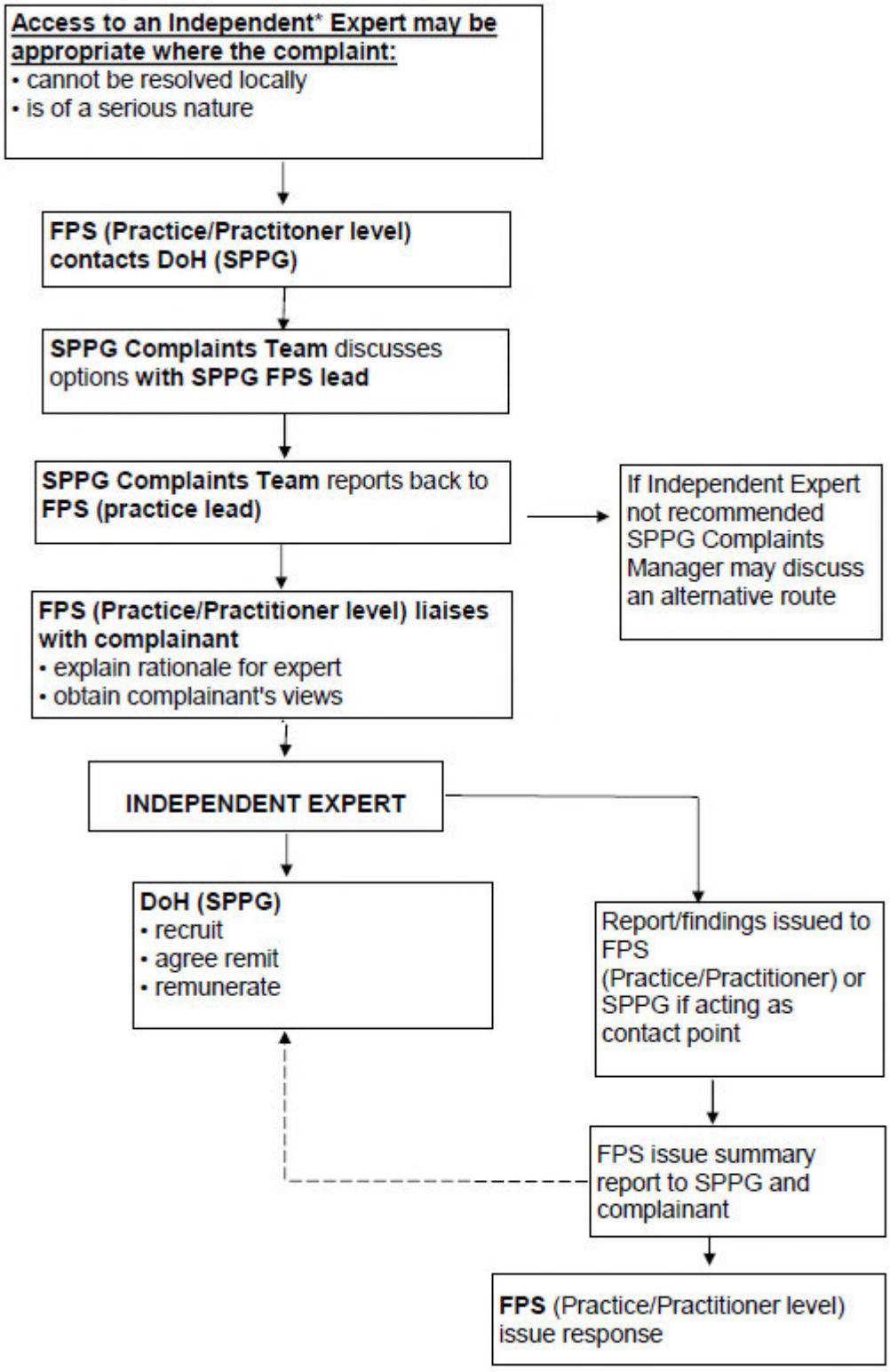
10. Independent Experts must be impartial, objective and independent of any parties to the complaint. Independent Experts should be recruited from another Local Commissioning group (LCG) area to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland).

Monitoring

11. The SPPG Complaints Team will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and FPS including the implementation of any recommendations in FPS.

12. A flowchart outlining the process for FPS is shown overleaf.

Independent Experts – FPS Access



*Definition of "Independent" = an Independent Expert must be recruited from another LCG area (and in certain circumstances outside Northern Ireland) and must have no connection with any of the parties to the complaint to avoid calling into question their objectivity and independence.

ANNEX 10: LAY PERSONS

1. Lay persons may be beneficial in providing an independent perspective of non-clinical/ technical issues within the local resolution process. Lay persons are NOT intended to act as advocates, conciliators or investigators. Neither do they act on behalf of the provider or the complainant. The lay persons involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. For example, the lay person could accompany the investigator during the investigation process where the complainant is considered unreasonable (Annex 13 refers).

2. Input from a lay person may be valuable to test key issues that are part of the complaint, such as:

- communication issues;
- quality of written documents;
- attitudes and relationships; and
- access arrangements (appointment systems).

3. It is essential that both the provider and the complainant have agreed to the involvement of a lay person.

4. Lay persons should have appropriate training in relation to the HSC complaints procedure and have the necessary independence and communication skills.

FPS arrangements

5. The Practice/Practitioner should approach the SPPG Complaints Team for advice.

6. Where a request for a lay person is received the SPPG Complaints Team **may** liaise with the relevant FPS lead to consider the best way forward. Where it is considered that a lay person's involvement would aid resolution then the SPPG Complaints Team will advise the FPS practice. In some cases the SPPG Complaints Team **may** consider an alternative to a lay person.

Agreement and consent

7. The FPS Practice/ Practitioner/ HSC Organisation/SPPG Complaints Team must contact the complainant and discuss the rationale for involving a lay person and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once received, the HSC organisation/SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

8. Where it has been agreed that a lay person will be involved the Practice/Practitioner/HSC Organisation/SPPG Complaints Team should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand the focus of the issue(s);
- ensuring all parties understand what lay person involvement means;
- agreeing the timescales;
- agreeing to the provision of a final report, and
- explaining what happens when this process is complete.

9. The layperson's findings/report will be forwarded to the Practice/Practitioner/HSC Organisation/SPPG Complaints Team. The full report will be made available by the Practice/ Practitioner/HSC Organisation/SPPG Complaints Team (for FPS only) and to the complainant.

10. The letter of response to the complainant is the responsibility of the Practice/Practitioner/HSC Organisation/SPPG Complaints Team.

Appointment of lay persons

11. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate lay person. In addition it is responsible for all other arrangements, including training, performance management and remuneration.

Monitoring

12. The SPPG Complaints Team will monitor the effectiveness and usage of lay person arrangements within HSC Trusts and FPS.

ANNEX 11: HONEST BROKER ROLE

1. "Honest broker" is the term used to describe the role of the SPPG Complaints Team in supporting and advising FPS on the handling of complaints. The complainant or the Practice/Practitioner can ask the SPPG Complaints Team to act in this role at any point in the complaints process. It is expected that the SPPG Complaints Team will not carry out the investigation but it is also expected that it will add value to the process by providing support and advice to FPS.

2. It is not an alternative to local resolution. Neither is it an opportunity for the SPPG Complaints Team to take over an investigation. Rather it is about facilitating communications and building relationships between the Practice/Practitioner and the complainant or reaching positions of understanding. The honest broker will act as an intermediary and is available to both, the complainant or Practice/Practitioner staff throughout the complaints process. For example, the honest broker may:

- provide advice to both the complainant and the Practice/Practitioner;
- act as a link between both parties and/ or negotiate with them; and
- facilitate and attend meetings between/with both parties together or separately.

3. Paragraphs 2.16 to 2.21 outline the options available to complainants when pursuing FPS complaints. This includes an option to lodge their complaint directly with the SPPG Complaints Team. Where the complainant contacts the SPPG Complaints Team the options available to resolve the complaint will be explained:

- that the complaint can be copied to the relevant practice/pharmacy for investigation, resolution and response; or
- that the SPPG Complaints Team can act as honest broker between the complainant and the Practice/Practitioner.

4. FPS co-operation in complaints of this type is essential for the role of honest broker to effectively assist in the successful local resolution of complaints. FPS will be asked for their agreement should the complainant prefer the SPPG Complaints Team's involvement.

5. Where the SPPG Complaints Team has been asked to act as honest broker they will:

- act as intermediary between the complainant and the practice/ pharmacy;
- make arrangements for independent expert advice, conciliation, lay person assistance, where appropriate;
- provide advice to the complainant and the Practice/Practitioner on target timescales[28]; and
- where there is a delay, ensure the complainant is advised as set out in paragraph 3.39.

6. Whichever process is used it is important to note that the Practice/Practitioner are responsible for the investigation and the response. The SPPG Complaints Team, however, must ensure that:

- a written response is provided by the Practice/Practitioner to the complainant and any other person subject to the complaint (whether this is direct from the Practice/Practitioner or from the SPPG Complaints Team after receiving a report from the Practice/Practitioner;
- the response is of sufficient quality and addresses the complainant's concerns;
- the written response is provided within target timescales and where this is not possible that the complainant is informed; and
- the response notifies the complainant of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure.

7. The complainant may contact the SPPG Complaints Team for further advice and support.

[28] For 'honest broker' this is 20 working days from receipt of the complaint: for FPS, this is 10 working days from receipt of the complaint.

ANNEX 12: ADULT SAFEGUARDING

Definition of vulnerable adult

1. The regional policy 'Adult Safeguarding – Prevention and Protection in Partnership' defines the terms 'adult at risk of harm' and 'adult in need of protection[29]'.

2. The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.

3. An 'adult at risk of harm' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain.

Life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

[29] 'Adult Safeguarding – Prevention and Protection in Partnership' (July 2015) (https://www.health-ni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership-key-documents), p10

4. An '**adult in need of protection**' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

AND

c) who is **unable to protect** their own well-being, property, assets, rights or other interests;

AND

d) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed.

5. In order to meet the definition of an 'adult in need of protection' either (a) or (b) must be present, in addition to both elements (c), and (d).

6. The decision as to whether the definition of an 'adult in need of protection' is met will demand the careful exercise of professional judgement applied on a case by case basis. This will take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

Reportable offences and allegations of abuse

7. Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk then the regional *'Adult Safeguarding Operational Procedures' (September 2016)* and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases' (August 2016)* should be activated (see paragraph 1.26).

ANNEX 13: UNREASONABLE OR ABUSIVE COMPLAINANTS

1. HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

2. In determining arrangements for handling such complainants, staff need to:

- ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- appreciate that even habitual complainants may have grievances which contain some substance;
- ensure a fair approach; and
- be able to identify the stage at which a complainant has become habitual.

3. The following *Unacceptable Actions Policy*[30] should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

Unacceptable Actions Policy

4. People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is forceful or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, we do consider actions that result in unreasonable demands on the HSC organisation or unreasonable behaviour towards HSC staff to be unacceptable. It is these actions that HSC organisations aim to manage under this policy.

[30] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman-Updated 18 January 2017

Aggressive or abusive behaviour

5. HSC organisations understand that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards HSC staff, it will consider that unacceptable. Any violence or abuse towards staff will not be accepted.

6. Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations will judge each situation individually and appreciate individuals who come may be upset. Language which is designed to insult or degrade, is racist, sexist or homophobic or which makes serious allegations that individuals have committed criminal, corrupt or perverse conduct without any evidence is unacceptable. HSC organisations may decide that comments aimed at third parties are unacceptable because of the effect that listening or reading them may have on staff. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

7. HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and staff should refer to the Zero Tolerance campaign launched in 2007 to clarify the HSC position in relation to attacks on the workforce. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

Unreasonable demands

8. HSC organisations consider these demands become unacceptable when they start to (or when complying with the demand would) impact substantially on the work of the organisation.

9. Examples of actions grouped under this heading include:

- repeatedly demanding responses within an unreasonable timescale;
- insisting on seeing or speaking to a particular member of staff when that is not possible; and
- repeatedly changing the substance of a complaint or raising unrelated concerns.

10. An example of such impact would be that the demand takes up an excessive amount of staff time and in so doing disadvantages other complainants.

Unreasonable levels of contact

11. Sometimes the volume and duration of contact made to the HSC organisation by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when a complainant repeatedly makes long telephone calls to the organisation or inundates the organisation with copies of information that has been sent already or that is irrelevant to the complaint.

12. The HSC organisation considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone, or dealing with emails or written correspondence impacts on its ability to deal with that complaint, or with other people's complaints.

Unreasonable use of the complaints process

13. Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about an organisation with which they have a continuing relationship, if subsequent incidents occur.

14. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the organisation from pursuing a legitimate aim or implementing a legitimate decision. The HSC organisation considers access to a complaints system to be important and it will only be in exceptional circumstances that

it would consider such repeated use is unacceptable, however it reserves the right to do so in those exceptional circumstances.

Unreasonable refusal to co-operate

15. When the HSC organisation is looking at a complaint, it will need to ask the individual who has complained to work with them. This can include agreeing with the HSC organisation the complaint it will look at; providing it with further information, evidence or comments on request; or the individual summarising the concerns or completing a form for the HSC organisation.

16. Sometimes, an individual repeatedly refuses to cooperate and this makes it difficult for the HSC organisation to proceed. The HSC organisation will always seek to assist someone if they have a specific, genuine difficulty complying with a request. However, the HSC organisation consider it is unreasonable to bring a complaint to it and then not respond to reasonable requests.

Examples of how the HSC manage aggressive or abusive behaviour

17. The threat or use of physical violence, verbal abuse or harassment towards HSC staff is likely to result in a termination of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

18. HSC organisations will not accept any correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. The HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful and ask them to stop using such language. It will state that it will not respond to their correspondence if the action or behaviour continues.

19. HSC staff will end telephone calls if they consider the caller aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that their behaviour is unacceptable and end the call if the behaviour persists. In extreme situations, the HSC organisation will tell the complainant in writing that their name is on a “no personal contact” list. This means that it will limit contact with them to either written communication or through a third party.

Examples of how the HSC deal with other categories of unreasonable behaviour

20. The HSC organisation has to take action when unreasonable behaviour impairs the functioning of its office. It aims to do this in a way that allows a complainant to progress through its process. It will try to ensure that any action it takes is the minimum required to solve the problem, taking into account relevant personal circumstances including the seriousness of the complaint and the needs of the individual.

21. Where a complainant repeatedly phones, visits the organisation, raises issues repeatedly, or sends large numbers of documents where their relevance is not clear, the HSC organisation may decide to:

- limit contact to telephone calls from the complainant at set times on set days;
- restrict contact to a nominated member of staff who will deal with the future calls or correspondence from the complainant;
- see the complainant by appointment only;
- restrict contact from the complainant to writing only;
- return any documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed; and
- take any other action that the HSC organisation considers appropriate.

22. Where the HSC organisation considers correspondence on a wide range of issues to be excessive, it may tell the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly.

23. In exceptional cases, the HSC organisation will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further.

24. The HSC organisation will always tell the complainant what action it is taking and why.

The process the HSC follows to make decisions about unreasonable behaviour

25. HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff. Wherever possible, the HSC organisation will give the complainant the opportunity to change their behaviour or action before a decision is taken.

How the HSC lets people know it has made this decision

26. When a HSC member of staff makes an immediate decision in response to aggressive or abusive behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing[28] why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

The process for appealing a decision to restrict contact

27. It is important that a decision can be reconsidered. A complainant can appeal a decision to restrict contact. If they do this, the HSC organisation will only consider arguments that relate to the restriction and not to either the complaint made to the organisation or its decision to close a complaint. An appeal could include, for example, a complainant saying that: their actions were wrongly identified as unacceptable, the restrictions were disproportionate; or that they will adversely impact on the individual because of personal circumstances.

28. A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They

must advise the complainant in writing[31] that either the restricted contact arrangements still apply or a different course of action has been agreed.

How the HSC record and review a decision to restrict contact

29. The HSC organisation records all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact as described above, may be reconsidered if the complainant demonstrates a more acceptable approach. A member of the Senior Management Team reviews the status of all complainants with restricted contact arrangements on a regular basis.

[31] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman-Updated 18 January 2017

ANNEX 14: CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Under the Children (NI) Order 1995[32] (the Order) HSC Trusts are statutorily required to establish a procedure for considering:

- any representations (including any complaint) made to it about the discharge of its functions under Part IV of, and paragraph 4 of Schedule 5 to, the Order, and
- matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
- those personal social services to children provided under the Adoption Order (NI) 1987[33].

2. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996[34].

3. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4 (a flowchart to aid decision making is attached).

4. The HSC Trusts should familiarise themselves with these requirements.

[32] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[33] Adoption Order (NI) 1987: http://www.legislation.gov.uk/nisi/1987/2203/contents
[34] Representations Procedure (Children) Regulations (NI) 1996: http://www.legislation.gov.uk/nisr/1996/451/contents/made

CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

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1. Complaint: Does it fit the definition of a Children Order complaint as below?

"…Any representation (including any complaint) made to the Trust … about the discharge of any of its functions under Part IV of the Order in relation to the child."
(Children (NI) Order 1995, Article 45(3))

OR

"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and para 6 of Schedule 5 to, the Children Order."
(Guidance & Regulations – Vol. 4, Para 12.5 – DHSS)

If **YES** to **EITHER** of above

If **NO** to **EITHER** of above → Progress via HSC Complaints Procedure

↓

2. Does it meet the criteria of what may be complained about under Children Order?

"… about Trust support for families and their children under Part IV of the Order."
(Vol. 4, Para 12.8)

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.

If **YES** to **ANY** of above

If **NO** to **ALL** of above → Progress via HSC Complaints Procedure

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3. <u>Complainant</u>: Does he/she fit the definition of a Children Order complainant?

a. **Any child** who is being looked after by the Trust;

b. **Any child** who is not being looked after by the Trust, but is in need;

c. A parent **of his**;

d. Any person who is not a parent of his but who has **parental responsibility for him**;

e. Any Trust foster parent;

f. Such other person as the Trust considers has a sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

- the person who had the day to day care of the child within the past two years;
- the child's Guardian ad Litem;
- the person is a relative of the child (as defined by Children Order, Article 2(2));
- The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
- a friend;
- a teacher;
- a general practitioner.
  (Children (NI) Order 1995 Article 45(3))

If **<u>YES</u>** to **ANY** of above → **Progress via Children Order Procedure**

If **<u>NO</u>** to **ALL** of above → Progress via HSC Complaints Procedure

<u>NB</u>: In order for a complaint to be eligible to be considered under the Children Order Procedure, the answer to 1 <u>and</u> 2 <u>and</u> 3 MUST all be YES.

Consent: *The (Trust) should always check with the child (subject to his understanding) that a complaint submitted reflects his views and that he wishes the person submitting the complaint to act on his behalf.* (Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered).

Definitions of Key Terms

Throughout the standards and guidelines the following terms have the meanings set out below:

Complaint	"an expression of dissatisfaction that requires a response"
Complainant	an existing or former patient, client, resident, family, representative or carer (or whoever has raised the complaint)
Chief Executive	the Chief Executive of the HSC organisation
Complaints Manager	the person nominated by an HSC organisation to handle complaints
DoH[35]	Department of Health in Northern Ireland
Family Practitioner Service (FPS)	family doctors, dentists, pharmacists and opticians
Honest Broker	this is the term used to describe the role of the SPPG on behalf of DoH in FPS complaints
HSC Organisation	an organisation which commissions or provides health and social care services and for the purpose of this guidance includes HSC Trusts, the Northern Ireland Ambulance Service (NIAS), the Business Services Organisation (BSO), the Public Health Agency (PHA), Family Practitioner Services (FPS), Out-of-Hours Services, and pilot scheme providers
Local Resolution	the resolution of a complaint by the organisation, working closely with the service user

[35] Formally the Department for Health, Social Services and Public Safety (DHSSPS)

NIBTS	Northern Ireland Blood Transfusion Service
NIPSO	Northern Ireland Public Services Ombudsman (NIPSO, known as 'the Ombudsman')
Out of-Hours services	refers to immediate necessary treatment provided by FPS 6.00 pm to 8.00 am Monday – Friday, weekends and local holidays
PCC	Patient and Client Council
Pilot Scheme	a small-scale experiment or set of observations undertaken to decide how and whether to launch a full-scale project (refers to personal dental services provided by an HSC Trust in this case)
Pilot Scheme Complaints Procedure	is a complaints procedure established by the pilot scheme
Practice based complaints procedure	is an FPS complaints procedure established within the terms of the relevant regulations
Registered Provider	person carrying on or managing the establishment or agency
RQIA	Regulation, Quality and Improvement Authority which is the organisation responsible for regulating, inspecting and monitoring the standard and quality of health and social care services provision by independent and statutory bodies in Northern Ireland
Registered Establishments and Agencies	for example, residential care homes, nursing homes, children's homes, nursing agencies, independent clinics/hospitals, etc. registered with and regulated by the RQIA
Regulated Sector	refers to registered establishments and agencies

Senior Person	means the person designated to take responsibility for delivering the organisation's complaints process e.g. a Director in the HSC Trust
Service User	means a patient, client, resident, carer, visitor or any other person accessing HSC services
Special Agency	For example the NI Blood Transfusion Service (NIBTS)
SPPG	Strategic Planning and Performance Group, DoH (formerly HSC Board)

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA

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

Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
Tel: [redacted]
Fax: [redacted]
Email: private.office@dhsspsni.gov.uk

For Action:

Chief Executives of HSC Bodies[1];
Chief Fire Officer

For information:

Director of Human Resources of each body

Our Ref: SUB/325/2012

22 March 2012

Dear Colleague

Please bring the content of this letter to the attention of all your employees, and make available with it your whistleblowing policy.

MESSAGE FROM EDWIN POOTS

YOUR RIGHT TO WHISTLE BLOW

1. I am committed to the highest possible standards of conduct, openness, honesty and accountability in our Services. In line with that commitment I expect staff to act on any genuine concerns they might have about any aspect of an organisation's work or colleagues, in the knowledge that such action has support from the highest level. I want every member of staff to be very confident that managers at all levels will respond positively to expressions of concern, and that, should it be necessary, you will be protected from victimisation if you make a genuine concern known under the whistleblowing arrangements.

You have the right to be heard by management if you have concerns about any ethical or safety issue, and a responsibility to speak up

2. The first kind of action that is appropriate is to speak up within your team or to the appropriate manager. The principles of clinical and social care governance empower all staff to speak up if they see or become aware of practice which is unsafe or which creates unacceptable risks to patients or clients.

[1] The Health and Social Care Board, HSC Trusts, the Public Health Agency, the Business Services Organisation, the Northern Ireland Blood Transfusion Service Agency, the Northern Ireland Guardian ad Litem Agency, the Northern Ireland Practice & Education Council for Nursing, Midwifery & Health Visiting (NIPEC), the Northern Ireland Social Care Council (NISCC), the Patient & Client Council, the Northern Ireland Regulation and Quality Improvement Authority and the Northern Ireland Medical and Dental Training Agency (NIMDTA)

It is the responsibility of any member of staff who is challenged on that basis to give proper consideration to the points being made by any colleague.
Similar principles should apply in all the other aspects of our services away from the clinical or social care front line. Managers and leaders at all levels are responsible for creating and sustaining an atmosphere of mutual support, mutual learning, and conduct based on the priority of the quality and safety of services and the health, well-being and dignity of the patients, clients, family members and carers whom we all serve. By far the most important concern for me, and for all who lead and manage HSC organisations, all DHSSPS' Arms Length Bodies and the Department itself, is to ensure that we provide the best possible services to patients, clients, and the wider public, and I am sure you share that commitment.

If speaking up is a problem, whistleblowing is both your right and your duty

3. If you have any concern that speaking up in good faith in the way I have described would lead to a problem, there are statutory procedures that protect you if you chose to blow the whistle and draw attention to something that is a cause for concern. All HSC staff have a moral duty to pass on any concerns to someone who can deal with it. I should therefore personally encourage you to speak up where you have genuine concerns about issues such as patient safety or possible malpractice in your workplace and reassure you that genuine concerns will be resolved quickly and effectively.

4. There is a common misconception that whistle blowing is solely fraud related. In effect whistle blowing can be wide ranging covering issues around health and safety e.g. unsafe products or working conditions.

5. Whistle blowing refers to "making a disclosure in the public interest" and it means that concerns relating to unlawful conduct, financial malpractice, dangers to the public or the environment, or actions otherwise contrary to the public interest can be reported in the workplace following the correct procedures and protecting employment rights. There should be an established whistle blowing policy and procedure within your organisation which should be followed for reporting your concerns.

6. I fully recognise that the decision to report a concern can be a difficult one to make. However, if what you are saying is true, you should have nothing to fear because you will be doing your duty to your employer and those for whom you provide a service.

7. I will not tolerate any harassment or victimisation (including informal pressures) and will take appropriate action to protect you when you raise a concern in good faith. If you report concerns reasonably and in good faith you are also formally protected against victimisation under The Public Interest Disclosure (Northern Ireland) Order 1998 (revised 2004).

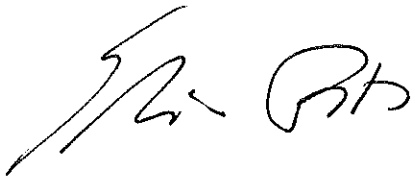
8. Your organisation's whistleblowing policy sets out how to go about expressing a concern both internally and, should it be necessary, outside line management. Each organisation's policy should make it clear that ultimately, you have the right to direct your concern to me.

Confidentiality of personal information about patients, families and members of staff must be protected

9. If you need to make a disclosure in the public interest it is important to be mindful of the need to avoid a breach of the privacy and confidentiality of personal information. It is wrong to give details of the condition or treatment of any patient or client without their explicit consent. Also, personnel records are protected by Data Protection legislation, and there are procedures for investigation and accountability of all staff in the HSC, in ALBs or within DHSSPS as part of the NI Civil Service, which should not be prejudiced or undermined by public or any other inappropriate disclosures of information. There are independent watchdog organisations, including the Northern Ireland Audit Office and the Regulation and Quality Improvement Authority which have specific duties to investigate confidential disclosure while protecting the person making the disclosure. The Patient and Client Council exists to act in the interests of patients and clients and to help with complaints. Where the duty to protect personal information is broken, it is sometimes necessary to investigate, however, any such investigation process should create no difficulty and hold no fear for anyone acting to disclose legitimate concerns in the public interest, as described above.

Conclusion

10. Finally, I would like to encourage you to feel confident in raising concerns and to question and act upon genuine concerns that you may have in relation to your workplace. This is a vital element of good public service based on the values and principles that are at the heart of Health and Social Care and all the related organisations.



Edwin Poots MLA
Minister for Health Social Services and Public Safety